BUILDING BRIDGES 2

A Pathway to Cultural Safety, Relational Practice and Social Inclusion

SCHEDULES “A” to “E” TO MAIN REPORT

November, 2010

Native Mental Health Association of Canada

Mood Disorders Society of Canada
La Société Pour **Les Troubles de L’Humeur** du Canada

Schedule A: Supporting the Mental Wellness of First Nations, Inuit and Métis Peoples in Canada: Cultural Safety
A Research Discussion Paper

Schedule B: Belonging: Social exclusion, social inclusion, personal safety and the experience of mental illness

Schedule C: Western Canada Focus Groups Holding Hope in Our Hearts: Relational Practice and Ethical Engagement In Mental Health and Addictions. Background Paper

Schedule D: Cultural Safety Project: Eastern Canada Focus Group Report

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SCHEDULE “A”

Supporting the Mental Wellness of First Nations, Inuit and Métis Peoples in Canada: Cultural Safety

A Research Discussion Paper

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Under the *Canadian Constitution Act*, 1982, the term Aboriginal Peoples refers to First Nations, Inuit and Métis people living in Canada. However, common use of the term is not always inclusive of all three distinct people and much of the available research only focuses on particular segments of the Aboriginal population.

SUPPORTING THE MENTAL WELLNESS OF FIRST NATIONS, INUIT AND MÉTIS PEOPLES IN CANADA: CULTURAL SAFETY

A RESEARCH DISCUSSION PAPER

Prepared for the Native Mental Health Association of Canada and the Mood Disorders Society of Canada

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Section 1.0: Introduction

1.1 Background

In an effort aimed at modifying the status quo and ensuring that the Canadian mental health and addictions systems respond appropriately to the needs of First Nations, Inuit and Métis and other mental health and addictions consumers and their caregivers, the Native Mental Health Association of Canada (NMHAC) and the Mood Disorders Society of Canada (MDSC) have launched *Building Bridges II: A Pathway to Cultural Safety* project. In keeping with their initial Building Bridges Project (2008/2009), both the NMHAC and the MDSC engaged in dialogue with their respective First Nations, Inuit and Métis communities and provincial Mood Disorders Associations and other provincial and local consumer networks regarding the notion of cultural safety and attendant practices that support mental health and well-being.

The two national NGOs are collectively developing a comprehensive planning framework on cultural safety which will enhance the ability of healthcare providers and others to deal more effectively with major structural and relational issues and barriers facing indigenous and non-indigenous communities.

As part of this landmark partnership for improving mental health in Canada, the NMHAC and MDSC commissioned this paper to research and analyze cultural safety and cultural competence as tools to deal with identified inequities in health, education and social services. The two organizations wish to develop a national framework for ensuring culturally and linguistically competent and safe mental health and addictions services for indigenous and non-indigenous mental health and addictions consumers.

The Native Mental Health Association of Canada and the Mood Disorders Society of Canada have a rich history of working collaboratively and sharing their respective expertise in regard to “what works” and “what does not work” in mental health and addictions programs and services. Groundbreaking national initiatives comparing and contrasting similarities and differences between their indigenous and non-indigenous constituents, along with finding common ground and identifying goals for future collaboration, serve as the pillars of this unique and effective partnership in Canada.

The purpose of this report is to provide an overview of current conditions and possibilities re: culturally safe and competent mental health and addictions services for First Nations, Inuit and Métis in Canada. First, we provide a brief introduction to key definitions used in this paper and to the concepts of cultural safety and cultural competence. Secondly, we provide a brief overview of the mental health and well-being of First Nations, Inuit and Métis in Canada in the context of colonial and neo-colonial processes and polices in which mental health and addiction services have been and continue to be provided to First Nations, Inuit and Métis, i.e., why the need for cultural safety. Then we move on to highlight the possibilities, i.e., how cultural safety could be used to create a space for critical reflection and dialogue within the mental health and addictions systems, a dialogue that would lead to action, improved mental well-being for all Aboriginal peoples and health equity for all people in Canada. Lastly, we engage with the concept of cultural safety as a means to support *social justice* and the mental well-being of First Nations, Inuit and Métis in Canada.

The goal of this paper is not to provide an exhaustive review of the available data, rather it is to highlight knowledge from various sources that provides insights into the topic of this report.

1.2 Key Definitions

Several key definitions are provided to ensure that the reader is clear about the way we are using various terms in this report. In much the same way as we have used the terms referring to *Aboriginal peoples* in prior literature (e.g., Browne, 2003; Browne, MacDonald & Elliott, 2009; Smye, 2004), we use these designations as consistent with the terminology used by the Royal Commission on Aboriginal Peoples (1996a). The term Aboriginal peoples refers generally to the Indigenous inhabitants of Canada, including First Nations, Inuit and Métis peoples without regard to their separate origins and identities. The Royal Commission stresses that the term Aboriginal people "refers to organic political and cultural entities that stem historically form the original peoples of North America, rather than collections of individuals united by so called 'racial' characteristics. The term includes the Indian, Inuit and Métis peoples of Canada (see section 35(2) of the Constitution Act, 1982)" (p. xii). Specifically, the term "First Nation" replaces the term "Indian" and "Inuit" replaces the term "Eskimo". The terms Indian and Eskimo, however, continue to be used in federal legislation and policy, for example, the Indian Act, and in government reports and statistical data, particularly those generated by the federal department of Indian and Northern Affairs Canada (INAC). INAC retains the terms "status" or "registered Indian" to refer to people who have been registered by INAC as members of a First Nations under the terms of the Indian Act. In this report, the term "Aboriginal peoples" is used to refer generally to the diverse groups of indigenous peoples within Canada. When distinctions between Aboriginal groups are needed, specific nomenclature is used.

We use the notion of mental wellness in keeping with the perspectives of the First Nations & Inuit Mental Wellness Advisory Committee (MWAC). After reviewing the Mental Wellness Framework (2002), and the National Native Alcohol and Drug Abuse Program (NNADAP) Renewal Framework (2000) [1] and to honour principles of wholism, connectedness, togetherness, cultural ways of knowing and core cultural institutions such as the family and community, the following definition of 'mental wellness' was chosen by MWAC (2007):

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[1] *These frameworks resulted from collaborative processes with key stakeholders, received a high degree of support from First Nations and Inuit communities, and set mental health and addictions within the context of the broad determinants of health (MWAC, 2007).*

> *Mental wellness is a lifelong journey to achieve wellness and balance of body, mind and spirit. Mental wellness includes self-esteem, personal dignity, cultural identity and connectedness in the presence of a harmonious physical, emotional, mental and spiritual wellness. Mental wellness must be defined in terms of the values and beliefs of Inuit and First Nations people*
> (Mental Wellness Framework, 2002, as cited in MWAC, 2007, p. 25).

In the same vein, an Inuit-specific Mental Wellness Action Plan was developed and the following definition used:

> *Mental wellness is defined as self-esteem and personal dignity flowing from the presence of harmonious physical, emotional, mental, spiritual wellness and cultural identity*
> (Inuit Specific Mental Wellness Framework, 2001,
> as cited in MWAC, 2007, p. 40).

According to the MWAC, 'mental wellness' is inclusive of "mental health, mental illness, suicide prevention, violence reduction, and reduction of substance abuse and addictions" – all components that contribute to a balanced life. It involves a holistic approach that brings together: i) Prevention and promotion; ii) Treatment, intervention and aftercare; and iii) Traditional knowledge and practices (p. 41).

1.3 Cultural Safety and Cultural Competence: A Critical Cultural Perspective

In this report, we examine the possibilities and challenges attached to the use of the concepts of cultural safety and cultural competence to support the mental health and wellbeing of Aboriginal peoples in Canada; this in response to i) colonizing processes that continue to privilege dominant culture perspectives in the construction of the mental health and addictions services, e.g., Aboriginal people tend to not use mainstream health care services, present at advanced stages of disease progression, show "non-compliance" and often drop out before the end of treatment; and ii) a recognition of the limitations of 'culturalist' [2] approaches in response to these issues (Browne & Fiske, 2001; McCormick, 1996; 1998; McGrath & Phillips, 2008; Nguyen, 2008; O'Neil, 1993a, 1993b; Smye & Mussell, 2001; Wilson, 2008). In our view, cultural safety has particular relevance because it draws attention to the issues embedded within the social, historical and political context of mental health and addictions care delivery – it is intended to shift attention from the 'culture' of the 'Other' to the culture of [mental] health care and structural inequities and draw attention to and address the power relations that shape

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[2] *Culturalism refers to the process of viewing people through the lens of culture, defined narrowly as shared values, beliefs and practices (Browne et al., 2009b). In the case of Aboriginal people, 'culture' thus defined operates as the primary explanation for why groups experience various health, social or economic problems such as, for example, poverty, substance use, low birth weight. This is problematic because the issues of social determinants of health, or the root causes of mental health and addictions, are viewed as necessarily linked to peoples' culture, when in fact, they are part of the colonial history of Canada, and ongoing inequitable social relations.*

[mental] health [and addictions] services and health (Anderson et al., 2003; Browne, 2005, 2007; Browne & Smye, 2002; Browne & Varcoe, 2006; Hartrick Doane & Varcoe, 2005; Smye, 2004; Smye & Browne, 2002; Smye, Willis & Rameka, 2006).

Increasingly, 'culture' is used in health care (and more widely) to explain difference in ways that overlook structural inequities and imply inferiority (Reimer Kirkham & Anderson, 2002). "Common applications of the construct of culture may draw on historical and colonial notions of race and in so doing, reinforce longstanding patterns of domination and inequities" (Reimer Kirkham & Anderson, p. 5). For example, higher rates of suicide and substance use are explained as "cultural" problems of particular groups, rather than as consequences of systematic inequities and discrimination. In these "culturalist" explanations, *race* often operates in tandem with *culture* as a silent subtext (Reimer Kirkham & Anderson, p. 5). More insidiously, conflating culture with racialized [3] characteristics, masks discrimination and inequity with more neutral terminology (Browne, 2007; Goldberg, 1993) and the perceived "inferiority" of the *Other* becomes normalized and naturalized[4] (McConaghy, 2000). Drawing on Anderson and Reimer Kirkham (1999), one of the definitions that we continue to turn to defines culture as:

> *located within a constantly shifting network of meanings enmeshed within historical, social, economic and political relationships and processes. It is not therefore reduced to an easily identifiable set of characteristics, nor is it a politically neutral concept (p. 63).*

Culture is dynamic, it is a relational concept.

Recently, a discussion of *relational* approaches has been growing in the nursing and the other health care literature. This approach recognizes that peoples' experiences, including health and illness experiences, are shaped by the contextual features of their lives – social, historical, political, cultural, and geographic, as well as by other factors such as age, gender, class, ability, biology and so on (Hartrick Doane & Varcoe, 2005, 2007, 2008). Relational approaches refer to more than respectful, supportive, caring and compassionate relationships etc.; although interpersonal connections are a central feature of excellent relational practice, this view takes

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[3] *Racialization refers to ways that people are labelled according to particular physical characteristics or arbitrary ethnic or so-called "racial" categories, and then dealt with in accordance with beliefs related to those labels (Agnew, 1998; Ahmad, 1993, p. 18, 19). For example, racialization occurs when health care professionals erroneously assume that alcoholism is somehow a "genetic" feature among Aboriginal people.*

[4] *Generally, cultural sensitivity is the practice of being sensitive to the values, beliefs, and practices of all people—a sensitivity that requires a recognition of difference and active engagement to provide care in keeping with that recognition (Smye, in press). However, because cultural sensitivity is most often tied to a notion of 'culture' as individual or group values, beliefs, and practices, it fails to address social and structural factors that shape well-being, health and health care (Hartrick Doane & Varcoe, 2005, p. 310). Culturally sensitive approaches run the risk of generating a cookbook response to cultural differences, which can do more harm than good; for example, practitioners learn about the values, beliefs, and practices of "others," such as "Muslim" values," "Aboriginal beliefs," or "Chinese practices" (Smye, in press). – there is a danger that assumptions, stereotypes and generalizations about the "cultural other," that are often based on race, class, gender, sexual orientation, ability, religion, age, and so on, will be perpetuated (Hartrick Doane & Varcoe, p. 310; as cited in Smye, in press).*

into account "how capacities and socioenvironmental limitations" influence health and well-being, the illness experience, decision-making and the ways in which people manage their experiences (Browne, Hartrick Doane, Reimer, MacLeod & McLellan, 2010). Thinking critically about how culture is being discussed and integrated into mental health and addictions services is particularly warranted given the tendency in health care for culture to be used in ways that run the risk of masking social and structural inequities that influence well-being, health and health care and illness and other experiences. In our view, the concept of cultural safety holds promise in this regard because it can orient mental health providers and planners, and funders of mental health and addictions services toward *relational* understandings of culture, and culturally meaningful services and programs.

In the late 1980s, the concept of cultural safety emerged out of concern with structural inequities by Maori nurse educators and leaders within Aotearoa/New Zealand (Anderson et al., 2003; National Aboriginal Health Organization (NAHO), 2008; Papps & Ramsden, 1996; Ramsden, 1990; 2000); in this context, cultural safety was used to foster an understanding of the relationship between minority status and health status as a means of changing health professionals' attitudes from those that continued to support current dominant practices and systems of health care to those that would be more supportive of the health of Indigenous and minority groups (NAHO; Polashek, 1998; Ramsden, 1993, 2000; Wepa, 2005).

In a Canadian context, in keeping with its roots, several researchers have taken up the concept of cultural safety as a critical lens to examine unequal power relations and the social and historical processes that organize these relationships (e.g., Browne et al.,2009; Smye & Browne, 2002;Walker, 2009). The notion of *culture* in cultural safety is used to address the *relational* aspect of Aboriginal peoples' lives, i.e., among people and between people and their contexts, including the broader social, historical and political realities that shape health care experiences of Aboriginal people. The notion of *safety* assists us to focus on risk and benefit – e.g., we might ask, 'Do strategies and interventions aimed at supporting Aboriginal people to address mental health and addictions issues fit with the unique experiences of Aboriginal people?'; and/or Are Aboriginal people who enter mental health and addictions services effective and safe in those settings given the realities of Aboriginal their everyday lives?'; and/or 'Will the individual and/or family qualify for housing supports given their Aboriginal status?'

In Aotearoa/New Zealand, cultural safety was designed to draw attention to the power imbalances between Maori and the dominant health care culture, which historically disregarded the illness and health belief systems of Maori and instead privileged those of the Pakeha or White culture (Ramsden, 1990; Ramsden, 1992; Ramsden, 1993). Under the premise that cultural safety in clinical practice would improve health outcomes for Maori, the Nursing Council of New Zealand formally adopted cultural safety into nursing curricula and state examinations for nurses and midwives in 1992 (Nursing Council of New Zealand, 2005). Since then, cultural safety has continued to be a powerful nursing concept (Wepa, 2003; 2005) but scholarly contributions from other fields, such as medicine (e.g., Crampton, Dowell, Parkin, & Thompson, 2003; Indigenous Physicians Association of Canada (IPAC) & The Association of

Faculties of Medicine of Canada (AFMC), 2009; Kearns, 1997; Nguyen, 2008), occupational therapy (e.g., Gray & McPherson, 2005; Jeffery, 2005; Nelson, 2007), physiotherapy (e.g., Haswell, 2002; Main, McCallin, & Smith, 2006), social work (e.g., Fulcher, 2001; Fulcher, 2002) and pharmacy (e.g., Stoneman & Taylor, 2007), show that cultural safety has permeated a spectrum of health and social disciplines in many parts of the world.

Although cultural safety as originally conceptualized by Ramsden (1990) is based on the notion of biculturalism (Maori and non-Maori), several authors convincingly assert that the concept of cultural safety also retains significance for multicultural contexts given that the experience and effects of colonization on health transcend geographical and political boundaries (e.g., Anderson et al., 2003; Reimer Kirkham, Smye, Tang et al., 2002). Other scholars have explored its applicability to the health care contexts in the United States (e.g., McCubbin, 2006) and the United Kingdom (e.g., Cortis, 2008; De & Richardson, 2008; Hart, Hall, & Henwood, 2003). However, the majority of international scholarly contributions originate from Australia and Canada. In contrast, within Canada, cultural safety has been taken up in various ways in health discourses affirming the transportability of cultural safety to a multicultural policy context. However, while cultural safety has been applied across diverse populations and social groups (Anderson et al., 2003; Baker, 2007; Ogilvie, Burgess-Pinto, & Caufield, 2008), the primary focus in Canada has been on cultural safety in relation to Aboriginal health care (Barkwell, 2000; Browne & Smye, 2002; Browne & Varcoe, 2006; Browne, 2003; Dion Stout & Downey, 2006; Jensen-Ross, 2006; MacLeod, Browne, & Leipert, 1998; Smye, 2004; Smye & Browne, 2002; Smye et al., 2006;).

Advocacy for the implementation of cultural safety into health education and clinical practice reaches from national Aboriginal health and political organizations to professional associations to government. For example, both the Assembly of First Nations (AFN) and the NAHO officially endorse the practice of cultural safety by health care professionals as a means to improve the health status of First Nations, Inuit and Métis (AFN; NAHO, 2008). In addition, Canada has undertaken several critical steps toward moving cultural safety into education. In 2008, NAHO released a guide for health care administrators, providers and educators, which provides a working definition of culturally safe practice and programming. Likewise, in partnership with the Association of Faculties of Medicine of Canada (AFMC), and the Canadian Association of Schools of Nursing (CASN) and Canadian Nurses Association (CNA), the Indigenous Physicians Association of Canada (IPAC) and the Aboriginal Nurses Association of Canada (ANAC) have generated frameworks for medical and nursing curricula to teach students and faculty how to build *competency* in cultural safety (ANAC et al., 2009; IPAC & AFMC, 2009). These efforts are supported by Health Canada through a five year Aboriginal Health Human Resources Initiative (AHHRI) (2005/06-2009/10), which provides funding to increase, and retain the number of post-secondary educational institutions with cultural safety curricula (ANAC et al., 2009; Chiefs of Ontario Office (COO), 2008).

In keeping with this movement, the concept of *cultural competence* has been taken up alongside cultural safety as a means of achieving cultural safety. The Canadian Nurses Association (CNA) (2004) is thinking about cultural competence as an "application of knowledge, skills, attitudes and personal attributes required by nurses [health care professionals] to provide appropriate care and services in relation to the cultural characteristics of their clients" (p. 1). Similar to cultural sensitivity, cultural competence includes valuing diversity, knowing about the cultural mores and traditions of the populations being served, and being sensitive to these while caring for a client. However, it also has been used to consider the broader context of health and healthcare (Spector, 2004) and, in Canada, to draw attention to power relations and dynamics and to consider culture in ways that directly address issues of racism and inequity (Srivastava, 2007). Currently, many health professional organizations and health institutions and agencies are incorporating the notion of cultural competence into Canadian healthcare settings (e.g., British Columbia Provincial Health Services Authority (PHSA), 2009; CNA, 2004; Canadian Registered Nurses Association of Nova Scotia (CRNNS), 2006). However, health professionals always need to be aware and cautious of the limitations of brief diversity or cross-cultural training programs that fail to address the structural and power inequities that affect healthcare and health (Browne & Varcoe, 2009) – those training sessions that focus the attention of the practitioner on the values, beliefs and practices related to the 'culture of the Other,' rather than beginning with relational understandings of culture and self-reflection.

Section 2.0: Historical and Present Context: The Need for Cultural Safety

Despite longstanding evidence for the disproportionately higher mental health burden carried by First Nations, Inuit and Métis communities (Royal Commission on Aboriginal Peoples (RCAP), 1995, 1996a, 1996b, 1996c; Canadian Institute for Health Information (CIHI), 2004, 2009), mental health and addictions remain a pressing issue facing many Aboriginal peoples in Canada (The Standing Senate Committee on Social Affairs, Science and Technology, 2006; Romanow, 2002). To engage in any meaningful discussion about Aboriginal mental health in Canada, it is critical to adopt a contextualized and historical approach that reflects a recognition of the aftermath and continued effects of colonization. There is a significant body of work by indigenous and non-indigenous researchers and scholars that speaks to the ways persistent disparities in mental health are entrenched in the history of relations between Aboriginal peoples and nation state colonization (e.g., Adelson, 2005; Dion Stout, 1996, 1997, 2003; Dion Stout, Kipling & Stout, 2001; Kelm, 1998; Kirmayer, Tait & Simpson, 2009a; RCAP, 1995, 1996b; Smye, 2004; Smye & Mussell, 2001). Firstly, colonization, systematic oppression and neo-colonial forces of discrimination and institutional racism have threatened almost every aspect of Aboriginal identity – individually, as well as collectively. Secondly, persistent mental health inequities cannot be understood in isolation of the background of colonial relations that continue to shape access to health care, health care experiences, and outcomes (Browne, Smye & Varcoe, 2005; Browne, Smye, & Varcoe, 2007; Browne & Varcoe, 2006; Smye, 2004; Smye & Browne, 2002; Smye, Rameka & Willis, 2006).

2.1 Impact of Colonization on Mental Health and Addictions for Individuals, Families and Communities

A century of colonial relations and neo-colonial forces including discriminatory and assimilationist government policies have taken a serious toll on the mental health of Aboriginal peoples in Canada (Brasfield, 2001; Browne, McDonald & Elliot, 2009; Kirmayer et al. 2003; Kirmayer et al. 2009a, McCormick, 2009; RCAP, 1995, 1996a, 1996b, 1996c; Smye, 2004). Drawing on the experience of psychologists and other mental health professionals, Waldram (1997) writes that the long-term trauma "that flows from colonialism and oppression" has had profound consequences for both "individual and collective behaviour" (p.43). For example, the social, political and cultural breakdown of Aboriginal communities can be directly linked to the assimilationist interventions and government control under the legal relations established by the Indian Act, 1876 (RCAP, 1996b; Smye; Waldram et al., 2006) and is considered to be the leading cause for the alarmingly high rates of suicide, depression, anxiety, substance use and despair in Aboriginal populations today (Brant, 1993; Kirmayer et al., 2003; Kirmayer et al., 2009a). The assimilationist agenda of the *Act* was pursued at many levels and gradually took control of most aspects of Aboriginal lives. For example, whole nations were forced to give up their traditional lands and self-government; residential schools were instituted with the goal of indoctrinating children into the dominant culture; and ceremonial and traditional practices that were integral to Aboriginal social, political and cultural life were outlawed[5] (Kelm,1998; Kirmayer et al., 2003; Kirmayer et al. 2009a; RCAP).

Residential schools and boarding homes have been the most cited cause of the mental health concerns of Aboriginal peoples (Chrisjohn & Young, 1997; Fournier & Grey, 1997; Kelm, 1998; RCAP, 1995, 1996b; Smye, 2004; Waldram et al., 2006; Waldram, 1997; Wade, 1995). Although residential schooling was not uniformly negative for all people[6], its overall impact has been devastating. Under compulsory residential school attendance, in many instances, Aboriginal children were forcefully taken away from their families to be subjugated to an institutional Christian regime that fiercely suppressed and punished any expression of Aboriginal culture, including the right to speak their native language (Kelm). In addition, many former residential school survivors report on the high prevalence of emotional, sexual and physical abuse that occurred within these institutions (Chrisjohn & Young; Wade). It is estimated that approximately one million children and in some instances, as many as five consecutive generations of children attended residential schools (Wade), for example, the last school in British Columbia was closed as late as in 1984 leaving behind about 35,000 British Columbian residential school survivors (RCAP, 1996).

As Kirmayer et al. (2003) note, the residential schools have “had profound effects on Aboriginal peoples at every level of experience, from individual identity and mental health, to structure and integrity of families, communities, bands and nations” (p. S18). On the individual level, narratives and life histories of residential school survivors suggest that former residential school students endure long-term psychological and social problems that manifest in the loss of individual and collective self-esteem and self-respect, internalized racism, substance use, suicide and a detachment to others, their families and cultural communities (Brasfield, 2001; Kirmayer et al., 2003; 2009a; Söchting, Corrado, Cohen, Ley, & Brasfield, 2007). In fact, Brasfield notes that in addition to a specific cultural impact, many residential school survivors experience symptoms that are characteristic of post-traumatic stress disorder (PTSD), such as “recurrent intrusive memories, nightmares, occasional flashbacks, and quite striking avoidance of anything that might be reminiscent of the Indian residential school experience” (p.79).

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[5] *For example, even potlatching was outlawed. Traditionally, this was central to the whole concept of status and rank, and played a pivotal role in the social organization of the community. Because there was no writing system, the potlatch “served to publicly recognize an individual’s claim to a particular status of inherited right. It also served an economic role, redistributing food and goods” (McMillan, 1995, p. 204). Today, potlatching remains an important aspect of community life for many West Coast people, although with somewhat different meanings than in earlier times.*

[6] *In her research with Carrier people of north central BC, Fiske (1996) carefully documents how women advanced their social, economic, and political roles within and outside their communities using some of the skills and knowledge acquired in residential schools. In spite of harsh treatment, these women were paradoxically able to build structures of resistance to a system that unintentionally provided them with the tools to do so. She states: “Women (and men) selectively utilized novel skills and knowledge beneficial to themselves. And, in doing so, they effectively subverted the missionaries’ intentions by broadening their economic strategies and by developing sophisticated political responses, which to a large measure were spearheaded by a schooled female leadership” (p. 181).*

On the societal level, residential schools have had trans- or inter-generational effects on the Aboriginal community as a whole (Kirmayer et al. 2003; 2009a; RCAP, 1996b; Waldram et al., 2006; Waldram 1997; Wade, 1995, Warry, 1997). As Smye (2004) writes, the loss of: i) attachment to community and the relationships of trust built there; ii) cultural values and norms which provided a sense of cultural identity including language and spirituality; iii) life skills usually taught by parents, elders, and other community members; for example, parenting skills; iv) self-identity, for example in one's creative abilities; and v) health and in some cases life, has scarred many Aboriginal communities and is implicated in the disproportionately large proportion of Aboriginal children in care[7] (Kelm,1998; Blackstock, 2005; Blackstock & Bennett, 2003) and Aboriginal people in federal and provincial prisons across Canada (Monture-Angus, 2000; Waldram). This is particularly concerning given that it is well known that children who are apprehended by the Child Welfare System and placed in foster families, often grow up with very similar experiences as their parents under the residential school system (Kelm, 1998); are more likely to become involved in the correctional justice system; and, less likely to complete high school (Browne et al., 2009a).

In assessing the mental health of Aboriginal people in Canada, transplantation and consequent sedentarization[8] are also important historical considerations. As Samson (2009) notes, "since their sedentarization, the Innu who were settled in the Labrador villages have suffered extremely high rates of suicide, alcohol abuse, solvent abuse and sexual abuse. The Inuit also have experienced profound changes in their lifeways in just two to three generations – mandatory schooling and social housing regimes have severely disrupted childrearing practices and family coherence for many Inuit (Kirmayer, Fletcher & Watt, 2009b).

The pervasiveness of poverty casts a similar shadow over the lives of Aboriginal peoples. Economic marginalization and welfare colonialism have resulted in a high degree of unemployment, a high degree on meagre social assistance payments (Fiske, 1992) and low incomes relative to other Canadians, making poverty endemic to many Aboriginal communities in Canada. For example, although income is gradually improving across First Nations peoples,

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[7] *Statistics indicate a steady increase of Aboriginal children in care, with a 6% national prevalence rate for 2000. The difficulty with this information is that it only refers to children in care who were living "on reserve" prior to coming into care, and it does not include any data from the North West Territories and Nunavut, any Self-Government First Nations, or First Nations which were not administered under a Child and Family Services Agreement (INAC, 2002). Bennett and Blackstock of the First Nations Child and Family Caring Society, note that "there are approximately 22,500 First Nations children in the care of Canadian Child welfare authorities" today – three times the highest enrollment figures of residential schools of the 1940s (Blackstock, 2003, p. 6). The ability to accurately reflect the reality of the percentage of children in care who are Aboriginal is limited by the differing definitions and methods of calculating total numbers of 'children in care', and 'Aboriginal children.' Available data suggest a range of 30%-40% of children in care are Aboriginal across Canada (Blackstock).*

[8] *Sedentarization involves the settlement of a nomadic group of people into a territory – it is often approached in terms of social (including legal), political, economic and territorial organization. The Innu are the northernmost Algonquian-speaking peoples of North America and have occupied the Labrador-Quebec peninsula for as long as 7,500 years. "Human understanding of this complex northern landscape is given its deepest meaning in Innu history, stories, legends, religion, and language, as well as in their lives as nomadic hunters" (Samson, 2004). However, aggressive systematic dismantling of this way of life was enacted through colonial process and practices of the state of Canada.*

First Nations' educational attainment and employment still considerably lag behind rates from the general Canadian population (First Nations Centre, 2007). Although there is a tremendous variability across First Nations communities, on most reserves despair is heightened by a lack of economy, inadequate educational facilities and shortage of housing (Smye, 2004; Browne et al., 2009a). Among Aboriginal people in Census Metropolitan Areas (CMAs), 41.6% were living in low income, more than double the national average for CMAs. As with lone parents and recent immigrants, Aboriginal people represented a disproportionately large share of the low-income population (Heisz & McLeod, 2004).

Today, poverty, employment and housing are identified as key social determinants of Aboriginal mental health with some researchers calling the high Aboriginal suicide rates indicators of community need (Cooper, 1995; British Columbia Provincial Health Officer (BC PHO), 2002; RCAP, 1996b). Poverty undermines self-esteem and self-worth, making people more vulnerable to alcohol and substance use and violence against others and oneself (ANAC, 2002; Dion Stout, 1997). For example, although there are enormous variations across communities, bands, and nations, the overall suicide rate within First Nation communities today is about twice that of the total Canadian population with suicide rates in some Aboriginal communities continuing to rise over the past two decades (Kirmayer et al., 2007). As Kirmayer and colleagues note, suicide is never the result of a single cause, rather is arises from an interaction of social, historical, political and personal factors (p. xv). In addition, as Samson (2009) writes about the Innu – the repercussions of suicide are widespread given that people generally living in small villages and are bound together by strong family ties.

Similarly, violence against women continues at alarming rates. In 2005, Statistics Canada's General Social Survey (GSS) reported that rates of spousal assault against Aboriginal women in the previous five years by a current or ex-spouse was more than three times higher (at 24%) than that of spousal assault reported by non-Aboriginal women (Native Women's Association of Canada (NWAC), 2007). As LaRocque (1996) states, "racism and sexism together result in powerful personal and structural expressions in any society, but they are clearly exacerbated under colonial conditions" (p. 15) making that the alarmingly high rates of domestic and sexual violence experienced by Aboriginal women and children are "one of the most problematic legacies of long-term colonization" (LaRocque, 1993, p. 74). This is particularly concerning given that Aboriginal people who commit suicide are likely to have experienced "higher rates of family and personal alcohol abuse, and/or physical or verbal violence either as a victim or as a perpetrator" (Cooper, 1995, p. 220).

Despite these disparities, it is important to note that many Aboriginal people are doing very well—it is for the more marginalized Aboriginal people that attention is drawn to health inequities and to the need for cultural safety. As this section has attempted to illustrate, the mental health inequities of Aboriginal peoples cannot be glossed over as lifestyle, behavioural, or cultural issues, rather, they are manifestations of the historical, social, political, and economic determinants. The cumulative losses in population, land and economic resources, language and cultural teachings, self-government and self-sufficiency “mortally threatened holistic health while disrupting the ways and means through which health was taught, maintained, and restored” (Mussell, Nicholls & Adler, 1993, p.21). This disrupted the circle of life and left wounds and scars on the bodies and minds of Aboriginal peoples, families and generations to come (RCAP, 1996b; Kelm, 1998). These issues compounded by the lack of mental health and addictions services are pressing issues for Aboriginal peoples in Canada.

2.2 Evolution of Health Services and Consequences for Aboriginal Health

Despite the shifting landscapes of Aboriginal health, mental health and addictions remain pressing issues facing Aboriginal peoples in Canada (The Standing Senate Committee on Social Affairs, Science and Technology, 2006; Romanow, 2002). Increasingly, it is being recognized that mainstream mental health services and programs are not effectual and often inaccessible to Aboriginal peoples (Adelson, 2005; BC PHC, 2002; CIHI, 2004; Dion Stout, Kipling, & Stout, 2001; NAHO, 2002, 2003; Smye & Mussell, 2001). To redress issues of access and effectiveness, it is critical to understand the historical and structural contexts in which mental health care for Aboriginal peoples has evolved.

As a central institution of dominant society, medicine, its perspectives, structures and practitioners, have been instrumental in shaping colonial relations, both within the dominant society through formulations of colonial power, and between the colonizers and their subjects (Kelm, 1998; Smye, 2004; Smye & Browne, 2002; Tait, 2008). The history of forced dependency on services upon former independent nations by Western forces can be directly traced back to the role that Western medicine played during the epidemics that plagued Aboriginal communities upon early contact with non-Aboriginal traders, explorers, and settlers, and the inception of the Indian Act in 1876 (RCAP, 1996a; Waldram et al., 2006). To ensure the survival of their people, Aboriginal leaders entered into agreements and treaties with the state (RCAP), which often offered limited food rations and medical resources[9] in exchange for economic gain and religious conversion (O’Neil & Kaufert, 1990). However, from the perspective of local governments, the provision of health care to ‘Indians’ was seen as an act of benevolent paternalism and generally took the form of crisis relief (Young, 1984). The construction of Aboriginal people as “diseased savages” in need of being “civilized” and saved provided the moral grounds for these actions.

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[9] *Aboriginal medicine was not supplanted by Western approaches; rather, a state of medical pluralism developed in which Aboriginal peoples drew on both Aboriginal and Western medicine to deal with new diseases (Kelm, 1998). Throughout the first decades of contact, early settlers availed themselves of Aboriginal substances and medicines and Aboriginal peoples built medical systems that incorporated new remedies while “maintaining an indigenous base of medical thought” (Kelm, p. 153). However, it was the processes of colonization, complete with systems of thought that excluded Aboriginal forms of medicine as quackery or superstition, that stifled the cross-cultural exchange (Kelm, p. 153).*

In 1867, the *British North America Act* gave legislative responsibility for health care and 'Indians' to the federal government. Aboriginal people became "administered people," "wards of the state," with a separate branch of the federal government devoted to their affairs (Smye, 2004). Yet, the *Act* did not obligate the federal government to pay for medical care or provide for doctors and thus, in reality the money followed the settlements of 'white' people who held the right to vote (Kelm, 1998). Ultimately, only the necessity to contain the spread of diseases and associated health care costs resulted in a systematic provision of 'Indian' health services with paternalistic and authoritarian models of care that legitimized compulsory treatment in segregated facilities (Kelm)[10]. Thus, growing demoralization and dependency were reinforced by authoritarian and paternalistic models of health care delivery (Smye) leaving a deep mark on the memories and bodies of many Aboriginal peoples.

Only a decade later, the government introduced the *Indian Act (1876),* which according to some, formed the basic argument for both the federal and provincial governments to abdicate from part of its responsibility to provide health care to Aboriginal peoples (O'Neil, et al., 1999). This *Act* "became one of the most divisive and destructive aspects of the Indian Act" (Smye, 2004, pp. 26-27) by dividing Aboriginal peoples into two mutually exclusive categories: the deserving versus the non-deserving "Indian" (O'Neil). Under the Indian Act, the Canadian government imposed "an arbitrary but devastating class structure" on Aboriginal peoples (Smye, pp. 26-27) by legally dividing Canadian Aboriginal peoples into First Nations, Inuit, and Métis and by then only assuming responsibility for the delivery of direct health services to Inuit and registered First Nations.

As Smye (2004) argues, the legal relations established by the Indian Act continue to be fundamental to the tensions and disjunctures that exist between Aboriginal peoples and the mental health and addictions systems of care today. For example, although under contemporary Canadian Aboriginal health policy, health services for First Nations are to be provided collaboratively by regional, provincial and federal governments in partnership with First Nations, the current federal position has only slightly shifted (Hanselmann, 2003a), perpetuating and reinforcing longstanding jurisdictional access barriers to health services for First Nations. In addition, today a First Nations person's ability to access services is determined by a complex set of questions of ancestry (status or not), place of residence (reserve or not), legislation (provincial and federal), and treaty negotiations (Lemchuk-Favel & Jock, 2004). While status, residence and treaty affect an individual's ability to access primarily federal Aboriginal-specific services, legislation and geographic jurisdiction affects an individuals' ability to access provincial services (Browne et al., 2009a). As a result, the health needs and rights of Aboriginal peoples, particularly Métis and urban non-Status First Nations, have often been lost in the jurisdictional struggle of who has responsibility for what population of Aboriginal peoples.

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[10] *For example, even today, "the question of whether a treaty right to free, comprehensive medical services exists for Status Indians is one of the most controversial areas of Aboriginal health care" (BC Ministry of Health Planning, 2002, p.86).*

One striking example of how these jurisdictional issues play out on the ground is the Downtown East Side of Vancouver; a community that is known to be the poorest neighbourhood in Canada with the highest concentration of Aboriginal peoples in Western Canada living in this part of the city (RCAP, 1996b). Despite the fact that the health and social conditions of Aboriginal peoples living in this neighbourhood is at least equally poor if not worse than for on reserve residents, they are denied direct access to most federal funds and programs that are available to Status First Nations living on reserve (O'Neil et al., 1999).

Another historical and contemporary source of tension that plays a major role in sustaining inequities in mental health for Aboriginal peoples is the disjuncture between Aboriginal understandings of mental health and the biomedical epistemological assumptions and approaches to mental health care (Browne & Smye, 2002; Josewski, 2009; Smye, 2004). Health care, including mental health and addictions care, has been dominated by biomedicine, liberal individualism, and more recently, corporatism. Although biomedical models are important in health care they are insufficient to understanding and responding to health-related issues because they are tied to conceptions of health as primarily located in individuals, peoples' physical bodies, and micro-level interactions, thereby leaving unexamined the underlying social and structural dynamics that actually produce health and health inequality (Weber & Parra-Medina, 2003). Corporatism refers to the primacy of a business model in which the dynamics of the marketplace and management and organizational theories shape health care, and mental health and addictions services, such that that economic and political values dominate (Varcoe & Rodney, 2009). Liberal individualism is the valuing of individuals over the collective that is common to liberal democracies. Individualism has tended to locate the problem of mental health and addictions in individuals, their individual failings, or their inability to engage as active citizens in dominant social processes. These social, ideological, and political forces have shaped the landscape of mental health and addictions services – with particular consequences for many Aboriginal people.

Under colonial relations, Indigenous practices including traditional forms of healing were viewed as unscientific superstition and replaced by a medicalization discourse that was part of the predominant Western paradigm (Smye, 2004), a perspective that continues to contour contemporary mental health reform in Canada (Morrow, 2004). For example, the key guiding policy document of BC's most recent mental health reform, the 1998 Mental Health Plan *Revitalizing British Columbia's Mental Health System,* states that "mental illness represents a diseased state of the human brain and not just disadvantaged social conditions" (p.58) and as such, "require[s] medical treatment" (BC. Ministry of Health and Ministry Responsible for Seniors, 1998, p.26). As a result, the 1998 Mental Health Plan falls short on addressing the majority of mental health issues experienced by Aboriginal peoples as well as their socio-political and historical root causes because it is only designed to address quality of care issues related to peoples with serious and persistent mental illness, such as schizophrenia and bipolar disorder as defined by the DSM-IV (Smye & Browne, 2002; Smye, 2004). Similarly, the Romanow Report (Romanow, 2002) continues to narrowly define access issues for Aboriginal people in terms of insufficient supply and distribution of health care providers while, at the same time, BC's Mental Health 'Best Practices' documents (2002) have been criticized for their omission of a critical cultural lens and its biomedical ideological underpinnings that continue to define mental health issues and treatment in individualistic terms (Smye & Mussell, 2001). Indeed, "the relational language of an Aboriginal worldview generally is missing from the 'Best Practices' documents" (Smye & Mussell, p. 29).

More recently, other documents, such as the Kirby Report (The Standing Senate Committee on Social Affairs, Science and Technology, 2006), adopts a more critical lens supporting the call by Aboriginal key leaders for a holistic and comprehensive wellness strategy for mental health and addictions. The Kirby Report is of particular significance because it resulted in federal support for the establishment of the Mental Health Commission of Canada (MHCC) in 2007, which is intended to guide mental health reform nation-wide. However, although the Canadian government followed Kirby's recommendation to establish the *Commission*, in response to advocacy for the separation of mental health and addictions led by a national group on addictions, addictions was purposively excluded from the mandate of the *Commission*; this exclusion runs the risk of marginalizing the mental health needs of people who are disproportionately affected by both, including Aboriginal peoples.

Mental health service delivery models that are designed in keeping with the dominant biomedical views of mental health and illness, create barriers to access and often only inadequately recognize the health care needs of Aboriginal peoples (Adelson, 2005; British Columbia Provincial Health Officer, 2002; Canadian Institute for Health Information, 2004; Dion Stout, Kipling, & Stout, 2001; NAHO, 2002, 2003; Smye & Mussell, 2001). They often are not effectual, underused and often not accessed by Aboriginal peoples (Smye & Mussell, 2001). In addition, research continues to show that tacit and sometimes overt discriminatory practices and policies continue to marginalize many Aboriginal people in the mainstream health care system (Benoit et al., 2003; Browne, 2005, 2007; Browne & Fiske, 2001; Culhane, 2003; Dion Stout & Kipling, 1998; Dion Stout et al., 2001; RCAP, 1996; Smith et al., 2006; Smith et al., 2005; Tang & Browne, 2008; Varcoe & Dick, 2007, 2008). As Browne et al. (2009a) point out, "these findings remind us that the micropolitics of health services delivery cannot be separated from the socio-political and historical contexts in which they occur" (p. x).

In response to the above challenges, Aboriginal peoples have been seeking responsibility for administering and controlling their own health programs with the belief that "true community healing and well-being can be found only through self-government and self-determination" (O'Neil et al., 1999, p. 149). A major contributor to building a vision on what healing for Aboriginal Peoples in Canada would look like was the work of the 1996 Royal Commission on Aboriginal Peoples. After extensive community consultation, the Commission published its final report five years after its creation. The following key principles and values identified for healing remain progressive ideas for Aboriginal health policy today and are consistent with Aboriginal perspectives articulated in the 2001 Provincial Health Officer's Annual Report on the Health and

Well-being of Aboriginal Peoples in British Columbia and the recent report on Canada's mental health care system by Senator Kirby (The Standing Senate Committee on Social Affairs, Science and Technology, 2006; BC PHO, 2002):

1. Adoption of a formal commitment to improve Aboriginal Health;
2. Recognition of the issues and challenges faced by Aboriginal peoples;
3. Support for Aboriginal self-determination and control;
4. Fostering of greater participation of Aboriginal peoples in designing, delivering and governing of programs;
5. Improvement of the social determinants of health, such as economic prospects and housing; and
6. Promotion of culturally appropriate, holistic approaches to health.

Thus, within the Indigenous health movement, the inclusion of Aboriginal voices in mental health care programming and delivery is imperative for improving Aboriginal health, and overcoming system-related barriers to access and to incorporating the element of choice for Aboriginal healing, if so desired. However, while Aboriginal self-determination is central to the Canadian Indigenous movement, it manifests differently for on- and off- reserve Aboriginal communities. On reserve, the primary mechanism for communities to increase self-governance is different degrees of health transfers. In contrast, urban communities are deprived from this right. Instead, for off reserve Aboriginal service providers and organizations, the notion of Aboriginal self-determination is engrained in the discourse of increased participation and shared decision-making power in health policy and practice. However, little real empowerment of Aboriginal communities may be occurring due to inconsistencies in transfer arrangements (Fleras & Elliot, 1992), the need for program enrichment (O'Neil & Postl, x) and notoriously scarce and short-term funding for Aboriginal mental health and addictions programs on- and off-reserve (RCAP, 1996b; Josewski, 2009). These constraints intersect with political economic interests that promote reduced expenditures on social programs, increased push for privatization as well as a shift towards self-management (Morrow, 2004). Over the past decade, for example, cost containment in health and social sectors has been paramount in the organization and delivery of health care services (Anderson, 2000; Burgess, 1996; Evans, 1992; Morrow, 2004; Morrow, Frischmuth & Johnson, 2006; Storch, 1996; Varcoe and Rodney, 2002). As one of the most vulnerable populations in Canada, the residents of Aboriginal communities are particularly sensitive to the consequences of downsizing and other cost-cutting measures in the health care system (O'Neil et al., p. 148), including the threat it poses to Aboriginal autonomy (Smye, 2004).

Nevertheless, Aboriginal peoples have achieved some significant accomplishments in negotiations with both federal and provincial governments in recent years. For example, following the recommendation of the Kirby report (The Standing Senate Committee on Social Affairs, Science and Technology, 2006), in 2007, the federal government established a First Nations, Inuit and Métis Advisory Committee to the Mental Health Commission of Canada (MHCC), chaired by William Mussell, a Stó:lō First Nations man from British Columbia and Chair of the Native Mental Health Association of Canada. This Advisory Committee is “dedicated to promoting overall mental health and reducing the threats to well-being among Indigenous people living in communities on and off reserves in Canada” (MHCC, 2009). In addition, there are other First Nations, Inuit and Métis members on several of the other sub-Committees of the *Commission* and one of the five Chairs of the Commission is Madeleine Dion Stout, a Cree speaker and esteemed nurse scholar in Canada who has expertise in Aboriginal health, including suicide prevention and Aboriginal women and violence. Yet, progress in the area of Aboriginal health in Canada is rather erratic and characterized by many tensions as illustrated by Canada’s recent refusal to sign the Declaration on the Rights of Indigenous Peoples adopted by the United Nations (UN) in September 2007.

2.3 What works well

Cultural discontinuity has been strongly linked to the disproportionate problems of Aboriginal communities with depression, addictions, suicide and family violence (Chandler & LaLonde, 1998; RCAP, 1995). According to a public opinion poll in 2002, 63 percent of Aboriginal participants reported that cultural discontinuity and loss of land have had a significantly negative impact on their health (Assembly of First Nations & Social Development Department, 2005). Reversely, studies found that the degree of control that First Nations communities have over civic life, such as education, health care, child and family services, and fire and police services, was negatively correlated with rates of suicide (Lalonde, 2005).

According to Brant Castellano (1999), “the healing process gains strength from many sources, but principally from rekindled confidence in traditional wisdom and a political-historical analysis of the genesis of present distress” (p. 95). As Kirmayer, Brass and Valaskakis (2009c) note, notions of tradition and healing are fundamental to the mental well-being of Aboriginal peoples – to address the legacy of colonization through “community-based initiatives and larger political and cultural processes” (p. 440). As such, there has been a resurgence of traditional ways of healing and healing concepts among Aboriginal communities. The Aboriginal Healing Foundation (AHF) was established in response to recommendations of the Royal Commission on Aboriginal Peoplesi[11] “to support healing projects that would address the transgenerational effects of the residential schools” Kirmayer et al., p. 453) and analysis of the projects funded by the AHF suggests the importance of addressing historical trauma experienced by Aboriginal people (e.g., the aftermath of the residential school experience) – an important step in the process of individual and

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[11] *On March 31, 1998, the Aboriginal Healing Foundation was created. It was given a ten year mandate: one year to set-up; 4 years to disburse the $350-million healing fund on a multiyear basis, and 5 years to monitor and evaluate the projects (AHF, Summary of Final Report, on-line).*

collective healing (Brant Castellano, 2006; Stout, 2003, as cited in Kirmayer et al., p. 455). However, although analysis of the projects of the AHF has demonstrated their importance, recently the AHF faced the threat of serious funding cuts by the federal government with potential far-reaching consequences (CBC, March 15, 2010). Aboriginal mental well-being continues to be seriously challenged by continued unstable funding arrangements and often a lack of political good will.

Under the conditions of colonization, Aboriginal systems of medicine were disrupted, delegitimated and challenged through new infectious diseases and Western forms of medicine. However, they did not disappear. ”Aboriginal ideas about the body, disease, and medicine, then, were not just remnants of some pre-contact past but were living ways of viewing the world” (Kelm, 1998, p.84). Traditionally, Aboriginal peoples understand health as a holistic concept, which results from a harmonious balance or equilibrium between different spheres of life, such as the physical, mental, spiritual, and social dimensions (Mussell et al., 1991; Smye & Mussell, 2001; Waldram, 2004). “Holism (as Aboriginal peoples use the term) means sensitivity to the interconnectedness of people and nature, of people and their kin and communities, and within each person, of mind, body, emotions and spirit” (RCAP, 1995, p.83). Family as an institution is central to Aboriginal culture and many Aboriginal peoples have argued that rehabilitation of Aboriginal families has to be part of the path to personal and community healing (Mussell et al., 1991). Hence, successful community initiatives distinguished themselves from mainstream services through the high degree of family involvement, a multi-disciplinary team approach and the mobilization of whole-communities under Aboriginal authority (RCAP, 1996b).

In the discussion paper on what works best for Aboriginal communities, the Aboriginal Mental Health “Best Practices” Working Group concludes that community-based initiatives and a balanced approach to mental health including treatment, prevention and health promotion strategies have proven to be more effective than treatment-oriented mainstream services under non-Aboriginal authority (Smye & Mussell, 2001). In addition, findings of analysis of the AHF projects suggest that the necessary elements of promising healing practices related to historical trauma (e.g., residential school abuse) include: programs that reflect Aboriginal values; ensuring personal and cultural safety as a prerequisite to healing from trauma; capacity to heal, i.e., the presence of skilled, healers, therapists elders and volunteers; and, reclaiming history with an understanding and awareness of intergenerational impacts of the residential school system and other aspects of Aboriginal history. Also, included in this framework are ‘three pillars of healing’: i) cultural interventions, ii) therapeutic healing, i.e., a combination of a broad range of traditional and Western therapies and iii) an environment that meets the conditions that influence both the need for healing and the success of the healing process (AHF, p. 12).

Section 3.0: What Cultural Safety Brings to Mental Health and Addictions Services

As discussed earlier, cultural safety is a relatively new concept that emerged in the New Zealand nursing context, and is being taken-up in various ways in Canadian health care contexts. We argue that cultural safety is particularly relevant to health care contexts in general, and to mental health and addictions services in particular for the following reasons: cultural safety, as we conceptualize it, is compatible with critical perspectives that focus on power imbalances and inequitable social relationships in health care; problems associated with culturalism and racialization in health care; and a commitment to social justice as central to the mandate of health care in Canada (Browne et al, 2009b). We have been using the concept of cultural safety in research and teaching in nursing and medical programs to draw attention to these critical issues; however, less is known about the application of cultural safety in health care contexts, and the services that could be possible if informed by cultural safety. What we have discerned over the years of working with the concept of cultural safety, both in health care, and in university-classrooms contexts, is that cultural safety cannot be easily defined and "neatly packaged" as a concrete set of standards for practice (Browne et al., 2009b; Anderson et al., 2003; Reimer Kirkham et al., 2002; Smye, 2004; Smye et al., 2006). In part, this is because using cultural safety in practice settings to draw attention to and prompt critical reflection on politicized knowledge brings an added layer of complexity (Browne et al.). For example, grasping the issues that we conceptualize as core to cultural safety, for example, the need for health care providers to reflect critically on issues of racialization, institutionalized discrimination, culturalism, and health and healthcare inequities in mental health and addictions services requires layers of understanding that are not necessarily translatable into straightforward "practice guidelines." Understanding of cultural safety requires health care providers (and policy makers) to engage in dialogue regarding the root causes of inequities in mental health and addictions, which creates the potential for discomfort related to a number of issues, including the call to be accountable and actionable. Yet, we argue, that there are fundamental issues that cultural safety draws attention to that are inherently valuable if mental health and addictions services for Aboriginal people in Canada are to be improved. In this section, we consider what cultural safety could bring to health services in the field of mental health and addictions, and what a framework for cultural safety services could look like.

3.1 Prompting Critical Reflection on How the Dominant System of Health Care Affects Aboriginal Peoples

Cultural safety prompts us to reflect on the values and ideologies that influence mental health and addictions services – and simultaneously, to reflect on whether there are new possibilities for conceptualizing and delivery mental health and addictions care. As we have argued, a central feature of cultural safety is critical reflection among health care providers, decision-makers, policy makers, students, educators, and researchers. However, it is important to note that critique or critical reflection is not synonymous with criticism; rather, critique and critical reflection refers to examining the conditions and assumptions upon which something exists (Reimer Kirkham et al., 2009). Such distinctions are important if health planners and policy makers are to engage meaningfully with the notion of critical reflection and critical inquiry with a view to improving the dominant system of care.

At its most basic, cultural safety would prompt reflexivity in the area of mental health and addictions services – it would involve practitioners holding up for scrutiny their own and others' knowledge claims, taken-for-granted assumptions, and practices (Taylor & White, 2001, p. 55). When considering the knowledge claims, perspectives, or assumptions of colleagues, you can apply similar questions and look for ways to engage in dialogue. Dialogue in health care delivery settings is central to the process of reflexivity, and in many cases, this may involve a tolerance for the discomfort of questioning usual practices in mental health and addictions. Aultman (2005) for example, calls for a "pedagogy of discomfort" in which students think critically about the various values that underpin peoples' perceptions of the health care system, and providers' and the system's responses to people (p. 263).

Cultural safety, because it draws attention to *relational* understandings of culture, can be used to question what premises and intentions are at the heart of the ongoing calls for "cultural sensitivity"[12] training and programming in mental health and addictions. As noted earlier in this paper, from the perspective of cultural safety, we understand culture as a relational aspect of ourselves that shifts over time depending on our history, our past experiences, our social, professional and gendered location, and our perceptions of how we are viewed by others in society (Browne & Varcoe, 2006; Smye, 2004; Smye, Rameka & Willis, 2006).

Simultaneously, because cultural safety reinforces relational understandings of culture, it can also help those who are working in mental health and addictions with Aboriginal people to appreciate how discourses about culture can be (and ought to be) interpreted and mobilized in many different ways for different purposes (Browne & Varcoe, 2006). For example, in the context of mental health and addictions services, claims about the importance of cultural considerations in programming may be essential for justifying claims for improved access to services, increased funding targeted to particular populations, or to illuminate inequitable practices that affect groups of patients in particular ways. In Canada, for example, it is critical for Aboriginal organizations concerned with mental health and addictions services to argue that residential schooling and intergenerational trauma have had a deleterious effect on Aboriginal culture, so that appropriate healing programs can be designed and funded, and so that organizations can claim their right to program funds (for example, programs through the Aboriginal Healing Foundation). Making claims about the cultural damage incurred as a result of

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[12] *Cultural sensitivity tends to be attached to notions of 'culture' that limit culture to the values, beliefs and practices of the other person. Although this is not always the case, generally, cultural sensitivity does not address the context in which well-being, health and illness occur – to the social, political, historical and cultural factors that shape well-being, health, illness and health care.*

many peoples' shared experiences at residential schools can be understood as using one's cultural positioning for strategic purposes. From a relational understanding of culture, and from the perspective of cultural safety, these can be appreciated as legitimate claims which ought to be heeded in order for past inequities to be redressed.

At a structural level, cultural safety can be used to draw our attention to those aspects of mental health and addictions policies that do not fit for Aboriginal peoples. For example, some of the key perspectives and understandings that underpin the goals of the Commission might not necessarily fit neatly with the perspectives underpinning the MWAC strategic action plan, i.e., the commitment to the centrality of culture and the role of holistic strategies; addictions understood as inextricably tied with mental health [well-being]; healing and recovery as linked and understood from a wellness perspective rather than beginning from an illness perspective; and the valuing of community-based practices and a coordinated continuum of services, from prevention to aftercare.

3.2 Creating Ethical Spaces of Engagement in Mental Health and Addictions Care

As Caroline Tait (2008) argues:

> *Individuals who are mentally ill, distressed, or struggling with addiction are among the most vulnerable in any Aboriginal community. However, in addressing their needs, Western medical models of diagnosis and treatment marginalize the historical and social context of their suffering, the social inequities that exacerbate their distress, and the inner strengths and resilience of Aboriginal peoples and their cultures to survive despite ongoing adversity (p. 30).*

Drawing on Ermine's notion of "ethical space," Tait (2008) suggests that ethical standards informed by the concept of cultural safety have the potential to inform the development of prevention, promotion, and treatment programming in the area of mental health and addictions involving Aboriginal people.

The notion of ethical space represents a space of engagement that facilitates the development of cross-cultural approaches that are ethically sustainable and aim to redress inequities (Ermine, 2005, 2007; Tait, 2008) – in this case, inequities in access to, and ways of addressing, mental health and addictions services involving Indigenous people in Canada. Cultural safety, with its focus on shifting the gaze from the 'culture of the Other' onto the 'culture of health care' as the source of the problem, is helpful for examining the extent to which mental health and addictions services for Aboriginal people are founded on Eurocentric and Western biomedical premises that undermine attempts to transform the "best practices" that could more optimally and explicitly benefit Aboriginal people (Ermine, 2005). As Tait reminds us, the problem of transforming mental health and addictions services lies not with individual front-line workers, but rather within the larger bureaucratic and health system structures within which programs, policies and services are designed and delivered. As Smye and Browne (2002) write, these questions include, for example, Do current mental health services fit well with Aboriginal understandings, illness and healing, or are they at odds with them given the current sociopolitical environment? How are the myriad social issues such as poverty and homelessness, that serve to curtail the life opportunities of many aboriginal people, and, as such, their health, being addressed? (p 47)

In the context of ethical space, and in consideration of the moral questions that cultural safety prompts, mental health and addictions services have the potential to be transformed in ways that "acknowledge the pain, suffering and intergenerational realities and experiences of Aboriginal peoples resulting from colonial assaults" and "the resilience and resistance of Aboriginal peoples to historical and contemporary adversity" (Tait, 2008, p. 32).
In an earlier paper that explored the relevance of cultural safety in the context of mental health reform in Canada, it was argued that the concept of cultural safety could be used to ask a series of moral questions about the "rightness" of policy decisions (Smye & Browne, 2002). We extend that argument to suggest that cultural safety can be used within the framework of ethical space to prompt questions related to service delivery in the field of mental health and addictions. In particular, we suggest that the concept of cultural safety can be used as a framework for assessing whether the values that underlie service delivery (at the organizational level, and at the level of provider-client interactions) are aligned with the ways services are organized and delivered.

One of the central features of integrated, culturally safe approaches to mental health and addictions services is explicit attention to what is valued as: (a) the causes and conditions that give rise to mental health and addictions issues, and (b) what are valued as approaches to treating/addressing mental health and addictions issues with individuals, families and communities. For example, if what is valued is explicit acknowledgement of the socio-political and historical causes and conditions that have resulted in disproportionately high mental health and additions issues, then services delivery would be organized in ways that reflect that understanding. Similarly, if what is valued are approaches to service delivery that acknowledge the impact of trauma[13] – meaning, historical, intergenerational, emotional, physical trauma – integrated services may be more highly valued (and resourced). By integrated services, we mean services that include interdisciplinary teams of skilled elders, community outreach workers, trauma counsellors, specialists in chronic pain, residential school healing circles, psychological services, social workers, housing services, etc.

How might this be operationalized at the practice level of service delivery? One way would be to ensure that mental health and addictions services are provided from a stance that acknowledges the historical trauma and family dislocation that is often at the root of mental

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[13] *In this report, we are conceptualizing trauma broadly as inclusive of historical trauma, trauma resulting from structural violence, intergenerational trauma (e.g., residential school traumas), and the effects of physical trauma and violence.*

health and addictions issues. Another approach would be to always frame mental health and addictions issues in relation to the contextual features of peoples' lives – by contextualizing addictions and mental health issues in a wider historical context, as one example, and responding with a wide range of services that could be offered, versus viewing those issues from an individualistic perspective.

At the organizational level, providing integrated mental health and addictions services that align with espoused values requires a commitment to recruit Aboriginal and non-Aboriginal staff who are committed to, and can enact, a particular philosophical approach to service delivery. Given the health human resource shortage in Canada, and the relatively few health care providers and mental health and addictions workers who are of Aboriginal descent in the Canadian workforce, it will be challenging to recruit Aboriginal staff. However, what remains exceedingly important is to recruit staff whose values align with the wider context of mental health and addictions issues as they affect Aboriginal people, families and communities and to provide educational and training opportunities for Aboriginal people interested in this area of focus.

Section 4.0: Recommendations and Conclusions

4.1 Engaging cultural safety as a concept for working toward social justice in Mental Health and Addictions Care.

Because it has been derived from experientially grounded reflection by nurses rather than from academic theorizing (Polaschek, 1998) cultural safety has been subject to ongoing theoretical and methodological criticism (Ramsden, 2000; Johnstone & Kanitsaki, 2007a; Johnstone & Kanitsaki, 2007b). As a result, proponents have continued to redefine cultural safety while maintaining the overall significance of cultural safety for moving toward transformative change and social justice (Anderson et al., 2003; Browne et al., 2009; Kirkham et al., 2002; Papps & Ramsden, 1996).

Although cultural safety is a concept that has clear applications to the field of mental health and addictions, there are a few cautions that we wish to highlight. As we continue to work with the concept in the context of Canadian health care services, we are increasingly aware that the label, 'cultural safety' is open to considerable ambiguity in interpretation – and often misinterpretation (Browne et al., 2009b). Cultural safety, as we have conceptualized the concept, requires explicit attention and understanding of several key issues that are at its core – for example, the need for health care providers, policy makers, and organizations to reflect critically on issues of racialization, institutionalized discrimination, culturalism, and health and health care inequities, and the root causes and conditions that give rise to mental health and addictions issues among Aboriginal populations. Without explicit commitment to grapple with these issues – the emphasis on 'culture' in the term 'cultural safety' runs the risk of misinterpretation.

In large part, the tendency for the notion of culture in cultural safety to be taken up in misinformed ways is related to the predominance of culturalist discourses in Canada. As Browne et al, (2009b) have argued,

> *Without a solid understanding of how culture itself is conceptualized in cultural safety, the risk lies in unintentionally implying that what is needed is more cultural knowledge – with cultural knowledge typically narrowly interpreted in culturalist terms as the values, beliefs, and customs that are assumed to be inherent to particular groups of people (p. 173).*

We argue that the concept of cultural safety cannot be used without first fostering an understanding of the critical conceptualization of culture that is foundational to the concept of cultural safety. As noted earlier in the paper, this includes firmly grounded applications of cultural safety in an understanding of culture as a dynamic, power laden process created by people *in relation* to one another, their environments, and sociopolitical and historical contexts – as relational (Anderson et al., 2003; Browne & Varcoe, 2006; Doane & Varcoe, 2005; Lynam et al., 2007; Reimer Kirkham et al., 2002; Smye & Browne, 2002). Otherwise, cultural safety can convey that the safety to be ensured is that of the 'cultural Other,' at once further entrenching notions of difference, focusing on individual 'preferences' and turning attention away from the importance of reflexivity on the part of the health care professional (Browne et al., 2009b). These are significant risks to consider given that the rationale for using the concept of cultural safety is to prompt transformative shifts in mental health and addictions services, and more broadly, in the culture of health care (Ramdsen, 2000).

Even in New Zealand, where cultural safety is part of the lexicon in nursing and medical education, it has been challenging to maintain the critical cultural roots of cultural safety (Ramsden, 2000, 2002). As Ramsden (2000) explained in the New Zealand context,

> *[t]he name remained a source of confusion to many. The popular understanding of culture as ethnicity only led to simplistic notions of cultural checklists avoiding the complex power relationships which the safety factor was intended to address' (p. 7).*

Without the opportunity to explore these issues in more depth, the unintentional risk is in fueling further misinterpretations. These opportunities must be built into mental health and addictions programming if the concept of cultural safety is to be used to its full potential (Browne et al., 2009).

Given the challenges encountered in relation to the use of cultural safety in New Zealand over the past two decades (Ramsden, 2002; Wepa, 2005), it will not surprising if we are met with similar challenges in the Canadian mental health and addictions context. Nonetheless, cultural safety will continue to hold value in the field of mental health and addictions when used to emphasize critical self-reflection; critique of structures, discourses, power relations, and assumptions; and because of its attachment to a social justice agenda. Continued work will be required to better understand how cultural safety can be used to transform the highly politicized and complex terrain of mental health and addictions services while addressing social justice issues of relevance to Aboriginal people and communities.

We conclude this report by featuring Ermine's (2007) call for critical self-reflection in relation to Aboriginal-state relations – here a prompt for critical reflection in the area of mental health and addictions services:

> *Currently, the situation, and very often the plight of Indigenous peoples, should act as a mirror to mainstream Canada. The conditions that Indigenous peoples find themselves in are a reflection of the governance and legal structures imposed by the dominant society. Indeed, what the mirror can teach is that it is not really about the situation of Indigenous peoples in this country, but it is about the character and honor of a nation to have created such conditions of inequity (p. 200).*

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List of Acronyms

Acronyms which appear more than once in the preceding report are included in the list below.

AFMC – Association of Faculties of Medicine of Canada

ANAC – Aboriginal Nurses Association of Canada

AFN – Assembly of First Nations

CIHI – Canadian Institute for Health Information

IPAC – Indigenous Physicians Association of Canada

MDSC – Mood Disorders Society of Canada

MWAC - First Nations & Inuit Mental Wellness Advisory Committee

NAHO - National Aboriginal Health Organization

NMHAC – Native Mental Health Association of Canada

NWAC – Native Women's Association of Canada

RCAP – Royal Commission on Aboriginal Peoples

Schedule "B"

Building Bridges 2

Belonging:
Social exclusion, social inclusion, personal safety and the experience of mental illness

By

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October 2009

Table of Contents

Overview: Social Inclusion

This paper was prepared for the MDSC and the NMHAC for the Building Bridges 2 project by Barbara Everett, PhD. It includes a review of research literature on social exclusion, inclusion, personal safety and the experience of mental illness, as well as an overview of various government policies aimed at promoting the social inclusion of marginalized people. The Executive Summary of the resulting discussion paper – Belonging – appears below.

Belonging:
Social exclusion, social inclusion, personal safety and the experience of mental illness

Executive Summary

Everyone wants to belong but it is clear that many people are denied the opportunities that others have and relegated to the margins of society. People with mental illness call this stigma and discrimination. Others call it social exclusion. Whatever language is chosen, it harms.

Around the world, factors such as the globalization of labour, people fleeing war, disaffected second generation children of immigrants, a widening gap between the rich and poor and 24/7 media reports of riots, bombings and terrorism have awakened mainstream society to the threat that marginalization can pose. What we previously thought "could never happen here" is now understood as all too likely to happen here – and soon.

Social inclusion is the formal name given to a fairly recent set of government policies aimed at including marginalized people more meaningfully in society – not only for their sake – but for the sake of protecting social cohesion and lessening threats to economic progress. Examples of social inclusion policies from the European Union, the United Kingdom, Italy, New Zealand and the Australian Ministry of Social Inclusion indicate just how seriously governments are taking the marginalization of certain groups within their borders. These examples also serve to show that social inclusion policies have widened to include not only ethno-racial minorities and immigrants but also the poor and the disabled, including people with mental illness.

Social inclusion policies are not without their critics who most commonly fear that they fail to state strongly enough that they value diversity or at worst, that they are simply assimilation or colonization dressed up in new language.

If adopted as a new way of thinking, would policies of social inclusion benefit people with mental illness? Certainly, examples of social inclusion mental health policies – those from Scotland are a prime example - indicate that yes, they very well may.

The path to belonging (social inclusion) is rooted in recovery which begins with establishing personal physical, relational and emotional safety aided by finding safe places to belong such as peer support, the psychiatric survivor movement, or through mechanisms of cultural safety. From this platform of personal safety, people can venture out into the community to establish (or re-establish) meaningful social roles. However, mental health services are often criticized for being siloed and cut off from their own communities and thus, failing to promote their clients' independence and integration into society. Policies of social inclusion, if carefully thought through, may provide openings for the second and necessary aspect of recovery – an opportunity for full participation and a chance to belong – in your community, your province or territory and your nation.

Social inclusion is a complicated set of ideas that requires careful consideration – from all angles. It is clear that in some parts of the world, mainstream society has heard the thunder of deep discontent. They are beginning to recognize the harm that marginalization does to people because the marginalized have struck back. Social inclusion policies, even those with teeth, can only do so much. Powerful historical and cultural forces divide the world while those that unit it are less visible and less commanding. The policies, as reviewed in the enclosed paper, do not speak strongly enough to the preservation of identity and the celebration of difference. Perhaps these ideas are implicit but comfort for many will come only from explicit statements and visible actions. Otherwise, social inclusion policies are open to igniting fears that they are really assimilation dressed up in new words. A possible way forward may be to establish the clear distinction between *political integration* (all groups have rights, protections and access to civic engagement) versus *social integration* (acceptance is the only passport to all that society has to offer). Is there something here for people with mental illness and their families? A cautious yes – if the goals of potential social inclusion policies are carefully thought through and clearly articulated.

Introduction

"To feel at home is to feel that people understand not only what you say, but also what you mean." Sir Isaiah Berlin [1]

Belonging is perhaps best understood as feeling at home in your own skin and among family and friends. But it is also an idea that has wider social implications because to understand yourself as a "member of society" means that you feel that you *belong* in your community, your province or territory and your nation.

In Canada, as in other countries, it is easy to see that many people feel that they don't belong. A personal sense of being excluded, of being different or of not being valued is harmful to the individual and this harm is only increased when the active dimensions of stigma and discrimination enter the mix, meaning that those who *do* belong (mainstream society) fear or even hate you for being who you are (or, better said, who they *think* you are) and act in ways to ensure that you have limited opportunities, restricted access to the resources and rights that others enjoy, and little or no opportunity to protest poor treatment or to make your voice heard.

People with mental illness and their families know all too well the negative effects of stigma and discrimination [2] and the pain of feeling excluded from their communities.

This paper will explore the theories and realities that accompany the concepts of social exclusion and social inclusion. It will examine social inclusion and its possible usefulness for people with mental illness and their families. It then moves on to the role of safety and security in the recovery journey and in the ability to take up the opportunities that social inclusion may offer. It offers examples of safe places, along with the very specific concept of cultural safety. It concludes with a discussion of the possible utility of social inclusion policies for the mental health field.

Social exclusion

People with mental illness and their families are only one example of society's excluded groups. Others include visible minorities, people with HIV/AIDS and other stigmatized health problems, some seniors groups, people in trouble with the law, lesbian, gay, bisexual or transgendered people, First Nations, Inuit and Métis, certain groups of youths, immigrants and refugees – the list can go on and on.

The purpose of using the term social exclusion is to counteract the tendency to blame marginalized groups for their own exclusion and concentrate only on interventions to "fix" them. While important, proper education, an emphasis on recovery for people with mental illness, rehabilitation for offenders, employment for visible minorities or settlement strategies for immigrants and refugees (as only a few examples) do not automatically lead to inclusion for marginalized groups.[3] The point of the theories surrounding social exclusion is to highlight the role that mainstream society plays in the exclusionary process. People who are recovered, rehabilitated or now employed know only too well that, while personally these achievements have been gratifying, they do not – at all - constitute an unconditional invitation to join those who are included.

Let's begin with a formal definition of social exclusion so that we know exactly what we are talking about:

"Social exclusion is a multidimensional process of progressive social rupture, detaching groups and individuals from social relations and institutions and preventing them from full participation in the normal, normatively prescribed activities of the society in which they live." (pg. 15) [4]

This definition is chosen because it actively emphasizes society's role in exclusion by using words like "detaching" and "preventing."

A well-defined (and deeply dispiriting) example of systemic social exclusion is contained in a recent study of Ontario's youth called the *Roots of youth violence.* [5] The dimensions of exclusion as described by the youths themselves in their testimony include:

Poverty – without hope, with hunger and with isolation. Poverty also in stark and obvious contrast to the bounty that surrounds them and which seems to be enjoyed by everyone – except people from their group.

Racism – systemic targeting and excluding non-white youth. While all groups suffer, the report particularly identified black youth as the persistent and primary targets of racism.

Community design – isolated enclaves of poverty, dangerous and unhealthy housing, poor and unsafe transportation, no place to gather for community exchange and communities designed to foster (instead of impede) crime.[6]

An unwelcoming education system – studies that mean little to non-mainstream youth, guidance counselors who discourage ambition, harsh policies and disciplinary actions that suspend, expel or even criminalize students, and teachers from the dominant classes who do not disguise their low expectations of non-white youth.

Criminalization and harsh treatment in the justice system – needless aggression and harassment on the part of the police, harsh treatment while in custody, belittling and degrading lectures in open court, an almost knee-jerk tendency to charge without regard for the life-altering consequences (a charge can follow youth into adulthood and further narrow their opportunities even when they are found not guilty).

Health consequences – particularly mental health where problems go unaddressed and, even if identified, access to services is limited.

Family problems – (speaking to the inter-generational impact of exclusion) single parent families, absent fathers, teenage parents, violence and substance abuse, poverty, youth in foster care or homeless altogether.

Lack of mainstream economic opportunity – youth who cannot get jobs but all too easily can make money in socially unacceptable ways (dealing drugs, crime, running guns or prostitution)

Denial of voice – youth, in general, but in particular, non-white youth have no opportunity to shape their own communities or education – and when they find the courage to protest their poor treatment, are actively ignored and silenced.

The results of such all-encompassing exclusion are, indeed, youth violence, but also a double-digit income gap among racialized groups (30% living below the poverty line), three times the level of unemployment, poverty twice as likely and contact with the criminal system increasing 200% for black males (from 1986 – 1995) as opposed to 23% for white males. [7]

Further consequences relate to poorer health overall, including more injuries due to accidents because of unsafe working conditions, increased levels of stress and mental illness, no benefits due to low paying jobs and limited access to health care overall.[8]

A recent examination of health inequities in Toronto found that three times as many people with low income reported poor health, that the incidence rates of diabetes are twice as high in low income neighbourhoods and that, although poor people go to their doctors for arthritis more than people with higher incomes, the rate of hip replacements for them is less than half that of their higher income counterparts.[9]

Social exclusion also has a circularity in that the problems experienced by the marginalized (mental illness, addiction, poor health, contact with the law, unemployment, isolation and violence) lead to even further exclusion.[10]

Belonging to an excluded group can mean that members mirror their social experience and adopt methods for awarding some of their group with insider status while rejecting others. [11] These internal splits are one of the reasons it is difficult for excluded groups to come together as a united front to fight the forces that have denied them opportunity and full membership in society.

Finally, members of excluded groups can come to believe, on a personal level, that they deserve the treatment they are receiving. They can hold the same prevailing beliefs as mainstream society and, much like the dynamics of self-stigma, [12] they can participate in their own exclusion by withdrawing (or attacking in defense) when discriminatory actions are anticipated, or by wearing an ever-present chip on their shoulder to guard against further hurt.[13] Understandably, once having been the object of exclusion, it is very hard to recognize instances where, in fact, the forces of exclusion are *not* at work.

Despite the fact that there are internal forces within excluded groups (internal splits and self-stigma/exclusion) that make it hard for them to come together to protest their lot, mainstream society can be afraid of them. Recent world events have only deepened this fear. The fact that there are now far flung pockets of displaced people with the internet as a communication tool no longer means that they all have to agree on resistance strategies in order to act. Instead they can operate in isolation from one another or even as individuals to disrupt the fabric of mainstream society.

As a result, the developed world now contemplates seriously the spectre of social breakdown. Compounding fears are the recent threats to prosperity as evidenced by the global financial disaster of 2008 but also the widely broadcast incidents of civil unrest, labour uprisings, riots, and terrorism.

Social inclusion

In its narrowest definition, social inclusion is a set of fairly recent strategies (most often government sanctioned) to counteract the extreme marginalization of certain groups so that society, as whole, can function in relative safety and with assurance of continued wealth accumulation.

This does not mean that strategies of social inclusion are without merit for excluded individuals and groups – or, perhaps, are evidence of a kinder, gentler evolution of society (it's good for everybody) – but it is helpful when examining the various manifestations of social inclusion to keep in mind that there can be a variety of motives behind the policies that guide their deployment. [1]

Obviously, people and groups have been marginalized and excluded from mainstream society since the beginning of time. So, why, now have certain governments decided that it is wise to do something about it?

The rise of government sanctioned social inclusion policies is attributed most often to events in France in the 1970's [1] which involved workers imported from North Africa and their subsequent marginalization and ghettoization (an experience that occurred in other countries as well). See Appendix 1 for a brief summary of the French experience.

Other forces driving policies of social inclusion may well be related to a whole series of troubling developments:

Globalization of commerce and manufacturing - meaning the easier movement of capital and labour across national borders. In Canada and the US, the news is often full of reports about "moving jobs to the third world." But there is a corollary and that is labour, itself, is on the move with large numbers of legal and illegal economic migrants seeking work in developed countries. As in France, many countries experience enclaves of unskilled and underpaid workers who are commonly ethnic and visible minorities, often viewed with deep suspicion by local citizens, and, if sufficiently angered, likely to engage in civil unrest or rioting in response to exclusion and injustice.

War torn countries experiencing protracted violence – The destabilization of populations living in perpetual conflict has many results including loss of livelihood, deteriorating health, unstable economies and currency, and the breakdown of law and order.[1] The common consequence is the out-migration of people seeking security and work. These groups are taken into developed countries under refugee status and combine with immigrant or migrant labour in ways that can ghettoize them, deny them the work they crave and the social inclusion necessary to start a new life. They also bring with them the after effects of severe trauma which can gravely affect their health.

The disaffected second generation – Enough time has passed that there are substantial numbers of second generation youth and young adults of immigrant parents – many of whom are doing well. Some, however, figure disproportionately among the under-educated and unemployed. Caught between not belonging to their parents' country of origin and feeling that they don't belong in the country where they were born, they are vulnerable to recruitment to gangs[1] and even terrorist organizations.[1] In addition, the recent global recession has disproportionately disadvantaged youth in the labour market, particularly visible minority youth.[1]

An increased gap between the rich and the poor in developed countries – In Canada, as in other countries, the rich are getting richer and the poor, poorer. According to 2005 census data, the richest fifth of Canadians increased their income by 16.5% in a 25 year period. Conversely, the poorest fifth saw their income fall by 20.6% in the same timeframe. Middle income earnings have been flat-lined and, as a group, they are shrinking. There are now more low income children in Canada than low income seniors. Fourteen and one half percent of children under five live in low income families (13% for children aged 6 – 14 and 11.4% for 15 – 17).[1]

Globalization of news and the deep penetration of all forms of media – We have become, indeed, a global village and incidents of rioting, bombing, looting and terrorism are broadcast in all their frightening detail world wide. Citizens of the developed world who previously felt "this could never happen here" are very worried that it could, very well, happen here. And it has evidenced by the bombings in Madrid, in the London subways and in Bali, by shootings in Mumbai and, most saliently, 9/11.

Another important measure of the rise to prominence of social inclusion as a government strategy is the growing concern that traditional measures of Gross Domestic Product (GDP) – a compilation of all goods and services produced by a nation in a one year period – have become inadequate. The criticism is that there is a growing gap between GDP reports and how citizens actually experience their lives.

France's Commission for the Management of Economic and Social Progress, at the request of President Nicolas Sarkozy, asked renowned economists Joseph Stiglitz, Amartya Sen and Jean-Paul Fitoussi to develop a report (delivered in September 2009) [1] that analyzes why traditional measures of GDP have become inadequate. These authors conclude that the fault with GDP is that it does not measure social well being. They argue that it is as important to know what is going on with the lower income earners as it is to know what's happening at the top. The measurements they suggest be added to GDP are those directly related to social inclusion; material well being, health, education, personal activities including work, political voice and governance, social connection, environmental degradation and the economic or physical security of the population. They also suggest that these measures be taken overtime to produce an index of the sustainability of social cohesion and prosperity of a nation. [1]

Not only do nations feel under threat from increased marginalization of certain groups within their borders, they are beginning to believe that lack of social cohesion is a direct threat to economic progress – powerful factors that have been known to move governments to action with haste.

An expanded definition of social inclusion

Broader definitions of social inclusion seek to expand its horizons so that it is not merely focused on the pressures of immigration and the mobility of the world's labour force, or threats of civil unrest and terrorism.

Amartya Sen (the Nobel winning economist mentioned above) has, for many years, asked society to re-think its ways of defining disadvantage and, by inference, social inclusion. He argues that inclusion is not just about what people *possess*, but what they can *do* to shape their own lives.[1]

Thus, the various definitions of social inclusion that have emerged (regardless of country) are focusing on common themes such as reducing poverty, ensuring citizen engagement, providing access to health care and education, and acknowledging difference (ethno-racial groups, but also disability, including mental illness). [1]

For example, in Canada, the Laidlaw Foundation refocused its child and youth strategy using the lens of social inclusion in 2000. In doing so, it developed a definition:

"…social inclusion extends beyond bringing the 'outsiders' in, or notions of the periphery versus the centre. It is about closing physical, social and economic distances separating people, rather than only about eliminating boundaries or barriers between *us* and *them*."[1]

Its tenets include:

- Valued recognition – acknowledging difference and common worth
- Human development – nurturing talents and abilities
- Involvement and engagement – in decisions that affect one's self
- Proximity – opportunities for interaction, sharing space, support for diverse neighbourhoods
- Material wellbeing – food, money and housing

A second, earlier version of a Canadian definition is:

"Social cohesion is the ongoing process of developing a community of shared values, shared challenges and equal opportunity within Canada, based on a sense of trust, hope and reciprocity among all Canadians." 1

These definitions signal the types of broad interpretations of social inclusion that underpin a number of formal government policies that have arisen. As another example, Australia defines social inclusion as:

“People have the resources (skills and assets, including good health), opportunities and capabilities they need to:

- Learn – participate in education and training,
- Work – participate in employment, unpaid or voluntary work including family and carer responsibilities,
- Engage – connect with people, use local services and participate in local, cultural and recreational activities, and
- Have a voice – influence decisions that affect them.” [1]

Examples of government policies and strategies of social inclusion

Many countries have formally adopted social inclusion policies, and sometimes legislation, which are intended to have a prominent influence in all that government does.

The following examples are not exhaustive but intended to provide evidence of the strength of commitment to social inclusion that is emerging in many jurisdictions and the efforts being deployed to measure first, the extent of the problem and second, the actual outcomes of the strategies to reduce disadvantage. A notable exception is that social inclusion has an extremely limited profile in the United States. Canada has a few pockets of activity but no federal policy.

European Union (EU)

The European Union Social Protection and Social Inclusion Process was established in 2000. The policy calls for the eradication of poverty and greater social cohesion by 2010. Strategies involve making labour markets more inclusive, ensuring decent housing for all, overcoming discrimination and increasing the integration of people with disabilities, ethnic minorities and immigrants, providing access to financial services and benefits for all (i.e. loans and mortgages) and tackling over-indebtedness. The main initiatives, in the near term, are child poverty, pensions for the elderly and access to long term care services and health equity for all.[1]

United Kingdom

In England, the government established the Prime Minister's Strategy Unit responsible for an action plan on social inclusion. The plan, published in 2006, has five guiding principles:

Better identification of populations at risk and the development of early intervention strategies,
Systematically identifying which social inclusion strategies work and which do not,
Promoting government support and health agencies working together,
Personalizing rights and responsibilities which means holding professionals and agencies accountable for positive outcomes based on "strong, persistent relationships" with those at risk, and supporting achievement in these agencies and managing under-performance.[1]

To accomplish these ends, the National Social Inclusion Program [1] offers ten good practice messages for United Kingdom government agencies and services in relation to mental health:

Social inclusion is:

1. about getting people back to work but also fostering wider social participation,
2. not just about access to services but broad community participation and engagement,

3. agencies working across traditional boundaries, among each other and with non-governmental organizations,
4. creating partnerships among and beyond government agencies and services,
5. for people with mild *and* serious mental health problems, and is also about mental illness prevention and mental health promotion,
6. public sector agencies actively (not passively) promoting equality and opportunity and acting against discrimination,
7. full involvement of people with mental health problems in a co-production approach,
8. ensuring that people with a mental illness understand themselves as whole people – not just a diagnosis,
9. the desegregation of mental health services and integration of concepts of mental health and illness into all services,
10. workplaces and learning venues that support good mental health with an accommodating environment and enabling attitudes.

Italy

Italy has a legal definition of "*esclusione sociale"* – poverty combined with social alienation. It also established the Commissione di indagine sull "esclusione sociale" as early as 1984.[1] The role of the Commission is to report to government yearly on measures of poverty and disadvantage.

Australia

In 2008, the Australian government developed a Social Inclusion Board and appointed its Deputy Prime Minister as the Minister of Social Inclusion.[1] It is focusing on at-risk children, jobless families, homelessness, Indigenous people, employment for people with disabilities (including mental illness) and at-risk and disadvantaged communities. Australia has also developed a toolkit for all its government agencies that holds them accountable, while at the same time, guiding the development of local social inclusion policies and service delivery. The implementation steps included:

1. Identify groups at risk of exclusion,
2. Analyze the nature and cause of disadvantage and exclusion,
3. Strengthen protective factors and reduce risk factors,
4. Work with other agencies to coordinate efforts across government and other sectors,
5. Redesign delivery systems and promote changes in culture, and
6. Establish a clear implementation plan and monitor delivery.[1]

Based on work in the EU, the Australia Social Inclusion Board has also developed a series of indicators it will use to performance measure and evaluate social inclusion activities in the country.[1]

New Zealand

The New Zealand government thinks of social inclusion in terms of fairness. Its policy statement is as follows:

"An inclusive New Zealand where all people enjoy opportunity to fulfill their potential, prosper and participate in the social, economic, political and cultural life of their communities and nation." [1]

The New Zealand government defines social inclusion as both the results it wants to see from its social policies and the means by which these results are achieved – through inclusion rather than exclusion and through the promotion of engagement and participation in all facets of society. [1]

New Zealand policy makers link the concept of social inclusion, as well as social capital, and social cohesion, to the development and maintenance of a strong national identity. They state that the key aspects of social inclusion are:

- Belonging - common experiences, aspirations, values and norms but also relations which are safe, secure and trusting,
- Inclusion - access to employment, services, institutions and social networks,
- Participation - the ability to contribute locally and nationally and to affect decisions,
- Recognition – acknowledgement and affirmation of difference while valuing the contributions diverse groups make to society, and
- Legitimacy – the protection of civil liberty and rights for all and equal access to trusted social institutions.

New Zealand's guide for implementing social inclusion policies in its government agencies is similar to Australia's with the steps including: Define desired outcomes and indicators, analyze and define the problem, set objectives, identify, analyze and design options, present recommendations to decision-makers, plan for implementation and service delivery and finally, monitor and evaluate. [1]

Critiques

While social inclusion seems like it would be good for everyone, there are possible negatives. For example, one author describes social inclusion policies as thinly disguised racism. Because immigrants and refugees are most often from racialized groups and because poverty and disadvantage are prevalent within racialized communities, these are policies that divide the world along racial lines.[1] Perhaps their real utility is to have governments appear to be genuinely inclusive while the status quo is maintained.

A second critique speaks to whether or not marginalized groups *want* to be included in the mainstream. First Nations, Inuit and Métis, as only one example, have strong identities and a culture that they want to maintain. Are policies of social inclusion an echo of government sanctioned colonization and assimilation – hugely damaging strategies from the mainstream that led to reservations and residential schools.

A third criticism arises from the Jewish experience but could apply to any outsider group. Marmur (2002)[1] argues that a conscious pariah is someone who maintains his or her dignity outside of the mainstream. Conscious pariahs accept their status as outsiders and refuse to imitate insiders and, instead, struggle for equality within their own identity. On the other hand, parvenus (an old fashioned term for upstarts who are trying to ingratiate themselves with their betters) long for insider status but are never really admitted to the inner circle. They are patronized by the mainstream – possibly tolerated but usually looked down upon in subtle (and not so subtle) ways. "Morality means that it was worth remaining a poor Jew even when one ceased to be a poor Jew." [1] This author makes the distinction between political integration (access to equal opportunities and human rights protection) and social integration (acceptance).

There is a fourth potential criticism, not well articulated in the literature but one which comes readily to mind given this review. While social inclusion may imply a welcoming of diversity, policies rarely state this value explicitly. To neglect an open statement of value for diverse identities leaves social inclusion policies open to the criticism that what they really mean is that the door to full participation in society requires you to morph from your marginalized identity into a mainstream one – to learn how to "pass," as it used to be called. Practically speaking, passing meant, for white people anyway, disguising one's original ethnicity by anglicizing your last name, by denying your religious roots or changing your diet to hot dogs and hamburgers. Certainly, many immigrants who came to the shores of Canada and the United States in past decades chose this path as a way to make life easier for their decedents. Today, our visible minority, multi-cultural immigration patterns do not present the choice of passing, whether or not it may be preferred, because people of different racial backgrounds simply cannot pass. Thus, social inclusion, if it is to be truly *inclusive* must offer real opportunities for people of diverse identities to participate in society and share equally in its opportunities and wealth.

Social inclusion and the experience of mental illness

With these ideas in mind, it can only be argued that the road to inclusion for people with mental illness has been long. In the 1980's, we began with the concept of *empowerment* – people being included fully in the treatment decisions made about them and having their opinions valued. In the 1990's we moved to *participation* – people with mental illness invited to become involved in Boards of Directors, task forces, and service planning and delivery. In the new millennium, *recovery* came to prominence – meaning that service providers, community members and others must recognize that people can live full and meaningful lives despite mental illness and that services must be delivered with recovery as a goal.

While the above definitions are brief and miss complicated nuances, they nonetheless imply some sort of progression for people with mental illness but no one can deny that stigma and discrimination remain common experiences. So what would adopting policies of social inclusion do for people with mental illness that empowerment, participation and recovery have not yet accomplished?

In answer to that question, it is useful to look at examples of where policies of social inclusion, specifically aimed at people with mental illness, have been enacted and applied. The following examples have been chosen because they are robust – involving legislation, policy, assignment of responsibility and monitoring – in other words, they have teeth.

Scotland

The Mental Health (Care and Treatment) (Scotland) Act 2003 defined a "statutory duty on local authorities to promote well being and social development for those who have, or have had, a mental disorder." [1] "Mental disorder" includes people with mental illness, learning disabilities and personality disorders. A toolkit of best practices has been developed that directs local authorities on the process by which they must change in order to comply with this statute.

Some salient aspects of the toolkit are:

- Mental health assistance is for everyone – not just those with the most severe disorders.
- All government services must become integrated and inclusive of people with mental illness - not just specialized mental health services
- The entire community must be involved in the support of people with mental illness by offering employment, housing and social networks.

In order to comply with the Act, local authorities and the services they fund are to get out into their communities and form relationships with employers, arts and sports groups, financial institutions, city councils, schools and charities. Through these relationships, they are to promote the full involvement of people with mental illness in their communities with a particular emphasis on employment.

A senior employee of each local authority is to be assigned responsibility for managing the necessary change and for achieving results. No new funding was be allocated but compliance is expected nonetheless.

The local authorities must report publicly on their progress and could be subject to legal challenge if they are not in compliance. Monitoring tools and inspections are under consideration.

Groups of service users – people with a mental illness, learning disability or personality disorder – have been formed to provide an audit function. This means that they will visit a service, community centre or education centre (places where people with mental disorders usually go) to access how they are treated and report on the results. In some cases, they will provide advance notice of their visit. In others, they will simply show up and see what happens (a "mystery shopper" approach). As well as visiting, they will interview other service users on their experiences of the chosen location. It is suggested that they provide written reports on what they have discovered to the local authority which funds these services and which is likely very interested in whether or not they are in compliance with the well being and social development statue of the Mental Health Act.

Ireland

The National Economic and Social Forum in Ireland commissioned a report on social inclusion and mental illness in 2007. [1] The report called for a focus on work as the cornerstone to recovery. It also sought to broaden the responsibility for mental health to whole communities so that they are better able to provide social support and decrease stigma – along with opportunities for integrated social and health services and a particular emphasis on peer support and self help.

Australia

In 2008, Australia conducted consultations [1] on experiences of social exclusion for people with mental illness and other disabilities finding that interventions to increase social inclusion must involve human contact (social support) first and foremost along with work, help for disadvantaged communities, alterations in government funding formulas to eliminate short term, one time and inconsistent funding for supports and services and an emphasis on measuring actual outcomes (as opposed to units of service).

Is this a step forward?

For people with mental illness and their families, policies of social inclusion have some aspects that are promising in the fight against stigma and discrimination. The policies feature work as a central goal. All too often, formal mental health services have neglected this aspect of a person's recovery. They have mechanisms for transparency and accountability that call for measurement of actual effectiveness – as opposed to quantifying activity. They challenge communities to step up the plate with employment, support and housing and call for social and mental health services to, themselves, better integrate into their community. Finally, the policies speak to the whole person, not just to a diagnosis.

However, the critiques of social inclusion need to be kept in mind. Can policies like these *really* make a difference in changing individual beliefs and attitudes towards people with mental illness? Don't people with mental illness want to be valued *because* of their experiences as opposed to in spite of them? And, finally, are social inclusion policies more about maintaining peace and prosperity for mainstream society than they are about *sharing* that peace and prosperity with all?

As a last note, is there just the faintest whiff of condescension to be detected? If governments are now going to entreat services, employers, educators and communities to treat you better, is the (perhaps unintended) message that you are to be pitied?

Belonging – safe places and recovery

The themes that have arisen from this brief review of social inclusion policies are:

1. A focus on poverty relief and at-risk groups
2. Access to education, work and health care
3. Civic engagement and participation in decision-making

An additional theme was raised in the New Zealand policy – but was not mentioned specifically among the various other policies sited in this paper. This is the idea of *belonging* defined as social relations which are safe, secure and trusting.

People who have been stigmatized and excluded have been harmed in fundamental ways. They need experiences of safety in order to be able learn, work, engage and participate. In other words, social inclusion is a two-way street. Society must offer openings for excluded groups to become fully engaged citizens (rights), but members of excluded groups must find ways of healing so they can take advantage of these new openings in healthful ways (responsibilities).

Safety and security at a personal level

If social inclusion is the societal version of safety and security, meaning that those who are included feel at home in their communities, provinces, territories and nation, then personal safety and security is its expression at the individual level.

The foundation for all human development is safety. Eric Erikson, a famous developmental psychologist, defined the beginning stages of child development as the creation of security for infants. In the toddler stage, parents become a safe refuge when children begin to explore the world.[1] Without these solid experiences, children do not develop (or develop inconsistently) the feelings of trust that are so necessary for their entry into the wider social world. Further child development theories relate to attachment, meaning that a secure relationship with at least one adult is required in order for children to develop socially and emotionally. [1]

Many people with mental illness have had traumatic experiences in childhood and can, in adulthood, live in unsafe neighbourhoods and with unsafe relationships. Others have found that hospitalization and a diagnosis of mental illness are traumatizing life events in themselves. Add to these experiences the fact that they are objects of stigma and discrimination and it becomes plain that there is a lot to recover from in the healing journey. [1] Creating personal safety and security is an essential first step in the process of recovery.[1]

People with mental illness can have a hard time believing that they deserve to be safe. The mental health system is itself unsafe with the spectre of involuntary treatment and hospitalization ever present for many. In fact, safety, as it is often talked about in mental health settings, can be code for one sided risk assessments [1] with mechanisms like no cutting contracts or the harsher implicit or even explicit demand, “don’t go killing yourself on my watch” message. What is meant is all too clear – it’s not so much about *your* safety as the safety of the professional’s reputation, of the service and of society as a whole.

While many members of marginalized groups may not have had the safe beginnings that children require for optimum human development, creating places of safety in adulthood – while never easy – is possible.

Establishing personal safety and security

Physical safety- For an organizing framework it is useful to reference Maslow’s well-known hierarchy of needs which specifies that the basics of life (food, shelter and clothing) must be present in order to launch the journey of human development. Similarly, the recovery process requires first, that people are housed in safe and affordable settings, have a stable income and live in non-violent communities – physical safety in other words.

Relational safety - Second, people need to examine their relationships as they may find that they have become used to being surrounded by people that are, themselves, unsafe (violent, sexually or financial exploitative, judgmental or cruel). Finding the courage to extricate yourself from damaging relationships is extremely difficult. There is a strong fear of abandonment (will anyone want to be my friend/partner now?) and the challenge of developing new social skills, new ways of judging whether or not a potential relationship can be healthy, all the while, suppressing fears of rejection.

Emotional safety - Closely aligned with relational safety is the need to learn to manage your own emotions in the recovery process while protecting yourself against others who are emotionally damaging. Here too, there can be mixed messages from mental health settings if medication is the only tool offered to manage thoughts and feelings. While many people find medication helpful, it is not a substitute for learning the skills of calming yourself, acknowledging your sadness or managing anger.

Examples of safe places

Healing and recovery takes place among people. Finding mental health services, treatments and medication regimes that are helpful – and safe – can be a long search. However, formal services are only one aspect of recovery.

Peer support

Self help and other opportunities to be among people who have "been there" (peer support) are valued for many reasons but the main one is safety.

"Peers are not professional caregivers but fellow travelers who have suffered (mental illness) and struggled with recovery – just like you. In rare instances, peers can be paid by mental health organizations to visits clients and provide support or run peer programs. Most often, they are unpaid volunteers wanting to give back – or prevent others from experiencing some of the suffering they have gone through." [1]

With peers, you can feel at home because you "feel that people understand not only what you say, but also what you mean." [1] You belong. In self help groups you give and receive help, learn new skills and coping mechanisms, and test out new ways of thinking and behaving among people who are just like you and in safety.[1]

Psychiatric survivor movement

In the 1970s and 80's people who had bad experiences in the mental health system came together to protest their treatment. As in the initial stages of most protest movements, their positions were anti: anti-psychiatry, anti-hospitalization, anti-involuntary treatment, anti-medication and anti-electro convulsive treatment (ECT). People who were drawn to the psychiatric survivor movement felt they were finally among others who understood them.

The movement was not without its internal struggles most often dividing along lines such as those who felt medication might be helpful versus those who thought that taking medication was akin to sleeping with the enemy. Other fault lines were naming your identity. Were you a survivor or were you a consumer? Those who identified as a survivors were capable of labeling consumers as the lap dogs of the powerful.[1]

Today, the movement remains alive and well although perhaps more subdued than in earlier times. Many founding members have moved from protest and advocacy to jobs within the mental health system that relate to arts programs, employment, peer support or formal system and government advisory councils – as the system itself has altered so that they feel more welcome and more able to express their criticisms.

The movement has had many victories, only one of which was its ability to provide a safe and secure outlet for expressing anger at the treatment its members have endured at the hands of psychiatric and mental health systems. While fissures arose, in the main, members viewed the movement as home – with the conflicted feelings that "home" holds for most people.

Cultural safety

First Nations, Inuit and Métis people have experienced harm due to experiences of colonization and the institutionalized discrimination that exists today. This harm affects them in many areas of their lives, not the least of which is physical and mental health. Western medicine perpetuates structural inequities that make the health encounter between practitioner and the First Nations, Inuit or Métis patient profoundly unsafe. [1]

Cultural safety was a method of health practice developed by Indigenous Maori nurses in New Zealand.[1] In order for health and mental health practices to be safe, clinicians are asked to recognize the unequal relations that stem from a colonial past and which remain in the post-colonial present.

Cultural safety is distinct from cultural awareness, cultural sensitivity and cultural competence.

- *Cultural awareness* – a beginning step in understand there is a difference among people.
- *Cultural sensitivity* – the experience of *all* people includes aspects of similarity and difference to the clinician's background. All difference is important and must be respected.
- *Cultural competence* – the skills, knowledge and attitudes to safely and satisfactorily deliver health and mental health care.[1]

These definitions tend to ascribe "culture" to the patient but not to the practitioner. Cultural safety, on the other hand, asks clinicians to be aware of their privilege and membership in the dominant class – and that their membership carries with it a whole culture (often invisible to the mainstream) which can interact unfavouably, if the power imbalance is not addressed, with the culture of the First Nations, Inuit or Métis patient.

"Cultural safety is both a process and an outcome – it is a relational concept. It includes those actions which recognize, respect, and nurture the unique cultural identity of those we engage with to safely meet their needs, expectations and rights. Although it is important to recognize both the shared and unique beliefs, values and attitudes of people in our relationships, including ourselves, culturally safe practice also involves recognizing and addressing power dynamics between people and structural inequities such as stigma and discrimination that influence health care, health and well-being." [1]

Thus, cultural safety is a methodology whereby First Nations, Inuit and Métis people can experience their encounters with the health and mental health systems as occurring in safety - and in a safe place.

In its strongest iteration, cultural safety is equated and measured along with clinical safety, and safety is defined not by those who deliver the service but by those who receive it.[1]

The above are but a few examples of safe places. In fact, a safe place can be a completely individual choice. Some may find that a return to organized religion is a safe place while others would not. Some may choose the gay community as a safe place. Others define a safe place as a geographic location – such as moving to your own apartment or to the country. The choices are endlessly creative.

These examples serve to illustrate the critical role personal safety and security plays in healing and recovery, and in the eventual goal of taking up one’s place in society – be it as a member of the mainstream or as a “loud and proud” member of a group that isn’t – and doesn’t want to be - mainstream.

The link between recovery, safe places and social inclusion

A crucial aspect in the recovery journey is access to life opportunities and finding a way to belong in your community. While formal mental health services may provide some of the help you need, too often they can form a sort of ghetto in themselves. Getting into services in the first place can be such an uphill battle that arrival in the “community” of supportive mental health services can be prized as a permanent home.

As the examples of social inclusion mental health policies from other jurisdictions show, mental health services have been criticized for their insularity – siloed as it is called in health planning circles. Canadian services are not immune from this criticism. There are many consequences of siloing such as community agencies that don’t know about other important services for their clients, the inability for clients to easily make their way through a complicated de-linked system and the oft- repeated complaint of having to tell your story over and over again to many service providers.

However, there is another consequence. Mental health services are failing to move clients towards membership in their wider communities. This is where policies of social inclusion specific to mental health may have their utility. As the example of - particularly - Scotland shows, agencies must actively reach out to their communities so that they have relationships with employers, landlords, recreation centres, religious groups, sports and arts venues – the very places where their clients must “graduate” to in order to belong as full citizens.

This is not to say that the *only* way to achieve positive membership in your community is with policies of social inclusion and the help of community mental health agencies. Many people find this path on their own. However, it emphasizes that a critical part of the journey of recovery is becoming part of your community – from two angles: First, through you establishing your own personal safety and security so that you can heal and recover and second, through wider society providing you with real opportunities to participate as a full citizen in your community, province or territory or nation (social inclusion).

Conclusions

Social inclusion is a complicated set of ideas that requires careful consideration – from all angles. It is clear that in some parts of the world, mainstream society has heard the thunder of deep discontent. They are beginning to recognize the harm that marginalization does to people because the marginalized have struck back. Social inclusion policies, even those with teeth, can only do so much. Powerful historical and cultural forces divide the world while those that unit it are less visible and less commanding. The policies, as reviewed in this paper, do not speak strongly enough to the preservation of identity and the celebration of difference. Perhaps these ideas are implicit but comfort for many will come only from explicit statements and visible actions. Otherwise, social inclusion policies are open to igniting fears that they are really assimilation dressed up in new words. A possible way forward may be to establish the clear distinction between *political integration* (all groups have rights, protections and access to civic engagement) versus *social integration* (acceptance is the only passport to all that society has to offer). Is there something here for people with mental illness and their families? A cautious yes – if the goals of potential social inclusion policies are carefully thought through and clearly articulated.

Appendix 1

The French Experience

France built a large number of public housing projects in the 1950's to overcome a shortage of affordable housing for its citizens. The projects were gladly occupied by people with low to middle income and functioned well. In the 1960's, foreign nationals (many from North Africa and other racialized groups) were hired in large numbers as unskilled labour for France's burgeoning manufacturing sector. These foreign nationals were not allowed access to the projects and began to occupy poorer neighbourhoods that were seen to deteriorate into slums. In the 1970's, the policy regarding entrance to the projects changed to include foreign nationals and was accompanied by two things; the government ordered the bulldozing of the slums where the foreign nationals lived while it built a second wave of public housing where people could buy their homes with low interest mortgages. The traditional French occupants of the projects took up the offer of affordable new housing while at the same time, fleeing the projects as they felt that the decision to admit foreign nationals was ruining their peaceful existence.

Also in the 1970's, France experienced a significant downturn in its manufacturing sector and the foreign nationals were the first to be let go. The projects became occupied – almost exclusively – by foreign nationals of visible minority status who were unemployed, at loose ends and angry.[1]

SCHEDULE "C"

Western Canada Focus Groups

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

Background Paper

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

November, 2010

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Executive Summary

Background

As part of their ‘Building Bridges’ initiative, the Mood Disorders Society of Canada (MDSC) and the Native Mental Health Association of Canada (NMHAC) collaborated with the First Nations, Inuit and Métis Advisory Committee (FNIM AC) to the Mental Health Commission of Canada (MHCC) in a joint research project to understand best and promising practices that constitute cultural safety and relational practice in the Canadian context. In 2009, they commissioned a total of forty-one focus groups in Western and Eastern Canada, a national symposium in Ottawa in 2010, and two research papers, one on social inclusion, the other on cultural safety. The purpose of this background paper is to provide an overview of findings from the Western focus group consultations. A report incorporating further analysis will be completed by April 2011.

Research Question

“What will improve practice in mental health and addiction services for all Canadians?” is the central question in this project. Focus group participants included practitioners and recipients of services, with approximately two-thirds aboriginal, one-third non-aboriginal, the majority working in aboriginal-led organizations serving indigenous people. The focus on mainly aboriginal agencies, their staff and clients, was intentional, as aboriginal voices have seldom been privileged.

Findings

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

1. *Direct care* refers to the qualities of the care provider/care recipient relationship.
2. As viewed by participants, the relationship needs to be accessible, inclusive of the disabled, respectful and responsive to the uniqueness of each individual, strengths focused, flexible, trauma informed, acknowledging of grief, and making use of human connection in healing.
3. *Interpersonal relations* refers to the range of relational networks and formal and informal supports in which both the care provider and recipient are embedded, including relationships with families, community members, colleagues, peers, mentors, supervisors, other service providers and agencies. Participants emphasized the importance of reciprocity and dialogue, support for self-care, self-awareness and conscious growth, and the necessity for circles of support for both care provider and care recipient.

4. *Professional development* refers to the informal, non-formal, and formal knowledge and skill development received by professionals in the course of their training to become a mental health practitioner, as well as the multiple life experiences and cultural practices that care providers draw upon in their work. On this topic, participants shared insights about informal, non-formal and formal education/training, mentoring, lived experience, balance and harmony, and wisdom teachings.
5. *Ways of knowing* refers to the approaches taken to understand, document and make sense of the social world. "All my relations", cultural continuity, the power of story, and tensions between Western and Indigenous ways are themes that emerged in the focus groups.
6. *Organizational context* refers to workplace norms, policies, resources, agency mandates and professional routines. Participants spoke about organizational norms, centralization vs. decentralization, integration of services, family and community context, and healthy effective organizations.
7. *Policy challenges* refer to government legislation, policies, and funding. Significant challenges identified in the focus groups include the tension between individual and collective rights, between biomedical and complementary approaches, and concerns about the capacity for response to ethical dilemmas.

Domains for Consideration

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

1. *Group process and leadership* – the research model chosen was based on inclusion, participatory methods and indigenous ways of sharing knowledge both with the focus groups and within the working group. Dialogue with the data and between researchers led to a new way of understanding mental health and addictions as a human experience.
2. *Principles* - eighteen principles are identified in the report: honouring humanity and human experience; centrality of connectedness and relationships; valuing and learning from diversity; "do no further harm"; patience; deep listening; radical acceptance; reconnection; respect; collective healing; community of practice; strengths based; relational attunement; honouring boundaries; recovery model; nature as healer; culture as healer; prayers and ceremony.
3. *Practices* - eight associated practices emerged as key findings: fundamentals first; becoming and honouring human process; silence, nature and "being with" as therapy; culture as therapy; shared living; manage fear; no experts' zone; programming with options, multi-year funding and community-driven.
4. *Metaphors* – three metaphors arise from the findings: spiral as connected completed circles, two-way street and walking together.

5. *Liberating Concepts* – twelve key ideas derive from the findings: many choices and freedom to choose; return to the large human tribe; all life matters; humanized and humanizing relationships; knowing self, knowing other in context; know what you stand for and change self; circles within circles; ripple effect; speak the truth in love to people; intentional disruption is good; healing and recovery as learning and growth; intuition, wholeness and change.

Recommendations

A. Next steps:

1. Endorse the Eastern Focus Group Report
2. Link with Ethics Working Group
3. Disseminate East and West reports together with a joint summary paper
4. Support development of "Building Bridges 3" through: a) dialogue forum, b) case studies of promising practices, c) mining of RCAP and AHF work to expand foundational learning (d) Website creation and (e) international collaboration.

B. System change: knowledge development through group dynamics paper, presentations and publications

C. Education and Training: curriculum development and training

D. Policy development: develop relational and ethical engagement policy lens for policy analysis

E. Program/Services delivery: joint development and sharing of resources for renewal of system.

1.0 Introduction

As part of their Building Bridges initiative, the Mood Disorders Society of Canada (MDSC) and the Native Mental Health Association of Canada (NMHAC) collaborated with the First Nations Inuit and Métis Advisory Committee (FNIM AC) to the Mental Health Commission of Canada (MHCC) in a joint research project to understand best and promising practices that constitute cultural safety and relational practice in the Canadian context. In 2009, they commissioned a total of 41 focus groups in Western and Eastern Canada, a national symposium in Ottawa in 2010, and two research papers, one on social inclusion, the other on cultural safety.

The question central to the project was: “What will improve practice in mental health and addiction services for all Canadians?” To find answers to this question we conducted focus groups in Western Canada involving practitioners and recipients of services, approximately two thirds of them aboriginal, one third non-aboriginal, the majority working in aboriginal-led organizations serving indigenous people. The focus on mainly aboriginal agencies, their staff and clients, was deliberate. It is generally accepted knowledge that historically, health care in Canada has been dominated by the illness and health belief systems of the dominant culture and has disregarded those of indigenous people (Smye and Brown, 2002). The outcomes for Indigenous health have been poor. By listening to people rarely consulted, situated in contexts seldom researched, the authors attempted to document some of the interests, values, beliefs, and principles that may hold promise for improving the health and well-being of indigenous and non-indigenous people, as a contribution to transforming the mental health system in ways beneficial to all Canadians.

This background paper describes how the authors conducted the Western focus groups and the analysis of the transcripts. It presents our findings about cultural safety, relational practice and ethical engagement and invites discussion regarding the implications and opportunities for a transformed mental health system in Canada. Further analysis is ongoing and will be incorporated in a final report to be published and disseminated by April 2011.

2.0 Method

The Western focus groups were held in Saskatoon, Winnipeg, Iqaluit, Yellowknife, and Whitehorse in October and November 2009. A total of 147 people participated. Of these, 97 identified themselves as indigenous (22 Inuit and 75 First Nations or Métis). Those in provider roles numbered 108 and those with lived experience 39. A significant number of providers (25) reported having gone through their own healing journey, with or without formal assistance, to evolve into care providers themselves. Participants working for or receiving assistance from indigenous based organizations constituted 56% of the total, non-governmental organizations approximately 29% and governmental 15%. A detailed demographic of participants can be found in Appendices A and B. The Executive Summary of the Eastern focus groups can be found in Appendix C.

The focus group facilitators' longstanding relationships with key stakeholders in the communities enabled them to draw upon existing community networks to form the sample population of convenience. Stakeholders' investment of time and energy was motivated by their interest in the purpose of the project and its outcomes.

Discussions were grounded in an overview of the project context. Focus group facilitators explained that the initiative is intended to contribute to the joint efforts of the FNIM Advisory Committee within the Mental Health Commission of Canada, the NMHAC, and the MDSC to further the understanding of culturally safe practice in mental health and addictions.

Through a process of circle dialogue and story telling, participants reflected on their experiences with mental health and addictions services, what was working, what was not working, and what could be improved. Participant concerns led the emergent discussion and spoke to the unique characteristics of group members with respect to their geographical location, the types of services and systems they dealt with (governmental, non-governmental, aboriginal or consumer-led), to their challenges, and ways of addressing these. Sessions were audio recorded and transcribed. Transcription totaled 583 pages of rich information, thoughts and stories from participants.

3.0 Analysis

The process of making meaning of this wealth of information was shared by the five members of the FNIM AC cultural safety working group (that includes the two focus group facilitators). Transcripts were closely read multiple times and emerging themes and potential framing metaphors were identified. The first meeting of the working group resulted in a shared vision of the intent and design of the focus group background paper. Given the complexities of current mental health and addictions challenges, and the multiplicities within society, the group saw the value of the paper to inhere in its ability to open a dialogic space between as many people as possible; to invite them to engage, reflect and work together to arrive at new understandings from which fresh solutions may emerge. To achieve this, the approach taken in analyzing the transcripts was an emergent, collaborative one, in which meanings were negotiated in group discussion, patterns were sought, and complexities maintained. Each of the five working group members read a set of transcripts from one of the five cities visited. Members then met to share their perspectives and discuss the iterative interplay between the lived experience of focus group participants, the published literature, and the policies and practices that constitute the context, in order to highlight the layers of complexity of current reality. The group continued to meet, either in person or through teleconference, to deepen their understanding and analysis.

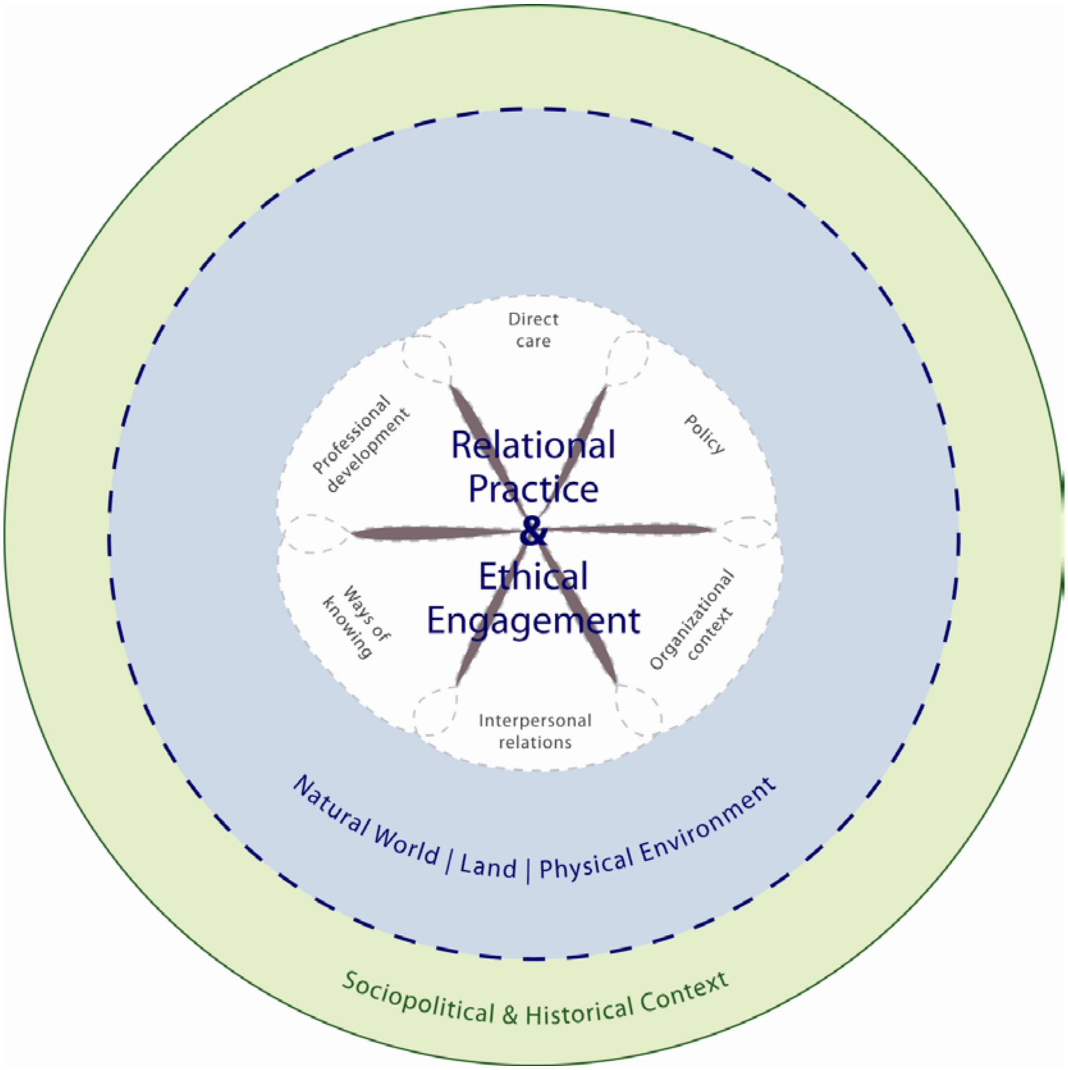
While focus group participants testified to the challenges in the current mental health system, they spoke more extensively of what works, how they conceptualize culturally safe practice, and what they want. Following multiple readings of the transcripts, and consistent with the literature (Smye & Browne, 2002), it became apparent that cultural safety is a process that is multiply determined, contextually embedded, and relationally mediated. For the purposes here, cultural safety is described as a relational concept marked by ethical engagement. Cultural safety is action-oriented in that culturally safe practice addresses power dynamics in health care, challenges social and structural inequality and is characterized by interpersonal relationships that take into account the social, political, historical and cultural factors that influence peoples' lives, understanding that health and health care are shaped by these factors. Cultural safety is *not* something that can be conferred or imposed. It is the outcome of relationships characterized by mutual respect and equality. Six interrelated categories were identified to capture the themes emerging from the focus group analysis:

1. direct care
2. interpersonal relations
3. professional development
4. ways of knowing
5. organizational context
6. policy

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

[1] Some of these categories have been drawn from Dr. Jennifer White (2007) *Knowing doing and being: A praxis-oriented approach to child and youth care*.

Figure 1



4.0 Findings

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

4.1 Direct Care

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

Access

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

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

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

> *“You can talk all you want, but after the talk is done and the session is over, they’re back on the street… so you know housing is an necessity, a major issue…and if they need to have psychological help, get them that help, and if they need detoxification, then get them into a treatment program, and if they need*

> *further education, you know, go for it, but if they're willing to take on a job, well then, get them one…" (Service Recipient [SR], Yellowknife)*

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

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

Inclusiveness and disability

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

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

Respectful and responsive

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

Strengths - focused

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

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

Flexible

Non-Government Organizations (NGOs) often are able to provide more individual, group and community-based creative responses that are also cost effective. Government agencies have more constraints around which they must manage in order to innovate and respond to community needs and challenges. *"What we do have as NGO's is a kind of freedom of thought; we don't have the government culture coming down on us, having to tow the party line." (SP, Whitehorse)* Flexibility in shaping a care plan according to individual needs and circumstances is a major determinant of successful outcomes. Underlying this is the principle that "the answers are within us"; the expert is the person who is living the life.

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

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

Trauma-informed

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

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

Grief as universal

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

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

Use human connection

One of the most important things aboriginal people have been deprived of has been human connection. To enhance and augment the value of individual therapy, many care providers use small groups and other collectives for re-creation through play, social and practical activities that support relearning the healing nature of "fun" while building positive relationships and developing life skills. Some services are activity based, rather than just "talk therapy"; for example, hunting on the land, going fishing, making a meal, crafting an implement or camping.

> *"We do cultural skills training…cabinet making, small tools, and repairing snowmobile engines." (SP, Iqaluit)*

4.2 Interpersonal Relations

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

Reciprocity and dialogue

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

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

Self-care

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

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

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

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

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

Circles of support

By definition, circles are inclusive. No matter where one is on the continuum of wellness, he/she deserves a place in our world and has gifts to contribute to others. Care providers see one of their most important roles as "bringing people into the circle", building social connections and peer support through healing and recreational approaches as well as group therapy.

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

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

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

4.3 Professional Development

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

Education/Training

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

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

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

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

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

Mentoring

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

> *"People with more advanced training need to go to the smaller communities more often to help support and train people working in the community." (SP, Whitehorse) "The nurses that are in a consulting role are using the resources in the communities to consult, to teach, to assist, all of that, so you are building up your communities." (SP, Whitehorse)*

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

The caution here is that mentoring and role modeling can also be the methods through which organizational toxicity is transmitted.

Valuing own woundedness and healing through lived experience

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

> *" If someone hasn't worked on their own stuff, they are of no help at all." (SP, Saskatoon)*

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

Balance and harmony

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

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

Wisdom teachings

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

> *"We don't need to teach the elders, they are already taught, and they are already professors and experts in their domain. It's the people that we are training right now in schools that we have to help them to think about the strengths, and alternative forms of healing for our people." (SP, Yellowknife)*

4.4 Ways of Knowing

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

All my relations

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

Cultural continuity

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

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

The Power of story, re-storying and restoration

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

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

> *“One night I was sitting with three co-workers and started talking about treaties and colonization. I was thanked by one co-worker who said she learned more from me in 15 minutes than from all the hours of equity training, aboriginal awareness. So, if that is going to be my role on the floor, I will educate them, I will try to ignore their ignorance and their discrimination to hopefully help them see a little more from my perspective, not the narrow view they have.” (SP, Saskatoon)*

Tensions between Western and Indigenous ways

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

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

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

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

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

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

4.5 Organizational Context

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

Organizational norms

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

> *"We are status blind; we serve anyone who is aboriginal, Inuit or Métis." (SP, Winnipeg)*

> *“The two systems (First Nations and non) are so different. One is about appointments and procedures; these did not work in the small communities.” (SP, Whitehorse)*

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

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

Centralization versus decentralization

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

Integration or linking of services

Innovation is needed in some cases to find new ways of integrating, bringing together or linking services. Focus group participants talked about people “getting lost in the cracks” due to lack of good linkages that work for people. Many participants spoke about the need for health services to link with housing and educational and employment opportunities. As one participant noted, *“like for me it’s hard to find a decent job because I’ve got no education. I can’t really get anywhere unless I try,”* and for another, *“it would be good to have small-income loans and low-rental places for people that need a place to stay.” (Service Recipients [SRs], Yellowknife) “Housing is a huge challenge for a lot of people, especially for women.” (SP, Saskatoon)*

Partnering between agencies or individual helpers is one way to link capacity to serve.

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

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

Family and community context

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

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

Healthy effective organizations

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

4.6 Policy Challenges

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

Policy supports for program funding

Program funding that truly serves people is adequate, equitably distributed, multi-year (up to five years) and begins to flow at the beginning of year one. In addition, the funding should continue uninterrupted for the full term, and if renewed, continue for the renewal period uninterrupted. The multi-year stability provides a real opportunity to demonstrate results. Monitoring, evaluation and reporting processes are strategic and should be easy to use and take a minimum amount of time and energy away from providing care. Policy and government implementation processes need to align with each other in order to maximize the ability of government and non-government community agencies to serve people. Ensuring sustainability for programs and services of proven effectiveness is also a challenge.

> *"Temporary funding is not the way to meet the health needs of the North." (SP, Whitehorse)*

> *"There's a lot of catches to this funding money. We operate, from quarter to quarter and uncertainty is the biggest problem we face because people are fed up, rightly fed up, after many years of programs being started and they start to improve their lives and all of a sudden your funding disappears and the program's gone. That's the biggest problem is the sustainability. We are looking to having to close the doors on March 31st after 6 full years thanks to the Aboriginal Healing Foundation (AHF). And this year, we are $8500 short because the feds haven't come through with the money though we signed the papers. I say live up to your commitments because if you don't, you kill the programs." (SP, Iqaluit)*

Individual rights and collective responsibilities

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

> *"What would it look like to create a truly family friendly service that engages the family and community? We don't think the language of diagnosis is friendly*

> *and office hours are unfriendly; there are a lot of things that are unfriendly." (SP, Whitehorse)*

Biomedical model and complementary approaches

The predominance of the biomedical model is problematic as it leaves little room for indigenous models and perspectives. It is an individualistic, curative rather than holistic approach that often conflicts with the indigenous. Participants called for building complementary approaches to create multiple ways of knowing and multiple pathways to healing and recovery.

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

Capacity for response to ethical dilemmas

Both individuals and organizations often find themselves faced with ethical dilemmas, some of which have cultural and professional dimensions. As one person said, *"Who is it we go to when something happens that we cannot tell anyone about?" (Symposium Participant [S], Ottawa)* Organizations need to have capacity to assist in these situations to prevent ethical blindness, burnout or moral residue as a consequence of unresolved ethical tensions that may compromise relational capacity at the service interface. Truth telling and speaking truth to power must be supported in order to build and keep trust. A recurrent example of a major ethical dilemma is the lack of program sustainability.

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

5.0 Discussion

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

5.1 Group process and leadership

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

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

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

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

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

5.2 Principles

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

1. Honoring humanity and human experience

Honoring humanity and the common ground of human experience entails recognizing pain in all of its human dimensions, supporting the voice of those who often do not have opportunities for expression, and affirming the health and resiliency of individuals, families and communities.

2. Centrality of connectedness and relationships

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

3. Valuing and learning from diversity

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

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

4. "Do no further harm"

To "do no further harm" is to honor that each person involved in relational engagement has vulnerabilities and past woundedness and as a fundamental principle, the intention is to not add to the burden of pain or trauma through negative relational experiences.

5. Patience

To have and express patience provides a quality to relationship that communicates that people are important and human connection takes time to unfold. Presence is not possible without patience to be with the other and wait for the next opportunity for deeper engagement to emerge. *"Time is love. The most important quality one can give is time." (SP, Saskatoon)* Healing from the cumulative effects of intergenerational trauma and other major disruptions to wellbeing takes time. *"Twenty-eight days after two centuries of trauma is not enough intervention for most people." (SP, Whitehorse)*

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

6. Deep listening

> *Following from patience is the ability to listen deeply to the other and hold space for their dignity to be protected and expressed. "It makes a lot of difference when somebody actually listens to people." (SR, Yellowknife)*

7. Radical acceptance

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

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

8. Reconnection

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

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

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

> *"So when they sent me back to my own people, they taught me how to take care of myself properly, they brought me back to praying, back to spiritual ceremonies and stuff like that. And they talked to me; they taught me how to be clean, how*

> *to survive, how to believe in myself, and how to feel more compete as a person." (SP, Yellowknife)*

9. Respect

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

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

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

10. Collective healing

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

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

11. Community of practice

The idea of community of practice or community of care is important in supporting the ongoing growth and development of care providers – both paid and unpaid. Collaborative relationships within and between agencies provide for a spirit of working together creating attunement and synergy that better serves the people.

12 .Strengths-based

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

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

13. Relational attunement

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

14. Honoring boundaries

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

15. Recovery model

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

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

16. Nature as healer

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

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

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

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

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

17. Culture as healer

Culture and cultural continuity is fundamental to positive identity.

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

> *Part of using culture to support healing involves exploration of music, art and creative expression as therapy. One's Mother Tongue is a powerful vehicle for connecting with culture." On the land is where I regained my language…and learned all the knowledge about the traditional roles of men and women and children…" (SP, Yellowknife)*

18. Prayers and ceremony

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

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

5.3 Practices

Fundamentals first

Food, clothing, shelter (housing), safety are important and foundational for healing as they meet the basic needs of human life.

Becoming and honoring human process

Ask people being helped how they are becoming and honour them as “works in progress”. The care provider offers stewardship in the care recipient’s process of healing, growing, and re-creating self.

Silence, Nature and “being with” as therapy

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

Culture as therapy

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

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

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

Shared living

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

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

No experts' zone
When a person is an "expert", there is no room for learning.

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

Programming with options, multi-year funding, community driven

> *These are the characteristics of some of the most effective programs; otherwise, enormous energy is consumed by continual fund raising. "I would say that 90% of the work I do for this center is keeping funds moving." (SP, Iqaluit)*

5.4 Working Metaphors

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

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

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

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

> *"We have to negotiate a shared understanding of the problems that confront us." (SP, Winnipeg)*

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

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

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

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

5.5 Liberating concepts as building blocks

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

> *"The opening up of spaces for many choices for people is critical." (S, Ottawa)*

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

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

All life matters

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

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

Humanized and humanizing relationships

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

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

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

Knowing self – knowing other in context

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

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

Know what you stand for and change self

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

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

Circles within circles

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

Ripple effect

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

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

Speak the truth in love to people

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

> *"We need to speak the truth in love to people. And there is no solo advocacy; it's about collective advocacy" (S, Ottawa.)*

Intentional disruption is good

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

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

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

Healing and recovery as learning and growth

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

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

Intuition, wholeness and change

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

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

6.0 Recommendations

6.1 Next Steps

Immediate Next Steps

1. Endorse the Eastern Focus Group Report – The report of the eastern focus group was very well done and fully endorsed by the western focus group leaders and the working group.
2. Link with Ethics Working Group – The Cultural Safety Working Group should link with the Ethics Working Group and find ways of bringing the work together into products that reflect both an ethical framework to support further dialogue and an ethical approach in furthering the thinking in relational practice and ethical engagement.

Intermediate Next Steps

3. Completion and Dissemination of Reports – Further data analysis following this background paper will result in a final report from the Western Focus Groups in April 2011. The East and West reports and a joint summary paper need to be broadly disseminated to inform dialogue and further work.
4. "Building Bridges 3" – The work is not complete and Building Bridges 3 would be an effective way to build on, and move the effective collaboration forward. Next steps for BB 3 could include:

(i) Dialogue Forum – Plan and implement a follow-up forum to review the results of the eastern and western focus group processes and move the thinking along. Document the forum to produce a DVD that can be used for educational purposes and to continue a broad based dialogue.

(ii) Agency and Service Promising Practices Case Study Stories – Build on the information collected in the focus groups by writing case studies as stories of those agencies that have found "good ways" to provide alternatives and complementary services to main stream bio-medical models

(iii) Royal Commission on Aboriginal Peoples (RCAP) and Aboriginal Healing Foundation (AHF) Foundational Learning -- Systematically mine RCAP and AHF for foundational learning. Find ways to remind change agents of the richness of Aboriginal perspectives, common sense and good solid recommendations for ways that work and next steps.

(iv) Web-Based Sharing -- Create a website or use existing web capability of MHCC to share findings from above initiatives and to provide a forum for on-going dialogue about relational practice and ethical engagement in mental health and addictions.

(v) International Collaboration – Invest in a more formal knowledge exchange and dialogue with international colleagues working in this area, beginning with Matua Raki, Christchurch New Zealand.

6.2 System Change

Knowledge Development

1. Group Dynamics Paper – Develop a paper that more fully captures the unique ways of working together developed by the FNIM Advisory Committee and the Cultural Safety Working Group as a contribution to describing alternative ways of working together.
2. Presentations and Publications – Invitations to publish or present the work at conferences and other gatherings should be taken and abstracts submitted to competitive processes in order to showcase the work, receive feedback, engage in the exchange of ideas and further develop the knowledge.
3. Audience-specific Short Papers – Develop a series of four to eight page papers building from this core document and targeted towards specific audiences (front line care providers, system managers, educators, policy practitioners, thought leaders, etcetera).
4. Cultural Safety Literature Review Document and Synthesis – Develop a synthesis paper that brings the cultural safety literature review completed by Dr. Victoria Smye and colleagues together with this core document.

Education and Training

5. Curriculum – Develop and disseminate education and training materials in relational practices and ethical engagement in mental health and addictions for care providers, groups and system leaders.
6. Training – Provide training directly and through arrangements with training institutions to invest in capacity development throughout the system. Also, take emergent opportunities to build into existing curriculum and training processes.

Policy Development

7. Relational Practice and Ethical Engagement Policy Lens – Work collaboratively to develop a lens or series of lenses to use in the analysis of policy propositions to test for cultural safety, supports to relational practice and assurance of ethical engagement between individuals, families, community and government agencies.

Program / Service Development

8. Sharing and Joint Development of Building Blocks to a Renewed System – Work collaboratively to develop program and service models as practical and helpful contributions to making the system over one piece at a time.

Appendix A

Demographics Western Canada Focus Groups

Participants	Number	% of Sample
Gender		
Male	42	28%
Female	105	78%
Ethnicity		
Aboriginal	97	66%
Non-Aboriginal	50	34%
Relationship with Services		
Consumers	39	26%
Service Providers*	108	74%
Location		
Saskatoon (5 groups)	12	8%
Winnipeg (5 groups)	28	19%
Iqaluit (4 groups)	28	19%
Yellowknife (7 groups)	60	40%
Whitehorse (6 groups)	19	13%
Total = 27	**147**	**100%**

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

Appendix B

Abstract: Cultural Safety Literature Review

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

Appendix C

Demographics Eastern Canada Focus Groups

Participants	**Number**	**% of Sample**
Gender		
Male	32	32%
Female	67	67%
Ethnicity		
Aboriginal	45	45%
Non-Aboriginal	54	54%
Relationship with Services [1]		
Consumers	47	47%
Family Members	5	5%
Service Providers	47	47%
Location		
Halifax (4 groups)	24	24%
Moncton (2 groups)	16	16%
St. Johns (2 groups)	13	13%
Montreal (2 groups)	16	16%
North Bay (2 groups)	14	14%
Sudbury (2 groups)	16	16%
Total = 14	**99**	**100%**

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

Schedule D

Cultural Safety Project: Eastern Canada
Focus Group Report

February 18, 2010

Executive Summary

Introduction

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

What brings people to mental health or addictions services?

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

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

What challenges do people face when trying to access services?

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

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

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

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

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

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

I think consumers who have the courage to keep trying when there is a 6 month wait list – we don't say that if someone has a broken leg – they are incredibly strong and patient people.
Service Provider, Halifax, Nova Scotia

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

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

What happens once people access services?

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

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

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

It is not uncommon for people to have unpleasant experiences when entering the system of services, even when they are the ones reaching out for help. The entry points where people most frequently report experiencing poor treatment are crisis services and hospital emergency rooms. Their concerns pertain primarily to unnecessarily long wait times, over-use of police and security guards who are not properly trained, and disrespectful treatment by service providers.

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

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

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

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

We need professionals who treat you like a human being.
Consumer, North Bay, Ontario

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

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

Everything can't be fixed with a pill.
Consumer, North Bay, Ontario

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

- Fragmented and uncoordinated services, reported by 12 groups.

Because organizations tend to operate as "silos", services are limited, not linked with each other, and difficult to access. Consumers with multiple needs are often bounced around from one service to another. As a result, they have to tell their stories again and again and there is no continuity of care. This is especially frustrating for people when moving to one service system to another, i.e. from children's mental health to adult services. Consumers and family members find it very challenging to have to navigate these service systems on their own and coordinate their own care. The disconnection between mental health and addictions services is especially troubling, as participants see a strong linkage between the two. One of the largest gaps seems to be between the health system and the community organizations that offer self-help and peer support programs. People often stumble upon these supports on their own, having failed to receive any information about them from health care providers.

What makes people feel safe?

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

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

> *I just want to be treated with respect.*
> *Consumer, North Bay, Ontario*

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

- Coordinated services and continuity of care, reported by six groups.

- Support from people who understand what they are going through, reported by six groups

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

- Respect for confidentiality, reported by three groups.

What makes people feel unsafe?

The mental health system and safety don't really go together
Consumer, Halifax, Nova Scotia

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

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

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

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

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

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

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

> *It's really frustrating – I'm trying my best but I fear that people will always see me as a junkie and a thief.*
> *Consumers, North Bay, Ontario*

What needs to be improved?

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

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

> *Everyone is a unique individual and they need to be treated as a whole person.*
> *Consumer, St John's, Newfoundland*

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

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

> *We need to start delivering our own services, and not just using the orthodox way but using a medicine wheel approach with our own ways of doing things. Otherwise, it just becomes the regular psychiatric/mental health system with a*

brown face. The white man's way is to separate things into categories and we see things as part of a whole.
Aboriginal Consumer/Service Provider, Halifax, Nova Scotia

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

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

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

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

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

Someone needs to look at the "big picture" and how the money is being spent.
Consumer, St John's, Newfoundland

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

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

We all need a little bit more understanding and public awareness.
Consumer, North Bay, Ontario

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

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

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

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

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

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

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

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

Eight of the fourteen focus groups emphasized the importance of addressing the multiple determinants of mental illness and addictions. When people do not have a safe and healthy physical environment, sufficient food, decent housing, access to meaningful work and social support, mental health and addictions problems are more likely and recovery becomes extremely challenging.

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

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

How do people take care of their own mental health?

The seven consumer groups were asked what they do to protect and promote their mental health. The following represents their responses and how many groups provided each response.

- Practicing spirituality and hope, reported by six groups.
- Helping others, reported by six groups.
- Social and peer support, reported by six groups.
- Being open/sharing your experience, reported by five groups.
- Good health habits, reported by five groups.
- Self-education and knowledge, reported by three groups.
- Other: Comedy/humour; Arts and Crafts, reported by three groups.

Introduction

In 2009, the Native Mental Health Association of Canada and the Mood Disorders Society of Canada partnered to commission a series of focus groups across Canada as part of their Building Bridges initiative. Participants included Aboriginal and non-Aboriginal consumers, family members/caregivers and service providers. The purpose of the discussions was to further knowledge and understanding of the kinds of experiences that consumers and family members have with mental health and addictions services. More specifically, participants were asked what brings people to mental health and/or addictions services, what happens when they attempt to access services, what happens once they succeed in accessing services, what makes them feel safe and comfortable or not, with the services and what actions they take to protect and promote their own mental health.

The report reviews the findings from 14 focus groups held across Eastern Canada between November, 2009 and January 2010. In all, ninety-nine people participated in the discussions, including 47 consumers, 47 service providers and five family members/caregivers. Forty-five per cent of the participants are Aboriginal and 54% are non-Aboriginal. A detailed demographic breakdown of participants may be seen in Appendix A.

Results

1. What brings people to mental health or addictions services?

There are many reasons why people seek mental health or addiction services. Help-seeking is frequently precipitated by some sort of crisis. Some consumer participants were not prepared to disclose the issue that led them to reach out for help. Some did not know exactly why they had sought help; they just knew they were no longer able to cope at that time. About one-half of the consumer participants shared the issue that initially caused them to seek help, and the most common responses were: serious depression, which often included suicidal thoughts, impulses or attempts; substance abuse; or substance abuse combined with a mental health problem.

Close to one-third of consumers reported a history of physical and/or sexual abuse. Two women were sexually abused by health care providers, one by a hospital orderly and one by a psychiatrist. A majority of the Aboriginal consumers have been abused and in many cases this abuse was systemic, severe, and institutional in nature, i.e. it occurred over long periods of time in foster care, group homes and residential schools.

When service providers talked about why people present for services, they gave different reasons depending on the mandate of the organization, although often the person seeking help was experiencing some type of life crisis. Community organizations may see people who are lacking basic needs (e.g. housing) or do not know how to navigate the system. In certain cases, people are mandated to seek treatment by child welfare or by a court order. Family members occasionally seek help because they are in crisis and afraid they might harm the person for whom they are caring.

Service providers noted that some people will not seek help no matter how desperate their circumstances because of shame, stigma or fear of consequences such as a job loss. This is more of an issue in small communities and within certain ethnic communities. Some Aboriginal people have an ingrained mistrust of mainstream service providers due to their history of colonization and systemic abuse, which makes it difficult for them to use these services.

> *I know someone who is intelligent and could use the help but he doesn't want mental illness on his record for fear of losing his job or having the insurance company find out, which will make him uninsurable.*
> *Family Member, Montreal, Quebec*

> *Stigma is a big reason for not accessing services, especially in rural areas. I've had people tell me that their doctor told them to go to another community to purchase their medication, so that people in the community won't know. People are also afraid that they wouldn't be able to get a job or housing.*
> *Service Provider, St John's, Newfoundland*

There are also cultural issues; some people never show up for help. Mental illness is not acknowledged in some communities – it doesn't exist – it's not accepted. If the culture can't accept it, the family won't.

> *Fear of having it labelled – this is true in the native communities as well due to the history of residential schools. Elders have memory of that and are very protective of children because they remember their children being taken. It takes a lot of work to work with them to overcome these fears. There's a lack of trust and this is understandable.*
> *Service Providers, Montreal, Quebec*

> *Intergenerational trauma affects attitudes. The history of interacting with government sanctioned organizations, institutions and the lack of trust of these gets passed down. It's hard to seek help and trust that people can help you.*
> *Service Provider, Halifax, Nova Scotia*

2. What challenges do people face when they try to access services?

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

Very few consumers have found it easy to access services. Of the 47 consumers participating in the groups, five people (11%) were able to access services with no difficulty. Two of these were professionals, both of whom accessed services through their work (one was a psychiatric nurse; the other worked for a municipal government). One woman in Montreal and one Aboriginal woman in Halifax did not encounter any problems with accessing services. One Aboriginal man in Halifax found services to be accessible within the prison system. This was endorsed by some of the Halifax service providers who said that traditional cultural services for Aboriginal people are indeed available within the criminal justice system.

With the exception of this small minority of consumers, all of the participants experienced some difficulties accessing mental health or addictions services. The following shows the challenges people face when seeking services along with the number of focus groups within which these themes emerged.

- They are unaware of what services are available and how to access them (7 focus groups)
- The services they need are unavailable or limited (14 focus groups)
- There are long wait times for services (12 focus groups)
- They have to push hard/advocate for needed care (4 focus groups)

2.1 They are unaware of what services are available

> *A lot of people we get calls from really don't know what is going on – they don't understand formal services and don't know what's out there and how to navigate the system.*
> *Service Provider, Halifax*

Oftentimes, people simply do not know how to access mental health or addictions services. This is true for consumers, for family members, and even for people who consider themselves well-educated and knowledgeable about community programs. Many find the multitude of services and the differing mandates of organizations very confusing. In some cases, services are available and available close to home but consumers just do not know about them. Because they are unaware of other options, family members often end up taking their loved ones to hospital emergency departments.

2.2 Needed services are unavailable, limited or hard to access

All of the focus group participants indicated that mental health and addictions services are in short supply. When people do get access to services, the services they need are often unavailable, limited in availability or difficult to access for other reasons. Whether or not a given service is available depends to some extent on where people live and rural and remote communities have very few services, if any. Even within larger centres however, access can be challenging. For example, in St. John's Newfoundland, mental health services have been consolidated in one location, which is difficult to access if people have no means of transportation.

> *Even in the St John's area, access is an issue. If you're in a crisis, you have to go all the way to the [psychiatric hospital] which is a fair distance to travel. Consumers, especially low-income ones, don't have the means to travel to these centres – there should be something centrally located in the city.*
> *Consumer, St. John's, Newfoundland*

Smaller communities face a serious shortage of family physicians/general practitioners. This was also reported as a significant problem by Montreal consumers, who said that a large majority of people in that city have no access to general practitioners.

> *I drove six and a half to seven hours each month to see a doctor, when I lived in central Newfoundland.*
> *Consumer, St John's, Newfoundland*

> *It's easier to find a Sasquatch than a family doctor around here – you can't even get on a wait list.*
> *Consumer, North Bay, Ontario*

At the same time, some consumers feel that they need specialist care because family doctors do not have enough expertise to treat mental health problems, especially those that are complex or severe.

> *Family docs really don't have the expertise to deal with serious depression.*
> *Consumer, Halifax, Nova Scotia*

> *When I came here …my GP wasn't qualified to help me, my issues were too complex and I ended up in the psychiatric ward.*
> *Consumer, St Johns, Newfoundland*

Psychiatric services are limited almost everywhere however, particularly community-based psychiatrists (outside the hospital system) and more so in rural/remote areas and small communities. This means that people needing help are often forced to rely on hospital-based emergency services.

There are a lot of psychiatrists up at the hospital but only two that work in community and they are not taking any new patients.
Consumer, North Bay, Ontario

I saw a psychiatrist after waiting six months. He recommended what drugs I should take and told me he wouldn't see me again and that if I needed a medication change I would have to be re-referred all over again.
Consumer, Halifax, Nova Scotia

In some small communities, the only addictions services available are those based on the 12-step approach and, unless people accept this model, they have to move away to get help. Services for people with concurrent disorders (mental health and addictions) are extremely difficult to access. Several people, including consumers and service providers, said that mental health services will not accept clients who are currently using substances. Nor will many addiction services, such as detoxification centres, accept clients who are on psychiatric medications. Some mental health or addictions services will not treat people taking methadone for an opiate addiction. It was suggested that this could be a result of the services not having medical staff available to manage detoxification for clients on medications. Nonetheless, it constitutes a significant service gap.

I went to see a therapist for help with self-medication with drugs and with panic attacks; she told me to come back in 6 months once I got clean, but I wondered how I was supposed to get clean without help? I saw a lot of that.
Aboriginal Consumer, Halifax, Nova Scotia

Some people on methadone are excluded from external services.
First Nation Services Provider, New Brunswick

I have a drinking problem. I drink every day and five years ago I tried to get help but few places will take someone who is also on anti-depressants.
Aboriginal Consumer, Sudbury, Ontario

Non-medical services such as psychotherapy are also very difficult to access unless people are able to get them through work or pay for them out-of-pocket. Services for trauma-based issues are sparse; this includes services to treat Post-traumatic Stress Disorder (PTSD) and the inter-generational trauma of Aboriginal people.

I fell into the system in 1996 and suffered many depressions, was hospitalized a lot, sexually abused, given meds, discharged and put back in. There was no

> *psychotherapy for me, because I had no money for it. I was abused by a health professional and there are many women like me and you can offer all the pills you want but they don't address the problem….So, it's not a psychiatric illness – sexual abuse – but it is a mental health issue. And trauma does not go away by itself.*
> *Consumer, Montreal, Quebec*

> *I'm especially interested in the idea of inter-generational trauma – the amount of PTSD responses and the related co-morbidities that are passed on – we don't even have the means to address these, never mind treat them. I would like to know what to provide to my Aboriginal clients and to be more informed.*
> *Service Provider, Halifax, Nova Scotia*

> *…the medical system doesn't do well with trauma: childhood sexual abuse or PTSD for any reasons, like vets coming back from Afghanistan. People are told in the system, "when you stop cutting yourself, we'll help you." In my opinion, it's because nobody is trained in the system to deal with these types of issues.*
> *Service Provider, Halifax, Nova Scotia*

> *I was told that residential school trauma has nothing to do with the problems of today – they [mainstream service providers] don't understand the intergenerational trauma.*
> *First Nation Services Provider, New Brunswick*

Culturally sensitive and safe services are in short supply for newcomers and for Aboriginal people. For those who speak a language other than English or French, supports such as translators and written information in their language are hard to find.

> *This is a big problem with newcomers – they put them full of medication in the hospital and don't understand them. There are agencies that deal with immigrants but it is hard to find translators at the hospital – you have to try to find someone from the immigrant centre who will come in and translate.*
> *Consumer, Montreal, Quebec*

> *Cultural barriers, for Inuit people in Labrador, are a huge barrier. Very few people here would speak the language; there are no written materials in their language. And there are no services in their communities, so they have to be sent here. But there is really no cultural sensitivity at all.*
> *Service Provider, St John's, Newfoundland*

> *We asked [the hospital] about building capacity within their community mental health programs for services or enhanced services for Aboriginal mental health and addictions, and the response was: they have their own places to go.*
> *Service Provider, Sudbury, Ontario*

2.3 There are long wait times for services

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

Where mental health and/or addictions services are available, consumers and family members often encounter long wait times. This is a significant barrier to access. The need for more timely access is most acute in rural and remote areas, but it still exists in larger cities.

> *I went to see a psychiatrist at a shopping centre [a mental health clinic that operates out of the shopping centre]. I asked him for another appointment and he said he didn't have the time or resources to see me again – I would have to be referred back to my family doctor.*
> *Consumer, Halifax, Nova Scotia*

> *It is very difficult to access these services: there is a 6 month minimal wait to access a psychologist or psychiatrist. That's in St John's – outside St John's it is worse. – I've been waiting for more than a year for a psychiatrist.*
> *Consumer, St John's, Newfoundland*

Even when people are in crisis, they often experience long waits for service. This includes waiting at hospital emergency departments and walk-in clinics, which can be detrimental to the well-being of consumers.

> *…a lot of people with mental health issues have to go to walk-in clinics and wait 6 hours to see a doctor.*
> *Consumer, Montreal, Quebec*

> *When I went to the hospital for help, it was a 6-8 hour wait and I'd be using drugs in the bathroom while I was waiting and then I would usually leave.*
> *Consumer, North Bay, Ontario*

Community organizations that provide support services such as peer support and self-help groups are much more accessible and normally have no waiting periods. However, these types of services are not available everywhere.

> *There are no support groups or services outside St. John's. People have to take care of themselves.*
> *Consumer, St John's, Newfoundland*

When faced with long wait times, people can become very discouraged. It is often difficult for them to seek help in the first place but to have to wait after having reached out, can be devastating. It is very stressful for family members who are concerned about their loved ones. It also results in the loss of a critical window of opportunity for prevention or early intervention, which could diminish the chances of a more serious problem developing. Some participants pointed out that lengthy wait times really highlight the inequities between health and mental health services.

> *…services I've been interested in, there is a long wait list and you don't know where you are going to be in four or six months, so you just give up.*
> *Consumer, Sudbury, Ontario*

> *People who are proactive and notice the signs of mental illness and want to get an appointment are told they have to wait four months and if it gets really bad to go to the ER. The impact of this is huge. Plus the family isn't doing well if their loved one is not doing well.*
> *Family Member, Montreal, Quebec*

> *I think consumers who have the courage to keep trying when there is a 6 month wait list – we don't say that if someone has a broken leg – they are incredibly strong and patient people.*
> *Service Provider, Halifax, Nova Scotia*

2.4 They have to push hard for needed care

> *It's a brutal task to try and get services, especially on your own.*
> *…Especially when you're not well.*
> *Consumers, St John's, Newfoundland*

Many consumers who were able to access needed services said that either they or their family members had to advocate very strongly so that they could receive the services. This can be very challenging especially when people are not well and/or are not familiar with the service system.

> *…it took many, many years for my needs/rights to be recognized. If it wasn't for my mother pushing, nothing would have happened.*
> *Consumer, Montreal, Quebec*

3. What happens once people access services?

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

- *Negative experiences at service entry points (9 focus groups)*
- *Concerns about assessments and diagnoses (13 focus groups)*
- *Disrespect, condescension, stigma, racism or discrimination (14 focus groups)*
- *Biomedical, rather than holistic and recovery-focused services (14 focus groups)*
- *Fragmented and uncoordinated services (12 focus groups)*

3.1 Negative experiences at service entry points

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

> *I knew I needed to go back to the [psychiatric] hospital and was told by the Crisis Centre phone line that the only way I could get there is if the police picked me up. That was hard for me because I had problems with the police previously and have PTSD for that. I was told in no uncertain terms to go make a major scene in public with a sword or a gun (not a real one) and the police would take you to Abbey Lane.*
> *Consumer, Halifax, Nova Scotia*

> *There is one mental health nurse at the regular hospital who will triage you but you will end up at the [psychiatric hospital] to be triaged again, and if you are a male in particular, you will be brought there by the police.*
> *Consumer, St John's Newfoundland*

When they arrive at a hospital emergency room, it seems that consumers are rarely treated with compassion and respect, or in a way that meets their needs. For example, people often have to wait for long periods of time and see a number of different professionals before they are able to see a psychiatrist.

> *I shouldn't have to go through emergency to see a doctor and then a counsellor right out of school to see a psychiatrist. I'm a big boy – I know I need to see a psychiatrist…. but I would have to sit at the hospital for 4-6 hours to see one.*
> *Consumer, North Bay, Ontario*

In the meantime, they are kept waiting for long periods of time, with people with a variety of other health needs, in an environment which may not feel safe or comfortable. Some consumers feel, for example, that crisis and hospital emergency services over-use police and security guards due to perceptions that people with mental health issues are potentially dangerous. A number of consumers reported that there is a heavy police/security guard presence in hospital emergency rooms, which can feel very threatening. At the same time, they feel that the police do not have the training required to function effectively in this role.

> *I was in four-point restraints, in the hallway in those for 12 hours and was threatened by a police officer with tasering, while restrained. Finally, a doctor came over and got the cop to stop harassing me. Now I have a standing order for an injection to break the psychosis, but I still have to wait four hours. Then a crisis intervention worker will say "there is nothing we can do for you" and I say "look at the form – I have a standing order". Finally, a doctor will come along and say "all you need is an injection". That should be done right away.*
> *Consumer, North Bay, Ontario*

> *It seems to me that they [hospital emergency department] over-use security guards. If you raise your voice they have guys on you right away, putting you on restraints.*
> *Up at the hospital, it's like a jail – they have about 15 guards walking around – they should get rid of some of the guards and get more medical staff.*
> *Consumer, North Bay, Ontario*

> *Police are very insensitive for the most part. Only a few have any sensitivity training.*
> *Consumer, Halifax, Nova Scotia*

Many consumers and family members would like to see changes made to services for people with mental illness in emergency departments. For example, emergency departments could set up a separate area, with specially trained service providers, for people with mental health problems. This would be better for people with mental illness as well as for those coming to the emergency department for other health issues.

I would like to see, in the future, a better triage system at the emergency departments. They need better trained people there to treat people with mental illness more effectively.

Plus, you wait for hours, in triage with everybody else.
Consumers, Halifax, Nova Scotia

They should separate the psych area in the ER.
Consumer, North Bay, Ontario

The emergency triage system does not always function in a way that meets the needs of consumers and family members. Several participants reported that people who should have been admitted to hospital, for example, were turned away. Those who are admitted may receive poor treatment from health care professionals. All of these factors can make people very reluctant to reach out for help even when they clearly need it.

A friend of mine went to Emergency – she knew her own symptoms – and they sent her home. Finally she called someone in her building for help and this person called Mobile Crisis Intervention. They put her in cuffs and brought her to hospital, which put her in an isolation room. She lost everything including her apartment and it took her six months to recover.
Consumer, Halifax, Nova Scotia

They are shown a lot of disrespect and people will not go to the hospital, even if they are very ill, because of the way they are treated. If we had a more humane, respectful system and no stigma from professionals, people would be more likely to go for help.
Family Member, Montreal, Quebec

… the second you go into that building [the psychiatric hospital] as an emergency case, they've been at it so long down there, they're completely dead and they don't care. They won't talk to you unless it's in a condescending tone – they mostly talk to the cop that brought you. If that's your first experience with the mental health system; that's bad. Either those people never had relationship skills or they lost them along the way.
Consumer, St John's, Newfoundland

A few consumers also reported bad experiences at service entry points for non-medical community-based services. Although these experiences do not appear to be common, the potential effects of them could be quite damaging.

I had contact with a court diversion program and would have been eligible because I'm bi-polar. I met with the nurse in the middle of an overdose and they

stopped the court proceeding. He gave me a note in my hand telling me when to re-appear and sent me away. And I was blue and in an overdose but rather than helping me medically, he just sent me out the door. A friend took me to the hospital. So, even if you get timely access, the service is terrible.
Consumer, North Bay, Ontario

One time when I was really depressed, I felt hopeless and I went to [a mental health service] office to try and access their services but in their eyes I wasn't mentally ill enough and they refused me. I was surprised how they came to their conclusion because they didn't take the time to get to know me and I really needed someone at the time. They didn't refer me to any other services, they just said no. I was crying and really needed some help.
Aboriginal Consumer, Sudbury, Ontario

3.2 Concerns about assessments or diagnoses

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

When consumers are able to access mental health or addictions services, a formal assessment or diagnosis may or may not follow. For caregivers or family members, it appears that there are few, if any, services that directly assess their needs.

We would like to see caregivers get assessed in their own right and it wouldn't take that much in the way of resources to do that, there are tools available, but once they are assessed, are the services available? However, assessing me as a caregiver in my own right recognizes the role and contribution that I make to society in that role.
Service Provider, Halifax, Nova Scotia

A number of consumers reported having been misdiagnosed or having to wait years for an accurate diagnosis. Across almost all of the focus groups, participants expressed some concerns about the accuracy of mental health diagnoses or assessments.

I had good doctors but they misdiagnosed me at first and it took many years to get a correct diagnosis.
Consumer, Halifax, Nova Scotia

I had a psychiatrist but she kept getting pregnant, so I ended up with about 10 different residents, but they all gave me a different diagnosis.

Consumer, Montreal, Quebec

I was diagnosed as manic-depressive, in Ontario. I attempted suicide a few times, was hospitalized a few times, tried lithium, but it didn't help with the mood swings. It turned out I wasn't manic-depressive, I was experiencing PTSD.
Aboriginal Consumer, First Nation, New Brunswick

When diagnoses are made, it appears they are made with little consideration of the individual's culture, lived experience and current life context. Both consumers and service providers indicated that traumatic experiences are not taken into consideration when diagnoses are made. Thus diagnoses are made with little or no understanding of the history or context within which the person's problems emerged. This is a concern for Aboriginal people in particular, many of whom are living with the effects of inter-generational trauma from colonization.

My experience with the immigrant/refugee population in Hamilton…. we interviewed refugees and their stories of traumatic experiences were just phenomenal. People were saying "nobody has ever talked to me like this before, or asked me about these things before." We are too much checking off DSM symptoms when checking in patients and not asking them about their experiences.
Service Provider, Halifax, Nova Scotia

Because we have no focus on the Aboriginal population as a unique and different culture, when they come into the hospital psychiatrists are diagnosing, not in the context of culture, history, family dynamics. People are diagnosed with very serious mental illness and put on heavy medication which may or may not be appropriate.
Aboriginal Service Provider, Sudbury, Ontario

People with mental health problems also face the risk of having a physical illness misdiagnosed or dismissed. Participants suggested that this is due, at least in part, to health care providers attributing the symptoms of a physical illness to the mental disorder or assuming that a person with an addictions issue is drug-seeking. These kinds of mistakes can be life threatening.

Often people with mental illness have physical problems and when they go to the hospital, these are very often dismissed as being "in their head" or psychosomatic. They don't even get the tests they need.
Family Member, Montreal, Quebec

Once my appendix was about to rupture and I went to hospital and they had it on paper that I had mental health and addiction issues, and the doctor told me you are not getting any drugs, there's nothing wrong with you. I went to another

> *hospital and they realized my appendix was about to rupture and they did surgery right away.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

On the other hand, people experiencing a health crisis resulting from a mental illness or addiction, such as an overdose, may fail to receive help for the underlying issue.

> *I often hear from other people that they have a chronic or serious mental health issue, like bi-polar disorder, depression, suicidality and sometimes they overdose, end up in hospital and are not treated for the mental illness but for the physical symptoms caused by the overdose. Then, they are released without getting the proper help.*
> *Consumer, St. John's, Newfoundland*

3.3 Disrespect, condescension, stigma, racism or discrimination from service providers

> *We need professionals who treat you like a human being.*
> *Consumer, North Bay, Ontario*

Participants from all of the focus groups related incidents where consumers were treated disrespectfully and with a distinct lack of compassion by service providers. This has happened with a broad range of service providers including mental health care providers, health care providers and others (e.g. welfare workers). Many consumers talked about being treated like a label or a number, rather than a person.

> *They process people like numbers. If you have cancer they will hold your hand; if you lose your foot they will be there to help you learn to walk again. If you have mental health issues, they just send you out on the street – you get no support.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

> *Lose the labels. I have bipolar, I'm not bipolar. People don't say I'm cancer, they say I have cancer.*
> *Consumer, North Bay, Ontario*

Many consumers also spoke of feeling unheard, judged and "looked down on", as if they were inferior in some way to the service providers. Those who had tried to complain found that their complaints were ignored or dismissed. Service providers did not disagree that consumers are often treated poorly and indeed, some suggested that the inherent power imbalance between consumers and providers is a key part of the problem. Poor treatment of consumers may also be a result of inadequate funding (e.g. for training) and service provider burn-out.

There is a hierarchy, in my experience – the clinician is "up here" and the client and family are "down there" so they are afraid if they say anything their care will be affected. Also, there is a lot stigma toward [consumers] from the professionals, inappropriate comments during rounds, etc. Staff will complain about [consumers] showing traits of personal disorders that they can't do anything about and would like to get training to help them but there is no money for this training.
Service Provider, Halifax, Nova Scotia

Addictions and mental health services, even health services generally, they are certainly lacking in sensitivity. To be on the receiving end, where you are treated dismissively – the provider knows best, isn't interested in your views – it's desperately condescending and I hope I don't operate like that, but it's a function too of a system that is under a lot of stress because there are a lot of sensitive people working in the field.
Service Provider, Halifax, Nova Scotia

People who have addictions, are poor or are Aboriginal are especially likely to feel judged and stigmatized and to experience discrimination from mental health service providers.

I'm lucky that I'm not on pills or alcohol; but when we First Nations people go for services, they assume we are all alcoholics. One doctor asked me if I ever drink, which I did, occasionally and moderately, and he put in my chart that I was an alcoholic.
Aboriginal Consumer, First Nation, New Brunswick

My granddaughter is on methadone and had to go to the hospital because she was afraid she was miscarrying and they didn't want to help her. They look down on addicts. Even the doctors who help people on methadone, the other medical staff look down on them.
Consumer, North Bay, Ontario

We have done an awful job with the First Nations in Nova Scotia, although there are partnership initiatives underway with them. The First Nations want their services in community, plus there are incidents of blatant racism, such as early discharge when not appropriate.
Service Provider, Halifax, Nova Scotia

Stigma and discrimination are magnified for people who have multiple needs and are socially marginalized in more than one way, for example, if they are

Aboriginal and living in poverty and struggling with a mental health or addictions issue.

To be honest with you, I think a lot of it [the way I was treated by the system] has to do with being a person of colour. Within the mental health system, if you go for help and you have any type of drug history, they don't believe you. They don't believe that you really want help.
Aboriginal Consumer, Halifax, Nova Scotia

People in this community face "shut doors"….There are racist attitudes that go with people from the community: services [outside the community] are not available or they are treated differently. For example, if you miss your appointment, you have to be re-assessed and start the process all over again. This is stressful for anyone, but complicated grief is an issue for our community; this community buries 12-14 people a year in all age ranges. Even we, the healthier people, can find it hard to function with this, so imagine how it is for those who are less healthy. Maybe they missed their appointment because they couldn't get a ride or have other challenges, but then they can't get back into the program.
First Nation Service Provider, New Brunswick

A number of consumers who are living on social assistance (general welfare or disability support) reported being treated very poorly by social assistance workers. Some feel they are discriminated against precisely because they have a mental rather than a physical illness.

Welfare has been so unhelpful I don't know where to begin. I've been very honest with them about my mental health problems and addiction, and like everyone else I get a letter every three months telling me that my benefits are being suspended. They tell me that it's just policy and that everyone ignores them [the letters], but it's really stressful. These people control my finances – they abuse power – someone I know they withheld his check for two days and now he's homeless. We're seen as welfare bums.
Consumer, North Bay, Ontario

I feel that if I had a physical illness, I wouldn't be harassed in that way and would get more respect, but I do have an illness, it's a mental illness. But anyone on welfare or ODSP [Ontario disability support program] is painted with the same brush.
Consumer, North Bay, Ontario

3.4 Biomedical rather than holistic and recovery-focused services

> *Everything can't be fixed with a pill.*
> *Consumer, North Bay, Ontario*

Participants from every focus group spoke about the need to change the mental health and addictions service system by adopting more holistic and recovery-oriented approaches. They suggested that the services focus too much on individual pathology – the diagnosis or label – and see medication as the preferred solution to every mental health problem. In many cases, consumers and family members questioned the value and efficacy of a system of care that dedicates the bulk of its resources to the dispensing of psychiatric medications.

> *I expect the psychiatrist to be more than just a prescription writer. It's a waste of time to go all the way there and back to get a piece of paper that could be phoned into the drug store.*
> *Consumer, Montreal, Quebec*

Many question of the effectiveness of psychiatric medications, particularly when this is the only form of treatment provided. A number of consumers have had bad experiences with medications, such as feeling less well on medication, being over-medicated and finding it difficult to get off medication.

> *Psychiatrists just keep adding your medications, building them up. I'm on so many anti-depressants right now (10 a day) and if I try to get off them, I just get all messed up. I want to get off some of it and he upped my meds last week.*
> *Aboriginal Consumer, Sudbury, Ontario*

> *When you go to the hospital, you see a psychiatrist, they give you meds, then you end up back there and by the fifth time they should realize that what they're doing is not helping you. Why doesn't the system understand it's not helping people if they keep coming back?*
> *Consumer, Montreal, Quebec*

Some suspect that these practices are a form of social control of undesirables: a way to damp down human suffering and keep people from acting out, so as not to have to deal with the underlying issues. This creates a great deal of mistrust on the part of consumers.

> *I would suggest to the psychiatrists that they give out too much medication and they are too influenced by pharmaceutical companies – it's like a form of control over people. Montreal Consumer*

> *The starting point for service providers is a premise which is part of the problem. The idea that whatever is wrong with you is a physical/chemical thing – the medical model – that if you have a problem, the solution is a pill to numb you out. These are chemical straightjackets. In the old days they put you in one in a rubber room, now they do it with drugs.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

> *Now, I get help from friends and family. I don't take any drugs or medications. If I was going to do any drugs, it would be street drugs – at least I know what they are going to do to me.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

Many consumers, family members and service providers agreed that the service system does not adequately attend to the underlying influences on mental health and addictions problems. These include poverty, social isolation, racism and a history of trauma or abuse. Because service providers are not trained to work with consumers in a holistic way, consumers feel unheard, misunderstood and devalued. As a result, the existing models of treatment are limited in their effectiveness.

> *The doctors don't understand and they don't see all the linkages and the underlying factors that cause the problems. When you clear up the pain and suffering you dealt with, that's when you start to feel better.*
> *Aboriginal Consumer, Sudbury, Ontario*

> *I don't think the mental health system here has ever understood inter-disciplinary team concept – there is no holistic care – they don't treat the whole person. The psychiatrists are not recovery focused; they don't ask how people are doing with their lives. They just ask "How are you sleeping? How are the meds?" And that's it.*
> *Service Provider, St John's Newfoundland*

Some participants suggested that newcomers who do not speak English or French are particularly vulnerable within the existing system of services.

I learned French to protect myself if something happened, and I was right because I was able to read up on medication but people who don't speak the language are very vulnerable and they might have to wait for a week for a translator. They just give them a pill and send them home.

> *This is a big problem with newcomers: they put them full of medication in the hospital and don't understand them. There are agencies that deal with immigrants but it is hard to find translators at the hospital – you have to try to find someone from the immigrant centre who will come in and translate.*

Consumer & Service Provider, Montreal, Quebec

Assessments of hospital in-patient psychiatric units were quite negative. Many have had unpleasant experiences in these facilities. According to a number of participants, psychiatric wards epitomize the biomedical model by confining and medicating consumers, while offering little or no personal interaction or attention to the underlying factors that cause people to be so ill as to require admission.

> *When I was admitted to hospital for anxiety and panic, I was diagnosed with psychosis. All they wanted to do was pump me full of drugs and stick me in a room…I had no sense of being helped there. There was no communication and no one to talk to.*
> *Aboriginal Consumer, Sudbury, Ontario*

> *I ended up in the psychiatric ward. I came out sicker than when I went in. I was disgusted with the mental health services they provided in the hospital. I wrote letters to the Minister of Health, Hospital CEO and everyone I could think of.*
> *Consumer, St John's Newfoundland*

One woman reported feeling safe and comfortable as an inpatient in a psychiatric ward. This was because of her history with domestic violence.

> *I like it there [at the hospital. I feel safe there, because nobody abuses me there. I was very abused by my ex-husband. He beat me up pretty bad.*
> *Aboriginal Consumer, Sudbury, Ontario*

The biomedical model is seen as especially unsuitable for meeting the needs of Aboriginal people. Many Aboriginal participants said that the current approach to service provision is too narrow and rigid and not in keeping with their unique needs. Many are still struggling with racism and the lingering effects of colonization. These include the loss of their culture, the residential school experience and intergenerational trauma, all of which they see as the root causes of their mental health and addictions problems. They want a more holistic approach to healing; one that views their issues and challenges within this context.

… healing from inter-generational trauma is long-term and takes a different path from the medical model and therapies. So even if they [Aboriginal people] could access these in a culturally safe way, use of them is still questionable because the treatment modalities don't fit their experiences and their needs.

Because we have no focus on the aboriginal population as a unique and different culture, when they come into the hospital psychiatrists are diagnosing, not in the context of culture, history,

family dynamics. People are diagnosed with very serious mental illness, and put on heavy medication which may or may not be appropriate…
Aboriginal Service Providers, Sudbury, Ontario

> *The lack of connection is the problem with mainstream service providers: they bring a linear perspective to everything they are doing instead of seeing how things are connected. Things are circular – when you're having a problem, there are all sorts of causes for it. The lack of humility of service providers is staggering. There are ways of dealing with problems that are better. There are a lot of problems with the psychiatric drugs. They have bad side-effects and are hard to get off. People need support structures, the medicine wheel. These can affect the mind and body just as much if not more than psychiatric drugs. There's no orthodox description of how these things are curative, but they are.*
> *Aboriginal Consumer/Service Provider, Halifax, Nova Scotia*

> *Why are we slicing and dicing our health? …Into mental health, physical health? It's all health. We chop things up and label other people and ourselves, it's not helping anybody and it never has. We need to look at this as a society as a whole. They don't ask what brought you there to services. They think you're broke and need to be fixed. I'm sorry, maybe if you were locked in a dark room [as happened to another participant], you should be afraid to sleep in the dark. You would be like that too, if that was done to you. We have to stop thinking of people as broken; we're not cars. My mental, physical, emotional and spiritual health are all connected; we're living the medicine wheel.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

3.5 Fragmented and uncoordinated services

Almost all of the focus groups talked about fragmentation and lack of coordination among existing mental health and addictions services. Because organizations tend to operate as "silos", services are limited, not linked with each other, and difficult to access. Consumers with multiple needs are often bounced around from one service to another. As a result, they have to tell their stories again and again to each new service provider and there is no continuity of care. This is especially frustrating for people when moving to one service system to another, i.e. from children's mental health to adult services. Consumers and family members find it very challenging to have to navigate these service systems on their own and coordinate their own care. A number of participants said that follow-up care, for example after a hospital discharge, is also inadequate.

> *…every time I saw a new person, it went to zero – I had to retell my story, they had to start a new file, no continuity of care, so no one seems to have the "big*

> *picture"; my file was often not forwarded to the new providers, and when it was, it seems the new people don't look at it.*
>
> *I had the same thing – having to tell my story over and over every time I see someone new.*
> *Consumers, Halifax, Nova Scotia*

> *Moving from youth to adult care is horrific. There no continuity of care – you get dropped from one program at 16 and then there's nothing for you until you turn 18. Sometimes I'm enabling and I know it, but I have to because of the lack of continuity. You're asking someone who is not well to fill in all kinds of forms; she is going to all sorts of different service providers. She has paranoia and anxiety and people are asking her to travel around to access services, and she is considered inconsistent if she can't make appointments, but there is no type of transit service to get her there and we [family] can't always take her. A case manager for me and one for her would be my dream. It's really hard for her to develop trust and there are always new people she has to tell her story to. She ended up in ER lately due to a crisis and missed so many appointments due to the crisis that she may lose the services she has.*
> *Family Member, Montreal, Quebec*

> *I'm the sole caregiver of my son and he's been hospitalized many times. When he's discharged, there's no follow-up and when I ask how I can help him, they say "give him a stable home". Well that doesn't help me when he's up at 4 in the morning having an anxiety attack and talking about suicide.*
> *Family Member, St Johns, Newfoundland*

One of the largest gaps seems to be between the health system and community organizations that offer self-help and peer support programs. People often stumble across these supports on their own, having failed to receive any information about them from health care providers.

> *I didn't even know [a community support organization] existed. I'm a nurse and had two stays in the hospital and after discharge, there was no information given me about supports in the community. The only reason I know about it is that the coordinator is a personal friend of mine.*
> *Consumer, St Johns, Newfoundland*

For the most part, mental health and addictions services are provided separately and not coordinated. People are unable to receive treatment for both issues simultaneously. A number of consumers and service providers identified this as a significant service gap because of the close connection between addiction and mental health problems.

> *There is very little service for dual diagnoses.*
> *Family Member, Montreal, Quebec*

> *I'm involved in a parent support group for adolescents with addiction issues, they don't get into any mental health issues but it is a wonderful group. There is also a place where kids can go to school and get help for their addictions issues; my son went there last year. But there is nothing there as far as mental health goes, even though of course they are linked.*
> *Family Member, St Johns, Newfoundland*

The lack of service coordination can be extremely frustrating for family members and other caregivers, because the burden of navigating the system of services and coordinating care for the consumer falls directly on them. This is especially challenging if the consumer is really ill.

> *…there is a limit to what they [mental health services and supports] will do and the family members have to follow through: be the caregiver, take them to their appointments. Doctors and dentists are not always empathetic or supportive; it's a whole ball of wax that never ends. It's like having a child. It's always up to the families, if they care, to be involved in daily activities like these. …it's absolutely exhausting for the caregiver. A day in the life of a caregiver is like a full-time job, on top of your regular job, and other family responsibilities.*
> *Family Member, Montreal, Quebec*

4. What makes people feel safe?

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

- Accessible, compassionate and respectful service providers (10 focus groups)
- Coordinated services and continuity of care (6 focus groups)
- Support from people who understand what they are going through (6 focus groups)
- Respect for confidentiality (3 focus groups)

4.1 Accessible, compassionate and respectful service providers

> *I just want to be treated with respect.*
> *Consumer, North Bay, Ontario*

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

> *I am very blessed to have my psychiatrist. What is great about her, she has a laid back approach, really listens, doesn't judge. When you have been a professional, like I was, it is hard to be the one cared for but she takes the time to ask me how I feel.*
> *Consumer, Halifax, Nova Scotia*

> *I've had good and bad. The good one takes his time with me, doesn't rush me out the door, he gives me an hour of time. He's not condescending: "I'm the doctor, you're the patient; you do as I say". He also trusts what I say; he validates my own experience and some don't.*
> *Consumer, St. Johns, Newfoundland*

> *You have to be able to trust them and they you, and you do need to know something about them, otherwise you might as well be talking to a brick wall. Another thing and it's related to the trust thing, my psychiatrist has given me her home phone number and said if it gets really bad "call me at 2 in the morning". I've never used it, but it's good to know that it's there if I need it, so I wouldn't have to go to the ER and talk to some random person who doesn't know me. When she's on vacation, she gives me another number I can call.*
> *Consumer, Montreal, Quebec*

Consumers also feel safe if they receive information from service providers that assists them in making their own decisions. They want service providers to work with them using a team approach.

> *I need someone who… sees me as a person, who explains to me why she is prescribing what she is prescribing, tells me why she is giving me this one rather than that one, talks to me about the side effects.*

Consumer, Montreal, Quebec

I benefit more from health care professionals if they work with me and respect me, like team work. It's not like "I'm the doctor and you're the patient".
Consumer, North Bay, Ontario

Several consumers suggested that finding good service providers is mostly a matter of luck, as the empathy and understanding that constitute good care are dependent more on individual personality characteristics than on professional training.

Good ones are about inclusion and understanding you are an expert about your own experience. These individuals are certainly trained, but they are not necessarily trained in human interactions, so if they're good, it's usually because of their personality, not their training.
Consumer, St Johns, Newfoundland

You have to have a good heart. You have to care. You have to be a real person. …Right, you can't train people to care; people have to care.
Consumers, Halifax, Nova Scotia

4.2 Coordinated services and continuity of care

Coordinated services and continuity of care help to make consumers and family members feel safe. Unfortunately services are often not coordinated but when consumers find someone to assist them in navigating the system and receive continuity of care, this helps to make them feel safe.

If it wasn't for the [community agency] who coordinated services for me, I would be lost in the system.
Aboriginal Consumer, Sudbury, Ontario

When I was 24 I tried to commit suicide and I met a doctor and it was the first time I felt safe. He's a good doctor and he stayed with me, he followed my care until he retired. Consumer, Halifax, Nova Scotia

4.3 Support from people who understand what they are going through

People tried to help me but I said to them: "have you ever had sex for a sandwich?" Because if they haven't, how could they understand me and what I'm going through?
Consumer, Halifax, Nova Scotia

For many consumers, support from people who understand their experience is critical in helping them to feel safe and begin to recover. A few have received this kind of support within the formal system of services.

> *When I ended up in [the psychiatric hospital], I had a psychiatrist who shared her experience in life with me, which was similar to mine….It made a real difference.*
> *Consumer, Halifax, Nova Scotia*

Many suggested however, that mainstream service providers are unlikely to be able to relate to consumer experiences, and consumers are altogether more apt to get this kind of support from community organizations, especially those that offer peer support and self-help groups.

> *The outside world might say they understand, including the doctors we deal with, but they really don't, unless they have been there.*
> *Consumer, Halifax, Nova Scotia*

> *The biggest thing about getting better is knowing that you aren't alone; isolation and loneliness makes everything worse. When you're in a room with other people… and knowing that you're not the only one like that, to learn there are other people who have suffered the same things – peer support is one of the most important things.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

> *At [community organization], there's camaraderie there and they don't talk down to you. I feel safe here.*
> *Consumer, St. John's Newfoundland*

4.4 Respect for confidentiality

Several consumers spoke about the importance of confidentiality in making them feel safe. This is more of an issue for those living in small communities where everyone knows everyone else, although it is important to some people living in larger centres as well. Some consumers prefer to call telephone support services or to have a service provider come to their home, in part because of confidentiality concerns.

The confidentiality of the services gives some feeling of safety because you can open up with the service provider and know that it is going to stay in the room.
Consumer, Halifax, Nova Scotia

5. What makes people feel unsafe?

The mental health system and safety don't really go together
Consumer, Halifax, Nova Scotia

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

- Feeling alone, uncared for, unheard, judged or disempowered (8 focus groups)
- Models of service that do not meet their needs, including their cultural or linguistic needs (8 focus groups)
- Experiencing racism, stigma and/or discrimination (7 focus groups)

5.1 Feeling alone, uncared for, unheard, judged or disempowered

When people feel that no one cares about them or listens to them, or that they are being judged and found wanting, this makes them feel uncomfortable and unsafe. Unfortunately, some consumers have essentially "written off" the formal mental health care system because of negative experiences with services or service providers.

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

I never felt safe, especially with the one doctor – I was sexually abused by an orderly and when I reported it, the psychiatrist said "do you realize this could cost him his job?"
Consumer, Montreal, Quebec

I used to work with a social worker and wondered why she was a social worker; she didn't listen carefully, judged right away. They need to have training to listen to people, to give them moral support and not to judge them.
Consumer, Montreal, Quebec

The power imbalance between consumers and service providers can make consumers feel unsafe, especially if they have emigrated from a country where abuse from the military or police was common. This is also true for consumers who are mandated to take treatment.

I did not feel safe in my country under the military. Here I'm not afraid of the police, but I am afraid at the hospital because they hold all the power and

whenever you don't have any power you will feel unsafe. In some countries the power is held by the military and in some countries it is held by psychiatrists.
Consumer, Montreal, Quebec

I know court-ordered treatments are necessary sometimes but what happens often in these cases is that people feel doubly ostracized, especially if they don't accept their illness. And the court-ordered treatment doesn't help, it makes things worse. All they do is go to the hospital and then they hide. Plus they are fearful the police will come and get them.
Service Provider, Montreal, Quebec

5.2 Models of service that do not meet their needs

Consumers and family members may feel unsafe when models of service do not meet their specific needs. For example, some feel safe only when they are at home, often because of a history of abuse and they would prefer to be able to access services at home, through telephone lines or outreach visits.

I feel safe in my own home and don't like leaving it.
We should have more services where counsellors go to your home. My [community support] worker comes to my home, where I feel safe and comfortable.
Aboriginal Consumers, Sudbury, Ontario

Many consumers, family members and service providers noted that services are not sensitive to the unique cultural and linguistic needs of newcomers and Aboriginal people.

Services here are not appropriate for immigrants yet. There is a lot of suicide of immigrants but you don't see it in the paper, you don't hear about it. If they have no jobs, or no good jobs, no language, no services, a lot of them are depressed and commit suicide, but you won't hear about it because it is shameful for the government. They know they need immigrants so they try to hide the problem.
Consumer, Montreal, Quebec

The hospital setting, inpatient mental health services – it's quite dangerous for Aboriginal people. It's the biological model, the main mode of treatment is medication, and the administration is not open to any programs, workers or education that speak to Aboriginal culture.
Aboriginal Service Provider, Sudbury, Ontario

> *All of my mental health service experiences have made me decide not to ever seek services, for myself, my kids or grandkids.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

5.3 Racism, stigma and discrimination

Racism, stigma and/or discrimination make people feel very unsafe, especially coming from service providers. Aboriginal people, poor people and people with addictions issues are particularly vulnerable with regard to this.

Nobody's mentioned the dire consequences of these agencies and government not caring at all. I know two people with systematic suspensions, harassment for no reason from either welfare or ODSP who committed suicide. And nothing is done about it.

> *You can feel the wall go up if you tell people about your background. I had custody of my kids for seven years and I was always under a magnifying glass with teachers, principals, neighbours and, at that time, I was doing OK. I had the same experiences with welfare. It's really frustrating – I'm trying my best but I fear that people will always see me as a junkie and a thief.*
> *Consumers, North Bay, Ontario*

> *There are no defined standards in this province for culturally competent care, and without this knowledge and these standards, many outside providers are falling back on stereotypes: undeserving clients, not really trying, wasting my time on them, would rather focus on more "deserving clients".*
> *First Nations Service Provider, New Brunswick*

> *There's still a lot of prejudice; one client went to a program where they were trying to get her anger out so they called her a [racial slur]. Stigma and racism are still a problem.*
> *Aboriginal Service Provider, Sudbury, Ontario*

6. What needs to be improved so that people feel safe and services are helpful to them?

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

- Provide holistic and culturally safe services, using a recovery model (13 focus groups)
- Build capacity for a continuum of coordinated services (13 focus groups)

- Make mental health and addictions a funding priority and direct the funding to where it will have the most impact (12 focus groups)
- Improve public awareness to reduce stigma and discrimination (12 focus groups)
- Make it easier and faster to get services (11 focus groups)
- Make services more client-centered (8 focus groups)
- Address the multiple determinants of mental illness and addiction (8 focus groups)
- Engage and support family members and caregivers (4 focus groups)

6.1 Provide holistic and culturally safe services, based on the recovery model

> *Everyone is a unique individual and they need to be treated as a whole person.*
> *Consumer, St John's, Newfoundland*

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

> *We need a whole recovery model and process… in the mandates and mission statements and they need to hire staff who know how to be recovery-focused. We waste a lot of money doing it the way we are now.*
> *Service Provider, St John's, Newfoundland*

> *We know that the population is out there, so if they aren't accessing our services, it must have something to do with us. … there is a culture shift within ourselves as an organization that needs to happen for all of the little pieces of the puzzle to fall into place. There are good people and good things happening, but we need to connect all of the pieces and this calls for a cultural shift within the organization.*
> *Service Provider, Halifax, Nova Scotia*

Implementing holistic models of care would involve putting supports in place to assist consumers in taking small steps toward recovery.

> *We need more flexibility for people with mental illness. Give them opportunities to contribute through part-time work, studies, volunteer work.*

Family Member, Montreal, Quebec

The current approach to mental health and addictions education would need to be changed for graduates to function effectively within a holistic model of care. As an example, direct contact with consumers could be incorporated into medical and nursing training so that students could better understand the consumer experience. This is not often part of the existing curricula for health education, although a number of participants thought it should be.

I would like to see medical students, nursing students and people in the health care system, talk to us and listen to us, so they know what it is like to have our experience.

That will never happen… there is no social training in health care training.

The medical model is not conducive to treating the person as a whole… you are diagnosed, they give you the meds and that's how it works. That's how they are trained.
Consumers, St John's, Newfoundland

Sensitivity training for service providers who interact with consumers outside the formal mental health and addictions system, such as police and welfare workers, would be helpful as well.

Police need training. They shouldn't be threatening to taser people who are agitated and in restraints.

Ontario Disability Support Program and Ontario Works workers should have to understand what we are going through.
Consumers, North Bay, Ontario

Integral to a holistic approach to service provision is an understanding of cultural diversity and unique cultural needs, and tailoring services to meet these needs. This is required for newcomers from other cultures, for Francophone consumers, for other groups (e.g. the African-Canadian population in the Maritimes) and, in particular, for Aboriginal people.

[There is]… no literature or supports for new Canadians or immigrants with language barriers.
Service Provider, St. John's, Newfoundland

Appropriate services are needed for indigenous black people and Francophones.
Service Provider, Halifax, Nova Scotia

The biomedical model of mainstream services is rarely able to meet the needs of Aboriginal people. Most of the Aboriginal participants would like to be able to access services within their own cultural traditions, which are holistic by nature. Most feel very strongly that their mental health and addictions issues must be viewed within the context of racism, colonization, and the resulting inter-generational trauma, and that this is the only way that healing can begin to take place. Otherwise, services are not culturally safe for them.

> *We need to go through decolonization – how can you be proud of who you are if you don't know? We have to get back to who we are. We need the facilities to maximize support for people in recovery. The wrong people are doing the job…we need to match up the right people with the right job, especially dealing with alcohol, drugs, suicide. The most important issue for native people is alcohol and drugs and we don't have the right people there.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

The majority of Aboriginal participants would like to develop and provide their own services. This would ensure that services are meeting the needs of the people in a culturally safe way. Others feel that good service is primarily about the qualities of the individual service provider, although having a cultural context is helpful.

> *What's important too, and I know this from experience…. the services don't have a cultural component. We need to start delivering our own services, and not just using the orthodox way but using a medicine wheel approach with our own ways of doing things. Otherwise, it just becomes the regular psychiatric/mental health system with a brown face. The white man's way is to separate things into categories and we see things as part of a whole.*
> *Aboriginal Consumer/Service Provider, Halifax, Nova Scotia*

> *I wouldn't even let a non-native dental hygienist in my mouth.*
> *Aboriginal Consumer, First Nation, New Brunswick*

For me, we are all the same race, the human race, as long as you are getting the love and the trust and the help you need, it doesn't matter what colour you are.

> *It doesn't come down to what colour you are, but the medicine wheel teachings help because I know about balance now and the importance of balance.*
> *Aboriginal Consumers, Sudbury, Ontario*

A number of service providers, both Aboriginal and non-Aboriginal, would like mainstream services and educational institutions to involve Aboriginal people as planners and decision makers and to provide appropriate training. This would help to ensure that services are more holistic and culturally safe.

We need more Aboriginal people as decision makers.
Service Provider, Halifax, Nova Scotia

Any new hires [at the hospital] should have to learn about aboriginal history and culture; this should be part of orientation.

And doctors should be oriented to aboriginal culture, as well as to our community. Most of them come from the city and from other countries.

The school of medicine doesn't teach cultural safety; it's not part of the curriculum…
Cultural training should be part of the training of all professionals, psychologists and social workers.
Aboriginal Service Providers, Sudbury, Ontario

People I know who are educated, staff that I respect, the negative comments you continually hear from them: complaining about Aboriginal communities getting the HINI shot before other communities or stereotypes about giving them money, that they are just going to drink it or gamble it away.

And we know that hearing somebody's personal story, from research, really changes attitudes—like people who say residential schools aren't a big deal, it was a long time ago, but if they were to hear someone's lived experience, it would change their attitudes.
Service Providers, Halifax, Nova Scotia

Some participants questioned the relatively small number of Aboriginal service providers being hired by mainstream organizations and government, especially those that have a mandate to treat Aboriginal people.

When the hospital has the amount of community-based services they have and all of the staff that they have, they have to change the numbers to be reflective of the population. The native social work program is pumping out workers, but [the hospital] needs to change their hiring practices.
Aboriginal Service Provider, Sudbury, Ontario

There is no expectation by the First Nation, Inuit Health Branch (FNIHB) of Health Canada that non-insured health benefit providers [approved by Health Canada to provide crisis counselling for Aboriginal people living on reserve] have appropriate training or continuing education, or that they have connections with the Aboriginal community.

It would be interesting to see how FNIHB recruits and retains Aboriginal treatment providers – there are a lot of qualified Aboriginal people out there – so why are there not more of them on the FNIHB list?
Aboriginal Service Providers, Sudbury, Ontario

6.2 Build capacity for a continuum of coordinated services

We need a real continuum of services.
Service Provider, Halifax, Nova Scotia

Almost all of the focus groups identified a need for a continuum of coordinated mental health and addictions services. Coordinating services is important for several reasons: service providers would be aware of and able to refer to other services and supports; consumers would not have to tell their stories over and over; and consumers and family members would find it easier to navigate the system of services.

There are too many silos, a lot of agencies are very isolated and don't share communications. Hospitals, doctors don't talk to other agencies, and the ACT team doesn't talk to consumer groups.
Service Provider, North Bay, Ontario

Everybody has to get on the same page. We have some wonderful services, but one hand needs to know what the other is doing. People are getting lost in the system...
Service Provider, Halifax, Nova Scotia

For those who are in immediate need and are not sure where to go for help, service coordination is especially critical. For instance, two consumers had reached out to a community mental health agency, in great distress and had been turned away because neither direct service nor referral was within the agency's mandate.

It's a constant battle to find support services. Even [a community mental health service] couldn't help me. They asked me what my issues were, and told them I wanted linking to community support services. They said this wasn't their mandate. I was in a crisis, crying in their office and they couldn't even give me a phone number to call or anywhere to go for help.
Consumer, St John's, Newfoundland

If the institution you're in can't provide the help you need, they should refer you to someone who can.
Consumer, Montreal, Quebec

Some participants suggested that there should be one location where people could access information about services. In addition, many suggested that service providers should receive training about the full range of available services and supports, so they are able to refer people as needed. This includes educating health care providers about community-based resources such as self-help, peer support and traditional Aboriginal healing programs.

We [hospital providers] need more intimate relationships with the community agencies.
Service Provider, Halifax, Nova Scotia

One of the things I called for during the Mental Health strategy consultation, was for a one-stop situation where patients and caregivers would be given information about all of the programs that could help them… as well as services like housing, income support.
Service Provider, St John's, Newfoundland

They [psychiatrists] were willing to consider to having their patients access traditional healing but they thought there was none around. They have no idea what resources are available. They are also unsure of whether we would or could work with them.
Aboriginal Service Provider, Sudbury, Ontario

Improving service coordination would enable care providers to work together as a team and to wrap services around consumers and families. This would benefit both consumers and family members, who often feel overwhelmed trying to navigate the system of services.
You need a care team.
Aboriginal Consumer, Sudbury, Ontario

We need case managers for people with mental illness. Families are not trained to do it and they will burn out. It takes a team approach.
Family Member, Montreal, Quebec

Many participants would like to see an integration of addictions and mental health and addictions. This might help to reduce the stigma associated with addiction, which is significant. Providing these services separately does not meet the needs of consumers who have both a mental health and an addiction problem, and it was noted that it is next to impossible for someone to have an addiction without also having a mental health problem.

Typically, if you present at mental health services with an addiction, they will send you to addictions and vice versa.

Service Provider, St. John's, Newfoundland

Addiction is a mental health issue, not a crime.
…It's an illness and should be treated like one.
Consumers, North Bay, Ontario

I attended the conference a couple of weeks ago on Complex Needs. One of the speakers said that there are people who are mental health consumers who do not have addictions issues, but there are never people with addictions issues who do not have mental health issues. That's their coping.
…Amen, I say amen to that.
Service Providers, St. John's, Newfoundland

Community organizations that provide information, education, peer and family support programs and advocacy are not used as effectively as they could be because they are not linked with the formal health care system. If all of these services and supports were better coordinated, some of the burden of care could be shifted from the medical system to community organizations, at a lower cost. To accomplish this, service providers need to be made aware of the range of community-based supports and to be educated about their effectiveness.

We know hospitals have limited resources but we're asking them to think about us [family support organization], so they can deal with the patient and we will deal with the families.
Service Provider, Montreal, Quebec

…there needs to be more understanding of what the [peer support] role is… what concerns me as a researcher is that it often gets put into a box. Professionals think "sure you have lived experience, but you don't have any other set of competencies". But they do in fact have an array of skills and competencies: knowing how to negotiate the system; knowing how to run a group; they have read a lot; they have an array of listening and helping skills.
Service Provider, Halifax, Nova Scotia

The mental health professionals need more education on the community resources, and there is not a lot of credibility in their minds for groups run by consumers for consumers.
Consumer, St John's, Newfoundland

6.3 Make mental health and addictions services a funding priority and direct the funding to where it will have the most impact

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

More money needs to be put into mental health care. There's a lot for cancer research and such but mental health care is definitely inadequately funded.
Consumer, St John's, Newfoundland

I think it [inadequate funding for mental health and addictions] does have a lot to do with stigma and discrimination.
Service Provider, Halifax, Nova Scotia

The overall system pays some lip service to what we do, but people working in mental health are at the bottom of the totem pole; we need to be socially included as care providers also.
Service Provider, Halifax, Nova Scotia

In order to improve funding for mental health and addictions services, several groups talked about the need for "champions" to help organize and advocate for better funding of services. Some suggested that identifying and engaging champions within government would be particularly useful. The fact that many of these champions have yet to emerge is thought to be related to the ongoing stigma of mental health/addictions problems. Others would prefer a more grassroots approach to advocacy.

I think the movement has to be organized and advocate together – you need public demand; you need a champion.
Service Provider, Halifax, Nova Scotia

The consumer movement needs to learn from the HIV/Aids movement…
But they had powerful champions, organization, clout and political influence and many of the rich, more influential [mental health] consumers are still in the closet.
Service Providers, Halifax, Nova Scotia

First Nation communities and agencies need to come together to go to the politicians and the hospitals with the expectation that there will be services and that we will help them to put the services together the way they should be. There

are other places that have these, like Edmonton. The voice has to come from outside the system, a community voice.
Aboriginal Service Provider, Sudbury, Ontario

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

Someone needs to look at the "big picture" and how the money is being spent.
Consumer, St John's, Newfoundland

Everyone really needs to start working together…the community is not big enough to have replication of services.

We have enough services, but we need to put our resources together to serve the population.
Service Providers, North Bay, Ontario

We had a couple of students this summer who compiled a list of all mental health services in the community and I was thinking, there's a lot. But they don't always have the great outcomes or focus they could have. And I wonder if it would be better to take the money and focus it on fewer programs that could maybe do better work.
Service Provider, St. John's, Newfoundland

Some noted that the funding models themselves function as deterrents to collaborative service provision.

We do our best to work together but funding-wise we are not set up to do that.

For Aboriginal people, there are all sorts of levels of funding: federal, provincial, municipal, band. How can you coordinate all of this to meet client needs?
Aboriginal Service Providers, Sudbury, Ontario

With regard to where funding should be allocated, a number of participants would like more money dedicated to prevention and early intervention services. Several questioned the amount of money put into short-term acute care and suggested that funding for prevention or earlier intervention would be a much better investment.

Those who are seriously ill do seem to get more service; it's the moderately ill ones who hide out and have no quality of life.
Family Member, Montreal, Quebec

If we could work with the worried well or moderately ill, we could prevent it [the mental health problem] from becoming more serious.
Aboriginal Service Provider, Sudbury, Ontario

We get less than 4% of the health budget in this province for mental health and the majority of that goes to the acute, seriously mentally ill, compared to a small minority for prevention, early intervention.
Service Provider, Halifax, Nova Scotia

Many participants would like to see more resources dedicated to community-based services and organizations, particularly those that provide family and peer support services. A number of people said that these organizations are doing excellent work, with woefully inadequate funding. Much of the work they do takes the pressure off hospital services and they are doing this work in the face of many challenges. Many organizations have to fund-raise on an ongoing basis or they rely on time-limited grants for which they are always submitting proposals. If they do not produce results, their funding is threatened; if they do produce results, it is assumed they no longer need the funding.

Good community organizations are starving. They are doing a service that provides continuity of care. Hospitals get more funding for short-term day programs that are six weeks long, but who changes in six weeks? But you don't get more money to work with people for a long period of time, help them get well and help them stay well. We need a reassessment of funding decisions.

Stable government funding for community organizations is critical. They shouldn't have to fundraise all the time.
Family Members, Montreal, Quebec

The CMHA, Self-Help Connection and the Schizophrenia Society here are not funded by the province, which I believe is unheard of across the country. The United Way does provide some funding but some organizations get into chasing the dollars. Good programs have been lost that had to close for lack of funding.

We're not only inadequately funded but if the non-profits closed there would be so much more pressure on the formal system. We keep a lot of people out of the hospital for example
Service Providers, Halifax, Nova Scotia

> *A lot of our services are short-term, grant-based projects. A lot of time has to be spent writing proposals to keep programs going. And, the funding dollars are attached to specific activities and short-term deliverables are required, but we can't do too good a job or the funding will be removed.*
> *First Nation Service Provider, New Brunswick*

It was suggested that building peer support into the formal system would improve patient care and outcomes, and possibly reduce costs.

> *If I had a magic wand, I would have a peer support worker in every mental health centre in Nova Scotia, in every catchment area, in hospital or community, especially the emergency departments. People have gone there and then jumped off the bridge. I think a peer support worker—and they should be paid and part of the health care team—who could have said "I understand what you are going through" would have made a difference. Plus, it is so valuable to have someone who has experienced what you are experiencing, and they can serve as a role model.*
> *Service Provider, Halifax, Nova Scotia*

Adequate resources are also needed for non-medical services such as psychotherapy and counselling. Several participants said that the existing service system, which in most cases provides funding only for medical interventions, is unfair and does not meet consumer needs.

> *If you need a psychologist, you can't afford it. They are not paid for by the government.*
> *Family Member, Montreal, Quebec*

> *We talk about the two-tiered system – if you have money you can access services privately and quickly, but not in the formal system. We have had people come from out West, who said they had been using Cognitive Behavioural Therapy… but there is not that available here. There is such specialist in the system, but you have to pay to see him. In the formal system, it's medical treatment, that's what you get, and there is often a long wait list.*
> *Service Provider, Halifax, Nova Scotia*

6.4 Improve public awareness to reduce stigma and discrimination

> *We all need a little bit more understanding and public awareness.*
> *Consumer, North Bay, Ontario*

Most of the groups talked about the need to improve public awareness to reduce and ideally eliminate the stigma of mental health and addictions consumers. Many participants questioned why mental illnesses are so stigmatized compared to physical illnesses. Others noted that, while the stigma of a mental illness is bad, the stigma of an addiction is worse.

> *Alzheimer's and Tourette's are not stigmatized. If you have a physical health problem you are not stigmatized, so why is mental illness? Other brain issues are not stigmatized.*
> *Family Member, Montreal, Quebec*

> *Addictions services are even further behind. There has been a lot of work to break down the stigma attached to mental illness but for addictions there's still a lot of work to be done. People with multiple issues have dual stigma.*
> *Service Provider, Halifax, Nova Scotia*

Professionals, as well as the general public, tend to stigmatize mental illness and addictions. For this reason, professionals are often reluctant to disclose their own mental health or addictions problems, although this could be very helpful for consumers.

> *When I talk to a group of 20 service providers and I tell them that one in five people has a mental illness so four of them have a mental illness, they looked shocked and they start looking around at each other. Although those four know who they are, I'm sure.*
> *Service Provider, St John's Newfoundland*

> *The stigma should be changed and also I would like to see the many people who work in the system who have an illness; that they come out of the freaking closet.*
> *Consumer, Montreal, Quebec*

Initiatives aimed at improving public knowledge and awareness should focus on breaking down barriers, so that people do not view those with a mental health or addictions problems as different or "other" from themselves. Awareness training should begin early, in schools, and should involve direct contact with consumers.

> *There's lots of reasons why people have mental health problems – family problems, home life – but we need to bring down the stigma. Everyone has skeletons and demons and we all have to face them.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

> *Knowledge is power. We need the knowledge of mental illness to break down the walls that separate the mentally well from the mentally ill. We all have some degree of mental illness.*
> *Service Provider, St John's, Newfoundland*

> *To reduce stigma, you have to get out there and be proactive…bring in consumers to talk about how to live with a condition and have a quality of life. And, if it's a high school, it should be a youth consumer.*
> *Family Member, Montreal, Quebec*

Public education about the history and unique challenges of Aboriginal people could help to eliminate the combined racism and stigma that many face.

> *If we are going to build political capital to make meaningful changes, we need a public awareness strategy to provide a context for Canadians about First Nations people; this will reduce stigma and prejudice. If people realize what the root causes of the problems are… this is key if we are looking at social inclusion.*
> *First Nations Service Provider, New Brunswick*

6.5 Make it easier and faster to get needed services

The majority of focus groups emphasized the need to improve access to services by making it easier for people to get the services they need, when and where they need them. This includes access to family doctors, to psychiatrists and to other mental health and addictions services.

> *Mental health services are so backed up they can only take the worst-case scenarios which tells me I have to get a lot sicker before I can get help.*
> *Consumer, North Bay, Ontario*

> *Make it easier and faster for someone to get help. You have to make an appointment for an assessment which could take months and then you have to wait after that to see a doctor or a therapist.*
> *Consumer, Montreal, Quebec*

> *We need better access to faster crisis services; you can go to the hospital but it takes forever.*
> *Aboriginal Consumer, Sudbury, Ontario*

Several focus groups also talked about the need for services that are more flexible, in terms of hours of operation and/or outreach capacity. This could include telephone help-lines and online support services. Some consumers, especially those who are most vulnerable, find it very difficult to reach out for services and some find it almost impossible to leave their homes to attend appointments. Some do not have access to transportation, which limits their mobility. In remote or rural areas, services are extremely limited in availability or, in some cases, not available at all, and lack of transportation is a significant barrier.

A lot of services don't operate on evenings or weekends either and that's a big problem.

> *Right, you need services or outreach outside the 9-5 timeframe.*
> *Service Providers, St John's, Newfoundland*

> *For me to go on the bus and go somewhere, it's hard. I know there are services here but I don't know if I could do that – go out to get services – so a phone line or online service would be good for me.*
> *Aboriginal Consumer, Sudbury, Ontario*

> *The only thing that ever helped me was meeting a man, while I was waiting on a corner to get high, and he asked me to go for a coffee. And he sat me down and we talked about the medicine wheel and how it could make a difference for me and traditional things and that was the only thing that made sense to me – it didn't mean drugs, locking you up, separating you from your family – it was just about helping you.*
> *Aboriginal Consumer, Halifax, Nova Scotia*

> *We get a lot of calls from people in rural areas and I'd love to give them a solution. They are often trying to get services but it's difficult in those areas. I understand that there may not be the population density to support groups etc but there are still individuals who need services.*
> *Service Provider, Halifax, Nova Scotia*

6.6 Make services more client-centered

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

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

> *I benefit more from health care professionals if they work with me and respect me – like team work – it's not like "I'm the doctor and you're the patient".*
> *Consumer, St. Johns, Newfoundland*

> *[Service providers should] include the client in team meetings for service coordination. I've been to meetings where they are trying to decide where to*

> *refer the person to and nobody is talking to him or her, or asking what they want. And the person is sitting right there.*
>
> *Yes the system infantilizes clients, but the ill person is the expert on him or herself.*
> *Service Providers, Montreal, Quebec*
>
> *I think that sometimes, going through the system, nobody has ever explained what bipolar disorder is or what schizophrenia is what the treatments are, etc. They are just told this is your label and this is your medication, so they [consumers] don't even have the words/language to talk about it.*
> *Service Provider, St John's, Newfoundland*

6.7 Address the multiple determinants of mental illness and addiction

Eight of the fourteen focus groups emphasized the importance of addressing the multiple determinants of mental illness and addictions. When people do not have a safe and healthy physical environment, sufficient food, decent housing, access to meaningful work and social support, mental health and addictions problems are more likely and recovery becomes extremely challenging.

> *The service providers should take into account the socio-economic factors that contribute to mental illness – poor, unsanitary living conditions, no job, no friends. People lose hope to get better, they give up. If you don't take those factors into account, then you're not looking at the person, just the diagnosis.*
> *Consumer, Montreal, Quebec*
>
> *The most important thing is the determinants of health – before we recommend a course of treatment – do we see if a person has a job, a place to live, food to eat. The number one thing that separates healthy people from less healthy people is income.*
> *Service Provider, Halifax, Nova Scotia*
>
> *We're living in a dump, a cesspool, a contaminated site; the government gave us contaminated land. Our culture is degraded; our environment is in worse shape, so you can imagine how it affects our mental state. If you live well, your mental health will be well, but that's not how it is here.*
> *First Nation Consumer, New Brunswick*

People with mental illness or addictions who are living in poverty, especially those on social assistance, face many barriers to recovery. These include discrimination and harassment, disincentives to work and lack of needed supports.

Anyone on welfare or disability is painted with the same brush. I'm just trying to stay alive. I don't drive, don't have a computer. They tell you to go on the website, but how many people on welfare have a computer and internet? One friend of mine lost his ODSP because he was in the hospital for a month, and then couldn't get a place to live, couldn't get welfare without an address, so it just goes down and down.
Consumer, North Bay, Ontario

I would like to get more involved in work, but I can't get the childcare for this. There was one program that I wanted to take that would have cost $20 a month for child care, but social services wouldn't pay for it unless my children were at risk for abuse, so I basically said "if I go back home and beat them, you'll help me" and she basically said "yes." So these are barriers for me as a single parent. It's hard to get involved in support groups or programs if you can't pay for a babysitter and I can't take that money out of the grocery money.
Consumer, St. John's, Newfoundland

Some participants questioned why people with mental illnesses have to live on social assistance at all. They think that mental illness should be treated as any other disability when it comes to income support. However even in cases where consumers are eligible for disability income support, the road to get there can be long and hard.

Why do the mentally ill, who have a disability, have to go through the welfare system?

Plus, with welfare, you have to re-apply every year and it is chronic and they need support for life and they end up back at home or on the streets. And if the person is ill, paranoid, they are not comfortable filling out forms.
Family Members, Montreal. Quebec

For ODSP [Ontario Disability Support Program] consumers have to go through Ontario Works [welfare] first, get instructed to apply for jobs and from there pick up ODSP forms. If you have a doctor he will fill in your forms, but the walk-in clinic won't sign the forms, so if you don't have a doctor you can't get ODSP at all. It is a lengthy and degrading process. It can take months to get access to ODSP.
Family Member, North Bay, Ontario

Access to adequate housing remains a significant need, especially for those with serious mental illness. Living in poor quality housing has a negative effect on the well-being of consumers and family members expressed great concern about loved ones who may not have a safe and secure place to live.

> *At this time, we have rooms available but only in what you might call crack houses. It's very hard for them to stay sober and clean in those environments. We need affordable one-bedroom apartments. Many people have no support from family…So they spend money from their basic needs allowance for rent, which means they don't eat properly.*
> *Family Member, North Bay, Ontario*

> *I'm having a hard time here…I've got no friends; I'm living in a place with booze, drugs, fights. Two weeks ago a woman threw herself off the roof and she's in the hospital now in a coma.*
> *Consumer, North Bay, Ontario*

> *Housing and all those problems are big issues for family members – where can your loved one live, how can they be taken care of? Right now my son is in a group home, but it's a transitional place and we're not sure where he's going to go next. The organization will try to place him, but he's not following their rules all the time…and if he doesn't, we're not sure where he will go.*
> *Family Member, Montreal, Quebec*

There is a multiplier effect with many of these issues: that is to say mental health problems make it difficult to obtain employment, poverty makes it difficult to get adequate housing or to access transportation, high rents make it difficult to afford healthy food, and all of these things together increase stress and make it very difficult for people to get well.

> *Employment is another factor that influences health and social status but a lot of people think that people with mental illness can't work. They might say "they can't work because it's too stressful" but it's stressful not to work.*
> *Service Provider, St John's, Newfoundland*

> *My daughter would like to work a little bit, but that would penalize her on social assistance. She can't do too much but would like to study on a part-time basis or work part-time and still get assistance; that would be great.*
> *Family Member, Montreal, Quebec*

> *Many people have no support from family and [apartments] are about $700 for regular, non-subsidized, and it's hard for people with mental illness to share. So they spend money from their basic needs allowance for rent, which means they don't eat properly.*
> *Service Provider, North Bay, Ontario*

> *Transportation is a big issue; it's $55 a month for a bus pass which is high. If you can't afford the bus pass and live outside the centre core, you can't attend any services.*
> *Family Member, North Bay, Ontario*

6.8 Engage and support family members and caregivers

While recognizing issues of privacy and consent, family members and caregivers would like to be more engaged in the care of their loved ones. If they had more information and were more engaged, they could be more helpful in the recovery process.

When someone is discharged from hospital after a physical illness, you get all kinds of information about after-care – why not after a discharge from a mental illness? It's all a big secret.

> *And families can be a real help in the whole recovery process, if they get some information about strategies they can use to avoid crises or to help their loved one*
> *Family Members, Montreal, Quebec*

This lack of engagement and information is especially frustrating for parents of adolescents who remain responsible for their care but have few rights.

> *I'm the sole caregiver of my son and he's been hospitalized many times. They will not give me any information since he is 14 or 15 years old. I am taking care of him, but I have no rights at all. The psychiatrist will only talk to me if my son gives him permission and can only tell me what my son has said he can share. I still don't know how to manage this child; nothing is available in the community for parents. I've talked to many other parents and they say the same thing: there is nothing to help them cope with these kids.*
> *Family Member, St John's, Newfoundland*

One participant noted that there are risks associated with not involving family members in care planning.

> *I would say to take a team approach, rather than just deal with the individual, to work together with the family…whether a husband and wife, or a teenager and parents. Also, sometimes the partners are so involved in their loved ones illness they almost get sick themselves and the way they cope isn't healthy, so it becomes a negative cluster and you end up sick together – service providers need to realize this.*
> *Family Member, North Bay, Ontario*

Family members and caregivers also need recognition for the important role they are playing along with support for themselves. It can be stressful and exhausting caring for a loved one with a mental health or addiction problem and this can affect the well-being of the caregiver. Some have found family member/caregiver peer support to be particularly beneficial.

> *Family member peer support allows family member to share their experiences with each other, so it gives them strength, motivation and hope. The same as the consumer groups – sharing their lived experience and their ups and downs – just knowing that they aren't alone helps them.*
> *Family Member, North Bay, Ontario*

> *Many caregivers feel alone and when they come to their first peer support group, they feel like there are others in the same boat, they're not alone and they tend to come back month after month. It's not for everybody but it does work wonders for some.*
> *Service Provider, Halifax, Nova Scotia*

7. How do consumers take care of their own mental health?

The seven consumer groups were asked what they do to protect and promote their mental health. The following represents their responses and how many groups provided each response.

- Practicing spirituality and hope (6 focus groups)
- Helping others (6 focus groups)
- Social and peer support (6 focus groups)
- Being open/sharing your experience (5 focus groups)
- Good health habits (5 focus groups)
- Self-education and knowledge (3 focus groups)
- Other: Comedy/humour; Arts and Crafts (3 focus groups)

Most of the consumer groups talked about the importance of spirituality and hope in supporting mental health. The form these take may be different for different people but for many, they play an integral role in recovery.

> *Spirituality is a huge part of my recovery. I have faith and I do believe I'm here for a purpose and there is a reason my overdoses have not been successful. Remembering there is a plan for me and everyone around me.*
> *Consumer, North Bay, Ontario*

> *The one thing that is most important is hope. I wouldn't be here if I didn't have hope. I've never lost hope. I'm happy now. Each human being merits being happy.*
> *Consumer, Montreal, Quebec*

> *Having tradition and prayers are very important in healing.*
> *Aboriginal Consumer, First Nation, New Brunswick*

> *At 3 to 4 o'clock in the morning, I call in the spirits of my Irish and Viking ancestors to give me strength*
> *Consumer, Montreal, Quebec*

Closely tied to spirituality is the theme of helping others, which many participants practice and which they believe benefits their mental health.

> *Now I work with people with mental illness and help them to paint, work with ceramic tiles. It helps people to re-integrate, between therapy and a regular job or school.*
> *Consumer, Montreal, Quebec*

> *I'm thinking about what I can do to contribute to society, to give back. I'm in the band here, I come here and teach people guitar and it makes me feel better. It's very therapeutic. It's something I know I'm good at and if I can help them get better at music, it makes me feel better.*
> *Consumer, North Bay, Ontario*

> *I help people where I can and use my connections to get things done for people. Drunk, sober, I don't care. I'm there for the kids beaten up and the women and men. I've treated gun wounds and broken hearts. I go into the schools and let the kids get angry and mad. I'll talk to them alone; I'll ask the teacher to leave the room and the kids will talk with me. Sometimes they are lashing out because they've been treated badly at home, so I advocate for them, that they not be punished if they are acting out.*
> *Aboriginal Consumer, First Nation, New Brunswick*

Social support, including support from friends and peer support, is a lifeline for many consumers. Some are inclined to isolate themselves when feeling unwell and they have come to realize how important it is to stay connected to others.

Isolating is part of addiction and we don't want to be around people. I did that a lot in the beginning – I had to force myself out the door to go to meetings….I have to take responsibility to do things that are good for me.
Consumer, North Bay, Ontario

Support from friends, family, support groups – this is critical – especially peer support.
Consumer, St John's, Newfoundland

Peer support is my life; without it I wouldn't be here.
Aboriginal Consumer, Halifax, Nova Scotia.

Sharing their feelings, being open about their illness and sharing their experiences are all therapeutic for many consumers. Some have found that by so doing, this helps other people to feel comfortable talking about their own mental health problems.

Learning how to open up about your emotions is important for your mental health.
Aboriginal Consumer, Sudbury, Ontario

I made a point a long time ago to not be ashamed about my illness and to be open about it. What I got from that is a lot of people sharing their experiences with mental illness or with their loved ones. My openness has helped other people to open up. This makes me feel not so odd; self-help groups do the same thing.
Consumer, Halifax, Nova Scotia

Practicing good health habits—eating well, exercising regularly, getting sufficient sleep and getting exposure to sunlight—are important in maintaining mental health. Some consumers have eliminated unhealthy substances such as tobacco and alcohol and found that this really helped their mental health. Some have found meditation and/or yoga to be helpful.

I self-medicated for a long time with marijuana and alcohol, and getting off the substances really helped my mental health issues. I wasn't eating well or exercising either. I quit smoking marijuana four years ago and then was smoking a lot of cigarettes and then I got off them too.
Consumer, Montreal, Quebec

Physical exercise really helps me – it's part of self-care for me – walking, hiking, going to the gym, yoga and the meditation part.
Consumer, St. John's, Newfoundland

Building knowledge through self-education and self-awareness is also beneficial as this helps people to understand their illness and what works for them. It also helps them to realize when they need to reach out for help.

[You should] read as much as you can on your illness so you can learn about it and what works for others.
Consumer, Halifax, Nova Scotia

Over a period of time you learn what works… I'm keeping a chart of my ups and downs to see the patterns so when I'm having a bad time, I know it's going to go back up because it always did.
Consumer, Montreal, Quebec

For me, it's watching the signs. You know when you are getting depressed and you get help before it gets too bad. My grandma passed in August and I knew I was going to be depressed, so I reached out right away.
Aboriginal Consumer, Sudbury, Ontario

Other factors that are seen as important in maintaining mental health are having a sense of humour and laughing with others, engaging in activities like arts and crafts and journaling.

Appendix A: Demographics Eastern Canada Focus Groups

Participants	**Number**	**% of Sample**
Gender		
Male	32	32%
Female	67	67%
Ethnicity		
Aboriginal	45	45%
Non-Aboriginal	54	54%
Relationship with Services [1]		
Consumers	47	47%
Family Members	5	5%
Service Providers	47	47%
Location		
Halifax (4 groups)	24	24%
Moncton (2 groups)	16	16%
St. Johns (2 groups)	13	13%
Montreal (2 groups)	16	16%
North Bay (2 groups)	14	14%
Sudbury (2 groups)	16	16%
Total	**99**	

Schedule “E”

Summary Notes

Cultural Safety Symposium

March 24 & 25, 2010
Ottawa, Ontario

Day One

Opening prayer – Dr. Ed Connors

Dr. Ed provided some opening remarks about life, work, bringing our gifts into the world, and seeing and welcoming the gifts of people who are marginalized. The purpose of life is to eliminate the language of disabilities and to create a world where no one is labeled or takes their identity from their disabilities, only from their gifts: "I am not what I am not able to do; I am what I am able to do – my gifts and my strengths." When we look at deficiencies; that is what we get. When we look at people's gifts and capabilities; that is what we get.

He explained that the smudge is offered as a way of giving thanks to the Creator, however we understand that Higher Power, and with respect for all the ways we relate to the Higher Power. We are using the smoke from the sage to cleanse ourselves of all the things disruptive to our purpose here today, so we can use all the gifts the Creator has given us to do what we have come to do this day.

Ed invited Chris Summerville to offer a prayer as well.

1.0 Welcoming remarks – Bill Mussell and Phil Upshall

Richard Chenier: Welcome everyone! It has been an exciting and challenging year with this pioneer initiative. In our review of the literature, we have not been able to see any other examples of such an initiative elsewhere in the world. It has come about through the partnership between Bill and Phil, two mental health leaders in Canada today.

Phil: It is fantastic to be among friends to share what we can share, provide guidance, and walk away tomorrow with hope in our hearts. It's a privilege to be able to partner with NMHAC and FNIHIB whose support has allowed us to develop this process in a way that we felt it needed to be developed. Too often, the structures of government prevent this kind of learning as we go on. We have come to different ways of learning, understanding and engaging over the last three years of Building Bridges. I would like to acknowledge the presence of the Directors of the MDSC– Bill Ashdown, Chris Summerville, Bill Mussell and Vicki Smye. Two others were not able to make it here. Both MDSC and NMHAC have wonderful boards that are very strong and supportive. Thank you, Ed for helping refocus us in a way that supports the work.

Bill: On behalf of the Board of NMHAC, welcome everyone. Our Association has been addressing much the same issues as the MDSC, and working very productively with it and FHINIB. I am pleased to se representatives from ITK and AFN. I am confident we can continue the good work that has been accomplished since Building Bridges started.

Richard provided an overview of the agenda. He explained that Bev and Terry are taking notes because every word is important to us. We will view “Glimpses of Light” and Vicki will talk about the linkages between cultural safety and relational practice, followed by a plenary discussion with Bill. Day two will consist of small group discussions and reports to the plenary.

2.0 Participant introductions and expectations

Howard Chodos: My job with the MHCC is to develop a MH strategy for Canada. I am pleased and honored to be here today. We are striving to incorporate the learnings from this and other initiatives into the work of the Commission. Hoping to learn more over the next few days, to help us all move forward in a common direction.

Winona Ryder-Lahache: I work in MH & Addictions for the AFN. I am from Long Point FN, a community of about 400 to 450 people, about 7 hours north of Ottawa. My expectations are to learn a lot more from everyone at this event. AFN is looking at establishing a MH & Addictions Advisory Committee to advise on the national work of the AFN. I am interested in having conversations about what is happening re: cultural safety that would help to inform this work.

Diane Williams: I am a Supervisor of Mental Health and Addictions in a FN (population 2900) in New Brunswick, north of Moncton. In New Brunswick, we have a project for adapting mainstream MH services to better serve FN needs. Our New Brunswick MH strategy is presently being rewritten.

Lorna Williams: I work at University of Victoria. My expectations are to listen and learn. These meetings are challenging because of the work everyone is doing, but enlightening and empowering because of the courage people have in trying to break open the doors that have been closed to so many people.

Farah Millany: I am part of the MHCC strategy team, working on goal three, incorporating diversities and strengths into a transformed mental health system. I serve as liaison with the FNIM Advisory Committee of the Commission. I am looking forward to learning a lot about how best to incorporate cultural safety into the implementation of the Strategy.

Jennifer White: I am at the University of Victoria, and a member of FNIM Advisory Committee. I have a long-standing interest in child and youth mental health and in youth suicide prevention. Expectations for today are to listen and learn. These gatherings are always the beginning of how to practice in a culturally safe and relational way; it is important to practice the process.

Brenda Restoule: I am a Psychologist at an Aboriginal Health Access Centre in Sudbury for two FN communities. I am from Doukees FN, five hours from Ottawa, and serve as a Board member of NMHAC. I am working with FNIHB to develop a pilot project to provide services to 10 communities, using a blend of traditional and western practices. Richard and Bev came to the

Sudbury Health Access Centre to conduct a focus group. I sit at a service provider meeting in the Sudbury area and advocate for the incorporation of cultural safety. Sudbury recently built a medicine lodge in the new hospital. The danger is that they think they have cultural safety because they have a new medicine lodge. There is often a real divide between community workers and the professionals supposed to work with the communities, in that the professionals do not acknowledge the knowledge of the lay workers. Cultural safety training has to take place with these service providers.

Eric Costen: I am Director of MH & Addictions at FNIHIB. Thanks for the invitation and to Phil and Bill for their generous acknowledgment of FNHIB for our small support. I was not able to be at the first BB because I was on parental leave. I work on the "inside" with a group sincerely interested in making federal policy processes more culturally safe.

Vicki Smye: I teach at the University of BC. I am here to learn; I am on a steep learning curve about cultural safety and relational practice, learning a lot from students who are very curious and always asking questions. I am involved in several projects related to the subject of cultural safety. I am very grateful for what I do and for being here today. Very much looking forward to the dialogue.

Ella Amir: I am from Quebec and serve as Chair of Family Caregivers Advisory Committee of the Commission. BB1 was one of the better conferences I have been to. I feel privileged to be here and hope this will bring us one step closer to recognizing cultural safety and inclusion are universal issues not unique to aboriginals.

Bill Ashdown: MDSC Board member, very interested in the topic because I have seen it come up repeatedly in my work across the world – e.g. at a major psychiatric conference in South Africa; a conference in Jerusalem; about to be on the agenda of an upcoming meeting in Chicago. This is a topic whose time has come, around the world. You have caught a tiger by the tail in terms of the topic.

Mona Stout: I am with the Mood Disorders Association of Manitoba, working hard at eliminating stigma and preventing suicide by putting on events, fairs in small communities, etc. Some of these touched people with the need to talk about their suicide challenges. I have also been working with a northern FN community, Oxford House, which has accepted me. I do not want to give them false hope, not promise what I cannot give to this community and others like it. I am hoping to gain knowledge through this process that could give me more information and resources to help in working with the northern communities and people in Winnipeg.

Chris Summerville: I have been the Director of Schizophrenia Society in Manitoba for 15 years, and serve as a Board member for the MH Commission. I feel a great responsibility to speak for those whose voices are often not heard. The most pressing issue in Canada is not mental health, but how the whole of Canada does not have a good relationship with indigenous people. Vicki’s paper connects cultural safety to social justice. The correlation between the MH movement and indigenous issues is one of social justice and if cultural safety can help us to address social injustices that would be wonderful.

Gary Carbonnell: I am Mohawk from the community of Oka, representing the National Native Addictions Partnership Foundation. Mental health and addictions are brothers and sisters. I have already learned so much but have much more to learn and it’s an absolute honour to be here with the brain power in the room.

Gwen Watts: From Labrador, Director of MH & Addictions for the Department of Social Health and Welfare for the Inutsiuk government, and a member of FNIM Advisory Committee. Cultural safety and relational practice fit daily into my work, from policy to putting out fires on the ground in the community. So many questions have been coming up for me lately. We have partnered in a Social Work training program with the University so people do not have to leave Labrador for training. The challenge is how to make things safe, so people can feel empowered in this kind of situation, working in models of status quo. I am excited to be here.

Patricia Wiebe: Psychiatrist working in an advisory capacity with FNIHB. Thanks to Chris and Ed. We are in the early stages with AFN and Tapirisat of exploring what cultural safety means. We are also looking at how cultural safety fits within FNIHIB. Heartened to see this work continue and move forward. I see what you are doing in this process is to give voice to those whose voice has been excluded and to move towards reconciliation of Canada’s peoples.

Tina Holland: Board member of MDSC of Manitoba. I have been living with bipolar disorder for over 40 years. My passion is to help people learn how to live a successful life with any mental illness. I speak in any group that will invite me. I help people learn how to take the next steps in their life and recovery. Here to learn and further my passion.

Norman D’Aragon: Psychologist from Quebec, board member of NMHAC and member of FNIM Advisory Committee. I was given a spiritual name recently; my Clan is the Bear Clan; name means Fire Lit by Thunder. One of my ways to celebrate this in my life is I had a close encounter with a polar bear. Very happy and honored to be part of the circle. I was at BB1. I stayed on the shore on the FN side, wasn’t on the bridge. My goal would be to more open, more connecting with everyone, not staying on the shore. I feel a bit more and more like a bridge myself with all the realities I connect with.

Caroline Tait: Professor of Native Studies, University of Saskatchewan and member of FNIM Advisory Committee. I am the lead of the FNIM AC project on ethics and accountability. Recently, I received tenure, which means it is more difficult to fire me (a classic Métis response!). I am exploring links to our work in Saskatchewan in terms of the broader philosophical lessons, and to the practice on the ground for people. The challenge is to bridge these, and take them backwards and forwards, to link research to practice on the ground. The metaphor of the bridge is wonderful and I'm optimistic.

Terry Adler – Member of FNIM Advisory Committee. Thanks to Ed and Chris for starting our gathering in a way that reminds us of our connectedness to each other and all things. Thanks Bill and Phil and those who organized the agenda, for "walking the talk" of cultural safety by recognizing that everyone has lived experience and for providing an opportunity for us to share and learn from one another's experiences. My expectation is that through the process, we can better understand what is meant by the words cultural safety and relational practice and how they link to social justice.

Bob Allen: Board member NMHAC, a background as a Psychiatric Nurse I Saskatchewan, and a lengthy career in Correctional Services. Sometimes in my work, there were challenging times, instances where it was overwhelming to meet the challenges of the work. It felt like I was riding the crest of a wave that sometimes felt like a tsunami. It feels like a wave again re: the whole issue of cultural safety. In Saskatchewan, we are looking at an initiative of patient-centered care, called Patients First. We are concerned about the cultural safety and cultural competence of systems, and how cultural safety applies more broadly to everyone. My expectation for being here is to learn from everyone.

Josephine Muxlow: I work with FNIHB in the Atlantic Region. I am honored to be here. I had the privilege of being part of BB1 and am delighted to be part of BB2 and contribute whatever I can. The topic of cultural safety is very important to my colleagues. It is important to see what cultural safety means to the communities from the systems perspective. It's important to flush out the concepts and what they mean to communities, organizations like FNIHB and how cultural safety can be applied in concrete ways.

Bill Mussell: We are each shaped by the forces in our lives, and I am grateful to have good ancestors and friends shaping my life. Went to high school with only a few Aboriginal students; graduated university and became Executive Director of native friendship centre. Community is so important. I taught at university part-time but wouldn't do it full-time because there is no community there. I joined the Native Indian Brotherhood and found we had a community. Communities are significant in my life and conform to the values of the collective, the team, the network, the society, the nation. We have a real need for community. We have created a wonderful community in the FNIM AC, same with the MDSC. We have made good friendships with members of the Commission, but it is not a community. I'm really pleased we are here to share our lived experience and learn from one another.

Phil:I come from the Western model. An important aspect of recovering from bi-polar was to be part of a peer support group, a safe place to be. I was able to drop some of the facades that you carry for your own protection. I had started to heal. When I started to think about CS and relational practice, I realized peer support was all relational, a place where we could recover our identity and relationships, feel safe and comfortable. I love the process we have embarked on in BB. There is so much honesty, commonality in our relationship and leadership. I want to take away some guidance from this group about how you see things. You can give us a hand in moving forward with our next steps because there is a richness of knowledge and experience in this room.

Ed Connors: I am of Mohawk Irish ancestry, of the Wolf Clan, my name is Eastern Thunderbirds Sounding as They Come. I have worked as a psychologist in FN communities for close to 30 years. I have seen it as another form of training in a world and a perspective about life, our relationship with self and all creation that was different from the one I had been immersed in during formal training. So I sought Elders as my teachers, to understand their perspectives on the world. As I've done that, learned and continued to reflect on that, I have come to understand that there is a whole world of indigenous knowledge, wisdom and perspective on healing that has informed my work with FN communities. I've been connected with NMHAC almost from its inception; and many other opportunities have evolved from this, including working with the Family Caregivers Committee of the Commission and other work. This is so worthwhile; it's all tied together, the cultural safety I have been doing for many years. What we are now doing is putting language, words to it, thus informing indigegogy. There is no better place for me to be in my life than here, because we are forming crucial understandings of mental health that are needed globally. I'm going to be speaking about these concepts, so others can understand what we mean by them. What we are unfolding here is seminal work in the evolution of all forms of mental wellness in the world.

Beverley Bourget: Thanks to Bill, I'm a member of the Commission's MH & the Workforce Advisory Committee and the lead on the Improving MH in the Workplace project. Thanks to Bill, Phil, Richard and the funders, I had the honor to co-facilitate the Eastern Canada focus groups and to develop the report, which I truly hope reflects the voices of the participants who trusted us enough to open their hearts and share their often difficult but also inspiring stories. In those groups, the themes of cultural safety, relational practice and social justice came through loud and clear, and I'm really looking forward to further exploring these topics over the next couple of days with such a diverse group.

Dave Gallson:I am from North Bay Ontario. I am very interested in and feel very strongly about these subjects. They are something I would like to do more work on. Over the last few years, I have developed relationships with new Canadians and see how applicable this is to their lives. I am here to learn and grow over the next couple of days.

3.0 Project Overview & Agenda Review – Richard Chenier

Richard reviewed progress to date, saying that Building Bridges Phase One ended in October 2007 and produced 17 recommendations. To put meat on the bones of those recommendations, it was decided to explore the themes of cultural safety and relational practice in the context of the five priority goals of the Mental Wellness Advisory Committee. Resources have been shared with the FNIM Advisory Committee, which made cultural safety one of its priority projects.

Richard provided an overview of the overarching objectives of Building Bridges Phase Two (see Richard's PPT for these). This current phase included 41 focus groups and consultations across every region of Canada, along with commissioned research papers. The final report will be produced in May 2010. Grateful thanks to FNIHIB, without whose support this initiative could not have been accomplished.

4.0 DVD "Glimpses of Light" – introduced by Bill Mussell

5.0 Cultural Safety as a path to effective Relational Practice – Dr. Vicki Smye

Vicki: Richard invited me to have a conversation with you on relational practice and cultural safety. I hope you had a look at the overview of the literature review of cultural safety circulated previously. I hope this conversation feeds into the CS and cultural competency report due out shortly. CS is not a panacea; it's a concept to help us think about and frame things and move to a place of working relationally in this country. I want to underline that relational practice is not simply about the inter-personal relationship, being nice and kind, caring and compassionate. It's about understanding ourselves and the care we provide in relationship to the contextual features of our lives, including where we live, how connected or disconnected we are from our past and how we are all deeply connected in many ways.

I'm learning so much from my brother as he transitions out of this world. I was with him a short while ago. He is a man of few words. I shaved his face. And you have to know my brother to know what this means to him, so this is relational. He is diminished only in his physicality. He looked up to me and said to me, good bye sis and I told him I would be back on the weekend and he looked up and said "I want to thank you so much and it's not just about the physical care. You know what I mean." We know each other; we understand where we came from, why we are where we are. We don't even have to say one word. Language is so narrow – how do I write a paper, the CS report and embed that in it? When I speak relationally I am speaking not just about being nice. How do I convey to the practitioner that there is that reality to everyone? Relational practice calls for vulnerability. That is our challenge, because many people are afraid of being vulnerable. I was taught in a tradition of keeping boundaries very clear, of being careful, not sharing. I would say to you that we have to learn how to shift practice to say it's OK to know and to be known. And we can be safe in that.

Bill: You remind me that 90% of communication is non-verbal, while the academic world is based in the verbal.

Caroline: The relational piece - I was talking to someone about indigenous rights in an international context. In this country, the relational piece is about land and it continues to be about land. The perception was that the land was empty when European's arrived, and the colonizers had the right to take the land. That tells us about power. Along with the taking of the land came the loss of fishing and hunting rights, which were restricted. So, my dad (Métis) had to sneak around with his hunting, and we were told not to tell the other kids at school about it. Those relationships over generations and generations are fundamental relationships. CS for me starts with that acknowledgement, that there were people here before Europeans arrived and Europeans were successful in dismantling the indigenous relationship with the land. That has huge implications for indigenous people. I think of how that must have been for my father, to have his children see him breaking the law. But that was the relationship. And the video, the relationship of the patient to the caregiver, this brings me back to the importance of the land. We children were watching my dad break the law, but he was doing what has been done for generations and generations.

Bill A: When I was reading the material for the conference, I could see a connection with the Ethiopian Jews who now live in Israel who have their own particular challenges because of the nature of the MH problems they live with – one form of mental illness that is culturally generated, and very different from anything you would see in the DSMIV. They were trying to teach the Israeli health system providers how to deal with the illness of the Fallasha. So much of their teachings revolve around not just cultural knowledge, but the ability to treat people with these illnesses in a way that is safe and acceptable and understandable to them. Before they could understand what the Doctors were trying to do for them they had to see it through the lens of their own cultural understandings, then it clicked into place for them. This to me exemplifies CS. South Africa has 11 cultural groups to deal with and nobody understands anybody. 90% of the time people don't want to be treated because they don't understand both parts of the equation, it doesn't fit them.

CS for me is what people express is culturally safe for them. There are so many people, immigrants coming here with PTSD – we need to empower them to tell us how they need to be treated. This is primary to CS.

Chris: When I had a mild heart attack 9 months ago, the doctor that was treating me told me – no computers, no blackberry – and as he left I said, would you pray for me? And he said yes and walked off. We both attend the same church and I could not understand why he didn't just come over and say a few words at the time. This is a classic example of relational practice.

I went to the psych hospital in Winnipeg to visit a young man psychiatrists wanted to diagnose with schizophrenia. He said "I don't have schizophrenia". He wrote 15 pages of why he was in the situation he was in, and gave them to me to read. He knew what was wrong with him– loss of his mother, loss of his girlfriend, ongoing tensions with his dad – very articulate – making his case how he was going to appeal the diagnosis, but told me that no one would read his paper. So I got him a meeting with the psychiatrist and asked him if he thought the paper had anything to do with why he was there. No one had read it – and he had been there 21 days. When you entered the psych ward, there was no relationship there, no privacy, a very disempowering place. I love that you are defining CS as relational practice and it fits in very well with what we know of recovery.

Vicki: There is a brand new facility for women with substance use issues in the West and my colleagues won't allow students there yet because the nurses spend all their time in the nursing station behind a door. My colleague was just floored by that. To me, that is so tragic, but the good part is that Vancouver Coastal Health has been trying to make some changes and have invited us in, but there is some fear on the part of the nurses. So, how do we bring CS and live relationally in a way that invites a different way of being? Even the door, the top opens and the bottom stays closed and that's how they give out meds. I thought we got rid of that, but there it still is. I think there is a great deal of fear of connecting because we have to face our own vulnerability. I think fear is part of the challenge and that prevents people from connecting and creating the join.

Josephine: It goes deeper than that. I think it is important for the people involved to understand their fears, their values and how they see the other person as a person – in order to have a relationship I have to empty myself and come with no preconceived notions so I can truly see the person and their gifts. We can look at this in different ways too – there is the person-to-person interaction but there is also the systemic issue. How do we make that cognitive shift to understand the power dynamics and inequities that are in place? How can we make this happen with the providers, because my own fears block me from engaging you? We really have to also look at the big picture, the systemic barriers – how do we start breaking these pieces down? Sometimes we connect through language, but sometimes the connection happens without language. So how can we transform this dialogue that we are having into the everyday work place?

Phil: If you want to know how to control a situation without words, talk to my deceased mom – she knew what I was doing without language – that was relational. But I go back to community and we need to offer something pretty substantial to make the changes that need to happen in health care delivery. When I was growing up, we had a real sense of community – the Minister knew you; the doctor would visit and spend time without concern for the length of visit, everyone went to the same church, the teachers knew the whole community and would come to the house and talk to my parents – there was that opportunity to build relationships and for people to know me as an individual. As I grew older, I noticed withdrawal of public service, away from house calls and a business model imposed. Then, all of the sudden in the community, the corner store was gone and the big malls came in and then they built a monster high school, very different from the small high school my sister went to, where everyone knew everyone. We have to get back to being small and recognize that time is not a commodity.

These are critical in moving away from the medical model. Today, even in high school, we are training kids to get jobs, not for their minds to grow and think, and be independent. We have to start examining these kinds of relationships to get the advice we need move forward from this symposium. We have to think small and that time is not a commodity. We have to move away from the medical model and the western model we now have.

Terry: What are we doing in the hospital settings? We put people in with nurses hiding behind nurses' stations or half doors, but I know there are other models, other strategies. What sense does it make to isolate people instead of reaching out and helping them to feel safe? I really feel the need to understand where the medical model came from, this paradigm that is gripping our societal health systems and impacts on the care we see. Is the Commission really going to be able to challenge this paradigm? There are many different cultural understandings of mental imbalances. In some cultures, they surround people with the extended family circle, and use rituals to bring them back into balance. There is a drive to export the western way of dealing with MI which is fueled by the pharmaceutical industry that wants to medicalize MH issues to create other markets they can tap into. This is the fundamental challenge that needs to be addressed. Even if the model isn't completely thrown out, there are other options – aboriginal or consumer led ways of responding to the person's situation that begin with accepting the person wherever they are and whoever they are, with no judgment, and helping them create the supports they need so they are not alone in their journey. These include helping people get what they need to stabilize their lives, like housing. I really need to understand the western paradigm, so I know why they would put a mentally imbalanced person in a locked ward with other mentally imbalanced people and nurses behind a closed door.

Patricia – Wanted to pick up on the comment on vulnerability and what it will take for these relationships to change. ITK is starting to explore what CS would mean for FHIB and its staff. For cultural safety, we tend to focus on those who have had less power. Yet both sides need to feel safe. What would that look like? Cultural safety is a power relationship; the risk is that there is a loss of power. If you look at the relational aspect of CS, both sides need to feel safe – so **what does it mean for health care providers to feel safe as well?** One of the risks/vulnerabilities of CS is that it involves a loss of power. And we all have personal histories that we bring to our work, as does our organization (have a history) and this influences how we do our work and how we perceive each other. These are some challenges that have to be addressed.

Diane: I'm the pragmatic person – the other definition of relational practice has to do with feminist theory – a simple example – my staff, working with kids not going to school, came to me and said we have a problem with lice and asked can we hire someone to clean the houses? I told them these are moms on welfare with 5-6 kids; what if, instead of hiring someone, we get a basket of supplies to allow them to clean themselves, and bring some people in to help them. And that's when the mom's started doing better and the kids started going to school. It was about giving the mom's what they needed. I think if we spent more time with people in the beginning, we could help to prevent a lot of mental illness from developing further. We have sufficient resources; all we need to do is talk to people. We would get further along with mental wellness if we could just talk to people more. Our systems do not allow for time. I am all for accountability, but the more accountable I am the less time I have.

Ella: What Diane is talking about is what I wanted to talk about but I think it's more about respect than about time. You cannot have relations without respect. This is the most fundamental element. If we don't have it inherent in ourselves we can't have any real relations. This forum is looking at MI and about colonization with specific communities, but I think it has a universal resonance and applies to anyone who is marginalized for any reason. We need to have respect for otherness – so with very little time, if we have that, we could make a difference. Plus, we aren't really talking about anything new – we know about this and have known for a long time, but lost it along the way. It's not reflected in our training – we are building intellectual capacity but the onus is on everyone, not just the Commission, to make changes. There are pockets of practice, doing the right things and we need to replicate those.

Howard: Back to Terry's question about what the Commission could accomplish. On most days I feel overwhelmed by the magnitude of what the commission has undertaken. If we have to move time backwards to the kinds of community relationships we used to have, it's not going to happen. We can't push time backwards, but we can take lessons from those. We also need to understand and respect the younger generation and their realities. Our collective task within the commission is to make change pragmatically, to make a difference and this requires attention to what is going to work in the world today. Somehow we need to be able to translate what comes from conversations like this one into change. And that's a big task and it relates to the vulnerabilities and fears people were talking about – one thing the commission might be able to do is **act as a catalyst for conversations about these things – open up a space for that** – we can't ride in with a lance and destroy the medical model and I'm not sure I would want to do that. But opening a space for this kind of dialogue – making sure that there is not one model that dominates and understanding from people around the country what works and what doesn't work, respecting people's choices, the pluralities of those choices, including people for whom medication or the medical model works. The opening up of spaces for many choices for people is critical. When I was writing the Out of the Shadows report I had a conversation with Connie McKnight about it and basically it's about respecting people's choices.

Bill A: The idea of CS has a few different aspects to it. My wife has been a geriatric nurse for over 37 years. With some dismay and disgust, she is thinking of retiring because in her opinion, nurses have become more bureaucrats, form fillers, technicians, rather than being with people and giving them support. This has been a change of culture that highlights a larger issue – we as a society have been allowing a lot of these things to happen – we are focusing on technology over empathy. The **commission** can't change this overnight but it's a message that needs to go to them, and that they can then take to others – medical schools, nursing schools – so they can adopt a more holistic, rather than a technical approach. Otherwise, we are sub-dividing ourselves into smaller and smaller tribes, none of whom will be able to speak to each other.

Gary: Are we here not part and parcel of the problem? I'm a layperson but how many times have I told my kids to "get out of here". This creates a system of low self-esteem that snowballs. When I was 9 years old, if someone was building a house, everyone would come and help. And I had to help by shoveling sand in the cement mixer. I had an axe I could shave with when I was 7 years old. I wouldn't trust my older kids with such a thing. As parents, we are not allowing our children to experience these things. We are here dealing with the symptoms of a problem, but who is looking after the things that create these mental issues? We're a small group, trying to change the world, but on the other side of the fence it's a lot bigger, it's going to get more and more. We are going to get more and more mental unwellness with the growing changes in the world. We have a baby here – that's culturally appropriate to have our kids at meetings – it doesn't bother us but it would never happen in a non-aboriginal context. I'm wondering if we collectively, aren't part and parcel of some of the problems. Everything everyone is saying makes sense, but are we missing the boat? What is causing these symptoms? One last thing, for a FN person, we sit and speak as long as everyone is comfortable, but we have people who want to push us out. So we are trying to deal with CS and can't even exercise it in our own forum.

Ed: I agree – we're talking about CS. In our teachings, we would continue until we were done, until we had completed what we came here to do. Here we are competing with the clock that says otherwise to CS.

Norman: Recently I was giving a suicide prevention workshop and in the Cree community with 30 non-Cree and 3 Cree teachers. The Cree teachers had a load of grief and trauma to share but the non-Cree teachers were not open to this at all– they asked if we were trying to get them into a therapy session. So we had to have circles in the evenings to honor the need for sharing on the Cree side. In another example in the far north, the opposite thing happened. Most of the people were Inuit from families who were relocated and very wounded. The Inuit people did magical healing in that situation. The Inuit healers would go to the non-Inuit professionals that were there who were able to talk about their own sufferings for maybe the first time in their lives.

Winona: There are several different lenses by which to view relational practice and it's difficult to look at it through each of the different slices of these lenses because it's such a large and encompassing topic. I wanted to talk about time and something that Howard was talking about, about adaptation. We as people evolve so the way things have been done in the past – how do we stay true to that and modernize it? Time is a big thing I hear about at a lot of gatherings I have gone to. There is the whole notion of Indian time and that's something that people sometimes use as an excuse for being late. That's not what it was about. Traditionally, time has been viewed differently; it was about dedication and commitment, taking time out of your life to get the job done. If everyone was comfortable doing that and the environment allowed it that is what you did. If you are meeting and there is a thunderstorm, you "lower the council fires" and go home to take care of things, but don't lose the commitment. Looking at it in the context we’re in with the fire chiefs waiting to use this room, you keep the commitment to come back and deal with what was left – we call that lowering the fire. We need to keep the things that are valuable, but within the current context. And there are many layers. At a systemic level there are different things that need to be addressed and have an impact on relational practice, and one is difference in worldviews. Part of what has to be taken into consideration is looking at the commonalities in worldviews. I think Brenda is going to be engaging in this on a very functional level, so that will be really interesting.

Vicki: “Finding the join” is what is required in relational practice. We can come back to this conversation; I would love to hear your ideas because I would love to write a report about your thoughts, challenges of relational practice and examples of good relational practice.

Ed: One thought I would like to throw out for us to consider in relational practice and healing – it’s a major component of recovery because we have to understand recovery in the context of relationship. But we also need to be looking at experiences that have already occurred that are good examples of relational practice. We have some powerful mental health models, in our country and others that have been proven to be very effective. One of these is Browndale. John Brown was an innovator, way ahead of his time in terms of his contributions to child and youth mental health. He established his work in other countries and was recognized by the Queen for his contributions. We need to look at these examples, in terms of what these are all about.

Day Two

Introduction: Bill Mussell

Bill: I would like to share the experiences Terry and I had doing the Western Canada focus groups as they are relevant to the discussion we are having today. We had 27 groups in Saskatoon, Winnipeg, Iqaluit, Yellowknife, and Whitehorse with 5-6 meetings in each centre. We learned a great deal through the sessions about **relational practice** as it takes place in everyday life. This represents more than just CS; it is in the doing that helps us to experience what it is, like tacit knowledge, it is impossible to tell it like it is in words. Remember the natural flow of the water in the DVD as Denise was speaking about her experience with the Elder.

We spent time with mental health and addictions service providers, consumers/constituents (a concept introduced in Winnipeg) and individuals willing to share their experiences. They shared with us what is important to know, from their perspective. We used the talking circle format. These are some examples of what seems to work to make a positive difference for MH & Addictions consumers.

In Winnipeg, there is a Wellness Centre, a multi-purpose community wellness center offering counseling, work, and education opportunities. They’ve created a community within a community where people can see evidence of who they are wherever they look and all of their activities are built on the core values of the people.

In Iqaluit there is a friendship centre, a home away from home for the homeless where they offer food from the land brought in each day by hunters. There is no prying by anyone. Two older host/staff/counselors are available. It's a warm space to spend time to begin building community for yourself. People are welcome to help themselves to the food from the land available on the floor, and a bowl of fry bread. It is a unique experience to go through the door. Like other centers that make a difference, there are no government funds; it's all funded by the Aboriginal Healing Foundation.

In Yellowknife, there is a Women's Retreat Centre where the staff members are grads of the healing program, not people with graduate degrees, but with lived experience who know what it takes to provide on going support to people. The staff takes real pride in the continuity of their services. They have an unfailing belief in the ability of people to modify themselves that is conveyed nonverbally as they interact. This is not government funded. Government funded agencies resent the existence of this centre and I believe it's because it does such good work. The director and staff are working very hard to beg and borrow to get grants to keep the centre going. At this focus group, I began to appreciate that the life of homeless people in that part of the country resembles traditional survival, the key to which is mutual support.

In Saskatoon, the White Buffalo Youth Lodge is a centre that serves youth. They engage newcomers into activities, not creating a file of their problems, no personal profiles; they just take names and contact information for emergencies. It costs $350-400,000 a year to run this centre with no direct government funding. The director raises the money through grants and other means, although they do have indirect government funding for two classrooms for youth and two teachers work there full-time. They offer legal services through an arrangement with the law school and provide space for dental and medical services. They've done this so young people can, in addition to receiving the services, think about professional careers. My fear was, once this director leaves, where will they find someone with the motivation and skill to accomplish what she has? A government department has hired her so she is leaving in three months.

In Yellowknife we met a correctional worker who described the work that he does in a Federal prison, which is very effective not because he has a degree, but because he is steeped in his culture through the teachings he received from his father and grandfather. He provides ongoing support to the men in the system, to help them find out who and what they are from a cultural perspective. This helps them to become self-caring, and encourages them to work with others as he works with them. When people with lived life experience get the help they need and become relatively healthy, they are able to assist others like them and have an ongoing commitment to their development. Also in Yellowknife, a FN is doing a variety of things, including a return to the land program that included some of the people considered to be homeless. When they moved out on the land, the people who provided the leadership for living off the land, developing shelters, setting up the food, were the so-called “homeless”.

We are familiar with the advice from the Aboriginal community about the “good ways”. One of the most common of these is to speak from your heart, which a lot of people in government and government agencies do not do. We need to understand what is meant by that advice: It takes confidence to speak from your heart, comfort with who and what you are, to show your face. We need to have a good awareness and understanding of what our own cultures and biases are, an understanding of what our world view is and to be in touch with that, if we are recruited to provide assistance to other people. Those bits of advice that I have heard for so many years are really important but I don’t think they’ve been taken seriously by the people to whom they’ve been directed. And most importantly, Friere talks about the importance of being “fully human”, the need for humanized societies, and the need for helping oppressed societies restructure their societies to become humanized. They have become what they are through the forces of dehumanization. These represent challenges for us all, including the MHCC.

Phil: Heard this on the radio last night - it is better to write for yourself and have no public than to write for the public and have no self. The spiritual and cultural aspects are beginning to emerge as we go through this process. As you go into your small groups, if you feel some of the answers to these questions require spiritual engagement, please feel free to say that.

Questions: Break Out groups

Group A

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

- That’s a challenge because the whole area has been bedeviling me for years – how do you operationalize a concept like CS? It could be very complicated or remarkably simple and straightforward. And, in many respects, the second part of the question is tough because to make it work you have to reshape thinking, attitudes and biases of a whole lot of people, simple in that you don’t need to be a rocket scientist to understand the basics of this. It’s kind of painfully common sense – in many ways our North American culture deemphasized common sense and cultural safety in such a way that it has created hazards – we rely too much on the men in the white coats and not enough on knowledge we've had for years. So how do you turn the clock back without losing the good things we have in the system – like therapy and some medications?

- The expression, the inequity of power, really summarizes issues related to CS. I had a lot of pieces to put together when I first connected with FN. I wanted to eat up that treasure that I found, eat it all. One special occasion was first indigenous youth conference in Quebec City. I cried for a week, realizing that what I thought I knew as a white professional was such a small part of what they knew. After seven years, an Elder came to me at an event and asked what are you doing here? He said, now you are ready, you have to start helping us. I could go on and on but I've realized that our knowledge is not complete; when people feel from the heart these are the strongest ties, and I still sit with them and honour them for surviving horrible decades of unfairness and hardships. I truly feel that together we can make things better.

- This question is talking about rooting a philosophy of CS and supporting it so it will thrive and in the work we've been doing – this question in the context of FN Métis – they've said to us "you don't know me and how can you work with me if you don't know me?" And what they mean by that is – the reduction of everything to something manageable is what we're really focused on – we don't like things to be messy – we like to put them in manageable chunks in order to move forward. And that's wrong. When I heard the person, an addictions counselor, say that, to a health care provider, "you don't know me but you get to define me and by defining me you get to decide what happens in our relationship", I realized that these are the conditions we live in – where there are power inequities and the people with the power get to define the others. These things happen all the time. So CS is about – I'm a pessimist in that I think the huge change of attitudes required is not going to happen – so when I look at how do you make this thrive – I think there are opportunities like the Commission that could help, but there has to be a shift in attitude there as well. There is a sense that the Commission doesn't have enough power, but they do, especially compared to that addictions counselor. For example, some think that treaties are special privileges and they aren't. So it comes down to education in schools, those levels.

- There's a connection there between what you're saying and what Normand said about the Elder telling him he was ready to teach, but that took what – seven or eight years to prepare for that transformative stuff.

- I think that what makes things unsafe is a lack of communication and knowledge sharing. In New Westminster in our program, there are so many new Canadians and every time I go there they bring food from their homelands, they sing, they do traditional dances. That is something that is really lacking in our work and our fields – we don't share our customs in that way. There is so much inter-cultural sharing that isn't happening in Canada and that feeds bigotry. If you don't know people, don't have a relationship with them, this is what happens. We need to learn about each other's families, beliefs and customs. E.g. a valuable employee in China knows a little about a lot of things but in Canada an employee is expected to know a lot about one area. That's a huge cultural shift for them. We need to get representation from all cultural groups and from youth. Social networking needs to be engaged for the latter to share this kind of information. Mind Your Mind is such a fantastic website.

- One thing that stands out is what Bill said – that it's complex but also simple. It's frustrating because it seems so basic to me. For me CS is humanizing and in terms of CS practice and being in a workplace – if I think about being on a particular team in the MHCC and the work we are doing to engage with other people – I think of it as circles within circles and it's difficult to work in a CS way in the larger circle if you are not supported in that way in the inner circle. There needs to be commitment to support it at that level. It does feel like an insurmountable task sometimes because of how much change is required. I have a very close friend, like a brother, whose been detained in Iran for months and I've been really involved in the campaign. This arose all of a sudden; it's of extreme urgency. Everyone involved is very emotionally affected. We don't know when it's going to end; nothing we are doing seems to work, yet, that work is something I seek solace in because it is a safe space – the way that we work together even though we are under so much stress. We have more than 10,000 people who've signed a facebook petition – they call our campaign a noble campaign and they are honoured to be part of this. So this for me is an example of CS.

- An important dimension of what you are saying is feeling safe in the midst of a chaotic situation.

- My hero of relational practice is Jesus – most of us walk around and they don't see the fine details of the other person – the other side. I think Jesus did that and that's the beauty of those stories. CS is the ability to see more than what most people see and that engagement. How do we do this? Well at the Manitoba Schizophrenia Society it means we don't just walk in and sit down at our computers – we ask each other how we are doing. You know the battle – we want to love but it's hard – I have to turn around and recognize that person, give them a hug. Those small moments of time that we take out to get to those details of the person – the fingerprints not just the fingers – it creates a certain environment. The task of the MH system is not to treat illnesses – it's to create environments in which we promote relational practices that can then address the bio-psycho-social aspects of illnesses. It's about personhoods and then you're more likely to get some kind of medical adherence.

- For me CS practice is that whole ability, that awareness of my own values, beliefs, attitudes and how I convey these when I'm interacting with someone. If I can feel that connection, and sometimes you just feel it, I have to know who I am and how I interact with people. I have to know myself and my own biases in order to start opening and accepting where someone is coming from. It's about mutual respect – you can't build a relationship without that respect and trust. It's a two-way street – we have to welcome and invite each other. From a practical, concrete perspective it comes back to how do we view people, how do we respect them? How do we put ourselves in their space? As a black woman in Halifax, I can tell you Saskatchewan may be challenging, but you have to live in Halifax. It's about my gifts and your gifts and our experiences and how they have impacted us, and how do we share those? That's the personal level. At the systemic level, we have to get mouthy – to talk about what is acceptable, how do we want to be treated, how do I want you to treat me. But we have to make it meaningful because it's about people and their lives and if we don't do it, the spirit and the soul are wounded.

- It's nice to hear so many things being said that I feel constitute CS. I would actually like to express my gratitude for the willingness of people to share roots of issues that need to be addressed, like colonization and power imbalances. These are at the root of how we as peoples live and interact on this land – so CS is about respect but it's also about a thorough understanding – yesterday I talked about world views and about how we as indigenous people see living and healing – it's about looking at the whole of a person, not just their own experiences but the experiences of their ancestors, all of the teachings, the knowledge and even more than that, all of the connections they have in the here and now – where are they in their community, what surrounds them, what impacts them? A youth with suicidal tendencies – what is going on in their life – what supports do they have in their community or not? We need to create an environment of care across community. This is a different way of looking at things in terms of worldview – it's about taking everything into account when looking at an issue. CS in a relationship between two people involves an understanding of that difference in worldview and that the person's needs have to be met within the context of their own worldview. The conditions for this – there are these larger pieces that impact relational practice – so if there is a systemic issue we need to look at addressing it from a policy perspective – how the systems restrict the ability to function and conduct ourselves in a CS manner. We need to unpack CS from all of these different perspectives. It's about a continuum.

- This is a very particular context from which to examine this issue but there is a universal component relevant to any context, any environment – racist communities, newcomers. I'm intrigued by the simplicity of the concept but also by how complex it is. You're talking about being human but Jean Vanier talks about becoming human – this recognizes that we have to undo, to disengage, in order to become human and re-engage. This means allowing yourself to feel the vulnerability we were talking about yesterday and also about not making assumptions. It includes respect and listening, but it is difficult because we are in a constrained system, but it is also hard for us to un-do, to become human, as individuals. But we have to work within these systems and we also created these systems. In my work, it is a CS place but it is removed from the larger system. These pockets can do a ripple effect. You can have an influence on the system – not easy but not impossible.

- In my area, what I see everyday – the concepts are so simple but it's work that takes a lot of consciousness and effort, being aware, educating others, knowing what you bring into the work, trying to get people from outside the culture to understand that – so they are aware of where they are coming from when they interact with Inuit people. A huge piece is being aware that the person in front of you includes the generations, the history, and the inter-generational trauma. It still feels very real and very recent to us. CS practice needs to take that into account and realize that, if someone seems to respond in a positive way to you, if you haven't been aware of your tone, your body language, they aren't really saying yes, they just want to get out of there. And the power imbalance is real – even for me; I'm very aware of it because I have more education and speak English. If staff are shut down, you will get nowhere in your work with community. I've had staff tell me that they don't feel respected in their indigenous culture. And if you have respect, even if you make mistakes, people will forgive you for that.

- The notion of power imbalance reminds me of a story – when I became involved with the Commission, the people I connected with the most were representing consumers, and as I think about that, what brought us all here is my relationship with Phil Upshall. The thing I see that is challenging is – when I studied with Paul Ofrere in the 1980's – he talked about not taking time to try to change the oppressors, you work with your own community and eventually you no longer need your oppressors. And eventually, they want to join you, because you have become fully human. Most of the people around us come from the oppressor community and they're not interested in our views.
- You don't want to get in my boat – there are some points I want to make – laughter and humour in Aboriginal communities is the number one issue. We can laugh at everything. You have to know people. Like the OKA crisis – nobody took the time to look at the underlying conditions. They went to the band council which was some of the major problems. 20 years later we still have the same problems – we have band council, Indian Act people – they're still divided. People in the community are predominantly French Catholic, people who are traditional and use their language and people like me who speak English and are educated to a degree – four or five factions within the community – how do you build CS in a situation like that? People talk about respect, like Ron Erwin, Minister of Indian Affairs, but he used to visit us with a suit and tie on. You have to know what the issues are. You know when you go to meet a psychiatrist or a psychologist, you are meeting a stranger and you have to tell him all of your issues – you know how intimidating that is? The issue in our community has to do with the crisis in the 1990's – it was the traditionalists who blocked the road, but the band council pushed them out – so there is a divide now between the two.

- You’re saying that we really need relational practices in our own communities, we just can’t assume it’s there – there are lots of challenges related to that.

- Policies and procedures are guidelines but we need to go back to common sense. When we go to northern communities as I have, respect has to be earned and when they feel safe and respected you will know because that door will be wide open. I had positioned myself in the school where everyone who walked by would be seen by everyone else, but no one would come to my office. So I moved my office to the library and I had people waiting to see me non-stop. They talked and I just sat there and listened and when there was silence I just sat there – there doesn’t always have to be talking. Sometimes after the silence people would start crying. It’s about being in touch and being in tune. I had to put my values in check and be there for them, be in tune with them. So for CS you need to be in tune with your environment, in tune with other people. There are no experts out there. You need to make people feel safe but you need to feel safe too – we all hide behind masks, we need to look past that hand as Chris put it. We all have stories; we wouldn’t be here if we didn’t care. For example, to buy a home, people will soon need more of a down payment, so people are buying up the market right now. We were looking for a home in a Muslim community and the agent knocked and walked right in – the woman was there with her little boy – she didn’t even speak much English and I thought that was so rude. So I asked her what was for dinner, just so she felt some respect. The cupboards were full of mould and the agent said she would have to fix that – they had been living there 9 years. This is an unsafe environment and they were living there. There needs to be consistency and follow-up for CS. We have immigrants who can’t do the work that they came here to do, because they said anything just to get in. These people need help and support.

- We need to restore family and communities.

- Lots of misinformation and ignorance, so it’s important not to work at one extreme to the extent of the other.

- The most effective organizations work collectively with politicians and bureaucrats and when that’s aligned that’s when change happens – you can’t just focus on bureaucrats.

- Just the history of the Commission itself shows that process at work – a Senate committee that galvanized people around MH reform and then there was a lot of work done politically to get people on board in the provinces, which persuaded the government of Canada to get on board. This exemplifies collective effort.

- The commitment and willingness to listen to the voices of the people; that is what that was about.

- You can't underestimate the power of changing what you do at an individual level, but you need to bridge that to carry the change forward – if you have a policy that restricts you from interacting physically at all with your client for example, or can only work with the client for so many sessions, half of which time is needed to build trust, then the policy is a barrier to CS work.

- The context piece is integral to safety. We do have to put it in context.

3. **What do all of us know that would contribute to advancing excellence in relational practice?**

- Where I sit, I've spoken about this already – I showed a documentary in my class about policy, indigenous healing, called No Turning Back – made by aboriginal people that looks at the Royal Commission on Aboriginal peoples (RCAP). RCAP is the biggest initiaitive re: aboriginal voices on what should happen and documents the relationship between the Canadian state and indigenous people in a way no other document does. There are people speaking their truth to the Commissioners in the documentary and documents their trip across the country talking to aboriginal people about what needs to be done. 20 years later we have the AB healing foundation, truth and reconciliation but when we watched this, we saw people speaking their truths and saying if I'm going to tell you my truth you have to do something about it. And the healing foundation is not being funded despite its success, so the government can change its agenda anytime it wants. Like the Kelowna Accord. So when we talk about relational practice, we can't ignore the fact that inequity of relationships continue to exist. So while there are many of us working in government and community, this is so enormous and the MHCC hasn't taken a stand on it. My point is that this is more of that same kind of breaching of trust that happens over and over again. I felt yesterday that the MHCC wanted to say "that's not us", but it's an ongoing issue. Why are we not using that knowledge base, i.e. RCAP, within the Commission? Why isn't it doing a micro-analysis of that report? That document and the funding cuts to AHF tell us a whole lot of stuff that we should know. It's almost an insult to go back and ask people what we need to know when it's already been said.

- I look at the Commission as the facilitator, while change is going to happen in small ways, in communities and organizations across the country. CS is going to be a large part of what we are doing and if we can start considering that content, it will be a huge benefit to the people of Canada.

- The phase the Commission is at in terms of the strategy – where we are and where we need to be and what we need to get there – the issue with the AHF is part of that. So, we can incorporate that into our analysis of where we are now and what we do from that point. It will change how we move forward but we do need to incorporate that and the bigger issues it speaks to into our work. We need to respect what all of us know and really listen to it, hear it and think about how to incorporate it.

- We can look at the Commission and the system but the system is us. I'm thinking of the Schizophrenia Society and our Board and how we treat each other – the toxicity, the shame-based interactions. I'm there because I'm a change agent and I'm looking at us at the lower levels – we can say we want the Commission or the government to do this or that but if we want to create a culture of recovery we have to practice it with each other. Rather than focusing on changing the whole system, we have to look at ourselves and at those smaller components.

- We know that when people have a sense of belonging, identity, feel respected, feel safe, they have the opportunity to open up that space to build healthy relationships From a systemic perspective, there are many barriers to that – there is a level up there that is really problematic and we have no control over that. To advance that, we have to have a humanistic face and this has to infiltrate from the bottom-up. We need to be aware of our own gifts, limitations, align ourselves with those who support our values and beliefs – there is a lot of talk but at the end of the day, how do we operationalize it and how do we know? If we can put our heads together and embrace each other's world view in order to do that, and for that we have to listen and be silent. Human beings have the potential to achieve anything in a supportive environment, but how do we infiltrate that system? We have to "chunk" it, and go way out into that space that will fit in what we want to do today.

- I want to start by clarifying that when I talked about policy this morning and the idea that policy is a lens by which to look at things – there are different ways in which we interpret what policy means, so what I was talking about was the way the system operates and how it is funded to operate. The policies outline how the programs in our communities will operate. The way that we are funded, the way that the policies exist that administer the funding to our communities. So, how do we get there? My opinion is similar to what Jo just shared. The way we operate on a functional level, a client-user level, is highly impacted by policies that dictate what you can and can't access in terms of programs and services. We need to take a broad view but work together to make the changes that are needed. We can't put the entire onus on the service provider or the client. It needs to be a strategic approach, with efforts happening through the different lenses. When we talk about CS what are we actually talking about? What are the core components to creating a CS safe? How do we ensure our policies, processes, behaviours are culturally competent? We need to break it into those chunks or pieces and each of these will be addressed in a different way. We need to identify how each of the key partners plays a role in working towards CS.

- This introduces the idea of ethical guidelines for policy.

- I see it in two ways. There is always a tension between what we know already and do we need to go over it again and again or can we move forward? I want to accelerate things but I came to appreciate the process and sometimes you have to trust the process. There is a fine line, to say enough is enough and move on. But it's not always evident and to bring everyone to the process has a value beyond the content we are dealing with. What we are doing right now has a huge value and is very informative. What was so meaningful about BB1 was that it was so humane compared to many conferences I've attended. Today, I think my org embodies a CS environment but it's an evolution, so the process is really important. On the other hand, to speak about policies and systems underestimates the power we have to make change within our own small places and communities. A concrete example – I hope the MHCC has very clear priorities like going into medical schools – this would have a huge ripple effect on other systems. In the meantime, sitting here will help me make my small world more CS.

- My understanding of relational practice is how we relate to each other, the interaction, but it's also the context. I want to bring it down to the real basics right now. I'm been getting education from the Elders over the past few years and was on the land with social work students recently and what the Elder's stressed really fits with what we're talking about and this was, really listen and also the value of silence and speaking from the heart. Not from the head or with jargon, professional jargon, but coming in as the person and being genuine. Because then, this is transferable to other communities. Just being aware of the context, the values and speaking from the heart. If you do this, people will listen because you are really seeing them and they can see you. And for Inuit people doing this on the land is the most powerful way of all. That's where you see the real person and a lot of knowledge comes out. But if we don't have the policies in place, this will happen in a hit and miss kind of way.

- This is citizen to citizen engagement that informs the whole. You embrace life by living it. Many people have lost that traditional way and by losing it are finding themselves increasing dependent on someone doing it for them and this is decreasing their quality of life. The main message is to do everything we can as citizens in the interest of the whole community, and get to work. If this means engaging other systems, then this has to be done. For example, in the Commission, most of the Advisory Committee members don't even know the Commissioners. So this is something we could do within the Commission. We could also extend the circle out to the communities.

- I don't see this just happening in certain places but everywhere, in every aspect of life.

- **Kathy – I was taken by the comments about RCAP – within our branch someone decided we needed to have a policy about** traditional healing, and I wasn't too happy about it because we are doing it. Finally, I went to RCAP to see what RCAP had to say about it, and found a wonderful piece about how policy should address traditional healing so I sent it to our policymaker and I got an email back saying “wow, thank you so much”. So, it’s not an agenda to bury RCAP; I think we just forget. I want to say to the Commission: let’s open up RCAP and see what’s relevant to the national strategy. And then, re: what Winona (AFN) was saying about CS and policy – we’re starting from trying to convince people that CS is valuable – people are not aware and there is a huge education piece so we have engaged AFN and ITK to help us. I would like to see something within FNIHB that defines CS and culturally safe analyses; I’d like to see a policy for Health Canada about how to do culturally safe analyses for policy development, along with a gender based analysis (which is already being used). In terms of roles, I agree it’s about us as individuals and I would like to ask: what is my best role as a change agent? I think if we had this CS analysis as a tool, we would not have seen the funding cut to the AHF. We were shocked and couldn’t understand why and why there isn’t more noise about it?

- Howard – The image that comes to my mind is the circles from a stone being thrown in the water – and gradually widening those circles. In terms of knowing where to go and how to get there, we need to listen carefully and make sure we understand. We know where CS comes from and the historical context – how can we take what is valuable there and widen it out? Although once you share, there is a risk that in the course of sharing and broadening the range of what we can accomplish, the understanding of it may change somewhat. At a policy level, people have to take responsibility at whatever level they are at. You have to trust your instincts and exercise judgment – hopefully this is a building process so whatever level you are operating at: you listen, make a call, listen again and broaden it out. Listening and acting on what we hear based on where we are at in the process are important.

- Policy and procedures: why do we need to reinvent the wheel? Let’s take what’s working and build on it. One individual comes to mind when I went up north – it took a while for her to speak to me, because so many people had come and gone. Consistencies, sticking with people, investing our time, these are really important for relational practice. A young man took his life in Oxford House and they didn’t call me to come up when he was becoming suicidal because there was no funding available. Is that relational practice, when there is a price for someone’s head? And I’m part of the problem because if it was my son would I have found the money and gone? We need the consistency.

- Bill A - I’m a little less than happy about how things are going, even here – we spend so much time talking and not doing. A lot of what we are talking about is good common sense, we’ve known this for years, and the system has forgotten it. So we need to demand to decision makers and policymakers that things actually happen – not another study or research paper for things we’ve known since time immemorial. We have a window here – MHCC – to make a difference. And this window may be closing – we may not make it to year ten. That means we have to move. We have the knowledge – it's already there. We need action this day.

- I don't know what the answer is, but one model doesn't fit all. We have not come to any type of consensus as to which way to go exactly. I'm wondering where we are going and what we want to get out of this. Not all of us here agree, so if we can't find a happy medium here, how can we get one outside?

- Normand – I've been guided by Elders for the last 15 years – the quotation – don't side with the oppressors, change them. We need to do what we need to do to change ourselves and they will come around. Guided by the right people, I use my label as a psychologist to build that network. Our conferences, these are about building a voice from the front-line, so we understand we are all facing the same challenges. Sometimes I'm ambivalent but we have built something at the annual gatherings, there is a feeling of home and haven there. There is an army of front-line workers who want to be trained. An army of administrative people who want the same. That's a good strategy – you can build up the voice by bringing people together to address an issue – like the suicide prevention conferences – this builds the voice and strengthens trust and expertise. I like the idea of pockets too, working in small pockets.

4. **Do we envision a relationship between social exclusion, peer support and relational practice?**

   - Ideally yes. We are talking about social inclusion, and this is what peer support is all about.

5. **Who do we need to target? What do we need to convince them of?**

   - I like the idea of chunks, doable chunks and relating them to one another. From the work I've done with women, one person can change a life. One woman, got a hug from another and just that recognition as a human being, it changed her life. Also, I hear a lot of women talking about walking in and not being treated well, by the system. And, that travels by word of mouth – that the service is not a good place to go, which means that people might stop using the service. And location of services is important. I think why the AHF was not funded, it was a strategic decision to ensure that Aboriginal people not become too strong and powerful and in my area the birth rate is high. Because linked to healthy people are their claims. If they are too healthy, they are strong, they can demand, they can dismantle the master's house using his own tools. So I think the AHF was way more successful than anyone thought. I think we need to write about it, in all sorts of forums, because I don't think the decision was made by chance. Also, the medicalization of AB resistance is absolutely huge. For example, they label gang members as having FASD, and there is no evidence that this is true, but some would rather look at it this way than look at the social determinants of why people join gangs. Or to say that 70% of people in prison have mental illness, that makes me really uncomfortable. The target is moving all the time, but I like the idea of taking our strengths and working on those chunks and coming together.

- We need to target those people we deal with on a daily basis – that it's OK for them to share their thoughts and beliefs ongoing. And when dealing with bureaucrats, get it on their agenda too – convince them that the people on the ground have the knowledge and that's who they need to engage with.

- We need to start with ourselves – the framework for the strategy, the vision is that there is no "us" and "them". We need to think about what that means and we need to live it. I'm working on developing a strategy to be inclusive of diversities, not by or for other people. It's especially important for us to be in CS environments to do that work. There has to be reflexivity that we take on as individuals and at an organizational level and never feel like that work is done.

- Chris – We have to target ourselves and the Commission needs to look at itself – the Board needs to take time to look at itself and have these kinds of discussions, not just deal with business. I think we do need to target the Commission – I'm not going to give up on that – there are beautiful people there. We need to speak the truth in love to people. And there is no solo advocacy; it's about collective advocacy. Whatever we are targeting, we can create that collective advocacy for it. Everyone has a voice, but do we hear that voice? There are multiple targets, but the advocacy needs to be collective.

- We need to target our leaders too – we need congruency between policies and practice and target a system that silences people's voices. How do we make the system support us in becoming?

- Sometimes those we don't make an effort to inform are the politicians. What do we need to convince them of?

- We need to utterly convince them that this is the will of the people and that it is common sense.

- We don't need to convince anybody, we need to enter into a conversation with them – people from all walks of life and I'm thinking of the Commission's roundtables. And we don't need to convince them; the conversations will help to create the change.

Group B

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

Phil: In my experience, cultural safety or a safe place is one in which the atmosphere is created where you can be yourself at any given time. I recognized this when I was in the psychiatric hospital where the nurses were wonderful. As soon as the nurses tried to persuade me to become a better person for the sake of my first wife with whom my marriage was on the rocks, I shut down. It took me a while and a change of nurses before that unsafe place became a safe place for me. The culture, my sense of it, was a relationship of not accepting who I was, as a male. Culture can be provided in many ways. That experience still rattles me when I think about it because I felt I was being taken advantage of. I needed to find out who I was as a person. My culture was male and they invalidated me. In terms of healing, you have to be secure.

Lorna: Safe places are those in which you are not threatened, but accepted and loved for whom you are, and others not making assumptions as to what your maleness is.

Phil: Exactly. I grew up with assumptions about who I was and what I should become. I didn’t know who I was and it would have been good to have the guidance much earlier in my life about who I was. I got nothing from the church in which I grew up, in terms of spirituality.

Vicki: It is practice that at some level disrupts. At the level of policy, there is disruption that occurs. Culturally safe practice would disrupt the status quo; there would be a broader effect, some actionability. One thing that is different about it is that is it meant to disrupt the system. People feel uncomfortable for some time at the personal level. Cultural safety means we don’t always feel good from a cultural perspective.

Tina: I feel safe in the MDS of Manitoba. Our Executive Director “cleans up behind us”. She asked me to take a look at cognitive behaviour and I re-wrote it myself. She has empowered each of us to do our best. Everyone is accepted where I work. It is okay if we are having a bad time, no one questions it. One time, I forgot to do a presentation, and my Executive Director said, “I hate when that happens.” I come from a background of real estate where that would get you fired. I had myself packing my bags, but her attitude was let’s get on with it. I have the opportunity to go at my own pace. Her biggest job is getting the self-help workers to have a normal life, keeping them engaged with their 20 hours a week. We are all allowed to have hopes and dreams. That is something we forget when we have an illness. The doctors at the Selkirk Mental Institution had a token consumer and were talking about what they could do for consumers. The consumer said he wanted housing in the best part of town. The Doctor gave him back the ability to have a dream, and began to help him take the steps to achieve that.

Ed: Cultural safety is a word that is now capturing different pieces, creating language for me. Often we try to summarize bigger ideas with one word, in a labeling process. I guess we try to do that to capture many concepts succinctly. Cultural safety summarizes many concepts I have been learning in my healing journey; trust, respect, equal, non-power relationships. I have been learning that through my own healing process with elders, the teaching process I have been through. This story is a core example of what it is that we are seeking, what we can call cultural safety, relational healing.

Years ago, when I was learning in North West Ontario with Alex Steed, one of my elders, we were waiting at a youth gathering for the youth to arrive. He was teaching me some things and all of a sudden, his gaze went to the floor. I followed his eyes and saw this little ant walking into the circle. Alex says, “See that ant?” I said “yeah”. He said “He is my brother. He is no better than I, and I am no better than him. When we as humans can think that way, we will have the peace we seek.” That has transformed my relationship with all people and all of creation. How do we bridge the gaps, those artificial barriers between us? I don’t believe we can help people on their journeys of healing if we are one up and they are one down. When people refer to me as a Doctor, I often do a teaching like this, especially with young people. I like that they respect the education I achieved but I don’t want that to be a barrier to the kind of relationship we want.

“Patient” automatically creates that relationship. I am not even comfortable with the word “client”. “People” is what I come down to. We are all humans, and I am no greater than you nor you, me.

Brenda: As a grad student going to Queens, a fairly white University, I was one of two visible minorities in my grad class. I asked how things would apply to Northern Ontario for FN communities, and they would say “I don’t know”. I found that difficult and challenging. Luckily, I met Ed and Dr. Clare Brandt who showed me there were different ways. I worked in a federal prison and realized it was only by the grace of G-d that I walked out the door every night rather than back into the prison. We had much the same experiences. In reflecting back, we can sympathize, empathize, see ourselves in others. The women didn’t see me as top down. They taught me more than I taught them. I didn’t know much of my culture and tradition and invited them to teach me. They showed me I did know lots about my culture, for example, about respect to our elders, the importance of family. I may not have known a lot about the ceremony, but I did know lots about our culture. We would be deep in conversation and this woman 20 years older than me, said she could have changed my diaper when I was a kid, and we laughed. They reminded me I was just the same as them. Just because I am a Doctor doesn’t mean I know it all and would refer them to others who knew more than me. You are there more as a guide. Being humble, not acting as an expert is part of cultural safety.

Last year, I was commissioned to write about mental health and illness. I consulted with elders who told me that in traditional times, people with mental illness would be seen as people with gifts, in our communities as teachers, to remind us of something about ourselves. We are all human beings, whether we are prisoners or not. During the riots, some of the women had been strip searched, and were told they had to have an internal exam before getting their clothes back. I was asked to go in and interview one woman. She was shackled, naked on a bare floor. I felt that as so wrong. As a human being, how would we treat each other?

Eric: So far we have heard vantages distinctly different from mine; front-line, researchers. I worked in an institution that ultimately represents the holder of power, rightly or wrongly, for centuries. What is interesting is how do we create an interest within the walls of that powerful institution to create balance, not make assumptions about others? That represents an enormous shift for a huge institution with a long history.

Trust and respect are fairly constant expectations. Patricia yesterday offered the notion that there needs to be respect between the holder of power and those historically who have been without power. The holder of power could feel guilty, and the person without power could feel angry. Achieving that at a systemic level is bigger, not altogether different. The challenge is to create conditions to help people understand. It feels like this massive locomotive plowing through the world for the past 4 or 5 hundred years may slowly be losing its momentum. There are those of us on the train trying to find the levers to convince the conductor to slow it down. I don't know what the strategy is to do that. Being invited into the circle and being able to hear may be in and of itself the most effective one. When Bill said this morning, government people don't speak from the heart, I bristled. The challenge is how do you reach people that are part of that institution?

Rose Sones: I apologize for being late. Yesterday, I was doing competency training for government. Sometimes I feel a lone voice. This is a values based discussion. There is no time line. The more I work with government, the more I realize this does take a long time. We should not be surprised that people who have had no opportunity to ask the questions are not on board. How do we build the intentional space in which people are safe to ask the questions? It is very rare to have those safe places to ask those questions in confidence. This is process, a learning opportunity, to build cultural competence that is a two way street. The people who hold onto the information are the FN, Inuit and Métis, and we have to be prepared to share. The opposite is also true; the level of secrecy in government prohibits sharing.

We have a lifetime of practice; it is not an open end state. Learning about FHIM may be a little different than learning about immigrants. That self-awareness of your immediate response to individuals is what we have to have. It is that intentional space. There are those willing to take the risk to be vulnerable. You need gate openers in government who are willing to have that conversation.

Patricia: We have been starting to explore how FNIHB could strive more to cultural safety. So, I have had the opportunity for a lot of discussions, including at the NMHA meeting in September, 2009. A phrase shared at that meeting by Sylvia McAdam was that our people would call this “walking together”. It is the closest, simplest way to approach talking about cultural safety. What are the barriers to doing this? They have a lot to do with power, and being self-reflective about power relationships. In my case, I am a white psychiatrist, working with the Feds, and I need to be self-reflective about that.

I see it operating on many levels, personal, individual, and organizational. From the ant story comes humility. A progress and flow comes from walking together, not a linear walk, but a striving. How do we get there, support cultural safety? The answers there are very complicated. Ideally, there should be supports in place. It goes beyond the individual and the roles people are expected to play. The problem, what drives it, is accountability and how that is perceived. If someone walks out of your office and commits suicide, you are accountable. I want to move beyond the push back, and develop some solutions. Walking together is how I understand cultural safety.

Rob: All of us have culture. Some have many within our beings. I think about the cultures I have worked within, for example, the culture of professionals, corrections, boundaries in all these areas in your life. It is about power and control. That affects us more than anything.

Culture is a dynamic thing. I have a lot of respect for aboriginal cultures from what I have learned. As a child, the Pentecostal Church system terrorized me with their speaking in tongues. Two neighbour boys were Catholic and told me I was going to hell and they weren’t.

Institutional powers and their cultures make you pay a price for going against their cultures. If you go against the dominant culture, you will pay a price for it. People inherently understand what culture is. There is a growing understanding of respect and what it means. Respect to me is when someone has been heard and also understood.

I have sat in many circles with many different purposes, healing, prayer, sweat lodges. You realize that everyone is your teacher and come to respect some people as elders. It is a lie long learning process to me about respect and cultural safety.

In Saskatchewan, we are talking about patient centered care. In the research I have done, it boils down to cultural safety. It is more than that. We can’t teach our care providers without making sure there is competence in the system. If the system doesn’t change, it won’t be safe for the care providers. Someone has to step in front of the train sometimes. The dominant system has exercised power and control to keep the status quo.

Diane: Thanks to Lorna, who I recognize as my elder, for facilitating the circle. How do we go about changing things? We are currently involved in a project that involves FNIHB, Addictions and Mental Health, community members, our Director of Health, about 10 people in all. Our Director of Health is competent, a Mik'Maw. We didn't get a shift in our colleagues until Claudia spoke about being able to go anywhere in this country, but when she leaves her community she doesn't quite fit. The people realized there is more to it; there is this outside part. What you are trying to do is connect with someone in a real way. We have been trying to get our professional people in a room so they will shift a little bit more.

My frustration is that it always comes from the people who are vulnerable. They have to do all the relationship building re: trust. When will our mainstream partners imitate them? They are willing to come into the circle, but when will this shift happen? To me, that is the biggest barrier, that it is always the most vulnerable reaching out.

I want to define cultural safety in a different way. A lady that has every label calls our office; no one wants to take her calls. One day, I picked up her call. She was angry because she could not see her psychiatrist. After my conversation with her, she was calmed, just happy that someone listened to her and didn't hang up. People should be respected for being living human beings. Another example is an alleged sex offender who wants to do the sex inventory. We take 3 hours to get through a quarter of the test. He came back 5 times in one day. Eventually, he said, I don't want to do this anymore and I want my file destroyed. So, I shredded his file. He asked me, "Do you feel safe with me?" I said I did. We have ugly jobs to do but we can do them in a culturally safe way.

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

It is easy for me to understand cultural safety in a therapeutic perspective. Cultural safety seems so benign. The concept may not capture what is required at a policy level where there must be disruption. There is a politicized aspect to cultural safety in New Zealand, a socially transformative agenda. I wonder, can cultural safety hold all these ideas? But maybe that openness is what is required. By standardizing it and saying what the competencies are might do injustice to the concept and the spirit of this. This notion of identity and categorizing ourselves, they are such "thin" descriptions of ourselves. I am attracted to "thickened" narratives that invite us to see the cultural restraints we are all up against. The possibility of collaboration presents itself.

Terry: Picking up on what Jennifer said when you enter a circle and it is safe, it permits whatever in you that is related to what others are saying to surface, and new understandings to emerge. Safe circles are where we continue our journey of learning. Thinking about Diane's comment that it is often the most vulnerable who have to initiate relationships and educate, I wonder whether they are in fact the strongest. Their circumstances may make them vulnerable, but if they have chosen to enter those circumstances with a purpose connected to the Creator, perhaps in providing leadership in cultural safety and social justice, they are fulfilling their purpose. Sometimes we spend a lifetime figuring out what our purpose is.

I have a need to understand institutional power relationships and how to unsettle them, dislodge and change them without pushing them to become more entrenched. I felt like an "adolescent" when I went on a diatribe about pharmaceutical companies and the biomedical model. Mentors, elders in the group brought me back to "adulthood" and the recognition that we must deal with these tensions in ways that bring groups into alignment, not opposition with one another.

I think hope exists in the way we are engaging with each other here. This we can duplicate in whatever spheres of influence we are part of. This has to be a collective process; the challenge is to get ego concerns, our individualism, out of the way to develop alliances with others. I still need to learn not to be conflictual with those with whom I do not agree; but instead to invite them into a dialogue. They are not the "enemy". We are all in this together. Some may be responsive to hearing my point of view, and be able to shift their own, just as I will in hearing theirs. The only reliable way of inviting cultural safety is through relationships. This means learning through encounters that provide an experiential, direct understanding of relational practice and cultural safety. A recent example is President Obama's reaching out across Party divisions to engage Republicans and Democrats in the health care discussion. Even though there was considerable resistance, having the gathering was a good example of "walking the talk", demonstrating what collaboration means, and his belief in the possibility of achieving it.

A final thought I have is my concern that these terms, "cultural safety and relational practice" may be co-opted so institutions can appear to be politically correct. Using the words and putting them into practice are two different things; only in relationships do people learn and experience these concepts. That is why what we are doing here is so important.

Lorna: One thing I have been hearing in my work with people who ware working in spheres where there have been inequalities of some kind, what comes up is shame; all different kinds of shame that people feel. It is from people who hold the power and wield the power they hold, people who have been acting a role they do not feel aligned with. Because we live and work in such hierarchical structures, though we might have power, there is always someone who has power over us. From the shame comes the anger, and often we don't get the opportunity to recognize it, sublimate it, so we push it back.

The other is that when people can be generous and appreciative in spirit with one another; I have been working with groups who have been newly in partnerships with one another. It was a challenge for me to learn what worked. I learned from the old people I spent some time with how generous each was to everyone. It was generosity of the whole spirit; how carefully they observed and were watchful of everyone in the community to be sure that everyone was in a state of wellbeing, and if they weren't they didn't make a big deal of it but helped them return to a better state. We haven't learned in our world how to be caring for the communities we are part of.

Phil: The experts to me are the patients and consumers in the system and experts should not be brought in to say what person centered care should be—let the people inform the services.

3. **What do all of us know that would contribute to advancing excellence in relational practice?**
4. **Do we envision a relationship between social exclusion, peer support and relational practice?**
5. **Who do we need to target? What do we need to convince them of?**

Lorna: This morning many things came up that contribute to this next set of questions. If each of could speak to these reflecting on what we heard this morning. These questions almost point to us coming up with a criterion base for defining cultural safety and relational practice, so be aware of that as we speak to these. What advances or contributes to relational practice?

Ed: I, too, have the fear that we are getting into defining, coming up with criteria, creating training. I think the point of this is to create the dialogue, the common language that can create the dialogue. It is people that tell the system how to change, not visa versa. I have many ideas to explore that are stimulated by this conversation. I am listening to what is going on and thinking what for me is cultural safety. I think of my relationships and I realize another part is speaking from the heart. The spiritual, the intuitive part is such an important part of us. Spirit is important in the healing journey. We talk about human relationships that are culturally safe, trusting, equal, respectful; all possible when we engage with each other on all those levels of heart, mind, spirit, physical. In my exchanges with people, I can identify moments of change for me as well as them because I am engaged on all those levels because we have had that full engagement. Often I will share my stories when the person triggers that for me, regardless of so called professional boundaries. We need to start with our own sphere of influence. It is a mindfulness of your personal beliefs and systems, and yours of mine, because we are all part of the same human family. We need to start with young people. Art Soloman said, "Your beliefs do not negate or change my beliefs and visa versa" and when we have that relationship we have cultural safety.

Phil: For myself, having been an observer for a long time, I think it has to start with ourselves, modeling the behaviours. Our elected and non-elected governments have allocated to themselves huge amounts of power. You can see it the way corporations conduct themselves. They used to give back to the community. I think we have to look to ourselves and our own conduct. Cultural safety is a daily practice. Relationships are things we build every day and don't come easily, and we have to work at it. We have to look at how we abuse the little bits of power we do have. Returning to some of the earlier teachings all of us have, developing a sense of respect for other people. Like Rob, I grew up with Pentecostalism. I now have a safe space for myself that I have carved out.

Rob: social and cultural institutions need to be reformed. When I saw what happened at the University of Ottawa when Ann Coulter spoke there and wasn't allowed to speak because of safety concerns, I was happy about that, but questioned myself. When you are or not allowed to speak is a big issue in cultural safety. It starts with the individual and goes out from there. There is a need for change in terms of what our government organizations are prepared to accept as acceptable. I don't have any answers as to how that change needs to happen.

Patricia: I agree that change needs to start with each of us, but what needs to happen at an institutional level that can support these individual attempts? In our own organization there are some emerging examples of how governance has been changed in terms of who is invited to the table, looking at what is in the parameters of what we can do together. Having AFN at the table has helped us move the process forward. Cultural safety is really exciting and perhaps one aspect of that is to lift up examples of what is working well in terms of working together—you sense movement. When we are striving for cultural safety, we sense movement. By lifting up examples, you have some role modeling. People can see both parties in the relationship benefitting.

Even in the short term, I can see an evolution that is happening in terms of how we are looking at partnership instead of consultations, a shift and movement in that, yet a long way from achieving anything that is truly culturally safe, giving voice to those who haven't had much voice.

In a lot of discussions, the medical model is seen as being fixed and top down, patients not being heard. I sense a transformation coming in the medical model through inter professional teams. I see the emergence of that. I see a budging happening within the medical model, a movement towards teamwork. In Health Canada we are looking at what that would mean in aboriginal communities. The recovery model having peers and consumers survivors at the table is informing the work of the MHCC. There is a democratization going on that is inclusive.

Diane: I would like to fin excellence in relational practice. At the systemic level, we could check the medical model from the medicine wheel. If we require our systems structures to ask those same questions, are the physical, mental, emotional, environmental, spiritual components culturally safe? Are we allowed to be essentially who we are in our system? We need to check our systems. How do we get the work done? When do we collaborate? Work in our office, the one on one, doesn't happen. I am for it 100%, but not sure how we do it in a way that balances it with one on one time. We are an outcome oriented group; it is all about stats at the end of the day. Relational practice is about process, not about stats. What if the person doesn't change, but the journey was worth the time? How do we evaluate that? We need to be able to find a way to balance our process with the systems expectations for certain outcomes. Where is the middle?

Jennifer: What counts, what is measurable, may obscure what is meaningful. So much at Universities is predicated on developing specialized knowledge and people can go away feeling they have specialized knowledge that is authorized against other kinds of knowledge. How do we honor the knowledge people gain but maintain openness to other knowledge? Outcome measurements authorize a single form of knowledge that is scientific knowledge, not specific to the medical model but to others as well, How as educators can we use a space for people to be reflective in what they know and do? Do we have to convince somebody? Isn't it about creating experiences like this to live it, to be transformed and open? It is not that any idea can be held without comment or being remarked on, but not convincing people that this is the way to go, rather setting up collaborative opportunities and engaging them in these.

Ed: Looking at the world, we can say there is a paradigm shift in the world. Can we institutionalize that paradigm shift and if we can what is the impact of that?

Rose: My background is psychology. Some of the weakness in the humanistic approach, just providing a space in which people can share, is not enough. There is racism so deep (for example, in Churches), there are remnants and structures in society that are against having that discussion. There are people that have to stand up and say there are things that are not right, not moral.

I want to make a pitch for criteria. I sat on the committee writing cultural competency curriculum for Doctors. That is a starting point. You have to set the bar. There is a total risk that people will stay with the check box approach to cultural safety. The New Zealand government was proud of their approach and put out a post card explaining how you introduce an elder that is a check box approach, not the relational. But that is a place to start.

Vicki: Your earlier point was about values. I believe that when we are targeting we are always targeting ourselves first. In different interactions, you are confronted with something different about yourself. I am involved in a nursing circle of mainly women. One woman in the group says she starts every day asking "what is the highest good I can do today?" The target is there. My students also teach me every day. One of the questions that regularly come up is where is cultural safety in terms of the providers when racial stereotypes are present? Sometimes, patients will say, "I don't want that nurse". That may be unsettling. How do we address those things? It has to be said, "That is not okay". Cultural safety is taking a stance. It is about health equity. Let's make it so we have health equity in this country. I struggle with how to do that so it is culturally safe for all. The kind of discussions we have in the classroom mean that in my evaluation I have a backlash for those desires. I have to keep the outcome in mind, which is health equity and wellbeing for everyone. Much of it is achieved by how we interact, but there are other things we are attuned to.

Terry: There is something I have been wondering for a while, and that is, how do we get our “best practices” supported so they are sustainable over time? It seems that so many of what we consider to be culturally safe programs are the result of the coming together of like minded people who manage to acquire funding and support for periods of time, then fade away because of contextual factors. Good examples of such programs are many of those funded by the Aboriginal Healing Foundation, Browndale, and some of the ones Bill briefly described earlier. I am sure many of us have experience with such programs, and lots of evidence as to why they were such good models of relational, culturally safe practice. How do we ensure they persist over time? It isn’t enough for us to have good conversations about what constitutes culturally safe practice; we need long range support for that embedded in systems, and a commitment by government through their funding mechanisms to these values and practices.

Eric: Thinking about that point and Lorna’s, it is an existential question. Is government meant to be a reflection of the values and perspectives of people it serves or does it influence the values and perspectives of people it serves? In some instances, government has to be visionary. In FNIHB some people have been leading this effort. Our Deputy Minister is the first who has ever been to communities, spending time with the Chief, being on the land. He has become a quiet champion for all these things. When we were talking to him about the need for a greater sense of cultural safety within the government, even with this personal experience, he said he has visiting a cutting edge program in Winnipeg that demonstrated cultural safety, so it isn’t new. What I wished I had said is that excellence has existed in corners despite the system, but the system has to evolve to support the excellence. Inviting people into the circle, physically and metaphorically is an essential element.

Rose: ITK does this, takes people from the government and sets them down at the kitchen tables, into the communities. It is simple.

Rob: Your comments yesterday regarding the fear of people who are threatened by cultural safety, the fear those providers have to deal with because of the shift to person centered care; cultural safety might need to find ways to eliminate that fear or lower that fear.

Brenda: I was thinking as I was listening and thought of a few things, how the elders connect with people and their ability to be present in what the person is saying, and to be a “safe haven”. How do we do that for others? I was struck by what Eric and Vicki shared about disrupting the status quo. Our elders do that with us sometimes about where we are going. The feather teaching is that the feather is the length of the distance from the mind to the heart. On the systemic as well as the personal level, that might be one way to look for cultural safety.

Ed: Cultural safety is a piece of a paradigm shift. It may be really simple. I had an experience with Frank McNaulty running a suicide prevention program on an Island, having the elders teaching the youth. We had the funder join in for a day. There was a thunderstorm and afterwards we had to get the elders back from the Island in the dark with the rain coming down. That was relational and it tied him and I together ever since. A while ago I was having some difficulty with FNIHB and Frank took the time out of his day to listen to me about the concerns and told me from the FNIHB perspective why some of those concerns were there. That is relational, based on people connecting and knowing those connections are there on so many levels. Having him explain in person was more effective than anything I could have written.

Lorna: I want to say how much I appreciate that story. This gathering is called BB2. There are lots of things that happen within our institutions and organizations that are long held habits of the way we treat each other and those who have been marginalized and excluded like those with mental health and addictions challenges; habits we developed in the way we “othered” them and excluded them. In Prince George at the gathering, people were telling stories about how people were treated up there by people of the medical profession. The first assumption when they come for care is that they are drunk.

When I was working with a group responsible for the treaty process, one person asked when are those people going to stop being victims, get back their history? They must feel safe to say that. How do people get to feel culturally safe enough to stand up to those statements? Especially in a country where we have perfected our ability to deny that racism, othering, exclusion, exist, and we are so quick to say “we are nice, we are not like that”.

That is what these questions are asking. How do we create strength in people to stand up and say that is unacceptable in all our work places? What got us into this place as intelligent, caring human beings? What keeps us here, upholding these practices and inhumane, exclusionary institutions? It has to be worked at, at many different levels, personal and institutional. The leadership is extremely important as models to others. What do we do to affect the leadership? We have to be included in these dialogues on mental health fully and take leadership roles.

I think of an evaluation I did in BC in which leadership between the indigenous and the western group had to sort things out, sit down and be open to each other. They hired two people, one that had understanding of the indigenous ways of being, and the other who acted for the company. They were trying to forge a working partnership to achieve something.

Each person had to make a statement about how this partnership would benefit the indigenous group and how it would benefit the company. It wasn’t just the benefit to the indigenous group who are usually seen as lesser than. The two people, whenever there were points of tension, would get together and hash it out, then go back to talk to their own side. Each of them had to see the tensions from the other side. That was the key to the amazing outcomes that occurred.

The sense of "we are in this together", there is something each of us is contributing to the collective work we are doing. It is gaining knowledge, getting to a deeper understanding of each other's cultural ways and values, and knowing when you can change those in order to work together.

Jennifer: My concern is that cultural safety not become formulaic, but rather a teaching relationship, teaching about how to think and how to relate, to prepare people to challenges, raise the issues in the workplace. People come in wanting the answers, wanting you to be the authority figure, and you have to challenge, de-construct that.

Terry: The challenge is not only in preparing students in this way, but in changing systems to support their ability to relate in this way.

Tina: From a business environment, people will only make change if they are convinced they will save money by focusing on mental wellness. The greater world is focused on business and making money.

Jennifer: Educating people one at a time is again individualistic, and we are looking for how to support this collectively. I heard this a.m. the need for solidarity, the need for social action, sharing a common vision that can stand up in solidarity against oppression in all its forms. There are people across all sectors who can share this vision.

Diane: Being part of this circle now ties me to you and to your ancestors.

Ed: All of this is processes for building critical mass, where all this becomes obvious.

Patricia: The challenge is to move it beyond individuals. FNIHB is looking to create a tool.

Reporting Back from Break-Out Groups

Group A Report Back

What constitutes CS practice and what are the conditions in which such practice could take root?

Caroline: We discussed the challenges of operationalizing this concept and how to mobilize action around it by bringing it to common sense concepts of core values. To try to keep it simple in terms of operationalizing it, we talked about power inequities and imbalances between individuals, groups of people and people and institutions, between communities and government. We need to acknowledge these and work to address them. We also talked about breaking things into manageable chunks, meaning in the places where we are situated. We can work as activists, clinically, as policy makers, so the people looking at it from one point of view can see it from other points of view. We have to make sure that we continue to talk to each other, relate to each other. Often the ways in which a policy is crafted has a direct impact on how a client and practitioner interact, setting the parameters that bound the relationship about which the clinician has no control, e.g. not being allowed to see the client outside an office. We talked about what kind of change agents we could be. We could be change agents as individuals and we work in organizations that can be as well. We must continually reflect back upon our own practice so it can be culturally safe. We need humanizing practices; we need to be aware of our own beliefs and assumptions about others. We also see the Commission as a change agent in certain areas. Also, we need to call on work that has already been done, such as the foundational documents of RCAP and the Aboriginal Healing Foundation. We talked about the complexity of communities and the different groups within communities; we mustn't assume there is only one cultural group even within a small community.

Do institutions need to be restored or reformed in any way and if so what needs to be done and how?

One of the main considerations is around curriculum. What we need is curriculum change in professional institutions, including schools and universities, so that cultural safety and relational practice and theory are taught as basic principles. Also, need support and training for workers already in the field doing the work. This also involves chunks – working at the inter-personal level as well as all levels. Collective advocacy is critical. We will have a stronger voice if it is a collective one. And we need to not focus on the oppressor, but as change agents, to look collectively at how we would like things to be and put our efforts there, to bring people into the circle with us. Take a multi-level approach; we need to work at an interpersonal level and at all levels. Need to have a commitment and willingness to listen to people in many different contexts; cultural safety can be the ability to listen to what people have to say. For example, Denise in the DVD talked about the Doctor not hearing her. There has to be systemic change in order for that to happen, e.g. if a physician has no time to listen to someone, then policies need to be changed – you can't blame the person who is caught in the policy.

What do we know that would contribute to advancing excellence in relational practice?

Josephine: We talked about the importance of creating an environment of trust, which involves self-knowledge and respect. Self-awareness is key in being able to provide respect, knowing where I am coming from so I can see and embrace where the other person is coming from, their values and beliefs. We also talked about different levels; the need to use the information that is known, including teachers from the Elders. The most important thing is to look at the other as a human being, to listen, to embrace silence when needed, to enable a person to have a voice. There is also change required at the systemic level, the organizational level, and the individual level. If we can put our heads together, with others who support the same values, we can make a difference. But it really has to come from the bottom up. The trust is what creates the personal and ethical space and we need to take responsibility as individuals to make that happen. Because it is so big, we also need to chunk the tasks, choose what aspect each of us will address, because it is so big. From the systems perspective, it's important to realize that power inequities and imbalances affect individuals at the personal level. We need to communicate that to people in leadership so these changes can happen.

Do we envision a relationship between social exclusion, peer support and relational practice?

All are interrelated. Social exclusion involves stigma and a severing of relationship. Messages we send both verbally and non-verbally exclude people many ways, convince them they are insignificant. We have to make people feel they belong, and have a voice to contribute to the dialogue and make sure they have that voice in the beginning, not at the end. Without the support, it is difficult to foster a relationship. Peer support enhances relational practice and social inclusion – because it gives people that voice. Social exclusion needs to be looked through different lenses, including all of the "isms" we label people with, and we need to be congruent in terms of our messages and actions. From a social perspective, we need to be mindful of the messages we send about who is excluded.

Who do we need to target and what do we need to convince them of?

Ella: There is lots of overlap with what has already been said. The simple answer is everyone – decision makers, policy makers, administrators. But it would be safe to start with ourselves, to look at our own practices, our own situations. What can we contribute to the process and what is the role of policy? You can design wonderful policies but they won't be useful if not infused with humanity. The challenge is how to get everyone on board. We have to enter into a conversation that everyone will be invited into, not necessarily to convince them of anything. They may know little about us, but we may be poorly informed about them. We are trying to break the divide between "us" and "them", so rather than convincing them, we need to invite people into the conversation. Ignorant and ill-informed people exist but most try to do their best. Opening the conversation is a good first step.

Group B Report Back

Lorna: From what I have heard, a lot of these themes came up in our group. It's important for us to be patient in hearing the stories over and over because each time we hear them, there are other dimensions that we hear to understand what CS and relational practice mean. it's interesting because I've been looking at the literature and what I've found is that these terms are coming up mostly in health and nursing, even though the ideas and concepts are important to other institutions as well. In the literature, people are grappling with what these mean and in our group, people were putting their own understanding and languaging into what these mean. As we were trying to convey our understanding, we each were learning from those stories people The first big idea people resonated with was to do this work we have to come up with and follow a simple plan and not make it so complicated. This brought to mind, when I was a teenager and my mom and older sisters and others were trying to sort out what had happened to us and they would be meeting and meeting and talking and talking and my oldest brother said one time, “You know, you went to all of these meetings, what are you solving with all these meetings and this talking – what are you doing about what you are meeting about?” To him, it appeared we were making it so complicated. So we need a simple plan. The idea that came up was to create opportunities for experiences of what relational practice and cultural safety is, so that people can feel it, experience it, and draw lessons from that. That came up from a story Eric told about his Director going to two FN communities and coming back having learned lessons from those experiences that influence the policy determinations and decisions.

The other big thing is connecting the head and the heart. In our relationships, our workplaces, or wherever we may be, we need to make that connection. So many of our institutions are predicated on the notion of rationality, of keeping things arms-length and not bringing the rest of yourself into things. I told a story that offered two ideas. The first was about the value and importance of leaders and what they do to model CS and to lead it for their community. This led to a dialogue about how do we create those leaders within our learning institutions? And is it possible? Leadership and what leaders do is really important.

The second idea was when partnerships are being developed between groups that are habituated to not working together, how do we build those bridges? An example I gave was of two organizations that created a position on both sides so that when misunderstandings, biases emerged, the two leaders met “on the bridge” and talked through the divide and were able to bring in understandings from each side. Language was what the divide was. They became, in a sense, interpreters, so there group understood how the other group understood the issues. When we are seeing the other side of the bridge from our perspective, we need opportunities to be able to see it from their perspective. In partnerships, there have to be those opportunities when people who have not worked together in the past, especially when there is a real power imbalance, people do not see themselves as oppressors usually, and neither do they see their own oppression. Each group started with what will benefit me by being a partner. Each group has to see how the other will be a benefit to them. They have to value what the other group brings to the relationship. But oftentimes the group that has had the power doesn’t see the benefit of partnering, so being able to see and value what each brings to the partnership, this creates the grounds for cultural safety.

Cultural safety can be seen not only viewing it only from the “safety” end, but also as a disruptive thing; we are disrupting institutions, families that have been unsafe, and there will be resistance. It’s important to take the time to look at that, especially when bringing it to families, communities, and institutions. Yet, resistance and disruption can be befriended. There is also the fear of CS becoming formulaic, standardized and manualized, because the western world is prone to do that, to come up with neat and tidy interpretations and definitions. We need to watch that. If it is relational practice, the meaning has to come from the relationship. The group appreciated the use of a circle to be able to gain that. To do that, in a circle, we are deconstructing and decolonizing ourselves. That needs to occur in any space we are engaged with.

It is important that we don't place the burden of change on the individual. Yes, each person has to act and react when the space is culturally unsafe, but we need to build collectives so they can be supported and people don't have to take on the burden of change feeling isolated and alone. The opportunity of coming together like this, allows us to build these kinds of collectives and communities to support each of us in building the change that we want to create. A term came up "peopling up the room" with people who are committed to relational practice and CS, and I really like that term.

Ed: One of the difficulties we are having as we are thinking about this new paradigm of holistic thought or holism, we are making the reconnection between the heart and the mind. But I often say we need to go beyond that. That's the first step but the true step is to connect the physical with the mental and emotional and spiritual. That's the full journey. We don't really get it unless we make the full journey.

Bill M: We are modeling being spokespersons for a collective, a group because when each of us speaks, we are speaking for the group we are representing, based on their best thinking. We are challenged to learn how to be more representative of our group, our community. This ability has been lost in our communities to some extent, and in the western world. It's like electing a chief and council; they are spokespeople for the communities.

Plenary Session

1. **What influence do we want to bring to bear?**
2. **What are the webs of relationships that constrain or permit the kind of relational practice we want?**
3. **What would it take to make that flourish?**

Bill: We are talking about implementing relational practices, and what influences we need to bring to bear. I like what Lorna said on behalf of her group, to make a simple plan. What is the first step we want to take?

Jennifer: "The process is the product" comes to me as a way forward. We can't always specify in advance how something is going to look, we can't know exactly where it's going to go. We are in a process that is against injustice, and for relational practice. Sometimes to put a plan in place forces me into a place that is technical, but we can be guided by a set of principles that are against oppression, for social justice, for people's dignity. So I resist the question a bit because I don't want to replace ethical practice with technicalities. So being guided by ethical principles is a good place to start.

Rob: We are already beginning and it is a good way to begin it. We are agreed that it's a huge thing we are facing. We concluded that there is also system change needed, along with individual change. Individuals can't accomplish it on their own. There are some systemic issues that could be addressed.

Diane: One of the things we can do as individuals that will have an impact on larger groups is to go back to our own organizations and ask them to adopt this philosophy. In New Brunswick, we are asking the colleges to adopt this principle, to include it in their missions, their expectations of their members. That's where we can actually have a policy influence by going to our regulatory bodies, our disciplines and asking them to incorporate this into the requirements of our professions. They can then push the Colleges to make curriculum changes. For example, is promoting and enhancing CS part of the CPA mandate?

Bill: What Jennifer said is really pertinent. I've been involved in this business for over 50 years and the issues in the 1960's and '70's have changed a lot in terms of our relationship as FNs with government and Canadian society and why? Because we used to be asking what the government was going to do for us and it wasn't until the late 60's that our leadership in BC started to say we can do a better job than the government is doing, if they provide the funds. We need to get them to give us the support so we can do it for ourselves. It's been a real struggle but that's been the trend. Now, we're sitting with government and doing more to enhance their understanding and at the same time, to enhance our own. Under that process is the belief in an optimistic future, things we can do for our people. So there is lots to say for process but underneath that process are the values and lifestyles that embrace humanistic practices. Some of our modern day leaders are falling into practices that are not progressive, like MOU's. There is a lot to be learned by reflecting on where we've been.

Ed: The process is the product. You're describing a process that has already begun. We need to promote CS dialogue as widely and broadly as we can, forever.

Dave: The pudding is the proof – we all need to lead by example with all of the people we communicate with. We have to be able to listen and learn from each other. That knowledge exchange is part of the process.

Gary: We need to influence the funding agencies who develop policies and in such a way that they understand it's our agenda for our people in our communities, for our well-being.

Lorna: What I've heard in the last day and half is, the influence I would like to bring to bear is for all of us to remember first our humanity and that all of us, whatever we bring, we are part of the human family; and second, as a member of the human family, I'm not any better or more than any of the other living beings on the planet. That's what gets us into trouble, when we say that one group of people has more right to breathe the air than another. I have learned from my students, that in the end, we all need the same thing, we need to be part of the human family, and to be visible to one another in any circles we are part of.

Brenda: We need to influence everybody and everything, from the bottom up and the top down. In our circle, I heard it from policy, from practitioners, we need to influence in both directions so that people can feel a sense of belonging and sense of community wherever they go and whatever they do.

Vicki: I would like to think about the excitement of the possibility of this coming to fruition and I would like to influence that vision for the possibility.

Caroline: One of us could get Stephen Harper's job and do it that way – we could go home and run for office, not entirely joking. But the excitement part of this is important for me. And some of Paul Farmer's work in Haiti and liberation theology and solidarity. He says it's not enough to bear witness to suffering. That is classically what many academics have done through research, but rather, any time we engage in an activity such as this, we need come up with practical pragmatic ways to have move things forward, practical pragmatic ways to mobilize change. I would like to see pragmatic solidarity with people on the ground, people who are doing this every day – like the idea of holistic medicine, which is now mainstream, but came from indigenous philosophy and feminist work. I love the idea of collective activism. That gives me hope.

Josephine: We all have gifts and something to contribute to the bigger picture. For me, at a concrete level, I can influence by modeling some of the things we are talking about, to embody them, to be congruent about them on a day to day level. I'm hopeful because the excitement is bringing our gifts and challenging the environment to live up to the values. In Halifax there is a mandate for cultural competency but how to we influence the system so there is congruency in a concrete way?

Farah: I feel strongly that we have to start with ourselves and walk the talk and the rationale for that, at a personal and organizational level. As the MHCC we can't be a catalyst for that unless it can be the change it wants to see. This is essential. Also, for myself, as an example, it's very challenging work that we're doing and we can't do it without feeling safe ourselves.

Bill: There have been lots of suggestions and philosophic good thoughts, but unless we put ideas like this on the ground and actively impact people, it is not going to happen. Very seldom do ideas change from the bottom up, mainly from the top-down, especially over the short-term. And that's not a bad way of doing it – and the Commission's bully pulpit status gives it that opportunity. We have an opportunity here of the Commission modeling that kind of behaviour. It should be incumbent on the Commission to have a presence at the upcoming CPA meeting and push the current president to have a keynote speech focus precisely on changing relationships from the podium, from the top-down. I'm reminded of the quote: "When you have them by the balls, their hearts and minds will follow" and that's what you need to create change. We need to push change in the most expeditious and bloody-minded way possible. Sometimes change is not welcome except by those of us on the bottom rung who have the least power to make change.

Howard: It comes back to Brenda's point about needing change from the top and from the bottom. We still have a way to go but I find it hopeful that the conversation is happening and it's becoming larger. Bill's is a hopeful message. We do have an opportunity here but we need to put pressure from the bottom-up as well as finding ways to engage the people who have power. We have to negotiate that in a very pragmatic way – transform our vision for change into something that allows that change to happen.

Chris: For me, it's all about relationships at the end of the day. We need to build in these kinds of learning circles into our conferences, board relationships. In the Jewish literature there's a quote; "What does the creator hope for us? To do justice, to love mercy, to walk humbly, and do right for your G-d". "Comforter" in the New Testament in the original Greek language is 'paraclete'; that means to come upon someone and help them to carry their bed. In the western model, it is a lot of talking and it is better for us to be paracletes than parakeets! We have the honor to be able to make that difference in the creation, and we are, we are, we are!

Phil: I love the process. It provides guidance for us. We need to follow the process. I so often define people who live their religion only on Sunday as hypocrites. It's a difficult balancing act.

In this process, it is one of centering for me. It allows me to develop a comfort and relate back to the days of peer support, but there is also a motivation to get out and do something to change the world. We could easily develop a paradigm of the rock in the pool and a group of concentric and expanding circles by providing the opportunity for dialogue for others in this kind of safe setting. But if we don't live our own philosophy, it's difficult to tell others to do it. We have a little piece of turf right now and we forget sometimes that we're all going to be gone in some years. I'd like to see us move forward in ways that takes the learnings we have in a safe way to others. I hope the Commission will incorporate CS into all its thinking, not as an add-on, but into all the work. I would like cultural safety to be in all the chapters, not only one chapter. I hope we can come back together and reinforce ourselves on a regular basis.

Ells: Process is also a teacher. My hope is that we can enlarge the process. For me that is by dropping the word “cultural” and just using the word “safety”. There is no one that feels safe everywhere, and if you speak of that, you can bring the dialogue to everyone in their own world, and focus on safety. Cultural safety could create more of an “us and “them” while everyone can relate to safety.

Gwen: Pleased to have been part of this. Everything is based on respectful relationship and realizing that each of us brings so many parts to our whole. There is so much more to each of us than what is initially seen. This kind of meeting helps us to get to genuine interactions and we need to carry this out there with us as we leave.

Normand: I plan to go on walking my healing journey, to be a better human being, more balanced, let my spirit shine, that's my responsibility.

Patricia: In terms of exerting influence, I'm optimistic that there has been a lot of change and we need to keep doing whatever we're doing, within our spheres of influence. Change has started to occur and it will keep occurring. We need to look for opportunities to broaden our circles and to continue to support each other so we don't feel isolated. And the partnership modeled in this meeting is an excellent example of that. The walking together is occurring and it needs to continue.

Terry: Everybody has expressed so well what our responsibilities can be within our spheres of influence. In terms of my responsibility, as part of this team, this project, there is the challenge of how to carry this process forward. I like the idea of broadening the dialogue in Building Bridges Three. We could think about the people that we want to influence and extend the strategy to include them in a process like this one. This relational process deepens our understanding as individuals and we know how valuable it is. The challenge is to alter perceptions. Bringing people in conflict into a dialogue can alter their perceptions and relationships. So I would like to extend the dialogue to groups that may not see themselves as needing to be engaged but do need to be included, to enlarge the circle of support and mutual understanding.

Bill: In the Round Table we organized in Saskatoon, lots o discussion took place about other issues besides cultural safety, but cultural safety was modeled in the process. If we gather in this way, no matter what we talk about, if we do it in this way, cultural safety will be modeled.

Richard: I'm taken with the first question – what influence do we want to bear? I spent four years in Northern Ontario evaluating CMH services and interacted with leaders, Aboriginal leaders, parents and children and it was really interesting: I kept asking myself the question: can non-aboriginal service providers provide culturally safe services to indigenous families? My answer there was "no" from the families perspective. In one of Bev and my focus groups, a psychologist wept and said "we provide service to aboriginal people but don't have the capacity to provide services that are culturally safe". This is the situation across Canada. I would like to see something coming out of this initiative where you are providing resource guides, training and education to support the professionals providing resources to aboriginal families, to help them be better at what they are doing.

Bev: One of the things that struck me was the critical importance of some of the community agencies working at the grass roots level and how starved they are for funding. Most of the resources go to the medical model. I think it is important to look at where the funding is going and where it could have most value. Focus on peer support, self-help and community-based organizations that are starved for funding, but where people feel safe and respected. These are healing places for many people.

Brenda: Last week, I heard a Doctor speak who made reference to Indigenous Knowledge and how western knowledge was catching up with us. There was a study I heard about, a brain study comparing English and Japanese people which showed that English people use more of the left side of the brain. The two groups were shown a picture of a sparkly fish in a fish tank, and the English speakers saw the fish while the Japanese people looked at the gestalt of the picture. We need to look more at the gestalt, the context, the big picture. We are confounded by the notion of confidentiality. We need to know what is happening, to talk to the family, to support them. Confidentiality is about individuality, it stops us from going to the gestalt part of it. Knowing these things can be a very important part of learning about CS.

Lorna: There are limitations in all languages. They focus on certain things, not so much on others.

Brenda: It was interesting when Bill and I were at a International Indigenous Mental Health meeting, for us to experience the divisions between the indigenous and racialized minorities. It was interesting to see the divide. One of the Maori women got up and she said something that struck me; "if you don't address disparities in indigenous people, nothing else will matter – if the people who conquered the land don't treat indigenous people well, they won't treat other people who come to this land well".

Diane: Just because there is so much more that the indigenous people need to teach the rest of us. Until they understand how much they can learn, other people won't realize how important a relationship with indigenous people is. It's a pot of gold.

Closing Remarks

Diane: I am thankful to have been here. It's important to know that the ground zero work can be translated into a more cerebral conversation as we have had in the last few days, so that's been great. There isn't often the chance for that.

Rob: The discussion speaks to me of the need for life-long learning, for all of us who are in the business of providing help to other humans. You see examples of change beginning to happen, in the medical model for example. The Medical Association is at step one of a twelve step process of needing to learn. I think back to words of wisdom from Bill – we don't know what we don't know – and in terms of this process, I spent many years working with FN, in circles and I am conscious of the need not to misappropriate what is learned. Someone said to me that I was a great student of their culture and I realized I needed to remember that, that I'm a student. We all have our own cultures and backgrounds, and sometimes we don't realize what these are until we're older and can see the patterns. The respect and sharing and learning are what is most important.

Normand: For me, one of the greatest pleasures in life is when you work on being yourself more, you realize that it allows other people to be themselves much more and the quality of dialogue and connecting improves.

Gwen: I'm really happy to be part of this. The biggest thing I got out of it is adding richness to my understanding of these concepts, to make them deeper and add more meat to them. This is a very comfortable, wonderful way of doing things. In our Advisory Committee, this is how we do our work; we're able to build a relationship and the work comes from that.

Chris: Different ways of knowing have helped me to know how to do different ways of being with people. Two days ago we were talking about recovery and now we are talking about relational practice and cultural safety and it's amazing how connected they are. Coming to Canada, being here, facilitates all of that for me. This dialogue has given me some new words for talking about recovery and not to get hung up on the word recovery itself. This has led me to a lot of self-analysis.

Ella: It becomes a model we can take elsewhere – I came here thinking I would be contributing something to a process, but I have gained as much and probably more than I have contributed.

This epitomizes for me a healthy process, engaging in a conversation that involves give and take and if we can bring others into the conversation we've done a good job.

Bill: The process has been interesting but I hope that we can use it to move things along – I'm always aware that opportunities come and go, and that the flavour of the month now, may not be in the future.

Farah: I feel like the timing has been particularly important for me personally. I have been feeling isolated and unvalued and just being part of the process has helped me be less isolated. I'm thinking about how I can continue to be supported by others who think similarly about these things.

Josephine: I'm grateful for the nourishment and sustenance I've received. It helps me to be all that I can be. I'm going to be reflecting on how I can take this and model it so that my environment can be safer and we can be congruent with what we say and what we do.

Caroline: This was really good. What I love about this is the optimism that if we are really nice people others will be nice to us. I believe that, but also I believe in being a bit subversive with the Commission. I find sometimes when I leave my safe haven I have at the University and take for granted, I'm often smacked in the face by the realities outside. I believe we should pull in people, nurture them, then take them out of their comfort zone, and. My concern with the Commission in that regard is that I feel like I'm patted on the head sometimes "she's so cute and so passionate" and it annoys me. I don't want to say to hell with them; I want to be productive and subversive. Through the work we did with the Round Table, in an indigenous space of uncomfortability for them, it did a lot of good.

Vicki: It's been great and the dialogue has been so rich and interesting and there are so many things to think about. Many of us feel like we are working in isolation and what I love about relational practice is the connectedness; so you're not alone even though you might feel alone, everyone is there with you. I'm leaving today feeling connected, so that's great. I feel recommitted to the decolonization of processes and practices and the influencing and shaping that's required. I also feel like our report will be enlivened by our dialogue.

Phil: I want to say that this process has taken Bill and I and our organizations almost four years and it's been building a relationship of trust, encouraging, educating each other and it's been one of the most incredible processes I've been involved with in my life. I think change will happen, it is an incremental thing. We will move forward. And thank you all for taking your valuable time to be with us, and coming and sharing your thoughts and ideas.

Patricia: As I shared with some of you, we have been reflecting in FNIHB, and this whole process has helped me deepen that reflection further. Certainly, I feel isolated at times too, and I suspect we all do. The chance to be here has been an important part of reconnecting and finding courage in this process. I see this as aspiring to a vision that we may never quite reach, but being here fuels continued optimism as well as connectivity.

Lorna: Thanks to Richard for his organization and making it easy to be in this circle, for what you did to help us to be here. Thank you to Ed for bringing your medicine bundle to keep us centered and knowing that we are not alone. Thanks to Bill and Phil for their facilitating and getting us to a place where we could have this conversation and to Terry and Bev for their recording. When we get the record, we forget so much that is important. I go away today feeling a little bit more at ease, although not entirely comfortable with the term CS. But any term that helps us to consider what people and communities need to feel that they belong and part of this place is important. For those of us who have experienced not belonging to many spaces in this world we call Canada, the more that we can name what that experience is, it can help everybody, not just us. Although the Commission has taken a big chunk of work to try to do as craftily as it can, to create the spaces in this country for those who have been invisible and marginalized, the fact that they are willing to bring people together to sit in circles, talk and share stories is a big thing and I'm grateful to them for that, and for all of the people in the organizations who have given of their time to be part of the dialogue. I come to these always open to where Bill and Phil are herding us, but I come willingly because there are so few opportunities to be part of such a community and I thank all of you for that.

Dave: I really related to what you said about the importance of taking time for ourselves – it's so sad sometimes when you see people on their blackberries, all stressed out – and I think cultural safety is about how you manage our personal life as well. We are sometimes guilty of behaving in ways different than how we are trying to lead. We need to lead by example. I really think that this is going to get done and the people in the Commission are there for the right reasons. What I heard here is very applicable to me and I will carry it into the rest of my life.

Brenda: I'm grateful to everyone in the circle, for being vulnerable to sharing their thoughts, feelings and experiences about CS and RP, for being human really. When we open ourselves up to that vulnerability, we allow people to learn more about us and when we do that we tend to learn about ourselves even more. I appreciate the opportunity to learn about myself. And I've learned more about my children, so thank you for the opportunity to bring them here. I take away from this, the realization that according to Mel, I am done having children. I'm going back to work full-time now. I am recommitting myself to the important things in my work. Hearing everything everyone said reaffirmed that there are pockets across the country doing the same things, and when we come together we get reenergized.

Ed: I am going to repeat a story I shared in our circle to reaffirm what I received here and what I am taking away. This was a seminal teaching in my life that transformed how I thought about myself, my relationship with everyone and the world. It is the story of the ant. Years ago, working in Treaty Three, on a suicide prevention program with Alex Steed, we formed a circle for an Elder-Youth teaching/learning opportunity on an Island, the traditional healing ground in that area. We were waiting for the Elders and youth to join us, we had the chairs set up and the big drum in the centre and Alex was sharing a teaching with me. All of a sudden he stopped talking and was looking down at the floor. I followed his gaze and there was a little ant walking into the circle and he said, “Do you see that ant there? I said, “Yeah”, and he said, “That’s my brother. He’s no greater than I and I’m no greater than him. When we have this kind of relationship with others in this world, then we’ll have the peace we seek”. This story really defines for me relational practice and CS. What I’m going to take away is a recommitment to engaging in and supporting relational practice/CS and doing so in the widest and broadest circles that I can, forever. I don’t want to limit that in any other way.

Bill: I learned more about who I am and what I am when I started university. I think that is because I am an approachable person and got into really interesting conversations. Many non-indigenous people would tell me that they had no culture. But in high school, there were about one thousand kids and only about 4 indigenous people and I became sort of the counselor there, as the students came to me with their issues. When I was hired to do probation work I realized, I know how to do this work though I had no professional training for it, I could rely on what I knew worked and this was being a whole human being and I had lots of success. I had lots of arguments with psychiatrists because they had no tools to assess strengths. So I always embraced life and am still doing it here. I’m bringing from here an affirmation that we are doing is really important and we can invite others to join in future circles and help them to create their own circles. It’s been a real pleasure to learn more from other people in our group. It is the relationships that are so helpful in anchoring us in our lived experience and helping us know the next steps.

As far as follow-up goes, we will be reviewing the transcripts that will be added to the pool of focus group information we have and that material will be used as the substance of the action plan for the FNIM AC to mediate the learning of others in understanding cultural safety and relational practice. A further challenge will be how to introduce it to the provincial and territorial authorities.