REGULAR MEETING OF COUNCIL

A G E N D A

Monday, May 16, 2022 @ 6:00 pm.

Blended Meeting: Small Room Community Hall & Zoom Access

1. CALL TO ORDER
   1.1 All participants to be informed this meeting is being recorded.
   1.2 Attendees will be listed verbally.

2. PUBLIC HEARING

3. ADDITIONS & AGENDA APPROVAL

4. MINUTES
   4.1 Minutes of the May 2, 2022, Regular Meeting of Council – Will be generated and approved for May 30, 2022, Council meeting.

5. DELEGATIONS
   5.1 Bashaw RCMP Detachment Commander – no response from email sent.

6. BYLAWS - none

7. NEW & UNFINISHED BUSINESS
   7.1 Development Permit Application No.2022-3
   7.2 Development Permit Application No.2022-1

8. COMMITTEE & STAFF REPORTS – Will be included in Next Meeting for May 30, 2022.

9. CORRESPONDENCE
   None.

10. <u>CLOSED MEETING OF COUNCIL</u>
    None.

11. <u>NEXT MEETING:</u> May 30, 2022 – 6:00 pm, Regular Meeting of Council

12. ADJOURNMENT

Approved: yes /no Motion # _____
Account Code: _____

Town of Bashaw

Request For Decision

Meeting:	Regular Council
Meeting Date:	May 16, 2022
Originated by:	Theresa Fuller, Chief Administrative Officer
Agenda Item:	7.1 Development Permit No. 2022-3

Background/Proposal:

Development Permit No. 2022-1 is for the addition on a pre-built 18 by 30 ft outbuilding shed to a Direct Control Zone located at 5007 – 54 Avenue, Bashaw, Alberta.
Upon review it was noted that additional accessory buildings have been placed on the property. There are a total of 4 accessory buildings on the site currently (2 tent sheds, 1 c-can, 1 garage). Therefore, administration has requested information regarding the dimensions, proximity to property line and use; and that they be included in this application.

Documents Provided:

- Completed Development Permit application 2022 – 3
- Ortho Diagram with location indication
- Proposal Commentary
- Addition of Outbuilding – with photo and commentary
- Floorplan diagram, picture and commentary.
- Property Ortho Diagram; provided by Camrose County with reflection of actual measurements
- Property diagram with additional sheds; etc. and value of the proposed outbuilding

The aforementioned materials submitted by the applicant have been attached to this report.

Primary application purpose: The primary purpose of the Development Permit application is to build the following accessory building:

- 18 by 30 ft pre-constructed building
- Proposed to be located 30 ft from southwest property line
- 200 ft from preexisting manufactured home – however we believe this measurement is off based on property ortho diagram – attached.
- The measurements indicate it may be close to the water body on the property.
- Building to be on skids
- Use Proposed: She/shed/man cave, guest house, storage space to accommodate large family when sleeping over, create an area for hobbies, and provide extra storage
- Warm – up shack for skating.
- Floor plan: two 10 by 8 ft rooms – no closets – loft above the rooms
- Balance of floorplan to be open space
- Heated with wood stove
- No washroom or running water has been included in application

As the applicant has indicated the space will be utilized for sleeping, the most applicable definition within the Land Use Bylaw for the proposed accessory building (shed) is Housing, secondary suite; being a self-contained living space. However, the applicant notes that the building will not have a kitchen or washroom facilities at this time. Should the building be used for human habitation, appropriate safety codes must be met, and as such this use must be clearly defined in the Development Permit and appropriate building permits required. A development defined as Housing, secondary suite, must meet the requirements of a regular house including heating, washroom facilities, kitchen, etc.

An alternative development option is a bunk house, which is not currently a use listed within the Land Use Bylaw. A bunk house does not require washroom facilities, kitchen, etc. However, it can only be used by the landowners, and the users must have access to the facilities within the house. As such the unit cannot be used as a rental or for guests. As a Direct Control district, Council can consider allowing a use not defined within the Land Use Bylaw. However, should Council wish to pursue this option, Council may wish to update the Land Use Bylaw to include the appropriate definition.

Furthermore, the Land Use Bylaw specifically states in section 8.1(3) that "An accessory building shall not be used as a dwelling unit." This exclusion effectively removes the possibility of a bunk house.

In addition to the proposed building, Administration recommends that all other accessory building on the site be considered as part of this Development Permit, as all accessory buildings identified by the landowner require Development Permits.

The Development Authority in the Direct Control district shall be the Council. There is no statutory plan within this Direct Control Zone.

Next Steps:
Council to determine if they have enough information to make an informed decision.

Community Engagement Consideration:
Administration is of the opinion this application does not require Community Engagement.

Discussion/Options/Benefits/Disadvantages:
Administration recommends Council consider the following options, or multiples of:

Option 1: Council issue the attached Complete Letter which deems the application complete. Take additional time to review the application details, as Administration is still obtaining input from Safety Codes.

Option 2: Deny the application as they are proposing a non-compliant secondary suite with the absence of running water or kitchen facilities.

Option 3: Approve the accessory buildings currently on-site and the new building application with condition that habitants are not to sleep in the building. This may be a challenge to enforce.

Option 4 – Approve the application with the condition that the development be built with full

secondary suite requirements, complete with separate water line connection, water meter, sewer connection, garbage removal, fully habitable facilities required, and all associated charges.

Option 5 – Issue an incomplete letter requesting additional information.

Costs/Source of Funding (if applicable)
n/a

Applicable Legislation:
MGA Section 685 – Subsection 4.
Land Use Bylaw - 780-2018, Section 12.14 (2)
This location does not have an Area Structure Plan – Section 633 MGA or Area Redevelopment Plan – Section 634 and 635 MGA.
MGA Section 641- Designation of Direct control districts

Recommended Action:
Administration declines provision of a recommendation.

Discussion Result:
Possible Motions:

MOVED BY _____ that Council issue the attached Complete Letter which deems application 2022 - 3 complete.

MOVED BY _____ that Council deny application 2022 - 3 as they are proposing a non-compliant secondary suite with the absence of running water or kitchen facilities and direct administration to generate a development permit refusal for council approval citing the reasons for the refusal.

MOVED BY _____ to approve application 2022 – 3; approve the accessory buildings currently on-site and the new building as a bunk house with condition that habitants who are not registered landowners are not to sleep in the building and direct administration to generate the development Permit for council approval.

MOVED BY _____ approve application 2022 - 3 with the condition that the development be built with full secondary suite requirements, complete with separate water line connection, water meter, sewer connection, garbage removal, fully habitable facilities required, and all associated charges; and direct administration to generate the development Permit for council approval.

MOVED BY _____ issue an incomplete letter for application 2022 – 3; requesting additional information.

Or other possible motions as determined by council.

Additional research Requested:

TOWN OF BASHAW

APPLICATION # Pd $75. 2022-3

DEVELOPMENT PERMIT APPLICATION *(to be completed by the Applicant)*

In accordance to the Land Use Bylaw 780-2018 Section 4.1(1) "An application for a development permit shall be completed and submitted to the Development Authority in writing, in the form required by the Development Authority." Please provide the information below; the following information, submission of documents, and payment of the applicable fee is required prior to processing this application. Thank you.

1. PROPERTY INFORMATION: "Where are you Developing?"

MUNICIPAL ADDRESS: 5007 54 Ave Bashaw, Alberta

LEGAL DESCRIPTION: LOT(s): " " BLOCK: G1 PLAN: 4350 HW

LAND USE DISTRICT: Zoning: Direct Control (DC)

PROPERTY OWNER'S NAME: Connie Nand

MAILING ADDRESS: Box 124

CITY/PROVINCE: Bashaw Alberta POSTAL CODE: T0B 0H0

PHONE/CELL: 780 678-5497 FAX: _____ EMAIL: connienand@live.ca

FORMER USE OF PROPERTY AND/OR BUILDING: acreage green space

PRESENT USE OF PROPERTY AND/OR BUILDING: " "

2. OWNER/APPLICANT INFORMATION: "Who is doing the Developing?" ☑ Owner ☐ Applicant

If not the Owner, complete the following: Applicant's interest in property: ☐ Contractor ☐ Agent

APPLICANT'S NAME: _____

MAILING ADDRESS: _____

CITY/ PROVINCE: _____ POSTAL CODE: _____

PHONE /CELL: _____ FAX: _____ EMAIL: _____

3. DEVELOPMENT INFORMATION: "What are you Developing?"

PROPOSED USE OF PROPERTY AND/OR BUILDING: addition of pre-built out building (shed) to acreage green space - 18 x 30ft - Height -

ESTIMATED PROJECT COST: Cost of building/shed + ~ $5000 or for site prep

START DATE: April end FINISH DATE: May end.

4. CLEAR SITE PLAN(S) DRAWN TO SCALE IS REQUIRED *(include the following in your drawing(s))*:

- ☐ compass point north
- ☐ lot size measurements
- ☐ alley, roadway, street name, etc. adjacent to lot
- ☐ location and measurements of existing structures on the land (fence, deck, house, garage, shed, etc.)
- ☐ preferred location of the proposed development and its measurements
- ☐ show distances between all of the improvements and the property lines
- ☐ identify front, rear, and side yard(s)
- ☐ off-street loading and vehicle parking plan
- ☐ access and egress points to the site
- ☐ all easements and utilities and the proposed connections to utilities
- ☐ the proposed site grading and drainage
- ☐ landscaping plan

I, Connie Nand., hereby make application under the provisions of the Land Use Bylaw 780-2018 for a Development Permit in accordance with the plans and supporting information submitted herein that form part of this application.

I hereby declare the information submitted is true, accurate and complete. Furthermore, that the work identified in this application will be conducted according to the plans submitted, in accordance to the regulations of the Land Use Bylaw 780-2018, all other applicable government regulations, and any conditions that may be set down as a requirement to approve this application. I agree to notify the Development Authority forthwith of any proposed changes or asides to the plans approved and shall seek additional approval for those changes before proceeding with the development project.

Furthermore, I hereby acknowledge that it is my responsibility to obtain a copy of and review the aforementioned documents, become informed and ask questions to ensure my project maintains compliance with the government regulations and conditions of the permit.

I fully understand that under Section 4.6(1) of the Land Use Bylaw 780-2018 a Development Permit does not come into effect until 21 days after the date on the Notice of Decision issued by the Development Authority. Additionally, this Development Permit is not a Building Permit and, where required by government regulation, must be applied for and obtained prior to construction.

C Nand.
Signature of Registered Owner/Developer

April 27, 2022
Date of Application

Signature of Municipal Employee

Date of Witness

Pd 75 Debit
Cash Receipt # and amount

RECEIVED
APR 27 2022
Paid this date

Witness: Obj Ayz

40
40
37
30ft
200ft
1527 H
072 65
RO

Proposal:

- Addition of 30'x18' barn-style out building (shed) to green space on acreage.
- Building is non-stationary (on skids)
- Will be pre-built, transported in, & set up on prepared site in open area / green space.

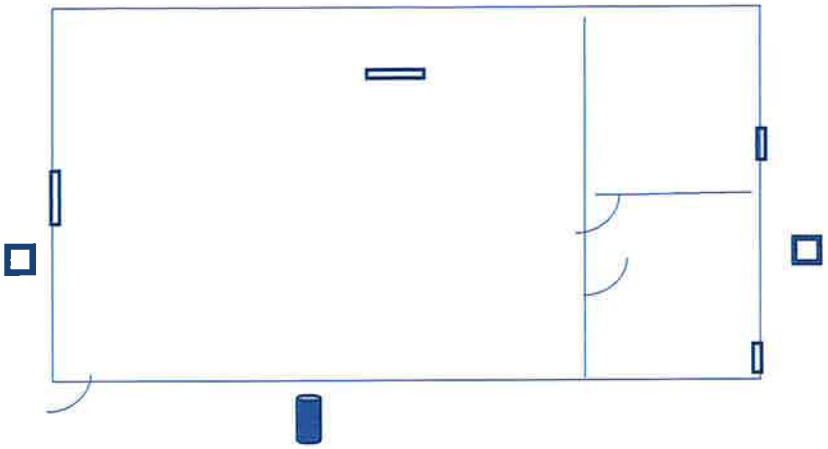
Addition of Outbuilding to Nand/Haryung property 5007 54 Ave

- 18' x 30' x approximately 15' barn-style outbuilding/shed
- Non-permanent/on skids, to be placed on prepared site in green space of acreage
- To be used as she-shed/man cave, guest house, storage space to accommodate large family when sleeping over, create an area for hobbies, and provide extra storage. It will also be used as a warm-up shack for skating parties

If more information is needed please contact:

Connie: 780 678-5497 or Byron: 306 215-7433

Development Permit Application 2022 – 3 – Pre-Built Outbuilding Shed. Block g, Plan 4350HW



2- 10 x 8 rooms with windows- no closets

The rest is open floor with 2 windows on ground level. Ceiling is open, with small window up top. Wood fire place adjacent to door side.

Above rooms is loft with small window on same side as windows shown

Property Ortho diagram. 2022-03

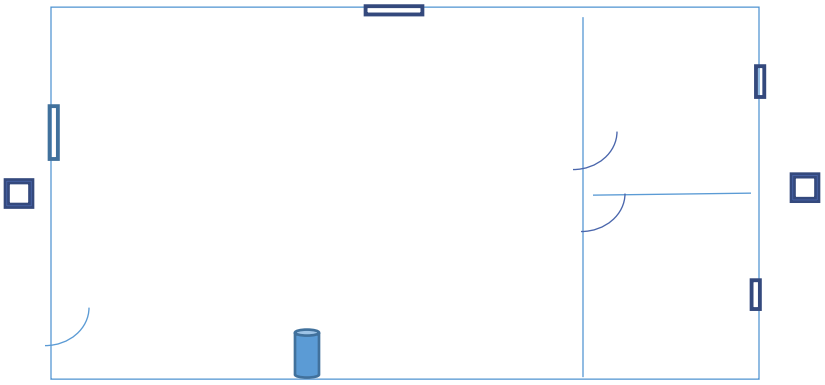
Nand/Haryung Development Information (Proposed use of Property and/or Building): 5007 54 Ave Block G Plan 4350HW Zoning: Direct Control

A. Addition of pre-built (approx.) 30' x 18' x 15' barn style outbuilding (shed) to green space on acreage.

1. Non-permanent, on skids.
2. Built off site and transported in, and set up on prepared site in open area/green space.
3. Building is wired, but does not have plumbing so water and sewer are not a consideration at this time.
4. The building has been engineered for the area's snow load, and has been built to code.
5. Has (2)- 10 x 8 rooms with windows- no closets
6. The rest is open floor with 2 windows on ground level.
7. Ceiling is open, with small window up top.
8. A Wood fireplace is adjacent to door side.
9. Above rooms is loft with small window on same side as windows shown.
10. Location will be ~ 30 feet from south west fence, so approximately 37 feet from property line, and ~200' from house.
11. Site preparation cost ~$5000.00. Building cost ~$75000.00

USAGE: Additional accommodation for guests (guest house), "she-shed"/"man-cave, "games room/hobby room/rumpus room", extra storage, warm up shack when skating.

crude floorplan below



Nand/Haryung Development Information (Proposed use of Property and/or Building): 5007 54 Ave Block G Plan 4350HW Zoning: Direct Control

B. (2) Re-vamped tarp sheds

1. (approx. 10’ x15’ x8’) Built over wind-torn tarp shed pole frame using recycled wind boards and tin
2. ~ 14’ from the east property line, and 60’ from the garage
3. Tarp shed cost: ~$350.00 each – purchased from Canadian Tire

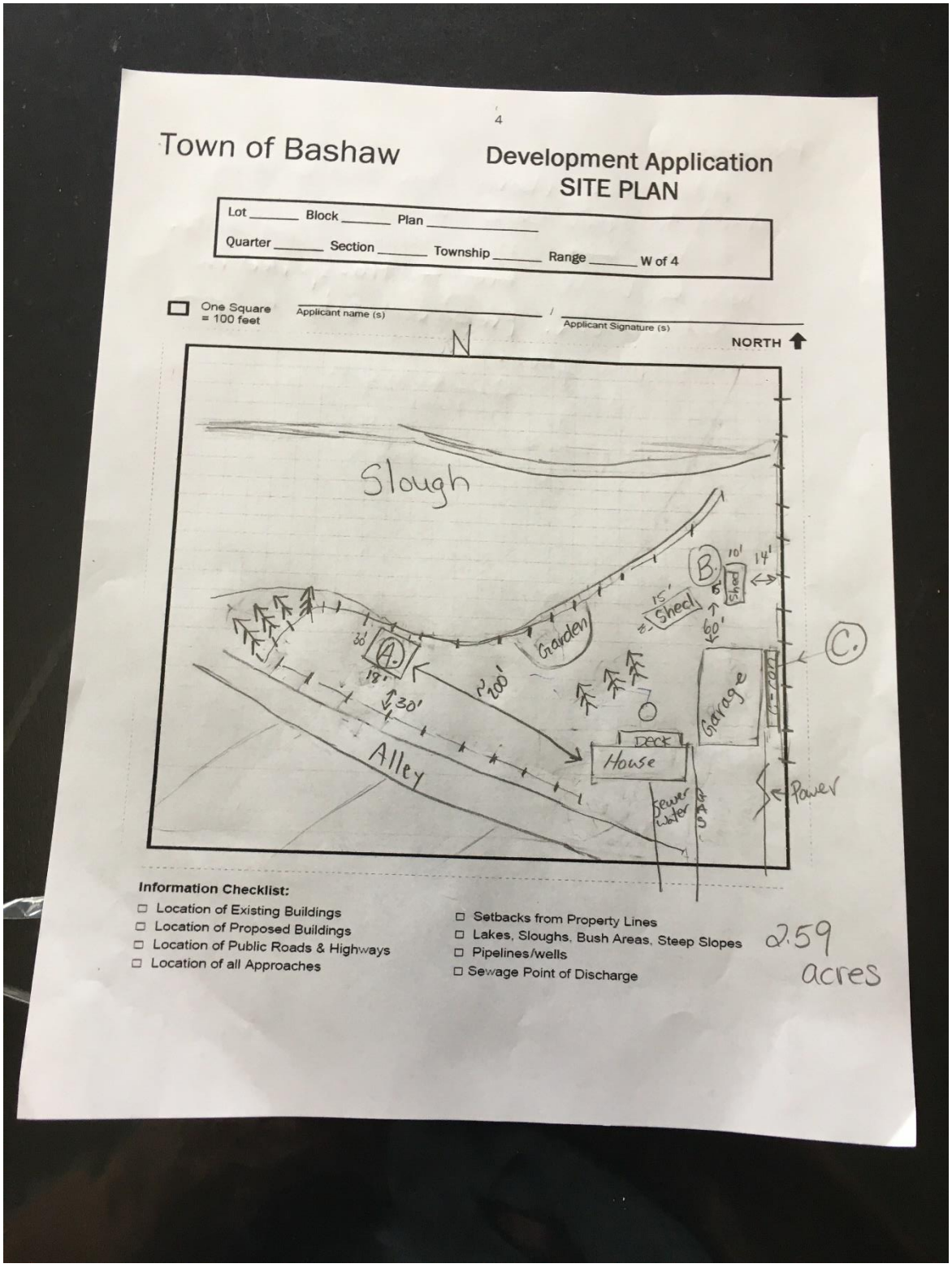
USAGE: Garden tractor (and attachments) storage, quad storage, outdoor tool storage, yard items/tool storage, deck furniture storage

C. C-Can

1. (approx.) 20’ x 8’
2. Approx. 3’ from the east property line, and ~ 3’ from the garage
3. C-Can cost: ~ $4000.00

USAGE: Household/furniture storage, work-related storage (unit plans/lesson plans, school resources)

Nand/Haryung Development Information (Proposed use of Property and/or Building):
5007 54 Ave Block G Plan 4350HW Zoning: Direct Control



4

Town of Bashaw

Development Application
SITE PLAN

Lot _____ Block _____ Plan _____

Quarter _____ Section _____ Township _____ Range _____ W of 4

☐ One Square = 100 feet

Applicant name (s) _____ / Applicant Signature (s) _____

NORTH

Information Checklist:

- ☐ Location of Existing Buildings
- ☐ Location of Proposed Buildings
- ☐ Location of Public Roads & Highways
- ☐ Location of all Approaches
- ☐ Setbacks from Property Lines
- ☐ Lakes, Sloughs, Bush Areas, Steep Slopes
- ☐ Pipelines/wells
- ☐ Sewage Point of Discharge

2.59 acres

Nand/Haryung Development Information (Proposed use of Property and/or Building): 5007 54 Ave Block G Plan 4350HW Zoning: Direct Control

Site Plan when moved house to acreage in 2017.

Nand/Haryung Development Information (Proposed use of Property and/or Building):
5007 54 Ave Block G Plan 4350HW Zoning: Direct Control

May 16, 2022

Ms. Connie Nand
Box 124
Bashaw, AB T0B 0H0

Dear Ms. Connie Nand,

RE: Complete Development Permit Application 2022 - 3 for 30 by 18 Ft Accessory Building (Outbuilding) and 4 existing Accessory Buildings (2 tent sheds, 1 c-can and 1 garage) at 5007 54 Avenue, Bashaw.

On April 27, 2022, the Town of Bashaw received your application for a Development Permit No, 2022-3 for a Discretionary Permit at 5007 – 54 Avenue, Bashaw. In accordance with Section 4.3 of Land Use Bylaw 780-2018, the Town has reviewed the application for completeness in relation to the Development Permit application requirements. The application is deemed complete.

This letter does not provide any sort of Development Permit approval or refusal. In accordance with the Municipal Government Act and the Town of Bashaw's Land Use Bylaw 780-2018, the Development Permit review must be completed within 40 days of issuing this letter. Should a decision not be made within 40 days, the application is deemed refused unless the Development Authority (Council) and the applicant make a written agreement to extend the 40-day period in which the Development Authority is to make a decision on the application.

Please note, that in accordance with the Municipal Government Act and the Town's Land Use Bylaw 780-2018, despite the issuance of this complete certificate, the "Development Authority may request additional information from the applicant, if, in the course of reviewing the application, the Development Authority determines that additional information is necessary to review the application."
Sincerely,

Rob McDonald
Mayor, Town of Bashaw

Approved: yes /no Motion # _____
Account Code: _____

Town of Bashaw

Request For Decision

Meeting:	Regular Council
Meeting Date:	May 16, 2022
Originated by:	Theresa Fuller, Chief Administrative Officer
Agenda Item:	7.2 Development Permit No. 2022-1

Background/Proposal:

Development Permit No. 2022-1 is for a property located at 5340-51 A Street. The application is for the Bear Hills Family Wellness Centre. The application has been submitted by James Carpenter, Dr. Tony Mucciarone, Lucy Smolcic and Audrey Ward. Maskwacis First Nations have expressed support for the proposed project.

The property is designated as Direct Control as per the Town's Land Use Bylaw 780-2018. Land Use Bylaw 780-2018, Section 12.14 (2) states that the Development Authority in the Direct Control District shall be the Council.

The applicant began discussions with the Town regarding this application in November 2021. The Development Permit application was submitted on January 10, 2022.

A Complete Letter was issued on May 3, 2022.

The intention of the May 16, 2022, meeting is to have an open dialog with council regarding the application submission. Administration recommends reviewing the application in accordance with the following list, which was provided in the previous council reports.

1. Confirmation of exact uses to be included on the site, including detailed description of each use / activity.
2. Confirm the number of beds to be utilized for overnight guests and their reasons/rational for the use of the overnight stay.
3. Confirm the age of guests, duration of stay, ratio of guests to supervisors, and type of supervision provided for guests and visitors,
4. Business Plan / Operation Plan
5. Building Access Plan.
6. On-Site Safety Plan
7. Off-site / Community Safety
8. Capacity of existing medical infrastructure in the Town of Bashaw
9. Confirmation of providers and governance structure for health care related services and childcare related services.
10. Integration of guests and visitors into the existing Bashaw community.
11. Traffic Impact Assessment
12. Environmental Public Health review

Upon completion of review the main submission, Council may begin reviewing the additional optional information. This may be done at the same meeting, or a meeting on another date.

The application materials and optional additional materials submitted by the applicant have been attached to this report.

In accordance with the Municipal Government Act and the Town of Bashaw's Land Use Bylaw 780-2018, this review must be completed within 40 days. Should a decision not be made within 40 days, the application is deemed refused unless the Development Authority (Council) and the applicant make a written agreement to extend the 40 day period in which the Development Authority (Council) is to make a decision on the application.

Furthermore, in accordance with the Town of Bashaw's Land Use Bylaw 780-2018, despite the issuance of the complete certificate, the "Development Authority may request additional information from the applicant, if, in the course of reviewing the application, the Development Authority determines that additional information is necessary to review the application."

Community Engagement Consideration:
Administration continues to recommend Council consider holding a Bashaw community information session upon receipt of publicly available information. In the spirit of reconciliation, the community information session should be held jointly with a Maskwacis Elder and Maskwacis service providers. Such a meeting will provide a formal venue to Bashaw residents to submit feedback directly to Council.

Administration is currently seeking the services of a third party to help support the invitation of the Maskwacis elders to a meeting. As Administration does not have experience in arranging these meetings, we need to be sure it is done correctly.

Discussion/Options/Benefits/Disadvantages:
n/a

Costs/Source of Funding (if applicable)
Discussion will determine the options and next steps.

Applicable Legislation:
MGA Section 685 – Subsection 4.
Land Use Bylaw - 780-2018, Section 12.14 (2)
This location does not have an Area Structure Plan – Section 633 MGA or Area Redevelopment Plan – Section 634 and 635 MGA.
MGA Section 641- Designation of Direct control districts

Recommended Action:
Administration declines provision of a recommendation.

Discussion Result:
Discussion will determine the options and next steps.

April 20, 2022
© First Nations Structures Ltd.

Development Permit Application No. 2022-1
Application submitted January 10, 2022
Applicant Bear Hills Family Wellness Centre
5430 51A Street, Bashaw, AB

Digital Response to Motion #041-2022 submitted to Town Council via email
Mayor Rob McDonald, rob.bashaw.council@gmail.com
CAO, Theresa Fuller, cao@townofbashaw.com

Digital Response sent via email to the above addresses on April 20, 2022
Hard Copy Response to be delivered in person by Dawn Mucciarone on April 21, 2022

On April 1, 2022, Ms. Smolcic delivered our hard copy response to Motion #041-2022 in person to the Town Hall in Bashaw, and it was received and accepted in the presence of both Darlene Tucker and Theresa Fuller. Ms. Fuller accepted the hard copy. We learned on April 14, 2022 by way of the Town's website and again on April 19, 2022 during the Town Council Meeting, that our response was not and would not be presented to Council.

On April 16, 2022, a digital response to Motion #041-2022 was submitted via email as per the publication of the Agenda on the Town's website on April 14, 2022, with the demand to do so or our Application could be permanently rejected.

Today, April 20, 2022, we are submitting our response to Motion #041-2022 in both digital and hard copy format as clearly indicated in the Incomplete Letter issued to us by Mayor Rob McDonald via email from the CAO, Theresa Fuller, dated April 19, 2022. April 20, 2022 a digital submission has been sent and the hard copy to be delivered April 21, 2022.

This document should be considered our response, however, we will include in a separate email, **optional** additional information in support of our response should anyone choose to review it.

As per the request by Council in their Incomplete Letter issued and dated April 19, 2022, we acknowledge that our response today is to be released publicly.

Kind Regards,

Audrey Ward
Lucy Smolcic

Wellness from an Indigenous perspective is a whole and healthy person expressed through a sense of balance of spirit, emotion, mind and body. Central to wellness is belief in one's connection to language, land, beings of Creation, and ancestry, supported by a caring family and environment.

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1. *Confirmation of exact uses to be included on the site, including detailed description of each use/activity.*

Wellness from an Indigenous perspective is a whole and healthy person expressed through a sense of balance of spirit, emotion, mind and body. Central to wellness is belief in one's connection to language, land, beings of Creation, and ancestry, supported by a caring family and environment.

Cultural interventions from within an Indigenous world view are not commonly identified as a "therapeutic intervention," as is typically the case in Western practice. Indigenous traditional cultural interventions are understood by First Nations to be a holistic approach: a way of seeing, a way of relating, a way of thinking, a way of being. There is common understanding. Indigenous traditional culture is vital for healing and wellness.

The support of culture-based practices is indicative of a broader acknowledgement made by governments and larger health organizations of the importance that traditional healing practices have in providing effective health care for First Nations.

All cultural interventions are spirit centered, including social activities. Social songs are primarily sung in a First Nations language, and use of natural medicines for smudging requires that one knows the Indigenous name of the medicine from a First Nations language. Hunting and fishing requires prayer to the spirit of the animal or fish being sought, by using their Indigenous name. There are protocols for facilitating cultural interventions that must be sanctioned and learned in order to fully benefit from the spiritual relationship that is central to cultural interventions.

People will experience differences in the benefits of cultural interventions - some may experience the benefit more at a spiritual level while others may experience the benefits of a cultural intervention more at a physical level. While this may be the case, one thing for certain is that every cultural intervention attends to the whole person. There is no one cultural intervention that will only attend to one aspect of a person's being. All cultural interventions attend to the whole person.

A. Teachings

i. Providers and General Information with Teachings

Community-sanctioned Elders, cultural practitioners, traditional healers, youth counselors, and many other key staff are typically identified as being sanctioned/bestowed/honoured with the responsibility to follow, respect, protect, and maintain the knowledge specific to cultural practices. Cultural protocols are not aimed solely at First Nations practitioners; rather, they are needed to be understood by all persons who work with Indigenous clients in order to be culturally aware or safe. This not only can be seen as respecting the needs of clients but can also be seen (from the lens of both a behavioural and technical competency) as promoting improved outcomes in clients where cultural interventions can be demonstrated to increase effectiveness. In that sense, understanding the relevance and application of cultural protocols becomes as important in the positive outcomes of a client as does the use of language or other customs that are pertinent to a diverse client population.

ii. Elder

Elder In Indigenous terms, an Elder is also a specialist in ceremonies, traditional teachings, language, and heritage as it applies to mind, body, emotions, and spirit. As each individual is

unique in their experience, learning, personality and knowledge of indigenous culture, each potentially has something different to offer. Some individuals may be specialists in certain teachings, ceremonies or healing practices, while others have another expertise. While age is a part of this, it is not the only part, but to a certain extent it is when you have experienced enough of the stages of life that you can look back and reflect on them.

iii. Cultural Teachings

The Centre will incorporate culture into their programs to make it fairly easy to remove or set aside. In these cases, cultural identity of staff, use of Indigenous language, and culturally specific art are not offensive or qualified as culture. Therefore, designing cultural-specific protocols would help, not only to quantify those activities that would be deemed cultural, but would also serve to qualify those cultural elements and to assign protocols that would ensure the right information and the right process are being used at the right time in a client's best interest.

Cultural-specific protocols refer to those practices that are incorporated into programs that reflect the First Nations region or territory where the program exists. These may be general protocols specific to the ceremony or protocols associated with practices that make up the program.

As noted by the National Native Addictions Partnership Foundation (NNAPF*) Cultural Practices Review Committee, ways of traditional healing are as many and different as there are First Nations cultures. There are, however, many aspects they have in common: traditional healers or cultural practitioners who work with natural medicines are
taught by other traditional healers, Elders, and cultural practitioners and are recognized by their communities.1 What challenges mainstream professionals who prefer an academic and professional designation is the understanding of how a cultural practitioner or traditional healer is sanctioned and by whom they are sanctioned in order to practice or speak openly about the use of cultural protocols and practices.

As communities heal from the symptoms and illnesses of cultural disconnect, more First Nations are establishing culture-based intervention programs that, by reconnecting an individual to his/her culture, aim to heal the root cause of many addictions.

There is a need to know why one should consider cultural-specific protocols. In 2010, the National Youth Solvent Abuse Committee (NYSAC) reported that although 36 per cent of youth do not communicate regularly with an Elder, more than double (82%) know of an Elder who is willing to listen. NYSAC's data on spiritual beliefs show that 40 per cent indicated they exercise traditional spirituality, 19 per cent stated they do not have any spiritual affiliation, and the remaining 41 per cent have affiliations that scatter across various religions. Likewise, the First Nations Information Governance Committee (FNIGC) recently reported only 15 percent of First Nations noted that health services were not culturally appropriate, with 13 per cent indicating they could not access traditional care.

Some researchers acknowledge the linkage between Indigenous culture and healing from substance abuse as rooted with traditional Knowledge Keepers and communities (Dell et al., 2011; Kirmayer et al., 2003; Mushquash, Comeau, McLeod, & Stewart, 2010). Alfred (2009)

shared that the central problem for Indigenous health rests on “the effect of colonially-generated cultural disruptions” (p. 42) and he and others (e.g., Kirmayer & Valaskakis, 2009) connect the subjugation of Indigenous cultures, including the exploitation of Indigenous lands, specifically to substance abuse. Dell et al. (2011) add that ongoing suppression of First Nations culture has significantly contributed to the problematic use of substances among recent generations of First Nations youth. It is necessary to recognize problematic substance use within this context, including the impacts of residential schooling, the Sixties Scoop (i.e., state apprehension of a generation of Indigenous children), and other legislative, social, cultural, and economic forms of oppression (Alfred, 2009; Barker, 2009). Kirmayer et al. (2003) optimistically offer though that, “Indigenous cultures have encompassed healing traditions that were then undermined by missionary efforts, but are now in a process of renewal” (p. 17). McIvor, Napoleon, and Dickie (2009) outlined the protective effects of culture (including traditional foods and medicines) and language thereby establishing connections between Indigenous cultural, economic, and political renewal, and overall health.

Culturally rooted addictions research can contribute to Indigenous wellness and cultural renewal by bringing awareness to the link between colonialism and addiction and by actively re-centering an Indigenous worldview and governance in the research process.
(Taken from Research as Cultural Renewal; thunderbird)

iv. Cultural Safety

Not harmful: cultural safety, verification of rites, and process of accountability.

Cultural safety refers to what is felt or experienced by a patient when a health care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-making and builds a health care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care. Culturally safe encounters require that health care providers treat patients with the understanding that not all individuals in a group act the same way or have the same beliefs. (Nova Scotia Department of Health. A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia. 2005.)

Culturally safe practices include actions which recognize and respect the cultural identities of others and safely meet their needs, expectations, and rights. Alternatively, culturally unsafe practices are those that “diminish, demean or disempower the cultural identity and well-being of an individual. (Nursing Council of New Zealand. Guidelines for cultural safety, the treaty of Waitangi, and Maori health in nursing and midwifery education and practice. Wellington: Nursing Council of New Zealand, 2002)

v. Holistic Health / Wellness

Health for First Nations is broadly envisioned as wellness and is understood to exist where there is physical, emotional, mental, and spiritual harmony. The Centre will take the approach to improve the health and wellness of its Clients that encompasses the physical, psychological, and spiritual aspects of an individual.

A holistic concept of health is an integral part of a strong cultural identity. Many First Nations communities believe that the way to achieve individual, family, and community wellness (a balance of mental, physical, emotional, and spiritual aspects of life) is through culturally specific, holistic interventions.”

Central to Indigenous intelligence is the belief that the Great Spirit placed everything within Creation that humankind would ever need to live. Key concepts of Indigenous intelligence demonstrate their application within addictions services, and the sweat lodge is an exemplary prevention strategy given its ability to strengthen cultural identity, address grief and trauma, facilitate recovery, and promote and maintain health. Indigenous Elders and cultural practitioners need to be valued for their cultural knowledge and skills, but their contributions are often not adequately recognized. It is
important to realize that cultural practices do not occur within a nine-to-five schedule. (Indigenous Services Canada and the Assembly of First Nations. First Nations Mental Wellness Continuum Framework. Ottawa: Indigenous Services Canada, 2015. 33.)

vi. Individual and Group Counseling

The utilization of special skills to assist individuals, families or groups to achieve objectives through: exploration of a problem and its ramifications, examination of attitudes and feeling, consideration of alternative solutions, and decision making. Counseling provided by certified counselors and Elders.

vii. Child and Youth Health and Wellness

Creating safe spaces refers to a physical and emotional area that ensures a comfortable and secure environment, which is free of perceived ideologies, discrimination, criticism, harassment, or any other form of emotional and physical harm. A safe space can be as much about the physical area as it is about the emotional space left for those found within it. Safe spaces are created to foster open and honest conversations and promote the usage of safe communication.

As Indigenous People who grew up within our communities, we have faced many of the hardships that our nations currently face, such as overcoming substance misuse and intergenerational traumas. However, despite the privilege of growing up in our home territories surrounded by nature, sacred sites, language, stories, and Knowledge Keepers, the connection to our identity was not one of them.

viii. Intergenerational Trauma / Transgenerational Trauma / Residential Schools

Trauma that is transferred from trauma survivors to their children and further generations of their descendants through complex post-traumatic stress disorder mechanisms. The ongoing intergenerational trauma of colonialism has damaged the cultural integrity and holistic health of Indigenous people and communities. While some events and policies have affected many Indigenous people (separation from the land, dissolution of communities, oppression, Residential Schools, Sixties Scoop, marginalization, and aboriginalism), it is important to know that some communities have also experienced their own unique traumas. This means that each community will have different needs for their healing journeys.

Traditional healers place significance on re-establishing a connection with spirit, family, extended family networks, and community. They use ceremonies to connect with ancestors in order to address grief and promote health and spiritual connection, and these ceremonies include family and community in order to promote healthy family and community interaction. This focus on resiliencies helps build a strong foundation prior to addressing unresolved trauma.

There should be a belief that Indigenous knowledge and culture are meaningful today.

ix. Life Skills / Personal Development

A series of activities that are taught to groups and individuals in order to enhance their social and personal skills.

The Centre will have mentors from Alberta who represent business, agriculture, education, interpersonal relations, communication and beyond. All mentors will have the opportunity to offer Clients in-house seminars as well as distance mentoring.

Clients will have access to courses, seminars, instruction and activities to improve, enhance or strengthen:

- Life skills
- Budgeting
- Plan
- Students
- Resume writing
- Job applications
- Debt
- Credit
- Goal setting
- Community

x. Traditional Medicines and Healers

Use of traditional smudge, spiritual cleansing and availability of knowledge and uses will play a significant role in this part of the Program. Daily smudges will occur. Health professionals should respect traditional medicines and work with Aboriginal heate traditional and western medicine.

When it comes to the assessment aspect of healing work, it was established that traditional healers employ established rites to find the spirit name, the clan family, and
the connection to the family, involving both Creation and land. These rites vary depending on spiritual and community-sanctioned knowledge. Their abilities to seek the Spirit name and interpret the spirit message are based on formal cultural education about reading, interpreting, teaching, and using knowledge sources such as scrolls or pictographs. In finding the spirit name, traditional healers begin by locating a source of strength the client can come to rely upon. This contrasts with Western mental health
professionals, as they are primarily deficit-focused and tend to “see” people in terms of their deficits — looking at them from within an empirical, disease-based, and
non-spiritual reality.

A process to sit, learn, talk, and walk with those Knowledge Holders through the trails, paths, and beside the water to learn how to forage, harvest, and seek out traditional medicines.Information sharing that includes the community’s plants and their uses.

With the help of Knowledge Holders or medicine walkers, communities are able to learn which plants will serve them, possibly begin to wean off of pharmaceutical medicines and to understand what the earth can give us. Knowledge and teachings of seasonal practice for community members to harvest and use traditional plants and medicines.

Elders have become adept at connecting to nature around them to receive messages, wisdom, or lessons from their life journey. Land is integral to our identity as Indigenous People, it is important to maintain our connection by being able to listen to what it has to tell us.

xi. Indigenous Knowledge

Indigenous Knowledge is more about understanding one's role and responsibility in the world than about classifying information. It is a form of consciousness intimately related to the ecological order, a response of a people to their responsibility to participate in maintaining that order. Although recorded and passed on by such means as art, song, myth, story and ceremony, Indigenous Knowledge is not cultural knowledge as such … Nor is Indigenous Knowledge a uniform concept shared in the same way by all Indigenous peoples. It is diverse knowledge held by different people in different ways in their respective societies. It is therefore personal knowledge, and is so much a part of the identity of a person, clan, group or nation that it cannot easily be separated from that sense of identity. For this reason, Indigenous Knowledge must be approached with respect and discussed in its own context according to the appropriate protocols.

(Taken from Research as Cultural Renewal; thunderbird)

xii. Addictions, Self Harm and Suicide Awareness and Prevention

As communities heal from the symptoms and illnesses of cultural disconnect, more First Nations are establishing culture-based intervention programs that, by reconnecting an individual to his/her culture, aim to heal the root cause of many addictions and explore and implement awareness and preventative techniques and methods through Cultural Teachings.

At least half of this population or 22 per cent would not change their belief system or engage in cultural health interventions of a spiritual nature, whether smudging, sweat lodge, prayer, or social cultural activities (e.g., singing or dancing). Despite the implications of the data, it is more common than not that First Nations who want nothing to do with cultural spirituality also do not have issue with environmental cultural influences, such as seeing a sweat lodge on the grounds of the program, knowing cultural activities are being practiced in the community, or sitting in a circle but not smudging, speaking a prayer out loud, engaging in a prayer, or being physically present during cultural activities. Regardless of this disconnect, First Nations people may still participate in culturally based programs, including attending counseling and other therapy, learning life skills, participating in physical recreation, speaking their native language, having both good and bad relationships with Native and non-Native staff alike, as well as being in the bush for various non-spiritual activities such as snaring rabbits, fishing, or going for walks.

Traditional healers place significance on re-establishing a connection with spirit, family, extended family networks, and community. They use ceremonies to connect with ancestors in order to address grief and promote health and spiritual connection, and these ceremonies include family and community in order to promote healthy family and community interaction. This focus on resiliencies helps build a strong foundation prior to addressing unresolved trauma. It should be noted that there are many healers who rely upon faith as much as science in their healing practices.26 Western professionals, by contrast, are primarily concerned with the individual and are focused instead on counseling, case management, behaviour, and function. Their authority is derived from institutions that emphasize theoretical evidence.

The Centre will have options of in-house cooperation and involvement of other organizations:

- ➔ Alcoholics Anonymous (AA)
- ➔ Al-Anon
- ➔ Narcotics Anonymous (NA)
- ➔ National Native Alcohol and Drug Abuse Program (NNADAP)
- ➔ Alberta Alcohol and Drug Abuse Commission (AADAC)

Provision and discussion of factual information on alcohol (alcoholism, problem drinking) and drugs (addiction, drug abuse) through, for example, lectures, film or readings, in order to stimulate behavioural change, awareness and prevention.

xiii. Medicine Wheel

A community is considered healthy when all of the 4 aspects are in balance (ie people/ health, culture,economics and politics).

The use of the Medicine Wheel facilitates balance, thus promoting health, growth, and positive development, and minimizing risk factors that impede balance.

Medicine wheels represent the alignment and continuous interaction of the physical, emotional, mental, and spiritual realities. The circle shape represents the interconnectivity of all aspects of one's being, including the connection with the natural world. Medicine wheels are frequently believed to be the circle of awareness of the individual self; the circle of knowledge that provides the power we each have over our own lives.

xiv. Nutrition

Communities learn how to be self-sufficient and rely on each other in time of need. This activity returns the community to traditional times where each community was responsible for growing, harvesting, and sharing foods and goods.

*Option to refer to our 27 page information guide submitted February 2022 along with additional supporting documents of Program details. We have provided some of the information above that has been copied from websites and approved by Alberta and Canada as Culturally appropriate wellness methods.

OPTIONAL Additional Information in support of our response is offered in a separate email which includes the following:

A. Our response to CAO of Bashaw February 25, 2022

B. Guidebook supporting the Use of Natural Medicines in Culturally-Based Healing Practices for NNADAP/ NYSAP Counsellors

C. Supporting Collaboration of Western and Indigenous Cultural Practices within NNADAP/NYSAP Services

D. A Life Promotion Toolkit by Indigenous Youth

E. What is the Indigneous Medicine Wheel?

F. Recommendations for Delivering eHealth Psychology Interventions to Indigenous Youth

G. Guidebook for NNADAP Services, with a focus on Inclusion of Community, Community Development as a Cultural Practice, and Culture-specific Prevention Strategies

H. Integrated Service Delivery Hubs - Supporting Indigenous-Led Implementation

I. Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada

J. Certification, Honouring our Strengths - Continuum of Care - Workforce Development Series

***** Response to Motion #041-2022 Digital Format - Part 2 of 5*****

2. *Confirm the number of beds to be utilized for overnight guests and their reasons / rationale for the use of the overnight stay.*

A. Maximum capacity for 38 rooms, 50 beds to sleep 96 people

B. An average of 30-40 Clients to sleep at the Centre

C. As this is a Wellness Centre that would operate its Programs for a period of up to 90 days, overnight stays would be considered mandatory and also the rationale for such overnight stays

Please refer to our previously submitted site map, also included on the following page for ease of reference.

EXIT
Staff Room
EXIT
Storage
Meeting 2
Freezer
Fridge
CR
Storage
JR
Storage
BR
Kitchen
Staff Laundry Room
Coffee Area
Dining Room
TV Area
Admin
BR
Fire Place Room
Meeting 1
EXIT
Front Lobby
EXIT
33
34
35
36
37
38
32
31
30
29
28
27
West Furnace Room
26
25
24
23
22
21
20
19
18
17
10
11
12
14
15
16
East Furnace Room
Guest Laundry
1
2
3
4
5
6
7
8
9
WC
1 Double Bed - 2 persons
2 Double Beds - 4 persons
1 Double Bed, 1 Twin Bed - 3
2 Twin Beds - 2 persons
1 King Bed - 2 persons
Public Washroom
Showers

3. *Confirm the age of guests, duration of stay, ratio of guests to supervisors, and type of supervision provided for guests and visitors.*

    a. Infant to elder (0-99)

    b. Duration of stay estimated at 90 days, some Staff may live in facility

    c. Supervision Ratio estimation. As per the appropriate Licensing Authority, there is no legislation or regulation determining a requirement for supervision, nonetheless we offer the following information:

        i. 24 Hour staffing that will be active and awake with a minimum of 2 Staff present ad awake at all times

        ii. Up to 40 Clients with approximately 6 day/evening Staff

        iii. Up to 40 Clients with a minimum of 2 night Staff present and awake at all times

        iv. There will be 3 x full 8 hour shifts in operation to ensure 24 hour coverage

        v. Although Clients do not require supervision, there will be at minimum 1 Staff member for adults and 1 Staff member for Youth/Children at all times. The Centre will be staffed for 24/7 operation and will at minimum have 2 Staff members present and awake at all times with no maximum, however an average of approximately 6 Staff members during days and/or evenings

        vi. Visitors do not require supervision. All visitors will be required to check in at the main entrance as per safety procedures (in case of emergency, evacuation, and such).

4. *Business Plan / Operation Plan.*

Organization Background

Maskwacis Family Wellness Center is a new Organization that is family oriented with a focus on the wellness of the family unit, while incorporating education/prevention and teaching cultural practices to achieve full success. With over 2,500 families in Maskwacis (which include parents, grandparents and siblings) and an average of 5 members per family, the location of the Wellness Centre in Bashaw, AB proves to be a perfect location in close proximity of the four distinct Nations. Over the past eight (8) years, MYSWS has operated in Maskwacis employing approximately fifty (50) trained Staff members, this reflects just how understaffed the Program has been due to limited funding to treat the number of youth and families with recovery needs. The new Centre will be open to over 250,000 First Nations in Alberta. Background to the existing Program, Maskwacis Young Spirit Winds Society (MYSWS) is governed by the four (4) First nations of Maskwacis. Existing since April of 2006, it has operated as a co-ed Program for Youth aged 12 to 17. Maskwacis Cree Chiefs and Council signed a Band Council Resolution (BCR) in

2006 for the operation and management of the Young Spirit Winds Program, with its mandate offering help to Aboriginal youth. The Program receives funding from Health Canada/FNIHB. MYSWS is in central Maskwacis, specifically on Ermineskin Cree Nation Lands, yet serves all four (4) First Nations' Youth. The Program has successfully served 1,000+ youth that are Residents of Maskwacis and in need of awareness and prevention for substance abuse and behaviours. The vision of the Maskwacis Young Spirit Winds Society Board of Directors along with the Maskwacis Cree Nation's Chiefs is to secure sufficient resources for a Centre to operate a Family Wellness Cultural Centre. There is a cry for help by Maskwacis Cree Citizens for the development of such a Centre that will play a significant role in reducing, and eventually eradicating, substance abuse, trauma, and addictions lifestyles, thus breaking the cycle.

Maskwacis Cree Nations were considering declaring a "State of Emergency" because of suicides, self-harm, gang violence and inter-generational dysfunction within families and homes. Although MYSWS has successfully helped youth, there would be far more benefit for the family unit as a whole to receive support. The Maskwacis Family Wellness Centre will follow the Medicine Wheel Teaching and be supported by the four (4) Nations: Ermineskin Cree Nation, Louis Bull Tribe, Samson Cree Nation and Montana Cree Nation and Chief Council Leadership. Existing Programs include: Maskwacis Young Spirit Winds, First Nations and Inuit Health Branch (FNIHB), Alberta Health, Jordan's Principle, Local Town of Bashaw, County of Camrose, the Hub and more.

Total Funding Request and Term of Project

A License application is in progress through the Mental Health Services Protection Act (MHPSA). We will be in search of funding for ten (10) youth beds from Alberta Health, twenty (20) family beds from FNIHB and seven (7) youth recovery beds, and capital funding from Jordan's Principle.

Project Description

Our Project at Maskwacis (Bear Hills) Family Wellness Centre will address issues of Indigenous People of all ages through training and education by various methods. Systemic issues cross cultural issues and roadblocks such as trauma from residential schools, mental wellness, cultural identity and addiction prevention will be addressed through the following:

- Cree language revival
- Spiritual Teachings
- Family Planning and relationship building/rebuilding
- Teachings
    - Elder
    - Cultural
    - Medicine wheel
    - Matrix
    - Goal setting
    - Teepee
    - Sweat lodge
    - Wellness plan
    - School work
    - Addictions awareness and prevention
        - NNADAP
        - AA
        - Al-Anon

        - NA
        - AADAC
    - Nutrition
    - Life skills
    - Hygiene
    - Budget planning
    - Life stages
    - Cooking
    - Self harm and suicide awareness and prevention
    - Anger management
    - Truthfulness
    - Counseling
        - Child
        - Youth
        - Individual
        - Group
        - Marriage
        - Couple
        - Family
    - Personal development
    - Relationship building
    - Medicinal
        - Herbs
        - Plants
        - Medicines
        - Animals

This Centre will become a hub for all First Nations in Alberta with its primary and initial focus being the four (4) distinct Nations of Maskwacis. Mental Health/Wellness and Addiction can partially be attributed to generational trauma, lack of identity and limited access to Cultural Teachings. We will reintroduce Cultural Teachings, awareness and knowledge to families who are seeking help. Families, youth, and individuals will reconnect with their identities and Indigenous roots using existing methods which have been proven, combined with Indigenous beliefs and practices. A holistic approach provides a larger support network and will be the unique aspect of this Program. Healing broken family relationships, renewing friendships and Cultural grounding will become the backbone to prevention and decreasing likelihood of potential relapse.

The Maskwacis Community is widespread, approximately 30 km by 40 km, which includes the Ermineskin Cree Nation, Louis Bull Tribe, Samson Cree Nation and Montana Cree Nation. The total population of the four (4) Nations is approximately 16,000 Members. The Family Wellness Centre will serve the Maskwacis Community and will be open to other First Nations within the Province of Alberta.

Some project activities will include:

- Cultural land-based camps (retreats)
- Core value teachings will be incorporated into the curriculum, they are as follows:

- Respect
- Empathy
- Honour
- Genuineness
- Understanding
- Honesty
- Compassion
- Love
- Kinship
- Acceptance
- Responsibility
- Patience
- Independence
- Sharing
- Reciprocity

This Centre will positively impact Albertans as it will encourage interaction between Indigenous and Non-Indigenous People which will also then resolve misperceptions between both groups of People. It will become evident that healing has begun and a ripple effect will be felt by all Albertans.

Our Organization is best suited because we will be the connection between Cultural Practices and Teachings of the First Nations, while using the support system offered by Alberta Health, First Nations and Inuit Health Branch, and Jordan's Principle. All resources will be based out of our Centre to have the largest impact on the First Nations of Alberta. We are the missing link. We will have the support and knowledge of Maskwacis Young Spirit Winds Society to back us up.

Knowledge and Evidence-base, Cultural Knowledge

As referenced in the "Statement by International Chief Wilton Littlechild, Samson Cree Nation" presented to the United Nations Permanent Forum on Indigenous Issues, found on following pages of this document, we offer in his own words below some statements which reflect the need and approach we intend to take:

- .."For many years, the issue of suicide has been a primary concern of the Maskwacis Cree Nation"..
- .."There is evidence available that cultural, spiritual and linguistic revitalization, that the provision of healthy, positive lifestyle choices be it arts, sports, recreation and leisure activities, all contribute to prevention. They provide youth an opportunity to choose life."..
- .."Unfortunately, the persistent and ongoing obstacles are the lack of political will to dedicate, adequate ongoing financial and human resources to prevention."..
- .. "As already mentioned this morning, "culture and treatment" is a good practice. Teaching relevant cultural practices and associated spiritual teachings in schools (Kindergarten to Grade 12) and in the home is critical."..

We ask that you read through the entire document referenced above as there is pertinent information that applies to the desperate need for this Family Wellness Centre and it has been long overdue. This Maskwacis (Bear Hills) Family Wellness Centre would bring resolution to

emergency issues which include suicide, self-harm and addictions within the Indigenous communities. The well-being of all age groups would be addressed and the revitalization of the Indigenous Cultural teachings and language would be crucial in offering resolution to these desperate lifestyle situations.

We are not reinventing an approach but are innovative with respect to how it will be offered and received. Our focus will be Cultural Teachings and the family unit. A Centre located on unceded land is innovative and creates an atmosphere of both unity with our local communities, and a change of environment for our Indigenous families to experience the full benefit of what the Centre has to offer all involved.

There is a cry for help by Maskwacis Cree Citizens for the development of such a center that will assist in reducing and eventually eradicating substance abuse, trauma, and addictions lifestyles, thus, breaking the cycle. Maskwacis Cree Nations were considering calling a 'state of emergency' caused by a serious situation including suicides, self-harm, gang violence and inter-generational dysfunction of families and homes. Although MYSWS has been successfully helping youth, there would be a much greater benefit for the entire family to receive help. Our focus will be Cultural Teachings which are part of our nature, our lifestyle, and commitment to ensuring everyone has the opportunity to benefit from such a strong, cultural base. The only innovation with respect to our Program is the fact that it will be offered to a family unit in a safe and stable environment.

The recovery-orientated approach we intend to offer, implement, and use at our Centre could include, but not limited to:

- Cultural Teachings
- Smudging
- Pipe Ceremonies
- Teepee Teachings
- Sweat Lodges
- Medicine Wheel Teachings
- Elder Storytelling and Ceremony
- Medicine Teachings
- Various Cultural Events

Project Activities and Timelines / average 90 Day Stays to Include
Below is an example of a schedule:

MONDAY
AM
7:00 - 8:00 Breakfast
8:00 - 8:30 Clean up
8:30 - 9:00 Smudge
9:00 - 10:00 Sharing circle
10:00 - 10:15 Break
10:15 - 11:45 Teaching
11:45 - 12:00 Break

PM

12:00 - 1:00	Lunch
1:00 - 1:30	Clean up
1:30 - 3:00	Physical activity
3:00 - 4:30	Teaching
4:30 - 5:00	Break
5:00 - 6:00	Dinner
6:00 - 6:30	Clean up
6:30 - 8:00	Activity

TUESDAY

AM

7:00 - 8:00	Breakfast
8:00 - 8:30	Clean up
8:30 - 9:00	Smudge
9:00 - 10:00	Sharing circle
10:00 - 10:15	Break
10:15 - 11:45	Teaching
11:45 - 12:00	Break

PM

12:00 - 1:00	Lunch
1:00 - 1:30	Clean up
1:30 - 3:00	Physical activity
3:00 - 4:30	Teaching
4:30 - 5:00	Break
5:00 - 6:00	Dinner
6:00 - 6:30	Clean up
6:30 - 8:00	Activity

WEDNESDAY

AM

7:00 - 8:00	Breakfast
8:00 - 8:30	Clean up
8:30 - 9:00	Smudge
9:00 - 10:00	Sharing circle
10:00 - 10:15	Break
10:15 - 11:45	Teaching
11:45 - 12:00	Break

PM

12:00 - 1:00	Lunch
1:00 - 1:30	Clean up
1:30 - 8:00	Flex afternoon (Doctor's appointments, haircuts, massages, acupuncture, shopping, etc)
3:00 - 4:30	Flex
4:30 - 5:00	Flex
5:00 - 6:00	Dinner

6:00 - 6:30 Clean up
6:30 - 8:00 Flex

THURSDAY
AM
7:00 - 8:00 Breakfast
8:00 - 8:30 Clean up
8:30 - 9:00 Smudge
9:00 - 10:00 Sharing circle
10:00 - 10:15 Break
10:15 - 11:45 Teaching
11:45 - 12:00 Break

PM
12:00 - 1:00 Lunch
1:00 - 1:30 Clean up
1:30 - 3:00 Physical activity
3:00 - 4:30 Teaching
4:30 - 5:00 Break
5:00 - 6:00 Dinner
6:00 - 6:30 Clean up
6:30 - 8:00 Activity

FRIDAY
AM
7:00 - 8:00 Breakfast
8:00 - 8:30 Clean up
8:30 - 9:00 Smudge
9:00 - 10:00 Sharing circle
10:00 - 10:15 Break
10:15 - 11:45 Teaching
11:45 - 12:00 Break

PM
12:00 - 1:00 Lunch
1:00 - 1:30 Clean up
1:30 - 3:00 Physical activity
3:00 - 4:30 Teaching
4:30 - 5:00 Break
5:00 - 6:00 Dinner
6:00 - 6:30 Clean up
6:30 - 8:00 Activity

SATURDAY
An assortment of options scheduled monthly with some being open to the community of Bashaw:

- Cultural day / overnight trips
- Pancake breakfast

- Community fire pit
- Teepee teaching
- Residential school awareness
- Cultural teachings
- Counseling services
- Celebrations

SUNDAY

Day of rest with options for Clients to:

- Go home and spend the day
- Travel to Red Deer movie theater etc

LEGEND for above schedule

- Activities (and Recreation Therapy)
  Something that is fun, active and rejuvenates a person. Something that is good for a person: has healing qualities, restores an individual to what he or she was before or what the individual wants to be.
    - Arena
    - Singing
    - Dancing
    - Walking trail
    - Garden games
    - Lake visits
    - Local gym
    - Berry picking
    - Arts and crafts
    - Knitting
    - Beading
    - Movie night
    - Camp fire
- Teaching
    - Cultural
    - Medicine wheel
    - Matrix
    - Goal setting
    - Wellness plan
    - School work
    - Addictions awareness and prevention
        - NNADAP
        - AA
        - Al-Anon
        - NA
        - AADAC
    - Nutrition
    - Life skills
    - Hygiene
    - Budget planning

- Life stages
- Cooking
- Self harm and suicide awareness and prevention
- Anger management
- Truthfulness
- Counseling
    - Child
    - Youth
    - Individual
    - Group
    - Marriage
    - Couple
    - Family
- Personal development
- Relationship building
- Medicinal
    - Herbs
    - Plants
    - Medicines
    - Animals

Evaluation Plan

We will conduct Internal Evaluations using a combination of Elders, Leadership (Board of Directors), Facilitators and Counselors. We will also conduct an Exit Interview with the whole family for feedback and learning tools. After each Exit Interview, the Staff will speak with the Program Director and implement immediate changes (monkey surveys will also be provided to collect data on the user experience).

This Program will be very fluid and because each family will have different needs, we will quickly adapt the individual family needs to meet the recovery-oriented needs. There will be a 1 week and a 2 week follow up call as well as a one month, weekend invitation to connect. It's important to note the Program will have a base foundation with an Entry Interview outlining the entire family's needs.

Key Measures

OUTCOME

Identify the expected changes (e.g., changes in knowledge and skills, level of functioning, behaviours) as a result of the project activities.

INDICATOR

For each outcome, identify the indicator(s) that will demonstrate whether the goals or objectives of your project have been achieved (e.g. # of individuals served, # and % of individuals whose wellness improved, # of professionals trained).

DATA COLLECTION METHOD

For the indicator(s), identify how the data will be collected including who data will be collected from. Data collection methods could include client surveys, interviews, focus groups, clinical assessment tools, summaries of records/documents.

OUTCOME
Family Support
INDICATOR
Over 100 people per year with improved relationships and communication
DATA COLLECTION METHOD
Proof they have connected to all programs offered provincially and federally

OUTCOME
Cultural Insights and Growth
INDICATOR
More than 1000 people impacted per year directly or indirectly
DATA COLLECTION METHOD
Monkey surveys

OUTCOME
Stable Family Relationships
INDICATOR
Recorded decrease in broken relationships with 60-70% success
DATA COLLECTION METHOD
Conduct entry and exit interviews

OUTCOME
Healing/Positive Outcomes
INDICATOR
High participation and involvement with 95% success
DATA COLLECTION METHOD
Recorded stories and testimonies

OUTCOME
Sense of Belonging
INDICATOR
High success rate expected
DATA COLLECTION METHOD
Surveys, interviews and updates

Risk Management

Specific Risk/Assumption
Qualified Staff Members

Mitigation Plan
Aggressive hiring campaign and support from YSWS

Specific Risk/Assumption
Racism

Mitigation Plan
On average monthly Open House, community teaching, community involvement, interaction with the community, Cultural Teachings shared online and in person

Specific Risk/Assumption
Stigma

Mitigation Plan
At times weekly, most often monthly, inclusion of the community to attend certain programs to better understand and prevent addictions, mental wellness and community. We will work on promotional media to share within the local community and reach out to all Albertans online.

Partnership and Community Collaborations

Maskwacis Health Services
- Doctor's office
- Diabetes
- Nutrition
- Health
- Wellness
- Community health

Maskwacis Education Schools Commission (MESC)
- Education requirements

Maskwacis HUB meetings: Ermineskin, Samson, Louis Bull and Montana
- Mentorship
- Guidance
- Evaluation process

Maskwacis Mental Health Services
- Mental health needs

Maskwacis Mobile Mental Health Services
- Mental health needs

Youth Needs and Support
- Youth needs

NNADAP (National Native Alcohol and Drug Abuse Program)
- Addiction issues for First Nations' People

Alcoholics Anonymous
- Addresses Addiction concerns, brings awareness and prevention

Narcotics Anonymous
- Addresses Addiction concerns, brings awareness and prevention

AADAC
- Addresses Addiction issues in family members of those with addictions

Dr. Tony Mucciarone

- Bashaw community Doctor if needed and available

This Program will target all Indigenous in Alberta with a primary focus on the four (4) Nations of Maskwacis. There will be a major program expansion currently being offered to the almost 16,000 First Nations in Maskwacis.

To date we have reached out to the Community and Town of Bashaw by way of the following:

- Mail out to every resident of the Town of Bashaw, Alberta
  September 22, 2021
- First public Open House at the facility
  September 11, 2021
- Second public Open House at the facility
  September 29, 2021
  With Facebook Live
  Facebook Live posted on Public sites
- Third public Open House at the facility
  October 12, 2021
  With Facebook Live
  Facebook Live posted on Public sites
- Business Community Consultation and Outreach
  October through November 2021
- Public Facebook Page opened
  Started October 13, 2021 and ongoing
  Information and sharing
  Posts and active conversations
  Bashaw Community Facebook Page
  Posts and active conversations
  Active involvement and presence
- Door to Door in person visit to Bashaw
  November 22, 2021
  Brochures and Survey drop off
  Gift drop off

We've made direct contact with 800+ residents of Bashaw on two specific occasions, direct mail and door to door.

LETTERS OF SUPPORT FOR THE CENTRE

- STATEMENT BY INTERNATIONAL CHIEF WILTON LITTLECHILD AT THE "UN SPECIAL ASSEMBLY OF TREATY CHIEFS MOTION"
- SAMSON CREE NATION COUNCIL RESOLUTION
- SUPPORT LETTER FROM DR. TONY MUCCIARONE

SUSTAINABILITY and REPLICATION

This project requires ongoing financial support. The long-term benefits are too important to have it be abandoned. Mental Health has suffered, especially since COVID, and the ongoing need to receive funding is crucial to the maintenance and quality of this program. Although we haven't reinvented the practices to be used, we are taking and combining existing Teachings and

Programs into a usable system for a higher outcome and success for Indigenous Families. Our proprietary system and procedures will be made available and a great system and model for future Centers.

The Centre will be unique in that it will be operating on unceded land, not on Treaty Nation land. The Centre in its entirety is unique and will prove to demonstrate a substantial increase in the well-being of the entire family unit and in turn, the Maskwacis community. We will provide support for all ages and will always have an Elder on site to guide, teach and nurture the family unit. With access to the various in-house resources and a direct interaction with a community of Non-Indigenous People, this Centre will prove to have a successful transition not only back into their own community, but build a long-lasting relationship within other communities in surrounding areas. Interaction with the people and businesses of Bashaw, the Maskwacis People will enhance their overall well-being and break existing racial tensions or misperceptions. By breaking these barriers we are confident there will be a ripple effect that reaches far and wide, to Indigenous and Non-Indigenous people. This Centre also collaborates with the Federal and Provincial Government as well as Jordan's Principle.

There will be an aggressive plan to go after Corporate Sponsors to grow this facility and expand on capital projects.

BUDGET and RESOURCE ALLOCATIONS

STAFF - First Aid Certified; Criminal Record Checks and Intervention Record Checks

Director
40 Hours/Week
Estimated Salary $90,000/year

Administrative Assistant
40 Hours/Week
Estimated Salary $45,000/year

Evening Team Lead
40 Hours/Week
Estimated Salary $50,000/year

Night Team Lead
40 Hours/Week
Estimated Salary $50,000/year

Weekend Team Lead
40 Hours/Week
Estimated Salary $50,000/year

Finance Controller
40 Hours/Week
Estimated Salary $70,000/year

Teacher
40 Hours/Week
Estimated Salary $70,000/year

Youth Care Worker x 4
40(x4) Hours/Week (160 Hrs Total Combined)
Estimated Salary $160,000/year

Casual Workers x 5
40(x4) Hours/Week (200 Hrs Total Combined)
Estimated Salary $100,000/year

Family Counselor x 3
40(x3) Hours/Week (120 Hrs Total Combined)
Estimated Salary $150,000/year

Custodian
40 Hours/Week
Estimated Salary $30,000/year

Cook
40 Hours/Week
Estimated Salary $35,000/year

Assistant Cook
40 Hours/Week
Estimated Salary $30,000/year

Cook/Baker x 2
32 Hours/Week
Estimated Salary $30,000/year

Maintenance Person
20 Hours/Week
Estimated Salary $20,000/year

Laundry/Housekeeping
24 Hours/Week
Estimated Salary $20,000/year

OTHER CONTRIBUTIONS

Jordan's Principle
FNIHB (First Nations and Inuit Health Branch)
Alberta Mental Health

COMMUNICATIONS

We acknowledge that substance abuse prevention is a growing need and for this reason, our services will be layered, customized and flexible. We will have a variety of in-house programs to include individual and group counseling, cognitive behavioral therapy, holistic methods, and aftercare support. Throughout the Program, the Cree Culture and Ceremonies component is also integrated and available for Clients that choose to participate.

There will always be an Elder available for Cultural Teachings, counseling, Storytelling and Ceremony. The Program will be developed as needed and required for each family or individual as there is not one cookie-cutter Program that will fit all clients' needs.

Over the years, MYSWS has been focusing on the healing aspect for Clients by using the Medicine Wheel. Each component is addressed throughout the Program.

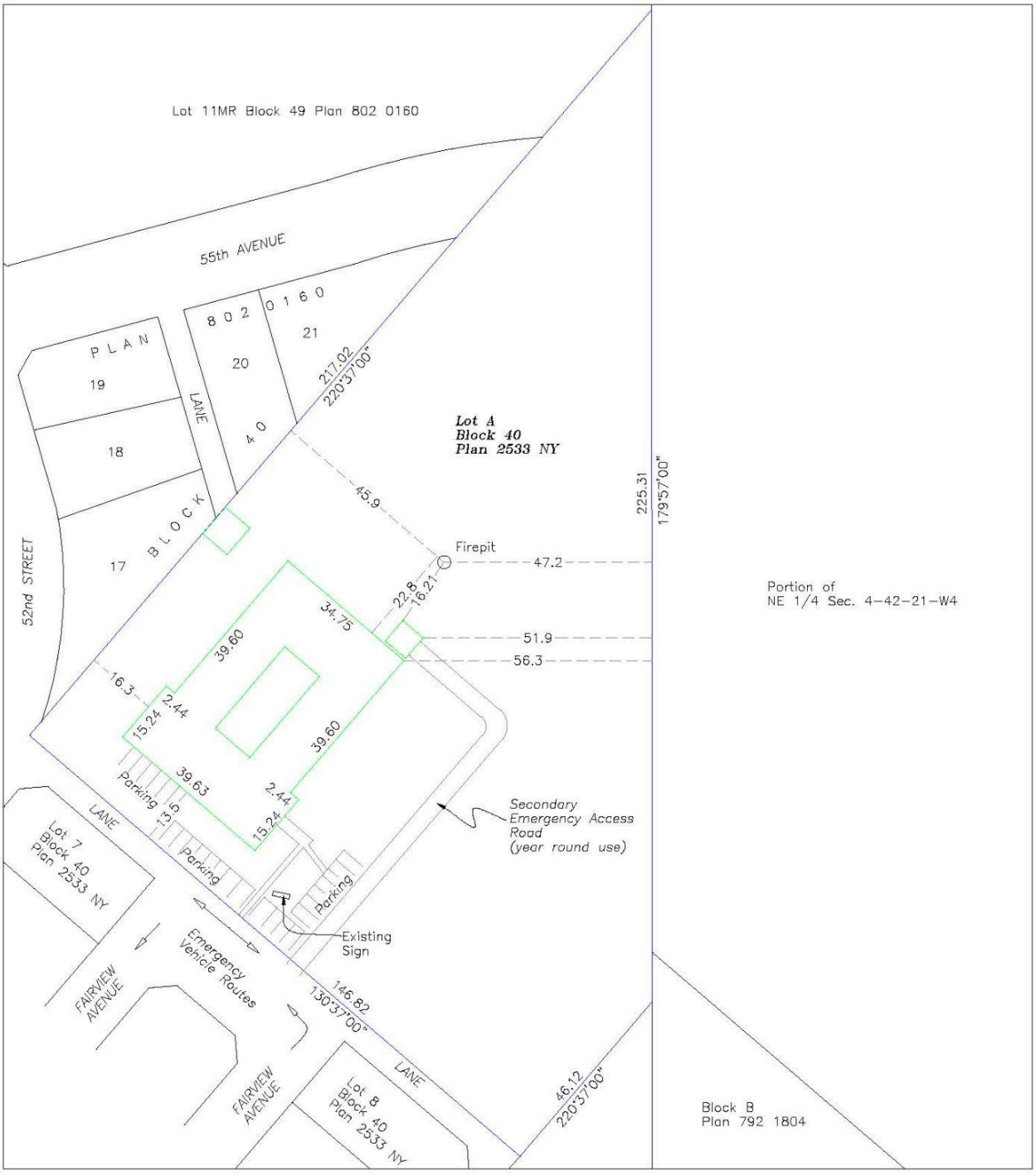
Yearly (or other regular interval) events or activities.

We have hosted three (3) separate Open House events in Bashaw, AB. We have reached out to the business and residential community of Bashaw, AB and spoken with citizens to inform them of our mission. The community of Bashaw has been receptive and supportive. We have created a Facebook page and begun interaction with the community online. Our continued efforts will include a continuation of both online and in person interaction to ensure open communication between Maskwacis and Bashaw continues to be built stronger.

OPTION to reference additional information in support which includes our 27 page information guide submitted February 25, 2022 (copy can be easily reviewed in the Optional attachment in section 1), along with additional supporting documents of Program details.

5. Building Access Plan.

Please review the Drawing on the following page. We have provided a plan showing Emergency vehicle routes and building access.



BUILDING ACCESS PLAN

Sketch
showing
Site Plan
within
Lot A Block 40 Plan 2533 NY
5430 - 51A Street Bashaw, AB

Scale 1:1250
Date 10 February, 2022

6. On-site Safety Plan.

Please review the drawing that follows the below information.

Client Safety

- Security cameras placed at each access point
- Security/motion sensor lights placed at each access point
- Security cameras placed throughout the walking paths and yard area
- Security/motion sensor lights placed throughout the walking paths and yard area

Congregate Space Configuration

- Desks and tables arranged to maximize space between staff/students if applicable
- If weather permits and without impact on internal systems, staff to be advised to open windows
- Staff will incorporate group activities that encourage greater space between people, minimize physical contact
- Congregate spaces will be decluttered and unnecessary furniture removed to create space
- Cleaning and disinfection at regular intervals and as needed
- Staff and support staff have been provided with disinfection solution and have been trained on its safe use
- All surfaces must be cleaned once a day, with high-touch items being cleaned twice daily
- Disinfectant and microfiber cloths to be placed in each room
- Ventilation and air exchange with air purifier to kill airborne illnesses
- Floor plans with exits and entrances marked available
- Daily Health Checks
- Staff, Clients and Visitors will be required to declare if they are unwell
- Staff are reminded to wash their hands upon arriving at the building
- Strategically located posters remind all of appropriate hand washing and safe practices

The Centre's Fire and Safety Plan will include:

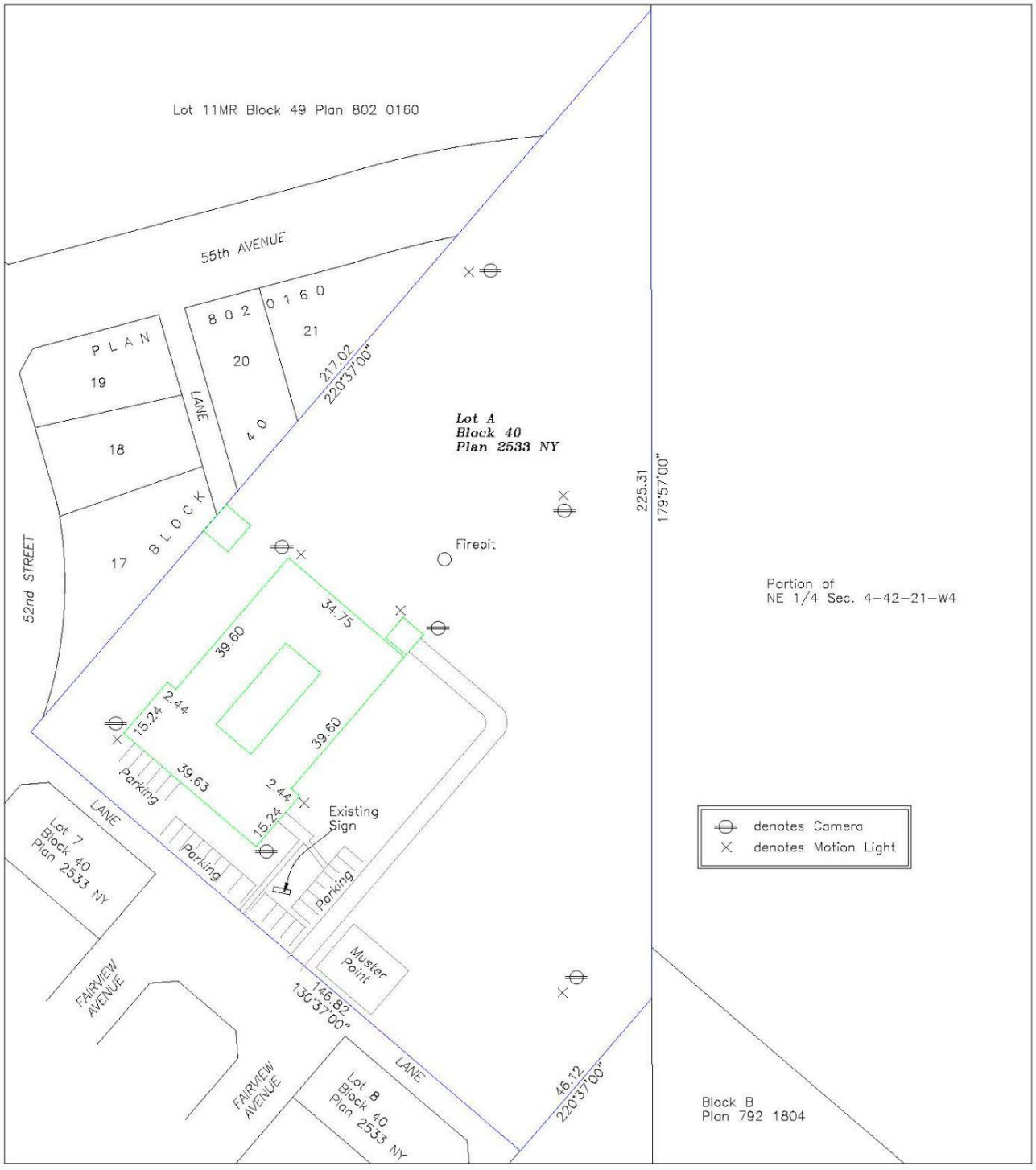
- Emergency procedures to be used in case of fire will be provided at Centre's opening and will include how to:
    - sound the alarm
    - notify the fire department
    - building or business officials, or other designated staff as specified in the plan (i.e. all telephones on site should have the emergency phone numbers listed and the address of the property posted close by)
    - how to evacuate occupants (e.g., procedures occupants should follow when the fire alarm sounds)
    - evacuate persons who may need assistance, and confine, control, and extinguish the fire where possible
    - how, and how often fire drills will be conducted
    - organization, education, and training for staff with fire safety duties
    - information and actions to take to prevent or control fire hazards for that building or business, where appropriate
    - other staff education and training that may be necessary
    - maintenance procedures for fire protection systems

- Emergency procedures will also include:
    - A site map (see example) marking Muster Point, all exits and emergency road access points
    - Telephone numbers of all emergency response resources
    - On site management telephone numbers

Upon approval from the Town Council and prior to active operation, we will create and include the Centre's site-specific Safety Plan to be included with our Licensing and Permit packages. We as the Applicant understand the need for such Plans but can not create a site specific safety plan without the approval from the Town and in turn, the appropriate set up of the building for its intended use (for example, the location and placement of laptops for learning activities, their proper and safe storage and in turn, the Client's use of said equipment and their proximity to an emergency access point, will all be crucial to ensure proper safety planning and realistic safety measures).

Once we receive Council's approval and we are in the position to prepare for the operation of this Centre, we will submit the On-Site Safety Plan with full compliance to the Town of Bashaw.

Please see the following drawing.



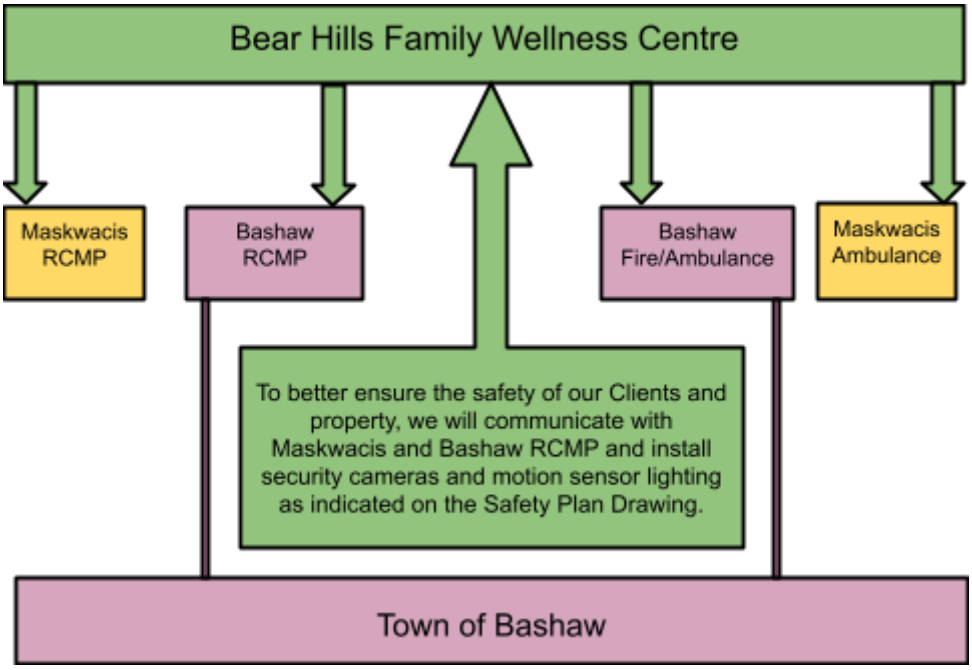
ON-SITE SAFETY PLAN

Sketch
showing
Site Plan
within
Lot A Block 40 Plan 2533 NY
5430 - 51A Street Bashaw, AB

Scale 1:1250
Date 10 February, 2022

7. Off-site Safety Plan.

We will utilize and implement security measures to protect our Clients and property by way of security cameras, motion sensor lighting and open lines of communication between the Centre and the RCMP in both Bashaw and Maskwacis. We will be committed to our Community offered events and/or Programs which would assist to educate, inform and acknowledge preconceived misjudgments or misunderstandings that have evolved through time in relation to stigma, racism and segregation. Our efforts will continue to build better relations with all communities and people. Building bridges between Indigenous and non-Indigenous people will be a benefit to Albertans and not reserved solely for Clients of the Centre.



We will adopt the 'Emergency Preparedness Plan' the Town of Bashaw uses as seen on the Town's website.

OPTIONAL Additional Information in support of our response is offered in a separate email which includes the following:

1. March 24, 2022 CTV News Article - Repeat offender arrested in Bashaw as police seize loaded gun, ammunition
    a. Police identify repeat offender with gun and ammunition seizures and arrests within a block from our property

2. What to do before an emergency
    a. Overview
    b. Be prepared
    c. Community
    d. Financial preparedness

e. The role of your local government
f. The role of the provincial government
g. The role of the federal government
h. We are all in this together
i. A 2019 list of partners of the NGO (Not-for-profit Organizations) Council of Alberta

3. What to do during an emergency
    a. Overview
    b. Protect yourself
    c. Shelter-in-place
    d. Community
    e. Stay informed
    f. Evacuation alerts and orders
    g. Protect your pets (not applicable to the Centre but informative nonetheless)
    h. If there is time…
    i. The role of your local government
    j. The role of the provincial government
    k. We are all in this together
    l. A 2019 list of partners of the NGO (Not-for-profit Organizations) Council of Alberta
    m. Financial preparedness

4. What to do after an emergency
    a. Overview
    b. Recovery is a process
    c. Community
    d. Re-entry
    e. Your mental health
    f. Financial preparedness
    g. Helpful resources
    h. The role of your local government
    i. The role of the provincial government
    j. We are all in this together
    k. A 2019 list of partners of the NGO (Not-for-profit Organizations) Council of Alberta

5. Evacuation - What you need to know
    a. Evacuation alerts
    b. Evacuation orders

6. Shelter-in-place
    a. At home
    b. Driving
    c. At work

7. Helping children during emergencies
    a. Overview
    b. Helping kids cope
    c. Using 9-1-1

    d. Resources

8. Power and water outages
    a. Overview
    b. Before an outage
    c. Financial preparedness
    d. During an outage
    e. Outage troubleshooting
    f. Know when to go
    g. Outage survival tips
    h. After an outage
    i. Safety tips
    j. How to prevent further damage

9. Severe weather
    a. Overview
    b. Before a storm
    c. Financial preparedness
    d. Evacuation alerts and orders
    e. During a storm
    f. Community
    g. After a storm

10. Thunderstorms, lightning, and hail
    a. Overview
    b. Be prepared
    c. Heavy rain
        i. Heavy rain facts
        ii. Heavy rain survival tips
    d. Thunderstorms
        i. Thunderstorm facts
        ii. Thunderstorm survival tips
    e. Lightning
        i. Lightning facts
        ii. Lightning survival tips
    f. Hail
        i. Hail facts
        ii. Hail survival tips
    g. Financial preparedness

11. Blizzards, freezing rain, and ice storms
    a. Overview
    b. Be prepared
    c. Blizzards and blowing snow
        i. Blizzard facts
        ii. Blizzard survival tips
    d. Freezing rain and ice storms

i. Freezing rain
ii. Freezing rain and ice storm facts
iii. Freezing rain and ice storm survival tips

e. Extreme cold
i. Extreme cold facts
ii. Extreme cold survival tips

f. Financial preparedness

12. Tornadoes and extreme winds
a. Overview
b. Winds
i. Wind facts
ii. Wind survival tips
c. Tornadoes
i. Tornado facts
ii. Tornado survival tips
d. Financial preparedness

13. Wildfires
a. Before a wildfire
i. How to prepare
ii. Protect your property and belongings
iii. Safeguard pets and livestock (not applicable to the Centre but informative nonetheless)
iv. Financial preparedness
v. Community
vi. During a wildfire
vii. Safety first
viii. Evacuation alerts and orders
ix. After a wildfire
x. Prevent fires from restarting

14. Flood preparedness
a. Overview
b. Flood facts
c. Financial preparedness
d. Before the flood
e. How to prepare
f. Protect you home and belongings
g. Safeguard pets and livestock (not applicable to the Centre but informative nonetheless)
h. During a flood
i. Prepare to leave
ii. Protect your home and belongings
iii. Safeguard pets and livestock (not applicable to the Centre but informative nonetheless)

i. Evacuation alerts and orders
    i. Evacuation alerts
    ii. Evacuation survival tips

15. What to do after a flood
    a. Overview
    b. Re-entry
    c. Clean-up
        i. Mold
        ii. Supplies
    d. Water usage
    e. Property assessment
        i. Heating and appliances
        ii. Food and medicine
    f. Financial preparedness
    g. Recovery assistance

16. Government of Alberta emergency preparedness toolkit for seniors

17. Resources for your Community

18. Dispelling Common Myths about Indigenous Peoples; 9 Myths and Realities

19. 8 First Nation reserve FAQs

20. Emergency-Preparedness-Brochure

21. Alberta Private Sector disaster guidelines

22. Emergency Preparedness week toolkit

23. Winter Hazards

*****Response to Motion #041-2022 Digital Format - Part 3 of 5*****

8. Capacity of existing medical infrastructure in the Town of Bashaw.

Deemed non-existent by way of the following:

a. We have reached out to the following Alberta Health Service authorities and contacts and no one has been able to confirm or provide information to allow us to provide a quantified response to this request Council has posed.

According to the list of contacts below, Bashaw has no current Alberta Health Services infrastructure, leaving the capacity at zero. We welcome any information the Council may have access to if the below resources we have reached out to are not the appropriate contacts:

i. Email request to 'info@ahs.ca' on March 16, 2022 requesting capacity with no response.

ii. Telephone request to Bashaw Community Health Centre, they did not have an answer and stated they were not Alberta Health Services nor did they know of any Alberta Health Services within the Town of Bashaw. They confirmed they were not Alberta Health Services.
    1. #780-372-3731 - Spoke to reception and she offered the Manager's contact name and number
    2. #780-608-5499 - Tamara, Manager
        a. Confirmed there is no Alberta Health Services in Bashaw, Alberta
        b. Their focus is home care

iii. Telephone request to Bashaw Medical Clinic, they did not have an answer and stated they were not considered to be part of Alberta Health Services nor did they know of any infrastructure Alberta Health Services has within Bashaw.
    1. #780-372-3740 - Spoke with reception and she confirmed they were not considered an Alberta Health Services building nor were they considered Alberta Health Services

iv. Telephone request to Alberta Health Services headquarters, they did not have an answer and stated they felt the question was odd, leaving us with the answer that there is no such infrastructure in Bashaw.
    1. #780-422-2700 - Spoke with Agent/operator who had no knowledge of infrastructure in Bashaw, Alberta and suggested I reply to Council with confirmation that all Albertans are able to use Hospitals, Clinics and use 9-1-1 in cases of emergency. She also recommended I offer #8-1-1 for anyone choosing to speak with a registered nurse or seek advice with health concerns and this too was open to all Albertans

v. Telephone and email request to Alberta Health Advocates, their response confirmed they reached out to several areas with no answer for this question. They are unaware of the said 'capacity of existing medical infrastructure in the Town of Bashaw'.
    1. ryan.bielby@albertahealthadvocates.ca - Ryan Bielby replied via email after he reached out to several contacts with no ability to confirm anything other than there is no infrastructure or capacity

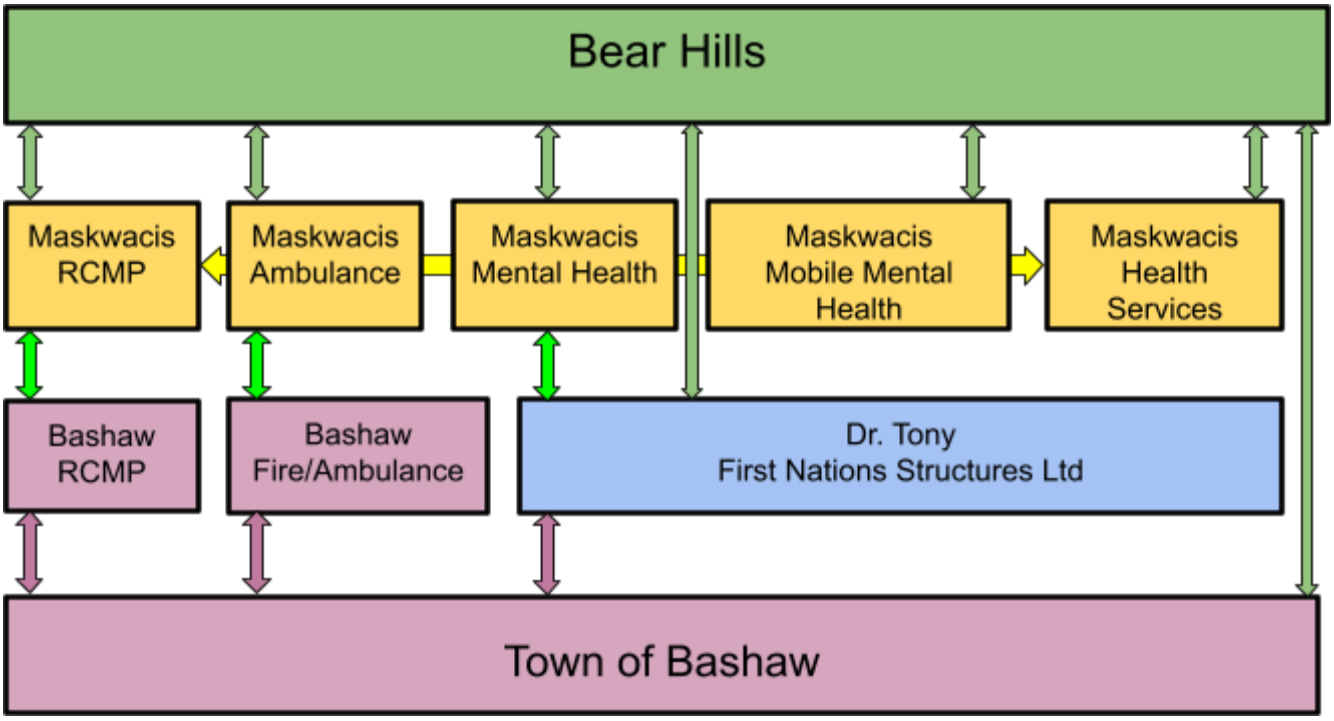
vi. Telephone request to Camrose County Alberta Health Services, they did not have an understanding of the question nor an answer for us and stated they were not aware of any infrastructure or suggested capacity in the Town of Bashaw. They offered me two further numbers:

1. #780-608-8602 - Spoke with Debbie on 2 separate occasions to seek a response for this question; she was unaware of any infrastructure in Bashaw. She offered additional contact information:
    - #403-356-6430 - On-call Medical Officer for the County, we left a voicemail requesting information regarding the infrastructure and capacity in Bashaw, on March 18th with no response
    - #403-356-6414 - County Nurse, we left a voicemail requesting information regarding the infrastructure and capacity in Bashaw, on March 22nd with no response

vii. Telephone request to a Director with Alberta Mental Health, she did not have any understanding of the question asked of us by Council and recommended we confirm with the Town Council that the intended Clients and Staff are no different than any other citizens of Alberta coming to, staying in or visiting Bashaw. She also recommended that we remind Council that the Clients of the Centre should not be assumed 'ill' or in need of medical attention nor should they be singled out because they will be attending a Culturally oriented wellness program.
    1. #***-***-**** - As we are in direct contact with Mental Health Directors and Licensing Authorities due to the process we began in 2021 and had to put on hold while going through the process set out by the Town of Bashaw, we have confidential phone numbers which we do not feel should be provided in this response. Should Council require direct access to the Director, we ask Council to request this of us formally and we will forward it to the appropriate people for review

viii. Ultimately, there is one Bashaw Community Health Centre and one Bashaw Medical clinic. As a result we will be working with Maskwacis, Camrose, Ponoka and Red Deer regions.

Please see the following page to view a chart which provides an overview of the process the Centre intends to implement for any health or mental health related needs and/or concerns that may arise during a Client's program. Please note that as we had opened the lines of communication with the Bashaw RCMP, we have been unable to fully establish a direct system or discuss a protocol/procedure to be in place until we receive Council's approval and licensing to be operational. We will revisit our communications with the Bashaw RCMP when the time comes and determine if the following chart will be revised to have a direct connection between the Centre and the Bashaw RCMP, or alternatively, if it is decided to have it remain as is.



We hope this satisfies the Council's request.

In consideration of what we found through the process of answering Council's request, the results brought awareness to us that Bashaw is not set up to fully support its residents, so we offer some additional information that may benefit the community of Bashaw. Some links and telephone numbers that are available are provided in the following pages and may aid in the apparent absence of a health services infrastructure. In our search to provide information to Council and upon reaching out to government and service providers, along with our first hand experience when we began the community consultations in 2021 and continue into the present day, we recommend that Council consider programs within the Bashaw community like AA, Al-Anon and NA. We do this out of respect and hope this is well received . All regions throughout Alberta benefit from such Programs, and it has been recognized that every community should have access to the availability of addictions support, awareness and/or prevention.

The proposed Bear Hills Family Wellness Centre is to provide Culturally based wellness programs to First Nations' families. As per recommendations from both Alberta Health Services and Alberta Mental Health Services, we have provided some informational material as reference in addition to printed material to provide resource information related to the Centre as an OPTION to be reviewed in a separate email.

OPTIONAL Additional Information in support of our response is offered in a separate email which includes the following:

1. Indigenous Peoples and Communities in Alberta, Alberta Health Services

2. 8-1-1 Information

3. Central Zone Stats
4. Alberta Health Services - Wisdom Council
5. Myhealth.Alberta.ca
6. About Alberta Health Services
7. Maskwacis RCMP
8. Bashaw RCMP
9. Maskwacis Health Services
10. Maskwacis Mobile Mental Health Services
11. Town of Bashaw website List of Health services
12. ABORIGINAL MENTAL HEALTH: A FRAMEWORK FOR ALBERTA
13. Mental Health Stigma
14. Reducing Stigma
15. Opening Minds - Report
16. What stigma looks like
17. Addressing Stigma - Canada
18. Alberta Health Services Zone Map
19. EMS in the Central Zone
20. Have a voice

*****Response to Motion #041-2022 Digital Format - Part 4 of 5*****

9. *Confirmation of providers and governance structure for health care related services and childcare related services.*

Providers are as follows:

a. Respected Elders

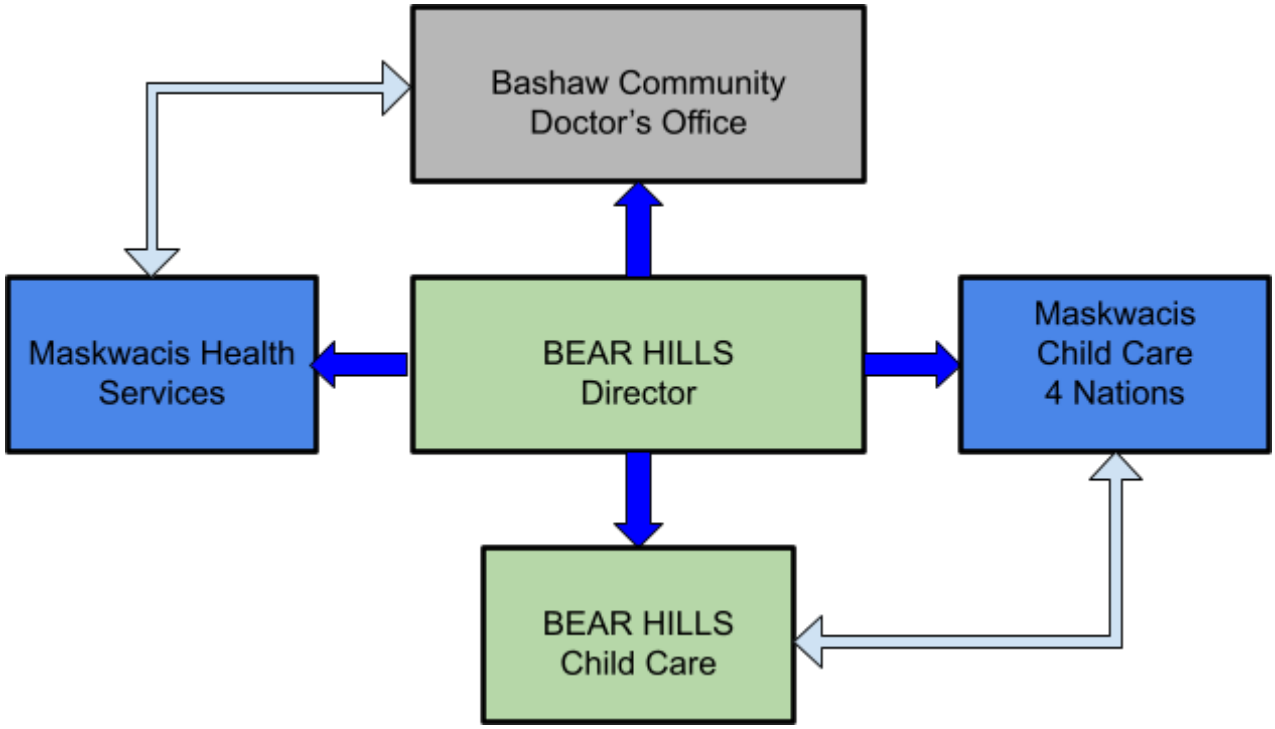
b. Accredited / Certified Counselors

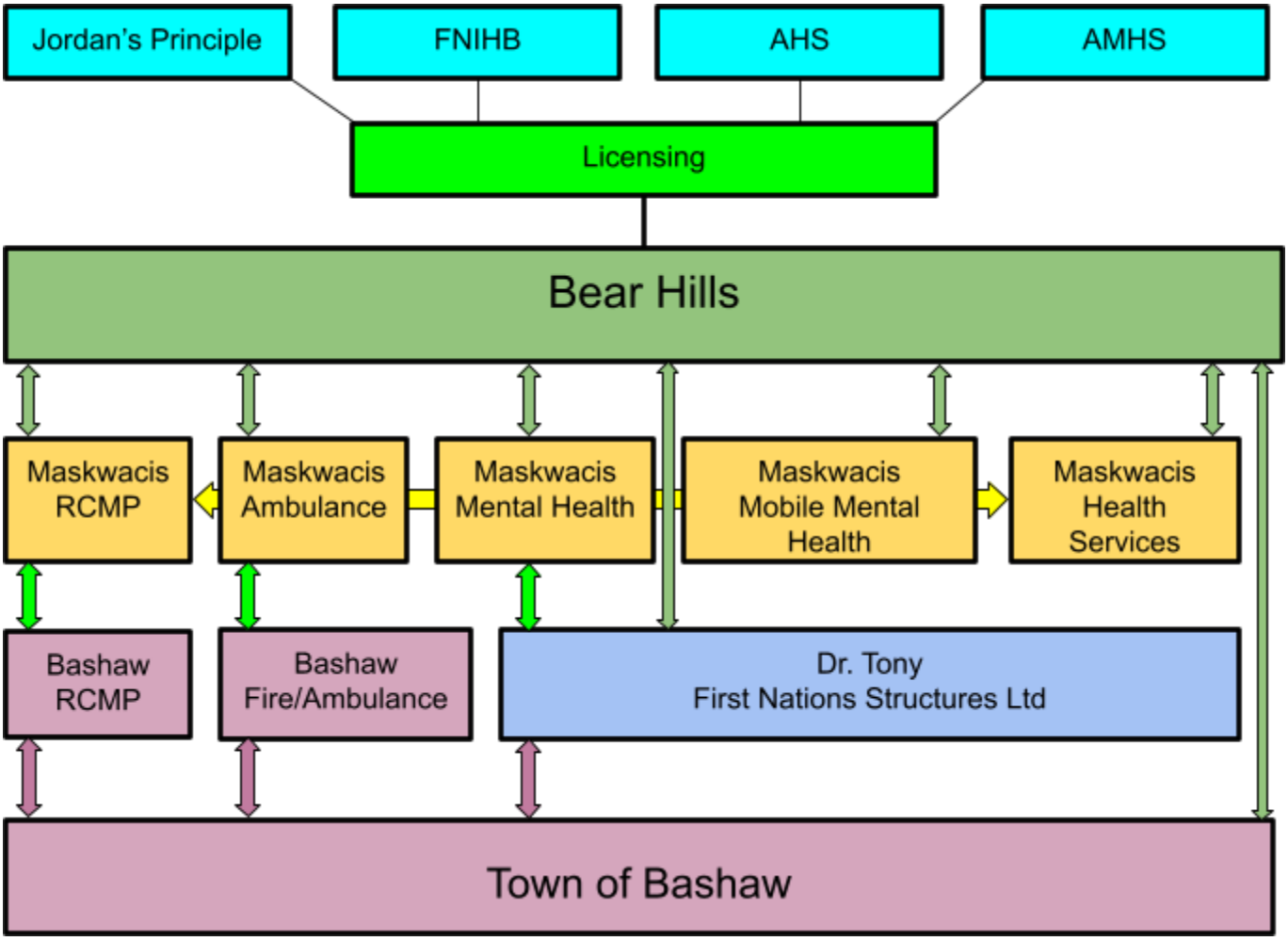
c. The Centre is not dealing with anything above the average Provincial health conditions set out for citizens:
    i. The Centre will work primarily with Maskwacis Child Care and Maskwacis Health Care to support its Clients. The Centre will also strive to ensure good relations with local Doctors and create a relationship between Maskwacis Health Care and the local Bashaw Medical Center. The Centre will ensure a solid connection between in-house child care and Maskwacis 4 Nations' child care.

d. Early childcare development to be in conjunction with the four Nations' existing Programs within their Community Services & Wellness Division for each Nation: Erminseksin, Louis Bull, Montana and Samson
    i. Louis Bull Band Daycare Center
    ii. Montana Daycare Center
    iii. Samson Daycare Center
    iv. Ermineskin Daycare Center

e. We will apply for all required Alberta Licensing and/or Permits upon receiving Council's approval.

HEALTH CARE and CHILD CARE GOVERNANCE STRUCTURE





We have established open communication with the Bashaw RCMP in 2021 and have relayed to them the Centre's proposed use. Upon receiving approval from the Council for the Centre, we will revisit this line of communication with the RCMP and any other agencies or services shown above.

OPTIONAL Additional Information in support of our response related to No. 8 above, offered in a separate email

10. Integration of guests and visitors into the existing Bashaw community.

We recommend some workshops be reviewed to help better understand a Municipality's role in Reconciliation and have included some examples for review and consideration. As we, the Applicant, have expressed our intent to extend invitations, openness and inclusion from within the Centre and the First Nations, and we have asked the businesses and residents within Bashaw of their welcomeness to the potential Clients, we understand that this request set out to us unanimously by Town Council may infer some direction is required as to how the Town of Bashaw might better understand how to reciprocate the efforts the Applicant has put forward in various ways. There are practical steps municipal governments can take to advance reconciliation and inclusion to create

positive and welcoming communities. The First Nations of Maskwacis and their Council have extended an invitation to the Town Council of Bashaw numerous times in efforts to build a relationship that is positive, welcoming and benefits the Town itself as well.

The Centre, during its consultations with the Town of Bashaw, found that most residents and businesses welcomed the proposed Centre. Still, the Centre intends to continue to communicate with the Town residents and businesses once approval is received by the Town Council to move forward and once funding is in place. The Centre will have a list of 'preferred' vendors, activities and events who have expressed their openness to have Clients partake in the Town's offerings. The Centre will also extend to the Town residents and businesses opportunities to partake in various events, ceremonies and pancake breakfasts scheduled and open to the public.

There are numerous educational and informational resources for non-Indigenous people to allow for the proper integration of Indigenous people into their communities.

Keeping in mind that the Centre is not a permanent housing option nor offering any type of permanent residency within Bashaw to any of its Clients, the Applicant is of the understanding that the Town of Bashaw is concerned and questioning the potential inclusion, involvement or participation by the Center's Clients within the Town itself, being that the Clients are First Nations. As the Applicant has clarified in previous correspondence, the intended Clients will all be voluntary, will not be in need for a diagnosis for a medical treatment for any physical or mental disability, will not be active addicts requiring detox or medications to begin detox, nor will they be at the Centre for the purpose of seeking medical attention. The Clients will be attending to benefit from a Cultural Wellness Program to enhance the wellness of family units. The requests by Council are not clearly explained and we have made our best attempt to answer regardless of the lack of understanding.

We believe that Alberta is a great example of a forward thinking and inclusive Province and therefore, although we may not fully understand the basis of the question, we have prepared some printed materials for Council to review to better be able to understand certain aspects of being inclusive and creating environments without discrimination. People should be encouraged to feel welcome in all Alberta communities regardless of gender, gender expression, colour, age, ancestry, mental disability, race, religious beliefs, family/marital status, place of origin, physical disability, income and/or sexual orientation. Everyone in Alberta has the right to be treated fairly.

Alberta does not have designated communities where integration of those wanting to attend a wellness centre should be segregated or required to establish a need to integrate into a community. Communities do not belong to one group, one typeset or one culture. Communities are open to all citizens of Alberta and we are to establish, support and promote a welcoming, inclusive Province for all visitors and residents alike. It is the hope of the Applicant that this request by Council will be satisfied within this document and with the informational printed material provided, in addition to previously explained intended relationship building with the Town and its residents.

We recommend Council review and hopefully participate in being proactive in creating welcoming and inclusive communities, and offer some printed material for your review. As Council is a member of **Alberta Municipalities** (as confirmed by reaching out to them during our process of providing answers to Council's requests), there would be great benefit to take advantage of the various courses and material offered to members. We will adopt or will reference the following and included

printed materials in the OPTIONAL addition information, that can be reviewed voluntarily by Council or the public in a separate email attachment which includes:

1. A Municipal Guide to the Truth and Reconciliation Commission's Calls to Action
    a. As members it should be noted that Council has access to this information but we have included it and recommend it be reviewed by all Council members:

    "Alberta Municipalities acknowledges the traditional land on which we are headquartered is in Treaty Six Territory. We honour and respect the history, languages, and culture of the diverse status and non-status Indigneous peoples who call this territory home such as the nehiyaw (Cree), Dene, Anishinaabe (Saulteaux), Nakota Isga (Nakota Sioux), and Niitsitapi (Blackfoot) peoples. We also acknowledge this land as Metis' homeland and the home of many Inuit.

    As the voice for urban municipal governments situated across the province of Alberta, we encourage all municipal governments to be informed about the traditional lands, Treaties, and history and cultures of Indigenous peoples local to our region." Found on Page 2

2. Workshops on Canada's history & the Municipal role in Reconciliation
3. Welcoming & Inclusive Communities Initiative
4. Coalition of Inclusive Municipalities
5. Indigenous Peoples
6. Forms of racism - Individual vs Systemic
7. What Reconciliation Is And What It Is Not
8. Working Effectively with Indigenous Peoples
9. Guide To Developing Indigenous Inclusion Policies
10. Creating an Inclusive Society: Practical Strategies to Promote Social Integration
11. Building Indigenous community capacity and the duty to consult
12. Reconciliation with Indigenous Peoples: A Holistic Approach
13. United Nations Declaration on the Rights of Indigenous Peoples
14. Reconciliation, the simplest gestures can make a difference
15. Appreciating or appropriating Indigenous Culture?

16. Principles

17. 7 Tips on building relationships with Indigenous Peoples

18. 7 First Nation Facts you should know

19. Mandate Letter from the Prime Minister to Minister of Crown-Indigenous Relations

20. Superficial Related to EA Legislation and Process, Embedded in Colonial Canadian Policy and Deeply Ingrained Systemic Fundamental Constructs

21. Land Acknowledgments

22. Sixties Scoop

*****Response to Motion #041-2022 Digital Format - Part 5 of 5*****

11. Traffic Impact Assessment.

A professional assessment by Al-Terra Engineering from Red Deer, Alberta has been completed with the stamped document for review provided on the following pages. As our previous correspondence with Council had already relayed, there would not be an increase in traffic and/or vehicles but rather a decrease in relation to the proposed Wellness Centre. In short, this assessment has produced the following results:

1. A comparison between previously approved uses to the current proposed use and its impact on traffic.

2. A conclusion determining that there will not be a significant increase in traffic and will more than likely decrease traffic with the proposed use within this Application before Council.

3. No improvements to nearby intersections would be required.

Please see the following 3 page assessment.

AL-TERRA Red Deer

Consulting Engineers
Serving Western Canada
For Over 30 Years

Technical Memo

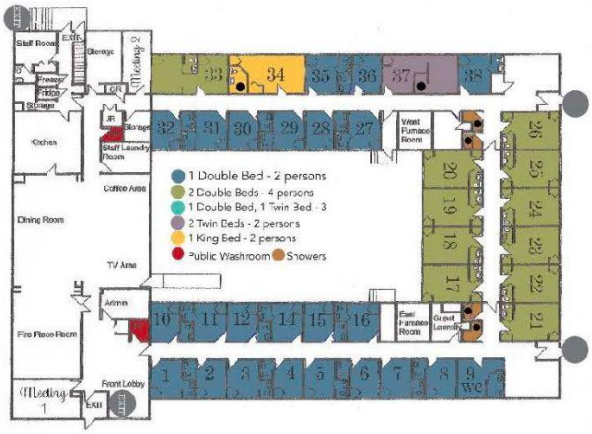
To:	James Carpenter	From:	Brandon Wetmore, P.Eng.
	Bear Hill Family Wellness Centre		AL-Terra Engineering (Red Deer) Ltd.
	5430 51A Street Bashaw, AB T0B 0H0		202, 4708 50th Avenue Red Deer, AB T4N 4A1
File:	5513-14	Date:	March 18, 2022
Reference:	Bear Hills Family Wellness Centre - Traffic Impact		

The Buffalo Lake Event Centre (5430 51A Street, Bashaw, Alberta) has been chosen to be repurposed for the new Bear Hills Family Wellness Centre. AL-Terra Engineering (Red Deer) Ltd. has been retained to evaluate the impact on traffic that this change in building use may have.

Building History

Previously this building has been approved as a senior's Lodge, an all-season festival and event centre, and a wedding venue. In addition to being used as an event centre, the building has 38 rooms available for visitors to rent. The building is 16,000 sq.ft. and it is situated on 4.9 acres of land. The centre also has a commercial kitchen and a congregate dining area. Events continue to be held at the Centre as of March 2022.

Figure 1 - Existing Building Layout



Proposed Building Use

The building is proposed to be repurposed to become the Bear Hills Family Wellness Centre. The wellness centre will provide housing for an average of 5 families at one time. Families will stay in the wellness centre for 3 month cycles. At the end of the cycle a new family will rotate into the facility. There will also be approximately 5 employees working at the wellness centre on any given day. Visitors may also attend events at the Wellness Centre. Families would be remaining at the centre for the entirety of their 3 month program and it is expected that the majority of vehicle trips would be from the staff. No renovations will be required for this change in building use.

Trip Generation

To compare the traffic generated by the past building uses and the proposed building use, trip generation rates from the Institute of Transportation Engineers (ITE) Trip Generation Manual, Version 10 were used. The ITE Trip Generation Manual is based on traffic data from multiple study sites over several years.

As the building was previously used as both seniors housing, an event centre and for lodging, all 3 land uses were evaluated.

Table 1 - Previous Trip Generation Rates

ITE Code	Building Use	Variable	Units	Trip Generation Rates			Total Generated Trips		
				AM Peak	PM Peak	Weekday	AM Peak	PM Peak	Daily
251	Senior Adult Housing	Units	38	0.20	0.26	3.70	8	10	141
495	Recreational Community Center	1000 Sq.ft.	16	1.76	2.31	28.82	28	37	461
320	Motel	Units	38	0.38	0.38	3.35	14	14	127

Based on the past trip generation rates, trips generated by the previous uses would not be cause for concern for any nearby intersections. The building use of the event centre would also be expected to have significant traffic generated on weekends.

Table 2 - Proposed Trip Generation Rates

ITE Code	Building Use	Variable	Units	Trip Generation Rates			Total Generated Trips		
				AM Peak	PM Peak	Weekday	AM Peak	PM Peak	Daily
253	Congregate Care Facility	Units	38	0.07	0.18	2.02	3	7	77

The change of building use to Congregate Care Facility would not be expected to produce any additional traffic. The facility is planned to have an average of five families of five, however 38 units were used in the trip generation to have a direct comparison. The congregate care facility would produce the least traffic of any building use. The change in building use and reduction of units from 38 to 5 family units would be expected to reduce traffic generated by the facility.

Conclusion

The Buffalo Lake Event Centre has been proposed to change to the Bear Hills Family Wellness Centre. Evaluation of the trip generation rates found that the change in building use would not result in a significant increase in traffic, and may decrease traffic generated by the facility. Based on the low traffic volume in Bashaw and the change in trip generation rates, no improvements to nearby intersections would be required.

Prepared by:

2022-03-17

Brandon Wetmore, P.Eng.

Reviewed By:

Mar. 23 2022

Dan GIlbertson, P.Eng.

PERMIT TO PRACTICE
AL-TERRA ENGINEERING (RED DEER) LTD.
RM SIGNATURE: P.Eng.
RM APEGA ID #: 67094
DATE: Mar. 23 2022
PERMIT NUMBER: P7355
The Association of Professional Engineers and Geoscientists of Alberta (APEGA)

Corporate Permit

12. Environmental Public Health review.

To be clear, this Centre can not operate without a Provincial License. This License covers the Environmental Public Health Review in the process of granting a License to the Centre. We can not apply for a License without approval of the use of the building.

With this being said, we have reached out to confirm with **Alberta Environmental Public Health**, **Alberta Mental Health**, **Alberta Education and Alberta Municipal Affairs**. The response given to us by all of these Licensing authorities and/or governing bodies was consistent with the Centre being operational or at the very least, ready to operate. We have documented our communications with these organizations and each has expressed their confusion and concern with a request for an Applicant to provide such information when applying for "use" of a building, not licensing of a Business. This will be and is only required by Authorized Licensing bodies of Alberta.

<u>Once we receive Council's Approval the Centre will immediately:</u>

- Apply for and obtain all necessary Alberta Licensing
- Obtain an Environmental Public Health Review and submit such document with full compliance to the Town of Bashaw

As agreed to by all above noted Licensing and Governing Authorities, to apply for and obtain Licensing in order to seek an Environmental Public Health Review to satisfy the Town of Bashaw Council, when there is no existing Operational Business to assess or review, is not proper protocol or considered reasonable prior to submitting Licensing application(s).

There will not be a review and the expenditure associated with time, money and resources, without zoning approval, is unwarranted as the building must be set up and functional for the use. For example, we can not be inspected for child care without being set up with employees hired with qualifications.

As per email and telephone confirmations with Alberta Public Health Authority, Alberta Mental Health, Alberta Education and Municipal Affairs, and only upon obtaining Council's Approval to allow the First Nations of Maskwacis to be permitted to rent this building from James Carpenter and Dr. Tony Mucciarone will they be prepared to provide and justify the need for and issuance of all applicable, necessary, required or operational Licensing, Permits, Reviews and/or Approvals for:

1. Environmental Public Health Review
    a. In-house daycare space
    b. Nutrition
    c. Elderly care

2. Any required or applicable Licensing from:
    a. Alberta Health Services
        i. Child care
        ii. Elder care

    b. Alberta Mental Health Services

i. The Centre is in the process of applying for Licensing with Alberta Mental Health and has been in direct and continued contact with them since 2021. This application has been delayed due to waiting for approval from Bashaw Town Council.
ii. Alberta Mental Health has provided guidance and answers to various questions posed to us, the Applicant, by the Town Council of Bashaw and/or the CAO.

c. Alberta Education
We have been in contact with Alberta Education but it must be noted that:
i. The MESC (Maskwacis Education Schools Commision) will be providing all educational requirements for child and youth Clients of the Centre during their stay as they are the primary educators for the community. This will ensure consistency and familiarity.
ii. There will also be an option for class involvement via zoom on laptops.

So we have a chicken before the egg scenario, but the good news is that the Town is protected by Alberta Government Licensing and the assurance of Public Health Environmental Safety, regular inspections and measurable outcomes are in place or the Business will be shut down.

Prior to being able to open the Centre we will require licensing under the **Mental Health Services Protection Act**. We apply for a license through the **Compliance and Monitoring Branch with Alberta Health**. They will work with us on all requirements once an application is submitted, but they wouldn't normally be involved prior to that. We would be able to show the Town Council that we have a license prior to opening.

We trust this addresses the Town's requirements as Authorized Government Bodies in Alberta are on standby for our zoning approvals to move forward.

Kindest Regards,

Audrey Ward, Executive Director, Maskwacis Young Spirit Winds Society
award@onehealth.ca

Lucy Smolcic, Executive Assistant, First Nations Structures and Energy Developers
lucyenergydevelopers@gmail.com

Bear Hills Family Wellness Centre

Wellness Plan

FIRST NATIONS STRUCTURES

Advanced Thinking/Advanced Structures

A Message to the Community of Bashaw from Chief Leonard Standingontheroad

“Good evening, everybody.

I came here to support our group that’s been working on this project for the last few years and we’re here to present an opportunity to create a respectful relationship. We had a tour of this Elder’s Lodge this Spring and it seems like it’s a good fit, but first we have to create a relationship and a cooperation from each other if it’s going to happen.

We’ve been neighbours since time immemorial but we haven’t really created any relationships with the Town’s people besides being consumers of your business throughout the years.

We’ve come here respectfully to allow you to hear out what’s presented here today and hopefully we can open doors for each other.

Thank you for taking the time to hear us out.”

Chief Leonard Standingontheroad

Private & Confidential

PROPRIETARY INFORMATION

The information shared within this document is to be considered the Property of First Nations Structures Ltd. and can be shared and distributed for the purpose of offering information and awareness for the proposed Bear Hills Family Wellness Centre.

This information is being shared in response to the Fourth Incomplete Notice sent to us from Theresa Fuller, the CAO of Bashaw, Alberta, with regard to our re-Application for a Development Permit submitted on January 10, 2022.

The CAO has stated in her letter dated February 24, 2022, "*Administration considers the application to be vague regarding the proposed activities, and is missing information; as such it continues to be deemed incomplete*".

This document is presented to the CAO via email on February 25, 2022 in response to this Fourth Incomplete Notice and is Proprietary Information. We have chosen to share this publicly as well. It is only offered in order for the Landlords to be permitted, by the Town Council of Bashaw, to rent their Centre to the First Nations People of Maskwacis and we respectfully acknowledge the privacy of anyone seeking mental health and wellness to have the right to privacy and confidentiality.

We acknowledge that the land on which we are located is Treaty 6 Territory. We respect the history, languages and cultures of First Nations, Metis, Inuit and all First Peoples of Canada.

Programs

All Programs offered in-house and available to all Clients of the Centre. As the Centre will provide tailored programs, not all Clients will participate in every available option but those deemed appropriate for the individual and in turn, the family. All services will be provided by Licensed and/or approved providers.

- Residential School Awareness
- Truth and Reconciliation
- Budget Planning
- Child Care and Safety
- Elder Teachings
- Community
- Cultural Teachings
- Education
- Elder Wellbeing
- Family Togetherness
- Generational Trauma
- Hygiene
- Life Skills
- Medicine Wheel Teachings
- Addictions Awareness
- Mental Health
- Mentorship
- Nutrition
- Self Harm and Suicide Prevention
- Smudging
- Counselling
- Core Value Teachings

Residential School Awareness

This is a vulnerable and sensitive area of the Program

Maskwacis was home to one of the two largest residential schools in all of Canada.

Schedule "N" Mandate For The Truth and Reconciliation Commission

…."The truth telling and reconciliation process as part of an overall holistic and comprehensive response to the Indian Residential School Legacy is a sincere indication and acknowledgment of the injustices and harms experienced by Aboriginal People and the need for continued healing"….page 1

…."Community Events…It is intended that the community events will be designed by communities and respond to the needs of the former students…. a: acknowledge the capacity of communities to develop reconciliation practices; e: educating the public and fostering better relationships with local communities"…. Page 9

…."Privacy…. The Commission shall respect privacy laws, and the confidentiality concerns of participants"…. Page 11

Truth and Reconciliation

For All. Truth and Reconciliation…

In keeping with Truth and Reconciliation, the community of Maskwacis has approached the community of Bashaw in hopes to build a relationship and to get to know one another.

Truth and Reconciliation

Reconciliation

43. We call upon federal, provincial, territorial, and municipal governments to fully adopt and implement the *United Nations Declaration on the Right of Indigenous Peoples* as the framework for reconciliation.

Budget Planning

Tailored to the individual and their needs. The below lists options available.

- In-house seminars to inform and educate
  - Budgeting
  - Debt
  - Credit
  - Life events
  - Fraud
  - Students
- In-house special guests
  - Business professionals from Alberta sharing knowledge and experience

Child Care and Safety

Tailored to the individual and their needs. The below lists options available.

- In-house daycare
- Safe and healthy environment for children which supports
  - Health
  - Happiness
  - Social interaction
  - Emotional development
  - Physical development
- In-house Teachers
  - Licensed programs to ensure and encourage continued education for school aged children

Elder Teachings, Story Telling & Ceremony

All Clients of the Centre will participate in Elder Teachings, Story Telling and Ceremony

Elder Teachings will be a daily event with all Clients of the Centre.

Truth and Reconciliation

Settlement Agreement Parties and the United Nations Declaration on the Rights of Indigenous Peoples

48.

ii. Respecting Indigenous People's right to self determination in spiritual matters, including the right to practice, develop, and teach their own spiritual and religious traditions, customs, and ceremonies, consistent with Article 12:1 of the *United Nations Declaration on the Rights of Indigenous Peoples*.

iii. Engaging in ongoing public dialogue and actions to support the *United Nations Declaration on the Rights of Indigenous Peoples*.

Community

Tailored to the individual and their needs. The below lists options available.

- Building bridges between communities
  - The Centre to host Events which welcome members of the Bashaw Community to join and participate
  - The Centre to host Events which welcome members from all of Alberta to join and participate
  - The Centre to host inclusion events open to the community
  - The Centre to host Story Telling and Sharing with the community of Bashaw and Alberta
- Sense of belonging
  - It is crucial to overall wellbeing to have a sense of belonging
  - Cultural Teachings and Elder Teachings enhance and create a sense of belonging
- Voluntary interactions within the community
  - Various businesses have expressed they welcome the Clients of this Centre to attend their functions, stores and services provided
  - Active participation, when possible, to engage in the community
  - A list of local business to be made available in-house to those wanting to contribute to the Town's viability and build positive, encouraging relationships

Cultural Teachings

All Clients of the Centre will participate in Cultural Teachings

We will reintroduce Cultural Teachings, awareness and knowledge to families who are seeking help.

Mental Health and Wellness improves with access to Cultural Teachings. Families, youth and individuals will reconnect with their identities and Indigenous roots using methods which have been proven, combined with Indigenous beliefs and practices.

A holistic approach provides a larger support network and will be a unique aspect to this program.

Healing broken family relationships, renewing friendships and Cultural grounding will become the backbone to prevention and likelihood of relapse and strengthening family and community unity.

Education

Tailored to the individual and their needs. The below lists options available.

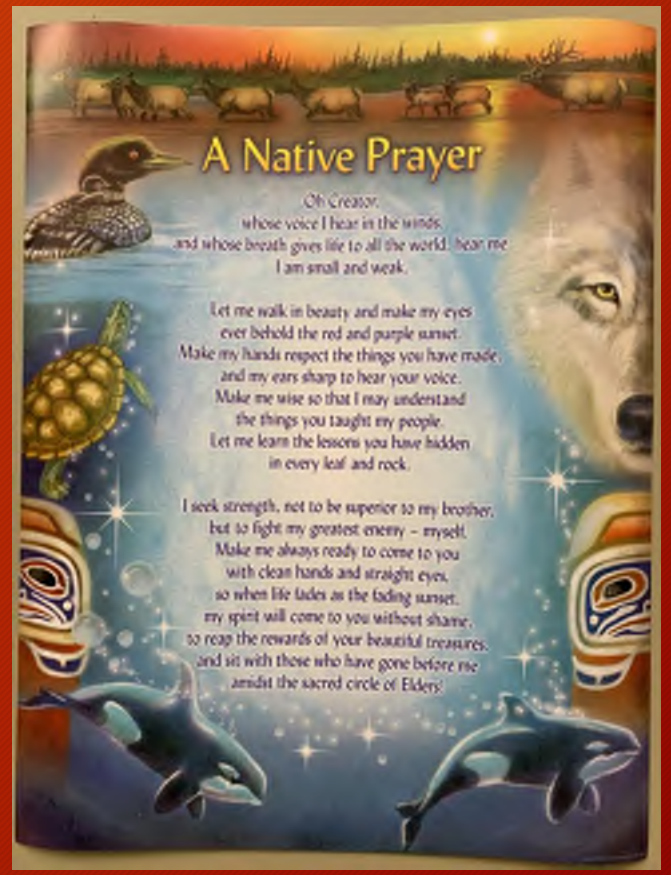
Maskwacis Education Schools Commission (MESC) and other Licensed Teacher(s) as needed will provide the Centre support for the educational needs of Clients during their stay at the Centre.

Access to zoom and online classes.

Elder Wellbeing

Tailored to the individual and their needs. The below lists options available.

The care of our Elders is such an important part of overall family wellbeing. Ensuring Seniors have a high quality of life and have access to necessary health and wellness is as important for them, as it is to every family member.



Family Togetherness

All Clients of the Centre will participate in Family Togetherness

With a combination of the tailored programs offered to Clients, ultimately Family Togetherness will be a part of the program for all involved. Bringing families together and enhancing, encouraging and supporting the family unit is the goal. Families who participate at the Centre will gain from a strengthened and improved family bond and unity. This then encourages others to benefit from the ripple effect and encourages community, support and unity on a larger level. Various family activities will be offered through the program.

The image to the right shows artwork created by youth who attend Maskwacis Young Spirit Winds Society.

Generational Trauma

All Clients of the Centre will participate in awareness and healing from Generational Trauma

Generational Trauma affects all members within a family. It affects First Nations' People. Our Centre will provide education, support, counselling, sharing circles, Elder knowledge and a safe place to share truth and heal.

Addressing generational trauma will be a part of a process that will be both individually tailored and group based. Cultural Teachings, Story Telling and Elder Support will play large roles in this process.

The particulars of this portion of the program are considered private at this time.

Hygiene

All Clients of the Centre will participate in safe and healthy practices of proper hygiene

Everyone at the Centre will have an introductory lesson on safe and proper hygiene which directly relates to congregate living type facilities. Close monitoring of health-related concerns or the potential spread of viruses will be taken as high priority.

- In-house seminars and lessons to inform and educate
  - Proper hygiene
  - Personal hygiene
  - Healthy vs unhealthy habits
  - Illness and virus protection
  - Grooming
  - Cleanliness

Life Skills

Tailored to the individual and their needs. The below lists options available.

Courses and training sessions tailored to specific age groups will be offered when available. All age groups benefit from life skills and the understanding, use and implementation of such skills.

Knowledge in life skills enhances the overall wellbeing of any age group.

Some of the life skills we will offer include (but are not limited to):

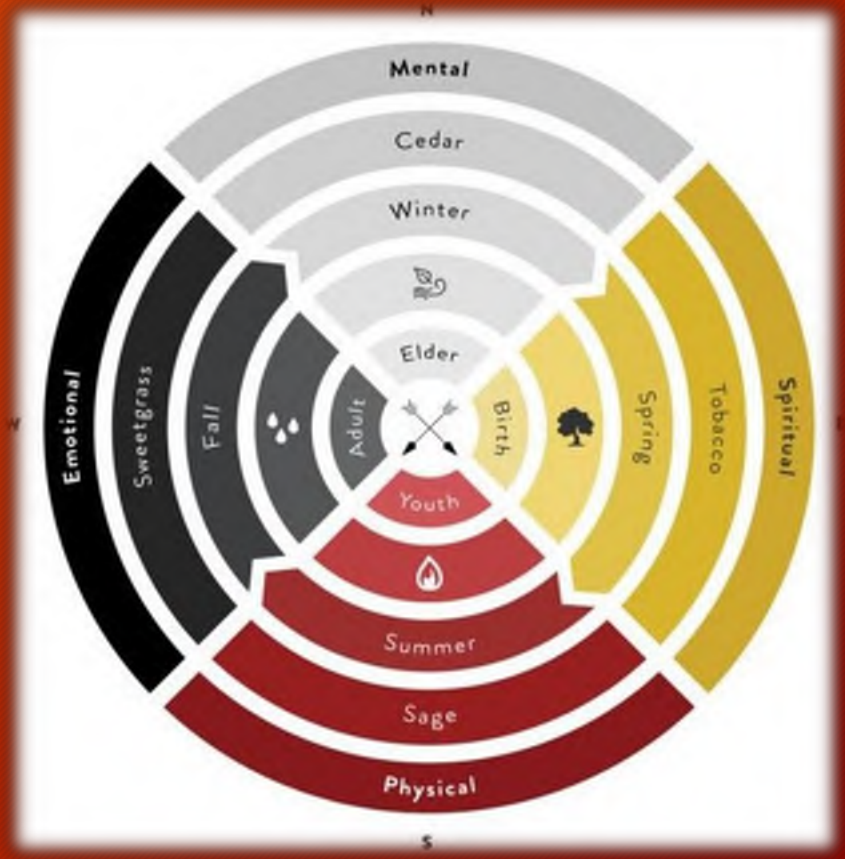
- Problem Solving
- Critical Thinking
- Interpersonal Relationship Skills
- Effective Communication
- Creative Thinking
- Self-Awareness Building
- Empathy

Medicine Wheel Teachings

All Clients of the Centre will participate Medicine Wheel Teachings

Daily Medicine Wheel Teachings for all Clients will be offered at the Centre.

Traditions give the guidance and support necessary for on-going healing and change. With time, the Centre will offer informational material shared with the public to better understand the beauty and necessity to ensure Medicine Wheel Teachings.



Addictions Awareness

Tailored to the individual and their needs. The below lists options available.

- Alcoholic Anonymous (AA)
  - To ensure continued sobriety and/or preventative addiction
  - Based on one alcoholic helping another
  - Helping alcoholics recover for more than 80 years
  - 12 Steps and 12 Traditions
- Al-Anon
  - Help and hope for families and friends of alcoholics
  - Help for people who are worried about someone with a drinking problem
  - Information, education and teachings to prevent addictions
- AADAC/Addiction and Mental Health
  - Opioid Dependency Program maintenance (for those who have already begun the process)
  - Support for those struggling with addictions and maintaining healthy lifestyles
  - Information, education and teachings to prevent addictions
- National Native Alcohol and Drug Abuse Program (NNADAP)
  - Health Canada program with a goal to help First Nations and Inuit communities reduce high levels of alcohol, drug and solvent abuse
  - Information, education and teachings to prevent addictions

Mental Health and Mentorship

Tailored to the individual and their needs. The below lists options available.

Mental Health is truly addressed through each of the Centre's program options. The goal is to improve and maintain overall wellness of all who attend and to be supported even after they return to their homes and have completed their program at the Centre.

Mentorship will be offered to those interested or in need. Mentorship by an Indigenous Elder, member of the community, professional and other… Mentors can be anyone who bring a positive to someone's life. Guidance provided by a mentor, especially an experienced person, has many benefits for all ages.

The Centre hopes to offer one-on-one mentorship, distance mentorship and group mentoring.

Nutrition

Tailored to the individual and their needs. The below lists options available.

Healthy nutrition affects us all which is why this part of the program would involve all age groups. We will strive to provide education, information and example of healthy choices, meal planning, cooking skills and more.

We will provide education and tools for Clients to be able to identify herbs and plants that naturally grow in our own environment. We will provide knowledge and lessons on how to identify natural medicines and their uses, how and where they are grown. This knowledge may be offered to the public during specified community events held at the Centre.

Self Harm and Suicide Prevention

This is a vulnerable and sensitive area of the Program

Self harm and suicide have been a concern for all people, regardless of ancestry. Maskwacis has had a devastating and long-standing history of self harm and suicide.

The Centre will help reduce and eventually eradicate self harm and suicide while taking a holistic, culturally based approach and solidifying a sense of belonging. Trauma, inter-generational trauma, discrimination, stigma, addiction lifestyles and more will be addressed and understood. This part of the program will be quite extensive and necessary in addressing a serious cry for help.

Maskwacis does have a youth Centre, Maskwacis Young Spirit Winds Society, and this Centre has proven to benefit and help the youth of the community. The Family Wellness Centre would bring resolution to emergency issues which include suicide and self harm and it's apparent that to offer the benefits to the family as a whole is necessary.

A Centre located on unceded land is innovative and creates an atmosphere of both unity and inclusion with nearby communities, but also offers a change of environment for Indigenous families to experience the full benefit of what the Centre has to offer all involved.

Smudging

All Clients of the Centre will participate in daily smudging

For the First Nations, Sage is one of the Four Sacred Medicines and is used in daily smudging. Sage is sometimes referred to as a woman's medicine as it is used in the Moon Ceremonies.

In the Medicine Wheel Teachings, Sage represents the Western direction.

A little Smudge Prayer

I bring the smoke towards me to surround my heart so that what has damaged can heal and what is to come will help me stay strong and grow in a good way.

In the circle we are all equal.

Counselling

Tailored to the individual and their needs. The below lists options available.

- Child and Youth Counselling
- Individual Counselling
- Marriage/Couples Counselling
- Family Counselling
- Behavioral Counselling
- Humanistic Counselling
- Cognitive Counselling
- Elder Support and Guidance
    - 24/7 Accessibility to Elder support and guidance as there will be one at the Centre at all times

Core Value Teachings

All Clients of the Centre will participate in Core Value Teachings

- Respect
- Empathy
- Honour
- Genuineness
- Understanding
- Honesty
- Compassion
- Love
- Kinship
- Acceptance
- Responsibility
- Patience
- Independence
- Sharing
- Reciprocity

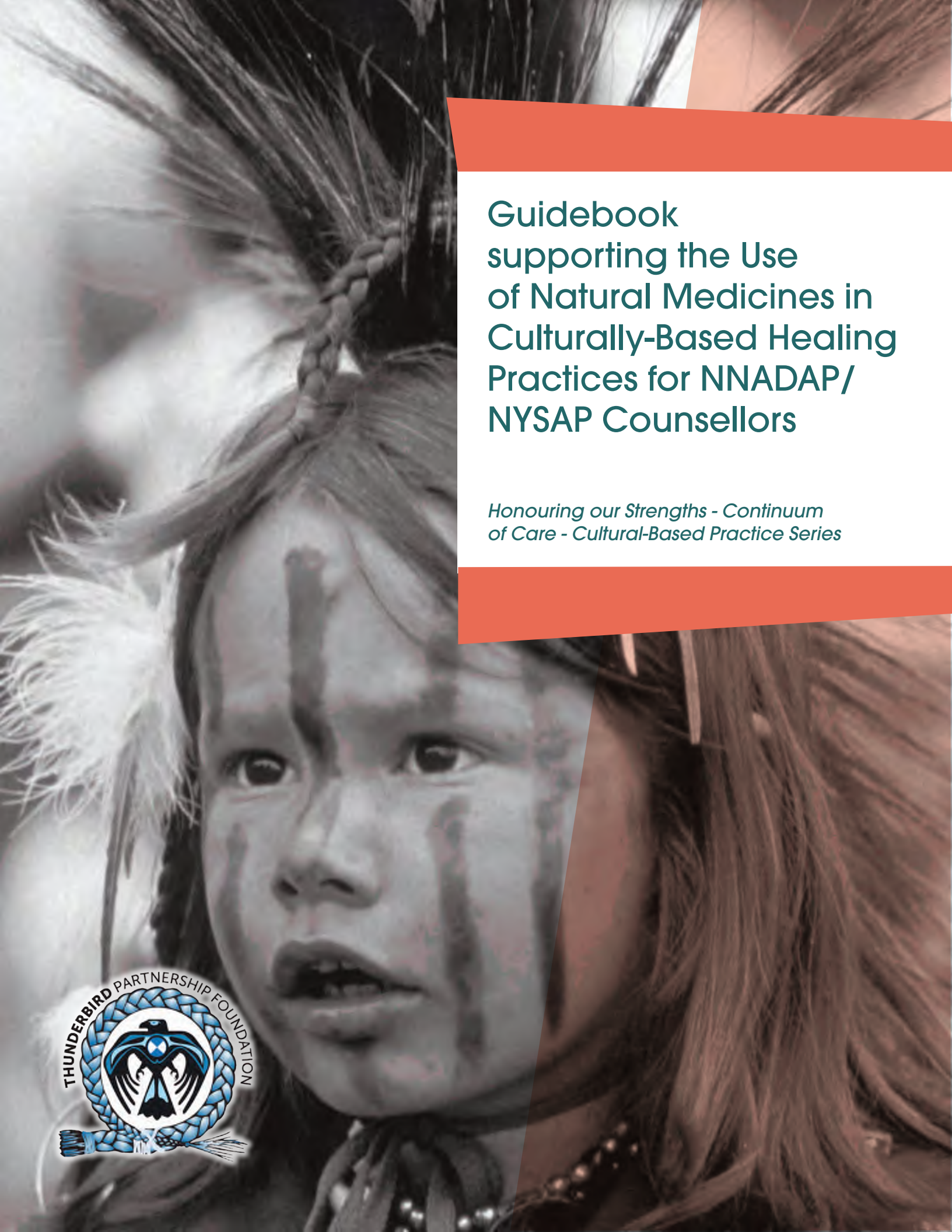
Safety Plan

The Centre will be equipped with an interior and exterior security system.

It has been researched and publicly documented, for example in the New York Times, that centers such as this have increased property value to the communities where they are located.

We are one

Bear Hills Family Wellness Centre



Guidebook supporting the Use of Natural Medicines in Culturally-Based Healing Practices for NNADAP/ NYSAP Counsellors

Honouring our Strengths - Continuum of Care - Cultural-Based Practice Series

THUNDERBIRD PARTNERSHIP FOUNDATION

Table of Contents[1]

Introduction and Acknowledgements 1

Part One: Contextualizing Illness and Treatment 2

1.1 Contextualizing Illness 2

1.1.1 Historical Background to Natural Medicines 2

1.1.2 Prevalence of Drug and Alcohol Abuse 2

1.1.3 Conventional Approaches do not Work 3

1.2 Contextualizing Treatment 3

1.2.1 The Link between Culture and Illness 3

1.2.2 The Link between Culture and Healing 3

Part Two: Examples of Appropriate Treatment 4

2.1 Examples of the use of Traditional Medicines in the Addictions Context 4

2.2 Traditional Medicines in a Government and Policy Context 5

2.3 Summary 5

2.3.1 Traditional Medicines are Placed Based 5

2.3.2 "Culture is Healing" 5

2.3.3 Fusion with Western Health Care 6

2.4 Summary Points - Guidelines 6

Part Three - For More Information 7

Appendices: 8

Appendix A:
Six Elements of the Continuum of Care 8

Appendix B:
Developing a Cultural-Based Practices Policy or Protocol 9

Appendix C:
Defining Cultural Awareness, Competency, and Safety 10

Endnotes 12

1 This tool kit was completed by Yvonne M. Boyer, LLD., with the assistance from Kurtis Boyer, M.A. This workbook or any workbook in this Informational Workbook for Culturally Based Healing Practices Series is not intended to be legal or medical advice and should not be relied on as such. Please seek the advice of a qualified professional for medical or legal advice.

Guidebook supporting the Use of Natural Medicines in Culturally-Based Healing Practices for NNADAP/NYSAP Counsellors

Introduction and Acknowledgements

The National Native Addictions Partnership Foundation (NNAPF)* acknowledges the contribution and guidance of the experts contributing to the review of this guidebook. From East to West, NNAPF is grateful for the guidance of Brian Augustine from Elsipogtog, New Brunswick, Virgil Tobias, Cultural Coordinator at Nimkee NupiGawagan Healing Centre, Ontario, Brenda Pierre-Leon, Alcohol and Drug Counsellor at Sts'ailes Health and Family Services, Stacey Nahdee, Addictions Counsellor at Walpole Island First Nation's Community Service Program, as well as NNAPF staff Linda Sullivan, Garry Carbonnell, Jenny Gardipy and Michael Martin. These guidebooks will serve to contribute to a better understanding of cultural practices and interventions being practiced nationwide.

The success of cultural-based practices and treatments continues to be demonstrated in the successful treatment and prevention outcomes of clients served in almost 50% of programming funded under the National Native Alcohol and Drug Abuse Program (NNADAP) and the Youth Solvent Abuse Program (YSAP). Whether the work of Treatment Centres, or one of the 600 plus NNADAP/NYSAP staff working at the community level, NNAPF is grateful for the ongoing feedback and support of these guidebooks, with the *Use of Natural Medicines Guidebook* as the first of five proposed under *NNAPF's Culture-based Practice Series.*

As noted by the NNAPF Cultural Practices Review Committee (CPRC), ways of traditional healing are as many and different as there are First Nations cultures. There are however many aspects that they have in common. One aspect is that the medicines used for healing came from the natural environment – Mother Earth. Traditional Healers or cultural practitioners who work with medicines are taught by other Traditional Healers, Elders, and Cultural Practitioners, and are recognized by their communities.[1] A challenge for mainstream professionals, who prefer academic and professional designations, is understanding how a cultural practitioner or traditional healer is sanctioned, and by whom they are sanctioned to practice or speak openly about cultural practices and the use of natural medicines.

* As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

A common example of 'earned' traditional knowledge is a cultural practitioner sanctioned by the community in the role of Pipe Carrier. With this role comes the responsibility to use sage or sweet grass for smudging, as well as tobacco for the pipe during ceremonies. This role can change from First Nation to First Nation. Whether cultural practitioner/traditional healers work in NNADAP or mainstream services, this workbook is to help guide programs and services that address addictions issues. It will provide a general understanding of cultural practices and the use of natural medicines, and foster respect for the integrity of First Nations knowledge.

This workbook does not propose 'recipes' or 'standards' for prescribing the use of natural medicines. Its aim is to encourage discussions between service providers and community on the role that natural medicines in culturally appropriate and effective health care. The questions and exercises will guide the discussion towards assisting you to develop culturally reflective program policy, protocols, and guidelines and staff training methods. This will help ensure that there is consistency in understanding the use of natural medicines in cultural practices.

Whether cultural practitioner/ traditional healers work in NNADAP or mainstream services, this workbook is to help guide programs and services that address addictions issues.

The relationship between traditional medicines and the treatment of addictions is presented in this workbook, not as an independent piece of traditional knowledge, but as an important and integral part of a broader system. While First Nations carry diverse cultural and healing traditions, traditional medicine plays a universal role in maintaining cultural integrity, and supporting an individual's sense of cultural meaning. Understanding the role of traditional medicine in treating addictions requires learning of its systematic repression carried out during colonization. Colonization led to a loss of meaning for many First Nations people, who in their attempt to deal with this intergenerational pain, seek to self-medicate through alcohol and substance abuse.

As communities heal from the symptoms and illnesses of cultural disconnect, more and more First Nations are establishing programs that, by reconnecting an individual to his or her culture, aim to heal the root cause of many addictions. (see diagram one in appendix A) As will be described, many of these programs are also aided by non-Native healing methods. As traditional medicines are part of a unique place-based culture, their specific make-up, as well as the method in which they are integrated in broader healing strategies, are also place-based. This workbook adds to a discussion on the role traditional medicines have in treating addictions, both by helping an individual regain a sense of cultural meaning, and in collaboration with conventional approaches.

Part One:
Contextualizing Illness and Treatment

1.1 Contextualizing Illness

1.1.1 Historical Background to Natural Medicines

There are many places you can find out about how First Nations peoples used and mixed natural medicines.[2] As Olive Dickason notes, they were doctors and pharmacists. They knew about "certain herbs, which they used successfully to cure ills that seem to us incurable. The process by which Amerindians acquired their herbal lore is not clearly understood, but there is no doubt about the results. More than 500 drugs used in the medical pharmacopoeia today were originally used by Amerindians."[3] A proof of how important knowing about traditional medicine was is that when Europeans arrived in North America, the fur traders, whalers and missionaries all turned to First Nations and their medicines for help.

It is important to understand that knowledge about cultural practices and natural medicines was passed on by within the clan by traditional healers to other traditional healers. This knowledge needed to be approved off by the community and clan. Knowing about how to use plant and animals is sacred knowledge. It is not easily shared with people outside of First Nations for fear of them not using it properly or not understanding how important the knowledge is.

The knowledge of using traditional medicines to prevent illness and promote health was common and wide-spread. When first contact was made, history recorded that the use of traditional medicines was a sign of First Nations' great well-being. The use of traditional medicines helped First Nations peoples live long lives. It was used in many ways, such as cleansing, sports-related and other ceremonies. There were some traditional medicines used only by women or by men.

However, in early Canadian history, laws severely limited the use of these practices and in some cases, made them crimes. First Nations healing practices were called "witchcraft and idolatry," and they were ridiculed, denounced, prohibited, suppressed, and invalidated. Western or European health care practices took over and suppressed traditional healing practices. *The Report of Royal Commission on Aboriginal People* describes how this dominance began and then took form in laws forbidding the use of traditional knowledge and health practices:

Traditional healing methods were decried as witchcraft and idolatry by Christian missionaries and ridiculed by most others. Ceremonial activity was banned in an effort to turn hunters and trappers into agricultural labourers with a commitment to wage work. Eventually, the Indian Act prohibited those ceremonies that had survived most defiantly, the potlatch and the Sundance. Many Elders and Traditional Healers were prosecuted.[6]

Traditional healing methods were decried as witchcraft and idolatry by Christian missionaries and ridiculed by most others.

Elders and Traditional Healers were brought to trial in places that had been colonized and had Canadian laws imposed on First Nations. Increased colonization came to North America with the intent to conquer and take possession of First Nations lands. People were forced to conform through religion, and to follow Western society's norms, rules, institutions, and ways of living and thinking. [7]

Colonization caused traditional knowledge and healing practices to be made less important or discarded. First Nations either lost the land where healing plants grew or the land has been affected by environmental damage. The impact that the colonialism had on entire communities went well beyond the suppression of their traditional medicines. Cultural assimilation through oppression, racism, and genocide, has resulted in social marginalization and a disconnection from their culture. This has put First Nations and Inuit Peoples at a much greater risk to social illnesses related to addictions. For many communities, the hopelessness and powerlessness that followed was often a form of self-medication. Research shows cultural breakdown is strongly linked with alcohol abuse.[8] In fact, Pedrigo (1983) believes that substance abuse is a survival mechanism for people whose culture and values have withered due to assimilation.[9] According to psychologist Dr. Eduardo Duran, "alcohol use and even suicide may be functional behavioral adaptations within a hostile and hopeless social environment."[10]

1.1.2 Prevalence of Drug and Alcohol Abuse

In brief, due to the impacts of colonization and the loss of traditional cultural values, there is a much higher rate of addictions among First Nations and Inuit than that of the Canada's mainstream population, for all causes of ill health and death.[11] Almost three-quarters of all deaths caused by accidents and violence (e.g., suicide, homicide and fires) among First Nations have been linked to alcohol.[12] Addictions workers jobs are made difficult by the different drug trends used in client care. It is important that they are trained to be familiar with these trends. This is very important for NNADAP staff, as they work with a migratory people on-reserve as well as off-reserve people.

Part One:
Contextualizing Illness and Treatment

1.1.3 Conventional Approaches do not Work

Conventional healthcare has not been successful in helping First Nations people recover from addictions. Author Ross (1992) argues that healthcare measures taken by mainstream services are mistaken and counterproductive.[13] In addition, as McCormick notes, First Nations tend to not use services provided by mainstream, and of those who do, approximately half drop out after the first session. [14]It is thought that differences in value orientations between First Nations and mainstream health service providers has led to different beliefs concerning the causes and solutions.[15]

1.2 Contextualizing Treatment

1.2.1 The Link between Culture and Illness

As we now know, a disconnection from their culture creates many of the addictions-related problems experienced by First Nations people. In fact, many Elders and Traditional Healers believe that the reconnection to culture, community and spirituality is healing. This belief is also supported by the research of Duran, McCormick, York and Pedrigo, which shows a strong link between cultural breakdown and addictions. Many cultural practitioners and traditional healers know and understand that a person's well-being is connected to the well-being, and the strength, of their relationship to their family, community, and relatives.[16] Values are described as collective sources of meaning, and values are the activities that provide meaning [17] to families, communities, and whole cultures. McCormick affirms that:

A collectively oriented culture such as Aboriginal culture is more likely to provide sources of meaning to its members through family, community, and cultural values than is an individually oriented culture. To be disconnected from those values is to be disconnected from potential sources of meaning. In an individually oriented society such as mainstream Canada or the United States, meaning tends to be derived from individual activities and generally not from collective sources. This is because the individual is less likely to be influenced by family, community, or cultural values.[18]

Although some values have changed, the use of First Nations values in the treatment of addictions has increased healing. It is important to know and respect the knowledge First Nations have of their history. It is important to respect First Nations desire to tell this history in their language(s) and respect when they wish to speak or not to speak. It is not as simple as being able to name the cultural practices and values of a given First Nation – but to also know the origin and meaning of the original story. This includes its words, spirit names, ceremony, and related-activities. Spiritual values need to be taught and practiced by children. It must be taught in elementary school to ensure it is learned early enough to become part of everyday life.

1.2.2 The Link between Culture and Healing

The level or rate of addictions among First Nations can be easily found in research. However, information on successful treatment is hard to find.[19] Brady (1995) believes that First Nations have a rich heritage of healing strategies in dealing with substance abuse.[20] In a study examining the facilitation of healing for First Nations in British Columbia, McCormick (1995) showed that reconnection to family, community, culture, nature, and spirituality was the primary source of healing. Connection to traditional Aboriginal culture and values means that a person must become connected to extended family, community, the natural world, the spirit world, and therefore all of creation.

For First Nations, the solution is based on cultural and spiritual survival.[21] An example of this is the First Nation's community of Alkali Lake located in Central British Columbia. Families, cultural practitioners and healers work together to help community members revive traditional dances, ceremonies and spiritual practices. Cultural activities such as pow-wow dancing, sweet grass and sweatlodge ceremonies, and drumming were also re-introduced to community members. As a result, alcoholism in the community of Alkali Lake decreased from 95% to 5% in ten years.[22] This was done by practicing traditional Aboriginal culture and by no longer tolerating alcoholism as acceptable behavior. [23]

Other First Nations treatment programs, such as Tsow Tun Le Lum, Nenqayni, and Round Lake Treatment Centres in British Columbia, White Buffalo Treatment Centre in Saskatchewan, Nelson House Medicine Lodge in Manitoba, Nimkee NupiGawagan Healing Centre in Ontario, and Lone Eagle Treatment Centre in Atlantic Region, have used similar methods. The guiding philosophy of these treatment programs has been: "Culture is treatment, and all healing is spiritual."[24] The outcome of this approach has been overwhelmingly positive.

Each First Nation has a medicinal system based on their culture and their land. In each successful program, the use of traditional medicines is vital throughout the treatment of addictions. Whether herbal remedy, prayer, to aid detoxification, or in healing ceremonies, each tribal group includes natural medicines into their own system of healing. The importance that natural medicines have in this process is getting more recognition. They are being used more often in First Nations communities throughout Canada.

Leadership and support from Chiefs and Councils and governing bodies is very important to using cultural practices in communities. This support means that First Nations values are demonstrated in the lifestyle of those work in the Band's administration. Some communities such as the Oneida First Nations in Ontario have more than a dozen 'medicine societies' help and guide their people. Other First Nations such as Sts'ailes Health and Family Services located at Chehalis First Nations, British Columbia, ensures cultural practices are part of all of the band's services and administration. Specific to health, the Sts'ailes Health and Family Services has traditional healers who are familiar with the local flora, fauna and elements. The healers borrow medicines from the land following traditional cultural knowledge passed from one generation to the next.

Part Two:
Examples of Appropriate Treatment

2.1 Examples of the Use of Traditional Medicines in an Addictions Context

Many First Nation, Métis, and Inuit communities provide healthcare that uses both western medicine with their own traditional[25] knowledge and medicine.[26]

There are many successful examples of this approach. NNADAP treatment centers integrate First Nations and Western methods in treating addictions. For a list of best practice examples, see *"Improving Mental Health Services and Supports in NNADAP."*[27] Below are some examples of communities using natural medicines for healing:

• The White Horse General Hospital (WHGH) works with local First Nations in its region. It has seven programs to address First Nations needs. These are: First Nations Health and Social Liaison Workers; Child Life Workers; Traditional Diet; Traditional Medicine; Interpretation Services; In-Service Training/Education; and Community Liaison Health Promotion.[28] Patients at this hospital can "choose to receive the services of a traditional healer, including traditional medicines."[29]

• In British Columbia, the White Haven Healing Centre uses western and traditional healing with an addictions specialist and a psychologist, who provide clinical support. Keeping culture in mind, White Haven Healing Centre provides a range of care including assessment, counseling and aftercare.[30]

• The Noojmowin Teg Health Centre serves the people of District of Manitoulin Island, Ontario. It is provincially funded and offers a blend of traditional approaches to health and wellness along with contemporary primary health care in a culturally appropriate setting.[31] Nurse practitioners, a dietitian, a nutritionist, and a psychologist staff the Noojmowin Teg. It has a fetal alcohol syndrome program, child nutrition program and a traditional medicine program.[32] The mission statement of Noojmowin Teg states:

The Noojmowin Teg Health Centre is committed to support and promote the overall holistic health and well-being of Anishinabek individuals, families and communities within the District of Manitoulin Island. To do this, we will operate quality community-based programs, establish partnerships and promote healthier communities through both traditional and western healing methods.[33]

The traditional medicine program at Noojmowin Teg is run by a traditional coordinator and is guided by a traditional advisory committee with Elders and members from all Manitoulin Island First Nations. The delivery of the program is done by referrals from health care providers or through self-requests. The program offers consultation, protocol teachings, intake assessments, and referrals to a traditional healer or another health care provider if need be. Traditional healers can provide and support ceremonial preparation, documentation, and fill herbal prescriptions. In Noojmowin Teg, patients also have access to follow-up appointments, referrals, and case management as required.34

There has been much discussion about the role traditional medicines have in treating the chemical imbalances that result from opiate addiction. NNADAP research suggests that in some cases, communities are conflicted about methadone treatment.[35] In many communities, abstinence is seen as the only valid way to deal with addictions.[36] At the root of some of this disagreement are some misconceptions: Hopkins and Dumont explain:

An indigenous understanding is that medicine is curative, placed in Creation to promote wellness so that people could fulfill their responsibilities within family and community. Plants, trees and animals give themselves up to their human relatives, in whole or in part, so that the medicines they carry can help their human relatives live, but "living" is not limited to physiological functioning. Instead, it is understood to involve "living in relation to others." As a result, methadone and other pharmacological therapies are often misunderstood, simply because there is little evidence that they promote those relational goals: while individuals are maintaining individual wellness, many remain inactive in terms of fulfilling their roles within family and community. There are many First Nations grandparents raising their grandchildren because the child welfare system has removed children from addicted parents, and parents on methadone have not returned to fulfilling their parenting roles.[37]

Traditional medicines may also be used to lessen the tension created by the medicinal use of opiates to manage withdrawal pain. In some cases traditional medicines can work alongside, or even in place of, western drugs. The limbic brain is the center for emotional processing and "natural" painkillers.[38] Its releasing function however, has a level of tolerance, and the threshold of tolerance, is among other things, culturally influenced.[39] As Hopkins and Dumont suggest, spirituality ceremonies like the sweat lodge have been used to "facilitate withdrawal from opiates and at the same time to re-establish "spirit-designed" chemical pathways."40 Moreover, and in specific relation to herbal treatments, it has been noted that sea salt or cedar water can be used in foot or full-body soaks to detoxify and to manage pain. Natural medicines can also be prepared as a tea for cleansing and detoxifying the liver.[41] As noted by Nimkee's Cultural Coordinator Virgil Tobias, a gifted healer once cautioned that "when you give a person a specific medicine, these are indeed powerful medicines that have been prepared for that person's needs and use only – it is not to be shared or used in any way that is not in accordance with the directions of the traditional healer.

Part Two:
Examples of Appropriate Treatment

2.2 Traditional Medicines in a Government and Policy Context

The support of cultural-based practices is indicative of a broader acknowledgement made by governments and larger health organizations of the importance traditional healing practices have in providing effective health care for First Nations.

Many programs are also connected to larger national or regional health initiatives. For example, the Noojmowin Teg Centre is part of the Aboriginal Healing and Wellness Strategy (AHWS), which is a "policy and service initiative that brings together Aboriginal people and the Government of Ontario in a unique partnership to promote health and healing among Aboriginal people."[42]

Governments in Canada are not alone in acknowledging the importance traditional healing methods play in providing proper health care. The importance that researching, regulating and properly integrating traditional medicines into national health care systems has long been acknowledged by the World Health Organization (WHO). WHO has been assisting its Member States to develop national policies on integrating traditional medicine into national healthcare programs.[43] To support this process, the WHO drafted *Guidelines for the Assessment of Herbal Medicines*, which detailed basic criteria for the evaluation of quality, safety and efficacy of herbal medicines.[44]

When adopted by the Sixth International Conference (1991) on Drug Regulatory Authorities, it was agreed upon that as a general rule, assessments of herbal medicines should take into account the medicinal, historical, and ethnological background of herbal products, as well as the traditional experience of their use.[45] The WHO further states that "traditional and complementary/alternative medicine has demonstrated efficacy in areas such as mental health, disease prevention, treatment of non-communicable diseases, and improvement of the quality of life for persons living with chronic diseases as well as for the ageing population."[46]

In New Zealand for example, the Ministry of Health has begun to emphasize the role that 'Rongoa Maori' (Maori traditional medicine) has in the National Health Service as part of a desire to create a health care system that respects the Maori right to self-determination. In 1993, the National Organization of Maori Traditional Practitioners was established.[47] There are over 600 Maori Traditional Healers offering services that are covered by the state health care system.

The services provided by Rongoa practitioners are covered under the state plan, but the criteria for registration and oversight of professional practice is the responsibility of traditional Maori health organizations.[48] In 2006, the New Zealand Ministry of Health released a Rongoa development plan outlining how Maori traditional healing practices would be supported within the health and disability sector.[49] In 2007, the Primary Health provider in the region of Lake Taupo signed a contract for services with the National Organization of Traditional Healers, which shows how to bridge the divide between Maori and mainstream services. The two organizations now work together to promote the benefits of Rongoa Maori, and the importance it has to an individual's health.[50] "A key characteristic is that Elders do not seek status; instead, it flows from the people. The numerous terms used within the Native languages refer to people who have earned their title (Meili, 1992)."[51]

"A key characteristic is that Elders do not seek status; instead, it flows from the people. The numerous terms used within the Native languages refer to people who have earned their title (Meili, 1992)."

2.3 Summary

General lessons can be seen in the above discussion. These lessons do not tell you how to use traditional medicines in treating addictions. The lessons are meant to help your community decide how to talk about how you want to use traditional medicines in your addictions programs.

2.3.1 Traditional Medicines are Placed Based

There are many First Nations in Canada and the rest of North America. This means there are many traditional medicines and many traditional ways of healing - it will be different in each First Nation. This needs to be remembered so that the traditional medicines and the healing methods chosen to help treat addictions in a community come from the culture, the land, and the plants or flora and fauna indigenous to the area and community.

2.3.2 Culture is Healing

To understand the use of traditional medicines in treating addictions, the historical and cultural reasons for the high rates addictions in First Nations communities must also be understood. Evidence shows when a person reconnects to his or her culture, it creates an increased sense of meaning and this lowers the risk of addictions. When traditional medicines are used in communities as the key part of a broader treatment program, these can help reestablish a sense of traditional society and cultural pride.

Part Two:
Examples of Appropriate Treatment

2.3.3 Fusion with Western Health Care

Mainstream techniques for treating addictions are of little use without a solid understanding and a good knowledge of the cultural context. While many of the successful programs mentioned have been developed and used in an Indigenous context, combining traditional knowledge and mainstream psychological approaches could increase success rates. [52] For example, as shown in the New Zealand example, traditional and Western/European-based health systems can effectively co-exist. In New Zealand, the formal fusion of health care is done largely in a bicultural policy framework. This example shows that any successful formal or institutional fusion between two health systems should be based on a respect of the Indigenous right to self-determination. This does not mean that traditional-based medicines and practices should not be guided by national regulations. On the contrary, a successful partnership can be created if national state regulations are met in a way that that the group in question retains the right to internally manage the classification, administration, and regulation of medicines and practitioners relevant to their placed-based healthcare.

2.4 Summary Points - Guidelines

• First Nations communities have a higher rate of addictions than other communities. Western healthcare practices have not been able to solve this problem.

• Because Western healthcare practices do not speak to the historical and cultural reasons that cause addictions, a practice more suitable for First Nations is needed.

• Some First Nations communities have started programs that have improved addictions treatments both for individuals and in the community. These programs aim to make community connections stronger by improving and making important a sense of cultural pride.

• Traditional medicines used in the treatment of addictions must come from the local area. The way the traditional medicines are used must also be rooted in community cultural traditions.

• Treatment programs for First Nations can be improved if traditional healing practices can be used with and within the Western healthcare system.

• Combining traditional and Western health systems must be done in a way that respects the Indigenous right to self-determination, as well as follow national healthcare rules.

Part Three - For More Information

1. In Saskatchewan, the Sturgeon Lake First Nation Health Centre took the initiative (from the community's wishes) to adopt a combined western and traditional holistic approach to plan the means to fight a pandemic. See Sturgeon Lake First Nation's, "Presentation on the Holistic Pilot Project against Pandemics," January 2009, Vancouver, B.C. online: http://goo.gl/CaM5r

2. Recently the Métis Nation of Ontario released its study on traditional knowledge of Métis plant and vegetation use in southern Ontario, which identifies medicinal practices of the Métis relative to plants and vegetation in "Southern Ontario Métis Traditional Plant Use Study," June 2010, online: http://goo.gl/QaMQE

3. Refer to the North American Aboriginal Plant Foods & Medicines Database, for a searchable online database of plant based foods, dyes, fibers & medicines of North American First Peoples at http:// www.herb.umd.umich.edu

The database contains 44,691 items of interest and documents their traditional uses by 291 separate Amerindian culture groups. They represent 4,029 species from 243 different plant families, of which half are medicinal.

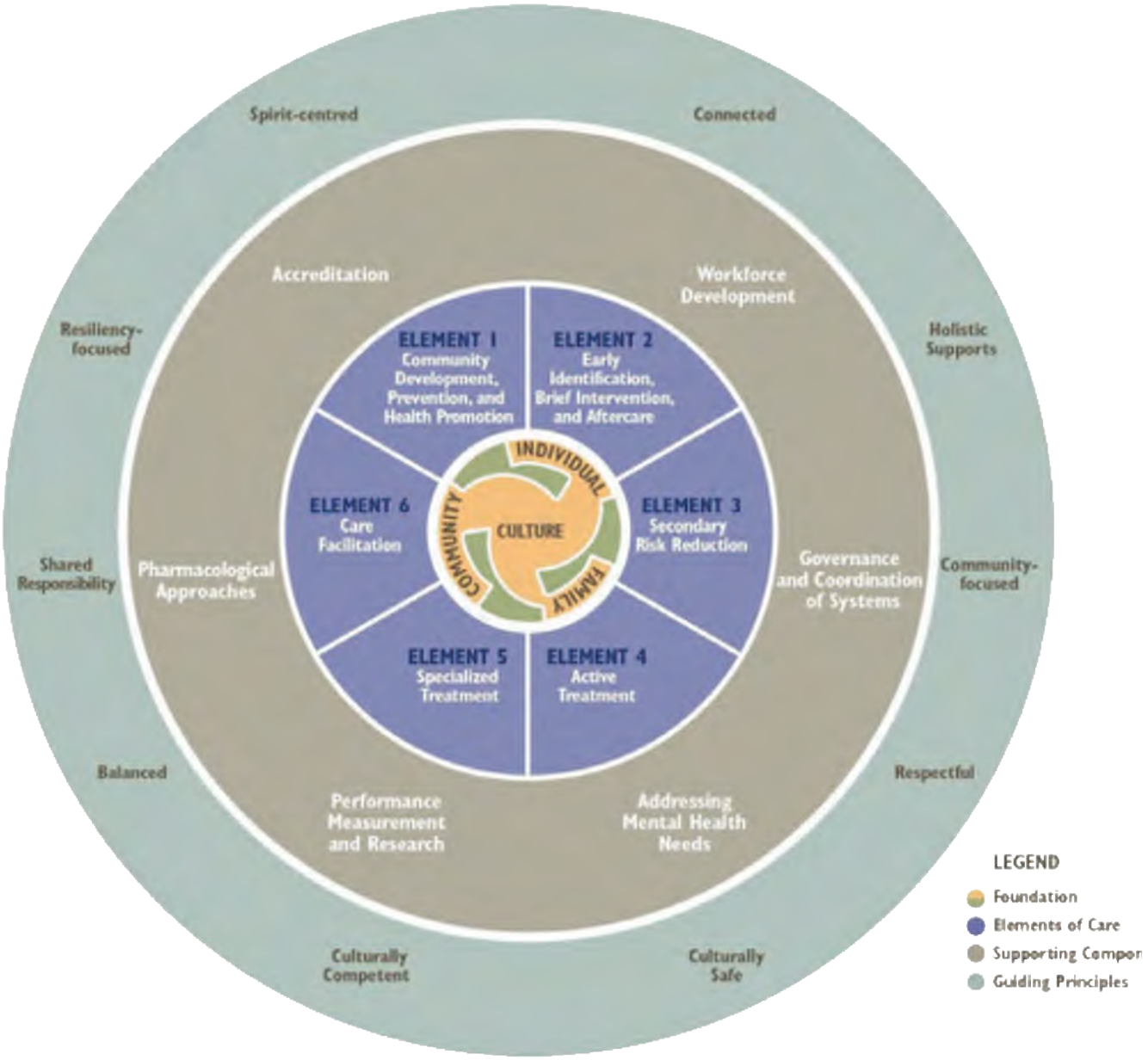
4. Raymond Obomsawin, "Traditional Medicine of Canada's First Peoples" June 2007, online: http://goo.gl/7Kn5A

5.NNADAP treatment centers integrate Traditional and Western methods in addressing alcoholism and drug abuse. Refer to McCormick and Quantz, "Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program", (Ottawa 2010), online: http://goo.gl/g20fc

6. Publications (From the National Aboriginal Health Organization (NAHO) website at http://www.naho.ca

Appendix A:
Six Elements of the Continuum of Care

The six elements of a continuum of care can be used to help persons, families, and communities with different addictions issues. They are also meant to meet help specific groups (e.g., women, youth, and people) who have other health issues at the same time:



Appendix B: Developing a Cultural-Based Practices Policy or Protocol

The draft policy template below can serve to kick-start discussion about what elements could be included.

DRAFT Policy Template supporting Cultural Practices

That_____, even though colonization has affected our way of life,
THE NAME OF COMMUNITY/ORGANIZATION
we reaffirm our use of traditional practices and medicines as part of our healing and wellness programs, while respecting the diversity in our community.

That in approving the use of cultural practices and medicines in the treatment of addictions, we as First Nations people will use the following medicines and practices in our traditional ceremonies and healing/health and wellness programs, including (identify the cultural practice):

_____

_____

_____

_____

In addition to our traditional resources available within our _____
we also rely on the additional resources offered through THE NAME OF COMMUNITY/ORGANIZATION, AND/OR PROGRAM, to support our use of cultural knowledge and practices in healing and wellness.

We as First Nations people also acknowledge a mutual respect and greater balance in our services to our community member and clients, in recognizing the blend/use of traditional and western medicines and healing practices in our approach to health and wellbeing.

We understand the need to better communicate about our cultural practices and programs within our own and with other communities. This includes health-related communities that use mostly Western-based practices, such as: (list other organizations you work with)

_____

_____

_____

_____

To create and offer a better understanding of our cultural practices, our community/organization will promote smudge offerings, medicine walks, and other practices in our working relationships and programs with the above-mentioned organizations.

For more information on our community's cultural practices policy, please contact:

_____

_____

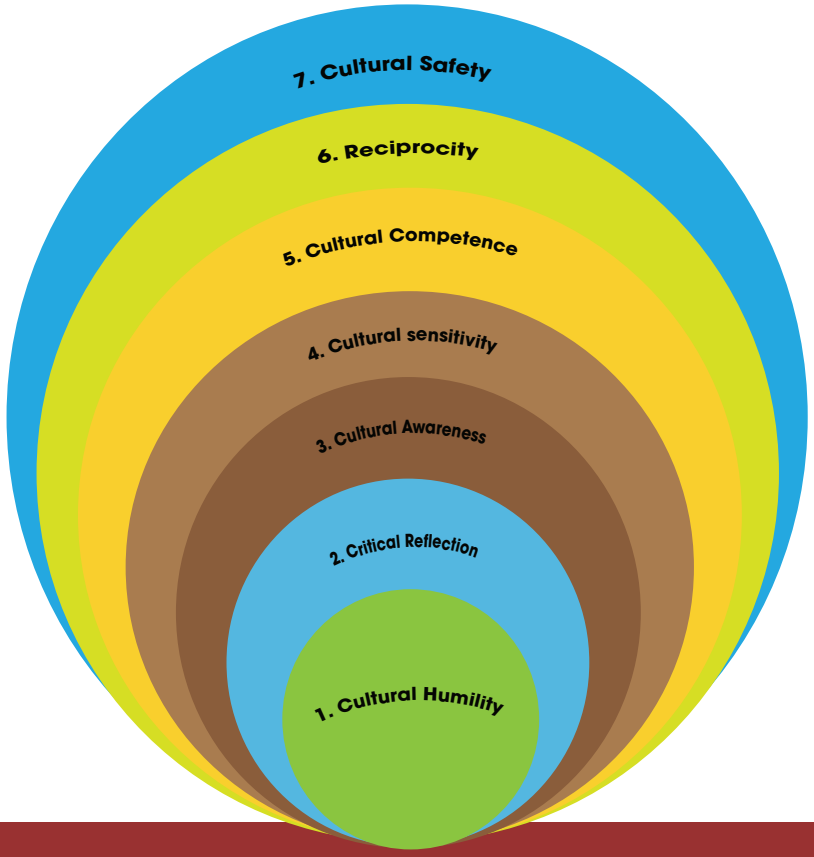
___

name and coordinates of contact person in community/organization.

Appendix C: NNAPF"s Renewal Stepping Stones' for Cultural Safety

NNAPF"s Renewal Stepping Stones' for Cultural Safety

NNAPF's Stepping Stones for Cultural Safety uses the Four Elements (Earth, Water, Fire, and Air) to explain the progression to Cultural Safety. The four elements are required in the physical realm of all human beings and there are a variety of interpretations of these four elements. Below is an example of an Ojibway perspective:



Earth represents the land we live on. The teaching of the earth "is to show respect for all BEINGS and to know the importance of all beings." Thus, beginning to understand Cultural Safety from the element Earth would ensure Cultural Humility by respecting all beings not just human beings.

Water represents healing and medicines. The teaching of water is "the place of deep introspection and reflection." The second step to cultural safety would be Critical Reflection because of need for self-reflection.

Fire represents the heart of Mother Earth. The teaching of fire is "the place of knowledge and wisdom." The third step to Cultural Safety is Cultural Awareness because it is the knowledge and wisdom of self and others "distinctive spiritual, material, intellectual and emotional features and to value systems, traditions and beliefs."

Air represents new beginnings. The teaching of air is "He (Waynaboozhoo or Original Man) looked up into the sky and noticed that the clouds were fleecy white, pure, and cold just like the snow at the tops of the mountains. He knew that high above the Earth there must be layers of air and elements that he had no name for. Nonetheless, he knew that something was up there that held it all together." (Benton-Banai, 1988). Thus, Cultural Sensitivity would be the next step because developing insight and understanding what culture is and the diverse relationship is the intention of Cultural Sensitivity.

Cultural Competence is when the health care provider works within the clients cultural needs by respecting and understanding the client's culture and historical trauma.

Reciprocity is about keeping the balance with in the relationship, as well as building trusting relationships.

In conclusion, Culturally Safety is an effect of a strengthening, encouraging, and empowering the cultural identity of Indigenous peoples with NNAPF's Renewal Stepping Stones.

For addressing substance use and mental health issues, we do not use the term "patient" and instead refer to the "client" as an individual, a family, a group or a community (AFN, Health Canada, NNAPF, 2011).

Cultural safety goes beyond the relationship between the health care provider and the client to ensure the health care environment is also cultural responsive by actively and continuously assessing and working to facilitate change through building cultural competency in health care structures and processes such as: service design, policy, human resources, service delivery and in achieving health outcomes that are culturally relevant and meaningful.

For addressing substance use and mental health issues, we do not use the term "patient" and instead refer to the "client" as an individual, a family, a group or a community (AFN, Health Canada, NNAPF, 2011).

Cultural safety goes beyond the relationship between the health care provider and the client to ensure the health care environment is also cultural responsive by actively and continuously assessing and working to facilitate change through building cultural competency in health care structures and processes such as: service design, policy, human resources, service delivery and in achieving health outcomes that are culturally relevant and meaningful.

Cultural safety goes beyond the relationship between the health care provider and the client to ensure the health care environment is also cultural responsive by actively and continuously assessing and working to facilitate change through building cultural competency in health care

ENDNOTES

[1] The terms "natural medicines" and "traditional medicines" are used interchangeably.

2 See for instance,the Traditional Dene Medicine Project by Joan Ryan, Martha Johnson, Diane Romie, Marie AdeleRabesca, LacLa Martre Band, Dene Cultural Institute and the Arctic Institute of North America, 1994.

[3] Olive Patricia Dickason, Canada's First Nations: A History of Founding Peoples from Earliest Times (Toronto: McClelland and Stewart, 1992), at 43-44.

[4] Canada,Report of the Royal Commission on Aboriginal Peoples, Volume 3, Chapter 3: Health and Healing (Ottawa: Minister of Supply and Services Canada, 1996) at 114.

[5] Eduardo Duran and Bonnie Duran,Native American Postcolonial Psychology, (Albany, NY: State University of NewYork Press, 1995) at 19.

[6] Canada, Royal Commission on Aboriginal People,Report of the Royal Commission on Aboriginal Peoples: Gathering StrengthVol. 3 Appendix 3A at 1(Ottawa: Supply and Services Canada, 1996) (RCAP).

[7] Yvonne Boyer, First Nations, Métis and Inuit Health and the Law, PhD Dissertation, University of Ottawa, 2010, unpublished at Chapter 2.

[8] Eduardo Duran and Bonnie Duran,Native American Postcolonial Psychology, (Albany, NY: State University of NewYork Press, 1995) ; Geoffrey York, The Dispossessed: Life and Death in Native Canada, (London: Vintage UK, 1990).

[9] JillPedigo, "Finding the "meaning" of Native American Substance Abuse: Implications for Community Prevention," Personnel and Guidance Journal, 1983 61(5), 273-277; quoted in Rod McCormick, "Aboriginal Traditions in theTreatment of Substance Abuse"Canadian Journal of Counseling, 2000, 34, 25-32.

[10] Eduardo Duran and Bonnie Duran,Native American Postcolonial Psychology, (Albany, NY: State University of New York Press, 1995) at 193.

[11] Rod McCormick, "Aboriginal Traditions in the Treatment of Substance Abuse" Canadian Journal of Counseling, 2000, 34, 25-32.

[12] Geoffrey York,The Dispossessed: Life and Death in Native Canada, (London: Vintage UK, 1990) (York)as quoted in Rod McCormick, "Aboriginal Traditions in the Treatment of Substance Abuse"
Canadian Journal of Counseling, 2000, 34.

[13] Rupert Ross,Dancing with a ghost: Exploring Indian reality, (Markham: Octopus 1992); as quoted in Rod McCormick, "Aboriginal Traditions in the Treatment of Substance Abuse" Canadian Journal of Counseling, 2000, 34.

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[15] W.G Darou, "Counselling the Northern Native," Canadian Journal of Counselling, 1987, 21

[16] In the Euro-Western field of psychotherapy, the type of therapy which best approximates this Aboriginal conceptualization of interdependent wellbeing is logotherapy. Logotherapy is an existential - humanistic approach that claims that the primary motivation for people is to obtain meaning in their lives. According to the theory, meaning can be obtained through sources such as spirituality, work, significant relationships with others, and contributing to one's community. Values are described as collective sources of meaning. Values are the activities that provide meaning to families, communities, and whole cultures. (Viktor Frankl,Mans search for meaning: An Introduction to Logotherapy,(Boston: Beacon Press, 1962); as quoted inRod McCormick, "Aboriginal Traditions in the Treatment of Substance Abuse"Canadian Journal of Counseling, 2000, 34).

[17] JosephFabry,The pursuit of meaning., (Boston: Beacon press, 1968).; as quoted in Rod McCormick, "Aboriginal Traditions in the Treatment of Substance Abuse" Canadian Journal of Counseling , 2000, 34.

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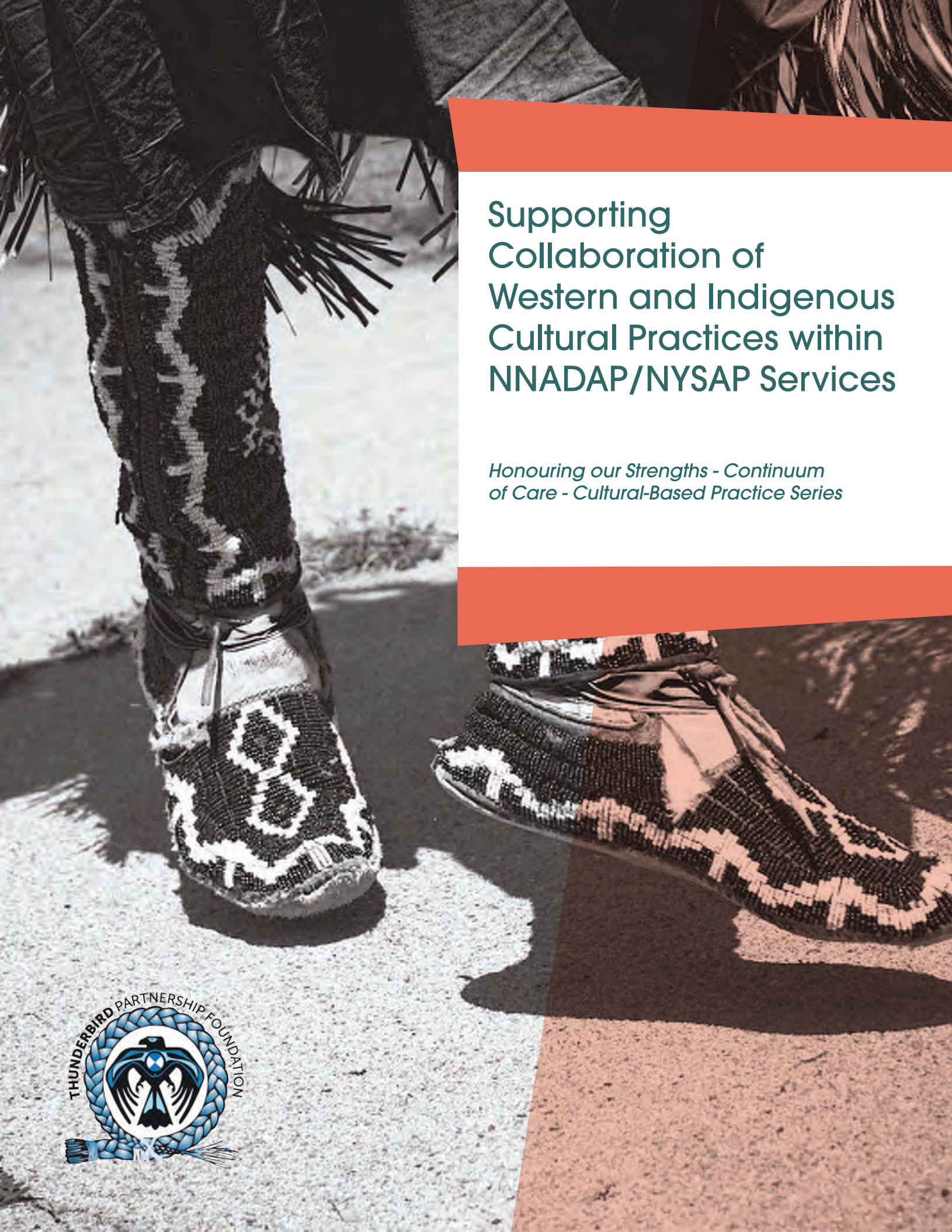


Supporting Collaboration of Western and Indigenous Cultural Practices within NNADAP/NYSAP Services

Honouring our Strengths - Continuum of Care - Cultural-Based Practice Series

THUNDERBIRD PARTNERSHIP FOUNDATION

Table of Contents

1.Introduction 1

2. Key Concepts/Constructs of First Nations Culture 1

2.1 Language as it relates to Culture 1

2.1.1 Workbook Exercise 2

2.2 Holistic Vision 3

2.3 Centrality of Spirit 3

2.4 Circle and Wholeness 3

2.5 Mother Earth 3

2.6 Universal Principles and Qualities 4

2.7 Indigenous Knowledge 4

2.7.1 Workbook Exercise 4

2.8 Directions of Indigenous Knowledge 5

3. Linking Western and Indigenous Traditional Healing Approaches 6

3.1 Resiliency Theory 6

3.2 Motivational Counselling 6

3.3 Developmental Psychology 6

3.4 Behaviour Modification 7

3.5 Cognitive–behavioural Therapy 7

3.6 Emotional Intelligence Theory 7

3.7 Prayer 8

3.8 Narrative/Group-based Therapies 8

3.9 Bio-psychosocial and Bio-psychocultural Approaches 8

3.9.1 Workbook Exercise 8

4. Re-establishing Indigenous Identity in NNAD 9

4.1 The Overall Structure and its Components 9

4.2 Common Examples of Setting Process into Practise 9

4.2.1 Workbook Exercise 10

5. Guiding Principles and Cultural Policy Template (draft) 11

5.1 Guiding Principles 11

5.2 Cultural Policy Template (draft) 12

6.Additional Resources/References 13

1. Introduction

The National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP) was founded on the principle that Indigenous-specific cultural practices drawn from an Indigenous world view would provide the best route to wellness for First Nations. Many of the cultural practice examples presented in this guidebook have come from regions in which the program operates, based on local cultural knowledge and practices. The guidebook is not intended to be a compendium of all of the practices; rather, it is a demonstration of how Western and Indigenous cultural practices can and do collaborate in the best interest of client outcomes. Recipes or descriptions of First Nations cultural practices will not be discussed, but reference to different ones will be made as well as their source or origin for the reader's knowledge. Little has been written or documented within NNADAP/NYSAP regarding structure, process, and outcomes of culture-based programming; however, the intent of this guidebook is to inform both Western and Indigenous practitioners on Indigenous world views deemed critical to sustaining an Indigenous way of life.

Within Western science, we understand that evidence-based decision making involves an approach that emphasizes the pursuit of evidence on which to base theory and techniques and, subsequently, better inform government policy and practices. It involves gathering ideas and observations from documented sources, some of which have been tested and demonstrated to be valid and reliable across specific populations of people and, more specifically, First Nations in Canada.

An Indigenous knowledge-informed evidence base is a similar approach found within NNADAP/NYSAP. It involves an approach to healing and wellness that emphasizes the manifestation and integration of physical and spiritual realities, which is also accepted as proof or evidence that can be tied to the majority of First Nations cultural teachings.

Both the physical and spiritual dimensions of the cultural evidence base identified in many of the working definitions are to better inform policy frameworks, program design, and, most essentially, in making sense of the meaning of culture for the lives of First Nations people. It is also essential to acknowledge the cultural differences of Indigenous peoples in Canada and to recognize no singular system of cultural practice exists nationwide. While there are similarities in terms of cultural meaning and purpose across groups, there are typically regional and local differences in how culture is used in practice by each First Nations population, regardless of being neighbouring communities, as in many cases.

As a consequence, standards of cultural practice or protocols within addictions programming must ideally be community-based and culturally specific, implemented to give consistency, organization, and clarity to cultural practice within specific NNADAP programs and services. Our intent is for this work to serve as a starting point to better understand and maximize opportunities for collaboration of Western and Indigenous cultural practices within NNADAP/NYSAP, and we look forward to feedback from our stakeholders on how to improve upon the presentation of this information.

[1] Refer to http://www.nnadaprenewal.ca/

2. Key Concepts/Constructs of First Nations Culture

Principles related to "culture" and its meaning appears commonly in Western literature, with very little discussion of its interpretation and relevance to a Western world view. This makes it a challenge for Western-based practitioners and policy-makers to understand and apply culture within an operational framework. This paradigm is changing within NNADAP/NYSAP; there is now greater collaboration with Health Canada, the Assembly of First Nations, and the National Native Addictions Partnership Foundation that better informs the renewal framework and reflects a culture-based programming, ultimately aimed at improving client outcomes.[1]

Until recently, Western perspectives and assumptions have served to reinforce Western world views and interpretation of cultural values, and it has been a challenge for Indigenous peoples to negotiate and create space for cultural meaning in all aspects of addictions services. Hays (2006) states that all parties—whether practitioners, and academics—share the responsibility of translating Western theoretical foundations and evidence base for their potential application to services for Indigenous peoples. NNADAP/NYSAP, as a program that serves a 100 per cent Indigenous client group, provides a unique opportunity to reflect on culture-based programming, as well as influence cultural safety and awareness throughout the continuum of addictions and mental health care. To begin, various constructs and co ncepts need to be understood and accepted as part of validating Indigenous values as it relates to the NNADAP/NYSAP program.

2.1 Language as it relates to Culture

"First Nations" is a general way to refer to one of Canada's Indigenous populations who differ substantially in language and customs nationwide. There are 614 First Nations bands or groups that share a range of common values, traditions, and practices throughout Canada, and these populations represent 11 language families (including Inuit) with 55 or more different dialects. While language and geographic location serve to inform various traditions and practices, First Nations believe and agree that common values are inherent in all dialects or locally spoken versions of the language.
As an example, Indigenous languages worldwide commonly refer to Creation as animate, recognizing the spiritual aspect of earth, plants, animals, and other living species. Indigenous languages describe the characteristics and behaviours of these living species, and these common values form the foundation for what is known as an Indigenous world view. This Indigenous world view explains that human and other-than-human relationships are fully captured within the Creation story, an interpretation that is also common to Western/European concepts of the beginning of humankind.

This construct has been conveyed across generations through Indigenous languages. Many Indigenous concepts cannot be translated into the English language but are preserved through petroglyphs, birchbark scrolls, wood, beadwork, carvings, sand paintings, appliqué, symbolic writing, and other ceremonial items (Benton-Banai, 1988; Beck, Walters, and Francisco, 1977). All Indigenous peoples had their own ways of transmitting and recording the original teachings of Creation.

For example

• the Anishinabe (Ojibway) of the Algonkian language family, the largest of the 11 language families, have the birchbark scrolls; and

• the Delaware or Lenni Lenape (also of the Algonkian language family) have the Wallam Olum (Red Record), revered as one of the oldest written records of an Indigenous people of North America (Weslager, 1972).

2.1.1 Workbook Exercise

Indigenous knowledge, similar to Western knowledge, is not static, but instead dynamic and ever-changing. As human beings, Indigenous peoples are continuously discovering or coming to new understandings about things that have existed in Creation and that have the benefit of the knowledge left by their ancestors, always rooted or founded in their stories of Creation. Indigenous Creation stories provide the structure, pattern, and processes of creation that are repeated in all aspects of life, from the structure of the universe to the structure of both human and other-than-human beings, with the difference being humans having the gift of free will while all other forms of Creation have a defined and persistent identity and, therefore, a purpose in their roles and responsibilities to everything else created.

For example, the Midewiwin teachings hold that all Creation stories are true; the teachings are drawn from the links, similarities, and patterns among the stories. A Western perspective may perceive the variation in the stories as conflicting, and such a misunderstanding of the oral tradition tends to exclude traditional knowledge sources as credible evidence. In fact, the oral tradition is based on a profound record keeping system not readily understandable without Indigenous language and knowledge. In many cases, song and ceremony for First Nations were linked as a much older and original form of communication to express the Creation stories among First Nations language families. The full extent of that knowledge is held within sacred societies and is demonstrated in ceremonial ritual, complete with knowledgeable use of traditional teachings and ceremonial articles.

In the broader workplace context, knowledge and awareness of self and others to perpetuate the sacred First Nations Seven Teachings in the workplace involve identifying, acknowledging, and analyzing one's own emotional responses to the histories and contemporary environments of First Nations peoples and offering opinions respectfully. Cultural practices in the work environment involve setting an example as managers with peers and staff while engaging in dialogue and relationship building with First Nations peoples and, ultimately, improving health through increased awareness and insights of First Nations cultures and health practices. In doing so, a First Nations community or organization that acknowledges and analyzes the limitations of one's own knowledge and perspectives can then incorporate new ways of seeing, valuing, and understanding with regard to First Nations health practice.

2.1.1 Workbook Exercise

From your understanding of the client groups you serve, which region(s) in Canada has your organization or treatment setting provided service to clients, whether First Nations, Métis, or Inuit? Do you know the language spoken from where they originated?

FIRST NATION, MÉTIS AND OR INUIT	LANGUAGE FAMILY/DIALECT	CULTURAL CONCEPT OR SOURCE/RECORD HISTORICAL IMPORTANCE

This organizational cultural practice serves to provide an orientation of the health programs to new leaders and community members when needed.[2]

The challenge for Western and Indigenous practitioners and managers involves understanding and describing how cultural knowledge explains an ever-changing physical world. The Creation stories, all of which are true no matter what their differences, have a common element: the Great Spirit placed everything within Creation that humankind would ever need to live. The greater challenge then is to understand where those answers lie within sacred knowledge, without scrutinizing and judging the understanding of an Indigenous belief system, no more than Western science can judge the validity of Christian, Muslim, Hindu, or a Buddhist-based understanding of Creation.

Indigenous intelligence is much more than one's mental or emotional aptitude. It is recognized as a formal system of knowledge, held by wisdom keepers, ceremonial practitioners, traditional healers/doctors, pharmacists, and counsellors and housed within traditional institutions such as the Midewiwin Lodge, the Longhouse, and their sacred societies. Indigenous communities assert that their right to control the use of their knowledge is an inherent right of self-determination—a right that must be recognized and respected. While there are indeed important differences in how traditional knowledge is used across Canada, there are a number of commonalities that can be expressed.

2.2 Holistic Vision

The Indigenous world view is said to be holistic, meaning it encompasses all aspects of life: physical, mental, emotional, and spiritual (Benton-Banai, 1988; Darussalam, 2001; Hill, 2003). With many First Nations, the medicine wheel reflects elements of a balanced approach to well-being, and health is a common symbol recognized by mainstream caregivers. It is also understood that all beings in Creation have the same physical structure and makeup, the capacity to think and reason, as well as the emotion and spirit. This includes First Nations' relationships with all elements of nature, both animate and inanimate, which supports the link between a person and the Creator and, ultimately, strengthens our belief system. The understanding that Indigenous people need to have a connection to the land expresses this holistic vision of interconnectedness: a dependency on the land not only for food and shelter but also for a place of belonging that informs both our individual and our collective identity (Kirmayer, Tait, and Simpson, 2009).

2.3 Centrality of Spirit

The very first concept is the "spirit" within an Indigenous world view and best understood through Creation stories as the foundation for all Indigenous knowledge and the interrelationships among all elements of Creation. The Creation story is healing in and of itself, and it reaffirms identity and provides direction in one's life (Benton-Banai, 1988; Freeman, 2007).
For Indigenous people, the spirit is at the centre of each individual just as it is at the centre of everything else within Creation.

When living with other spirit-centred beings, the relationship with the Creator becomes, first and foremost, one of spirit to spirit. Our role as human beings is to preserve that relationship and to maintain the spiritual order and structure of the world.

Within many Indigenous languages of Canada there are words that describe this space where physical and spiritual realities meet. The Indigenous way of life is directed by spirit: spirit-driven, spirit-defined, spirit-motivated, and spirit-centred. There is nothing mystical about it. Consistent with a First Nations construct of holism within this reality, the spirit is housed within the physical, mental, emotional, and social quadrants of the medicine wheel. In our life within this earth realm, these work together in such a way as to be inseparable and functioning as a whole. The spirit is always central and is always working in relation to the other quadrants of our being, which is critical to one's whole health.

Within the Indigenous world view, being spiritual means that the Indigenous person is spirit-motivated and that Indigenous culture is spirit-centred. In recognizing this, it unlocks the key to understanding the Indigenous way of being, knowing, perceiving, behaving, and living in the world. Indigenous psychology and Indigenous culture can only be fully and properly understood from within this belief that the spirit is the central and primary energy, cause, and motivator of life.

2.4 Circle and Wholeness

Another primary concept of the Indigenous world view that comes from the Creation story is the "circle." When life moves out equally in the four directions of the medicine wheel it forms a perfect circle. There are four different energies that cause the circle to move equally in all four directions. The energies of the four directions are what hold all of life together in the great circle of life's unfolding. It was established for all time that the circle would be the way in which all life unfolds as it moves forever toward the creation and re-creation of life. This concept is of primary significance in understanding the Indigenous world view, since it is the primary pattern of unfolding, growth, and change.

The circle is also synonymous with wholeness. The circle is continuous and remains the same regardless of changes in life, good or bad. Despite constant change in the universe, all things work together in an interdependent fashion, forming an interconnected web of integrated wholeness. Though each part is a recognizable unit, it only has meaning when in relation to the whole. Wholeness is the perception of the undivided entirety of things and to see life in a circular manner, which is to envision the interconnectedness and the interdependence of life. The circle is an all-embracing principle that is timeless and absolute, and it incorporates and helps in understanding all the parts of the created whole.

2.5 Mother Earth

We are all relatives because we have the same Mother Earth. This concept sums up best for us of our relationship to Creation, and it underlies our identity and relationship with the land. People were not only shaped by the land but were also created from the land, and it is this placement on the Island that sits on the back of the Great Turtle (North America) that is essential to the Creation story.

2 First Nations Health Managers Association (n.d.). See: "Domain 2: Professionalism."

The idea of being created from the land and being placed on the land forms an essential aspect of "aboriginality" or "indigenousness." First Nations are inseparable from the land, and their identity, sense of place, and history are intimately related to the land.

In the mind of the Indigenous person, though humankind is a special Creation event, the human being is of the earth and from the earth. Like the entire created world, the human being is part of the balance of nature, and it must find a special yet interconnected place within the created whole. The Indigenous person is a relative to all other persons of the earth and, along with all creatures, calls the earth "Mother." First Nations throughout Canada live within a great extended family and are related to the environment, and this view not only observes such links and intercommunication but goes further, upholding a world view that is personal, reciprocal, and spiritual in nature.

2.6 Universal Principles and Qualities

Key to understanding the Indigenous world view is the recognition of a fundamental principle: the universe cares. The manner by which Creation unfolded, and the order in which it evolved, is governed by the guiding principles of kindness and caring, with the understanding that the Creator cares for his creations. Given that Creation originated in this way, it endures and thrives by means of an underlying orientation toward kindness. This is especially important when we consider ourselves, as we understand it, put in the world in a kind and caring way.

Within Indigenous cultures, all things are regarded as related, and this not only applies to human beings but also to plants, trees, animals, rocks, as well as visible and unseen forces of nature that are considered spiritual entities and/or sacred beings. Because all things have the potential to be entities, they have a range of qualities that are commonly attributed in Western ideology exclusively to human beings. Once this is accepted, "other-than-human" beings are elevated to a higher quality of being, and the nature of the relationship moves to an all-inclusive, ethical level that reflects both spiritual and physical worlds.

2.7 Indigenous Knowledge

Since mainstream contact, knowledge has been defined for Indigenous populations through the eyes of a Western/European science that has a limited understanding of Indigenous world views. Since contact, Indigenous populations worldwide have been expressing their world view as involving more than the acquisition of knowledge and the manipulation of thoughts. In fact, Indigenous knowledge involves activating information into something useable that is also charged with meaning. In essence, it is the wise and conscientious embodiment of exemplary knowledge and the use of this knowledge in a good, beneficial, and meaningful way.

Indigenous knowledge requires fulfilling our responsibility to family and community—past, present, and future—using the gifts bestowed by the Creator and following the pathways left on this earth by our ancestors. As such, Indigenous ways of seeing, being, relating, and knowing have a sacred foundation. They are a spiritual gift to Indigenous peoples, and the challenges concerning how Indigenous knowledge has been acquired and learned needs to be expanded upon within Western science constructs in order to fully understand its role in the healing journey.

2.7.1 Workbook Exercise

From your understanding of the key constructs/concepts that are foundational to an Indigenous world view, what examples can you provide concerning clients you have helped, whether First Nations or Inuit?

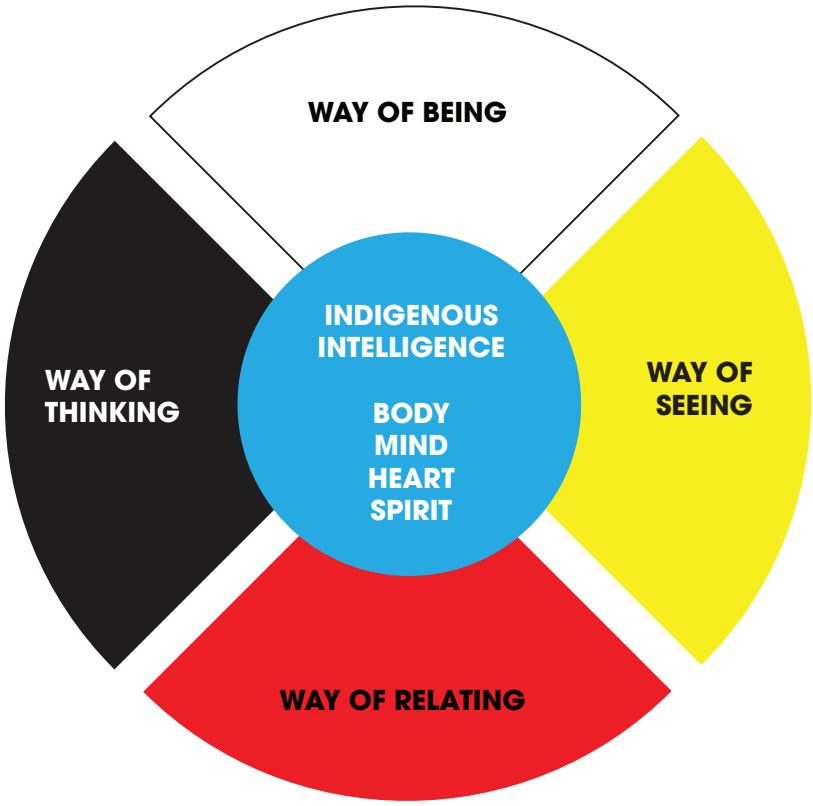
KEY CONCEPT/CONSTRUCT	FIRST NATIONS	INUIT
LANGUAGE		
HOLISTIC VISION		
CENTRALITY OF SPIRIT		
CIRCLE AND WHOLENESS		
MOTHER EARTH AND FATHER CREATOR		
UNIVERSAL GUIDELINES		
INDIGENOUS KNOWLEDGE		

2.8 Directions of Indigenous Knowledge

As NNADAP/NYSAP addictions services work through the renewal framework, they must consider renewal and revitalization from the perspective of Indigenous knowledge; otherwise, they risk perpetuating a system that focuses on individuals only instead of individuals and families and community as a whole. They also risk renewing a system that focuses on individual deficits rather than on the promise of positive change rooted firmly in Indigenous identity. Renewal of addictions services must not be seen as an isolated enterprise but as a central force in the re-establishment of a healthy Indigenous identity. It is time we re-connected ourselves to the health, direction, and wisdom of our ancestors. The following illustrates the directions of Indigenous knowledge, and each quadrant shows the deep level of intelligence that exists when Indigenous ways of being, thinking, seeing, and relating are engaged:

FOUR DIRECTIONS OF INDIGENOUS KNOWLEDGE

The Indigenous Way of Being is the whole response of the whole person with the whole environment. It is a way of doing that involves the whole person – body, mind, heart and spirit. The way of being and doing generates the finest creative Expression and the highest quality of experience of an individual person within an environment.



The Indigenous Way of Thinking uses the totality of the mind in its intellectual, intuitive and spiritual capacity as well as sensory and emotional inspiration. The Indigenous way of knowing involves all-inclusive learning and calls on the total responsiveness of the whole person. It is a way of knowing that is inspired from the heart as well as generated from the mind's intelligence.

The Indigenous Way of Seeing is spirit-centred. It is a total way of seeing. The person has the capacity for "whole vision," which encompasses the whole of reality, considers all levels of knowing, is informed by all of the senses (physical, emotional, intuitive, and spiritual), and maintains the interdependence, interconnectedness and holistic experience and integrity of the whole environment.

The Indigenous Way of Relating is an all-encompassing way of relating in a world that is personal, caring, responsive and sharing. It is inclusive of all beings: human and other-than-human. This way of relating is respectful of the individual and responsive to the integrity of the collective whole.

3. Linking Western and Indigenous Traditional Healing Approaches

The Royal Commission on Aboriginal Peoples offers this definition as context:

Traditional healing has been defined as "practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western 'scientific' bio-medicine." When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counseling and the accumulated wisdom of elders (RCAP, 1996, Vol.3: 348) (as cited in Hill, 2003:7).

Linking Indigenous culture and sacred knowledge with Western theoretical models is based on the understanding that although different, "they share a primary goal: changing the way the client thinks" (McDonald and Gonzalez, 2006:33). The most fundamental difference involves coming to know one's spirituality in relation to Creation. The Creation stories of Indigenous people are about real events that are vital to the psychological and spiritual growth of the individual personality. Within Creation is the original pattern for the forever unfolding of life and the wellness that involves restoring connection to others, including the spiritual connection to family and community.

As an example, Indigenous prophecies such as the Seven Fires Prophecies (Benton-Banai, 1988) discuss a period of time when the eighth and eternal fire will be lit. The marker for the eighth fire is a time of respect, when there is an honest understanding that differences have their place and purpose. The Creator placed the Indigenous peoples across this land as its caretakers, and it is this relationship to the land that is a primary foundation for differences between Western and Indigenous cultures. It is also important to understand that it is the sacred foundation of our differences that binds us together in commonalities: we have the same Creator and it is this principle that lights the eternal fire of mutual respect.

Indigenous cultural practices are not directed specifically towards one aspect of an individual. Because they are spiritually influenced, they are said to be holistic. These practices impact the mind, body, emotions, and spirit all at once and to varying degrees. Indigenous science integrates the sacred learning about Indigenous knowledge as an activity of "coming-toward-knowing" rather than achieving. One is initially transformed by Indigenous knowledge and then has the responsibility of extending this knowledge by translating its meaning to others.

When reviewing Western-based approaches, it is important to understand that they were not created to attend holistically to the mind, body, emotions, and spirit of an individual; many do not attend to family and community, and few place spirit as central to healing. Gaining an understanding of the differences requires self-awareness of one's own personal beliefs, value system, world view, and negative biases surrounding spirituality as well as training/education (Coyle, 2001).

There are many common cultural elements across NNADAP/NYSAP primarily within the meaning of practice. Rather than giving the description of cultural practices, the following provides an outline of principles of Western theoretical models applied to many Indigenous knowledge and cultural practices that are both meaningful and relevant.

3.1 Resiliency Theory

Resiliency theory in a Western theoretical model focuses on the force that drives a person to grow through adversity and disruptions (Richardson, 2002). Resiliency theory in an Indigenous context is based on the understanding that unresolved trauma, oppression, and colonization are forces that have created risk factors within all aspects of health across multiple generations and underlie substance abuse/misuse and addictions. Within Indigenous teachings, connection to one's spirit is facilitated through the identification of the individual's spirit name, clan family, and nation identity (Dell, Dell, and Hopkins, 2005). It is also dependent upon socially invested resources, culture, and networks (Ledogar and Fleming, 2008).

Resiliency theory in an Indigenous context focuses on culturally informed elements established between individuals and the community of resources around them or between the treatment centre and community. Activities that support the creation of resilience include talking and healing circles, drum and dance groups, Indigenous language acquisition activities, craft activities, community gardening, or other strategies that develop volunteerism such as the gathering and use of traditional medicines.

3.2 Motivational Counselling

Motivational counselling in a Western theoretical model focuses on personal choice, de-emphasizing labels such as "alcoholic" or "addict" and encouraging change instead of examining discrepancies between present behaviours and personal goals and values. While expressing empathy to facilitate change, motivational counselling in a Western context encourages an evaluation of pros and cons that assists client self-reflection and supports self-efficacy to facilitate belief in change and possibilities (Center for Substance Abuse Treatment, 2008).

Utilizing motivational counselling for Indigenous peoples is premature without first establishing a foundation of strength. Without reconnecting to cultural identity, the onus to change is on the individual without regard for social determinants of health (e.g., in a culturally crippled community environment). The motivation for change within Indigenous teachings is spirit-driven and originates from the Creation story. Spiritual identity is a necessary foundation for establishing motivation for change, and while a focus on cultural identity is expressed through spirit name, clan, and one's relationship to Creation, all is built upon unconditional love and acceptance.

Change is thus facilitated through an emphasis on strengths, not a focus on deficits, and this process is focused on teaching vision first, then planning for a future. Prayer, for example, is an important cultural practice in facilitating hope, supporting vision, and instilling a belief in change.

3.3 Developmental Psychology

Taken from the work of Carl Jung, psychotherapy in a Western theoretical model aims at guiding individuals to wholeness by helping them gain connection to all aspects of self. Developmental counselling facilitates a connection to the trauma of early life experiences that have been repressed or that have been stored unconsciously, and psychotherapy is typically not preoccupied with mental illness. Existential theory, such as logo therapy for example, is focused on extending psychotherapy to include the influence of spirit in defining meaning and purpose of one's life.

Within Indigenous circles, the Path of Life teaching articulates the various stages of life according to the spirit journey of walking through the physical world. A disconnection from spiritual nourishment can result in many forms of distress, including suicide. Suicide itself is understood as a response to not knowing one's purpose in life; whereas for First Nations, developmental stages of life are expressed through various ceremonial practices or rites of passage.

Examples of ceremonial practices and rites of passage include the walking out ceremony for babies who take their first steps; fasting ceremonies for adolescents; and ceremonies that celebrate gender roles and responsibilities such as Full Moon, taking care of Fire and Water, celebrating the arrival of new life, pre-birth and at-birth, burial ceremonies, and memorial (or ghost) feast ceremonies. In contrast, healing ceremonies typically facilitate unburdening and moving beyond the unresolved trauma of early life experiences, and these include the sweat lodge, healing dances, memorial feasts, etc. as examples of practices.

3.4 Behaviour Modification

In a Western theoretical model, behaviour is motivated by thought processes and patterns together with environmental stimulus. The emphasis is upon shifting efforts toward future expectations rather than past reinforcements.

Within Indigenous teachings, human behaviour is influenced by mind, body, emotions, and spirit. The medicine wheel presents a framework for emphasizing the interdependence of all aspects of self. Thought processes and patterns, coupled with environmental stimulus, are two parts of the self that influence behaviour.

Cultural teachings are focused on influencing behaviour, and more than that, they draw upon the past to inform the present. Knowing that our ancestors' footprints on the earth have left a spiritual path to follow ensures our future. Full or complete understanding of what the ancestors passed on for the future is critically important for informing the present.

3.5 Cognitive–Behavioural Therapy

Cognitive–behavioural therapy (CBT) in a Western theoretical model is based on the idea that thoughts cause feelings and behaviours. If we change the way we think, we can change our perceptions and beliefs for the better, even if the situation itself does not change (National Association of Cognitive-Behavioral Therapists, n.d.). There are generally five components to any problem: thoughts, emotions, physical sensation and symptoms, behaviour, and environment (McDonald and Gonzalez, 2006). Based on an educational model, this form of therapy is very structured and goal-oriented, specifically around the interaction among thought, feeling, and action.

Indigenous knowledge suggests that cultural aspects have either been overlooked in cognitive–behavioural assessments or framed in negative terms. Strengths associated with the cultural-specific environment need to be considered within Indigenous practices, such as the impact of colonization, oppression, racism and discrimination, access to resources, and exposure to endemic (pervasive) trauma like residential school and child welfare.

Indigenous interventions also take into account the extended family and clan family structures, the relationship to the land, the physical as well as spiritual environment, and culture-specific supports. Formal processes of transmitting Indigenous knowledge are very structured, especially those involving ceremony, given that they facilitate connection to mind, body, spirit, and emotion simultaneously.

From an Indigenous perspective, cognitive–behavioural therapy specific to addictions services would focus on decolonization through the development of a cultural identity (McDonald and Gonzalez, 2006). Cognitive restructuring involves teaching culturally based beliefs about self, family, and community all derived from the Creation story of the specific Indigenous population. Practical actions that can support identity development can include, at the very least, prayer and the use of natural, sacred medicines. Tobacco, for example, is a common sacred medicine understood across First Nations in Canada to be a spiritual means of transmitting prayer and establishing communication with the spirit world.

3.6 Emotional Intelligence Theory

Emotional intelligence theory in a Western theoretical model places emphasis on the meaning of both pleasant and unpleasant emotions, as well as cultural and genetic influences on emotional expression. It is not about diagnosing and labelling but about understanding the scientific evidence base for the physiological process of emotions: how the brain operates in relation to emotions or the emotional patterns (chemical flow) that are created when one suppresses emotions.

Complex post-traumatic stress disorder, attachment disorder, and stress disorder are all outcomes of environmental influences. They shape how we respond, leading to altered patterns and chemical imbalances that shift and trigger genetic responses over time. Healing programs, especially addictions programs, often talk about emotions as negative and painful and as something we need to get rid of, which only supports the notion that emotions are not useful and that they themselves are pathological.

An Indigenous world view acknowledges that all people were given unique gifts that distinguish their identity and that what is common to all humanity is the gift of free will. From a Western theoretical perspective, there is a dichotomy or contrast between humanistic theories that support free will and behaviourist theories that support determinism. From an Indigenous perspective, there is a relationship between one's free will and environment and how one influences the other. In the Creation story, there is an emphasis on knowing oneself through the creation of the universe, and the physiological process of putting Creation together is continuously replicated in human beings and throughout life. Within Indigenous constructs, a person does not exist unto themselves; instead, their physiological functioning is directly connected to and influenced by the environment.

A reconnection with one's Creation identity creates opportunity for shifting chemical imbalances, for strengthening the genetic string into the next generation, both physically and spiritually, and for changing patterns of behaviour, thinking, and emotional response to one's environment.

3.7 Prayer

Prayer is also a powerful tool to facilitate vision and hope. It is often given when looking to the future and when requesting the Creator's help in living with trauma or community dilemma. As an example, in one case, a patient with schizophrenia was visited daily by his elder aunty. When the patient was discharged and asked what made the difference in his recovery, his belief in spiritual help through prayer and his aunt's facilitation are what brought about the healing (Durie, 2009). Cultural teachings specific to one's genetic makeup are important for creating emotional and Indigenous intelligence and for realizing one's potential for healthy functioning within family and community.

3.8 Narrative/Group-based Therapies

Western psychology seems to be discovering the advantages of bringing people together to discuss their lives and challenges in a non-confrontational and mutually supportive process, calling them "narrative therapies in a group format." In Connecticut, for instance, a study of what its originators called a "Relational Psychotherapy Mother's Group" for heroin-addicted mothers drew positive conclusions, and great promise was found in this ancient Indigenous process, given that it is strength-based, non-hierarchical, interpersonal, and discovery-based.

3.9 Bio-psychosocial and Bio-psychocultural Approaches

Bio-psychosocial and bio-psychocultural approaches hold that biological, psychological, and social factors combine to influence behaviour. The biological component of the model seeks to understand how the cause of the illness stems from the functioning of the individual's body. The psychological component of that same model looks for potential psychological causes of a health problem, such as lack of self-control, emotional turmoil, and negative thinking. The social element of the approach investigates how different social factors such as socio-economic status, culture, poverty, technology, and religion can influence health (Santrock, 2007).

Likewise, a bio-psychocultural approach has also been developed paying specific attention to the inter- and intra-cultural variables that directly and indirectly influence behaviour (Eshun and Gurung, 2009). The drawbacks, however, are the apparent equation of culture and religion in the Western approach and the denigration of religious beliefs as being without scientific basis and as having, for that reason, no ultimate truth value. Religious beliefs are seen as merely customs passed from generation to generation, which is in direct contradiction to Indigenous beliefs.

3.9.1 Workbook Exercise

Please rate from "good" to "fair" to "needs work" in your familiarity with the following:

WESTERN THEORETICAL MODEL	INDIGENOUS PRACTICES AND APPLICATIONS INVOLVING CULTURAL AND TRADITIONAL HEALING
Resiliency Theory	
Motivational Counselling	
Developmental Psychology	
Behaviour Modification	
Cognitive–behavioural Therapy	
Emotional Intelligence Theory	
Prayer	
Narrative/Group-based Therapies	
Bio-psychosocial and Bio-psychocultural Approaches	

4. Re-establishing Indigenous Identity in NNADAP/NYSAP

4.1 The Overall Structure and its Components

NNADAP/NYSAP has played a significant role in facilitating the development of Indigenous identity, recognizing that a secure identity requires more than the superficial knowledge of cultural practices. In fact, it depends on gaining an understanding of Indigenous language, history, teachings, family, community, and land and emphasizing healthy connections need to be established simply because individuals must always "go home"[3] to find their truth and continue their journey. Some of the component parts of a broader healing and wellness process ultimately need to address.

• **physical needs:** including detoxification with natural medicines, traditional foods, rest, and exercise or ceremonial games;

• **emotional needs:** through ceremonial welcoming to the community or wellness circle;

• **mental needs:** focusing on education regarding Indigenous identity and Indigenous practices; and

• **spiritual needs:** through spirit name/clan/nation identification and teachings as well as opportunities to experience relationships with Creation.

4.2 Common Examples of Setting Process into Practise

Celebration-of-life Ceremonies: Focusing on strengths and enhancing Indigenous teachings that follow the Creation stories speak to the stages of life and are directed by the developmental processes that bind the physical and spiritual life experience.

Cultural Assessments: Having a spiritual reading done to determine specific needs to strengthen spiritual connections through the use of feasts, natural medicines, or other ceremonies.

Indigenous Identity Awareness: Meaning that the client, cultural activities, and ceremonies are inclusive of family, clan, and community (e.g., learning bush skills like hunting, trapping, and harvesting medicines as well as learning interdependence by living with others at a land-based camp). Treatment centres that include fasting ceremonies also rely on a strong connection to, and understanding of, the relationship to both the land and to the volunteerism and participation of the community.

Plan-of-CareGoals: Supporting our inherent strengths as Indigenous persons by focusing on establishing meaningful connections of mind, body, spirit, and emotion through education, cultural experience, and ceremony is essential.

Indigenous Languages: Facilitating the opening of spiritual doorways from an Indigenous perspective to language and ceremonial song. Ceremonial language contains the closest links to spiritual language, and it is the best stimulus for full-brain engagement, both physically and spiritually.

Sacred Foods and Medicines: Addressing physical and chemical imbalances created by opiate use with sacred foods and medicines. For example, sea salt or cedar water can be used in foot or full-body soaks to detoxify and to manage pain; natural medicines can be prepared as a tea for cleansing and detoxifying the liver; and traditional medicines like sage, sweetgrass, cedar, or tobacco can be used for smudging or other ceremonies.

Sweat Lodge: Using the sweat lodge as the most prominent in a multi-faceted approach to wellness is widely used across NNADAP/NYSAP, even though the process for conducting it varies and is specific to a First Nation. For instance, community-based sweat lodge ceremonies occur almost every evening across 12 First Nations communities in Nova Scotia, and they welcome people referred by the Native Alcohol and Drug Abuse Counselling Association of Nova Scotia.

Ceremonial Instruments: Using the pipe, shakers, and various drums together with the teachings behind their use are seen as important "touch-stones" in defining/redefining oneself as an Indigenous person. Smudging, for instance, speaks to the need to come into conversation with open eyes, mind, ears, heart, tongue, and body and be ready to listen and respond with care. The eagle feather speaks to the need for honesty and humility, acknowledging how little we fully understand the Creator's truths.

Seven Fires Prophecy: Using the Seven Fires Prophecy or other Indigenous prophecies serve as illustrations for the need to use the spiritual vision that will guide entire communities over generations, whereby growth and development can be focused on and motivated by responsibility to future generations.

Inherent Strengths and Goodness: Designing policies, protocols, and curricula to draw out the inherent strengths of everyone involved allows services to be delivered with a firm belief in the goodness of others, just as a community's capacity building can focus on inherent strengths. The focus is not on risk factors but on the inherent protective factors that are defined culturally and are specific to the First Nations community.

Community Inclusion: Including the community in ceremonies within the treatment centre (or within the community itself) is critically important as ceremonies are not facilitated solely through the one conducting the ceremony. Including the community is the same as replicating the universal family in the physical presence, with all contributing to the movement towards health and wellness.

Outcome Measurement: Focusing on measuring the advancement of inherent strengths and the fulfillment of roles and responsibilities within family and community as defined by the individual.

Other Examples of Services: Having NNADAP/NYSAP program services focus on the individual's specific needs—whether employment and training, child welfare, social income assistance, or the like—will assist clients in reducing the stress and burden while participating in treatment services.

Western Theoretical Models: Taking care when using a Western model to ensure that it clearly supports the perspectives of Indigenous knowledge and to ensure it will not threaten the re-establishment of Indigenous identity.

[3] "Go home" is a common phrase used to express a return to one's family, community, and land as this is the source of truth around identity, place, and purpose in Creation. Place is not restricted to geographic location, instead it means one's place within the universe, family, and community and is based on the knowledge that all beings in Creation have a place of belonging.

4.2.1 Workbook Exercise

Please rate from "good" to "fair" to "needs work" in your familiarity with the following:

NNADAP/NYSAP PRACTICE	EQUIVALENT APPLICATION WITHIN YOUR COMMUNITY OR TREATMENT CENTRE
Celebration-of-life Ceremonies	
Cultural Assessments	
Indigenous Identity Awareness	
Plan-of-Care Goals	
Indigenous Languages	
Sacred Foods and Medicines	
Sweat Lodge	
Ceremonial Instruments	
Seven Fires Prophecy	
Inherent Strengths and Goodness	
Community Inclusion	
Outcome Measurement	
Other Services	
Western Theoretical Models	

5. Guiding Principles and Cultural Policy Template (draft)

Community development efforts vary considerably from one First Nations community to the next. The National Native Addictions Partnership Foundation (NNAPF)* is presently developing a tool with which to assess community development efforts and, more specifically, to determine whether the community has reached a level of competency in its community development initiatives.

5.1 Guiding Principles

Central to Indigenous intelligence is the belief that the Great Spirit placed everything within Creation that humankind would ever need to live. Key concepts of Indigenous intelligence demonstrate their application within addictions services, and the sweat lodge is an exemplary prevention strategy given its ability to strengthen cultural identity, address grief and trauma, and facilitate recovery and health promotion/maintenance.

Collaboration between Western approaches and cultural knowledge would be ideally founded on cultural knowledge that incorporates Western approaches that are culturally relevant to Indigenous peoples and supported by policy based on the following seven guiding principles:

1. Indigenous knowledge is valued as a credible source of evidence. NNADAP promotes and supports a cultural evidence base that monitors the influence of culture in healing and wellness;

2. Healing and wellness should be understood within NNADAP and within the context of meaningful purpose, identity development, connections, and an ever-evolving path;

3.Indigenous culture and traditional healing practices are community-sourced within NNADAP at the present time, and more resources need to be invested in public health and primary health care development within the community to maximize program effectiveness;

4. Cultural practitioners and cultural knowledge must be included in ALL workforce development strategies, whether human resource policies, contracted services, salary compensation, professional development, or cultural-specific standards of practice;

5.Service design should reflect a cultural evidence base through clearly defined indicators, such as the increased positive connection and contribution from and to family and community, the continued practice of spirituality, etc.;

6. Community development and capacity building, in addition to prevention and residential treatment, need to improve cultural relevancy by building an evidence base using both Western theoretical approaches and traditional cultural healing practices; and

7. Principles for determining the cultural evidence base are proposed for the renewal of all NNADAP community-based and treatment centre programs, specifically

• Indigenous knowledge is founded on the Creation story of the people;

• Indigenous evidence is the continuous and consistent process of making meaning of Indigenous knowledge in its role in healing and intervention through the generations;

• Colonization must be understood as the cause of Indigenous knowledge and healing practices being diminished or discarded;

• Indigenous practices are tied to the community, and its practitioners are sanctioned by, and accountable to, their community;

• Indigenous health practices impact on health and wellness and is evident in one's physical life; and

• Indigenous ways of life are neither mystical nor magical but solidly grounded in physical life and connected to spirit.

* As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

Cultural Policy Template (draft)

The_____, while acknowledging the impact that colonization has had on
NAME OF COMMUNITY/ORGANIZATION
our way of life, we reaffirm our use of cultural practices and traditional knowledge as part of our NNADAP healing and wellness program, while respecting the diversity of religion and other practices as expressed in the various denominations within our community.

In defining cultural practices and traditional knowledge in the treatment of alcohol and substance abuse, we, as First Nations people, incorporate the following cultural practices in our traditional ceremonies and healing/health and wellness programs, including the following uses: (list of cultural practice/traditional knowledge or medicine in relation to the particular practice/program):

_____

_____

_____

_____

In addition to our traditional resources available within our _____), we also
COMMUNITY/ORGANIZATION
rely on the additional resources offered through the _____, to support our
COMMUNITY/ORGANIZATION/PROGRAM
use of cultural knowledge and practices in healing and wellness.

We as First Nations people also acknowledge a mutual respect and greater balance in our services to our community members and clients in recognizing the blend/use of natural or traditional and Western medicines and healing practices in our approach to health and well-being.

We also acknowledge the need for improvements and greater awareness of our practices and programs within our own and neighbouring communities, including health-related environments where there is a predominance of Western-based practices, such as the following: (list other organizations you work with)

_____

_____

_____

_____

As part of our ongoing efforts to better inform and create understanding of our use of traditional medicines, our _____ will promote smudge offerings, medicine walks, (list as many as
COMMUNITY/ORGANIZATION
possible), and other practices (list as many as possible) in our working relationship and (list affiliated) programs with the above-mentioned organizations, such as the following: (list practice in relation to what traditional medicine that may include what program)

_____

_____

_____

_____

NNAPF and its Renewal Partners (Health Canada and the Assembly of First Nations) hope this workbook has contributed to a better understanding of Indigenous knowledge and of the essential contribution it can make, not only towards the treatment of addictions and substance abuse, but also toward the restoration of Indigenous identity across Canada.

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NOTES

NOTES

THUNDERBIRD PARTNERSHIP FOUNDATION

STRENGTHENING OUR CONNECTIONS TO PROMOTE LIFE:

A Life Promotion Toolkit by Indigenous Youth

THUNDERBIRD PARTNERSHIP FOUNDATION

The Thunderbird Partnership Foundation is a leading culturally centred voice across Canada on First Nations mental wellness, substance use and addictions. The organization supports an integrated and wholistic approach to healing and wellness serving First Nations and various levels of government, through research, training and education, policy and partnerships, and communications. Thunderbird strives to support culture-based outcomes of Hope, Belonging, Meaning and Purpose for First Nations individuals, families and communities. Thunderbird's mandate is to implement the Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (HOS) and the First Nations Mental Wellness Continuum (FNMWC) framework.

The Thunderbird Partnership Foundation is a division of the National Native Addictions Partnership Foundation Inc.

THUNDERBIRD
PARTNERSHIP FOUNDATION

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Strengthening our connections to promote life: A toolkit by Indigenous Youth.
National Native Addictions Partnership Foundation, Inc.

This toolkit features artwork by: Page Chartrand, Cynthia Edwards, Carly G Morrisseau

Cover art by Page Chartrand (Instagram: @pagechartrand_)

Honouring the Gift of Life

I am pleased to welcome you to our Indigenous youth life promotion toolkit. It has been my privilege and honour to participate with and support our Indigenous team of youth from across Turtle Island who have developed this exciting and inspiring toolkit. It is our hope that this toolkit supports our youth across our lands to aspire to live long and good lives. The knowledge and wisdom of our ancestors from before colonization created healthy lifestyles that frequently lead to our relatives living much longer and healthier lives than many of us experience today. Our youth have also told us for many years that they are more interested in learning how to promote life as opposed to how to prevent death.

Through the ideas shared within this life promotion toolkit, our youth team is inviting you to explore and reform the wisdom from our ancestors to once again lead you to live healthier and longer lives. We hope that you discover, as we have, the excitement about cherishing and honouring our Creator's gift of life. In doing so, it is our hope that you also discover from this journey how to promote your life to be a long and good one.

In peace and love,

(Elder Ed) Waubinabenasi kwekwetchgun
Eastern Thunderbird Sounding

Introduction
Background 4
Who is the Youth Action Group for Life Promotion? 5
What is Life Promotion? 11
Statement on Life Promotion From Youth Action Group for Life Promotion
What Does Life Promotion Mean to You?
Creating Safe and Brave Spaces 12
The Importance of Having Gentle Teachers 13
Before You Begin 14
What to Do if Someone Checks-Out?

Connection to Land
Preface 16
Full Moon Activity 19
Food Sovereignty, Gardening, and Food Programs 20
Living Off the Land and Building Your Own Fire 21
Seasonal Activities/Exploring Communities Capacity for Land Based Activities 22
Medicine Walks, Harvesting, and/or Foraging 23
Connection to Nature Using Mindfulness 24
Identifying Local Knowledge Keepers 25
Movement is Medicine 26
Closing Reflection 28
Resources 29

Connection to Self
Preface 32
Introducing Yourself in the Language 35
Knowing My Response-Ability 38
Changing the Way We Speak 39
The Power of Affirmations 40
Creativity Activity *(Music, Drawing, Journaling)* 41
Fidgeting and Its Importance 42
Creating a Self-Care Kit 43
Morals and Values Activity 44
Self-Reflection Activity 45
Stretching Activity 46
Exploring Our Identities 47
Meditation 48
Healthy Communication and Boundaries 49
Ceremony With Intention 50
Resources 51

Connection to Community
Preface 54
Engaging Role Models for Mentorship and Peer Support 57
Craft Night 58
Communal Challenge/Repair Activity 59
Festivals 60
Family Tree Activity 61
Sharing Circle Activity 62
Tea Talks for Intergenerational Healing 63
Ceremony With Communal Intention 64
Resources 65

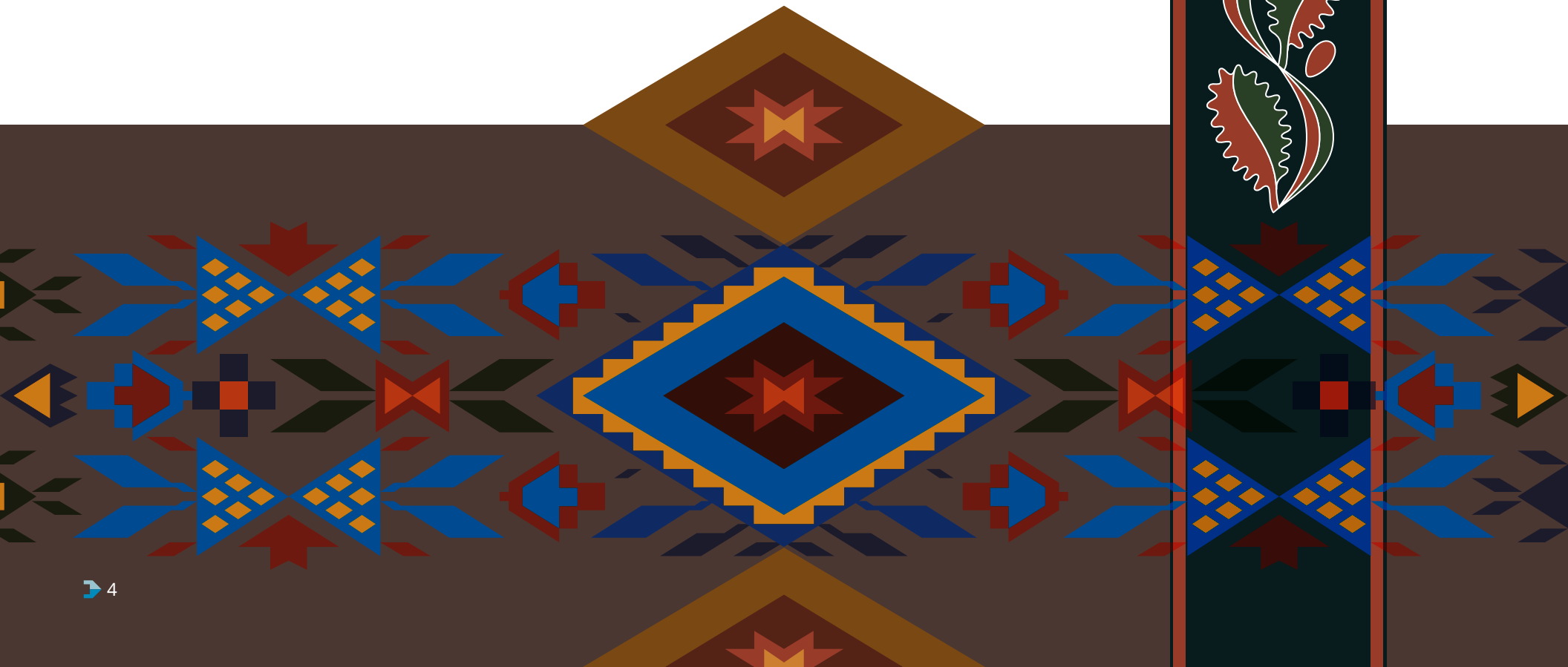
Connection to Spirituality
Preface 68
Naming Ceremony 71
Making a Traditional Dwelling 72
Creating Spiritual Items 73
Learning Your Creation Story 74
Drumming and Singing 75
Resources 76

Resources
Community Contacts and Resources Sheets 77
Tools and Templates 77
Indigenous Multimedia 78
Friendship Centers in Canada by Province and Territory 79
Post-Secondary Institutions With Indigenous Councils/Resources 81
Life Promotion Videos 82

Wise Practices for Engaging Youth 83

Background

Strengthening Our Connections to Promote Life: A Life Promotion Toolkit by Indigenous Youth was proposed in 2019 to develop a youth-focused and youth-led response to suicide, mental wellness, and substance use in Indigenous communities. A life promotion lens was used in the creation of this guide, which will be presented at the World Indigenous Suicide Prevention Conference. The conference was scheduled for 2020 but was pushed ahead to 2021 due to the COVID-19 pandemic. The theme of the conference is Strength in Our Communities. Originally the guide was to be developed over one year with in-person gatherings, but the Youth Action Group for Life Promotion had to adapt in response to the pandemic, and everything was done virtually.



Who Is the Youth Action Group for Life Promotion?

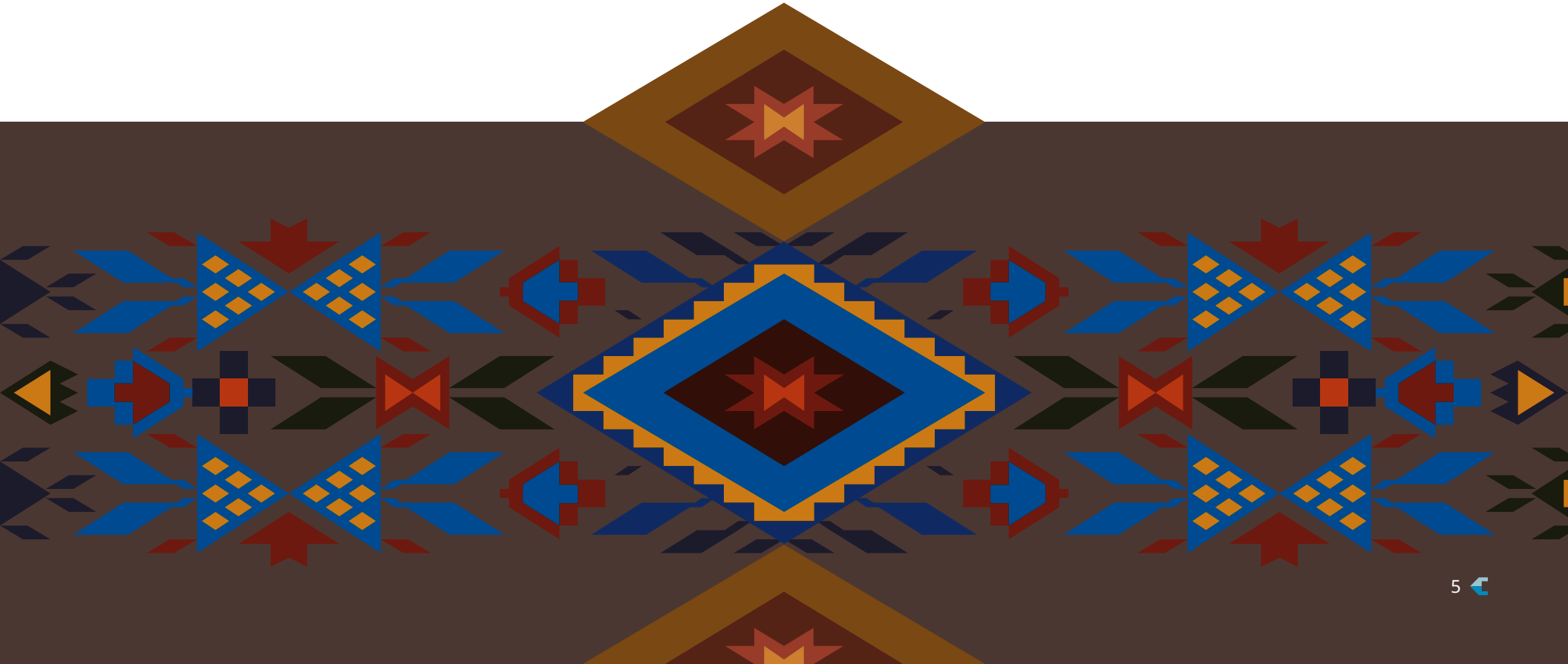
Our Youth Action Group for Life Promotion is a collective of Indigenous youth across Turtle Island. Through weekly virtual meetings, and with the support of Elder Dr. Ed Connors and Thunderbird, our group was able to learn from each other and create this toolkit focusing on life promotion in Indigenous communities.

As is our custom, we would like to introduce ourselves.

Over the following pages, we invite you to read more about each member of the Youth Action Group: to learn more about who we are, what Nations and territories we come from, and what strengths we each contributed to create this new resource to support living life!

In peace and friendship,

The Youth Action Group for Life Promotion



Elder Dr. Edward A. Connors, PH.D. C.PSYCH.

Waubinabenasi kwekwetchgun *(Eastern Thunderbird Sounding)* **– Wolf Clan**

Ed is a Psychologist registered in the Province of Ontario. He is of Mohawk and Irish ancestry and is a band member of Kahnawake Mohawk Territory. He has worked with First Nations communities across Canada since 1982 in both urban and rural centres. His work over this time has included Clinical Director for an Infant Mental Health Centre in the city of Regina and Director for the Sacred Circle, a Suicide Prevention Program developed to serve First Nations communities in Northwestern Ontario. While developing the latter service, Ed worked with Elders and apprenticed in traditional First Nations approaches to healing. Today his practice incorporates traditional knowledge about healing while also employing his training as a Psychologist.

Since 1993, he and his wife Donna, have managed Onkwatenro'shon:'A, a health planning firm which provides health consultation and psychological services to First Nations individuals, families and communities throughout the Georgian Bay Muskoka region.

Dr. Connors has been a board member and vice-president of the Canadian Association for Suicide Prevention between 1990 – 1998 and 2012 to the present. He is currently on the advisory council for the Ontario Suicide Prevention Network. He was a member of the Family Caregivers Committee of the Mental Health Commission of Canada (2008-2010). He also serves as an lder/advisor for Enaahtig Healing Lodge and Learning Centre and the First Peoples Wellness Circle.

Some of his current work includes consultation and community training to assist First Nations in the development of Restorative Justice and health programs and a board member of the Waypoint Mental Health Centre Penetanguishene. *(September 2009-present)*.

Ed's work has included membership on the Family Caregivers Committee of the Mental Health Commission of Canada between 2008 and 2010. During this work he consulted with the First Nations Inuit and Metis Advisory Committee of the Commission on their cultural safety/relational practice/cultural competency project. Ed has consulted with the University of British Columbia on the adaptation of the Indigenous Cultural Competence Training Program that was developed for the B.C. Health Authority. This model of on-line training has been culturally adapted for use with Ontario Health care providers.

Over the past several years Ed has worked with John Rice and many other community members in the development of Feather Carriers Leadership for Life Promotion. This work includes a partnership with the Canadian Foundation for Health Care Improvement to develop Life Promotion projects with regional Health Authorities across Canada.

Taylor Behn-Tsakoza

(She/Her) Age 25 – Dene
Fort Nelson & Prophet River First Nations, BC Treaty 8 Territory

Taylor Behn-Tsakoza is a Dene cis woman from the Fort Nelson & Prophet River First Nations in BC Treaty 8 Territory. She holds a degree in Health and Physical Education and a Graduate Certificate in Indigenous Sport and Recreation Management. Currently, Taylor works as a community educator bringing sexual health and harm reduction workshops to youth across BC using a holistic wellness model and traditional teachings. She is passionate about elevating youth voices and addressing the need for programs that connect youth to culture and community. Having been guided by her grandparents, mother, aunties and mentors, Taylor is a language learner in the Dene K'e (South Slavey) dialect and is an emerging artist of traditional Dene crafts. When she is not out in the community delivering programs, you can find her out on her traditional territory with her family exercising their treaty rights.

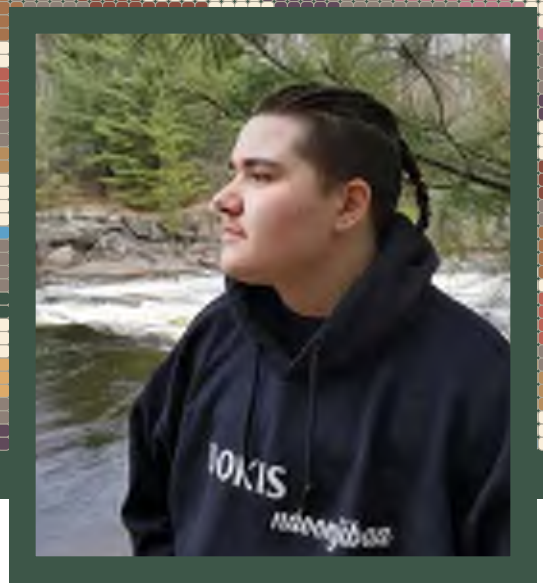
"My goal is to help other Indigenous youth realize their potential and feel empowered to live a long and good life"

Gabrielle Dawn Jubinville – Youth Leader

(Her/She & They/Them) Age 25
Maskêkosihk (Enoch Cree Nation)

Gabrielle Jubinville is half plains Cree and European background of quarter Scottish and quarter English. Gabrielle worked toward becoming a successful athlete playing basketball at the Junior college level in New Rochelle, New York at Monroe College and went on to play at the highest level of the sport at Alcore State University NCAA Division 1 basketball, earning her numerous scholarships to play basketball and get educated across the United States. While getting educated, Gabrielle found her passion for advocacy for those who could not help themselves, breaking the cycle of Indigenous People's stigma and labels through setting an example. While playing basketball competitively Gabrielle's strong cultural background in traditional teachings grounded her in her success and continues to do so to guide her in a good way. Currently residing in Brandon, MB she is studying at Brandon University. She is majoring in Natives Studies and minoring in Sociology: mainstream crime and community, in hopes of achieving a higher education and creating content as an inspiring influencer. Gabrielle is involved with We Matter, as an Ambassador of Hope where her main goal is to uplift Indigenous youth all over Canada with the We Matter Campaign along with other ambassadors. Gabrielle sits on the Brandon Women Bear Clan Council, where she volunteers her time with other women to help the less fortunate.

"My goal is to help others, achieve my basketball dream of playing overseas, and continue to lead by example."



Connor Lafortune

(He/Him) Age 19 – Bird Clan, Anishinaabek
Dokis First Nation, Robinson-Huron Treaty Territory

Nimkiins ndizhinikaaz bineshiinh ndondem Okidendawt ndonjiibaa Anishinaabe nini ndow.

Connor "Little Thunder Spirit" Lafortune is a second-year student of the Indigenous Studies program with a double major in Law and Justice as well as Race and Gender Studies. He is the acting Male Traditional Coordinator and Vice-President of the Indigenous Student Circle at Laurentian University. He occupies various roles on boards in Sudbury Ontario as both a Francophone and Indigenous person. Since high school, Connor has been a youth facilitator for La Fédération de la Jeunesse Franco-Ontarienne, where he runs workshops, activities, and speaks on panels for Franco-Ontarian high school students. In high-school, Connor sat on the First Nation, Métis, and Inuit council for his school board, where he still sits as a community member and had acquired an internship on his First Nation working alongside O'gema and council. Throughout his post-secondary career, he was able to participate in various Indigenous symposiums, panels, and policy paper writing sessions that aim to give a voice to Indigenous post-secondary students.

In the future, Connor aspires to attend Law School in Moncton, travel to Northern First Nations during his year of articling, and thereafter return to his First Nation to open his own Law practice. He would like to major in Indigenous law, human rights for Indigenous Peoples, and law and timber claims.

"My goal is to give a voice to those who have had theirs taken away – and to encourage their words in the language their ancestors spoke"

You can reach Connor on Facebook by name, or on instagram @connorrandy9.

Will Landon – Youth Leader

Waabishkigaabo (Will Landon) is a citizen of Wauzhushk Onigum Nation which is on the northern shores of Lake of the Woods in Ontario. He is of the Lynx Clan, and is Seventh Generation from the signing of Treaty #3. He is the proud father of a daughter.

Waabishkigaabo studied Political Studies at the University of Manitoba and represented Indigenous students as the Indigenous rep on the Student Union. From University he was elected to multiple youth representative positions at Grand Council Treaty #3, Ontario First Nation Young Peoples' Council, and AFN National Youth Council. Holding multiple portfolios but focused primarily on mental health, treaty issues, social policy, and health policy. He has since used his experience to elevate the work of health policy organizations and Western institutions in improving Indigenous quality of life outcomes.

Megan Metz

ǵándauxʷ (She/They) Age 22 – Blackfish Clan
Haisla Nation

nugʷ Megan ti ǵándauxʷ xe'ábexʷexλayu gáiqelan ćimáućixi xá'is'la núgʷa hélx'inixʷen.

Megan Metz, traditional name ǵándauxʷ, hails from the Haisla Nation on the Northwest Coast of BC and belongs to the blackfish clan. Megan recently graduated from Okanagan College with an Associates Degree in Arts. Now, she is working on completing a First Nations Language Certificate in xá'islaḱala from the University of Northern British Columbia. She is one of the founding members of the Life Promotion for All My Relations youth advisory committee, an Indigenous youth-led initiative put forth by First Nations Health Authority, Fraser Health, and the Canadian Foundation for Healthcare Improvement. On this committee, Megan receives mental health and wellness skills training and helps provide input toward initiatives and organizations in BC. She is passionate about mental health advocacy, language, and cultural reconnection. Megan openly shares the lessons she has learned on her wellness journey in a presentation which she gives at the annual Haisla Youth Cultural Camps. Preserving and passing on the knowledge that has been shared with her is of the utmost importance to Megan. This is something she practices often in her role as the Digitization and Preservation Technician with Haisla Nation Council. In this position, she has the opportunity to work with and contribute to her Nation's Library and Archives, something she has grown to love and sees herself continuing to pursue in the future.

"My goal is to empower our communities to reconnect to their culture and language. When we turn inward and begin to better understand ourselves, we can then start to find peace from within."

Marshall Morrisseau – Youth Leader

(He/Him/They) Age 24
Opaskwayak Cree Nation

Marshall Morrisseau is a First Nations, Metis advocate. Currently residing in Brandon Manitoba and attending University, Marshall is studying a Bachelor of Arts Degree for the purpose of pursuing law. Marshall is involved with community organizations such as Brandon Bear Clan Patrol where he coordinated a youth mock patrol. This opportunity lets him build positive relationships in the community, educate future generations about harm reduction philosophies and traditional teachings. Marshall also takes part in the We Matter Campaign as a National Ambassador of Hope, delivering messages of hope, culture, and strength for Indigenous youth. In the beginning of 2020, Marshall attended the United Nations Drug and Crime Commission as a Youth Delegate. He now is involved with the International Youth Initiative to help develop and deliver drug prevention strategies. They are now working with the Thunderbird Partnership Foundation to help develop youth led projects.

"My biggest goal in life is to help all my relations in a meaningful way and ensure that the next seven generations are agents of culture and traditional worldviews."

Tia Piché

(She/Her) Age 27

Tia is a 27 year old Métis female born in Leaf Rapids, Manitoba on Treaty 5 land. Tia is a registered social worker who graduated in May of 2020 with her BSW. She is now a mental health worker with youth in crisis. Tia aspired to be a mental health worker from a young age when she had a tragic experience losing a very close friend to suicide. It is her hope that she is making a difference for others, and helping to heal herself. In her role, she has the opportunity to engage with youth and their caregivers, understand their needs, and advocate for those needs to be met.

Tia is a proud mother of a kind, empathetic son who is learning to be a support to others, standing up for what is right. Living in the Hub of North, Tia gets to experience the beauty of the Boreal Forest and the resilience of the Northern people. Tia is a spiritual individual, currently on the path of finding her true self. Tia practices using a wholistic approach when it comes to her own needs and the needs of others.

Tristen Schneider

(She/Her) 24-year-old curvy, plus size Anishinaabe/Dene sister

Tristen is an Anishinaabe-Dene facilitator, advocate, and entrepreneur from Shawanaga First Nation Ojibway Territory. She is a forthcoming young woman distinct in various trilateral political advocacy work for First Nations Youth focused on Mental Health and Life Promotion initiatives through previous networks; the Independent First Nations, Ontario First Nations Young People's Council, Feathers of Hope: Justice and Juries Youth Advisory, Chiefs of Ontario, and the Thunderbird Partnership Foundation.

She is the owner of Flourishing Embers, an upcoming Indigenous-owned business focusing on sexual health and life promotion. She is celebrating the strong stories of Indigenous sexuality by creating a resource platform for Indigenous People to begin having healthy conversations on sex and body positivity. Tristen has continued to thrive by allowing the intimate energy to flourish in her creativity to promote the understanding of Indigenous worldview of sex to educate around consent, well-being, gender, and identity.

Tristen has been actively involved with Life Promotion since 2014. She is a registered Applied Suicide Intervention Skills (ASIST) Trainer and Suicide Alertness for Everyone (SafeTALK) Trainer with LivingWorks. She has previously facilitated the work for "Stories from our Roots" a regional wide youth led program for First Nations youth in Ontario, that was supported by the youth steering committee.

What is Life Promotion?

Statement on Life Promotion from the Youth Action Group for Life Promotion

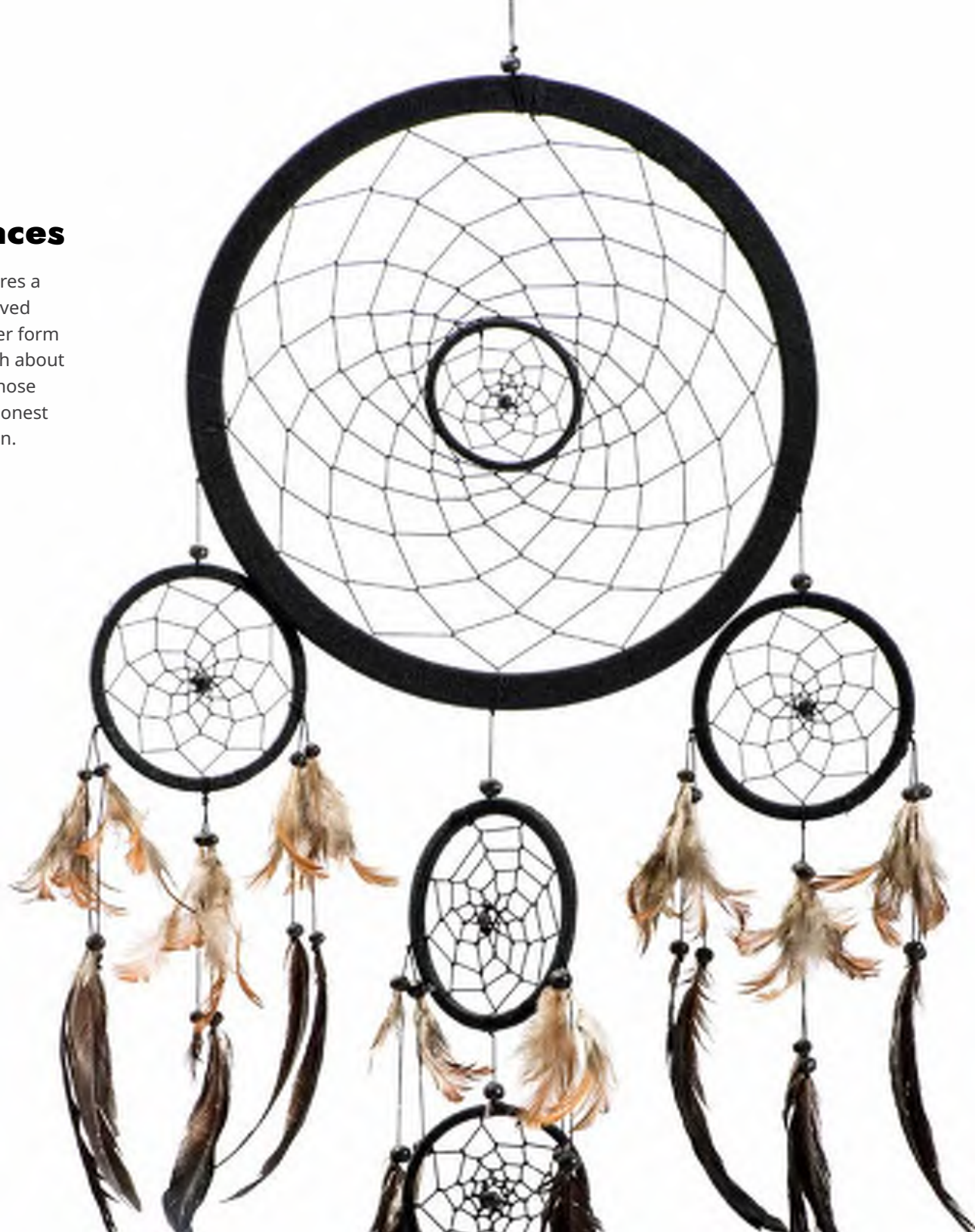
When confronting obstacles in our lives, we have always turned to our Elders for guidance. Through storytelling and knowledge transfer, we have collected the tools and strength to overcome the hardships that we may face. This toolkit was developed in response to our communities who desired to implement life promotion initiatives. As the first step to suicide prevention, life promotion aims to build on the intergenerational strength of our relations who came before us. This toolkit aims to restore Hope, Belonging, Meaning, and Purpose to our Indigenous young people. By relying on our stories and wise practices, we work to empower our communities and ensure that intergenerational resiliency can be passed on from our ancestors to the present and the future. Life promotion encourages people to strengthen a connection to land, community, self, and spirit, equipping them to live a long prosperous life.

What does life promotion mean to you?

1. In a group or individually, reflect on what life promotion means to your community
2. If it is beneficial, develop a collective statement for life promotion signed by participating youth in your community

Creating Safe and Brave Spaces

Safe spaces refer to a physical and emotional area that ensures a comfortable and secure environment, which is free of perceived ideologies, discrimination, criticism, harassment, or any other form of emotional and physical harm. A safe space can be as much about the physical area as it is about the emotional space left for those found within it. Safe spaces are created to foster open and honest conversations and promote the usage of safe communication.



Tips for making safe spaces:

1. Create inclusive and diverse spaces
2. Avoid segregation
3. Make sure to clearly open the dialogue and ensure everyone understands the speaking protocols
4. Ensure that everyone who chooses to is allowed the time to speak
5. Have a mental health support or cultural support person present
6. Make it clear that the space is safe and ensure everyone in the space follows the rules set in place
7. Create a "here and now" protocol that implies what is said here stays here, and what is learnt here can leave here
8. Make the physical space comfortable and inviting
9. Create a community agreement on safe spaces

Resources

- *10 tips for creating a safe space | IofC*
- *Safe Space Checklist*
- *Creating a Safe Space: Psychological Safety of Healthcare Workers (Peer to Peer Support and Other Support Models)*
- *Creating Safe Spaces*
- *"Make Your Meetings a Safe Space for Honest Conversation." (2019)*

The Importance of Having Gentle Teachers

A gentle teacher creates a comfortable learning environment where everyone is welcome to ask questions and begin to heal and reconnect. Gentle teachers encourage learning and growth for those around them and do not shame, embarrass, or laugh at anyone for making a mistake. Instead, gentle teachers nurture each learner's curiosity and meet them where they are at. They help provide necessary support in the passing of knowledge from one generation to the next, effectively rebuilding the cycles of knowledge transfer that were interrupted by the residential school system.

A crucial part of this journey of reconnection is learning to heal the wounds of our past; part of this learning journey involves turning inward to see what parts of our trauma we may be deflecting onto others. The goal is not to repeat history, but rather, to allow our history to inform the decisions we make moving forward so we may grow and learn from it. Many of us will make mistakes along this journey, some may have negative experiences approaching people with requests for knowledge. In such instances, we must remember that many of us are still healing from our past so these negative interactions should not be taken to heart. As long as we continue to learn from these experiences, we will feel the wounds slowly begin to heal within ourselves. Each of us is on different points of this journey and all are valid and worth tending to. Everyone deserves to heal and reconnect to their culture and language. A gentle teacher understands these sentiments and respectfully guides those willing to learn.

"The greatest power is the Creator.
But, if you want to know the greatest strength..
That is gentleness."

Chief Leon Shenandoah, Onondaga Nation

Before You Begin

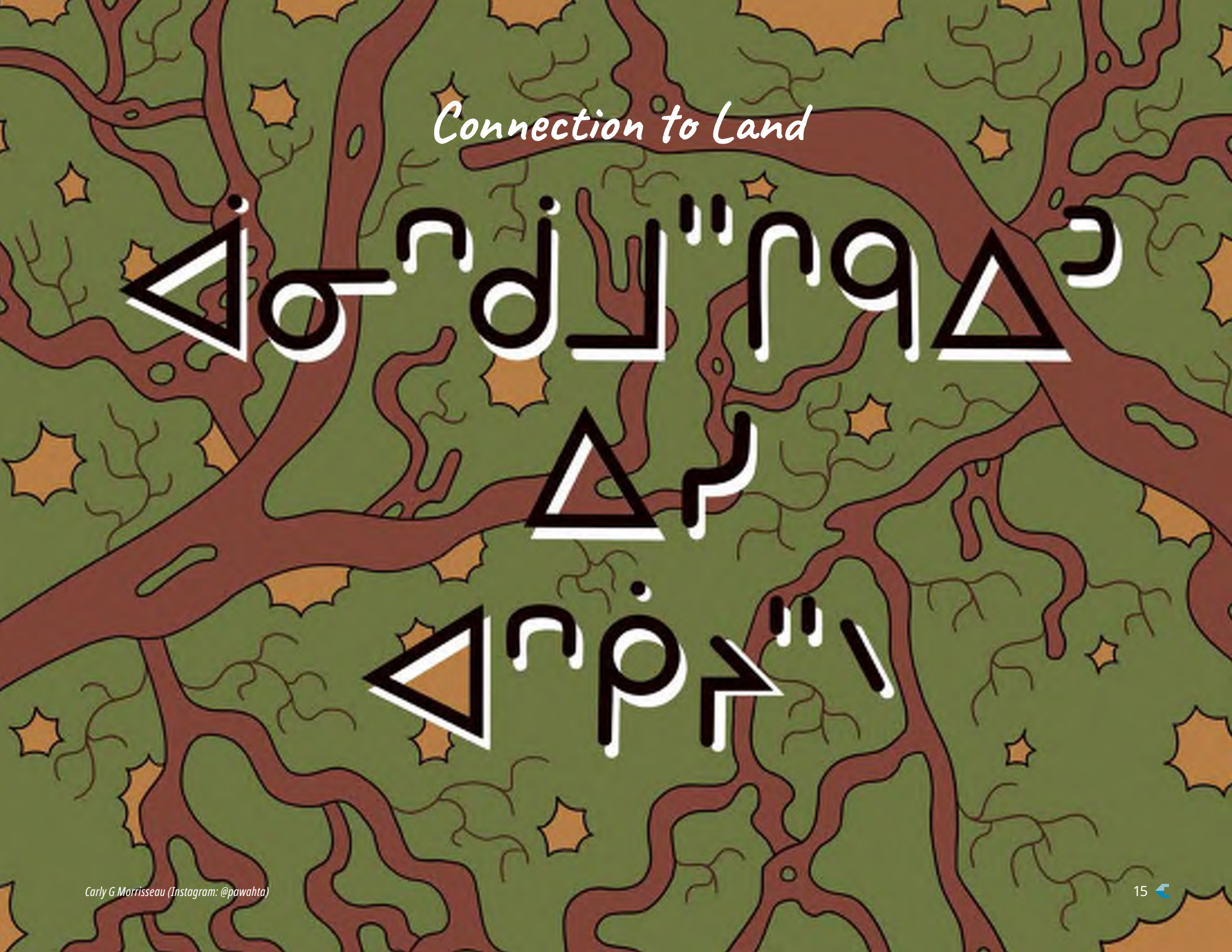
During the creation of this toolkit, the Youth Action Group acknowledged that much of this information can be new to certain individuals. We spent months discussing the topics, activities, and resources provided in order to ensure that we are creating and maintaining a safe space. Throughout the toolkit, you may be presented with unfamiliar content— we have prided ourselves on creating an open and honest space, thus introducing pieces that can affect you in various ways. We encourage you to embrace those thoughts, emotions, and feelings, and to put them into the work you're accomplishing throughout the toolkit. Keeping in mind that if we do not address something, we can not begin to fix it, the Youth Action Group included topics of discussion that can push the boundaries of what you know. This being said, we have included tips, tricks, and resources to help address your feelings towards the information such as *Creating Safe and Brave Spaces, The Importance of Having Gentle Teachers,* and *Knowing my Response-Ability.* We encourage you to use this information to empower yourself within your Indigeneity.

What to Do if Someone Checks Out?

For facilitation purposes

During the facilitation of toolkit's such as this, it can be common for some individuals to check out and detach themselves from the content. If this happens, we encourage using traditional medicine, berries, water, and any other item that is used as medicine in your community. We also recommend you begin with the mention of safe and brave spaces *(please refer to page 12 to understand the concept if needed)*. The content provided may bring upon emotions, they are welcomed and encouraged. We encourage the usage of non-verbal cues, quick assessment tools, and self-reflections in order to maintain those safe and brave spaces. Once we understand what affects us, we can begin to move past it and heal!

Connection to Land



Carly G Morrisseau (Instagram: @pawahta)

Perspectives from the Youth Action Group

Our connection with the land helps us foster healthy habits. The relationship is different depending on someone's location. However, Indigenous Peoples must develop this connection for our well-being. Connection to land is not only dependent on the physical territories we find ourselves on, but also on the stories found within them. By rekindling the relationship with those stories, we can begin to understand our own.

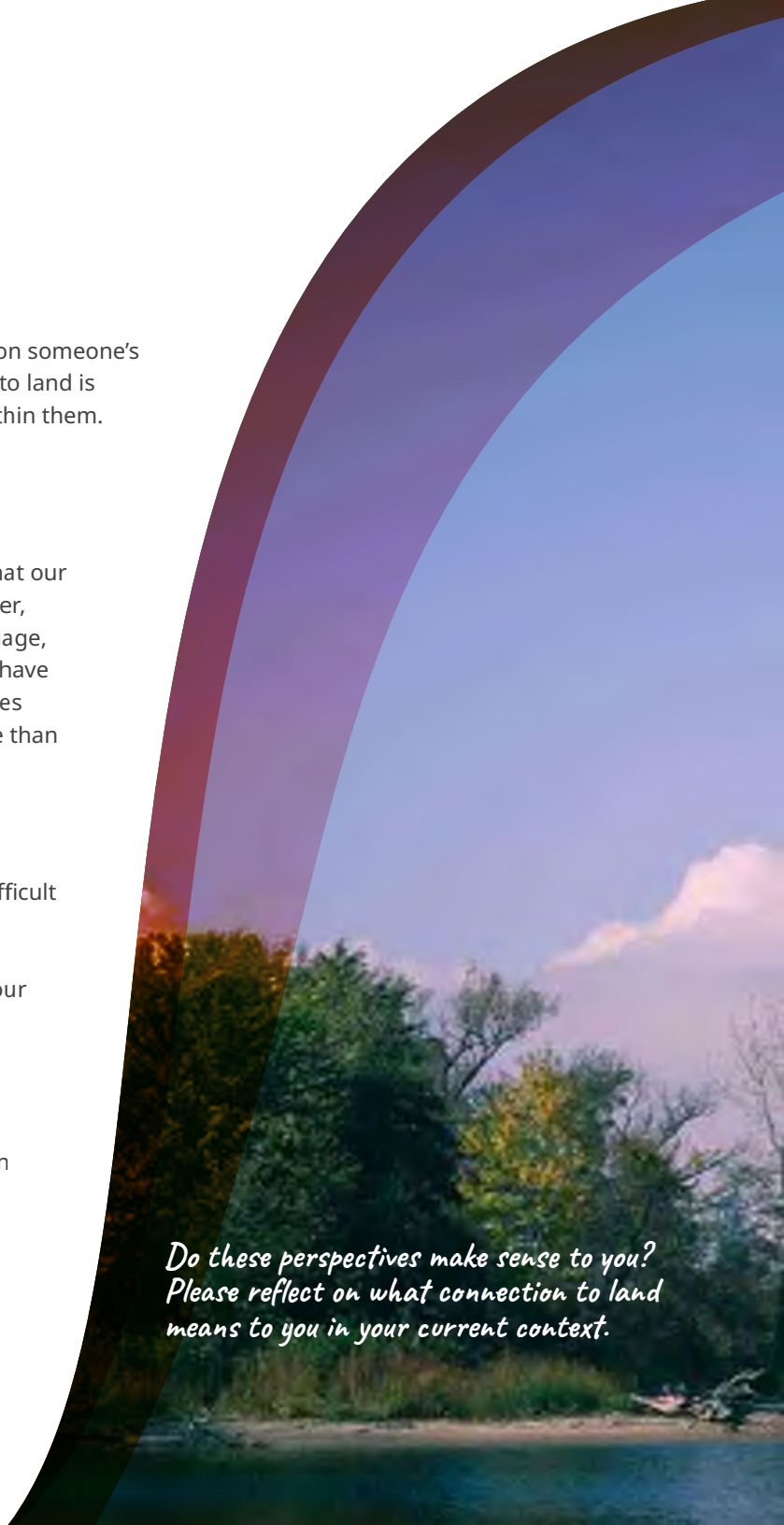
Rural/Remote Perspective on Land

As Indigenous People who grew up within our communities, we have faced many of the hardships that our nations currently face, such as overcoming substance misuse and intergenerational traumas. However, despite the privilege of growing up in our home territories surrounded by nature, sacred sites, language, stories, and Knowledge Keepers, the connection to our identity was not one of them. As a result, we have built a grounded connection to our ancestors and past since childhood, we have thus rooted ourselves within our traditional teachings and rely on them to survive. Connection to land for us refers to more than simply what's physically before us, but also the stories told within it. *~ Will and Connor*

Urban Perspective on Land

When we are living away from our traditional territories, communities, and families it can become difficult to find the connection to land; the best way to strengthen the connection to land is by being a good relative. In our Indigenous culture we recognize all our relations, as we are all one people on Turtle Island; it's understanding how each of us is here to support one another, it's the intersectionality of our nation community as Indigenous People. *~ Tristen*

Being an urban youth or adult can be hard due to the odds stacked against you in the education system, justice system, child welfare system, and poverty. The systems are filled with Indigenous Peoples and the stigmatization of being Indigenous is hard in and of itself to navigate. Just know there is land everywhere you are. The water, grass, trees, wind, and rocks are there to support you on your journey while living in an urban setting. Learn to explore the land when you do not think you have that connection to land yet. Be open. Just remember even though you lost your identity and connection to the land, your ancestors are still looking over you and are connected to land.
~ Gabrielle



Learning Objective

In this section you will learn that you have a relationship to the land, that the land has a relationship with you, and how to define, maintain, and navigate this for yourself.

"The beauty of the trees, the softness of the air, the fragrance of the trees... speaks to me. The summit of the mountain, the thunder of the sky, the rhythm of the sea... speaks to me. The faintness of the stars, the freshness of the morning, the dew drops on the flower... speaks to me. The strength of fire, the taste of salmon, the trail of the sun and the life that never goes away. They speak to me and my heart soars."

Chief Dan George, Tsleil-Waututh Nation

"What we do to the land, we do to ourselves"

Chief Seattle, Earth Day

Reflections from Youth Action Group

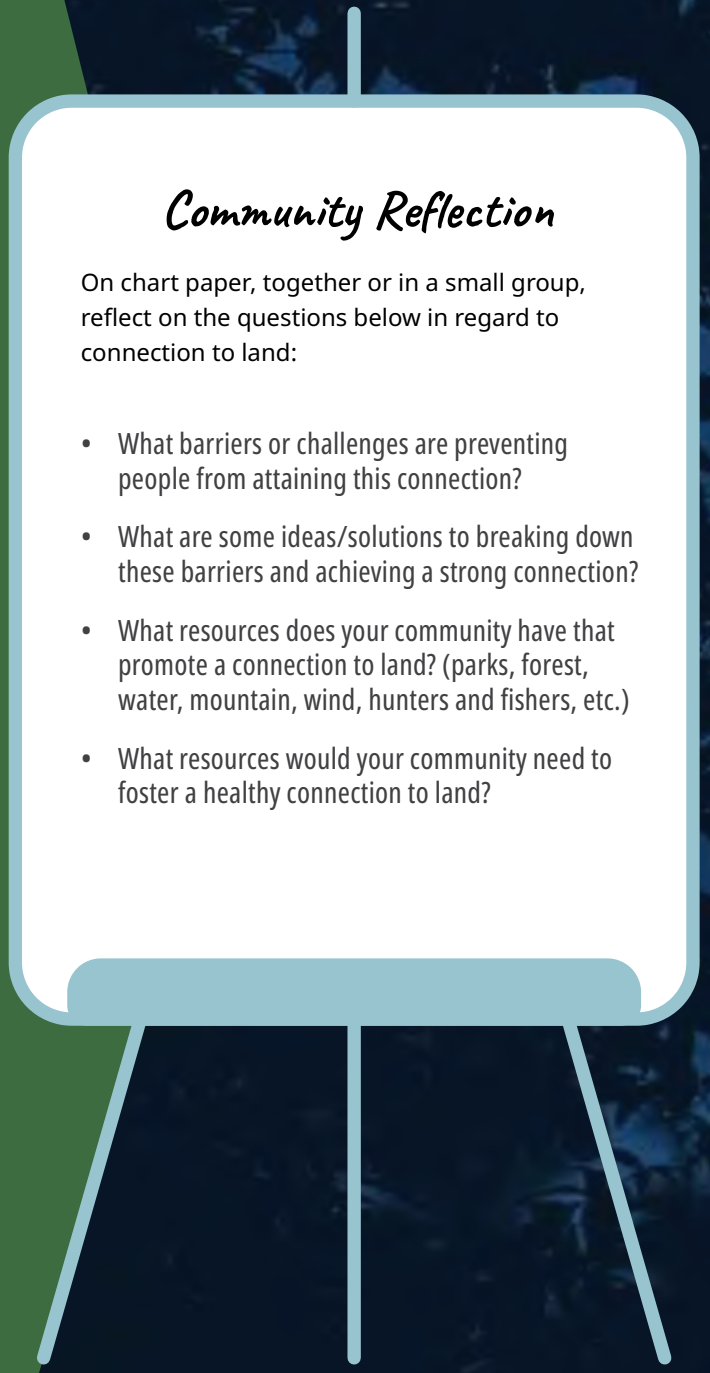
What barriers or challenges are preventing people from attaining this connection?

Accessibility is often a challenge when we refer to our connection to the land. Some communities may not have access to sacred, safe, or calm sites where the people can connect to the land. Transportation in and around the community can also be a challenge, if one cannot get to the sites because of their location/accessibility, or the sites have been compromised, i.e. from pollution, flooding or fire. Traditional limits can also pose a challenge— access to Elders, understanding protocols, and approaching others for help. Although these limits may discourage some from renewing their connection to land, we encourage you to find solutions in breaking down these barriers.

What are some ideas/solutions to breaking down these barriers and achieving a strong connection?

Accessing land can be both a question of resources and environment, however our connection to land does not need to depend solely on our access to nature. Connection to land and spaces can be created even in urban settings. We encourage communities to create safe, positive, and accessible sites. Whether they are out in nature, in a school gym, or on a front lawn, a safe space can allow for open conversations, appreciation for the terrain, and an overall sense of connection to the things, people, and spaces around you.

Communities may choose to follow oral histories and traditions to guide them. By identifying Elders and kind teachers, a community can begin to heal and create protocols for approaching Elders and Knowledge Holders. Youth in partnership with their communities may consider coming up with a budget and a plan to cover the costs of spending time on the land, sharing circles, video teachings, travel, and providing other resources to access outdoor activity equipment, i.e. canoes, camping gear, tipis, etc. Indigenous communities may find it beneficial to follow traditional ways of learning by seeing, speaking, and doing.



Community Reflection

On chart paper, together or in a small group, reflect on the questions below in regard to connection to land:

- What barriers or challenges are preventing people from attaining this connection?
- What are some ideas/solutions to breaking down these barriers and achieving a strong connection?
- What resources does your community have that promote a connection to land? (parks, forest, water, mountain, wind, hunters and fishers, etc.)
- What resources would your community need to foster a healthy connection to land?

Full Moon Activities

Activity

1. Full Moon meditation. Go outside barefoot to feel the connection to the land along with the energy from the full moon. I like to find a comfortable spot to sit under the moonlight, close my eyes, and visualize the moon's beam filling the space around me and my body. I then start to focus on my breathing and imagine the moonlight purifying my body, mind, and spirit.
2. Moon Water. I like to leave a bottle of water in the moonlight to charge overnight. Make sure you grab it before the sunlight hits it; if you sleep in and forget, that is okay it's still moon water but with some sun energy. With this moon water, I like to drink it, use it in a bath, or clean my floors around my house. When I make moon water, I can feel the energy in the bottle that it carries from the moonlight. It is said that this water is only good for three days, after that it no longer holds the energy of the full moon.
3. Cleansing. This is a time when I reflect and allow myself to let go of things from the past. I also cleanse myself and my home by smudging, taking a bath, decluttering, and releasing any negative energy I have building up inside.
4. Self-Reflection. This is a time where I engage in some self-reflection–where I am currently at, any patterns or behaviours of my own that do not serve myself or others, and any relationships that are no longer serving me. I allow this time to let go or simply question why these relationships/ behaviours are still there.
5. Dream. I absolutely love the full moon and when I see the moon shine so bright in the sky, my eyes are locked in. Staring at the moon I feel its energy radiating through my body. Sometimes I become emotional and cry about what was, what is, and what will be. When I stare at the full moon, all my wishes, hopes, and dreams are sent into that energy of light. I make sure I set pure intentions that will not bring others or myself harm.

Lessons

- The moon teaches us that we are always growing, changing, and evolving. The phases of the moon are constantly reminding us that this too shall pass, and that life is full of beginnings.
- It also teaches us that imperfection is beautiful, as the moon is full of rough patches and full of craters, yet it is always so beautiful lit up in the sky.
- What I learned from the full moon is it allows me to be calm, compassionate, and to find light in the darkness
- I feel more connected to the land when I meditate under the full moon light; I learned to release the past and heal from old wounds.

Written by Tia Piché

Food Sovereignty, Gardening, and Food Programs

Activity

- Communal gardens and fields are encouraged to promote not only healthy land but also healthy communities.
- Gardening and food programs can be put in place to share goods and create a greater bond between community members, and to the earth.
- Communities are encouraged to reach out to food and gardening programs or create their own program themselves.

Lessons

- Communities learn how to be self-sufficient and rely on each other in time of need.
- This activity returns the community to traditional times where each community was responsible for growing, harvesting, and sharing foods and goods.
- Communities learn to use the land as a way to serve themselves and begin to understand the impact healthy land can have on a community.

Examples of programs:

1. *Canada | Improving First Nation Nutrition — Food Security Programs*
2. *Indigenous Foodways — Nourish Health*
3. *Creating space for Indigenous culture through food programs*
4. *Beyond the Three Sisters Garden: Indigenous Communities and Public Gardens in Dialogue*

Written by Connor Lafortune

Living Off the Land and Building Your Own Fire

Activity

1. This activity encourages communities to create an overnight trip in the woods and try to live while only relying on the land to eat and sleep; think of this as a survival activity that is done safely and without any real threat.
2. Communities may choose to create their own shelter or use ready-made shelters such as tents.
3. Communities may also choose to fish/hunt/harvest their own foods or to bring ready-made food and simply cook the food in nature.
4. This activity is adapted according to the community's needs, wants, and capacities.
5. Communities are also encouraged to learn how to build their fire and teach everyone how to do the same *(this can be a ceremonial or survival fire).*
6. Around the fire, communities may choose to share stories, teachings, and rebuild communication between generations.

Lessons

1. Communities can learn how to rely on the land for their needs as well as rely on each other.
2. They are encouraged to each play their part in their mock "survival".
3. They may each learn how to create a shelter, hunt/fish/harvest, create their own fire and cook over the fire.
4. Traditional knowledge is encouraged.

Written by Connor Lafortune

Exploring Community Capacity for Land Based Activities

Activity

1. This activity is dependent on the climate, environment, and traditions of the community.
2. It aims to engage the communities in an outdoor activity that evolves some challenges and teachings along the way.
3. It is recommended to reach out to someone who knows these activities before doing them *(for example an experienced canoer or hunter).*
4. Activities involving animals are to be done according to traditional teachings.
5. Activities on the water or snow aim to push your physical boundaries a little and allow you to listen to the earth.
6. Embark on a canoe journey, a kayaking journey, or walk with your snowshoes and make your own path.

Lessons

1. Lessons may depend on the activity performed.
2. Things that can be learned from land-based activities include patience, hard work, strength, doing something from start to finish, accomplishment, listening.
3. The goal is to embark on a journey related to the land and to learn how she can both work with and against you in given situations.
4. You are challenged to learn to move with the earth and begin to understand how you can hear her as you do so.
5. Through this activity, you may regain or create a deep connection with the earth, along with appreciation.

Examples of activities:

Hunting | Fishing | Spearfishing | Fishing with Nets | Trapping | Kayaking | Canoeing | Snowshoeing | Hiking

Written by Connor Lafortune

Medicine Walks, Harvesting, and/or Foraging

Activity

- We encourage communities to seek out the holders of knowledge regarding natural medicines and plants.
- Communities can sit, learn, talk, and walk with those Knowledge Holders through the trails, paths, and beside the water to learn how to forage, harvest, and seek out traditional medicines.
- Medicines can be used for a variety of things: smudging, teas, gum, nutrition, etc.
- Each community may have its way of doing and knowing, we encourage communities to follow their teachings or seek out this knowledge if it cannot be found in their community.
- We also encourage communities to create an information board that includes their community's plants, their uses, and a picture.

Lesson

1. The lessons surrounding this activity can vary according to the traditions of the community and the willingness to share.
2. Communities may begin to understand that the earth can provide us with everything we need to survive.
3. This activity takes us back to a time when foraging was our greatest way to survive.
4. With the help of Knowledge Holders or medicine walkers, communities are able to learn which plants will serve them, possibly begin to wean off of pharmaceutical medicines and to understand what the earth can give us.
5. This activity could become a daily or seasonal practice for community members to harvest and use traditional plants and medicines.

Examples of plants and medicines that can be harvested:

(please consult someone before harvesting the plants)

- Fern tea
- Sage
- Tobacco
- Sweetgrass
- Cedar
- Wild rice

Examples of websites that can be used:

1. *Native Foods Nursery – Buy native plants that you can eat!*
2. *15 Wild Plants You Can Eat - Outdoor Canada*
3. *Native Plants for Edible Landscaping*

Written by Connor Lafortune

Connecting to Nature Using Mindfulness

Activity

1. As a group, go outside and find a quiet spot in a greenspace that is nearby.
2. Using your five senses, quietly reflect on your environment.
3. What comes to mind during your time? A memory, a thought, an "ah-ha" moment to something that's been bugging you? Keep that in mind.
4. Head back inside and share what came to mind with the group if you are comfortable, which sense triggered the thought?

Lesson

1. Our Elders have become adept at connecting to nature around them to receive messages, wisdom, or lessons from their life journey.
2. Land is integral to our identity as Indigenous People, it is important to maintain our connection by being able to listen to what it has to tell us.
3. This connection should help you build a deeper understanding of yourself and your journey.

Written by Will Landon

Helpful Tip

If you are unsure how to approach someone with these requests for knowledge, try to find a community member who is well versed in local protocols. This ensures you are well informed on how to approach Knowledge Keepers respectfully.

Written by Megan Metz

Identifying Local Knowledge Keepers

How to Identify Local Knowledge Keepers

- Reach out to your local friendship centres, Elders centres, and youth centres to see what kind of resources they have available. They may have already established contacts with the local community, including mentors, role models, and Knowledge Keepers.
- Ask your group what kinds of things they are interested in learning about them put a call out on social media for individuals with experience in those areas. Outline the reason you are seeking this knowledge, who it will be taught to, and why.
- Seek out individuals in the community who have specialized knowledge and ask if they would be willing to share their skills and experiences. (Examples: harvesting plants and medicines, hunting, weaving, carving, beading etc.) In doing so, you play off the strengths of your community and build up members, encouraging them to pass on what they've learned to the next generation.

How to Approach Knowledge Keepers

- After you have been informed of the local protocols on how to respectfully approach a Knowledge Keeper, it is typically best practice to have an explanation prepared on what knowledge you are seeking, for what, why, and for whom.
- Ensure you have brought an appropriate gift if necessary, to acknowledge the Knowledge Keeper for considering your request.

How to Thank Knowledge Keepers

- Knowledge Keepers should be compensated for their time, energy, and knowledge sharing, whether through financial honoraria or a suitable gift following local protocol.
- They may also appreciate copies of any photos or videos taken on the day of the event.
- Sending them thank you cards and invitations to return is encouraged.
- Gifting them traditional foods or medicines is another great way to express your thanks.

Movement is Medicine

Activity

Movement is important because it is a part of life and helps to keep one's body, mind, and spirit healthy. Indigenous Peoples were never static, they were always outdoors. Indigenous Peoples had healthy ways of being on the land and with movement before the contact of colonizers. Following contact with colonizers, Indigenous Peoples have become prone to diseases such as obesity, diabetes, addiction, etc. It is vital for Indigenous People to take it upon themselves to take back their power and learn to move by taking care of fires, sweats, medicine walks, dance powwows, hunting, sports, etc. Preparing for a ceremony is not easy and takes lots of work from people in a community and involves movement and learning about the land around them.

Starting to move can be difficult. Maybe you're not familiar with moving. The key is to just start. Your journey with movement is going to be a roller coaster until you can find what works best for you. In addition, a key point to remember is movement is not about losing weight it is about developing a healthy habit to keep you moving because it is a blessing that your body can move. You do not always need weights to achieve the best workout, use what is around you for example, rocks, trees, big water bottles, and detergent. Movement should be what you want it to be, for example, it can be difficult to earn results you want, it can be for mental health, or just enjoyable.

Access to Movement

A way to access movement is by going on YouTube, searching up videos, following influencers that you love.

- https://www.youtube.com/watch?v=eI2gnTZh0-I&t=11s
  (Powwow dancing)
- https://www.youtube.com/watch?v=eos-Xx-TNvQ
  (N7 fitness inspiration)
- https://www.youtube.com/watch?v=g-D7ncAC9rQ
  (Simple 10 min workout)

Ideas for Movement

- Walking *(the easiest form of movement)*
- Yoga/stretching
- Strength training
- Cardio *(slow jog, bike ride, playing sports, powwow dancing, nature walk, stairs)*
- Mindfulness is not static either
- Chopping wood, taking care of fire
- Camping
- Mobility movement
- Learning how to pick medicines
- Hunting

Written by Gabrielle Jubinville

Healthy Indigenous Influencers

- *@newo.wellness*
- *@wellforculture (they also have a podcast)*
- *@shayla0h*
- *@jennarobar*
- *@kendrajessie*
- *@notoriouscree (focus on dancing)*
- *@ashleycallingbull*
- *N7 has video on YouTube*

The list of Indigenous influencers is robust. Remember to look within your communities at home whether in an urban or rural setting. Do not be afraid of moving. Your ancestors always moved, travelled, and were not given the same chance to practice their ways of healthy movements. Choose to move as your ancestors did. Learn about traditional foods, learn how to take care of your body. Your body is your temple, it takes care of itself and no matter how you treat her/him it always takes care of you.

Resources

- *Well For Culture*

Closing Reflection

Although the connection to the land is subjective and different for everyone, much of our identity, stories, and histories are land-centred, therefore this connection is essential for us to maintain our sense of self and sense of place.

Resources

Traditional Medicines

- *Article Indigenous Peoples' Medicine in Canada*
- *The Four Sacred Medicines – Indigenous Website*
- *First Nations Traditional Plants and Uses*

Health Benefits for Mental, Physical, Spiritual, Emotional Wellness

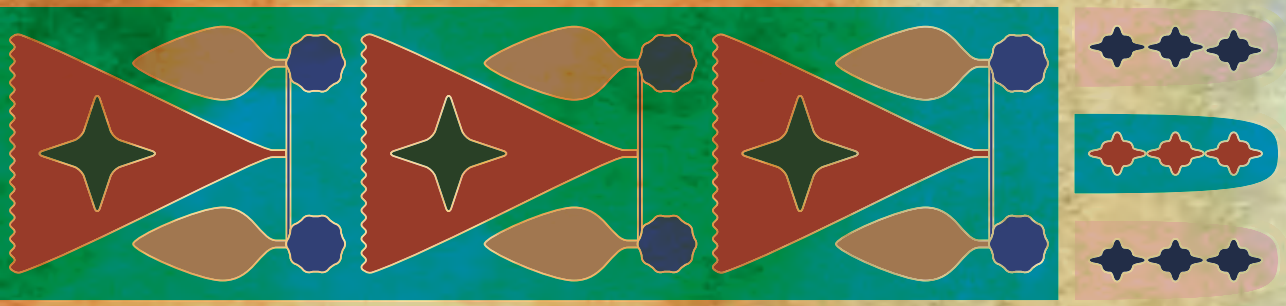
- *First Nations Perspective on Health and Wellness*
- *Incorporating the Medicine Wheel in the Treatment of Aboriginal Communities: Brad Lafortune*
- *The Medicine Wheel and the Four Directions - Medicine Ways: Traditional Healers and Healing - Healing Ways - Exhibition - Native Voices*
- *The Medicine Wheel*
- *Aboriginal traditional healing*
- *Traditional Healing and Wellness*
- *What is Land-Based Treatment and Healing*

Knowing Your Responsibilities to the Land

- *First Nation Relationship to the Land*
- *Creative spirits - Meaning of land to Aboriginal people*

Books About Edible Plants and Medicines

- ***Edible & Medicinal Plants of Canada***
  – Andy MacKinnon, Linda Kershaw, John Arnason
- ***A Field Guide to Poisonous Plants and Mushrooms of North America***
  – Charles Kingsley Levy and Richard B. Primack
- ***Indian Herbalogy of North America***
  – Alma R. Hutchens
- ***The Boreal Herbal. Wild Foods and Medicine Plants of the North***
  – Beverley Gray



Carly G Morrisseau (Instagram: @pawahta)

Connection to Self

Perspectives from the Youth Action Group

Our connection to self is foundational in developing confidence and the comfort to be ourselves. This connection requires learning, understanding, and adaptability. Connection to self refers to the ability to understand what does not work for us and choose to continue and search for what does. As people, we are constantly changing— the connection that we have with ourselves does too. Knowing ourselves is a constant journey that we find ourselves on. We are continuously searching to find our goals, passions, and what we value. Our journeys are not stagnant and neither are we— we constantly have to adapt to completely understand and accept ourselves for who we are or who we might become. We each can listen to our wants and needs, and take action to address them. Determining your strengths and values will help you face and overcome challenges that life may give you.

Connection to Self (Mind and Body)

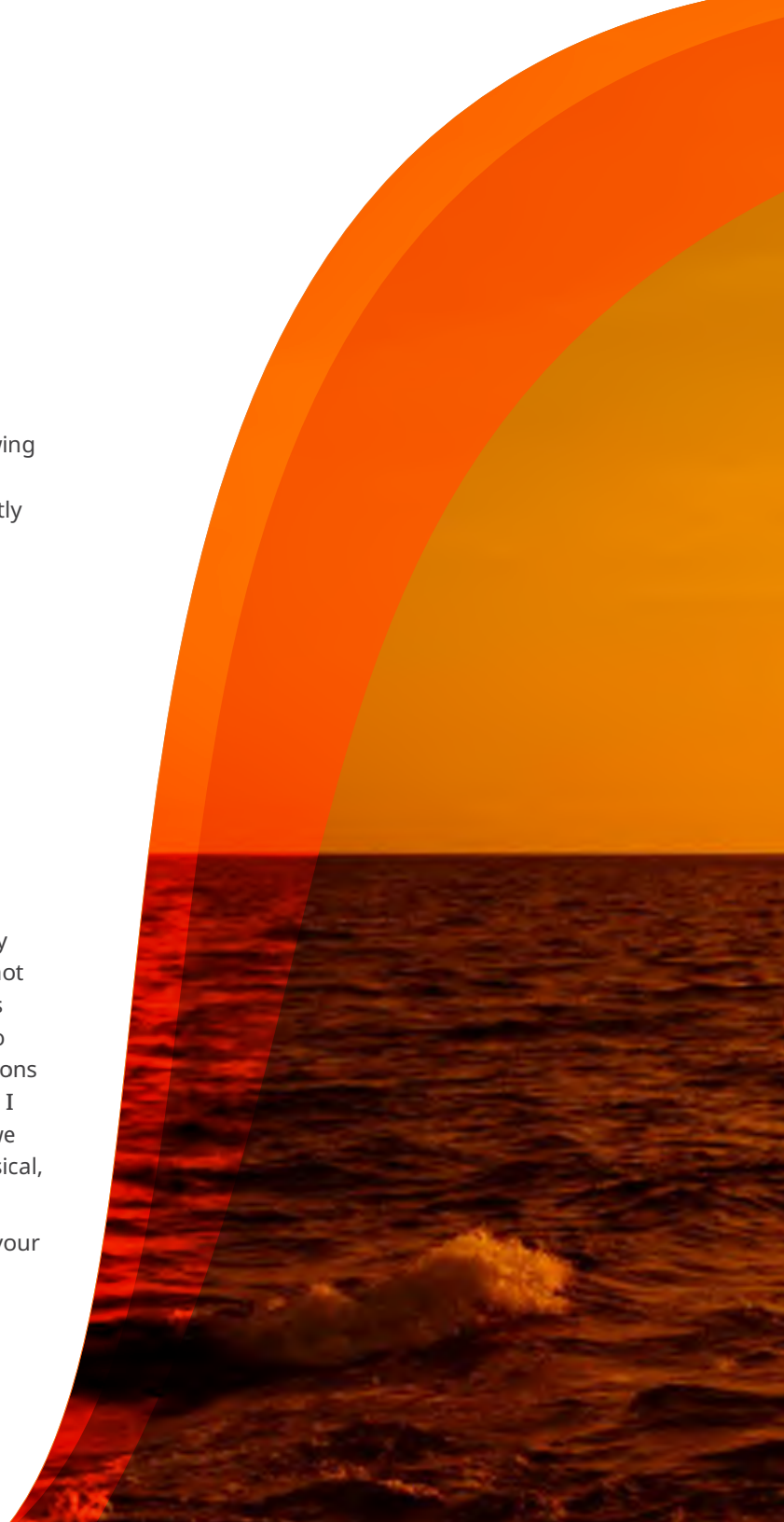
What does connection to myself look like for me?

In a group or individually reflect on what connection to self means to you and your community.

What does the strongest connection to self look like to you?

For Indigenous Peoples, identity can present a challenge. We are constantly bombarded with identity challenges that could make it difficult to find a place and a sense of belonging. These identities are not only limited to our Indigeneity, but also our linguistic identity, sexual orientation, and gender. That is where connection to self steps in— when we can ground ourselves within our being, we can begin to change how we see the world. The connection we have with ourselves informs all the other connections we have. During difficult times, we may find ourselves turning to the question "who am I? Where am I from? Where do I belong? What is my purpose? Who am I accountable to?" As Indigenous Peoples, we often return to the concept of balance. We must constantly nurture every part of our being, the physical, mental, emotional, and spiritual.

When you are connected to yourself, you are aware of your limits and boundaries. Knowing what your triggers are can better help you cope, prevent, and understand any emotional outbursts.



Learning Objective

In this section, you will learn how to use the tools, guides, and resources provided to facilitate a better connection to yourself. Through activities, self-reflection, and the information in this toolkit, you will be able to understand the importance of connecting with yourself and begin the process of maintaining or reaffirming that connection, thus, improving the quality of your life and relationships with others.

Connecting with yourself means seeing all of you and choosing to believe you can do better.

~ Nimkiins/Connor Lafortune

Healing is a subjective and adaptable journey.

~ Will Landon

Reflections from Youth Action Group

What barriers or challenges are preventing people from attaining this connection?

There is a plethora of challenges that can arise when we speak about the connections we have with ourselves and maintaining that connection. Communities may have a history of lateral violence, societal expectations and pressures, the need for validation, and/or the pull away from our spirit.

What are some ideas/solutions to breaking down these barriers and achieving a strong connection?

We can begin to break down these barriers by setting goals for ourselves and achieving them slowly every day. Authenticity, honesty, and respect can be helpful virtues to establishing a healthy relationship within ourselves. We encourage individuals to do what makes their spirit feel good, whether that be a daily walk, journaling, or simply taking a bath. Communities can begin to spread lateral kindness in the place of pain, practice their culture in the way they feel comfortable doing so, and begin to speak to themselves in a possessive way.

Community Reflection

On chart paper, together or in small groups, reflect on the questions below in regard to connection to self:

1. What barriers or challenges are preventing people from attaining this connection?
2. What are some ideas/solutions to breaking down these barriers and achieving a strong connection?
3. What resources does your community have that promote a connection to self? *(mental health support)*
4. What resources would your community need to foster a healthy connection to self?

kwe kwe · Haih · Cơᒧ · Tansi · ·◁ᒋᔭ · dahooja · ’alhwá7acw ·

Introducing Yourself in the Language

We encourage you to learn to introduce yourself, say thank you, and say hello in your language. Due to the nature of our backgrounds, we have not been able to include every Nation’s language. If you do not see your language, feel free to seek out this knowledge. If your dialect is different then please use it in your way, if you are unsure reach out to an Elder or Knowledge Holder. If you need help finding a gentle teacher please refer to the section on gentle teachers in this toolkit.

Knowing our language and introducing ourselves can be a first step in building a connection with ourselves.

baaqiidaχaʔƛik? · ya’uć · láw · čɛčɛhaθɛč · Nanjit dahonch’e ? · Yáu · ‘uy’ skweyul · Kwe · Shé:kon · gilakas’la · k Kwīingu-néewul · Alo · ʔéxkʷń · Lukw’ilaam · ʔaʔaa · Boozhoo · Y, SCÁĆEL HÁLE · ‘Nit · ʔedlanet’e · Taa haanach’e’ · Hunilht’ih · kwatchexw ?et ?iy · Weyt-k · Dànìt’ē · ‘Siingaay’laa ·

kwe kwe · Haih · ᑕᓂᔨ · Tansi · ᐊᐢᑎᔨ · dah
láw · čɛčɛhaθɛč · Nanjit dahonch'e ? · Yáu

Cree (6-7 dialects in Cree)

• Hello	Tansi
• Thank you	Ekosi

Moose Cree

• Hello	wâciye
• My name is	_____ nitišinikãson
• My age is	_____ nitahtopiponesin
• Where I am from	_____ nitõhcīn
• My clan	_____ nitašīkān
• Where I work	_____ nitāpatisin

Anishinaabemowin

• Hello	Aanii/boozhoo
• Thank you	miigwetch
• My name is	_____ ndizhnikaaz/ndigoo
• My age is	_____ ndoo-sidboonez
• Where I am from	_____ ndoonjibaa
• My clan	_____ ndoondem
• Where I work	_____ ndoo-nokii

Mohawk

• Hello	Shé:kon
• My name is	_____ iónkiats

Inuktitut

• Hello and goodbye	aingai
• Thank you	nakurmiik

Michif

• Thank you	maarsi
• Hello	taan-shi
• I am	_____ niiya

Mi'kmaq

• My name is	_____ teluisi
• Hello	kwe'
• Thank you	wela'lin

Blackfoot

• Hello	oki
• My name is	_____ niitanikko
• Thank you	nitsiniiyi'taki

Sioux

• My name is	_____ emáčiyapi
• Hello	hau
• Thank you	pilamaya

Oji-Cree

• Hello	waachi'ye

Français

• Hello	bonjour
• My name is	je m'appelle _____
• My age is	j'ai _____ ans
• Where I am from	je viens de _____
• My clan	mon clan c'est _____
• Where I work	je travaille à/au _____

Athabaskan

• Hello	edlanete
• Thank you	chin'an gu nin yu

Cayuga

• Hello	sgé:no'
• Thank you	nyá:wẹh

Stoney

• Hello	âba wathtec

Squamish

• Hello	nú
• Thank you	huy chexw

Dene K'e

• Hello	Doh'nánìì
• My name is	Sazee cłah _____ ot'é
• I am from	_____ gots'ẹh á aht'e
• Thank you	Mussi

Kwīnqu-néewul · Alo · ʔéx kʷ ṅ · Lukw'il aan
Pedlanet'e · Taa haanach'e' · Hunilht'ih · kwato

Oneida

Source: Oneida Language & Cultural Centre
https://oneidalanguage.ca/oneida-culture/enjoy-some-oneidalanguage-videos/introducing-myself/

• Hello	Shekoli
• Thank you	Yaw^ko
• _____ is my name	_____ ní: yukyáts
• _____ is my clan	_____ niwaki’taló:aʌ
• _____ is my nation	_____ niwakuhutsyó:tʌ
• _____ is where I live	_____ nú: teknakéhl̲e’
• _____ is my mother’s name	_____ né: yutatyáts aknulha
• _____ is my father’s name	_____ né: luwa:yáts lake’niha̲

x̄ á’islaḱ ala

• Hello fellow villagers/community members	ya’uć gúkʷelut
• My name is	_____ kelásu nugʷá
• I come from Snag Beach/Kitamaat Village (over there, away)	gáiqelan ćimáućixi
• I come from Snag Beach/Kitamaat Village (right here)	gáiqelan ćimáućigaxg
• _____ and _____ are my parents	_____ du _____ ẃíẃaiɬenc
• _____ is my mother	_____ ’ebúkʷenc
• _____ is my father	_____ ’áupenc

Knowing My Response-Abilities

Understanding what you're good at and what you can do.

Purpose of the Activity

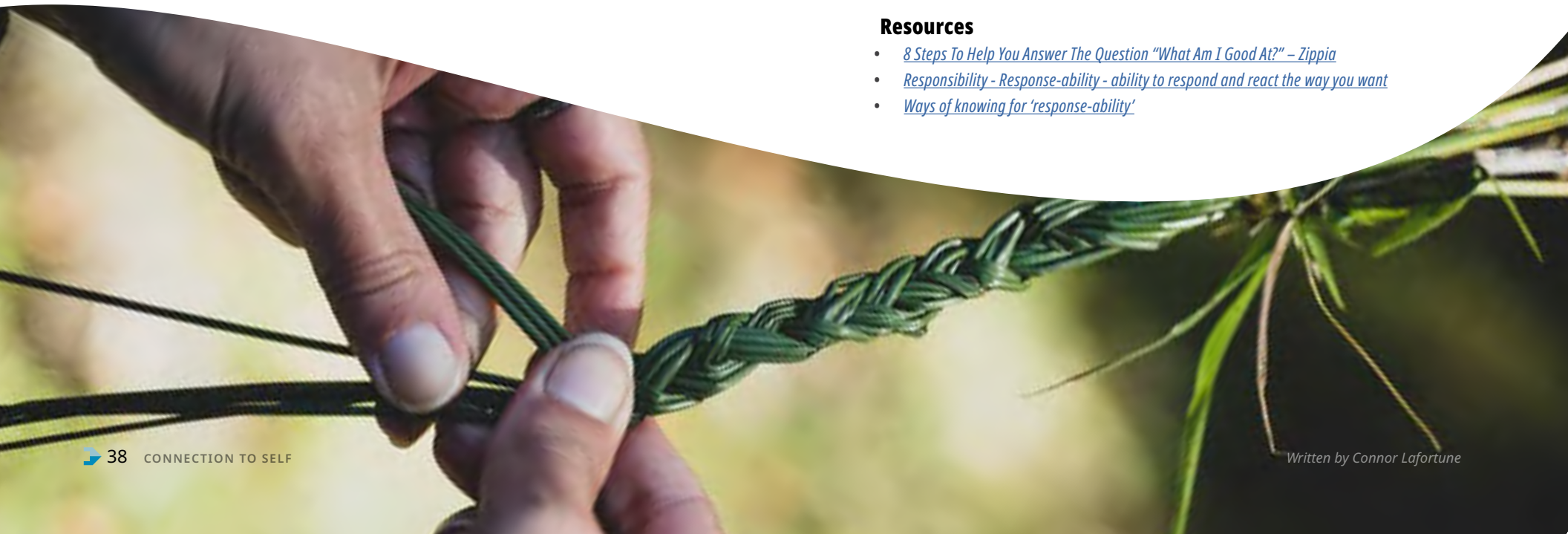
Our responsibilities often refer to our ability to respond. If we understand what we can undertake, we can better accomplish our tasks. This activity is a self-reflection, you will be presented with a list of questions and you are challenged to answer them about yourself. Your responses can be done orally, written out, or shared with a trusted person. You can choose to answer all the questions, some, or simply one. These questions and your answers challenge you to determine how you can manage your responsibilities. Understanding our "response-abilities," better prepares us to succeed in accomplishing what is expected of us. This activity aims to determine your strengths, capabilities, and ability to respond.

Questions

1. What skills have helped you thrive?
2. What activities make you feel empowered?
3. What comes to you naturally?
4. How do you spend your free time?
5. What do others think you're good at?
6. What are you passionate about?
7. Do you overwhelm yourself with tasks?
8. Do you have enough time in your day to accomplish everything you set out?
9. Do you need to limit the things you undertake?
10. Do you take control of your life?
11. Do you learn from those around you?
12. Do you keep an open mind?
13. What is one thing you would change about your ability to respond to challenges?
14. How will you work to change it?

Resources

- *8 Steps To Help You Answer The Question "What Am I Good At?" – Zippia*
- *Responsibility - Response-ability - ability to respond and react the way you want*
- *Ways of knowing for 'response-ability'*



Written by Connor Lafortune

Changing the Way We Speak

Understanding language.

What?

Language is one of the many ways we have learned to communicate as people. However, how we use language can influence how we make others feel, and how we feel. This activity/practice aims to change how we speak to ourselves. This practice can be done when speaking about ourselves to others, and when we self-talk. When we change the narrative, we can begin to notice its positive effects on our lives.

1. When speaking about work, we often state *"I have to go to work tomorrow" *sigh** We are challenging you to change that narrative. Instead, say *"I get to go to work tomorrow."* Using a positive language can help affirm you. When we acknowledge that others may not have a job and that we are lucky to have one, we begin to see the privilege we have in working.
2. When creating a list of things that need to get done, we often title it a *to-do* list. This practice does not help show initiative and urgency. We encourage you to instead write a *will-do* list. How we use language can subconsciously encourage us to get things done. When we say we have a *will-do* list, we are encouraged to get things done. This being said, we do not recommend adding everything to this list and overworking yourself, we do however recommend you create yourself small, accomplishable, *will-do* lists and complete them daily.
3. This practice can be adapted in various ways. Once we learn how to use language within ourselves positively, we can include it in every aspect of our lives. Instead of saying *"I procrastinated all day,"* say that you *"prepared yourself for tomorrow."* Instead of saying you *"did nothing all day,"* say that you *"took time for yourself to breathe and recharge."*
4. Studies show that it takes nine positives to combat one negative. This statistic does not only include the negative comments that we make about ourselves in our heads but also speaks to the negative way we speak of ourselves to others. Changing the way we speak about and to ourselves can be challenging, however, it is immensely beneficial to our mental health. Language impacts us in various ways, why not let it **positively** impact us!?

The Power of Affirmations

Affirmations are positive statements we can say to ourselves to reframe a negative mindset. It is not a practice of ignoring our negative feelings or experiences, but rather a practice of replacing negative self-talk with positive self-talk. The way we speak and think about ourselves impacts our outlook on life significantly. Your thoughts become your reality. What you think about and focus on is what you attract in life. This is why positive affirmations can be so powerful.

Examples of positive affirmations:

- I am worthy
- I deserve happiness and healing
- I love and care about myself
- I nourish and fuel my body with healthy food
- I am enough
- I love being me
- I believe in myself

Resources

- *Self-Talk: Why It Matters*
- *How to Change the Way You Talk to Yourself*
- *How to Change How You Talk to (and See) Yourself*
- *Motivation & Goals What is Positive Self-Talk? (Incl. Examples)*
- *Positive Self-Talk: Benefits and Techniques*
- *Mayo Mindfulness: Overcoming negative self-talk – Mayo Clinic News Network*
- *Power Of Words - How Words Affect Our Lives & Behavior*
- *Effect of Daily Affirmations (Positive thoughts) on Subconscious Mind, Health and Happiness - Wholesome Ayurveda*
- *Positive Affirmations (apuzzledmind.com)*

Written by Connor Lafortune

Creativity Activities

(Music, Drawing, Journaling)

Activity

Challenge your creative self. This can be done in various mediums such as visual art, written art, and auditory art.

1. Gather some art supplies *(paint/pencils/crayons/canvas/paper)* and create an artistic piece.
2. Grab a pen and paper or journal and write about your day, your feelings, or create a story. Journaling can be beneficial as it can let out pent-up thoughts and act as a release.
3. Auditory art can include listening to music, playing music, and singing. This can be both traditional and modern music. Create a self-care playlist, dance to your favorite songs, or go for a drive and listen to the radio.

Lessons

1. **Releasing pent-up emotions.**
2. **Allowing yourself to be free.**
3. **Having fun alone.**
4. **Learning to take care of yourself mentally.**

Resources

- *17 Journaling Tips For Beginners (And How To Start)*
- *75 Journaling Prompts for Your Best Life — The Bliss Bean*
- *How To Create A Self-Care Playlist*
- *100 Silly Drawing Prompts to Engage Your Students*
- *ArtPrompts | A Prompt Generator for Artists*
- *Ultimate Guitar Tabs - 1,100,000 songs catalog with free Chords, Guitar Tabs, Bass Tabs, Ukulele Chords and Guitar Pro Tabs!*

Written by Connor Lafortune

Fidgeting and Its Importance

Backstory

Anxiety is very prevalent in Indigenous communities due to various factors. It is manifested physically in a plethora of ways:

- Movement
- Shaking
- Tapping
- Deconcentration
- Panic
- Silence
- Shyness
- Avoiding eye contact
- Not knowing what to do with your hands

Fidgets allow the body to use up its energy and calm down. Anxiety often involves the looping of thoughts— if an activity is done continuously instead, the mind does not have to continue its cycle. Fidgets help to reduce that anxiety— keeping the body occupied so the mind can rest.

For many, fight or flight occurs even when one is not in danger. To be stagnant might make some feel vulnerable; like the canoe, if we keep floating along we are consistently going somewhere. When one does not have control of their environment, situation, or in this case, a presentation, having something they can control can be euphoric.

For many, movement means safety due to the nature of having control.

Finding Your Roots

Movement and sounds can be grounding— like placing our feet on the earth and taking a breath, movement can allow our bodies to find comfort in a space. Fidgeting often causes sound, although this can be bothersome, a light tapping sound, the sound of keyboard keys, or the clicking of a pen can allow for comfort, much like the sound of the wind, the waves, or the rain.

Anxious Minds, Anxious Bodies

The restless mind makes the body move— when one cannot find structure in their thoughts, one often searches for a physical manifestation of that structure. A structure can simply be a drawing, a doodle, or writing on a piece of paper. When anxious thoughts arise, it can be difficult to focus on anything else, therefore, having something to manifest that anxiety physically allows your mind to rest.

Concentration by Deconcentrating — Action vs Thought

For some individuals, having to focus on only one thing can cause a lot of stress. These individuals often require a second activity to make their experiences more enjoyable. The concept of concentration by deconcentrating is something that can be used when reading, writing, or learning something new on an instrument. By doing two or three things at once, you allow your brain to not hyper-focus one thing but rather to naturally act.

Drawing Distracts You From Unwanted Thoughts

Art can be relaxing; it is a way to express yourself and be creative. It does not have boundaries— said simply, you can colour outside the lines without consequence or worry of reprimand.

Things that can be used to fidget:

- Fidget spinner
- Fidget blocks
- Colouring books
- Pens/markers/crayons/pencils and paper
- Slinkies
- Beadwork kits
- Hand sewing project
- Mr. Tangle
- Rings/necklaces/jewelry
- Pen caps
- Bobby pins
- Elastics
- Tape
- Magnets
- Playdough

Resources

- *Anxiety Disorders and Aboriginal Peoples in Canada: The Current State of Knowledge and Directions for Future Research*
- *Drawing for Anxiety: Benefits, Easy Exercises, & More.*
- *12 Effects of Anxiety on the Body*
- *Aboriginal Mental Health: The statistical reality | Here to Help*

Written by Connor Lafortune

Creating a Self-Care Kit

Why?

Creating a self-care kit can be both beneficial and practical. Your kit is customizable, it aims to help comfort you in times of need. This kit is meant to help you feel more relaxed and give you a break from stress. While creating your kit, you can add various things to keep your morals high when you are in need. For example, you might want to add positive notes to yourself, affirmations, words of advice, or your favourite quotes.

How to Create Your Kit

We recommend you gather up items that make you most comfortable, this can range from activities, food, clothing, etc, and store them in one place. Create a self-care basket, bag, or bin that can include all your favourite things. This kit is meant to be accessible and fun. This kit can be used every day, periodically, or only when you need to relax. Self-care is an important activity that can be done simply for yourself.

Examples of things to put in your kit:

- Bath products
- Your favourite snacks
- A list/playlist of your favourite songs
- Movies
- A journal
- A sketching pad
- Stress balls
- Fidget toys
- Your favourite activity *(video games, baseball glove, beadwork kit)*
- Your favourite blanket
- Comfy clothes *(PJ's, a hoodie, jogging pants, cozy socks)*
- A book
- Words of affirmation
- Face masks
- Candles
- Your traditional medicines
- Tea/coffee
- Teddy bear
- Pictures
- Essential oils/diffuser/incense

Written by Connor Lafortune

Morals and Values Activity

Activity

1. Provide a bunch of small stones and smooth rocks for the youth to pick from or let the youth go outside and pick one for themselves. Ensure that the rocks can be written on and that they are approximately 2 inches in diameter.
2. Provide the youth with a list of morals and values, encouraging them to come up with some on their own as well. *(A list will be attached at the end of the activity.)*
3. Tell the students to pick five values or morals that they believe in.
4. Once they have five, tell them they need to leave one behind. This typically works better if you create a story, for example, you are headed on a trip and your suitcase can only fit four values, which one are you taking with you?
5. Afterward, tell them they need to leave two more behind, for example, you can only have a carry-on this time, two more must be left behind.
6. Now you need to make them choose one out of the two they have left, for example, you can only carry a backpack on your journey, you can only fit one value.
7. Once the youth have picked their one value, explain that just because they left the others behind doesn't mean they aren't part of their values, but they are not the most important one at this time.
8. After the youth has reflected on their value, have them write it on their stone on one side, and the date on the other.

Purpose of the Activity

The youth can deduce what is important to them at this moment. They can bring the stone home and every time they look at it, they can see a value that they find important. Placing the date is also important as it reminds them how people can change and what one believes is the most important thing right now, might not be the most important thing later on. It can also help remind them in what direction they are headed and remind them of all the activities you might have done that day.

Examples of values:

Written by Connor Lafortune, Inspired by an activity by La Fédération de la Jeunesse Franco-Ontarien

Self-Reflection Activity

Activity

1. Grab a piece of paper and something to write with *(crayon, pencil, marker).*
2. Close your eyes and think about this statement *"how are you feeling today?".*
3. Draw the image that came to mind with a lot or a little detail.

Self-Reflection on Activity *(this can be shared as well)*

- How did the visualization of your thoughts/emotions make you feel?
- Were you able to see a clear picture?
- Was physically seeing your thoughts/emotions helpful?
- Would you ever use this practice to express yourself if you could not find the words to do so?

Written by Connor Lafortune

Stretching Activity

Cobra Pose

1. Lie on your stomach with your hands under your shoulders, your arms tight to your chest, and your fingers facing forward.
2. Pushing through your hands, lift your upper torso off the ground as you straighten your arms. Tilt your head back if you want to make the stretch deeper.
3. Hold the position with a slight bend in your elbows for 30-60 seconds.

Neck Rolls

1. Relax and sit upright with your head aligned over your shoulders.
2. Roll your head forward and then to the right so you feel a stretch in the left side of your neck. Hold for 10 seconds.
3. Return to the starting position and repeat on the other side.

Knees to Chest

1. Lie flat on your back and bring one knee to your chest.
2. Hold it in position with your arms or hands.
3. You can also do this with both knees to your chest at the same time.
4. You can also bring both knees to your chest, put both hands on either knee and create circular motions with your knees to give your lower back a nice massage. Repeat in the opposite direction.

Upper Back Stretch

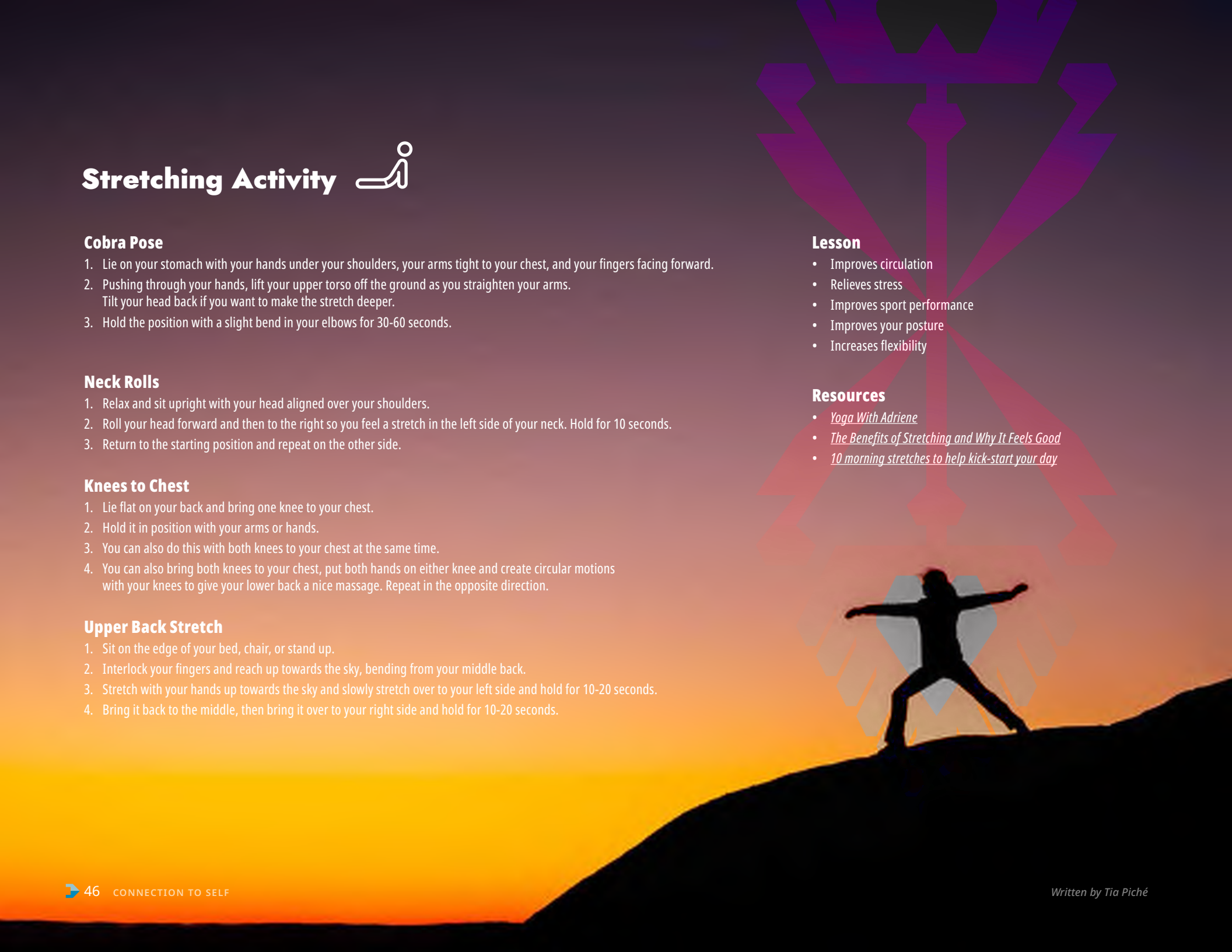
1. Sit on the edge of your bed, chair, or stand up.
2. Interlock your fingers and reach up towards the sky, bending from your middle back.
3. Stretch with your hands up towards the sky and slowly stretch over to your left side and hold for 10-20 seconds.
4. Bring it back to the middle, then bring it over to your right side and hold for 10-20 seconds.

Lesson

- Improves circulation
- Relieves stress
- Improves sport performance
- Improves your posture
- Increases flexibility

Resources

- *Yoga With Adriene*
- *The Benefits of Stretching and Why It Feels Good*
- *10 morning stretches to help kick-start your day*



Written by Tia Piché

Exploring Our Identities

The goal of this reflection activity is for us to explore our ideas behind our identities. Taking the time to honestly answer these questions can help us better understand ourselves so we can feel grounded as we move through the many phases of life. It's important to note that our answers may change over time as we continue to strengthen our identity and learn more about who we are at our core. When we truly begin to feel comfortable with ourselves, our confidence grows, and we can flourish spiritually, emotionally, mentally, and physically.

Who Am I?

This first question helps us explore the many intersections that make up each of our unique stories. As we start to think about who we are as individuals, we can uncover more of our history. This can include our family history as well as our clan and tribal history. Reflecting on our connections to family crests and houses can help deepen our understanding of our place within these cultural contexts, helping us find our sense of Belonging. Other areas of life to explore with this question include sexual orientation, gender, and linguistic identities.

Where Do I Come From?

This second question helps us explore our nation and tribal connections. As we reflect on what communities we come from, we can start to find Meaning for life through our respective cultural worldviews. Another way to approach this reflection could be: who am I accountable to?

Why Am I Here?

This third question aims to help us narrow down our self-identified Purpose. What work fuels and energizes you? What or who inspires you to do the work that you do? Who is this work for? In what moments do you find you feel the happiest? Who or what is around when you feel this way? Answering these questions openly and honestly can help us understand the passions that drive us to do the work that we do.

Where Am I Going?

This fourth question helps us begin to visualize the future we desire for ourselves. When faced with difficult life decisions, it's important to take a step back and ask ourselves *"does this decision support the life I envision for myself? Does this decision make me happy?"*
When we can picture and feel excited about our future, we can then have Hope for what is to come.

Resources

- *The Four Essential Questions — Regional Feather Carriers*

Written by Megan Metz

Meditation

Activity

1. Dim the lights in the room.
2. Empty the lungs of air.
3. Breathe in quietly through the nose for 4 seconds.
4. Hold the breath for a count of 7 seconds.
5. Exhale forcefully through the mouth.
6. Repeat the cycle up to 4 times.
7. While breathing focus on your breath and chest, ensure you are filling up your entire diaphragm which involves engaging your stomach muscles.

Lesson

1. The diaphragm is key to improving the way we breathe; it encourages our body to make more use of oxygen, which slows our heart rate, lowers blood pressure, and overall improves our mental wellbeing.
2. Being able to connect with yourself quietly is a crucial step to healing as these moments also offer a chance to take stock of the day with a clear mind, thinking of both the good and the areas in which we need to improve.

Resources

- *Headspace: Meditation for Beginners*
- *Diaphragmatic Breathing*

Healthy Communication and Boundaries

Communication plays an important role in our relationships as it is what allows us to express our thoughts and feelings. Practicing effective communication is something many of us continue to learn as we try to better connect with each other. If we find ourselves struggling to share our point of view, we risk a situation where our information can be misunderstood. Misunderstandings can also arise when we are not listening attentively and respectfully. Thus, we should work to communicate in a healthy, efficient manner while actively listening when others speak.

Communication also comes into play when we need to express our boundaries within our relationships. Healthy boundaries help us maintain our values as well as our sense of self. They help establish mutual respect in our relationships and let those around us know how we wish to be treated. If we start to feel uncomfortable in specific situations, it can act as an indicator to us that a boundary may need to be communicated.

Practicing healthy communication is often easier said than done. Many struggle and feel the need to constantly justify the reasoning behind their boundaries. The fear of saying no and experiencing backlash may cause some to resort to people-pleasing, meaning we put the needs and comfort of others before our own. When we do this on a regular basis, it can result in us feeling burnt out or feeling as if we've lost our sense of self.

Luckily, there are ways to build these communication skills so we can create healthier relationships with ourselves and others. An example of an exercise you can do to practice involves the Setting Boundaries worksheet found below. The goal of this exercise is to help us understand our boundaries, and know what to do when setting them. There are some examples of what we can say to communicate effectively. Another example below teaches us the acronym: J.A.D.E. This acronym stands for don't justify, argue, defend, or explain. It can act as a helpful reminder for us in cases where we may be experiencing difficulties with codependency or gaslighting in our relationships.

Resources

- *Worksheet: Setting Boundaries*
- *Dealing with Difficult Family Members: Don't Justify, Argue, Defend, or Explain*
- *Effective Communication - HelpGuide.org*

Written by Megan Metz and Gabrielle Jubinville

Ceremony With Intention

Activity

We encourage individuals to enter into ceremonies with themselves. Although ceremonies are often done with larger groups of people, ceremonies conducted with only oneself can help develop individual spirituality. We have listed some ceremonies that can be performed, however, there are many others. These ceremonies do not need to be elaborate, time-consuming, or difficult, they simply aim to engage your spiritual side. For many, ceremony means taking the time for yourself, listening to Creation, or engaging in the four parts of oneself *(physical, mental, emotional, spiritual)*. For certain ceremonies, namely fasting ceremonies and naming ceremonies, we recommend individuals reach out to Elders and Knowledge Holders to conduct and learn from the ceremonies. Individuals must also ensure their safety at all times. Ceremonies could be as simple as going for a walk or journaling, or as elaborate as a fast. The ceremony is defined according to the intentions put into it. These intentions need to be set before entering into the ceremony. We recommend this be the first step after having chosen what ceremony will be done. Individuals may feel free to do one, some, or all of the ceremonies listed. Many can be performed daily if one chooses to do so.

Purpose of the Activity

The activity aims to put your spiritual needs at the forefront of your mind. Our spirituality is something we need to continuously feed and nurture, much like our bodies themselves. Through these activities, you may learn to reconnect those ties to your spirituality and yourself as well.

Examples of ceremonies:

- Smudging
- Being in nature
- Naming ceremony
- Learning your colours
- Taking a cedar bath
- Having a cedar tea
- Berry fast
- Vision fast
- Putting down tobacco
- Learning your clan

Resources

- *Ode' imin, Ceremony and Law*
- *Article Vision Quest*
- *Everyday Wellness - Cedar*
- *How to make cedar tea*
- *Tobacco Offering Protocol - Centre for Indigenous Initiatives*

Written by Connor Lafortune

Resources

How to Create Healthy Boundaries

- *Setting Emotional Boundaries in Relationships*
- *Positive CBT How to Set Healthy Boundaries: 10 Examples + PDF Worksheets*
- *The Guide to Strong Relationship Boundaries*

Building Healthy Relationships

- *Building healthy relationships | healthdirect*
- *13 proven ways to maintain a healthy relationship*
- *Read: Tips for Building a Healthy Relationship*

Sexual Health Resources

- *Sexual Health Ontario | your source for sexual health information*
- *Sexual Health Resources*
- *Resources*
- *Sexual & Reproductive Health Resources For Adolescents and Young Adults – SAHM*

Water and the Way We Speak to Ourselves

- ***The Hidden Messages in Water*** – Masaru Emoto
- *Power Of Words - How Words Affect Our Lives & Behavior*

7th Generation Principle

- *What is the Seventh Generation Principle?*
- *7th Generation Principle*

Cynthia Edwards (Instagram: @ningaabianong_ikwe)

Connection to Community

Perspectives from the Youth Action Group

Community is a broad term that is not limited to blood relatives. A community can be friends, work-family, ceremonial family, your parish, your teammates, etc. A community refers to a group of people sharing a common goal, attitudes, and interests. It can also refer to the pride we have in our home territories and our relations to nature and the animals. They can give us a sense of belonging— we are united by our Clans, our Nations, our territories, and our names. Our community is a vital support system—the importance of building meaningful relationships helps us excel in many aspects of our lives. Furthermore, a reciprocal relationship with our communities promotes opportunities to engage in activities, events, and ceremonies.

"In the place of intergenerational trauma, we encourage intergenerational healing, kindness, and communication as a foundation for all else."

~ Nimkiins/Connor Lafortune

"A community is where you feel at home"

~ Nimkiins/Connor Lafortune

Our communities are who we turn to for support and knowledge sharing. Through our connection to community, we can find healing and a sense of belonging."

~ q̓ándauẍʷ / Megan Metz

"Indigeneity is rooted in community and connection. Community is what guides us to have a connection to ourselves and the land"

~ Taylor Behn-Tsakoza

"Connection to community is knowing your neighbours and lending them a hand if needed; smiling and waving to your community members as you pass by."

~ Tia Piché

Do these perspectives make sense to you?

Please reflect on what connection to community means to you in your current context.

Learning Objective

In this section, individuals are encouraged to evaluate their relationship with one another to strengthen their community. Individuals may feel free to first define their community, then work to restore, create, and maintain the connection to them.

Reflections from Youth Action Group

What barriers or challenges are preventing people from attaining a connection to the community?

Due to the injustices suffered as Indigenous Peoples, many of our Knowledge Holders no longer understand the significance of their knowledge. Further, the younger generations may not see the importance of gathering this knowledge and sharing it. Our communities may have suffered the effects of segregation, racism, and isolation. To foster a healthy communal connection, we need to recreate the spaces that were taken from us.

What are some ideas/solutions to breaking down these barriers and achieving a strong connection?

To rebuild the connections we have with our communities, we need to begin the conversations of healing. Sharing circles, designating cultural sites, and communal activities such as gardens can be implemented to begin healing together. The designated areas could include traditional teachings, the promotion of cultural practices, and the preservations of ancient knowledge. Indigenous Peoples often return to traditional ways of speaking, to begin that healing process – creating safe spaces to share, regaining the connection between the Elders and the younger generation, and fostering the conversations between community members. To break the barriers and achieve a strong connection to the community, we must rebuild those intergenerational connections and pave the way for lateral kindness.

Community Reflection

On chart paper, together or in a small group, reflect on the questions below in regard to connection to community:

1. What barriers or challenges are preventing people from attaining this connection?
2. What are some ideas/solutions to breaking down these barriers and achieving a strong connection?
3. What resources does your community have that promote a connection to the community?
   (e.g.,community centres, sports programs, youths programs)
4. What resources would your community need to foster a healthy connection to the community?

Engaging Role Models for Mentorship and Peer Support

Purpose

Peer support is the key for developing a healthy lifestyle and promoting positivity through action. Role models are individuals that lead by example. They have the ability to demonstrate compassion for others, encourage, and uplift. Being a role model is about taking on expectations and accountability. If one pursues being a role model, they must accept the responsibility that comes with it!

Activity

1. As a group, or by yourself, create a list of people in your life that you consider to be role models. Think about certain situations where someone was a role model.
2. Ask yourself, are they engaged in the activity? Are they taking the lead? Are they supporting everyone's input with feedback? Once completed, reflect as a group and share what you reflected on.

Lesson

- The objective of this exercise is to reveal natural qualities that emerge when called upon to be a role model. Additionally, as a collective, you will draw out your own observations that can describe a role model. You may also find that a role model could have been anyone in your life, a parent, older sibling or cousin, friend, teacher, coach, etc. It is important to understand anyone is capable of being a role model in any given situation. Yes, some folks are gifted and these qualities are already a part of their character. However, with practice and genuine effort, anyone can become a successful role model.

Example phrases:

- Good job!
- I really value your comments and thoughts.
- Please take your time.
- It's ok if you don't have an answer.
- I like that idea! I also think...*(elaborate on their input)*
- Is there anything I can do to help?

Remember....

Empathetic listeners use direct eye contact while listening and give their full attention. Avoid being on your phone or any other distractions while listening. Also provide feedback on what was said! This is a good step to developing your ability to become a good role model.

Examples:

- **Person 1:** I really think that we should take this approach with the event. I feel that if there's going to be a younger audience that we should include content for them.
- **Role Model:** That's a great idea! Thanks for pointing this out, maybe we can provide cartoon segments?

Hint:

A good response should be modeled as follows:

Respond,
Acknowledge,
Feedback.

Written by Marshall Morriseau

Craft Night

Activity

- Gather as a community and have a craft night.
- These crafts can be a combination of traditional and non-traditional crafts.
- The crafts/activities are dependent on the community's needs, capabilities, and wants.
- If the community would like to hold a traditional craft-making night, Knowledge Holders can be contacted to properly facilitate the event.
- Communities are encouraged to gather in a common area (gym, community centre, hall), set up tables, provide materials, and craft together. Individuals are also encouraged to bring their supplies.
- These activities can be combined with music, snacks, and movies.

Purpose of the Activity

Communities are encouraged to step out of their creative comfort zone and create something together. Although this craft night is highly adaptable, we encourage communities to share knowledge, tips and tricks, crafting material, and even to gift the piece that was worked on. Communities may learn to better communicate, share, and gain a better understanding and appreciation for crafts, art, and traditional items.

Examples of crafts:

1. Beading
2. Sewing (ribbon skirts, ribbon shirts, aprons)
3. Carving
4. Painting
5. Drawing
6. Drum making
7. Rattle making
8. Regalia making
9. Origami
10. Scrapbooking
11. Hide tanning
12. Mitt making
13. Moccasin making
14. Birch basket making
15. Pottery
16. Sculpting
17. Knitting/crocheting
18. Roach making
19. Dream catcher making
20. Suncatcher making

Written by Connor Lafortune

Communal Challenge/Repair Activity

Activity

- Communities are encouraged to find a challenge in the community and find ways to address it and fix it together.
- This activity can be completely adaptable to each community.

Examples:

- Pick up garbage on the roadside.
- Help to paint someone's home.
- Have a clothing drive.
- Start an afterschool program.
- Help a neighbour with their garden.
- Mow someone's lawn.

Lesson

Communities will learn how to work together to accomplish something. This communal activity can range from a garbage clean-up to an after-school sports program. The goal is to address a challenge that the community faces and fix it together. Communities are encouraged to use everyone's skills and talents to help fix things in the community. This activity aims to bring back a communal sense of responsibility and the sharing of tasks and goals.

Resources

- *Community repair: a pop-up alternative to the throwaway society*
- *60 Ways to Better Your Community: Ideas for Community Service Projects*
- *101 small ways you can improve your city*
- *100 ways make a difference in your community through kindness*

Written by Connor Lafortune

Festivals

Annual Winter/Summer/Fall Festivals

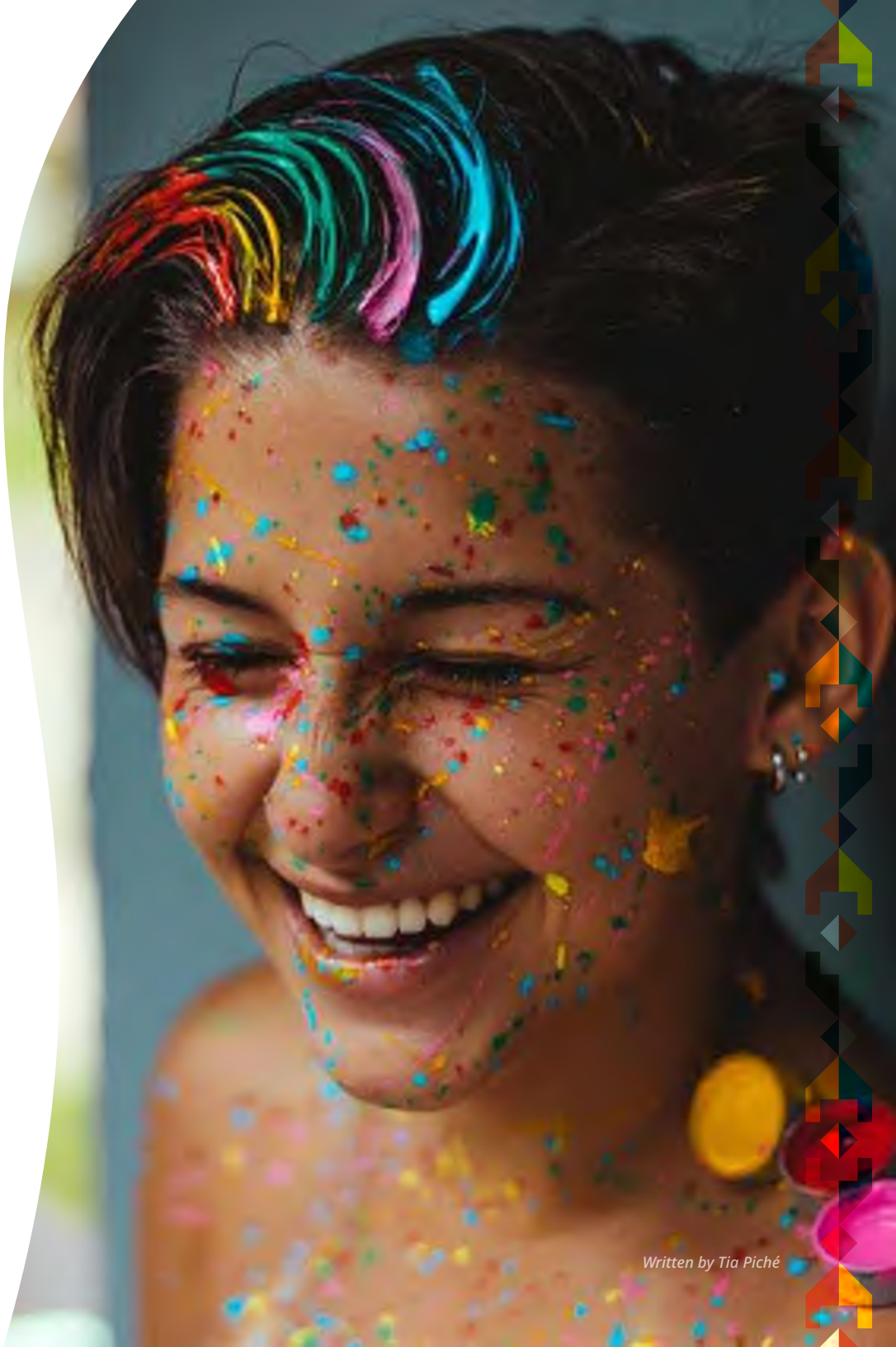
Festivals are great ways in which communities can come together to showcase various talents and strengths in a fun and healthy way. Below are just some ideas that can get the ball rolling. What other activities do you know about or that your community does every year?

Activities

- Pumpkin carving contest
- Rock painting contest
- Talent show
- Dancing
- Mazes/Obstacle courses
- Tug of war
- Fishing derbies
- Three-legged races
- Eating contests
- Face painting
- Sack races
- Pie throwing
- Scavenger hunt
- Animal calling
- Jigging contest

Lessons

- The community gets together and hosts a variety of outdoor games and contests, alongside serving food and the opportunity to get to know each other.
- Opportunity for participation, volunteering, communication skills, and attracting tourists into your community.
- Building relationships and positive memories with your community and community members. *(I reflect on my days in my hometown and dearly miss the annual festivals/games my community would put together. It brought us all together and made us feel more connected to "home").*



Written by Tia Piché

Family Tree Activity

Purpose of the Activity

This activity can be done communally or within families. The activity challenges communities to learn about and draw out familial ties. We encourage communities to use this time to showcase these family trees and begin to reconnect the lines between families.

Potential material

- Photos
- Poster board
- Pencils/markers/pens
- Glue
- Piece of paper to sketch on

Activity

1. Collect the photos of the people you want to include in your family tree.
2. Sketch out your family tree on scrap paper and write out the names that you want included, along with their generations.
3. Add the last generation *(youngest generation)* at the bottom of the poster board and work your way up the branches. Don't forget to leave room for the pictures!
4. After you're done writing out the names, glue each photo in its proper spot along with the date of birth, if you wish.
5. You may also want to include marriages and deaths if you'd like.
6. Try and see how far up the family tree you can go!
7. Post your family tree in a prominent place such as in each home or the community centre.

Note:

If the activity is done as a community, we encourage families to set up in a communal area and sit at tables with their immediate family. As everyone does their trees, communities can begin to draw the lines between family trees and see the interconnectedness. This activity can be combined with music, snacks, and movies.

Written by Connor Lafortune

Sharing Circle Activity

Activity

1. Communities are encouraged to gather either in small groups or in their entirety. This activity can be done indoors *(gym, hall, school)* or outdoors *(sacred sites)*.
2. Knowledge Holders, circle facilitators, and someone to facilitate counseling is needed for this activity.
3. Everyone is encouraged to gather in a common space, sit in a circle and share safely.
4. The first step in the sharing circle is to have everyone understand the importance and values found within the circle. This can be done in various ways according to the community's teachings, customs, and knowledge.
5. Talking sticks, stones, feathers, or any other object are encouraged to better facilitate conversation and allow for the respect of each person's words.
6. A Knowledge Holder may open the circle in their way *(prayer, smudge, song)* and explain how the circle should proceed.
7. Each participant is welcomed to speak, going around the circle.
8. The circle may go around once, twice, or more times depending on the needs and time constraints of the community.

Purpose of the Activity

Communities are encouraged to share openly and honestly. This can help reignite the connections between community members and families. This activity is completely adaptable according to the community's needs, wants, teachings, and capacities. These circles can be done in various ways as long as they respect the basic principles found within the community's teachings.

Resources

- *Sharing Circles – Pass The Feather*
- *Learning from Indigenous Peoples - Sharing Circles | Do Justice*
- *Talking Circle: Fact Sheet – Talking Together*
- *Talking Circles Overview from the First Nations Pedagogy Online Project*
- *About Sharing Circles*

Talking Stone by Randy Knott, Curve Lake *Written by Connor Lafortune*

Tea Talks for Intergenerational Healing

Goal

Bring together Elders, Knowledge Keepers, youth, and your community to promote knowledge sharing and intergenerational healing through story-telling. After the Elders and Knowledge Keepers have shared their stories and answered any questions, the event can end with an optional activity that reinforces self-reflection and lessons learned.

Purpose

When we share our stories in this way, we are effectively recreating what we would have done in the past. Storytelling was a method used by many nations to share their history as well as pass on knowledge, life lessons, and values. Through sharing and reclaiming our stories, we can inspire others and begin to break down barriers that many of us face in our lives. We are also given the opportunity to learn more about our true histories which can help us better relate to and understand one another. Re-establishing these healthy community connections can increase our sense of belonging, continue the transfer of knowledge to the next generations, as well as provide a space for healing for all involved.

Event Ideas

- Create a comfortable learning environment by offering some tea, coffee, water, and snacks.
- Provide space for elders and Knowledge Keepers to engage in storytelling with the community. Some examples can include creation stories or tribal history.
- Provide space for Elders to share their personal life stories with the community. Some examples of topics can include important life lessons learned, advice or wisdom, experiences with intergenerational trauma, and ways to promote healing.
- Ensure proper cultural support is present when heavy topics and stories are going to be shared.

Activity

- Begin writing and reclaiming your story using the *Native Storytelling Handout*.

Resource

- *Native Storytelling Handout*

Written by Megan Metz

Ceremony with Communal Intention

Activity

We challenge communities to perform a ceremony. These ceremonies can differ according to the community's needs, traditions, and capabilities. Ceremonies could be as simple as a feast or as elaborate as a powwow. Listed below are a set of potential ceremonies that could be done. These ceremonies can either be all completed, or just one specific ceremony can be chosen. When beginning to plan a ceremony, the proper Knowledge Holders must be contacted and the protocols must be followed. Each community may define what a ceremony looks like to them.

Significance of the Activity

Ceremonies aim to heal us, show gratitude, give us purpose, honour our histories, and allow us to gather. Each ceremony may bring a different type of gratification and teachings. It is up to the community to define what intentions are set out, how the ceremony will be facilitated, and what is expected. Ceremonies may also be defined according to the community's understanding. This activity aims to reconnect communities to themselves, each other, and the ancestors and spiritual world.

Examples of ceremonies:

- Sweat Lodge
- Smudging as a community
- Pipe ceremony
- Blanket ceremony/teaching
- Powwow
- Round Dance
- Socials
- Drumming Circles
- Feasts and Giveaways
- Moon Time Ceremonies
- Potlatches

Resources

- *Ceremonies and Socials – Our Stories*
- *Symbolism and Tradition*
- *Potlatch*
- *Ceremonial Spaces*
- *Indigenous Ceremonies*
  (7 Most Common Native American Ceremonies & Rituals)
- *Article Sweat Lodge*
- *Article History of Powwows*
- *How Indigenous communities are holding Round Dances virtually*

Written by Connor Lafortune

Resources

Lateral Kindness Declaration

- Lateral Kindness - Declaration of Commitment (PDF)
- Lateral Kindness Gram (PDF)
- Practise Lateral Kindness to Help Reduce Stigma and Fear of COVID-19
- Let's use Lateral Kindness to "lift each other up"

Fostering Communal Healing

- 2020: The Power of Communal Healing — Listen First Project
- Communal Healing: An Interview with Camesha Jones
- Addressing the Healing of Aboriginal Adults and Families within a Community-owned College Model
- A Year Long Wellness Approach

Healing Through Story-Telling

- Understanding the Healing Power of Storytelling
- Storytelling in Native American Cultures
- The Power of Indigenous Storytelling

How Colonization Fractured Our Communities

- The Effect of Colonization on First Nations
- The Impact of Colonization and Western Assimilation on Health and Wellbeing of Canadian Aboriginal People

The Impact of the Dismantling of Women's Traditional Roles

- Aboriginal Women and Aboriginal Traditional Knowledge (ATK)
- Gender Identities – Our Stories
- Indigenous Women: A Gender Perspective
- Marginalization of Aboriginal women - Indigenous Foundations

Healthy Relationships

- Healthy Relationships (nativewellness.com)
- Healthy Youth Dating Relationships - Canadian Red Cross

Creating Healthy Relationships and Partnerships

- Healthy Relationships (nativewellness.com)
- Healthy Youth Dating Relationships - Canadian Red Cross
- Read: Tips for Building a Healthy Relationship
- How to build a healthy romantic relationship: 5 tips
- Quizzes - The 5 Love Languages®
- What Are the Five Love Languages?
- Healthy Friendships and Relationships (ct.gov)

Cynthia Edwards (Instagram: @ningaabianong_ikwe)

Connection to Spirituality

Perspectives from the Youth Action Group

As a chance to reflect on our previous sections, the action group concluded that "spirituality" is one of the most unique perspectives we can have. As our relationship with Spirit is individual, we felt it was best to write in our own words what it meant to each of us and encourage you to do the same.

Acknowledgement

The Youth Action Group acknowledges that spirituality is a complex system of beliefs with varying approaches. We acknowledge the following approaches may not reflect the beliefs of religious ideologies, atheism, values, and other worldviews. These perspectives are informed by personal experiences and teachings. We acknowledge that our team members come from a place of Indigenous spirituality however, we welcome all spiritualities, worldviews, faiths, and religions.

"To me, spirituality is how I conduct myself in my daily life, the act of living is ceremony within itself"

- Waabishkigaaboo/Will Landon

"Spirituality is what connects me to everything around me. It's an intentional act to connect to the higher powers in our universe"

- Taylor Behn-Tsakoza

"Spirituality is something we turn to for strength, wisdom, and purpose. It is a belief in a higher power that we can connect to and learn from, which helps us find meaning in many different aspects of our life. When we are grounded in our spirit, we can then feel connected to and appreciative of everything around us."

- q̓ándaux̄ʷ / Megan Metz

"Spirituality for me is vested in my connection with my Elders and all of my relations. As beings, we walk this earth searching: searching for our dreams, our goals, and our answers. Spirituality is not only a way of thinking, but rather a way of breathing, seeing, and living. To live spiritually means to continuously nurture our being and all living beings around us. To be spiritual means to see the world in two dimensions but chose to search for the third."

- Nimkiins/Connor Lafortune

"Spirituality to me means something bigger than myself in my human form. I often find myself searching within for my purpose and meaning in this life. It is connecting myself to the higher power and learning to trust my gut and intuition. Through connection to spirituality, I find calmness, peacefulness, understanding, and forgiveness. It is a great reminder for me to be in the present moment and not fear the future or dwell on the past. It reminds me to treat everyone and everything with kindness, empathy, and understanding."

- Tia Piché

Learning Objective

In this section, you will learn ways to connect to yourself spiritually. Through activities, self-reflection, prayer, and ceremony, you may begin to foster that relationship with your spirit.

Reflections from Youth Action Group

What barriers or challenges are preventing people from attaining a connection to spirit?

Due to the various historical challenges faced by Indigenous Peoples, a connection to self is often compromised. Communal shame, loss of connection to self, culture, and community, and intergenerational trauma all play their part in the threat to one's connections to spirit.

What are some ideas/solutions to breaking down these barriers and achieving a strong connection?

When we lose the connection to ourselves, we often find ourselves searching for connection through another medium. This connection can be with Elders, friends, church, family, and Knowledge Holders. If we know where we came from, we can begin to understand where we are going— when we hear our Creation stories we are better able to understand ourselves within the world. Other ways of achieving a strong connection include the normalization of differing world views, the normalization of languages, and the understanding of ourselves as living beings affected by everything around us.

Community Reflection

On chart paper, together or in a small group, reflect on the questions below in regard to connection to spirituality:

1. What barriers or challenges are preventing people from attaining this connection?
2. What are some ideas/solutions to breaking down these barriers and achieving a strong connection?
3. What resources does your community have that promote a connection to spirituality? *(sacred sites, ceremony)*
4. What resources would your community need to foster a healthy connection to spirituality?

Naming Ceremony

Activity

- Naming ceremonies can be done in various ways. According to different nations, practices, and traditions, the ceremony itself can mean various things. We encourage individuals to reach out to their local Knowledge Holders and inquire about their area's naming practices.
- A naming ceremony most often refers to a time when a child, youth, teen, or adult is given a second name in their traditional language, although some Indigenous cultures give these names at birth.
- Due to the overwhelming difference between each ceremony and practice, we can not provide a clear example of what a naming ceremony might look like for you. However, we have included various resources that describe different naming ceremonies.

Lesson

A naming ceremony is a time when a family gathers to let the spirits and the ancestors name an individual. These names also come with protection and wisdom from the spirits. These ceremonies are often conducted in conjunction with other ceremonies and ceremonial objects and practices. Our spiritual names can help to connect us to our spirituality, our culture, and our ancestors. When we are given these names, we must cherish and honour them.

Resources

- *What having a naming ceremony for my kids meant to me*
- *Claiming a Name | This is a Canadian Issue: Reflecting on TRC Calls to Action*
- *Naming Ceremony*
- *When A Child Is Given An Anishinaabe Name*

Making a Traditional Dwelling

Activity

- Originating with the Plains people, the tipi is a Lakota word, thípi, meaning *dwelling* or *they dwell*. A tipi is a cone-shaped dwelling traditionally made using animal hide and 8-15 wooden poles. Today's tipis are often made with a canvas tarp and poles made of various types of materials.
- Originating with the Algonquian people, the wigwam is an Algonquian word, wigwam, meaning *their house*. A wigwam is a long-term dwelling ranging in shape from cones to rounded-edged houses. Traditional wigwams are made with small dried and bent trees, bark, hide, and matting. Wigwams were typically used during colder months. Today's wigwams are often covered with a synthetic canvas cover.
- Originating from the Inuit people of the Arctic, the igloo (iglu) is the word for house in Inuktitut. An igloo is a rounded dwelling made of blocks of snow that have been strategically cut to slowly incline into a half sphere. The typical size of an igloo for one family is 3 to 3.5 metres high and 3.5 to 4.5 metres in diameter. Different materials were used as well such as animal skins to line the inside.
- Originating with the Indigenous peoples of the Northwest Coast, namely the Coast Salish, Kwakwaka'wakw, Nuu-chah-nulth, Nuxalk, Haida, and many others, the plank houses were commonly used for community and ceremonial purposes. Although every nation had their own way of contracting these structures, they typically all relied on heavy timbers and were decorated with various symbols.
- Making these dwellings can be a spiritual activity if the right intentions are put into it. Since every nation may make their dwelling differently, we have included various resources.
- Knowledge Holders always encourage to properly prop up your tipi or wigwam, however, you can make do without if needed.
- They can be made the traditional way with dowels made of trees and an animal hide cover, or as a modern way with synthetic tarp and metal poles, as desired.
- These dwellings can then be used as shelters, to cook, for ceremonies, or other spiritual reasons.
- If your community traditionally used a different type of dwelling, we encourage the construction of that, when possible!

Resources

- How to Build a Teepee | The Pioneers
- How to Erect a Tipi
- How to set up a canvas tipi and liner
- Making a Wigwam
- Building a Wigwam (Time Lapse)
- Wigwam Building
- Building a Wigwam with Natural Materials | Bushcraft Shelter (Part 1)
- Wigwams - Basic Wigwam Construction
- How to Build an Igloo
- How to Build an Igloo - National Geographic
- Building a Native American Plank House
- Chinookan Plank Houses - Native American Domestic Architecture & Culture

Lesson

Creating our People's original dwellings can help reconnect us to our ancestors and our spirituality. The creations of these dwellings also help to humble us as people. We often live in a materialistic world that aims to consume quickly. When we take the time to create our shelter or spiritual site, we can begin to see how the world once worked, and learn how to incorporate what we have learned into our modern life. The dwellings may also provide us with a specific location where we can practice our spirituality and invite others to do so as well. Not only does this activity promote our spiritual selves, but it also promotes our community engagement in spirituality. These sites can then be used by whole communities to reignite their spiritual flame.

Written by Connor Lafortune

Creating Spiritual Items

Activity

- Spiritual items can be defined differently depending on individual's traditions, nations, and practices. The creation of spiritual items can help ground us in our spirituality by giving us a physical representation of it. Below we have provided a list of spiritual items that may be created, however we encourage you to also come up with some of your own.
- Spiritual items can be created individually or in groups. For more elaborate items, such as a drum that comes with many teachings, we encourage you to reach out to Knowledge Holders.
- Spiritual items do not need to be elaborate! They can range from an entire regalia to a simple tobacco pouch. The monetary value and effort put into creating the item do not matter, only the desire to do so is important.

Examples:

- Tobacco pouch
- Drum
- Drumstick
- Rattle
- Decorating an eagle feather
- Medicine bundle
- Regalia
- Ribbon skirt
- Ribbon shirt
- Beadwork

Lesson

By creating our items, we can begin to reconnect with our spiritual selves. These items can also allow us to reconnect to our spiritual community. Each item may have a different meaning, teaching, and lesson; we encourage you to seek those lessons on your own. These teachings may also vary according to the practiced culture. For example, a drum often represents the heartbeat of our people and the manifestation of our ancestors. Different drums can represent different people, for example, a hand drum may be a grandmother, whereas the big drum can represent our grandfather.

Resources

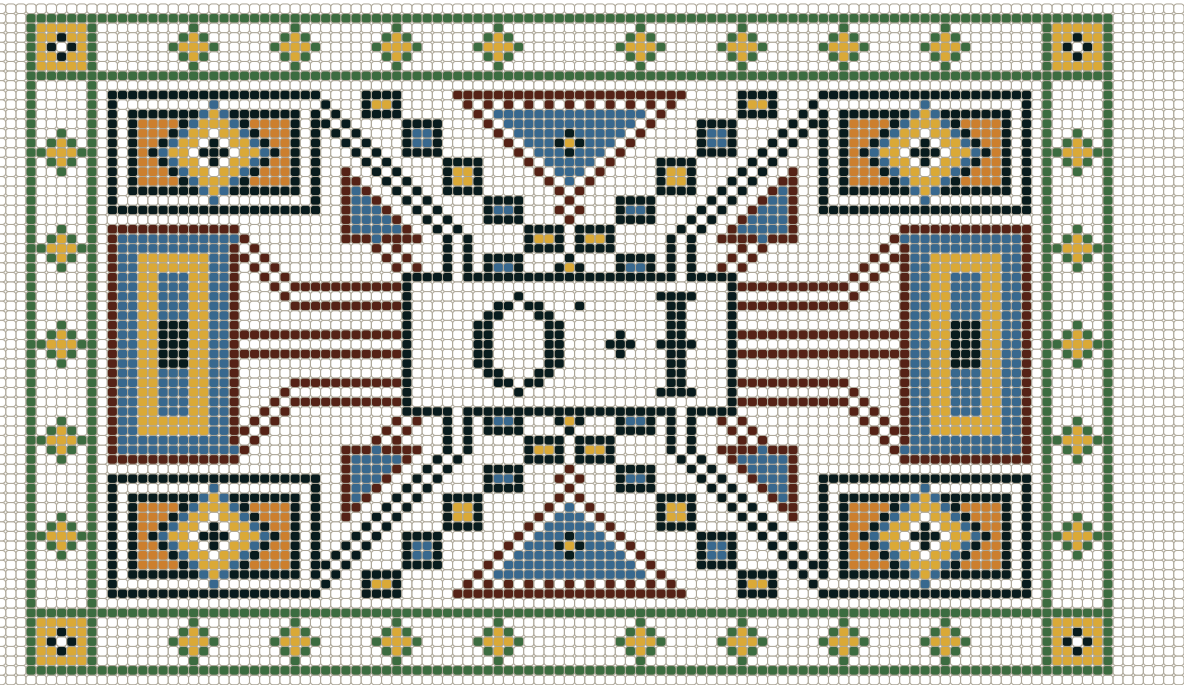
- *Ribbon Skirt Tutorial With Billie Jo Kruger*
- *Simple AF Ribbon Shirt Tutorial Part 1: Measuring and Pattern Drafting*
- *Simple AF Ribbon Shirt Tutorial Part 2: Cutting Fabric and Sewing*
- *Sacred Items and Bundles – Indigenous Website*
- *Cultural ignorance at heart of skirt-shaming controversy*
- *Beads: Symbols of Indigenous Cultural Resilience and Value*
- *Tribal Spirit Hand Drum Kits*
- *Medicine Bags or Bundles – Legends of America*

Written by Connor Lafortune

Learning Your Creation Story

Activity

We encourage individuals to learn their nation's Creation Story. These first stories can help us reconnect to our original instructions and our spirituality as a whole. These stories can be learned from videos, audio files, in written form, or through conversations with others. We acknowledge that everyone's Creation Story is different. We have provided variations of Creation Stories across several nations below. However, we encourage you to reach out to Elders, or the holders of this knowledge in your community if you can do so.



Examples of Creation Stories:

- An Anishinaabe creation story - Pukaskwa National Park
- The Creation Story – Turtle Island For the Ojibway/Anishinabe people, Long ago, after the Great Mystery, or Kitchi-Manitou
- The Creation Story
- Haudenosaunee Creation Story
- Raven: A Haida Creation Story
- Elder Bill Reid: The Haida Creation Story
- Oneida Creation Story Oneida Sign Language 2017
- The Mohawk Story of Creation | Lee Claremont | TEDxPenticton
- Grandmother : Creation Story | Opening to the World | Culture
- The Legend of Weesakayjack - First Nation Legend - How North America came to be - Canada
- Creation Stories - The Origins of Culture
- Cree Creation Story
- Métis—Stories of Long Ago - Voices of Métis - Our Voices, Our Stories - Library and Archives Canada
- The Creation Story – Historical and Contemporary Realities: Movement Towards Reconciliation
- Algonquin Creation Myth - An Algonquin Legend
- The Creation of the World | The Tribal Council
- Mi'kmaq Creation Story
- Blackfoot Creation Myth – Legends of America
- Blackfoot Creation and Origin Myths
- Creation Story (Iroquois/Haudenosaunee)
- Onondaga Creation Story
- The Inuit Creation Myth
- Sedna, by Heather Dale - The Inuit creation myth retold in American Sign Language
- Inuit Creation
- A Dakota Creation Story
- Tlingit Creation Story (Raven)
- Creation Myths -- Iroquois Creation Myth

Written by Connor Lafortune

Drumming and Singing

Lesson

Drumming and singing is a ceremonial and cultural aspect that is practiced by Indigenous People across Canada. The drumming and singing styles can be different among the groups with some even having a distinction between powwow style singing and traditional style. It is used as a way in which to communicate with the spirits and call them to the drum, as particular songs have particular uses and it is important to sing the song that fits the needs of the community, meeting, etc.

Anishinaabek Water Song

Wichita do ya do ya do ya
Wichita do ya do ya heh
Wichita do ya do ya do ya
Wichita do ya do ya heh
Wacha tonaya hey ya hey ya
Wacha tonaya hey ya hey
Wacha tonaya hey ya hey ya
Wacha tonaya hey ya hey

Anishinaabek Nibi Song

Wayaa hay-yaa away ya hay-yaa yo, way-haa way-ay-yaa-yo. Wayhaa way-ay-yaa-yo!
Miigwech, Manitou! (Thank you, Great Spirit!)
Wayaa way-ay-haa-yo wayaa way-ay-haa-yo
Miigwech Ikwe! (Thank you, Woman!)
Mee-ay Nibi Kinagajitoyan! (Who takes care of the Water!)
Miigwech Benesiak! (Thank you, Thunderbirds!)
Wayaa way-ay-aa-yo wayaa way-ay-haa-yo
Miigwech Nokomis! (Thank you Grandmother Moon!)
Wayaa way-ay-yaa-yo wayaa way-ay-haa-yo

A.I.M. Song

Lead:
Maamwi gida-maashkozimin o hey ya hey o
Together we should be strong
Maamwi gida-maashkozimin o hey ya hey o
Together we should be strong

Verse:
Niizhwaasing ishkode gii-boodawewaad
The seventh fire has been lit by them
Boochigo Anishinaabemyang
We have to all speak Anishinaabemowin
Minobimaadziyang
We are living well
Minobimaadziyang
We are living well
O hey ya hey o

Written by Will Landon

Resources

Learning About Kinship, Identity, Nationship, and Clanship

- Kinship ~ Walking Together
- Traditional Indigenous Kinship Practices at Home: Being Child-Centered During the Pandemic
- Reviving Indigenous Kinship — Freedom Rising
- What is Indigenous Identity?
- Clans – Indigenous Website
- Article Clan (Indigenous Peoples in Canada)
- Aboriginal Identity & Terminology
- Governance

Indigenous LGBTQ+2S Identities

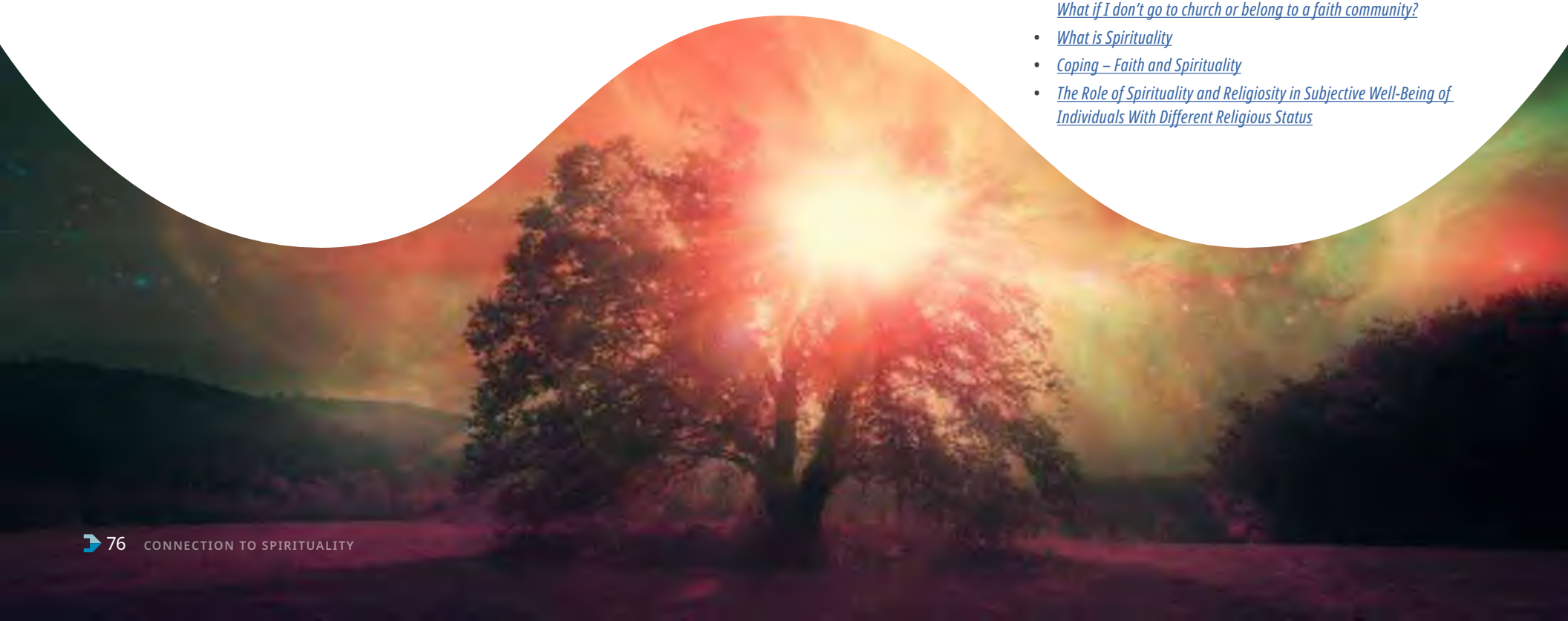
- Researching for LGBTQ Health
- OACAS Library Guides: LGBTQ2S+ identities and child welfare: Two-Spirit identities
- Two Spirit and LGBTQ Idenitites: Today and Centuries Ago - HRC
- An Introduction to the Health of Two-Spirit People: Historical, contemporary and emergent issues
- Indigenous Sexualities: Resisting Conquest and Translation

Indigenous Spiritualities

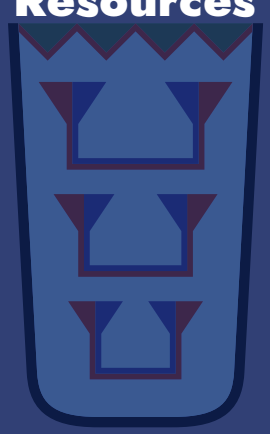
- What is Aboriginal spirituality?
- WRC-2017: (2/9) Indigenous Spirituality and Canadian Values
- Article Religion and Spirituality of Indigenous Peoples in Canada

The Different Forms of Spirituality

- What is spirituality
- What is Spirituality?
- The Mental Health Benefits of Religion & Spirituality
- What is spirituality? Is it different from religion? What if I don't go to church or belong to a faith community?
- What is Spirituality
- Coping – Faith and Spirituality
- The Role of Spirituality and Religiosity in Subjective Well-Being of Individuals With Different Religious Status



Resources



Community Contacts and Resource Sheets

Health Services

- *Health care services for First Nations and Inuit*
- *Health services and social programs for Indigenous Peoples - Canada.ca*

Youth and Adult Support Lines

- *Indigenous crisis supports – Life Voice workshops*

Youth Funding

- *Jordan's Principle | The Caring Society*
- *Updates on Jordan's Principle*

How to Create a Resource List for Your Community

- *How to Create a Community Resource Guide*

Tools and Templates

Writing a Letter

- *How to Write a Letter: Letter Writing Tips and Examples*
- *Letter Format Example and Writing Tips*

Budgeting Worksheet

- *How to make a budget*

Brainstorming Activity Worksheet

- *Brainstorming Printable Worksheets*

Personal Self-Care and Self-Reflection Template

- *22 Self-Care Plan Checklists & Printables for a Happier & More Productive You*

Event Organization Checklist

- *The Event Planning Checklist Used By Top Event Planners*

Resume Template

- *Resume-Now*

Cover Letter Template

- *Cover Letter*

Goal Setting

- *Personal Goal Setting Templates - Download PDF*

How to Apply for School Funding Template

- *50+ Scholarship Application Forms*

Applying to Scholarships Template

- *50 Free Scholarship Application Templates & Forms - TemplateLab*

Indigenous Multimedia

Tiktok

@daybirdBeauty
@drivesthecommonman
@ticaks2.0
@kendrajessie
@ladybeardesigns
@4generationscreations
@tabilaahmvrinn
@jayroymakokis
@feathernews
@twochiefs
@chiefladybird
@sequinwapimikwan
@scottwabano
@aptmnews
@tomaskarmelo
@desertndn
@shinanova
@lavinahoule
@tiamiscihk
@ojibwaylegacy
@aichella
*@allytrick_*
@raybaans
@bannockkash
@aungelle
@eric_assinewai
@youngdreama
@sillygoosekalei
@ohkairyn
@darrellbrerttonjr
@willowredstar
@jacob_sinclair16
@aliciakayley
@motoriouscree
@deadlyconway
@haraqiq
@ladybird_ra
@geronimo.warrior
@dreadfulbird
@rez_reports
@sherry.mckay
@monikkamcgregor
@modern_warrior__
@the_land
@beccajewels

Instagram

@odemin_giizis
@naanokaazii_designs
@nimkii_shkode
@myminingtee
@teribeads2019
@odenibkwe_singers
@divingloon.co
@ntvdsgn
@indigenoussupplies
@ella_wholesale
@dineh_largo_jewelry
@smudgetheblades
@powwowjackets
@rockymountain.designs
@kanatan_health_solutions_inc
@western_varieties
@beadworkbylib
@najinisowin
@tsista.kennedy
@decolonizemyself
@cedarfoxbeads
@byellowtail
@mangeshig
@otsitdesigns
@assinewejewelry
@katielongboat.beadwork
@monarch.beadwork
@chiefladybird
@blueberrybead
@reclaimyourpower
@cheekbonebeauty
@sarainfox
@zazegaakwe
@mini.tipi
@ravenrising.ca
@raven_reads
@officialsherrymckay
@natalierosestudios
@redbird_beads
@nativereacts
@manitobah
@_pourfection
@kokum_scrunchies
@ntvsclothing
@ginew_usa
@indigenousfriends
@sweetmoonphoto
@anishinabeknation
@oxdxclothing
@urbannativeera
@realnativesonly
@beadeddreamsca
@jocy.bird
@notoriouscree
@ashleycallingbull
@nikitaelyse
@kendrajessie
@singsinthetimber

Books/Articles/Writers

Mishomis book
- Benton-Banai-baa

Ojibway ceremonies
- Basil Johnston

The Truth about stories
- Thomas King

Indigenous Relations
- Bob Joseph and Cynthia F Joseph

21 things you may not know about the Indian Act
- Bob Joseph

Braiding Sweetgrass
- Robin Wall Kimmerer

Indigenous healing
- Rupert Ross

Seven Sacred Teachings
- David Bouchard

Ways of Knowing
- Yale D Belanger

Ojibway Heritage
- Basil Johnston

The Sacred Pipe
- Black Elk

47,000 Beads
- Koja and Angel Adeyoha, illustrated by Holly McGillis

Indian Horse
- Richard Wagamese

Jonny Appleseed
- Joshua Whitehead

Firekeeper's Daughter
- Angeline Boulley

Return of the Trickster
- Eden Robinson

Nedi Nezu (Good Medicine)
- Tenille K. Campbell

A History of My Brief Body
- Billy-Ray Belcourt

Indians On Vacations
- Thomas King

The Break
- Katherena Vermette

This Place: 150 Years Retold
- Kateri Akiwenzie-Damm

NDN Coping Mechanisms
- Billy-Ray Belcourt

This Wound Is a World
- Billy-Ray Belcourt

#IndianLove: Poems
- Tenille Campbelle

The Inconvenient Indian
- Thomas King

The Back of the Turtle
- Thomas King

Medicine River
- Thomas King

Truth and Bright Water
- Thomas King

BreadfulWater
- Thomas King

Green Grass, Running Water
- Thomas King

Medicine Walk
- Richard Wagamese

One Native Life
- Richard Wagamese

Keeper'n me
- Richard Wagamese

Embers: One Ojibway's Meditations
- Richard Wagamese

Ragged Company
- Richard Wagamese

One Story, One Song
- Richard Wagamese

Starlight
- Richard Wagamese

Dream Wheels
- Richard Wagamese

For Joshua
- Richard Wagamese

One Drum: Stories and Ceremonies for a Planet
- Richard Wagamese

Him Standing
- Richard Wagamese

A quality of light
- Richard Wagamese

Wampum at Niagara: The Royal Proclamation, Canadian Legal History, and Self-Government
- John Borrows

Ground-Rules: Indigenous Treaties in Canada and New Zealand - John Borrows

Indigenous Multimedia

Movies/Documentaries/Talks

- Rumble: The Indians Who Rocked The World
- Indian Horse
- Smoke Signals
- We Were Children
- *The Late Elder Don Cardinal, sharing at the 2nd Annual Igniting the Fire Gathering (2007) - Part 1* (Don Cardinal Talk)
- *Onaubinisay at the 2018 Parliament of the World's Religions (Onaubinisay Talk)*
- The Grizzlies
- Angry Inuk
- Trick or Treaty?
- Monkey Beach
- The Body Remembers When the World Broke Open
- Blood Quantum

Music/Artists

- A Tribe Called Red
- Keith Secola
- Jim Boyd
- Willie Nelson
- Link Wray
- Redbone
- Snotty Nose Rez Kids
- DOKIS
- Faceless Bassist
- Jimi Hendrix
- Buffy Saint-Marie
- Cody Coyote
- Quantum Tangle
- Greyson Gritt
- Jeremy Dutcher

Visual Art/Beadwork/Painters

- Tehatsistahawi Kennedy
- Bill Reid
- Christi Belcourt
- Charles Edenshaw
- Tim Restoule
- Norval Morrisseau
- Kenojuak Ashvak
- Juanita Growing Thunder Fogarty
- Skye Paul *(Running Fox Beads)*
- Molina Jo
- Elias Jade Not Afraid
- Lenise Omeasoo
- Tania Larsson
- Bobby Dues
- Hollis Chitto
- Catherine Blackburn
- Daphne Odjig
- Kenojuak Ashevak
- Tanya Tagaq
- Robert Davidson
- Alanis Obomsawin
- Susan Aglukark
- Freda Diesing
- Micheal Nicoll Yahgulanaas
- Kananginak Pootoogook
- Nicotye Samayualie
- Drezus
- Elle-Maija Taifeathers

Podcasts

- Well for Culture
- All My Relations
- Coffee with My Ma
- Missing and Murdered
- Métis in Space
- New Fire with Lisa Charleyboy
- Secret Life of Canada
- The Henceforward
- This Land
- Unreserved
- Red Man Laughing
- Stories From The Land
- Coffee & Quad
- Toasted Sisters
- While Indigenous
- Kiwew
- Think Indigenous
- 2 Crees in a Pod
- Young and Indigenous
- Indigenous Urbanism
- Well for Culture
- Nation to Nation
- Native Calgarian
- Urban Indianz

Friendship Centres in Canada

Ontario

- Kapuskasing Indian Friendship Centre
- Brantford Regional Indigenous Support Centre
- Wawa Native Network
- United Native Friendship Centre
- Toronto Council Fire Native Cultural Centre
- Timmins Native Friendship Centre
- Thunderbird Friendship Centre
- Thunder Bay Indigenous Friendship Centre
- Sarnia-Lambton Native Friendship Centre
- Red Lake Indian Friendship Centre
- The Indigenous Network2
- Parry Sound Friendship Centre
- Odawa Native Friendship Centre
- North Bay Indigenous Friendship Centre
- Nogojiwanong Friendship Centre
- Nishnawbe-Gamik Friendship Centre
- Niagara Regional Native Centre
- Ne-Chee Friendship Centre
- N'Swakamok Native Friendship Centre
- N'Amerind Friendship Centre
- M'Wikwedong Native Cultural Centre
- Ininew Friendship Centre
- Indian Friendship Centre
- Hamilton Regional Indian Centre
- Georgian Bay Native Friendship Centre
- Fort Erie Native Friendship Centre
- Dryden Native Friendship Centre
- Can-Am Friendship Centre of Windsor
- Barrie Native Friendship Centre
- Atikokan Native Friendship Centre

New Brunswick

- Under One Sky Friendship Centre

Northwest Territories

- Ingamo Hall Friendship Centre
- Deh Cho Friendship Centre
- Tlicho Friendship Centre
- The Tree of Peace Friendship Centre
- Zhahti Koe Friendship Centre
- Soaring Eagle Friendship Centre
- Uncle Gabe's Friendship Centre

Yukon

- Skookum Jim Friendship Centre

Prince Edward Island

- Native Council of Prince Edward Island
- Mi'kmaq Confederacy of PEI

Nova Scotia

- Mi'kmaw Native Friendship Centre

Newfoundland

- Labrador Friendship Centre
- First Light St. John's Friendship Centre Inc.
- People of the Dawn Indigenous Friendship Centre

Québec

- Le Regroupement des Centre d'Amitié Autochtone du Québec
- Native Friendship Centre of Montreal
- Maison Communautaire Missinak
- Native Montreal
- Centre d'amitié Eenou de Chibougamau

Alberta

- Alberta Native Friendship Centres Association
- High Level Native Friendship Centre
- Sagitawa Friendship Centre Society
- Nistawoyou Association Friendship Centre
- Grand Prairie Friendship Centre
- High Prairie Native Friendship Centre Society
- Slave Lake Native Friendship Centre Society
- Athabasca Native Friendship Centre Society
- Lac La Biche Canadian Native Friendship Centre Association
- Hilton Friendship Centre Society
- Edson Friendship Centre
- Canadian Native Friendship Centre
- Rocky Native Friendship Centre Society
- Red Deer Native Friendship Centre
- Aboriginal Friendship Centre of Calgary
- Miywasin Friendship Centre
- Sik-Ooh-Kotoki Friendship Centre Society
- Napi Friendship Centre Association
- Mannawanis Native Friendship Centre Society
- Cold Lake Native Friendship Centre Society
- Bonnyville Canadian Native Friendship Centre

British Columbia

- Fort Nelson Aboriginal Friendship Society
- Fort St. John Friendship Society
- Tansi Friendship Centre Society
- Nawican Friendship Centre
- Friendship House Association of Prince Rupert
- Kermode Friendship Society
- Dze L K'Ant Friendship Centre
- Sacred Wolf Friendship Centre
- Prince George Native Friendship Centre
- Quesnel Tillicum Society
- Cariboo Friendship Society
- Sacred Wolf Friendship Centre
- Wachiay Friendship Centre
- Port Alberni Friendship Centre
- Tillicum Lelum Aboriginal Society
- Hiiye'yu Lelum (House of Friendship)
- Victoria Native Friendship Centre
- Vancouver Aboriginal Friendship Centre Society
- Fraser Region Aboriginal Friendship Centre Association
- Mission Friendship Centre Society
- Lillooet Friendship Centre Society
- Conayt Friendship Society
- Kamloops Aboriginal Friendship Society
- North Okanagan Friendship Centre
- Ki-Low-Na Friendship Centre
- Ooknakane Friendship Centre

Manitoba

- Brandon Friendship Centre
- Selkirk Friendship Centre
- Dauphin Friendship Centre
- Flin Flon Friendship Centre
- Lynn Lake Friendship Centre
- Portage Friendship Centre
- Riverton and District Friendship Centre
- Elbert Chartrand Friendship Centre
- The Pas Friendship Centre
- Ma Mow We Tak Friendship Centre
- Winnipeg Friendship Centre

Saskatchewan

- Battlefords Indian & Metis Friendship Centre
- Buffalo Narrows Friendship Centre
- Ile a la Crosse Friendship Centre
- Indian and Métis Friendship Centre of Prince Albert
- Kikinahk Friendship Centre
- La Loche Friendship Centre
- Newo Yotina Friendship Centre
- North West Friendship Centre
- Qu'Appelle Valley Friendship Centre
- Saskatoon Indian Métis Friendship Centre
- Yorkton Friendship Centre

Nunavut

- Pulaarvik Friendship Centre

Useful Resources

- *Friendship Centres — The National Association of Friendship Centres (NAFC)*
- *Find a Friendship Centre - OFIFC*
- *Aboriginal Organizations in New Brunswick*
- *BCAAFC – Working together for a brighter future*
- *Manitoba Association of Friendship Centres (MAC)*
- *Guide to Indigenous Organizations and Service in Alberta*

Post-Secondary Institutions With Indigenous Councils/Resources

Ontario

- Algoma University, Anishinaabe People's Council
- Algoma University, Anishinaabe People's Council
- Algonquin College, Indigenous Education Council
- Brock University, Aboriginal Education Council
- Cambrian College, Circle for Indigenous Education
- Canadore College, Indigenous Circle on Education
- Carleton University, Indigenous Education Council
- Centennial College, Aborginal Education Council
- Collège Boréal, Comité d'éducation Autochtone
- Confederation College, Negahneewin Council
- Durham College, Indigenization Council
- Fanshawe College, Indigenous Education Council
- Fleming College, Indigenous Student Services
- George College, Sahkitcheway Indigenous Education Council
- Georgian College, Indigenous Services
- Humber College, Humber Indigenous Education & Engagement
- Lakehead University, Ogimaawin Indigenous Education Council
- Lambton College, Indigenous Student Centre
- Laurentian University, Indigenous Student Circle
- Loyalist College, Indigenous Student Council
- McMaster University, Indigenous Education Council
- Mohawk College, Indigenous Education Council
- Niagara College, Indigenous Education Services
- Nipissing University, Indigenous Council on Education
- Northern College, Indigenous Council on Education
- OCAD University, Indigenous Education Council
- Ontario Tech University, Indigenous Education and Cultural Services
- Queen's University, Aboriginal Council
- Ryerson University, Aboriginal Education Council
- Sault College, Indigenous Student Council
- Seneca College, Indigenous Education Council
- Sheridan College, Indigenous Education Council
- St-Clair College, Indigenous Student Services
- St. Lawrence College, Indigenous Education Council
- Trent University, Indigenous Education Council
- University of Guelph, Indigenous Student Society
- University of Ottawa, Indigenous Education Council
- University of Toronto, Aboriginal Advisory Council
- University of Waterloo, Indigenous Advisory Circle
- University of Windsor, Aboriginal Education Council
- Western University, Indigenous Student's Association
- Wilfrid Laurier University, Indigenous Education Council
- York University, Indigenous at York University

British Columbia

- British Columbia Institute of Technology, First Nations Technology Council
- Camosun College, Indigenous Advisory Council
- Capilano University, First Nations Student Services
- Coast Mountain College, First Nations Council
- College of New Caledonia, Aboriginal Resources
- College of the Rockies, Indigenous Student Services
- Douglas College, Indigenous Student Services
- Emily Carr University of Art and Design, Avoriginal Gathering Place
- Justice Institute of British Columbia, Indigenous Advisory Council
- Kwantlen Polytechnic University, Indigenous Advisory Committee
- Langara College, Indigenous Education & Services
- Nicola Valley Institute of Technology, Elders Council
- North Island College, Indigenous Education Council
- Northern Lights College, Aboriginal Services
- Okanagan College, Aboriginal Education Council
- Royal Roads University, Indigenous Education Advisor
- Selkirk College, Indigenous Services and Elders Program
- Simon Fraser University, Office for Aboriginal Peoples
- Thompson Rivers University, Aboriginal Human Resource Council
- University of British Columbia, Indigenous Education
- University of Northern British Columbia, Aboriginal Governance
- University of the Fraser Valley, Aboriginal & Non-Aboriginal Relations
- University of Victoria, Indigenous Academic Advisory Council
- Vancouver Community College, Indigenous Services
- Vancouver Island University, Services for Aboriginal Students

Saskatchewan

- Briercrest College, Indigenous Centre
- Campion College, Relations with Indigenous Peoples
- Carlton Trail College, Aboriginal Initiatives
- Cumberland College, First Nations and Métis Advisory Council
- Great Plains College, Indigenous Awareness and Truth and Reconciliation: Speaker Series
- Horizon College, Northern College Indigenous Council on Education
- Lakeland College, Indigenous Student Committee
- Luther College, Indigenous Initiatives
- North West College, North West Indigenous Council
- Northlands College, Indigenous Cultures Centre
- St. Peter's College, Indigenous Youth Leadership Program
- The First Nation University of Canada
- University of Regina, Office of Indigenization
- University of Saskatchewan, Indigenous Engagement and Aboriginal Mentorship Program

Alberta

- Alberta Bible College, Canadian Indigenous Ministry Committee
- Alberta College of Art and Design, Arts Aboriginal Student Council
- Ambrose University College, The Road to Reconciliation
- Athabasca University, Various Aboriginal Organizations
- Bow Valley College, Advisory Council
- Concordia University College of Alberta, Indigenous Directions Leadership Council
- DeVry Institute of Technology, Indigenous Council on Education
- Grande Prairie Regional College, Circle of Indigenous Students
- Grant MacEwan University, Kihew Waciston Centre
- Keyano College, Aboriginal Student Centre
- Lakeland College, Indigenous Student Committee
- Lethbridge College, Niitsitapi Strategy and Indigenous Services
- Medicine Hat College, Indigenous Support Office
- Mount Royal University, Office of Academic Indigenization
- NAIT, Nîsôhkamâtotân Centre
- NorQuest College, Wahkôhtowin and Indigenous Student Services
- Northern Lakes College, Indigenous Council on Education
- Olds College, Indigneous Services
- Portage College, Advisory Committee
- Red Deer College, Indigenous Student Services
- SAIT, Chinook Lodge Aboriginal Student Alliance
- St. Mary University College, FNMI Committee
- University of Alberta, Aboriginal Student Council
- University of Calgary, Indigenous Student Advisory Council
- University of Lethbridge, Aboriginal Council

New Brunswick

- Mount Allison University, Indigenous Student Support
- St. Thomas University, Indigenous Student Support
- Union of New Brunswick Indians Training Institute, Union of New Brunswick Indians
- Université de Moncton, Service Autochtone
- University of Fredericton, Mi'kmaq-Wolastoqey Centre
- University of New Brunswick, Mi'kmaq-Wolastoqey Centre

Manitoba

- Assiniboine Community College, Indigenous Affairs
- Brandon University, Aboriginal Student Collective
- Red River College, Indigenous Advisory Circle
- University College of the North, Ininiwi Kiskinwamakewin Centre
- University of Manitoba, Indigenous Students' Association
- University of Winnipeg, Aboriginal Students' Council

Post-secondary Institutions With Indigenous Councils/Resources

Newfoundland and Labrador

- Memorial University of Newfoundland, Office of Indigenous Affairs

Nova Scotia

- Acadia University, Indigenous Student Society of Acadia
- Cape Breton University, Mi'kmaw Band Council
- Dalhousie University, Indigenous Student Support
- Mount Saint Vincent University, Aboriginal Student Centre
- Nova Scotia Community College, Indigenous Student Supports

Prince Edward Island

- Holland College, Indigenous Resources
- University of Prince Edward Island, Mawi'omi Indigenous Student Centre

Northwest Territories

- N/A

Nunavut

- Yukon University, Indigenous YukonU and First Nations Initiatives
- University College of the North, Ininiwi Kiskinwamakewin Centre
- Cumberland College, First Nations and Métis Advisory Council
- University of Saskatchewan College of Law, Indigenous Law Centre
- First Nations University of Canada

Yukon

- Yukon University, Indigenous YukonU and First Nations Initiatives

Québec

- Bishop's University, Indigenous Student Support
- Centennial College, Aboriginal Education Council
- Collège d'Ahuntsic, Espace d'autochtonisation
- Concordia University, Centre culturel autochtone
- Dawson College, First Peoples Centre
- John Abbott College, Indigenous Student Resource Centre
- McGill University, Indigenous Support
- Séminaire de Sherbrooke, Santé autochtone
- Université Laval, Réconciliation autochtone
- Vanier College, Indigenous Circle

Life Promotion Videos

Life Promotion: A Strength-Based Approach to Indigenous Wellness
– Thunderbird Partnership Foundation

How to use the First Nations Wellness Continuum Framework
– Thunderbird Partnership Foundation

Life Promotion Photovoice Project
– Collateral Damage Project

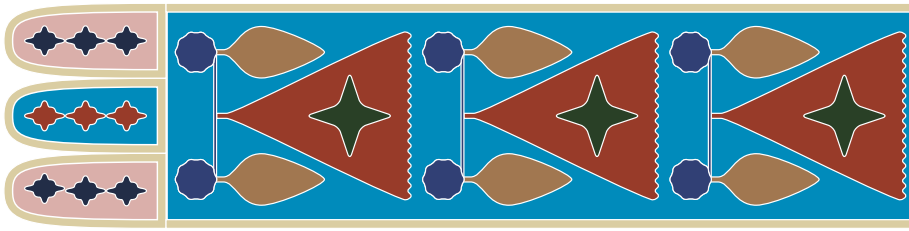
Suicide Prevention 1, *Suicide Prevention 2*
"I Choose... to Live" First Nation youth life promotion video
– Loretta Seshequin

Tseshaht Life Promotion V2
– Imagination FX

Life Promotion for All My Relations
– FNHealthCouncil

Wise Practices for Engaging Youth

Throughout the life promotion toolkit, the Youth Action Group had come up with the best ways to engage youth. Below, we have listed various ways youth can be better engaged:



Telling stories and listening

Giving cultural teachings and stories

Having updated videos and content *(remove outdated materials)*

Having youth leaders and facilitators

Sharing personal experiences

Having a relaxed appearance to make them comfortable *(jeans)*

Keeping it real *(ie. honesty, authenticity)*

Showing a movie, documentary, or videos

Using visuals aids *(flip charts, sticky notes, posters)*

Having the youth be heard and seen

Giving them something physical to take home *(ie. plant a seed, arock with a message, a mind map)*

Providing meals, snacks, and drinks

Giving them question sheets

Incorporating grounding techniques and breathing exercises

Using icebreakers and ensure that you do proper introductions

Giving breaks *(giving them time to get up and stretch or to switch seats)*

Giving away prizes for asking or answering questions, and giving away swag or take-home bags for everyone

Utilizing technology and media *(iPads, phones, and computers)*

Providing fidget toys, coloring books, markers, crayons, playdough, rocks, crafts, etc

Having a PJ day, with blankets, pillows, and couches

Having social media take-overs

Stick to engaging activities rather than presentations, we encourage speaking with the youth rather than at them and utilizing games and activities.

Creating a Safe Space

- Having trigger warnings
- Using non-verbal cues for checking-ins/check-outs
- Having a support person from mental health emergencies
- Having constant follow-ups
- Physically making the space safe
  (using circles, spacing individuals, avoiding obstacles, controlling the temperature, controlling the amount of noise, having blankets)

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What is an Indigenous medicine wheel?

May 24, 2020

Bob Joseph

> "The circle, being primary, influences how we as Aboriginal peoples view the world. In the process of how life evolves, how the natural world grows and works together, how all things are connected, and how all things move toward their destiny. Aboriginal peoples see and respond to the world in a circular fashion and are influenced by the examples of the circles of creation in our environment". [1]

There isn't a simple answer to the question as medicine wheels (sometimes called hoops) come in more th
significance and use is culture-specific. There is, however, one fundamental similarity besides the shape - medicine wheels represent the alignment and continuous interaction of the physical, emotional, mental, and spiritual realities. The circle shape represents the **interconnectivity** of all aspects of one's being, including the connection with the **natural world**. Medicine wheels

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are frequently believed to be the circle of awareness of the individual self; the circle of knowledge that provides the power we each have over our own lives.

Two images jump to mind when thinking about medicine wheels. One is the ancient stone version. According to the Royal Alberta Museum, "a medicine wheel consists of at least two of the following three traits: (1) a central stone cairn, (2) one or more concentric stone circles, and/or (3) two or more stone lines radiating outward from a central point. Using this definition, there are a total of 46 medicine wheels in Alberta. This constitutes about 66% of all medicine wheels known. Alberta, it seems, is the core area for medicine wheels."

How long ago stone medicine wheels were first created is still up for discussion but some have been dated to 4000 BC, which is when the Great Egyptian Pyramids were built; there are suggestions that the Bighorn Medicine Wheel, the largest and oldest, could be millions of years old. The original name for medicine wheels was “sacred circles” - the term “medicine wheel” was coined by non-Native Americans in response to the Bighorn Medicine Wheel, Wyoming, the largest in North America, around the turn of the previous century.

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The other familiar medicine wheel image is the iconic circle divided into four separately coloured quadrants. The number four has great significance in most Aboriginal cultures. The black, white, red, and yellow medicine wheels that we frequently see in logos, on drums, in art are all somewhat different. The one shown here is a compilation of some of the many attributes or powers that can be included in the medicine wheel. This one does not include the inner circle, or centre, which is usually green and given the attributes of learning, self, balance and beauty. Certain culturally significant animals, being part of the natural world, are also often included.

The medicine wheel is interpreted uniquely to each culture. The order of the colours is not the same in each culture, nor are the attributes, and it would be wrong to make a sweeping generalization that indicated otherwise. The next time you see a medicine wheel, take a moment and think about its history and cultural significance.

If you found this article on the Indigenous medicine wheel interesting, perhaps you would enjoy this article on **sacred plants**.

[1] Dumont, J. (1989). Culture, behaviour, & identity of the Native person. In NATI-2105: Culture, behaviour, & identity of the Native person. Sudbury: Laurentian University Press.

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Recommendations for Delivering eHealth Psychological Interventions to Indigenous Youth

THUNDERBIRD PARTNERSHIP FOUNDATION

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Thunderbird Partnership Foundation

www.thunderbirdpf.org

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The Thunderbird Partnership Foundation is a division of the National Native Addictions Partnership Foundation, and is Canada's leading voice advocating for culturally-centred addictions and mental wellness services for First Nations.

TABLE OF CONTENTS

Introduction 4

What is eHealth and why use it? 4

Relevance of eHealth Interventions for Indigenous Peoples 5

Method 6

Review of eHealth Interventions 6

Scoping Review Results 7

Cost effectiveness of eHealth Interventions 8

Health Promotion, Prevention, and Education 9

Early Identification and Intervention 11

Crisis Response 19

Coordination of Care and Care Planning 21

eHealth Intervention Implementation Considerations 23

Community Engagement and Consultation 25

Youth Consultation Results 25

Stakeholder Consultation Results 30

Focus Group Results 33

Aspects of Useful Mental Health Services *33*

Barriers to Mental Health Services *34*

Use of an eHealth Intervention for Mental Health *35*

Recommendations for e-Health Intervention Implementation 36

Conclusions 39

References 40

INTRODUCTION

EHealth intervention outcomes that address mental health concerns for Indigenous youth are limited. Despite the increasing creation and dissemination of eHealth interventions, few studies exist that have assessed the efficacy or effectiveness of these psychological treatments. Fewer studies use rigorous methods to describe outcomes of interventions, resulting in limited evidence-based recommendations of the viability of eHealth psychological interventions. The provided recommendations were generated from a review of peer-reviewed and grey literature that described outcomes of various types of eHealth initiatives, as well as community member engagement, using qualitative and quantitative assessment methods. Rigorous systematic reviews and experimental designs were prioritized within the systematic review. Those studies that described outcomes for youth, particularly those identified to be Indigenous, were also prioritized, although minimal literature for these population groups existed. The authors call upon the greater body of literature developed primarily for non-Indigenous people in developing these recommendations to provide greater direction than would be possible based on the limited Indigenous-specific literature. The community member engagement demonstrates stakeholder and youth perspectives about what would be useful and practical within the contexts that they live and work in.

What is eHealth and why use it?

For more than 20 years, eHealth initiatives have been appealing to researchers and practitioners aiming to provide accessible and effective services to a larger demographic that require mental health intervention. *EHealth* refers to the implementation and delivery of health services through the Internet and other related technologies (Eysenbach, 2001). This term refers to specific implementation processes, as well as a greater style of thinking, such as an attitude or commitment toward a network of global thinking that would improve health care at a local level (Eysenbach, 2001). Eysenbach (2001) described 10 concepts of eHealth that characterized the intention of eHealth initiatives and described why an academic or practitioner would choose to implement health services this way. These principles not only described some advantages of the use of eHealth, but also prioritized concepts that must be explored for the continued use of eHealth solutions. **The proposed "10 e's in eHealth" are as follows:**

1. **Efficiency.** By increasing efficiency of services, costs can be decreased, particularly through the avoidance of duplicate services or unnecessary interventions.
2. **Enhancing quality of care.** The quality of care can be improved by allowing comparisons between providers, increasing user quality control, and providing the best allocation of services for the user.
3. **Evidence-based.** Intervention effectiveness should not be assumed but should be based on rigorous scientific evaluation.
4. **Empowerment of users.** Interventions can make knowledge more accessible.
5. **Encouragement of new relationships between patient and health professional.** Decisions can be made in a shared manner and contact with the health professional can be more accessible to the patient.
6. **Education.** Health professionals and users can be educated online.
7. **Enabling information exchange.** Communication in a standardized way between health care establishments can increase proficiency.
8. **Extending the scope of health care.** Health care can be provided outside of geographical sites. Users can access information in multiple ways to easily obtain health services.
9. **Ethics.** With new practitioner–user interactions, new challenges and ethical issues must be explored.
10. **Equity.** It is possible that eHealth supports may increase a gap in accessibility to services by requiring technology and skills to access health information.

In contrast, interventions referred to as *mHealth* interventions are a subset of eHealth interventions that focus on using mobile technologies, such as cellular phones or tablets, as platforms to disseminate interventions (Kazemi et al., 2017). MHealth interventions can be delivered using mobile applications, text or SMS messaging, GPS tracking devices, or other mobile-capable formats. These differing mediums will be distinguished from one another when necessary throughout this document.

Relevance of eHealth Interventions for Indigenous Peoples

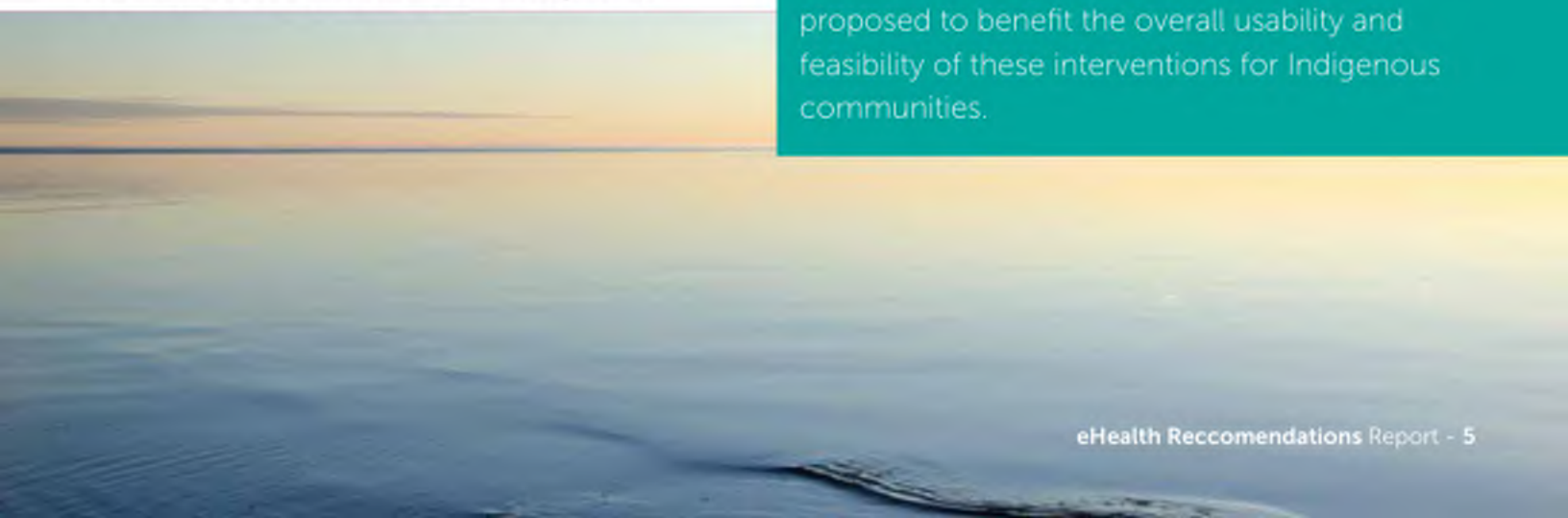
Indigenous populations tend to have differential access to health services and technology in comparison to mainstream populations (Health Canada, 2015; O'Donnell et al., 2016). Many Indigenous communities are in rural or remote regions within countries such as Canada, the United States, Australia, and New Zealand. The distance between these communities and urban centres influences the level of access to needed health services, such as mental health specialists (Kruse, Bouffard, Dougherty, & Parro, 2016). Often, the length of travel is too costly when considering the time, it takes to travel, lost wages, lost time with family, or the financial expenses for travelling to services to be a sustainable solution (Kruse et al., 2016). In 2010, Maar, Seymour, Sanderson, and Boesch put forth a research agenda for eHealth supports within Indigenous communities. They suggested that when services are implemented, these are evaluated by examining basic demographic information (e.g., age and sex) of the clientele as well as a basic description of the services provided (Maar et al., 2010). It was further suggested that each community be surveyed to determine their eHealth service preferences, current availability, infrastructure, and barriers (e.g., low levels of broadband Internet connectivity and costs of maintenance). Maar et al. (2010) suggested that training institutions can provide students with technological skills that pertain to eHealth service delivery (e.g., setting up teleconferences, video conferencing, and website updating) to improve implementation and use of such services.

Few of these research priorities have been examined in Indigenous communities within Canada to date, but eHealth resources have been examined globally.

Trzesinski and HealthInfoNet (2015) have surveyed Indigenous communities in Australia and have identified community needs related to an online resource centre to reduce alcohol and drug use. The suggestions provided by community members included the following:

1. **Relying on a strengths-based approach (i.e., focusing on positive outcomes and what is working as opposed to what the problem is)**
2. **Working in collaboration with community members**
3. **Providing information related to cultural models of health, including information about where to go for help**
4. **Using Aboriginal symbols and terminology**
5. **Including resources that use plain language, including audiovisual content, fact sheets, service listings, and shared stories of success**
6. **Including community role models** (Trzesinski & HealthInfoNet, 2015)

Incorporation of community specific needs when developing eHealth interventions was proposed to benefit the overall usability and feasibility of these interventions for Indigenous communities.



Purpose

The following describes the purpose of this report:

1. Describe relevant evidence of eHealth intervention implementation for Indigenous youth populations in Canada, specifically through efforts relating to mental health strategies in these four areas:
   a) **Health Promotion, Prevention, and Education**
   b) **Early Identification and Intervention**
   c) **Crisis Response**
   d) **Coordination of Care and Care Planning**
2. Extrapolate information about the usefulness and feasibility of eHealth intervention implementation, through examination of Indigenous and non-Indigenous research that may aid in the design of future eHealth interventions.
3. Contextualize research through ongoing engagement with youth and community members. Report on community-identified preferences, needs, barriers, and prior experiences with eHealth interventions, mental health support, and technology usage based on community consultations.
4. Generate evidence-based recommendations for best practices of implementing eHealth mental health interventions with Indigenous youth populations.

METHOD

To embed the reader in the methods used for each portion of this project, the method and results for each of the sections are grouped together. Thus, the scoping review methods and results are followed by the community engagement methods and results.

Review of eHealth Interventions

A scoping review of published articles that describe and evaluate eHealth interventions was conducted. Academic databases that were searched include Academic Search Premiere, Educational Resources Information Center, PubMed, Psychinfo, Psycharticles, ScienceDirect, Social Sciences Index, Social Services Abstracts, Social Science Research Network, and Web of Science. *Search terms* included smartphone, short message service, SMS, text messaging, text message, cellular phone, telemedicine, ehealth, e-health, mobile health, electronic health, distance-based intervention, Internet intervention, Internet-based intervention, telehealth, or teleintervention. For the Indigenous-specific findings, articles were located using the following search terms: Indigenous, Aboriginal, Inuit, First Nation, Métis, Native, or Indian.

In total, 1,924 articles were found. After the titles were initially reviewed, 97 articles were included for abstract review. The preliminary review, meta-analyses, systematic reviews, and randomized control trials of eHealth interventions were included. In order to capture content relevant to specific populations (e.g., substance use, LGBTQ+, and depression) secondary searches were conducted with population-specific search terms. In total, 431 abstracts were reviewed, with results from 115 articles informing this report.

SCOPING REVIEW RESULTS

Numerous studies have speculated about common advantages and disadvantages of using eHealth to deliver mental health interventions. Although many of these ideas have remained commonly cited since the early implementation of eHealth interventions, few have been evidence-based. Many of the proposed advantages to eHealth initiatives are also commonly cited disadvantages of using eHealth technology. Some commonly cited advantages have been found to be unexpectedly untrue or remain unresolved when rigorously examined. For example, the high cost effectiveness of implementing interventions using eHealth platforms is commonly cited as an advantage; however, when examined, it has been found that high initial costs of implementation can actually be more expensive than in-person services (Shore, Brooks, Savin, Manson, & Libby, 2007). Many of the advantages and disadvantages described below are those that remain commonly described within literature pertaining to eHealth topics, although many are not evidence-based.

Commonly described advantages. The advantages of using eHealth interventions are commonly related to the following:

1. Accessibility of interventions to a larger demographic than in-person services. Most services are free of charge, and users can save on travel costs and can access an intervention at any time.
2. Prevention of increased population need due to access to information for individuals with mild to moderate concerns.
3. Reduced stigma of seeking mental health services for users.
4. Cost effectiveness of implementing services to a large population.
5. Promotion of user self-efficacy through self-monitoring and self-management of symptoms.
6. Interventions can be customizable to meet user needs.

Commonly described disadvantages. Disadvantages of eHealth initiatives have been attributed to the following:

1. Limited research assessing the effectiveness of interventions reduces the availability of participant outcomes.
2. Implementation issues related to purchasing and continuous use of technology required.
3. Higher initial costs can reduce the overall cost effectiveness of interventions.
4. Interventions delivered using eHealth strategies may not be appropriate for high-needs users. In-person services may be required.
5. High user attrition within interventions when compared to in-person treatment.
6. Limited accessibility for users, such as users not having required devices to use a program (e.g., recently updated mobile phones and webcam with microphone) or having to travel to reach distance-based implementation sites in or near their community. For example, clients would be required to travel if telehealth services are only available at a community nursing station or in an adjacent town. Users must be somewhat familiar with the technology being used to implement, and communities have to maintain a roster of staff that can operate the technology.
7. Ethical implications of providing distance-based services are not fully understood.

A Note on Cost Effectiveness of eHealth Interventions

Given that the cost of eHealth implementation has been described as both an advantage and disadvantage of implementing eHealth interventions, further discussion of implementation costs is warranted. Some studies have examined the cost effectiveness of eHealth resources, but, generally, results were variable, and generalizable data describing cost effectiveness of eHealth interventions remain limited. Cost effectiveness of eHealth interventions were largely dependent on the type of treatment intervention used as a comparison and the ability to provide initially inexpensive materials or technology to aid eHealth implementation. Costs were typically based on an intervention previously developed; few articles reviewed the costs to develop novel eHealth initiatives.

Hilty et al. (2013) reviewed 21 studies published since 1998 that examined the cost effectiveness of providing telehealth interventions for mental health concerns in various populations. Studies varied on how costs were calculated. Predominant ways of calculating intervention costs were described as such:

1. Comparing in-person to distance treatment options or various types of distance treatment options to each other.
2. Comparing costs of consultations with the amount of money invested in the program, otherwise considered to be a *break-even* analysis. This is highly specific and can vary on the number of participants using a service and the specialized cost for the type of treatment completed.
3. Comparing broader social costs related to quality of life, such as clients seeking treatment who are returning to work, reductions of child care costs, travel to appointments, and other broader costs associated with seeking treatment. This can be completed using a budget impact analysis, which examines the financial consequences of intervention within a health care system (Sullivan et al., 2014).

Overall, costs of in-person services compared to telehealth mental health care results varied within the reported studies. Authors noted cost effectiveness evaluations were highly individual to the specific treatment program goals, the type of population accessing services, the location of the community seeking treatment, and the implementation costs embedded within specific organizations.

A study identified in the Hilty et al. (2013) review compared telehealth interventions and examined cost effectiveness of each one. Shore et al. (2007) examined the costs of providing telehealth and in-person clinical interviews to assess mental health concerns for American Indians living on a reservation located approximately 600 miles from the nearest mental health services. Costs of the in-person treatment program were calculated in U.S. dollars and were incorporated in the cost of travel to the community. From the implementation of this telehealth program in 2003, using telehealth was approximately $1,700 more per year than conducting similar in-person interviews. Fixed costs associated with the set-up and purchasing of equipment necessary for program implementation were cited as being a major contributing factor to the higher cost of implementing telehealth. However, market change can affect these fixed costs, and during study implementation, change in the price of these costs had decreased over time. It is possible that costs may be reduced for similar interventions developed today.

Telehealth clinical interview time was compared to in-person interview time (including travel time). Overall, telehealth interviews (131.5 hours) were significantly shorter than in-person interviews (352 hours). Total costs of the telehealth program were $33,230 compared to $31,465 for in-person assessments. Given that fixed costs may be lower as the length of program duration increases, the authors predicted that the cost of telehealth in the upcoming year would be lower than in-person assessments (Shore et al., 2007).

The cost to implement an eHealth intervention may initially be high; however, the length of time that an intervention remains implemented can affect the overall cost. For interventions that are provided for longer durations, the initially higher start-up costs can be mitigated throughout the time of implementation. Costs can be lowered when the intervention remains relevant to users and continues to be used effectively, particularly if the intervention reduced later-life mental health concerns (Lokkerbol et al., 2014).

While cost effectiveness is an integral aspect to consider when contemplating the development of an intervention, effectiveness and outcomes can similarly inform the appropriateness of these interventions. A summary of the literature in these areas is provided below.

Health Promotion, Prevention, and Education

Numerous interventions have been developed for educational, prevention, and health promotion purposes. Examples of two of these interventions, provided in breakout boxes, include the Strongest Families educational intervention and MoodGym anxiety prevention intervention. The number of eHealth preventions for mental health concerns is relatively low in comparison to the number of treatment interventions available. While the outcomes from these preventions are mixed, some have noted significant reductions in the targeted health concern.

Technologies have been used to prevent and problem solve issues related to bullying and cyberbullying. In a review conducted by Nocentini, Zambuto, and Menesini (2015), 13 interventions targeted at preventing bullying or reducing victimization were identified. Of these, seven were serious games, which are games that provide the user with information and skills while engaging in an achievement-oriented game-like interaction. These interventions have promoted children's affective states, social connectedness, as well as increasing engagement and self-actualization experiences (Nocentini et al., 2015). Most of the articles relied on an increased awareness of bullying and acceptability of the intervention to users. Only four interventions (FearNot!, SMART Talk, NoTrap! and KiVa) demonstrated reductions in bullying or cyberbullying, and two of these also had an in-person component (Nocentini et al., 2015).

An example of a preventative eHealth solution for mental health is the Competent Adulthood Transition with Cognitive Behavioural, Humanistic, and Interpersonal Training (CATCH-IT) program, which was developed for implementation by primary care physicians for patients with sub-threshold depressive symptoms (Kruger et al., 2017). When clients received a motivational interview (MI) and were provided with a description of the website they demonstrated greater amounts of time on the website and completion of treatment modules over a 2.5-year follow-up period (Kruger et al., 2017). However, educational impairment—not negative thinking or perceived social support from friends or family—was reduced, and there was no significant difference between groups on these measures (Kruger et al., 2017). This study demonstrated that the inclusion of health professionals into eHealth interventions can increase the acceptability and capacity to reduce or prevent symptoms, although the sustained effects of this may be minimal. These results also emphasized the need for long-term assessment of the outcomes from preventions.

The importance of comparison groups when assessing the outcomes of these interventions is underscored by the findings from Espie et al. (2012) who compared an mHealth app that utilized cognitive behavioural therapy (CBT) strategies for insomnia to a placebo treatment. Sleepio, the app, was compared to a treatment as usual

STRONGEST FAMILIES

(Lingley-Pottie & McGrath, 2008; as cited in Boydell et al., 2013)

- **Distance education** for parenting skills intervention

Population:

Families of children aged 3 to 12 years

- Experiencing anxiety and conduct disorders

Outcomes:

Participants feel safe, comfortable, non-stigmatized

- Significant decreases in diagnoses for anxiety & conduct-related disorders
- Improved dropout rates (decreased from 40%–60% to about 10%)

MOODGYM

(Calear, Christensen, Mackinnon et al., 2009)

Prevention of adolescent anxiety using CBT

Outcomes:

Use of two or more modules associated with a reduction of depressive and anxiety symptoms

- A randomized controlled trial (RCT) found reduced depressive symptoms for male, but not female, participants with depressive symptoms in comparison to wait-list participants

(TAU) group and a placebo control. The placebo treatment, Image Relief Therapy (IRT), was administered using the same app platform (Espie et al., 2012). IRT has been used in other studies as a non-pharmacological intervention control and known to contain no active components of evidence-based interventionw. Although treatment outcomes of IRT were not comparable to the reported effectiveness of CBT treatment using the app, some positive results were reported for the IRT treatment condition (Espie et al., 2012).

Secondary preventions that identify populations at risk of developing depression have also demonstrated mixed results. For example, a series of studies (Ranney et al., 2016; Ranney et al., 2018) demonstrated significant reductions in depressive and physical peer violence symptoms for adolescents receiving a CBT- and motivational interviewing-based intervention after entering into an emergency department in an initial efficacy study (Ranney et al, 2016). However, a larger sample did not demonstrate significant results (Ranney et al., 2018). Nevertheless, a meta-analysis that examined the results from 10 independent samples of depression and anxiety preventions demonstrated that universal preventions tend to have a slightly larger effect in comparison to preventions that are targeted at selective groups of people (Deady et al., 2017). Most of these preventions were based on a CBT model, but these also include interventions such as acceptance and commitment therapy (ACT) and non-specific support (e.g., emails or texts from counsellors; Deady et al., 2017). While these results suggest that eHealth interventions can help prevent some depressive or anxiety symptoms from progressing, they did not demonstrate clinically significant symptom reductions and, therefore, may require complementary services to best reduce symptoms.

EHealth solutions have also been developed for the prevention of substance and alcohol use disorders. O'Rourke, Humphris, and Baldachchino (2016) identified eight studies that assessed electronic communication for the reduction of hazardous drinking among youth. These authors found that when young drinkers (aged 18 to 25 years), who were experiencing negative impacts from their drinking or were highly motivated, reduced their drinking after receiving personalized feedback via text (O'Rourke et al., 2016). Having young drinkers rate the drinking behaviour of their peers, and providing corrective feedback, has been tied to decreased drinking frequency and quantities among the youth providing the ratings (O'Rourke et al., 2016). However, an unintended effect of this feedback was demonstrated when providing young drinkers with an approximate measure of their blood alcohol level, as this practice was associated with increased drinking among males (O'Rourke et al., 2016). Thus, electronic communication can contribute to lower alcohol and substance use, although unintended effects can occur with some interventions.

The majority of eHealth research for suicidal ideation and behaviours has focused on developing preventions, or treating disorders such as depression, in an attempt to address suicidal behaviours and ideations. To demonstrate, Perry, Werner-Seidler, Calear, and Christensen (2016) reviewed literature for eHealth applications for suicidal ideation, attempts, or completion and found only one study had been completed. The application, Reframe-IT, relied on cognitive restructuring, behavioural activation, and problem solving to reduce suicidal ideation, clinician- and patient-reported depression, as well as helplessness (Perry et al., 2016). An adult host character provided education, there were fact sheets and MP3s, as well as video diaries of people's experiences, activities to complete, a message board, and a personalized safety plan available for each participant on a mobile application (Perry et al., 2016). This intervention provided promising results.

Indigenous people and mHealth promotion or prevention.

One review of health promotion using mHealth was identified for Indigenous populations, and this review was limited to Australian Aboriginal people. Brusse, Gardner, McAully, and Dowden (2014) identified 10 interventions aimed at smoking cessation, sexual health, and otitis (infection or inflammation of the ear) medication. These studies demonstrated that most interventions used SMS or text messaging to provide reminders, education, or preventative messages (Brusse et al., 2014). Notably, texting was helpful for smoking cessation either by itself or in combination with other treatment aspects (Brusse et al., 2014). However, across studies, results were mixed with some reporting increased healthy behaviours or symptom decreases and others reporting no significant effects (Brusse et al., 2014). Publications about the use of technology within Indigenous populations for prevention and health promotion tend to focus on the development process without describing the outcomes of the intervention.

Early Identification and Intervention

Within the broad literature base, most eHealth interventions for mental health focus on interventions for mild to moderate symptoms. In order to group this review in a meaningful way, the following results are presented based on the type of technology platform that was used to deliver the intervention. Within each section, examples of interventions that have demonstrated preliminary evidence are provided in blue breakout boxes.

Telephone-based Interventions. The use of telephone-based mental health services can be effective, can help reduce stigma, and are often more convenient for clients than in-person counselling (Boydell et al., 2013). Studies have demonstrated that telephone interventions have helped to reduce overall distress, anxiety, and depressive disorder diagnoses; reduce obsessive compulsive disorder symptoms; as well as improve well-being (Boydell et al., 2013). Reductions in suicidality and improved mental state have also been observed with telephone interventions (Boydell et al., 2013).

When implementing interventions using the telephone, multiple sessions with a user can facilitate better therapeutic alliance than single-session endeavours. Given that a therapeutic alliance can facilitate the creation of shared goals and facilitate between-session tasks, having a favourable bond with an intervention facilitator may increase positive outcomes of the intervention. Telephone-based psychological interventions tend to result in the development of a therapeutic alliance better than similar synchronous text or chat-based interventions delivered online. Increasing the development of this relationship over multiple sessions may improve user outcomes.

The leading psychological treatment for addiction is motivational interviewing (MI). A recent review of MI using technology by Jiang, Wu, and Gao (2017) demonstrated that the telephone was the most effective eHealth mode of delivery of MI in comparison to the Internet or SMS. However, it should be noted that the number of studies using web-based or SMS modes were limited (6/25) in this study. Two studies compared the use ofMI for cannabis delivered via web-based interventions to control condition with mixed results; where as one study examined the use of telephone services for adolescents using marijuana which demonstrated greater reductions in dependence symptoms in comparison to a control group . This review also demonstrated a diversity in the methods of the eHealth interventions (with sessions ranging from 15 minutes to 3 hours), combined theoretical bases (e.g., CBT and motivational enhancement), and health professionals delivering the intervention (e.g., clinicians, psychologists, nurses, and students). The authors found that MI delivered through the use of technology was just as effective, if not more than face-to-face delivery, although only two studies directly compared these delivery modes.

TELEKIDCARE

(Nelson, Barnard & Cain, 2003; 2006)

- Cognitive behavioural therapy via video conferencing

Population:

Children with depression

Outcomes:

Similar depressive symptom decreases with face-to-face treatment

- Clients, parents, & clinicians very satisfied with video conferencing

Comparatively, Young (2012) found mixed results for outcomes of telemedicine interventions for substance use regarding participation, level of substance use, satisfaction, and resource use among 50 studies. The majority of studies (56%) reported that there was partial support for increased participation due to the use of telemedicine, 27% were completely supportive, and 18% were not supportive of increased participation rates. No studies included in the review reported increased substance use; 61% reported that there was an overall reduction, 25% were partially supportive of having reduced substance use, and 14% reported no change or non-significant changes in comparison to the control group. Participant levels of satisfaction were clearer, with 76% of studies reporting that telemedicine was supportive, convenient, comfortable, or discreet; however, 24% of studies reported reservations or concerns about telemedicine. Telemedicine was associated with less frequent contact with shorter duration in comparison to face-to-face sessions, although the replacement of face-to-face therapy with telemedicine was viewed as a disadvantage in some studies. Shorter interventions (14 vs. 26 weeks) with synchronous responding were more favourable in terms of satisfaction, although asynchronous participant-initiated contact was associated with greater participation.

Web-based Interventions. Web-based interventions include those that are 1) static information on a webpage, 2) webcam or online chat synchronous content delivery, 3) self-guided online/interactive intervention content, 4) health promotion interventions disseminated using social media (e.g., Twitter, Instagram, or Facebook), or 5) online peer support forums. Of these methods, delivering intervention content via webcam or through online modules had the most support in the literature. Many studies have adapted content that were evidence-based and used web-based platforms to disseminate information. Many web-based approaches to target youth mental health concerns, particularly those that used CBT frameworks, were found to be effective (Ebert et al., 2015).

Evidence-based psychological interventions using web-based technology with a trained therapist were found to be similar to in-person treatment methods (Andersson et al., 2014). No significant differences were found in a meta-analysis of 13 randomized controlled trials that compared treatments for depression, anxiety, and somatic or body-related symptoms (Andersson et al., 2014). These results suggest that web-based interventions are a viable treatment option when administered by a trained professional. Children aged 4 to 12 years stated that they found online worksheets easier and more convenient to complete in comparison to paper-based worksheets (Boydell et al., 2013).

A meta-analysis of 13 Internet-based CBT studies for anxiety and depression demonstrated similar reductions in anxiety and depression symptoms as would be expected with in-person treatment (Ebert et al., 2015). Symptom reductions were the greatest for adolescents in comparison to children (Ebert et al., 2015). The vast majority of these studies (11/13) provided some form of guidance within the treatment, which was either therapeutic or administrative (Ebert et al., 2015). However, the interventions were mixed in how long they were, ranging from brief interventions (< 6–7 sessions) to typical length (> 8 sessions).

In a review of web-based interventions, with some therapist support for addictive behaviours, mixed results were demonstrated in the 16 studies reviewed (Chebli, Blaszynski, & Gainsbury, 2016). For smoking and gambling behaviours, overall positive effects were demonstrated. Alcohol interventions had a positive effect on drinking behaviours and resulting negative consequences, although the treatment effect of face-to-face therapy was greater in comparison. One study that examined an intervention for opioid use demonstrated comparability between online and face-to-face interventions, although participants preferred the online intervention. Within this study there was a large diversity in the theoretical orientation of interventions, although most included some form of CBT, MI, or behavioural intervention. The authors found that increased levels of technology-assisted therapist contact were associated with better client outcomes. Furthermore, women were more likely to adhere to the interventions, and middle-aged people were most likely to use the online treatment.

Oosterveen, Tzelepis, Ashton, and Hutchesson (2017)

ICBT

(de Bruin et al., 2017; Karyotaki et al., 2018; Lenhard et al., 2017; Murphy et al., 2017; Vigerland et al., 2016)

Adults diagnosed with depression, trans-diagnostic concerns, adolescents with obsessive–compulsive disorder (OCD), adolescents with insomnia

Outcomes:

RCT demonstrated significant improvement compared to control groups

- moderate effect sizes when compared to control groups

MASTER YOUR MOOD

(Gerrits, van der Zanden, Visseher et al., 2007; van der Zanden, Kramer, Gerrits et al., 2012)

CBT for adolescents and young adults with depressive symptoms

Outcomes:

RCT demonstrated significant reductions in depressive symptoms in comparison to a wait-list control at post-intervention, and 6-month follow-up

identified 45 studies that utilized an eHealth intervention for alcohol (n = 26 studies), smoking (n = 7), physical activity (n = 4), obesity (n = 4), nutrition (n = 1), and multiple behaviours combined (n = 3) among ages 18 to 35 years. The majority of interventions were using web-based platforms, and, overall, there were positive effects when compared to control groups. When interventions for alcohol were examined, a meta-analysis showed a reduction in the number of drinks consumed in a week was greater in the intervention groups in comparison to the control groups. These reductions were similar to the face-to-face intervention rates. Thus, web-based services appeared to be just as effective, but not more effective, when compared to face-to-face interventions, and these services had greater improvements when compared to receiving little or no intervention.

Retention rates for web-based therapy can range, with results suggesting that these typically have lower retention rates than in-person treatment (Melville, Casey, & Kavanagh, 2010). A systematic review of 16 study attrition rates for web-based treatments, delivered predominantly to adults, found that rates ranged from 2% to 83%, with mean weighted average (corrected for sample size) attrition rate of 35%. Age was not found to influence these outcomes. Many clients withdrew prior to beginning treatment, thus self-selecting out of receiving the intervention. If these clients were not included in attrition analyses, attrition rates of web-based interventions would lower (Melville et al., 2010).

Evidence suggests that interventions delivered using online chat rooms, texting, or other methods that facilitate synchronous communication with a therapist were helpful, although this literature base is minimal. When compared to telephone counselling, web-based synchronous communication produced worse outcomes. Unlike telephone counselling outcomes, therapeutic alliance ratings of web-based services with synchronous communication is lower than in-person interventions. King, Bambling, Reid, and Thomas (2006) compared single-session online communication to the telephone and found that youth-reported outcomes were better for those that received telephone counselling.

Few studies have compared synchronous communication using texting or online chat forums to asynchronous communication—such as email or forum posts—although it remains hypothesized that synchronous communication produces better outcomes (Dowling & Rickwood, 2013). Further research is required to determine if synchronous or asynchronous methods are viable options for delivering web-based services. A systematic review of six studies that described the best available outcomes of these communication methods suggested that neither perform as well as telephone-based communication (Dowling & Rickwood, 2013).

BITE BACK: INTERACTIVE WEB-BASED PROGRAM

(Manicavasagar et al., 2014)

235 youth aged 12 to 18 years living in Australia

Outcomes:

Significant reduction in depression and stress compared to control group.

- High treatment adherence
- No significant improvements for those that did not adhere to treatment or who used intervention less frequently
- Program was interesting, fun, and easy to use

KIDS HELP PHONE: SYNCHRONOUS LIVE CHAT

(Haner & Pepler, 2016)

Canadian youth seeking supports for mental health concerns

Outcomes:

Users tended to have mental health and suicide concerns

tended to not be heterosexual compared to those that used phone-based services

Mobile Phone Applications (apps). Bakker, Kazantzis, Rickwood, and Richard (2016) generated 16 recommendations to inform the development of mobile apps that may effectively target mental health concerns. Recommendations were made based on a review of available literature and were intended to guide future mental health app development and ongoing research. These recommendations were as follows:

1. Ensure the app is based in a cognitive behavioural therapy model of care.
2. The app should address both low mood and anxiety concerns of users. Targeting these concerns will increase accessibility and address high co-morbidity between these concerns within a trans-diagnostic model of care.
3. Avoid diagnostic labels when designing the app. The app should be designed for non-clinical populations, as populations experiencing concerns may not have a formal diagnosis. Users may not use the app for preventative care if diagnostic labels are used.
4. The app should automatically tailor content to meet the user's needs. Tailored interventions have been more efficacious than non-tailored models, such as basic self-help materials.
5. The app should incorporate some form of self-monitoring, behavioural reporting, and progress evaluation. Reporting thoughts, feelings, or behaviours can align with a CBT model of care, allow the user to monitor change, and promote progress evaluation.
6. The app should recommend pro-social activities for the user to engage in. Behavioural activation can boost self-efficacy and expand the coping skills available to the user.
7. The app should provide some psycho-education to increase the mental health literacy of the user.
8. The app should engage with users in real time to help reduce symptoms or distress in the moment of the experience. It can provide coping behaviours or relaxation techniques.
9. Daily activities should be explicitly linked to symptoms to establish cause-and-effect relationships among thoughts, feelings, and behaviours.
10. Encourage limited time on technology devices by promoting non-mobile phone-based activities.
11. Promote the use of an app through rewards or internal triggers. Promote self-motivation motivation through positive reinforcement and behavioural conditioning strategies.
12. Log user data and monitor past app usage. Encourage app usage by directing user attention to the personal investment in using the app.
13. Provide the user with reminders to engage with the app.
14. Provide a simple and user-friendly app design.
15. Provide supports and links to crisis support services.
16. Conduct experimental trials to establish efficacy before recommending the app as an effective solution.

A comparison of existing iOS apps (n = 21) demonstrated that no app met all of the above standards (Bakker et al., 2016). A more recent review of anxiety-specific apps demonstrated that only half of the available apps offer evidence-based recommendations, and most of these cost money (Bry, Chou, Miguel, & Comer, 2018). These anxiety-specific evidence-based strategies included exposure (in 1/5 apps) or cognitive restructuring or both (1/5; Bry et al., 2018). However, few apps provided any type of psycho-education about anxiety (1/6; Bry et al., 2018). Most of the available apps were distraction techniques, such as colouring, relaxation exercises (53%), or games (Bry et al., 2018).

Despite the drawbacks of these publicly available apps, mobile phone interventions, including those delivered using apps, may be ideal for adolescents, given that this demographic has frequent use and familiarity with mobile devices. As described by the Kids Helpline breakout box, high school-aged children preferred to use a chat line

KIDS HELPLINE

(King et al., 2006; Haner & Pepler, 2017)

- Compared telephone to chat line counselling for ages 12 to 17 years
- More males preferred telephone
- High school-aged youth preferred chat line services
- Chat line had a greater occurrence of serious risk conversations (i.e., suicide and mental illness) compared to telephone conversations

in comparison to a phone, and they discussed serious risk issues more often using this medium. Furthermore, when adolescents were asked about preferred methods of self-monitoring, the majority of youth indicated they preferred to record data using their mobile phone rather than traditional pen and paper recording (Matthews, Doherty, Sharry, & Fitzpatrick, 2008). Of those that were randomly assigned to self-monitor mood data on paper, it was observed that participants were more likely to backdate paper forms or manipulate data than those in the mobile phone group. Youth in this study reported that recording data using a phone required less effort than paper monitoring methods (Matthews et al., 2008). Adolescents reported that self-monitoring apps should be discrete and the use easy to conceal to increase app privacy (Grist, Porter, & Stallard, 2017).

Adolescent treatment preferences may be influenced by prior experiences with in-person mental health treatment providers. Adolescents that have a greater number of negative experiences may prefer an alternative treatment method. A qualitative study describing homeless youth preferences of mHealth interventions reported favourable outcomes. Youth reported that they would potentially use such an intervention for self- monitoring, emotional support, day-to-day stressor management, online access to a therapist, and additional difficulties related to homelessness (Adkins et al., 2017).

Few apps have been specifically developed for youth, and there is limited evidence to suggest that apps are effective solutions to reducing mental health concerns for adolescents (Dubad, Winsper, Meyer, Livanous, & Marwaha, 2018; Grist et al., 2017; Lui, Marcus, & Barry, 2017). A review of these apps found only 15 interventions that aimed to promote positive mental health in either preadolescents or adolescents (Grist et al., 2017). Of these, only five articles were identified that reported mental health outcomes of participants. A meta-analysis of 36 randomized controlled trials assessed generalized mHealth interventions for children and youth, which reported a small, but significant, effect for intervention effectiveness (Fedele, Cushing, Fitz, Amaro, & Ortega, 2017). In this review, many interventions were targeted at children below the age of 5, and the majority did not treat mental health concerns.

Research for eHealth interventions that targeted specifically to populations identified as part of a sexual minority or the queer community (LGBTQ+) is limited. Predominately, eHealth interventions have prioritized youth populations but do not seem to target additional age categories. Alternative interventions to promote mental health for LGBTQ+ populations do exist, but rigorous evaluation has not been completed on any of the retrieved studies. The majority of studies retrieved tended to examine sexual health interventions, particularly targeted to men who have sex with men and HIV transmission (Muessig, LeGrand, Horvath, Bauermeister, & Hightow-Weidman, 2017) or sexual health intervention preference (Green, Fisher, Kuper, Andrews, & Mustanski, 2015).

This literature review retrieved a mobile app study for smoking cessation (Baskerville et al., 2018) and some computerized cognitive behavioural therapy (CCBT) programs (Rainbow Sparkx and Today!) specialized for LGBTQ+ populations. These apps demonstrated preliminary effectiveness (Fleming, Hill, & Burns, 2017; Lucassen, Merry, Hatcher, & Frampton, 2015), with LGBTQ+ content (such as "My Coming Out Plan") rated highly.

In terms of substance use, Kazemi et al. (2017) reviewed 12 studies utilizing mHealth interventions for secondary or relapse prevention of substance and alcohol use. The authors found mixed results regarding how mHealth strategies contributed to better health outcomes. A comparison of these interventions was challenging due to the variance among theoretical orientations used, eHealth platforms (including websites, SMS, and chat-based services), and evaluation methods. The comparison of these interventions is further complicated by the assessment of outcomes, as most of the studies neglected long-term outcomes and used only a pre-post evaluation, with the

BROTALK

(Mak, Pratt, Black, & Simon, 2015)

- Live chat service delivered using an app
- Reframes seeking help as an act of strength

Population:

157 male youth in 21 focus groups throughout Alberta, Ontario, and Quebec

Outcomes:

Youth described barriers to services that may impede live chat use.

- App will be created that simulates text messaging and facilitates contact with a counsellor.

longest follow-up being 4 months post-intervention. Based on the described results, it seems like the use of smart phone accessible formats (e.g., mobile application or SMS) were consistently tied to positive outcomes. The authors emphasized that the use of the intervention rapidly decreased unless there was regular contact and prompts that were not initiated by the participant, and participants did not use educational information, regardless of how it was presented. This review also found that when clients had co-occurring depression and alcohol use, the use of messaging was associated with decreases in depressive scores.

More inclusive reviews of mHealth interventions have been completed (i.e., Luxton, June, & Kinn, 2011; Perry et al., 2016; Huguet et al., 2016; de la Torre, Castillo, Arambarri, López-Coronado, & Franco, 2017; Franco-Martín et al., 2018), and these demonstrated that many mHealth interventions exist for suicide or self-harm, but few provided an evaluation of effectiveness of the applications. Two specific apps were identified that described the development of the app as well as provided an evaluation. The iBobbly mHealth application uses acceptance-based commitment and mindfulness therapies to reduce suicidality in an Australian Indigenous population (Shand, Ridani, Tighe, & Christensen, 2013). This intervention contained three modules: (1) identifying thoughts and grouping them based on the frequency of occurrence, and creating links between thoughts, feelings, and behaviours; (2) regulating thoughts through mindfulness, acceptance, and self-soothing (social, cultural, and self-soothing) activities; and (3) identifying values that participants would like to model and setting small, achievable goals to get there. The modules are completed over 6 weeks, and participants completed assessments after each module. Participants had access to a 24-hour helpline and were asked to complete safety contracts before joining the study, stating that they would call the helpline if they thought they were going to attempt suicide (Shand et al., 2013). The evaluation demonstrated that depression scores decreased for the iBobbly participants in comparison to a control group (Cohen's d = 0.71, representing a substantial effect; Tighe et al., 2017). Depression scores also decreased for the control group when they received the intervention after the wait, and the reductions between groups were not significantly different (Tighe et al., 2017). At the end of the intervention, fewer individuals (42%) in the iBobbly arm met criteria for depression, whereas 58% of controls did; although this difference was not statistically significant. A similar pattern for psychological distress was demonstrated. Distress was also significantly reduced pre- to post-intervention for the intervention group in comparison to the control group, which showed a medium to large effect; although the decline in controls was not as large.

IBOBBLY

(Tighe et al., 2017)

- Acceptance and commitment therapy strategies and principles

Population:

61 Indigenous youth (aged 18 to 35 years) living in remote communities in Australia

- Experiencing suicidal ideation, depression, psychological distress, and impulsivity

Outcomes:

RCT compared intervention to wait-list control

- Suicidal ideation significantly decreased in the intervention group (pretest and post-test)
- Suicidal ideation did not significantly differ from control group outcomes
- Psychological distress and overall health improved after completion for both groups

Franklin et al. (2016) developed a game-like application that relied on evaluative conditioning principles. This app aimed to decrease non-suicidal self-injury (NSSI) and suicidal ideation by developing an aversion to self-harm images and content. The game required people to pair NSSI-relevant stimuli (e.g., blood, razors, and skulls) with negative words. By pairing these, the hope was that this evaluation pattern would become permanent over time, with participants being less likely to think NSSI was helpful. Participants could use the app as much as they wanted, and it took about 1–2 minutes to complete one activity. The evaluation demonstrated short-term reductions in NSSI behaviours, thoughts, and suicide plans; although these were not maintained at 1- or 2-month follow-ups. The treatment effects increased in a dose-response relationship related to the frequency of app usage. Decreased levels of aversion toward the self (which were developed

through pairing self-evaluative words with positive stimuli) were associated with decreases in self-cutting and suicide ideation and plans. The results from the Franklin et al. (2016) study demonstrated that it is important to assess long-term outcomes for suicide interventions, as individuals with suicide ideation tend to re-experience symptoms later on, and short-term reduction may not be maintained.

Text (SMS) or picture (MMS) Messaging. SMS/MMS services have been implemented as stand-alone interventions but also used to support ongoing mental health interventions for youth. An example of a stand-alone text-based smoking cessation is provided in the Text-2-Quit breakout box. Providing therapy using text messaging-based services may facilitate engagement with youth, as the platform is familiar and accessible (Gibson & Cartwright, 2014). Youth that engaged in this type of intervention have reported that privacy, autonomy, accessibility, control of the process, and anonymity were all valued. The text messaging supportive counselling was deemed to be valuable for youth participants; though this has yet to be explored using a randomized controlled trial (Gibson & Cartwright, 2014).

The use of text messaging for addiction treatment was addressed in a review by Keoleian, Polcin, and Galloway (2015). The authors found that the greatest body of literature was developed for smoking cessation (n = 11 studies) interventions, followed by alcohol use (n = 4 studies). The types of messages included some based-on people's stage of recovery, generalized information about the positive influence of healthy eating and sleeping for recovery, using distraction as a coping mechanism, and supportive or advice-based messages. These messages were generally well-received and associated with higher abstinence rates for smoking at short-term, but not long-term, follow-ups. One study found individuals who received only text messaging in comparison to web-based or web-based with texting interventions had higher rates of abstinence. For alcohol text-based interventions, the use of texting to provide strategies, safe drinking guidelines, and other supports were more effective in reducing the number of heavy drinking days than feedback alone. Texting that was one component of a comprehensive treatment demonstrated good short- and long-term outcomes. In the studies that examined age effects, no differences were found for any age groups (Keoleian et al., 2015).

Quanbeck, Ming-Yuan, Isham, Johnson, and Gustafson (2014) found that using text messaging as part of a comprehensive intervention for alcohol use disorder was associated with reductions in the number of drinks per day as well as the number of heavy drinking days. Additional components of the comprehensive system included assessment and feedback, high-risk location monitoring, supportive people, craving coping strategies, communication skills training, and pleasurable activities. The combination of text messaging and these resulted in greater retention in comparison to a stand-alone web-based service. The authors suggested that providing clients with training in using the device/medium contributes to a greater success, and they stated that access to regular and emergency resources is ideal.

Retention of individuals in text messaging interventions for illicit drug and alcohol use was greater than 80% for the majority of studies included in a recent review (Tofighi, Nicholson, McNeely, Muench, & Lee, 2017). These interventions lasted from one to eight weeks. Clients in these studies rated that having immediate access to a health care provider or peer through text messaging was highly acceptable, and no concerns about intrusiveness were expressed. The authors recommended that future interventions should include real-time responses to support requests.

There is minimal research to suggest how SMS interventions compare to in-person treatment (Free et al., 2013). One study demonstrated similar outcomes when comparing a technology-assisted CBT treatment for depressive disorders to treatment as usual in youth (Kobak, Mundt, & Kennard, 2015). When therapeutic alliance was examined for SMS interventions delivered to youth, it was found to be comparable to in-person interventions (Hanley, 2009). When incorporated as a component of CBT, clinicians rated therapeutic alliance higher when they

TEXT-2-QUIT

(Bock, et al., 2013)

- Smoking cessation intervention

Population:

Youth living in New Zealand

Outcomes:

Intervention group had significantly more abstinence at day 7 in comparison to the control group.

could use online interactive examples and text-based prompts, with automated problem solving or supportive responses (Kobak et al., 2015). Concerns have been raised about the depth of counselling services when provided using SMS (William, Bambling, King, & Abbott, 2009). It is possible that the facilitation of consistent therapeutic tasks using SMS intervention is limited, with the majority of interventions engaging in relationship building and supportive listening (William et al., 2009).

SMS intervention may be best used to support youth treatment engagement and consistent participation in an alternative intervention, but it may not be best suited for sole treatment delivery. If using an SMS-based intervention, it may be best used for supportive counselling, between session check-ins, behavioural reminders, or positive reinforcement of behaviour. For example, providing daily reminders for behavioural monitoring or using text messaging to set up times for appointments may be useful for clients. Receiving a text message reminder to complete intervention content or a brief message from intervention staff asking about content implementation may be helpful. Similar strategies have been found helpful for email support (Siau & Shen, 2006). Text messaging to facilitate in-person sessions—such as reminders about appointment times, being late for an appointment, or seeking to schedule an appointment due to a relapse of mental health concerns—have been cited to be helpful (Nolan, Quinn, & MacCobb, 2011). For youth randomly assigned to a 12-week SMS intervention group for program drinking, automated positive reinforcement of low reported drinking was found to have a reduction in post-intervention consumption rates (Suffoletto, Callaway, Kristan, Kraemer, & Clark, 2012). Although authors reported that results were promising, no significant differences between the non-intervention control group and the intervention group were detected.

The use of an SMS intervention as the sole treatment strategy for clients with complex needs may be inappropriate. Although some evidence in support of crisis counselling using SMS has been published, using this as the sole treatment may not be aligned with evidence supporting best practices for populations experiencing complex needs. Of the programs available, some provided youth with 24-hour access mobile phone numbers for support from intervention staff members. In one program, youth could contact staff when in need of support, with few limitations placed on the logistics associated with client–staff interactions. If 24-hour support is not intended to be part of a SMS program strategy, alternative treatment strategies to support youth should be explored. It is possible that the intervention may be less effective if youth have to wait long for a response or do not receive a reply in the time that they expect. For youth experiencing severe concerns, providing an alternative emergency contact number is required.

YOUTHLINE NZ

(Haxell, 2015)

- 24-Hour crisis text messaging support line

Population:

Youth population in New Zealand; staff consisted of volunteers supported by a counsellor

Outcomes:

No formal evaluation to date

- Positive client feedback

Indigenous people and eHealth early identification and interventions.

Research surrounding the use of technology for health services in international Indigenous communities suggested that there are improved outcomes when eHealth services were used; however, a lack of comparative studies made it difficult to develop firm conclusions (Fraser et al., 2017). Several studies reported that clients receiving telehealth services tended to be satisfied with them (e.g., DiGiacomo et al., 2011) due to the accessibility of care; although there are often concerns about confidentiality and privacy (e.g., Fraser et al., 2017). Most of the evidence relates to health services (e.g., Fraser et al., 2017; Jones, Jacklin, & O'Connell, 2017; Kruse et al., 2016; Smith, Chenhall, McQuire, & Kowal, 2016) and smoking cessation programs (e.g., Brusse et al., 2014; DiGiacomo et al., 2011; Johnston et al., 2013).

Crisis Response

Most articles discussing the issue of technology to prevent suicide acknowledge that the increased accessibility of technology-delivered services would be ideal (e.g., de la Torre et al., 2017; Luxton et al., 2011), yet few studies of interventions specifically target suicidality, and fewer yet provide measured outcomes. Within the suicidality-related studies, most interventions that aimed to prevent suicide were not intended for those who were actively suicidal. Authors identified that this was due to safety issues and were only aimed to target mild to moderate suicidal ideation. The most common forms of technology used for addressing suicidality are web-based services (51.61%), mobility/mHealth services (22.58%), machine learning (i.e., computer-generated algorithms to identify individuals likely to be suicidal; 23%), social media (12.9%), and other forms of technology (9.68%; Franco-Martín et al., 2018). These services are aimed at providing training to mental health professionals as well as education and skills to families and patients about how to address and prevent suicidal behaviours (Franco-Martín et al., 2018).

Luxton et al. (2011) stated that the availability of technologically delivered services (e.g., telephone, online, and mHealth) can be especially relevant for individuals with suicidal ideation, as it allows crises to be discussed while they are happening, regardless of the time or day. However, it is important to clearly communicate the typical or expected response times, especially for mediums that are immediate in nature, such as text or email, so that users are fully aware of how quickly someone will be in contact (Luxton et al., 2011). Furthermore, one potential advantage of online or mHealth intervention is anonymity and confidentiality; yet anonymity is not ideal when individuals are actively suicidal. Often when clients are actively suicidal, safety measures, such as contacting authorities, may be necessary to ensure no harm comes to the individual. However, having access to an anonymous service may encourage individuals to seek face-to-face services (Luxton et al., 2011). Furthermore, King, Nurcombe, Bickman, Hides, and Reid (2003) demonstrated that a brief telephone call with a trained mental health provider can improve mental states and can reduce the level of suicidal ideation and suicide immediacy for individuals who are actively suicidal.

Indigenous people and eHealth for crisis response.

The application of eHealth technologies to Indigenous people experiencing crisis is very limited. One exception is the iBobbly application that was developed by Tighe et al. (2017)depression, psychological distress and impulsivity among Indigenous youth in remote Australia. Setting Remote and very remote communities in the Kimberley region of North Western Australia. Participants Indigenous Australians aged 18-35years. Interventions 61 participants were recruited and randomised to receive either an app (ibobbly for Indigenous youth in Australia using acceptance and commitment therapy. The application had mixed findings for suicidal ideation. Youth that received the treatment on the first implementation had reduced suicidal ideation, whereas youth who waited to use the app did not have significant reductions (Tighe et al., 2017) depression, psychological distress and impulsivity among Indigenous youth in remote Australia. Setting Remote and very remote communities in the Kimberley region of North Western Australia. Participants Indigenous Australians aged 18-35years. Interventions 61 participants were recruited and randomised to receive either an app (ibobbly. However, average psychological distress and overall health improved after youth completed the app (Tighe et al., 2017)depression, psychological distress and impulsivity among Indigenous youth in remote Australia. Setting Remote and very remote communities in the Kimberley region of North Western Australia. Participants Indigenous Australians aged 18-35years. Interventions 61 participants were recruited and randomised to receive either an app (ibobbly. These findings are too limited to provide any specific recommendations about the type of technology services that will work differentially or in crisis situations with Indigenous people.

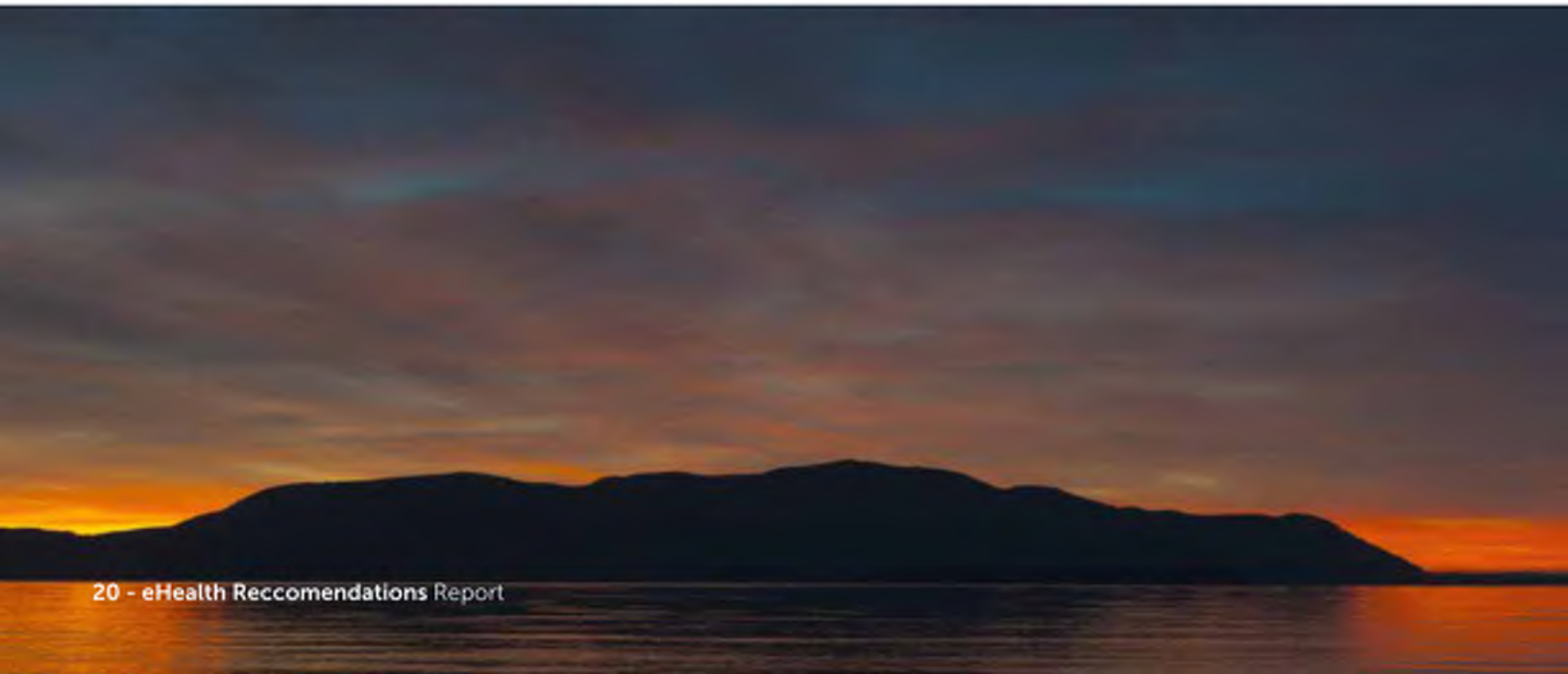
Summary of eHealth Intervention Outcome Review

Empirical evidence supporting the effectiveness of eHealth platforms promoting positive mental health outcomes remains limited. For example, although a systematic review identified over 1,500 apps designed to target depressive symptoms, only 32 studies could be identified in peer-reviewed literature that specifically examined apps for depression (Martínez-Pérez, De La Torre-Díez, & López-Coronado, 2013). Overall, the evidence supporting the available eHealth interventions for those seeking help for mental health concerns remains limited within the general population, as well as a limited number of replicated experimental designs that have assessed the effects of available eHealth treatments.

Many eHealth intervention outcomes have been comparable to those obtained from in-person interventions. Of these outcomes, few describe specific user outcomes or preferences when using in-person or eHealth delivery models. Younger, female, and more educated participants were significantly more likely to prefer Internet delivery rather than in-person interventions for mental health concerns, according to an online survey of social media preferences (Batterham & Calear, 2017). When these approaches are compared, it is likely that self-selection for an eHealth intervention has been based on user preferences. For example, those more familiar with the intervention implementation technology may be more likely to seek services using that specific platform. For those unfamiliar with the platform, it is likely that users would select in-person or other service platforms. Despite increased familiarity with intervention technology, evidence has suggested that many users of this technology still prefer in-person services. Youth populations, for example, are commonly cited to prefer eHealth interventions; but, when preferences were examined, it was found that most preferred in-person treatment (Bradford & Rickwood, 2014).

Despite high access and use of both the Internet and cell phones, many users preferred not to receive eHealth interventions for mental health services (Musiat, Goldstone, & Tarrier, 2014). When asked to speculate about the most important feature of mental health interventions, most participants reported that the perceived helpfulness of interventions were the most important criterion for making a treatment choice, and personal support was the second-most important. Participants rated any form of self-help intervention as less helpful than in-person treatment. When eHealth interventions were compared to in-person treatments, participants were significantly more likely to indicate they would use in-person models than mobile apps. There were no significant differences between self-help and web-based approaches (Musiat et al., 2014). This may suggest that for those accessing psycho-education, it may not matter if participants receive it using biblio-therapy (such as self-help books) or web-based interventions. Despite the increased accessibility of mobile apps or web-based interventions, participants did not describe this access to increase their likelihood to use these interventions. Individuals who had experienced past mental health concerns were significantly more likely to prefer in-person treatment (Musiat et al., 2014).

Study designs that compared apps to placebo treatments were not typically used to assess app effectiveness, when apps are empirically assessed at all. It is unknown if using app technology may increase placebo effects of the treatment administered. Although this may provide short-term relief, the reoccurrence of symptoms may be greater if no active treatment effect is present.



Coordination of Care and Care Planning

Platforms used to disseminate eHealth interventions are predominantly targeted to users that are directly experiencing and seeking help for mental health concerns. There are other uses of eHealth initiatives that can be used by service providers or by larger systems dedicated to improving mental health outcomes for various populations. By extending care provision from an individual to a health systems level, eHealth interventions may better meet the needs of those with mental health concerns. Labrique, Vasudevan, Kochi, Fabricant, and Mehl (2013) provided 12 applications of eHealth interventions and listed which types of platforms may be best suited for these needs. The 12 applications for eHealth care were as follows:

Application of eHealth	Suggested Platforms
Client education and behaviour change communication	SMS, MMS, interactive voice response, voice/video communication, web-based learning, apps
Sensors and point-of-care diagnostics	Mobile phone camera, GPS, accelerometers, accessory sensors/devices for tracking app usage
Registries and vital events tracking	Apps, SMS, voice/video communication, web-based
Data collection and symptom reporting	Apps, SMS, voice/video communication
Electronic health records	Web-based information, interactive voice response, apps
Electronic decision support, including information, protocols, algorithms, and checklists	SMS, MMS, video/voice chat, web-based
Provider work planning and scheduling	Interactive client lists online, SMS alerts, mobile phone calendars
Provider training and education	Web-based information, MMS, SMS, audiovisual clips
Human resource management	Web-based information, SMS, voice communication, GPS
Supply chain management	GPS, SMS, web-based
Financial transactions and incentives	Mobile money transfers, banking services, transfer of phone minutes

Telephone. Telepsychiatry demonstrates numerous similarities to face-to-face services. For example, in a literature review, Boydell et al. (2013) demonstrated that diagnoses provided in-person or through telepsychiatry were similar 96% of the time. Using telephone services can be equally effective for the treatment of depression, and clients and their families tended to prefer telepsychiatry services (Boydell et al., 2013). It also enhances the ability of clinicians to address complex cases and reduce professional isolation for rural or remote clinicians (Boydell et al., 2013). When interventions occurred over multiple sessions, the therapeutic alliance for clients receiving services via telephone was comparable to therapeutic alliance ratings of those receiving face-to-face services (Lingley-Pottie & McGrath, 2008).

SMS/MMS. The majority of interventions that incorporated SMS messaging used the platform to facilitate reminders or support for face-to-face appointments between sessions. Studies have demonstrated that the use of SMS for such purposes can be helpful. One study examined 80 conversations, consisting of 941 messages for a 7-month duration, and found that the majority of these (98%) were appropriate and topical within a client–counsellor relationship. Inappropriate messages by youth were those that contained content that described specific acts of self-harm, substance use, abuse or threats to the therapist, or sexual content (Furber et al., 2011). Text message reminders for in-person therapy appointments delivered to minority youth demonstrated a significantly higher attendance than with outpatient therapy (Branson, Clemmey, & Mukherjee, 2013).

Establishing some client demographic information, such as age and gender of youth seeking services, can be helpful when tailoring intervention content. Some youth that engaged with a 24-hour SMS support line did not state their ages, which made providing appropriate therapeutic strategies challenging for staff at times. For example, for youth seeking support for sexual activity, the age of the client must be known as it is necessary to determine if the child is at risk of abuse (Haxell, 2015). Given that mandatory reporting of suspected child abuse must occur, mechanisms for reducing some client anonymity for those seeking support through text messaging services is required.

Indigenous Populations. Robinson et al. (2015) demonstrated that within an Alaskan Native and American Indian sample, older adults aged 65 to 80 years reported that they were not likely to use technology in communicating or planning their health services despite having access to the Internet. However, most of the respondents, regardless of age, stated that email communication with providers would be helpful, as would online appointment scheduling, online prescription refills, and text or email screening reminders (Robinson et al., 2015). In 2014, Brusse et al. (2014) demonstrated that when SMS or texting were being used in smoking cessation or sexual health programs, these were often limited to reminders, educational messages, or preventative health messages.

Within Canada, O'Donnell et al. (2016) examined the ability to effectively implement eHealth technologies in remote and northern Indigenous communities. The successful implementation of technology within a community was suggested to be tied to active community support: the community should be closely involved in the development, maintenance, and management and should be provided with training to use the technology (O'Donnell et al., 2016). The use of technology ranges within communities and often depended on the services available, although it was generally lower in comparison to non-Indigenous people in Canada, as was the speed and capacity of the available Internet services (O'Donnell et al., 2016). The implementation of computer banks (i.e., publicly available computers) allowed greater access to eHealth for individuals that did not otherwise have access, and they are used when they are available within communities (O'Donnell et. al., 2016). The use of social networking sites increased the social bonds between community members in Nunavut, which was viewed as stemming from cultural prioritization of interconnectedness (O'Donnell et al., 2016). One service, KO Telemedicine, which serves over two dozen First Nations communities, demonstrated success in using technology to integrate Westernized medicine with Indigenous models of care (O'Donnell et al., 2016). Video conferencing can be used for professional development on a regular basis (O'Donnell et al., 2016). Using mobile technologies, such as a webcam and a laptop, can further reduce transportation difficulties that may be a barrier for treatment, a service that was implemented in Fort Severn First Nation (O'Donnell et al., 2016). The authors suggested a local technological team that could problem solve and deal with any technical issues that might arise (O'Donnell et al., 2016).

eHEALTH INTERVENTION IMPLEMENTATION CONSIDERATIONS

Overall recommendations for telehealth interventions have focused on troubleshooting technological concerns that arise when implementing distance therapy using the telephone or Internet. Many of these considerations overlap between literature and community consultations, and these are reported accordingly.

Training. Providing health professionals training about and how to use online services before asking them to implement these services can foster the use and acceptability of these interventions. Initially, staff exposure to the technology may be necessary to overcome anxiety about the ability for technology to foster appropriate therapeutic abilities (Boydell et al., 2013). Notably, adolescents demonstrated an adequate therapeutic alliance when they used online interventions (Boydell et al., 2013). Furthermore, mental health professionals should be provided with adequate training to administer the online programs independently, as a lack of trainingwas identified as a barrier to its use and to its effectiveness (Boydell et al., 2013).

Equipment. Updated computers and software are necessary to have effective online services. The maintenance and upgrading of this equipment can be costly (Boydell et al., 2013); thus, adequate budgets that anticipate the need to regularly update computing systems are required for long-term online interventions. Technical difficulties stemming from software or firewall difficulties can also be a barrier (Boydell et al., 2013).

It is recommended that when such technology is implemented, knowledge about how to troubleshoot common issues with implementation be shared by all those that work consistently with this technology. Identified concerns were described as those that related to connectivity (such as video delay when using video calls, freezing, or pixelated images), hardware, or software of telehealth interventions (Lee et al., 2015). Staff implementing telehealth interventions must be familiar with both the intervention content and the platform used for implementation, including the technology embedded within the design. IT support, perhaps with 24-hour access, may improve the success of the intervention dissemination.

Protection of Privacy and Informed Consent for Web-based Interventions. Verification of users and log-in information may be necessary to protect the privacy of youth (Boydell et al., 2013). Online chat rooms provide an ideal environment for ill-intentioned adults to have access to vulnerable youth. Moderation of online chat forums is also recommended to ensure the suggestions that are provided are evidence-based (Boydell et al., 2013). It is recommended that informed consent models be adapted to facilitate service delivery using web-based interventions. For interventions that incorporate client video conferencing with professionals, research suggested that informed consent was typically completed in-person, despite the client receiving services that used web-based models (Chouinard & Scott, 2009). Inter-agency standardized consent processes must be maintained. Developing and providing detailed privacy, confidentiality, and safety mechanisms for the intervention was recommended.

Privacy breaches may lead to unintended consequences for specific youth populations. For example, privacy breaches associated with unconsented release of confidential health information can affect LGBTQ+ populations in different ways than their heterosexual counterparts (Lemberg, 2017). Unintentional or intentional *outing* of people through their use of eHealth technologies can affect psychosocial functioning and have broader consequences to affect other aspects of life, such as career or family relations, particularly in regions that do not support LGBTQ+ rights (Lemberg, 2017). Interventions targeted specifically to these groups, particularly for youth populations, may benefit users by being discrete about the overall intervention purpose.

Security of Participant Data. Storing participant information has been a documented concern of previous mHealth apps. Participant data should be encrypted and secured using methods that ensure confidentiality and privacy of information, similar to methods that would be used for participant data collected in-person. A recent review completed by the United Kingdom's National Health Service (NHS) of health apps that were considered to be "safe and trusted" identified that 35 of 79 apps did not appropriately encrypt or protect identifiable participant information, such as names and birth dates (Huckvale, Prieto, Tilney, Benghozi, & Car, 2015). Privacy concerns can extend to the use of the app for those experiencing mental health concerns, although further research is required. In one pilot study, a youth reported not being comfortable with using the app entitled "Mobile Mood Diary," as the youth did not want peers to know. Within this study, 20 of 21 participants felt that their app data was more secure than paper-based charting (Matthews et al., 2008).

Developing safety planning and emergency intervention guidelines and standards for suicidal clients; providing the ability for users to remain anonymous, while also engaging in safety planning (e.g., a hierarchy of service acquisition if needed when suicidal). Within the studies reviewed, most interventions were aimed at preventing suicide and were not intended for those who were actively suicidal. Authors identified that this was due to safety issues. One attraction of online or mHealth interventions was anonymity and confidentiality, yet anonymity was not ideal when individuals were actively suicidal. Often when clients are actively suicidal, safety measures, such as contacting authorities, may be necessary to ensure no harm comes to the individual. However, having access to an anonymous service may encourage individuals to seek face-to-face services (Luxton et al., 2011). Furthermore, King et al. (2003) demonstrated that a brief telephone call with a trained mental health provider can improve mental states, reduce the level of suicidal ideation, as well as reduce suicide immediacy for individuals who are actively suicidal. Having clearly defined response times and user guidelines for any intervention are needed for any crisis situation that may arise.

Monitoring and moderating the content of any social forum is necessary to ensure security and appropriateness of the messages. Technological mediums, and social networking in particular, present an opportunity for networking about the ways to complete suicide. Individuals on social forums may also provide inappropriate suggestions about how to cope with suicidal thoughts or impulses. Thus, moderating sites is essential for safety and intervention fidelity. Despite the potential for safety risks, Franco-Martin et al. (2018) found that interventions on social networking sites, such as Facebook, were more beneficial than harmful.

Lack of engagement. In a qualitative assessment among service providers in Ontario, Boydell et al. (2013) demonstrated that service providers were concerned that youth would not engage with online services and might not have adhered to the treatment program as intended. However, a review of the literature suggested that there was a high level of engagement with services among youth (Boydell et al., 2013). Despite this, website users were hesitant to complete initial screening assessments (Boydell et al., 2013). Boydell et al. (2013) also demonstrated that there was a lack of desire among adolescents to engage with online services when in crisis due to a perception of services being impersonal and impeding the effective communication of emotions..

Treatment Attrition. Given that participant dropout with web-based programs was highest before participants began the program, it may be valuable to follow up with these participants to determine reasons why. It is possible that attrition rates may be due to the platform used to deliver the intervention. Follow-up services for those that did not begin or dropped out of the intervention are required. Given that attrition rates are approximately 35%, it is possible that a number of participants found the program did not meet their needs.

COMMUNITY ENGAGEMENT AND CONSULTATION

Method

Community member surveys. Community members were comprised of two groups: stakeholders and youth. The 100 stakeholders were community members that worked in health or mental health-related fields or that worked within organizations that conduct health research, specifically with Indigenous groups within Canada. In total, 51 youth were recruited from existing Indigenous community committees and organizations. Stakeholders and youth were asked to complete an online quantitative survey. This survey assessed familiarity with eHealth interventions, perceived acceptability of eHealth, access to the Internet and personal communication devices, perceptions of seeking mental health treatment, barriers to seeking treatment and eHealth implementation, perceived preferences for eHealth services, potential benefits of eHealth services, and any cultural factors that need to be taken into consideration when developing an eHealth intervention.

Focus groups. Focus groups were also conducted with two groups of Indigenous youth representing distinct Indigenous communities and regions across Canada. These groups asked the youth about mental health services in their communities, barriers to youth seeking mental health treatment, preferences for mental health and eHealth services, perceived appropriateness of eHealth, suggestions for features that should be included in an eHealth intervention, as well as any cultural factors that should be included or considered.

A total of 16 youth from the Assembly of First Nations Youth Council and 7 youth representing the Ontario First Nations Young Peoples Council participated in these focus groups. Interviews were recorded and transcribed. Qualitative analyses were completed independently by two researchers using open coding procedures in NVivo, with high inter-rater agreement of codes.

Results

Youth Consultation Results

Although 51 individual youth consented to the survey, only about 35 responses were recorded for each question. Specific response rates for individual items will be described with the survey results.

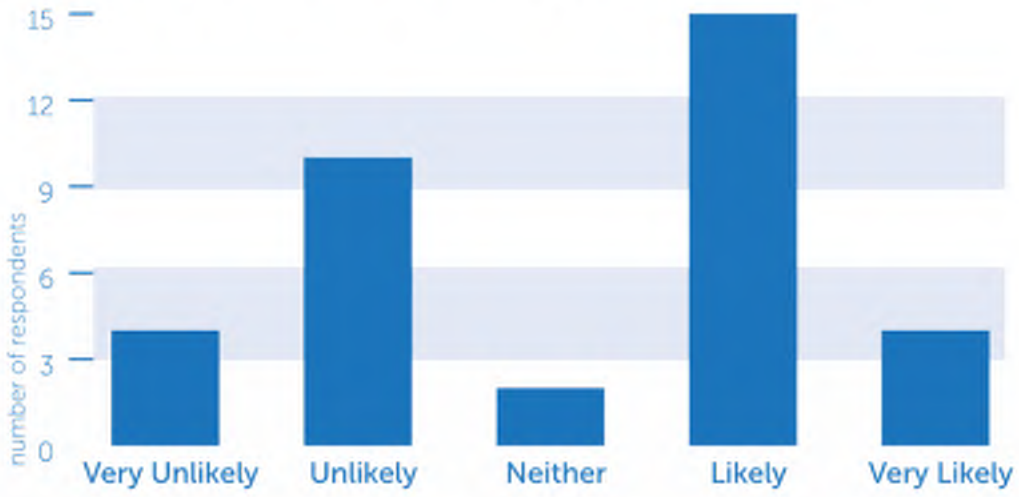
Mental health information seeking. There were 41 youth that reported they had thought about looking for mental health information independently, and 2 youth reported they had not. Out of 31 youth, 27 indicated that they used the Internet to find information about mental health. Of youth that sought mental health services on the Internet, they tended to do so fairly infrequently, with 17 of 26 stating they did so less than once per month. Some youth stated that they did so when needed, such as when they are experiencing new challenges. Out of 26 youth, 21 stated that they preferred to find information related to mental health independently. When they did consult the Internet for mental health information, 4 youth stated it was not useful, most (n = 13) found the information somewhat useful, 4 reported very useful, and 6 stated it was extremely useful.

Of 37 responses, 17 youth indicated they had sought information primarily for themselves, 10 for a friend, 6 for a family member, 3 for more than one person, and 3 indicated for others (listed as a teacher, student, and for work purposes). When youth (*n* = 37) were asked where they predominately sought mental health information, most indicated from websites (n = 28) or social media (n = 20). A full list of the most commonly used information sources is provided below.

Where do you seek information about mental health in community?	Number of Respondents Selecting Each Response
Websites	28
Social Media	20
Parents/Caregivers	17
Friends	16
Health Providers	16
School (Teachers, guidance counsellor)	15
Mobile Apps	8
Books	4
Television/Movies	3
Not looked for mental health information	2

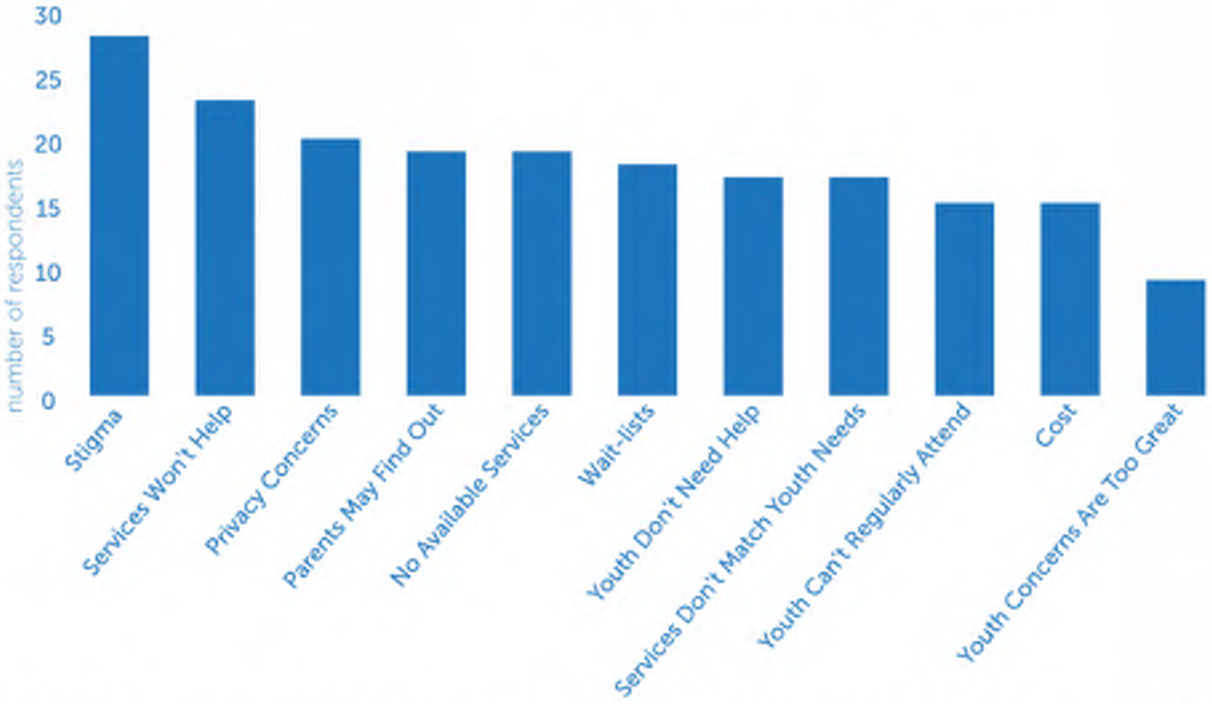
When youth (*n* = 35) were asked about how likely they were to seek mental health services if they had mental health concerns, 19 youth reported they were either likely or very likely, 14 reported they were either unlikely or very unlikely, and 2 reported neither. Graphical representation of this data is provided below.

Youth Likeliness to Seek Mental Health Support



Barriers to seeking mental health support. Youth were also asked to rank the top three barriers they perceived to reduce the likelihood of youth seeking mental health support in their communities. A total of 36 youth responded to this question, and counts for each barrier were tallied below. Some youth did not rank three barriers; instead, selected one or two, resulting in an uneven count. Of the barriers provided to youth, 28 reported that stigma (reported as embarrassment or believing others would judge them negatively for seeking mental health services) as the highest-ranked barrier to mental health. When youth believed the services would not help them, 23 indicated that they would not access them, while 20 indicated privacy concerns as a major barrier to seeking mental health support.

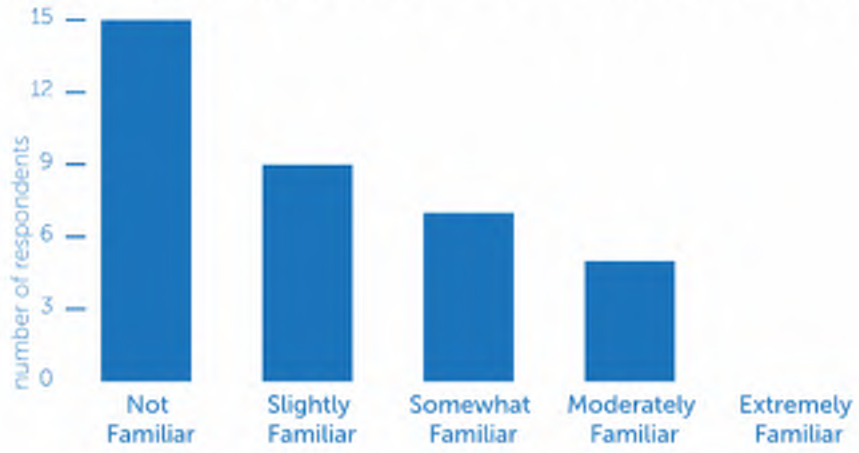
Commonly Cited Barriers to Mental Health Support in Community for Youth



Youth mental health service preferences. Youth were asked about their preferences for mental health services. Of 36 youth respondents, 16 preferred in-person services with a trained mental health professional, 11 preferred a combination of in-person and other services, 3 preferred telephone-based or video counselling services, 1 preferred a web-based service, and 0 wanted to receive information from friends, web-based services, or other resources. There were 5 youth that preferred services other than those listed in the survey.

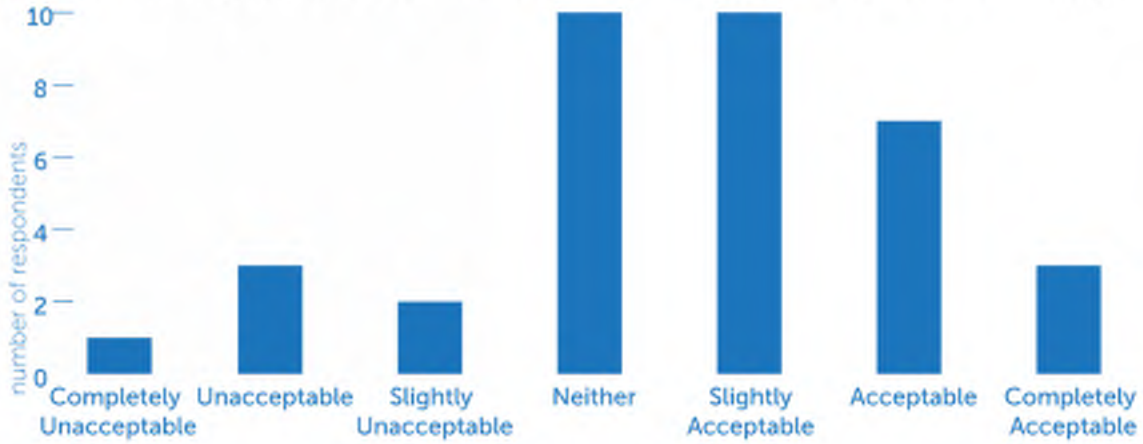
Overall perception of eHealth interventions. Youth were asked about familiarity with eHealth resources to access mental health supports. There were 36 youth who responded to this question and most (15 youth) were not familiar with eHealth resources and none were extremely familiar with these resources. The results are described in detail below.

How familiar are you with eHealth resources as a way to access mental health supports?



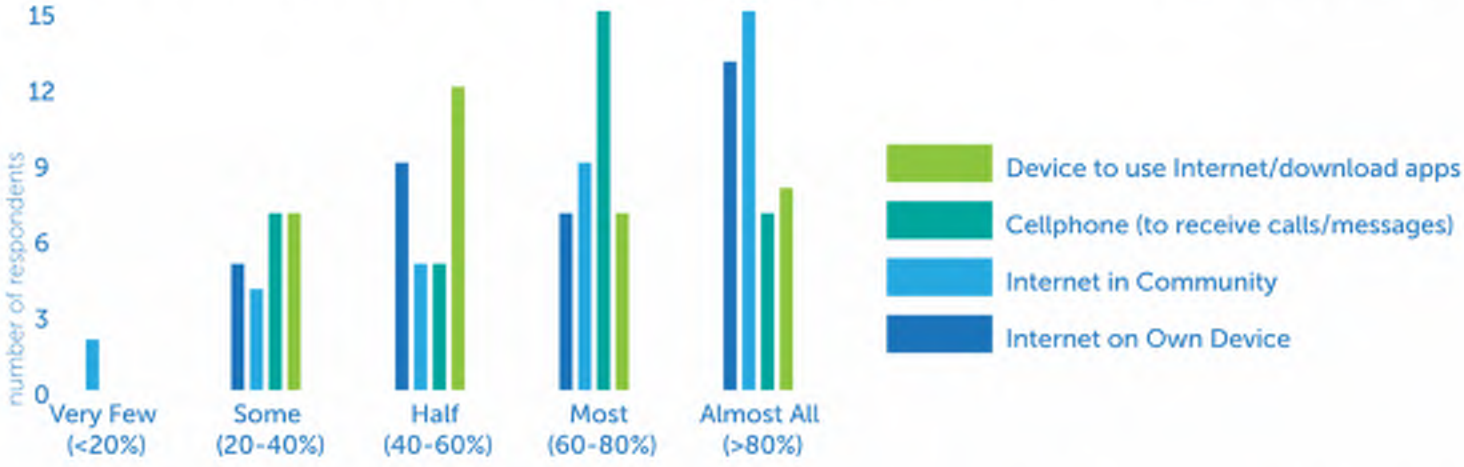
Acceptability. A total of 36 youth responded to a question that asked how acceptable they feel e-Health interventions would be for youth in their community. Overall, more respondents indicated that eHealth resources were slightly to completely acceptable for community members than not. Results are described below.

How acceptable do you think eHealth services are for youth in your community?



Accessibility. One barrier described in the scoping review was a decreased accessibility of eHealth interventions due to reduced access to the technology required to deliver the interventions. Respondents were asked in a series of four specific questions about the level of access that youth in the community have to specific devices and the Internet. A total of 34 participants responded, with the exception of the question about cellphones, which had 35 respondents. Results, described below, indicate that most respondents felt that almost all youth in their community had access to the Internet on their own device and in the community. Respondents felt that most youth (60% to 80%) had access to a cellphone to make or receive calls and that about half of youth (40% to 60%) had access to a device to download apps or use the Internet. This data is based on respondent perceptions of youth technology usage in their respective communities.

Number of Participants Reporting Percentage of Youth in Community Daily Access to Devices

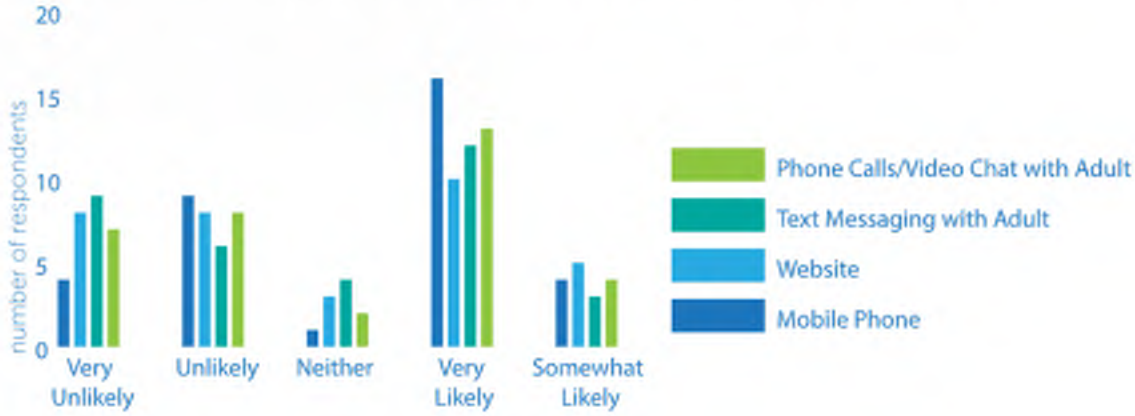


When asked about cellphone device usage, 18 of 33 youth indicated that the majority used Apple products, 5 indicated they primarily used Android, 9 indicated both were popular, and 1 responded to the category "other" but did not provide a comment.

Specific eHealth intervention preferences. When asked about various options of eHealth mental health interventions, 12 of 33 youth indicated they would prefer a mobile phone app (including apps with a chat option to a mental health counsellor). There were 10 youth who selected the "other" category; of these, 8 stated that face-to-face counselling was preferred, indicating no preferences for eHealth interventions. Some youth (6) stated video conferencing was preferred, while a few preferred a texting program (3), or a website (2). No youth preferred telephone-based services as their method of eMental health intervention.

Likelihood of use. Most of the 34 youth indicated they were somewhat likely to use various types of eHealth interventions, including mobile apps, websites, chat-based services with a mental health professional, and telephone-based services with a mental health professional. Results are described below.

Total Youth Likelihood Ratings For Use of Various eHealth Platforms



mHealth usage. When asked about usage of a mobile phone app, most youth (21 of 30 responses) indicated they have not used a mobile phone app to improve their mental health. Of the few responses that provided information about the apps they have used in the past (6), 5 used the app for either meditation or mindfulness purposes. Of the 9 youth who used an app to improve their mental health, 7 indicated they used their preferred app less than once a week, and 4 used it less than once a month.

Youth engagement in eHealth interventions. Youth were asked about suggestions to improve engagement with eHealth interventions. A total of 29 participants indicated which strategies they felt would be helpful for youth.

Engagement Strategy	Number of Responses
Use of images and infographics	20
Video presentations	18
Simple and easy to read text	17
Music or audio clips with information	17
Animations or gifs	14
Slideshows	7

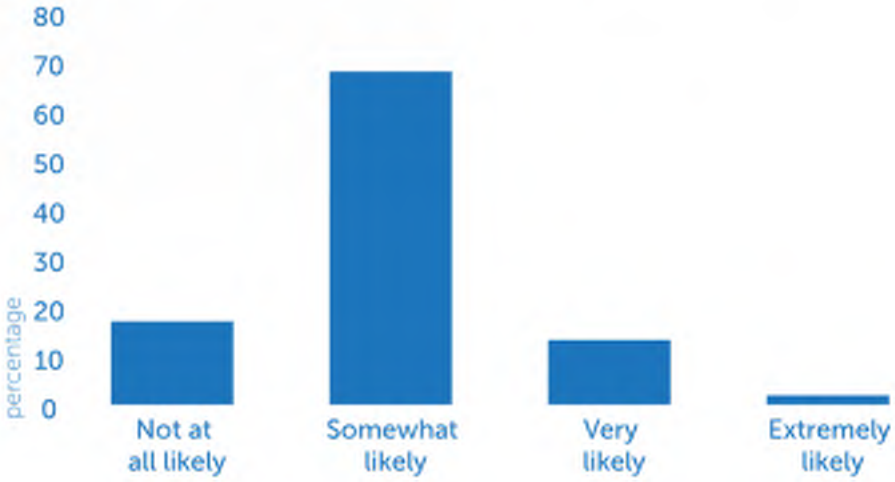
Youth indicated that culturally specific programming would be valuable to incorporate in eHealth interventions, with 10 respondents answering this question. Important to include were land-based activities (9), traditional practices (8), spiritual or traditional teachings (8), incorporation of First Nations languages (7), and cultural symbols and images considered useful (4); 2 participants indicated other but did not specify the intervention type.

Stakeholder Consultation Results

Out of 100 stakeholders, 56 provided responses for the majority of the questions. Within the subsequent results, the number of respondents will be clarified if it differs from this.

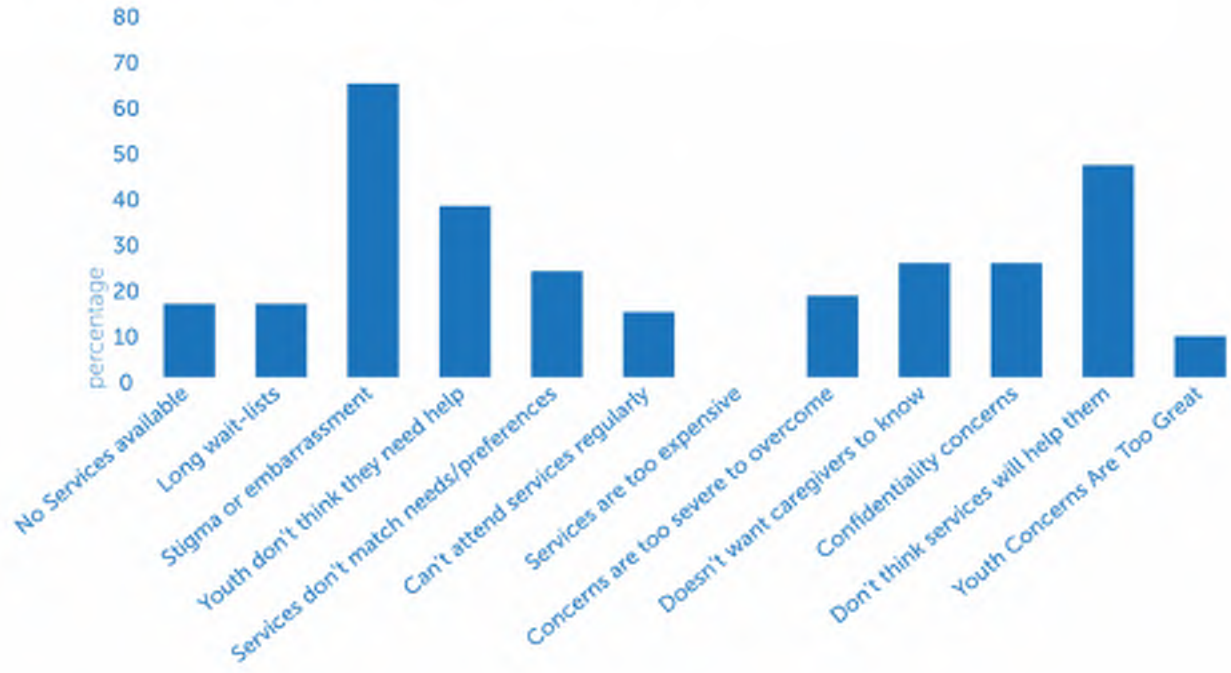
Stakeholders were asked how likely youth were to seek mental health if they were experiencing concerns (summarized below). For the 53 stakeholders that provided a response, the most common answer was that youth are *somewhat likely* to seek mental health services if needed.

Likelihood of Youth Seeking Mental Health Services



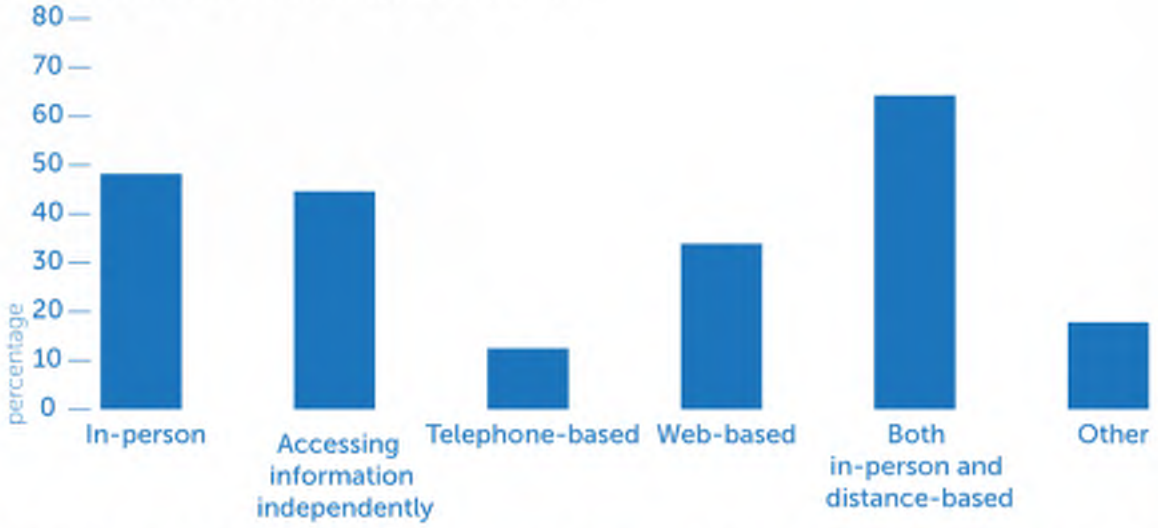
A total of 56 stakeholders ranked their perception of the most common barriers youth experience when seeking mental health services. These commonly mentioned barriers are detailed below; however, the three most commonly endorsed were stigma or embarrassment (64%), not thinking the available services will help them (46%), and not thinking they need help (38%).

Barriers to Youth Seeking Mental Health Services



Perceived youth preferences. Stakeholders were asked which type of mental health service format youth in their community or organization prefer. The most common response was a combination of both in-person and distance-based services (64%). These preferences differ from stakeholder responses about the types of services youth access within their community. Stakeholders reported that most youth receive services in-person with mental health professionals (50%), followed by accessing information independently (41%), a combination of services (21%), and web-based counselling (18%).

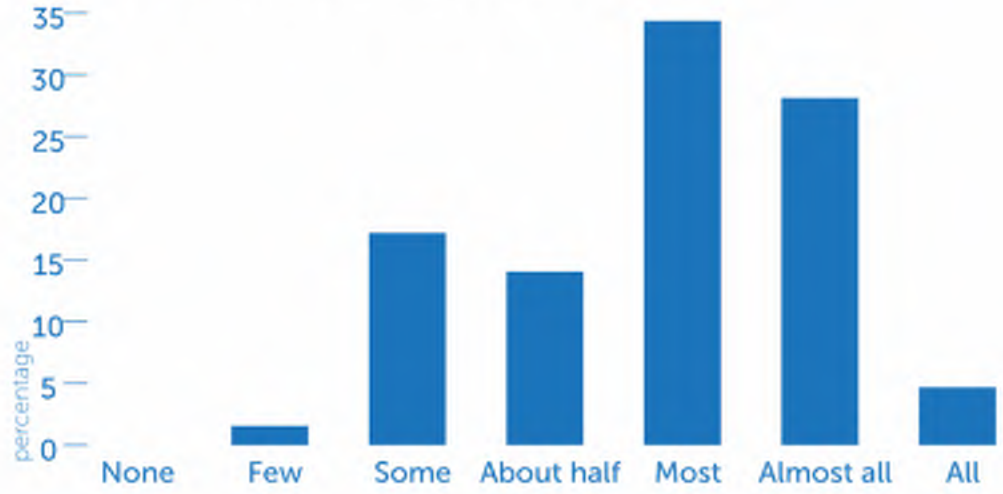
Perceived Youth Service Delivery Preference



Acceptability. A total of 67 stakeholders described how acceptable they perceive eHealth programs are considered in their community. The most common response was that they are acceptable (39%), followed by neutral (22%), and completely acceptable (13%).

Accessibility. The majority of stakeholders (n = 64) stated that most (28%), almost all (40%), or all (6%) of the youth in their community had daily access to the Internet on their own personal device. These responses were similar for cellular phone accessibility, where 34% of the stakeholders stated less than half of the youth in their community had daily access to a cell phone. Internet access was also commonly available, with 78% of stakeholders stating that most to all of the youth in their communities had daily Internet access through personal or public devices. However, access to a device that is capable of downloading an application was more varied, as can be seen below.

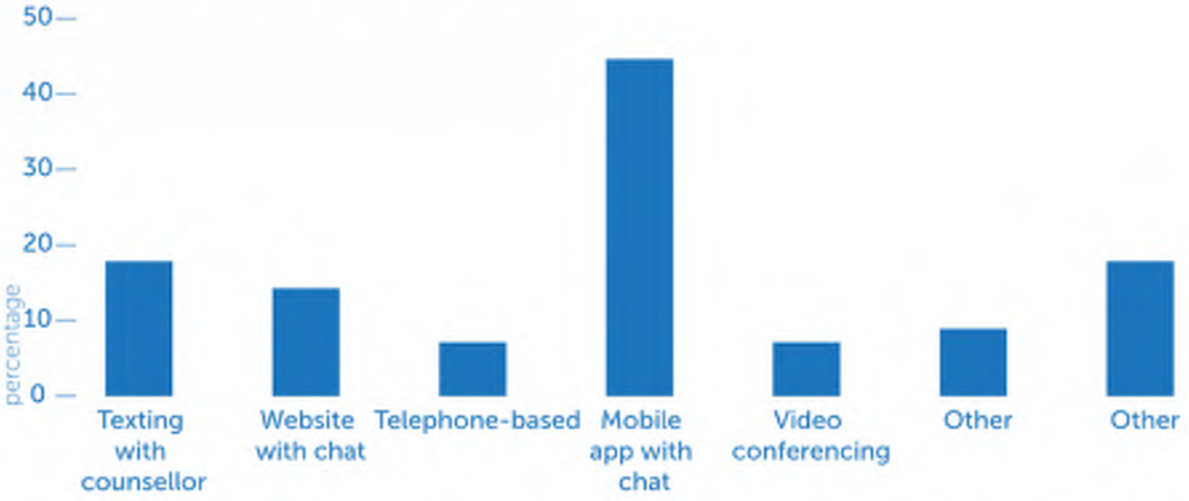
Youth Access to Mobile Device with App Capability



Perceived eHealth preferences. Most stakeholders (82%) were not aware of any eHealth interventions implemented with youth within their community. Among those who were aware of programs (n = 7), initiatives such as We Matter, access to counsellors through social media or online chats, video conferencing, and health monitoring were used.

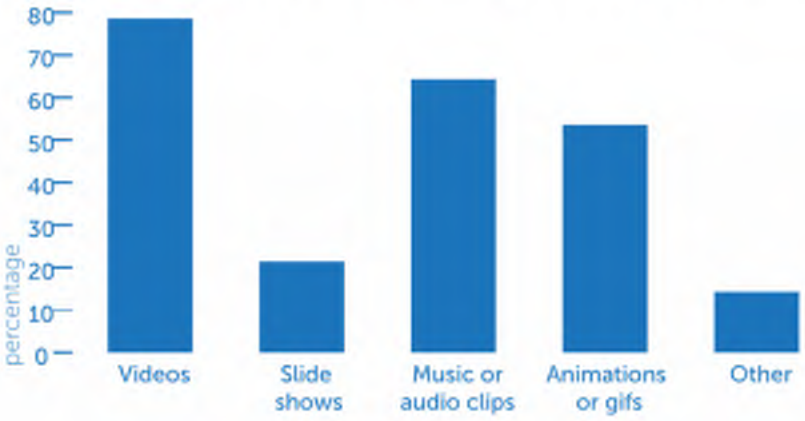
The majority of stakeholders thought youth are somewhat likely (51%) or very likely (38%) to access eHealth interventions in comparison to not at all likely (2%) or extremely likely (10%). Stakeholders also thought the likelihood that youth would participate in a solely technology-delivered service similarly (somewhat likely [64%] and very likely [25%]). Stakeholders were asked to endorse the type of services they believe would best suit youth needs within their community or organization. As can be observed below, the most frequently endorsed format was an application with an option to chat with a counsellor.

Suggested Format for Youth Services



Stakeholders were also asked to indicate all of the content formats they think would be useful within an eHealth intervention for youth. These responses are available below.

Recommended Types of Content Within eHealth Interventions



Culturally specific elements. Stakeholders were asked what type of cultural information could be included in an eHealth intervention. The graph below demonstrates that most stakeholders endorsed the majority of options provided.

Focus Group Results

Interview questions asked youth to report on useful mental health services in their community, barriers to accessing these services, and how eMental health interventions may help or hinder youth seeking mental health support. Themes were generated based on each of these topics using thematic analysis.

Aspects of Useful Mental Health Services. Youth were asked to describe aspects of mental health services in their communities that were helpful, useful, or facilitated engagement in services. These were generalized to include a range of mental health services (both in-person- and eHealth-related) that youth may access. Sources of mental health resources, including general information and support identified to be useful by youth, are health centres, counsellors, psychologists, schools, social media, youth centres, and peer support. Specific aspects of these services were reported to facilitate seeking help for mental health.

Theme	Description
Community-based	Services should incorporate individually specified community needs. Some youth reported they wanted services provided by local community members, while others requested mental health services provided by people living outside the region (as a way to maintain confidentiality). Regardless of those providing services, they were requested to be present within individual communities to promote accessibility and reduce barriers.
Culturally driven	Incorporating Indigenous components of mental health care was reported to be a priority for youth. Cultural programming, in conjunction with non-Indigenous services, was requested. Services were requested to incorporate Two-Eyed Seeing approaches, prioritize holistic definitions of well-being, and incorporate traditional teachings, land-based activities, and spiritual care.
Confidential	Youth requested services that prioritize confidentiality and privacy of participants, particularly when seeking services in less populated regions. It was reported that confidentially when seeking services in the community can be difficult for some youth. Privacy when seeking support, particularly in remote and rural communities, was a priority for youth.
Individualized	Services should be targeted to meet the needs of the individual, rather than use a one-size-fits-all approach. Youth expressed the need for requested services to target specific concerns within the context of their community.
Youth-informed	All strategies must incorporate the specific needs of youth and tailor services in such a way that best meet their needs. Services must embed youth decision making and needs.
Increased Options for Services	Given that youth may have different needs, it was requested that multiple formats and service types (including face-to-face, peer support, and Indigenous-specific programming) are supported. Mental health strategies that are offered in a variety of formats were reported to resonate with a broader youth demographic.
Preventative Care	Youth described the need for strength-based programming and community strategies to promote self-care. Suggestions about targeting children at a younger age were provided.

Barriers to Mental Health Services. Youth were asked to list common barriers to accessing mental health services in their communities. Themes were generated, based on their responses, and prioritized under accessibility, availability, continuity of care, and confidentiality. Perceived stigma and limited training of service providers were also reported by youth.

Theme	Description
Service Accessibility	For those living in remote or rural communities, accessibility of services was a concern. Geographical location of services was a commonly reported barrier, with youth reporting the need to travel to receive services.
Service Availability	Services that may meet the needs of youth (or those that were requested) were not available to youth in their community. The lack of mental health workers in communities also reduced service availability. Some youth reported challenges with receiving consistent mental health services due to a limited availability of services in their region.
Continuity of Care	When programs or services were provided in the community, youth reported they were commonly disrupted (due to staffing, shortages, inconsistent funding, and reduced accessibility or usage). Youth requested better continuity of care, particularly for programs that are preferred by community members.
Confidentiality	Seeking services in a remote or rural region, particularly those that are provided by community members, was a concern for some participants. For children under the age of 12, parental consent is required, which may reduce service seeking for this demographic.
Perceived Stigma	Youth stated that youth may not wish to seek services due to perceived stigma associated with it, including lack of trust of workers, reduced perceptions about the ability of the professional to help them, and concerns with confidentiality.
Limited Training	Workers in communities may not have proper training to work with complex populations or have adequate knowledge of the community where they are working.

Use of an eHealth Intervention for Mental Health. Youth were asked to share perspectives regarding the feasibility of eMental health interventions within their communities. Some youth were hesitant to speak for their peers, and they provided their own personal perspectives of their use of the services. Overall, youth reported that eHealth interventions may be beneficial to use in conjunction with other health services, but they were hesitant for such initiatives to be used as the primary service for youth seeking mental health support. They were hesitant that eHealth options would replace in-person services. Themes were generated based on youth preferences of best practices to successfully design and implement eHealth services. They are as follows:

Theme	Description
Accessibility	Youth reported that eHealth services may reach more youth than face-to-face services only if the eHealth services were compatible with devices used by youth. Providing services that require the Internet may reduce accessibility, as many communities were reported to have slow or reduced Internet access.
Used in Conjunction with Other Services	Many youth stated they were concerned about eHealth interventions replacing face-to-face services. Many participants reported that providing services in conjunction with other service formats may be helpful. Giving youth more choices for mental health supports was considered to be helpful.
Interference with Therapeutic Relationship	Some youth were concerned that providing services online would reduce the quality of care. Youth reported they were concerned that the quality of the relationship between worker and client may be affected due to conversing through technology.
Indigenous-specific	Youth were concerned that those providing services may not be Indigenous or may not have knowledge of community-specific concerns that affect the mental health of youth.
Confidentiality	Youth stated that although providing services may feel more confidential to youth, it may be challenging to provide telephone-based services. Text-based services were supported. One participant was concerned about the storage of data.
Adequately Promoted	Youth stated that eHealth services would need to be well promoted to encourage youth involvement. Using social media campaigns and initiating youth consultation panels to promote these resources may be better than other methods.
Youth-driven	Youth should be involved in all aspects of the project: from project conception to service delivery.

RECOMMENDATIONS FOR E-HEALTH INTERVENTION IMPLEMENTATION

Based on the available literature, evidence-based recommendations for the most useful type of eHealth technology platform cannot be made. Usability and feasibility studies of intervention platforms seemed to suggest that the technology that was the most available to the targeted user population was the most recommended. Such recommendations are informed from both the literature review and the community engagement.

Basing eHealth solutions on existing evidence-based practices and theories have the potential to strengthen these interventions. Notably, a review of cognitive behavioural therapy (CBT) and behavioural activation (BA) that focused mHealth interventions for depression demonstrated that adherence to evidence-based practices was low, as only 15% of 12 identified apps adhered to CBT principles and practices, and only 18% adhered to BA practices (Huguet et al., 2016). Of the identified apps, the *Depression CBT Self-Help Guide* adhered to 75% of the CBT criteria, which represents the highest rated application reviewed (Huguet et al., 2016). The most commonly neglected CBT aspects were monitoring physical sensations, conceptualization, and monitoring behaviours (Huguet et al., 2016). Of the identified applications, only 4 (i.e., 1/3rd) had a mechanism to deal with a high risk of suicidality among users (Huguet et al., 2016).

Tailoring content. Participants generally preferred that online mental health interventions be tailored to their needs rather than generic information (Batterham & Calear, 2017; Morrison, Yardley, Powell, & Michie, 2012). Youth in the focus group stated that a *"one size fits all"* approach should be avoided for eHealth interventions. Personalization of the intervention, through input of client information (such as name, age, or gender) to modify content, can increase the uptake of an intervention. Tailoring the content to meet the needs of the client through exposure to specialized content needs or by modifying the content the user experiences can increase intervention usability and feasibility (Wozney et al., 2016).

Tailoring content can be completed through the targeted user characteristics as well. Some interventions have been designed for those specifically diagnosed with a psychiatric disorder. Diagnoses can inform best practice treatment decisions, but these may not be feasible for all targeted users accessing an intervention. By clarifying what type of population will be using the intervention, and understanding what groups are best suited for the treatment strategies provided, better interventions can be provided. Considerations about severity levels of symptoms, access to ongoing care or alternative treatment strategies, and how the chosen intervention best meets these needs must be made. Information or messages sent to clients also need to be tailored to the individual, including such features as personalizing it for the individual's goals, interests, or needs; providing them with the ability to respond directly to the message; and adjusting the frequency of messages.

Platform-based development. Intervention content should be tailored to the delivery platform. Many resources describe how to create effective and useful online content for consumers. These recommendations provide suggestions about the length of content, the writing style, language use, and user engagement strategies. For social media strategies, information about reviewing and responding to comments, the use of hashtags, and overall how to engage with users through these platforms can increase the likelihood the intervention will be favourable to youth. It is recommended that prior to delivering content for youth, a review of specific strategies used in online interventions by platform experts be completed. Some strategies about how to tailor intervention content to youth are provided by Campbell and Robards (2013).

Integration of multiple forms of media. Reviews of adolescent and Indigenous literatures, as well as community engagement responses, indicated that using more engaging formats (such as videos, music, pictures, etc.) is recommended. When these are developed, it is suggested that user preferences be considered as well as the quality of the medium. Low quality content can affect the usability of an intervention. Consulting with content experts throughout the development of the intervention is required to ensure that the intervention is using up-to-date technology and that the content is delivered appro-

priately within the parameters of the chosen platform. Using various ways to present content—such as through the use of music, videos, animations, and chat forms—has been favoured by youth reviewing an online smoking cessation intervention (Whittaker et al., 2008) as well as among Indigenous populations.

Sharing of personal stories. The use of technology can allow for novel interventions and mediums, such as allowing individuals to develop an intimate connection with others who have had similar experiences while also retaining anonymity and confidentiality. For example, numerous online sites provide users with the capacity to use avatars when sharing personal stories or discussing current feelings (Luxton et al., 2011). This often requires users to record short videos and to replace their voice with that of an avatar. There are also YouTube videos that have been developed by the United States Center for Disease Control, as well as videos of individual testimonies, about experiences with suicide and how to manage these (Luxton et al., 2011). Within the focus groups, youth identified that having available a story of success of a community member or an Indigenous person would make eHealth interventions more relevant for them. This was also identified within the Indigenous literature as an integral component. It was stated that these stories could be presented through any video, music, written account, or mixture.

Youth preferences. Incorporating identified youth preferences when designing interventions may promote the usability and feasibility of eHealth interventions. Specific youth preferences for addressing the targeted mental health concern must be identified when selecting an intervention delivery style. Although there is a potential for adolescents to positively endorse mHealth apps, this does not mean that they prefer such platforms instead of in-person treatment (Bradford & Rickwood, 2014). The community engagement results presented here demonstrate that almost equal amounts of youth would prefer to use in-person services in comparison to using a combination of both in-person and technology-delivered services. This aligns with evidence from the research, as a non-clinical sample (n = 231) of adolescents was asked about preferences for mental health treatment platforms, and only 16% preferred an eHealth treatment. While 23.8% of the sample preferred to not seek help at all, the majority (58.9%) of participants preferred in-person treatment methods (Bradford & Rickwood, 2014). Within the community engagement presented here, less than 3% of the youth wanted a stand-alone technology-delivered service.

Session frequency and duration. Batterham and Calear (2017) found that adult participants preferred shorter sessions when completing content online. The majority of participants (58%; n = 254 of 438) stated that shorter 10-minute sessions spread over 10 days was preferred to one 2-hour session. If sessions had a longer duration, participants preferred them to be less frequent. For sessions that were an hour, participants preferred once a week and indicated a willingness to participate in three or more sessions (Batterham & Calear, 2017).

Access to content. Content must be organized in a logical and structured way. When accessing content, participants generally prefer intervention content to be delivered in a logical order, rather than having access to all intervention content at once (Toombs, Unruh, & McGrath, 2018). Focusing and chunking content in a way that is brief and to the point for youth can improve the overall clarity of content and can encourage youth to focus on one section or strategy, rather than an entire intervention.

Synchronous communication and monitoring of client data. It is recommended that intervention facilitators engage in synchronous communication with youth who are seeking intervention. The community engagement results demonstrate that youth and stakeholders identified having the option to chat or communicate with a clinician as an ideal feature of any intervention that is implemented. Regardless if there is a synchronous chat component between the user and intervention facilitator, user-input content needs to be monitored for safety and security reasons. Unmonitored access to mental health interventions may be ineffective or may create lower outcomes for youth (Christensen, Reynolds, & Griffiths, 2011).

For example, some studies have highlighted negative experiences with technology for LGBTQ+ populations, particularly cyberbullying for youth. The positive value of access to social support, obtained through increased engagement in social media platforms, is at times mitigated by increased cyberbullying (McConnell, Clifford, Korpak, Phillips, & Birkett, 2017; Martin, 2016). Although LGBTQ+ youth may use social media similarly compared to other peers, they report greater use of security controls as a way to manage their *outness* to social media contacts (McConnell et al., 2017). Given that many eHealth interventions use chat rooms, text messaging, or forums to encourage peer support, features should be monitored for cyberbullying by clinicians.

Technological mediums, and social networking in particular, present an opportunity for networking about the ways to complete suicide. Individuals on social forums may also provide inappropriate suggestions about how to cope with suicidal thoughts or impulses. Thus, moderating sites is essential for safety and intervention fidelity. Despite the potential for safety risks, Franco-Martín et al. (2018) found that suicide interventions that facilitated the use of social networking sites, such as Facebook, were more beneficial than harmful.

Maintenance of confidentiality. Client monitoring needs to be balanced with confidentiality concerns, as youth frequently mentioned confidentiality as a primary barrier to seeking or receiving help. One draw of online mHealth interventions is anonymity and confidentiality, yet anonymity is not ideal when individuals are actively suicidal or experiencing other acute mental health concerns. Intervention developers may consider how client safety can be ensured when they are experiencing crises, as relying on authorities such as police or paramedics may be necessary to ensure no harm comes to the individual or others. Consideration of client desire for seeking anonymous treatment that would remain anonymous even in a crisis should be considered by developers.

Continuous evaluation. Monitoring user data also provides an opportunity to evaluate and monitor the effectiveness of an intervention. The literature surrounding what types of technology will be beneficial with Indigenous populations is limited. Thus, any intervention should be continuously monitored to ensure it is achieving its intended effects, not inadvertently causing symptoms to increase, and is being used as intended. Continuous evaluation is thus suggested for any intervention that is developed. The health needs of communities can change over time, which can reduce the relevancy or usefulness of specific interventions.

Integration of cultural content. Indigenous health and well-being models differ from mainstream conceptualizations. Incorporating more holistic and Indigenous-specific content was identified within the literature and in the engagement sessions.

Inclusion of LGBTQ+ specific content. Many LGBTQ+ eHealth users may have unique needs when compared to other users of an eHealth intervention. For example, content-specific phrasing or word use may be inappropriate for these groups. Content related to family structure, relationships, or gender pronouns may require modification to be more inclusive for LGBTQ+ users. Referrals to additional mental health services made through the eHealth intervention can also be specific to LGBTQ+ populations. Given that LGBTQ+ users may experience higher rates of depression, suicide attempts, non-suicidal self-injury, substance use, and physical and sexual abuse than their heterosexual counterparts (Lyons, Rozbroj, Pitts, Mitchell, & Christensen, 2015), content may require modification to be relevant for LGBTQ+ users. Additional recommendations, provided in a toolkit for the e-health interventions for gay and lesbian populations included: 1) a statement about how content was tailored for LGBTQ+ populations to reduce invisibility felt by users, 2) use of inclusive language, 3) avoid labelling users by their sexual identity, 4) use of appropriate imagery and symbols that convey inclusive relationships with same-sex partners, 5) relevant examples that relate to LGBTQ+ populations, and 6) content about coming out (Lyons et al., 2015).

Assessing community needs. Indigenous communities differ in their level of available resources as well as the types of mental health or wellness concerns they might experience. Both the literature base and youth in the focus groups suggested that having the capacity to target interventions to specific community needs is needed for services to be used and to be appropriate. A common theme identified within the literature and in community engagement was the inclusion of community members,

especially youth, in the development of the intervention. This can provide developers with more youth-specific content that can increase uptake or acceptability but also allow for a nuanced inclusion of community differences in a cultural content.

Increasing accessibility. Within the Indigenous-specific literature and in focus groups, having ready access to devices and to the Internet were challenges. Developing interventions that have a limited need to maintain a continuous connection, or streaming content, may be more appropriate. Furthermore, having devices that are supplied to the user may be another way to increase accessibility.

The type of language that is used can influence the accessibility of an intervention. Results from the literature and community engagement suggest that using plain language when developing an intervention can help reduce this barrier. Furthermore, incorporating Indigenous language, imagery, and symbols can increase accessibility.

Offered in combination with in-person services. Use in-person consultations before initiating eMental health interventions. A clear preference for some form of in-person service was displayed in the community engagement portion of this project. Therefore, it is recommended that eMental health approaches are used to support in-person intervention approaches, not replace them.

Align with existing frameworks. EMental health approaches can be aligned with the *Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* and the *First Nations Mental Wellness Continuum Framework* to best match relevant elements of care. For example, health promotion and education-based approaches (Element 1) and early intervention approaches (Element 2) seem to have the most breadth in terms of options. However, the current literature is underdeveloped in terms of secondary risk reduction (Element 3) and active treatment (Element 4).

CONCLUSIONS

Overall, eHealth services are promising interventions for mental health care, but more information is required to determine if such services are the best solution to address Indigenous youth mental health concerns. Specific research regarding cost effectiveness, youth preferences, and actual mental health needs for Indigenous populations are required before specific recommendations regarding intervention use can be made. EHealth interventions may be a viable way to facilitate youth engagement in their preferred choice of mental health service, but these may not be the best solution to disseminate interventions.

Focus groups with First Nation stakeholders and youth demonstrated mixed perceptions of eHealth solutions for mental health interventions. Commonly mentioned barriers to accessing mental health services included stigma and embarrassment, inappropriate services (e.g., services will not help, or services do not meet personal needs), a lack of services, as well as concerns about confidentiality. Certain eHealth solutions may be accessible for youth in First Nation communities, as many report having regular, consistent access to technology platforms. Despite this access, a large proportion of youth reported wanting to maintain face-to-face mental health services, with some stating that technology can be used in a complementary way. Ideally, any services developed for First Nations youth would be youth informed, culturally- and community-based, as well as amenable to individual preferences.

Taken together, the results from the literature review and the engagement process suggest that eHealth interventions may provide some utility within Indigenous communities although caution needs to be exercised in the development and implementation of these services. Community and youth consultation in the development of services will contribute to more acceptable and appropriate services. Furthermore, ongoing evaluation of any services developed is key to ensuring that the intended effect for these services is taking place as the literature in this area is limited. Any technology-based services should be provided in addition to existing, or enhanced, face-to-face, community-based services. Future research can examine the feasibility and usability of eHealth interventions available to various Indigenous youth populations as well as examine how eHealth interventions may support the promotion of mental health outcomes for Indigenous youth.

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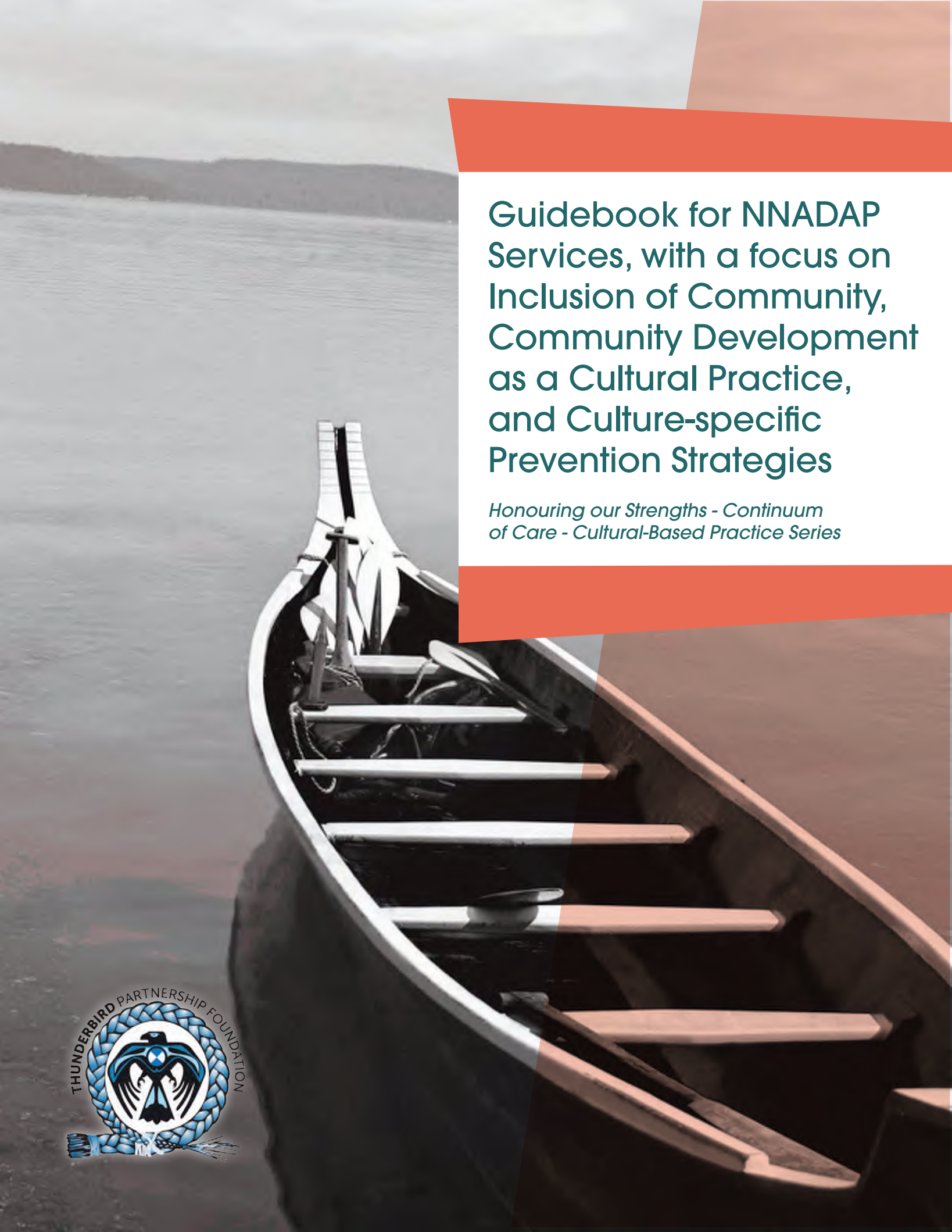

Guidebook for NNADAP Services, with a focus on Inclusion of Community, Community Development as a Cultural Practice, and Culture-specific Prevention Strategies

Honouring our Strengths - Continuum of Care - Cultural-Based Practice Series

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Table of Contents

1.Introduction 1

2. What is Community Development? 2

3. Who should be involved in Community Development? 2

4. Community Development to Develop Resilience 2

5. Assessing Community Development Competency Community Development Assessment Exercise 3

6. A Case Study of Community Development 6

- Linking Social Determinants of Health

7. Select Examples of Community-based Holistic Healing Models 7

- Alkali Lake (Esketemc First Nation) – British Columbia
- Nogemag C.A.R.E. Project – New Brunswick
- Tribal Journeys – West Coast of British Columbia
- Charles J. Andrew Youth Treatment Centre – Labrador
- Jackson Lake Land-based Healing Camp – Kwanlin Dün First Nations

8. Community Service Coordination as an Approach to Case Management 8

- Service Coordination
- Case Management and Cultural Practices
- Measuring Success

9. Additional Land-based Camps Resources 10

10. Summary Observations 10

References and Additional Resources 11

Appendices:

Appendix A: Community Bylaw to Prohibit Illegal Drugs (sample) 13

Appendix B: Community Policy concerning Illegal Drugs (sample) 15

Appendix C: Continued Employment Agreement and (draft) Motion 21

1. Introduction

The National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP) were founded on the principle that Indigenous-specific cultural practices, drawn from an Indigenous world view, would provide the best route to wellness for First Nations, Inuit, and Métis. The NNADAP Renewal Framework lists Community Development as one of the primary elements of care that is key to NNADAP's renewal framework (Assembly of First Nations [AFN], National Native Addictions Partnership Foundation [NNAPF]*, and First Nations and Inuit Health Branch [FNIB], 2011). This element is paramount from a community development context, given that First Nations in Canada includes more than a dozen Indigenous groupings or families whose cultural practices include 11 different languages, 55 dialects, and customs represented throughout the provinces and territories in more than 600 First Nations communities.

First Nations that are impacted by substance abuse can live in communities that vary from communities near major urban centres to rural communities far from any town or city and with minimal services, where access to needed services in itself can be a challenge. The community or region can also make a difference as to whether mental health and addiction services are accessible to First Nations locally, at a distance, or not at all within their province or territory. Likewise, depending on the impact of colonization, the presence and use of First Nations language, ceremony, and traditions may or may not be utilized in addressing substance abuse problems in any given region, and Canada's leading national substance abuse organization recognizes this gap. As noted in its current environmental scan, the Canadian Centre on Substance Abuse (CCSA) recommends the importance of developing culturally relevant tools that will assist academic institutions and others to implement CCSA competencies specific to the addictions workforce, with particular attention to First Nations communities (Whynot and Associates, 2011:26).

As in mainstream, First Nations communities can also have different levels of wellness, and these can be impacted by many factors such as leadership, shortage of housing, access to clean water, as well as access to education. Natural community strengths and well-being are identified by many sources as important factors in limiting the extent of addictions and in helping to support people on their healing journey. Case in point: the landmark studies by Canadian researchers Dr. Michael Chandler and Dr. Christopher Lalonde (1998) as well as The Harvard Project on American Indian Economic Development founded by Stephen Cornell and Joseph P.Kalt are several examples. These leading thinkers have demonstrated that the more control First Nations have over the social and economic aspects of their lives, the greater the degree of experiencing community harmony and stability.

The evidence also supports that culture is vital for community healing and development, although how culture is defined and practiced will vary from region to region given the diversity of First Nations. For the majority of First Nations, "culture" can be generalized as a way of being, knowing, perceiving, behaving, and living in connection with the world. It is recognized as a dynamic because the beliefs, values, customs, and traditions that are passed on from generation to generation remain relevant to day-to-day realities and ways of living for First Nations.

Culture is expressed in First Nations language (McIvor, Napoleon, and Dickie, 2009); methods of hunting, fishing, and gathering foods; crafts and artistic expression; ways of relating to each other; knowledge that informs family, community, and governance structure (McCaslin and Boyer, 2009); the gathering and use of traditional medicines (Martin Hill, 2009); traditional diets; spiritual journeying; drumming, dancing, and singing; and, most important, ceremonies. Within these various expressions of culture, some First Nations people see culture as exclusive of spirituality, while others define it as an understanding that the spirit is the central and primary energy, cause, and motivator of life (Hopkins and Dumont, 2010).

2. What is Community Development?

Community development is the intentional actions taken by a community to increase overall community health and wellness. Effective community development builds on community strengths while addressing community challenges, and it is inclusive of the perspectives of those most affected by substance abuse and in need of supports. Most sustainable community development initiatives are those that are initiated by the community, achieve community consensus, and build community ownership and empowerment. The scope of community development can vary from small projects within a small group to larger projects that involve the whole community. No matter what the scope of the activity, community development works best when it is community-driven, long term, well-planned, empowerment-based, and holistic and when it considers the broader social and economic contexts of the particular First Nations community.

Building capacity within a community is an important foundation to effectively plan, implement, and evaluate activities in any given priority, including actions to ensure community health and wellness. Community capacity includes the practical, team-building skills of facilitating community consensus—leadership skills, not only in individuals involved in community governance, but in informal leaders as well (Wesley-Esquimaux and Calliou, 2010:3–6). Community capacity and development also includes health knowledge and expertise in holistic health, social determinants of health, mental health promotion, addictions treatment and prevention, and so on.

Community development in First Nations communities is unique mainly because the intergenerational impacts of residential schools contribute to levels of individual mental illness and trauma, which could hinder the collective action of the community (Bombay, Matheson, and Anisman, 2009). Hence, individual healing sometimes needs to start before effective community development can begin. Just as important, supporters and partners of community development with First Nations need to have a level of cultural competence in order to effectively support First Nations communities to address their chosen priorities.

* As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

2. What is Community Development?

As noted by Jo-Anne Fiske, "Implicit in all healing practices is the modelling of community relationships. At all times, the community of clients will include members who have been abused, who have been abusers, and whose abusive behaviour has resulted in imprisonment" (Fiske, 2008:68). A holistic community development model challenges the community and clients of treatment "to confront the extremes of trauma as victims and perpetrators are brought face to face in intense emotional moments" (Fiske, 2008:68).

3. Who should be Involved in Community Development?

As a key element of care in the treatment of substance abuse, community development also includes efforts supporting universal prevention and health promotion. Networks of support that engage individuals within communities include people in the same age group (peers), Elders, neighbours, co-workers, teachers, and families—whether they are located in workplaces, places of recreation, faith groups, medicine societies, or homes. They often include relationships with, and connections to, culture, environment, and clan or kinship systems. Many First Nations see these as critical elements relating to safety and belonging, sense of purpose for community members, and harmony (Chansonneuve, 2007:46).

Natural networks within communities can also be a valuable source of prevention and health promotion. During periods of stress and substance abuse challenges, whether one is beginning or sustaining a healing journey, these social and community support networks provide critical support and encouragement for personal, family, and collective change (Hopkins and Dumont, 2010). When these healing journeys take individuals out of their community, the person may still see family and community as the most important source of continued support. Hence, a network of strong social supports (Mignone, 2009) helps to establish a healthy community-based foundation for all aspects of the continuum of care.

President and CEO Clint Davis of the Canadian Council for Aboriginal Business echoes this point, acknowledging that "Aboriginal people in Canada continue to be the poorest of the poor and are normally on the lowest ranking of every socio-economic indicator—household income, health, education and employment…[and that] many problems would simply dissipate with a greater focus on creating economic prosperity in Aboriginal communities" (Davis, 2011:2). Addressing those most affected, relevant employment policies and supporting local and economic growth are key to success. Following a series of regional meetings across Canada that identified more than 100 programs and strategies, the Health Council of Canada reflects the concern that "many non-Aboriginal Canadians—including those who work in health care, child welfare services, and government offices—simply don't understand or value the Aboriginal world view, and don't understand how the multi-generational effects of the residential school experience have affected their entire culture.

Imbedded in many of the success stories we heard was the importance of rebuilding what had been stripped from Aboriginal people—knowledge of their language and traditions, pride in their culture and self-determination" (Abbott, 2011).

Community well-being and development rests upon strong patterns of good parenting, where the community helps to raise children who are healthy in mind and body, which will ensure continuity from generation to generation. Also known as "generational patterning," it may also involve learning, preserving, and transmitting traditional values/ways where practiced, as First Nations continue to work toward a future where individuals, families, and communities thrive. Most important, community development includes the involvement of staff from all community programs, the broader community, as well as leaders in the community—both formal and informal (Hopkins and Dumont, 2010).

4. Community Development to Develop Resilience

Despite the decades of challenges faced by First Nations communities, many continue to be resilient. As noted by Robert Blum (1998), resiliency-based programs are built upon community-wide, intersectoral collaborations that:

- are not bound by traditional agency roles or administrative constraints;
- focus on enhancing enough competence in young people to at least reduce a given risk behaviour or undesirable outcome;
- see youth as part of the solution, not just the focus of the problem;
- start early in the life of young people;
- are intensive, continuous, and developmentally appropriate;
- have staff who are collaborative, interdisciplinary, and not overly "professionalized";
- will allow whatever action it takes to be successful; and
- value young people.

Community wellness is based on strengthening cultural identity and promoting individual, family, and community interconnectedness through traditional teachings and cultural ceremonies. Communities can also present opportunities that would help individuals develop resilience (Tousignant and Sioui, 2009). School systems, churches, Elders' centres, recreational and sports programs, parenting programs, youth groups, and the like can provide support, opportunities for community involvement, positive problem-solving strategies, positive challenges, guidance, and other elements that build resilience. Further, Marja Korhonen (2007) notes that a community as a whole can be a role model of resilience.

4. Community Development to Develop Resilience

A community can be said to be resilient when members:

• support each other;

• are optimistic about their ability to solve community problems;

• work together to solve crises and difficulties;

• have control over decisions and choices that affect everyone's well-being; and

• participate in community activities and volunteer for various tasks (Korhonen, 2007:21).

Prevention and health promotion initiatives are that much stronger when they come from the grassroots level, where community development activities are built from the ground up. Successful and holistic community development takes into account and organizes itself based on local realities, hopes, and goals to provide a shared direction for community wellness for individuals both young (Dell et al., 2011a) and elderly.

A Health Canada literature scan and analysis of on-reserve substance abuse prevention programming noted that many overlapping themes relevant to First Nations approaches to substance abuse prevention touched on important points such as the need to recognize the heterogeneity of First Nations populations across Canada; the value of Indigenous knowledge in the formation of prevention strategies; the importance of harmony or balance between aspects of self and community; and a recognition of, and value placed on, traditional carriers of knowledge, such as healers and Elders (Gifford, 2009:21).

5. Assessing Community Development Competency

Community development efforts vary considerably from one First Nations community to the next. The National Native Addictions Partnership Foundation (NNAPF) is presently developing a tool with which to assess community development efforts and, more specifically, to determine whether the community has reached a level of competency in its community development initiatives.

As noted in the NNADAP Renewal Framework, the first element of care associated with community development, universal prevention, and health promotion "includes broad efforts that draw upon social and cultural systems and networks of support for people, families, and communities. These…provide the basis for a healthy population and are accessible to the broader community" (AFN, NNAPF, and FNIB, 2011:2). This model for assessment recognizes that a system is typically managed by people through processes that are designed to ensure efficiency, effectiveness, as well as economies of scale.[1] The descriptions below are also consistent with the broad criteria described in Honouring our Strengths, as well as with the competency standards developed by the First Nations Health Managers Association.[2] In the Banff Centre for Management's review of best practices in Aboriginal community development, seven "wise practices" were identified as key success factors for bringing culture back into the community development process, which include:

- identity and culture;
- leadership;
- strategic vision and planning;
- governance and management;
- accountability and stewardship;
- performance evaluation; and
- collaborators, partnerships, and external relationships (Wesley-Esquimaux and Calliou, 2010:22).

[1] The phrase "economies of scale" is defined as factors that cause costs to lower as production increases, thus decreasing prices to consumers.
[2] Refer to http://www.fnhma.ca/content.php?doc=27

COMMUNITY DEVELOPMENT ASSESSMENT EXERCISE

In the following exercise, please assess as past, present, or future those criteria that would apply to your community development initiatives. There is no right or wrong answer, and the intent of the exercise is to provide the reader with an indication of your community's development progress or milestones achieved.

Assessing your Community Development

Check all that apply

Foundational Level: Technical ability to apply the competency in most situations	PAST	PRESENT	FUTURE
Majority of efforts focused on economic development without culture-specific emphasis.			
Lack of priority placed on mental health and well-being, whether individual or family.			
Lack of flexibility in funding mechanisms.			
Random community development projects are implemented that target mental health and addictions issues, whether the focus is on the individual or on families.			
Community has set up an integrated, comprehensive approach to prevention, pending its population, as smaller, rural/remote communities may not have.			
Community has funding for a part-time addictions worker with a basic understanding of the program.			
Training and certification are not geared toward prevention; focus on personal development in the field with little or no emphasis on population level responses.			
Basic Level: Consistent ability to apply the competency in most situations			
Health prevention and promotion delivered by a wide range of community workers, including NNADAP, Brighter Futures, suicide prevention, community health representatives (CHRs), youth workers, and teachers.			
Typically part of a broader range of services and supports to address crisis response, treatment needs, and other demands.			
Basic support is provided to clients in the form of counselling and/or transporting clients to and from treatment facilities.			
Community supports bylaw policies that create dry communities; however, bootlegging and enforcement are significant challenges.			
Lack of knowledge, resources, or a coordinated plan to support culturally relevant, community-based prevention and health promotion activities.			
Workers have only basic qualifications to undertake prevention and promotion programs.			
Workers receive limited annual training to advance their knowledge of addiction issues and to increase their skills in areas such as treatment and administrative services			
Intermediate Level: Proactive Ability to apply in a full range of situations.			
Development, prevention, and promotion efforts that engage the full range of health and other professionals, with full leadership support.			
School interventions, public speakers, and participatory events such as active community engagement during NAAW week involving Elders and community members, with cultural elements expressed throughout (e.g., language, sweats, ceremony).			

In the following exercise, please assess as past, present, or future those criteria that would apply to your community development initiatives. There is no right or wrong answer, and the intent of the exercise is to provide the reader with an indication of your community's development progress or milestones achieved.

COMMUNITY DEVELOPMENT ASSESSMENT EXERCISE

Assessing your Community Development	Check all that apply		
Intermediate Level: Proactive Ability to apply in a full range of situations.	**PAST**	**PRESENT**	**FUTURE**
Bylaw policies relative to alcohol and substance abuse, coupled with a broader community wellness approach, are encouraged.			
Communities and regions work together to coordinate and collaborate across sectors in response to crisis situations or where funding is available to support coordination.			
Workers progress their skills in counselling that target individual clients toward levels of counselling that can target broad community intervention efforts.			
Advanced Level: Complete understanding and ability to apply the competency in the most complex situations			
System-wide approach to community development guided by leaders and the community that promotes local control and a sense of meaning and pride for individuals, families, and communities.			
Community development efforts linked to Aboriginal-specific social determinants of health (education levels, living/working conditions, poverty, awareness of culture, traditional language, social environments, colonization, access to health services, income, employment, housing, and social supports).			
Services are linked and understanding of ways to address substance use are increased, including partnerships and better collaboration with communities, programs, multiple levels of government, and other federal departments.			
Mobilization and support of community volunteers to provide community development activities, including recreation, community events, and general activities in support of prevention and health promotion.			
Process for collecting and sharing success, challenges, and lessons learned from local community development schemes for regional knowledge exchanges to occur and to inform a national perspective.			
Coordination of services in the community including partnerships with police, justice, child welfare, housing, education, job and training, social assistance, health, cultural programs, and community governance to ensure a multi-faceted, community wellness-focused approach; may include multi-disciplinary, mental wellness teams, and/or leadership round tables composed of local program managers supported by community leadership.			
Ongoing community discussion about the role and understanding of culture so that communities can more clearly define culture's role in service design and delivery, as well as within broader commun ity development efforts.			
Community development plans that involve changes to, or adding of, programs to build a continuum of care such as crisis response and intervention, self-help, referrals, pre-treatment, basic addictions and mental health counselling, cultural support, and aftercare.			

6. A Case Study of Community Development

Linking Social Determinants of Health

For Sagamok Anishnawbek First Nation, their community development approach is viewed as the planned evolution of all aspects of their community's well-being, including economic, social, environmental, and cultural (Sagamok Anishnawbek First Nation, n.d.; Menzies, 2011). Community members come together to take collective action on, and generate solutions to, common problems, and the scope can vary from small initiatives within a small group to broader initiatives involving the entire community. Sagamok's community development approach links all determinants of well-being, whether basic physical needs are being met such as clean water; adequate nutrition, shelter, clothing, and sanitary waste disposal; those associated with spirituality, cultural integrity, and identity; and strong families supporting bonds of unity, co-operation, social, as well as belonging. Similar to Maslow's hierarchy of needs, protection, safety, and security are equally important determinants, where adequate power, freedom, and voice within the community ensure parity and adequate income and sustainable economics for all who live within the community. Open, healthy communication and access to information is critical in providing learning opportunities and in advancing the development of adequate infrastructure and human services, while providing a social safety net for those who need it.

Sagamok Anishnawbek First Nation's administration plays a key role in its community development. It has the responsibility in developing plans and making recommendations to implement and facilitate community supports that lead to change, while continuously monitoring and evaluating the impact of these changes and evolving accordingly to meet new challenges. Sagamok's leadership—politicians, policy-makers, and lawmakers—is also an integral part of community development, acting as legitimate community representatives who advocate on behalf of its membership and in managing relations with the public when implementing new and vital strategic direction. Principles of governance ensure that the community's development also supports transformation and healing that is guided by a vision that respects the value of culture and spirituality, interconnectedness, honour, unity, community participation, an approach to justice that reflects the community's morals and ethics, as well as a learning environment that encourages sustainability and leads to positive change.

What is key to Sagamok's community development efforts is Minowanigoswin, which provides a foundation for Sagamok Anishnawbek Law to move the community away from the control of the Indian Act; to help guide leadership selection and community administration; to provide mechanisms for conflict resolution; and to give a strong base for Sagamok's unique Citizenship Law. Quality management ensures the development of processes for every key activity such as defining standards for each process, evaluating the process itself on a constant basis, including the employees' performance in terms of standards, and monitoring and correcting the deviations when necessary.

For Sagamok Anishnawbek First Nation, community development begins first and foremost with community healing, and it is described by them as the process of moving beyond the hurt and dysfunction that had been internalized and had stifled the social and economic developments of the community (e.g., residential schools, colonization, loss of identity, loss of land, and loss of roles). Sagamok's community development focuses on the future, building new patterns of life that leads to sustainable well-being and prosperity. The ultimate goal of Sagamok's community development is to move the population as a whole toward higher levels of prosperity and well-being—socially, economically, politically, and culturally. It is also intended to ultimately lead to an effective form of First Nations Government in Sagamok and to rebuild its government system to reflect Anishnawbek cultural values and practices. This commitment to reach out includes everyone in the community's rebuilding process, which could foster community healing from the legacy of past trauma.

Beginning with an assessment of issues in the community, Sagamok's community development story began with the engagement of KPMG[3] in an organizational review, whereby community members examined the strengths and weaknesses of children, youth, women, men, families, and elders concerning Sagamok's social, economic, political, cultural, and spiritual dimensions. They looked at current conditions, lessons learned from the past, as well as pathways to the future. A 10-year action plan resulted with the development of a professional and volunteer team of workers, a family violence and sexual abuse response team, a crisis intervention team, as well as a leadership development program that supported continuous learning for a community where youth made a large proportion of the population that was not represented on Council. Total immersion into healing and personal growth training with a hard commitment to cultural and spiritual resources resulted, with new governance options being explored that included a municipal model, direct democracy, as well as a traditional clan-based government. Achievements over the past three years alone resulted in a better matching of departmental work plans to broaden goals, regular communication with the community using a professionally developed monthly newsletter, and a well-functioning senior management team. Addressing the broadly recognized 12 determinants of well-being was paramount, which began with teaching a cultural sensitization training curriculum, The Story that Was Never Told, concerning Sagamok Anishnawbek First Nation history.

Strategies currently being undertaken by Sagamok Anishnawbek First Nation include targeting youth, social reform, economic development, culture and language, early childhood development, waste management, emergency response, land stewardship, a financial and election code, ISO certification, dispute management, as well as community consultation throughout the community development process. In summary, the future is bright for Sagamok Anishnawbek First Nation: it is a relationship-based society that includes relations with each other, the environment, and their Anishnawbek spiritual world. Living in harmony and respect is a key element for Sagamok's community development efforts, and from their lens, the federal government has a responsibility to live up to its fiduciary responsibility by making available adequate resources so that Sagamok can achieve its community development goals.

[3] KPMG offers audit, tax, and advisory services to businesses and organizations across Canada.

7. Select Examples of Community-based Holistic Healing Models

Alkali Lake (Esketemc First Nation) – British Columbia

There are a number of examples of First Nations communities who have developed holistic approaches to community-based healing. These approaches have often begun with wide-spread substance use issues or a crisis in a community, but then these are expanded to transform health and social conditions, promote individual and community wellness, and revitalize traditional teachings and practices. One of the more dramatic examples of community healing is Alkali Lake (Esketemc First Nation) in British Columbia. The community took action against widespread alcohol abuse through leadership, commitment, support, and honouring spiritual and cultural foundations. It transformed its health conditions from within to suit its own self-defined needs. Among other measures, it issued vouchers for food and other necessities to its heaviest drinkers in place of social assistance funds.

Other models of healing, such as the Round Lake Treatment Centre, in British Columbia, and the Hollow Water Community Holistic Treatment Healing Circle, in Manitoba, derive their successes from the participation of community members in holistic, long-term healing strategies that target balance and wellness throughout the community's web of relationships.

Nogemag C.A.R.E. Project – New Brunswick

Nogemag is offered in partnership with the Elsipogtog First Nation and the Elsipogtog School, and support for the project is through Justice Canada, Human Resources and Skills Development Canada, Crime Prevention, and the Royal Bank of Canada. Since the summer of 2002, Nogemag C.A.R.E. has created original projects and programs to help at-risk youth of the Elsipogtog community. Programs include the summer cultural camp project on eldership development, "Reclaiming our Ancestral Footsteps," which is now part of the New Brunswick Youth Suicide Prevention Initiative. The camp focuses on immersing and training youth leaders in traditional life skills and spiritual teachings to help them have cultural pride and develop positive self-identity.

Tribal Journeys – West Coast of British Columbia

Tribal Journeys has become a movement embraced by international coastal First Nations communities. For two weeks each summer, canoe families (all ages) from up and down the coast make a drug- and alcohol-free journey to a host community. Spiritual, emotional, social, physical, cultural, and mental challenges are supported by Elders and knowledge keepers such as canoe builders, skippers, traditional food gatherers, cooks, and paddlers. Team meetings allow people to speak of their emotions during the trip. Skipper meetings recognize the skills of those who know the water and embrace the longing of others to learn. In each First Nations community, members feed the visitors. The success of these tribal journeys is based on strong doses of culture that embrace the past in a modern world. Family involvement allows for intergenerational healing and relationship building that spans decades. Families and friends celebrate in sobriety, a practice that reflects strong ancestral processes.

Charles J. Andrew Youth Treatment Centre – Labrador

Cultural camps or land-based camps make use of the land to facilitate culturally based intervention and healing for substance abuse and addictions. The Charles J. Andrew Youth Treatment Centre in Labrador, for example, under Executive Director Iris Allen, has incorporated land-based camps as a regular feature in their programming, with outings every other week year-round. These camps are considered the most successful part of their youth treatment program, with program dollars shifted to accommodate this invaluable service to youth (Allen, 2011). As noted on their website:

For the past 10 years, CJAY [Charles J. Andrew Youth Treatment Centre] has helped save lives through its tried and true program components.

One of the main and most successful components of the program is what we refer to as Nutshimit or land based program. This program runs every second week for a period of six days.

This is a program that teaches the youth self-sufficiency and builds resiliency skills. It nurtures a sense of belonging and gives the youth a purpose in life.

The program provides opportunities to channel energy towards healthy risk-taking choices and calms anxious youth, especially those with ADHD.

The land based program provides a safe and comfortable environment for healing. It offers youth the opportunity to build relationships, develop self esteem and a strong aboriginal identity while teaching responsibility, values and beliefs.

It involves relearning or learning a traditional way of life that is passed on to youth by Elders (CJAY, n.d.).

Jackson Lake's Land-based Camp – Kwanlin Dün First Nations

Jackson Lake's land-based healing camp is another excellent example of a community-based healing model; in this case, assisting women and men in separate camps and at separate times during the months of July, August, and September. As noted by Kwanlin Dün First Nations, the land-based camp was an integral part of the healing process for many; it increased pride in local culture and history and helped ground and heal participants. Elders and community members were considered important to the success of the program, as it brought the community together as they learned and shared new skills.[4]

Participants in both groups lived full-time at the centre. They slept in wall tents, ate in a common dining room, and showered in a new trailer at the centre. They were away from cell phones, radios, TVs, computers and other distractions.

The camps integrated traditional and contemporary approaches to healing. Each morning started with a circle and a smudging ceremony. People share how they were feeling. They talked about what they might be struggling with or dreaming of becoming. And they listened to each other (Kwanlin Dün First Nation, 2010:1).

[4] See: www.kwanlindun.com

Jackson Lake's Land-based Camp – Kwanlin Dün First Nations

Other land-based camps operate successfully through the Whiskeyjack Treatment Centre and Nelson House Medicine Lodge, both in Manitoba. Many communities support community-based interventions, such as those services offered through White Buffalo Youth Inhalant Treatment Centre in Saskatchewan, Carrier Sekani Family Services in British Columbia, and the Kapown Rehabilitation Centre's Family Wilderness Camp at Narrows Point on the North Shore of Lesser Slave Lake in Alberta. For contact information concerning the above, please refer to Section 9: Additional Land-based Camps Resources in this guidebook.

8. Community Service Coordination as an Approach to Case Management[5]

Service Coordination

Community development is the planned evolution of all aspects of community well-being, whether economic, social, environmental, or cultural. Community members come together to take collective action and generate solutions to common problems. The scope of community development can vary from small initiatives within a small group to large initiatives that involve the whole community. Regardless of the scope of the activity, effective community development should be well-planned; a long-term endeavour; inclusive and equitable; holistic and integrated into the bigger picture; initiated and supported by community members; of benefit to the community; and grounded in experience that leads to a best practice.

From a social work perspective, community development involves the management of various "ecological systems," including families (micro level); organizations and communities (mezzo level); and the broader societal context (macro level). Ecological meta-theory assumes that change-strategies must be planned and implemented across multiple systems in order to be effective. For example, an Indigenous approach to service coordination understands the dynamic relationship between people and systems. Interdependent systems recognize the influence between or among each system without a measure of power or hierarchy. Such interdependence is important for ensuring good case management for clients throughout a continuum of care. It also involves the recognition that while personal autonomy must be respected, respect is mutual: individual choices impact upon the health not only of oneself but of family and community as well.

Linking community programs as part of service coordination is important for developing community capacity to address addictions issues. Partnerships with policing, education, employment and training, social assistance, health, cultural programming, and community governance help to ensure a multi-faceted approach. The following programs are typical examples of community development-focused NNADAP/NYSAP programming:

• Land-based Programs: these need to be supported by local schools so that students attending them are not penalized but given further academic standing for their participation;

• Mobile Treatment Programs: these programs, offered in partnership with treatment centres as a first step in intervention, recognize that mobilizing community resources, including volunteers, contributes substantially to community development and capacity building;

• Cultural and Language Camps: these are critically important for developing strength around cultural identity as a key determinant of health;

• Inclusion of Community: whether ceremonies take place in treatment centres or in communities, community participation is vital. Programs like ceremonies for grief, feasts for the dead, funeral potlatches, headstone potlatches, sweat lodge ceremonies, full moon ceremonies, fasting ceremonies can all involve the larger community;

•Spiritual Healing: ceremonies can facilitate the healthy functioning of chemical pathways. Pharmacological therapies are sometimes in conjunction with therapeutic counselling;[6] and

• Community Bylaws Prohibiting Alcohol: because the ban on alcohol itself will not be enough to keep alcohol out of the community, it is also necessary to offer cultural programs that facilitate community engagement, which might include informal support networks that provide primary social support—a natural role for the extended family—as well as those listed previously. For examples of a community bylaw to prohibit illegal drugs, community policy concerning illegal drugs, as well as a continued employment agreement and (draft) motion in relation to the above please refer to appendices A, B, and C.

[5] Hopkins and Dumont (2010).
[6] Lester & Tschakovsky, 2006, from Hopkins, C. and Dumont, J. , Cultural Healing Practice within National Native Alcohol and Drug Abuse Program/Youth Solvent Addiction Program Services, Discussion Paper prepared for Mental Health and Addictions Division, Community Programs Directorate, FNIHB, Health Canada, February 2010.

Case Management and Cultural Practices[7]

The challenge for many First Nations communities remains how to best encourage service collaboration as an approach to case management through community development that is specific to substance abuse issues within their community. There are several case illustrations of Indigenous approaches where clients within addictions services have participated in culture and medicine practices. Some of the traditional cultural practices presently in use across Canada include:

• fasting ceremonies (three treatment centres; BC, Manitoba, and Ontario[8]);

• sweat lodge ceremonies (consistent across NNADAP and reported by National Treatment Directors[9] focus groups and two community-based[10] NNADAP programs, one of which was a provincial organization);

• memorial feast, also known as the ghost feast, ghost suppers, feast for the dead, funeral potlatch, or headstone potlatch (three treatment centres; BC, Manitoba, and Ontario);

• ceremonial and social feasts (common across NNADAP and generally in celebration of treatment program completion within treatment centres, and can include a powwow);

• naming and clan identification (four treatment Centres; BC, Manitoba, Saskatchewan,[11] and Ontario);

• use of traditional foods as medicine (reported by two National Treatment Directors focus groups);

• use of traditional medicines (common in smudges consistent across NNADAP and used for detoxification in BC, Saskatchewan, and Ontario); and

• inclusion of family and community within ceremonies (BC, Manitoba, Ontario, Saskatchewan, and Nova Scotia).

Measuring Success

Specific to case management within a community development model is a need to develop outcome instruments that recognize and support Indigenous world views of health and well-being. Within Western cultures health status is defined as the degree to which a person is able to function physically, emotionally, and socially with or without aid; whereas quality of life is defined as the degree to which a person perceives themselves as able to function. Both aspects are focused primarily on the individual, and in order to embrace an Indigenous perspective, the definition would have to include the ability to assume responsibility for family and community health as well. Indigenous perspectives on health outcomes can be examined by asking questions like the following:

• Has the intervention enhanced the individual's relationship with their family?

• Has the intervention enhanced their capacity to function as part of their community?

• Have their spiritual beliefs been considered as part of the outcome assessment process?

• Does the person self-identify as Indigenous?

• Is there knowledge of family for three generations (parents, grandparents, great grandparents)?

• How many community or land-based visits have happened in the past year?

• Does Indigenous language proficiency exist, including the ability to speak, understand, and write in the Indigenous language?

If outcomes involve the development of Indigenous knowledge, consider the following concepts as guides for establishing more specific outcome measurements:

• Indigenous Centredness = living life from one's spirit centre;

• Indigenous Consciousness = reconnecting to cultural/spiritual identity raises consciousness about who one is and one's purpose for being; and

• Total Responsiveness = relating from mind, body, spirit, and emotions.

As these questions illustrate, becoming a healthy Indigenous person places greater demands on individuals, but the human rewards of being a part of the Indigenous community make those demands worthwhile.

[7] Ibid.
[8] Tsow Tun Le Lum Treatment Centre in BC; Nelson House Medicine Lodge in Manitoba; and Nimkee NupiGawagan Healing Centre in Ontario.
[9] Focus groups were facilitated through two National Treatment Centre Directors Meetings organized by NNAPF. One meeting took place in Winnipeg, September 2008, and the other took place in Vancouver, January 2009.
[10] Community-based NNADAP key informant interviews were held with Executive Director Joe Denny, Native Alcohol and Drug Abuse Counselling Association of Nova Scotia (NADACA).
[11] With reference to the White Buffalo Treatment Centre in Saskatchewan.

9.0 Additional Land-based Camps Resources

For more information, please feel free to check out these websites or contact:

Charles J. Andrew Youth Treatment Centre
Executive Director Iris Allen
PO Box 109
Sheshatshiu, NL A0P 1M0
Phone: 709-497-8995
Fax: 709-497-8993
Toll Free: 800-497-8995
www.cjay.org

Whiskeyjack Treatment Centre
Executive Director Roxanne Kozak
PO Box 580
Norway House, MB R0B 1B0
Phone: 204.359.8995
Fax: 204.359.6497

Nelson House Medicine Lodge
Executive Director Ed Azure
PO Box 458
Nelson House, MB R0B 1A0
Phone: 204.484.2256
Fax: 204.484.2016
www.medicinelodge.ca

White Buffalo Youth Inhalant Treatment Centre
Executive Director Ernest Sauve
PO Box 2500
Prince Albert, SK S6V 7G3
Phone: 306.764.5250
Fax: 306.764.5255

Carrier Sekani Family Services (Health Services)
Director Mabel Louie/Mental Health Manager Christina Brazzoni
PO Box 1219
Vanderhoof, BC V0J 3A0
Phone: 250.567.2900
Fax: 250.567.2975
www.csfs.org

Kapown Rehabilitation Centre
Chief Executive Officer Connie McKee
PO Box 40
Grouard, AB T0G 1C0
Phone: 888.751.3921
Fax: 780.751.3831

Kwanlin Dün Justice Program
Justice Director Jeanie Dendys
7 O'Brien Road
Whitehorse, YK Y1A 6H6
Phone: 867.633.7851

10. Summary Observations

NNADAP and NYSAP have played a significant role in cultural revitalization in First Nations communities. Many people returning home after treatment have continued their search for Indigenous identity and cultural meaning within the context of their communities. It is all of the people who continue to manifest wellness in their life—together with their extended family networks—that support the recovery of those who never do seek treatment but find their wellness seemingly all on their own.

Likewise, community development is just one of several elements that influences the uptake of wellness within the community. In combination with other critical elements and supports, community development becomes a powerful force in the treatment of addictions and mental wellness, and it can assist entire communities at becoming healthy and well. For a full or summary version of the Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada, please visit: http://nnadaprenewal.ca/

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Appendix A – A Community By-Law to Prohibit Illegal Drugs[12]

ByLaw to Prohibit Illegal Drugs for_____
Name of First Nation community

Whereas _____ has and continues to exercise an inherent right to self-government;
Name of First Nation community

Whereas in addition their inherent right of self-government, _____ has authority under the Indian Act to make by-laws;
Name of First Nation community

Whereas the use, possession and selling of illegal drugs on the _____is causing
Insert name of First Nation community
misery and turmoil amongst the people of insert name of First Nation community and is a major cause of social concerns and problems of the community;

Whereas the Council of _____are desirous of declaring in effect a prohibition
Name of First Nation community
against the use, sale and possession of illegal drugs on the insert name of First Nation community (subject to the exceptions provided herein);

Whereas subsection 85.1 (1) (a) and (c) of the Indian Act authorizes the Council of the_____to make such a by-law;
Name of First Nation community

Whereas a majority of the electors of the _____ who attended a special community
Insert name of First Nation community
meeting of the _____on _____ called by the Council of the
Name of First Nation community Date
_____on _____ for the purpose of considering the contents of this by-law,
Name of First Nation community Date
assented to the contents of this by-law,

Now therefore, it is hereby enacted pursuant to section 85.1 of the Indian Act:

1.00 Title
1.01 This by-law may be cited as the _____ Illegal Drug By-law.
Name of First Nation community

2.00 Interpretation
2.01 In this By-Law:

a) 'Lands' means all of those Lands defined as a 'reserve' within the meaning of the Indian Act, R.S.C. 1085, C. 1-5, and set apart for the use and benefit of the _____.
Name of First Nation community

b) 'Illegal drugs' means those drugs and substances prohibited or controlled und the Controlled Drugs and Substances Act, S.C. 1996, C. 19;

c) 'Council' means the Chief and Council of the _____.
Name of First Nation community

3.00 Prohibitions
3.01 No person shall sell, barter, supply or manufacture and illegal drug on the Lands.
3.02 No person shall be in possession of an illegal drug on the Lands.

4.00 Exceptions
4.01 No person contravenes section 3.00 of the by-law where illegal drugs are possessed, used or intended to be used solely for medical purposes upon prescription by a medical doctor in accordance with the Controlled Drugs and Substances Act, S.C. 1996, C. 19 and the Marijuana Medical Access Regulations, S.O.R. 2001/227.

[12] Acknowledging reference to the By - Law to Prohibit Illegal Drugs, Fisher River Cree Nation, June 10, 2004.

Appendix A – A Community By-Law to Prohibit Illegal Drugs[12]

5.00 Enforcement

5.01 Every person who fails or refuses to comply with a provision of this by-law commits an offence.

6.00 Penalty

6.01 Every person who commits an offence under this by-law is liable on summary conviction:

a) In the case of an offence under paragraph 3.01 of the by-law, to a fine of not more than $5,000.00, or to imprisonment for a term not exceeding 6 months, or to both;

b) In the case of an offence arising out of paragraph 3.02 of this by-law, to a fine of not more than $500.00, or to imprisonment for a term not exceeding 3 months, or to both.

6.02 In addition to the above penalties, every person who commits an offence under this by-law may also be subject to the following sanctions:

a) Employment with the insert name of First Nation community may be terminated;

b) Assistance of any kind, including but not limited to social assistance, economic and education support, may be terminated or denied;

c) Housing on the Lands may be denied;

d) Names will be removed from the housing list;

e) Eviction from the housing on the Lands;

f) Names may be publicly posted or otherwise made public;

g) The insert name of First Nation community and its affiliated or related companies and their agencies may refuse to do business with such persons; and,

h) Removal or banishment from the Lands.

7.00 Band Council Resolutions

7.01 The Council may make Band Council resolutions respecting any matter that the Council considers necessary or advisable to meet or further the objectives of this by-law.

8.00 Drug testing

8.01 To further the objective of this by-law, the Council, from time to time may declare by Band resolution or otherwise, that all employees or prospective employees of the First Nation, undergo drug testing as a condition of their employment.

9.00 Miscellaneous

9.01 Should a Court determine that a provision of this by-law is invalid for any reason, the provision shall be severed from the by-law and the validity of the rest of the by-law shall not be affected.

9.02 This by-law comes into force on the day of the enactment.

9.03 The provisions of this by-law apply to all Lands of the _____
Name of First Nation community

9.04 Nothing in this by-law shall derogate or abrogate the _____ from existing Aboriginal or Treaty Rights.
Name of First Nation community

This by-law is hereby made at a duly convened meeting of the Council of the _____ on this ____ day of _____, 20_____. Voting in favour of the by-law are the following members of the Council (quorum requirement):

_____ Chief

_____ Councillor

_____ Councillor

_____ Councillor

Appendix B – Community Policy concerning Illegal Drugs[13]

I. What is a Drug?

A drug can be a psychoactive substance which has the potential to change or adversely affect the way a person thinks, feels, or acts. For the purposes of the policy, the drugs of concern are illegal/illicit drugs that inhibit an employee's ability to perform their job safely and productively. The primary drug groups and their characteristics are as follows:

1.Depressants

These drugs slow down the central nervous system and affect a person's ability to think clearly and make decisions. Depressants include barbiturates, sedatives and tranquilizers. Some examples of these drugs are valium, seconal and thosamine.

2.Stimulants

These drugs stimulate the central nervous system and increase a person's activity and level of alertness. Stimulants include cocaine and amphetamines. Some examples of these drugs are speed, cocaine, crack and uppers.

3.Hallucinogens

These drugs cause a person to hallucinate which alters their mood, behaviour and perception of reality. Some examples of these drugs are acid, LSD and ecstacy.

4. Cannabis

Another type of hallucinogen that includes drugs such as marijuana and hashish.

5. Narcotics

These drugs are used to relieve pain and induce sleep. Some examples of these drugs are heroin, morphine, Demerol and codeine.

II. What is an Illegal Drug?

An illegal drug is a drug is a drug that is prohibited or controlled under the Controlled Drugs and Substances Act, S.C. 1009, C.19.

The misuse of illegal drugs can affect an employee's job performance, and may cause the employee to be less productive, less reliable, and more prone to accidents and have higher rates of absenteeism. This can result in increased risks and costs to the_____. Misuse of illegal drugs may also have a devastating
Name of First Nation community
impact on lives, businesses and on the community in general.

III. _____ Illegal Drug Policy
Name of First Nation community

The _____is committed to the safety and productivity of all Band entities,
Name of First Nation community
organizations and employees. Band Council recognizes that illegal drug use can limit the ability of our employees to properly perform their jobs. The Band Council also recognizes that illegal drug use can have a serious and negative impact on the health and safety of our employees, and members of the community.

The _____will not tolerate employees being unfit for any assigned duties
Name of First Nation community
due to the use or after-effects caused by the use of illegal drugs. The implementation of this policy works to minimize the risks caused by impairment due to the use of illegal drugs, to ensure a safe, healthy and productive workplace.

Exceptions

An employee will not be in violation of this policy where illegal drugs are possessed, used, or intended to be used solely for medical purposes upon prescription by a medical doctor, in accordance with the Controlled Drugs and Substances Act, S.C. 1996, C. 19 and the Marijuana Medical Access Regulations, S.O.R. 2001/227.

Employees who are permitted to possess and use illegal drugs under the guidance of a medical doctor must report such use to their supervisor is such use could have a negative impact on the performance of their employment duties or the safety of themselves or others.

[13] Acknowledging reference to the Fisher River Cree Nation Illegal Drug Policy, Revised November 2006.

Appendix B – Community Policy concerning Illegal Drugs[13]

Prevention

Employees are encouraged to seek assistance should they suspect they might have a substance abuse problem before it becomes a concern in the workplace and/or before the individual contravenes the terms of this policy or the name of First Nation community by-law #_____ The _____or responsible
Name of First Nation community
Band entity will attempt to accommodate and modify duties where reasonably possible, if employees choose to access such assistance. All employees who suspect that they might have a problem are encouraged to seek help through the name of First Nation community Employee Assistance Program (if applicable to the community).

IV. Who does this Policy apply to?

This policy applies to all current employees, including full-time, part-time, temporary and casual employees, who are employed by the_____ and related Band entities, whether or not they are
Name of First Nation community
carrying out their employment duties on or off the Reserve. It also applies to any person doing business with the _____ and to all appointed or elected Board members of Band entities
Name of First Nation community (collectively referred herein as 'employee(s)').

Safety Sensitive positions

Safety sensitive positions have greater risks involved in their performance. Employees who work in safety sensitive positions are required to perform work where impaired performance could result in a significant safety risk to themselves, co-workers, Reserve land, property, the community or the public in general, including the environment. Due to the significant risk associated with these positions, employees will be expected to meet additional requirements with respect to illegal drugs under this policy. Certain occupational groups that have been identified as safety sensitive include, and are not restricted to the following:

- School bus drivers;
- Medical service drivers;
- Health care workers;
- Daycare workers;
- Teachers;
- Child and family service workers;
- Heavy equipment operators; and,
- Health program workers.

Employees in safety sensitive positions will be subject to more frequent drug testing, and positive drug tests will result in such disciplinary action as determined appropriate by the Chief and Council, Director, or Board of Directors.

V .What are the Responsibilities of the Employees?

All employees of the _____ and Band-related entities must do the following:
Name of First Nation community

1. Report fit for any and all duty. For the purposes of this policy, fit means being able to safely and acceptably perform all duties without limitations due to the use or after-effects caused by the use of illegal drugs.

2. See advice and follow appropriate treatment if the employee suspects he/she has, or is beginning to have a problem with illegal drug use.

All employees of the name of First Nation community and of the Band-related entities, including those who are not employed in safety sensitive positions, are further required to do the following:

1. Be subjected to a drug test in certain situations at the discretion of Chief and Council, or responsible Band entity;

2. Report the use of any medications that could have a negative effect on performance or safety to his/her supervisor; and,

3. Report to their supervisor immediately any criminal charge and/or conviction involving or related to illegal drugs.

Appendix B – Community Policy concerning Illegal Drugs[13]

If an employee tests positive for an illegal drug, they are required to follow any recommended monitoring or aftercare program after receiving primary treatment for an illegal drug-use related problem. The employee may be required to participate in a modified work program if recommended. Ultimately, if an employee who has tested positive refuses help or continues to use illegal drugs, disciplinary action, including termination from employment will occur.

VI. What does the name of First Nation community Prohibit?

The _____prohibits an employee being unfit for any and all assigned duties due to
Name of First Nation community
the use or after effects caused by the use of illegal drugs. For the purposes of this policy, anyone in a safety sensitive position is prohibited from reporting for duty, or remaining on duty, if they have been using illegal drugs within 24 hours of performing a safety sensitive position.

Illegal drugs

The_____prohibits employees from engaging in the following while carrying
Name of First Nation community
out their employment duties:

1. The use, possession, distribution, offering or sale of illegal drugs, or illegal drugs paraphernalia;

2. The distribution, offering or sale of prescription medication; and,

3. The presence in the body of illegal drugs.

Medications

The _____ prohibits the intentional misuse of medications, whether prescribed or over
Name of First Nation community
the counter. The onus is on the employee to determine if a medication will negatively affect their performance and discuss this with their supervisor. Employees in safety sensitive positions are required to report any medications that may negatively affect their performance to their supervisor. If the Band Council or responsible Band entity determines there is the possibility the employee's performance may raise safety concerns, the Band Council or responsible Band entity in consultation with appropriate supervisor, may temporarily reassign the individual, or modify work where reasonably possible.

VII. When will Drug Tests be Required?

The following situations may trigger the requirement for an employee to undergo a drug test:

1. Pre-employment: A drug test will be required as a final condition of employment;

2. Post-accident: A drug test must be conducted as soon as possible after an accident, and/or incident involving loss of human life, and/or an injury that requires immediate medical treatment, and/or where there is disabling damage to a vehicle and a citation is received for a moving traffic violation;

3. Reasonable suspicion: A drug test may be required if a manager or supervisor has reasonable cause to suspect that an employee is under the influence of an illegal drug;

4. Random testing: Employees will be subject to random testing for illegal drugs;

5. Return-to-duty and follow-up: A drug test will be required upon the employee's return to work after a positive test result for illegal drugs, and/or upon return to work after receiving treatment, and/or as part of the follow-up or monitoring program recommended; and,

6. Any other time as determined by the employer or the Chief and Council, in consultation with the employee's supervisor.

VIII. How will Drug Tests be Conducted?

Testing for illegal drugs will be conducted by using either a five (5) panel urine drug screen and/or a five (5) panel hair drug screen which will detect five (5) different substances:

- Opiates
- Phencyclidine (PCP)
- Cocaine
- Cannabinoids; and,

• Amphetamines.

Appendix B – Community Policy concerning Illegal Drugs[13]

VIII. How will Drug Tests be Conducted?

The test to be utilized will be at the discretion of the direct Supervisor, and/or Chief and Council, or the responsible Band entity.

The collection of specimens will follow a strict medical/legal process to ensure that the results are those of the appropriate donor, and the test results will follow strict confidential protocols.

The collection of specimens will be performed by an individual(s) who has received the appropriate training on the collection process and protocols. The specimens will then be forwarded to a laboratory for analysis where the results will be reviewed by a Medical Review Officer (MRO), or licensed physician, who is knowledgeable about substance use disorders, and has the appropriate medical training to interpret and evaluate the individual's test results. Upon review of the results, the MRO will release the results to the direct Supervisor or designated entity, with an explanation of the test results. The Supervisor will then contact the _____Council to report a positive test result and initiate corrective measures.

In the event of a positive test result, the MRO will attempt to contact the individual to discuss the test results, and to identify what factors may have contributed to a positive test result. The MRO will attempt to contact the individual three (3) times and if unable to establish contact, the results will then be forwarded to the supervisor.

IX. What happens if an Employee Tests Positive?

In the event of a confirmed positive drug test, the employee must contact the supervisor or appropriate Band entity to arrange a meeting for an assessment within a two week period after the confirmed positive drug test. If the employee does not contact the supervisor or designated Band entity within the two week period, the employee will be suspended from employment without pay for a two week period. During the two week suspension period, the employee must contact and meet with the supervisor or designated Band entity for assessment. Failure to contact or meet with the supervisor or designated Band entity during the two week suspension period will result in termination from employment.

Further, in the event of a confirmed positive drug test, the employee will be required to sign the Continued Employment Agreement (see document that follows).

The following steps will take place to assist and accommodate the employee:

1. The designated Band entity will:
a) notify the employee's supervisor (or Chief and Council and Board of Directors if appropriate), and the employee of the confirmed drug test;
b) conduct an initial meeting with the employee within the two week suspension period; and,
c) develop an appropriate treatment plan for the employee in consultation with NNADAP services, or other appropriate resource (if applicable).

2. The designated Band entity (or Chief and Council or Board of Directors if appropriate) and the employee will meet to discuss the positive drug test and the employee's treatment plan.

3. The designated Band entity will conduct on-going monitoring to ensure and verify that the employee is following his or her treatment plan. The employee will be subject to on-going random drug testing. A monitoring program will be mandatory for all employees who test positive. Such employees are required to meet with the designated Band entity and/or NNADAP addictions counsellor at three (3) month intervals for 24 months, for ongoing assessment, or as otherwise determined by the designated Band entity.

The monitoring program will include certain minimum requirements. These may include, but are not limited to, unannounced random drug testing, attendance at an alcohol/drug dependency program such as Alcohol and/or Narcotics Anonymous, and/or other additional requirements as may be identified in writing at the time the employee returns to work.

If an employee re-tests positive for drug use on a random drug test (during his or her treatment plan), the employee will be required to attend and satisfactorily complete a residential treatment program. If the treatment program is out of the Province/Territory, the employee will receive out-of-province/territory travel, and an escort, if determined by the designated Band entity. If the employee refuses or does not complete the residential treatment program, he or she will be terminated from employment. Termination from employment will also result if the employee tests positive a third time during his or her treatment plan.

Appendix B – Community Policy concerning Illegal Drugs[13]

X. What happens if an Employee refuses to take a Drug Test?

Refusal to take a drug test, or to sign a 'Consent to Release Information' form, will be treated as a positive test result. Such employees' will receive a two week suspension without pay. During the two week suspension, the employee is required to contact the designated Band entity to take a drug test. Failure to meet with the designated Band entity during the two week suspension period will result in termination from employment. The designated Band entity shall have the discretion to use either the urine or hair sample drug test, except where an employee initially refuses to take a drug test, then a hair sample test must be used.

XI. Employees who fail to show up for their scheduled drug test:

Employees who do not attend to their initial scheduled drug test with the designated Band entity must reschedule their appointment within 24 hours with the designated Band entity. Such employees will be given the hair sample test. Failure to schedule or attend the second scheduled drug test will be treated as a positive drug test, and such employees will be subject to the appropriate steps/action depending on the specific employee circumstances.

If the designated Band entity, in his or her discretion, or if this policy directs that a hair sample drug test be used, refusal by the employee of the hair sample test on the basis of 'traditional grounds/beliefs' is not acceptable, and appropriate steps/action will be taken depending on the specific employee circumstances.

XI. What are the consequences for breaching the policy?

If an employee violates the provisions of the policy, or fails to meet the satisfactory standards or work performance as a result of illegal drug use, reasonable efforts will be made to accommodate the employee. However, notwithstanding any provision/step set out in this policy, the Band Council or responsible Band entity may, in consultation with the supervisor, use discretion in determining the appropriate corrective action, including termination from employment, depending on the nature of the circumstances and the seriousness of the violation.

The consequence of a positive test result or tampering with the test, may include but is not limited to, an immediate, formal monitoring program, treatment, or termination from employment.

XII. Questions or Concerns?

To assist the employees of _____ to better understand the obligations and requirements placed upon them with respect to this policy, or to answer any questions regarding the policy or the drug testing program employed by _____employees are encouraged to contact the Band Manager at :

Name of Band Manager_____ First Nation Community_____

Address_____

City_____Province_____Postal Code_____

Phone Number (_____) - _____-_____

Appendix C – Continued Employment Agreement and (draft) Motion [14]

Continued Employment Agreement

To: _____
Name of Employee

This notice will confirm our understanding concerning your continued employment with the _____ _____ Concerning the issue that we were informed that your employee drug test was found to be positive, in consideration for continuing your employment, the following conditions shall apply:

1. You must personally contact the _____ as well as the designated Band
Name of relevant NNADAP addictions counsellor
entity/person, to develop a treatment plan.

2. You are to provide a copy of your treatment plan to your direct supervisor for their approval. A copy of your treatment plan will be provided to the designated Band entity/staff person.

3. You are to attend and complete and Alcohol and Drug treatment program, if recommended by the NNADAP addictions counsellor, as well as attend weekly counselling sessions, support group meetings, and workshops.

4. You shall be accountable to your immediate supervisor for confirming treatment, permitted through the use of earned employee credits and benefits where possible.

5. You are required to meet with the NNADAP addictions counsellor for ongoing assessment at intervals stated within the _____
'Human Resources Policy Regarding Illegal Drugs'

6. You will be retested after 90 days of the original test, or at other intervals as determined by the NNADAP addictions counsellor and designated Band entity/staff person.

7. Failure to pass the re-test may result in termination of your employment with _____
Name of organization.

I have read and understand the above conditions, and I understand that failure to comply and adhere to any of the above stated conditions will result in immediate termination of my employment with

_____
name of company and or related entities.

Employee name: _____ Date: _____

Director: _____ Date: _____

Immediate supervisor: _____ Date: _____

DRAFT MOTION

Whereas, the Board of Directors has reviewed and agreed to adopt the Drug Policy;

Therefore, be it resolved that effective the date of this motion, the Board of Directors hereby adopt the Drug Policy developed by _____ Date:_____
Name of Organization

And be it further resolved that effective immediately, the Director/Band Manager is directed to notify and review the _____

_____
name of drug policy with all employees

[14] Acknowledging reference to the Fisher River Cree Nation Illegal Drug Policy, Revised November 2006.

THUNDERBIRD PARTNERSHIP FOUNDATION

PolicyWise
for Children & Families

Integrated Service Delivery Hubs

SUPPORTING INDIGENOUS-LED IMPLEMENTATION

Acknowledgements

PolicyWise for Children & Families (PolicyWise) would like to acknowledge that integrated service delivery hub work is taking place in 13 communities across Treaty 6, 7, and 8 territories. We acknowledge the many First Nations, Métis, and Inuit whose footsteps have marked these lands for generations. It has been a privilege to work alongside and learn from Elders, youth, families, and partners in the following Indigenous communities and Indigenous post-secondary institution located in Treaty 6 territory: Alexis Nakota Sioux Nation, Enoch Cree Nation, Samson Cree Nation, and Maskwacîs Cultural College (which serves Samson Cree Nation, Ermineskin Cree Nation, Louis Bull Tribe, and Montana Cree Nation).

PolicyWise would like to thank *Elder Sharon Pasula*. As a person of Nehiyaw-Metis/Jewish ancestry, Sharon played a unique role in the project through ceremony, spiritual guidance, and consultation. We are grateful for her role modeling of traditional practices and for her commitment to building bridges through shared knowledge.

PolicyWise would also like to thank the *Mental Health Foundation* for the additional funding provided to support the implementation of community-based integrated service delivery hubs.

Overview

This journey map is written from the perspective of PolicyWise staff in consultation with their Indigenous communities and/or partner organizations located in Treaty 6 territory. The purpose of this journey map is to contextualize the implementation experience in Indigenous communities and/or partner organizations and share lessons learned to guide provincial support of Indigenous-based integrated service delivery hubs. We share these lessons in the spirit of continuous learning in hopes of fostering allyship between provincial ministries in supporting Indigenous-led integrated service delivery hubs.

Project Background Page 4-5

Journey Map Page 6-7

Lessons Learned Page 8-14

Going Forward Page 15

To take best advantage of the graphics in this document and with the environment in consideration, we decided to make this a digital journey map that is best viewed in PDF. To zoom in to any specific graphic, hold the alt or option button and scroll up with your mouse.

Project Background

In 2017 PolicyWise was contracted by Alberta Health, a provincial government ministry, to support the development, implementation, and evaluation of community-based integrated service delivery hubs to address mental health needs of youth across Alberta. Early on, parameters, defined by current evidence and contextual needs, were outlined for the Integrated service delivery hubs project.

The parameters included an emphasis on: small-to-medium population centres; shifting existing community resources to create locally-led solutions to better meet addiction and mental health needs of youth ages 11-24; integrated service delivery across health and social sectors; and, authentic engagement of youth and their families. The overarching goal of the project was, through integrated service delivery hubs, to: enhance youth engagement and empowerment in their care; promote early identification and intervention of mental health concerns; and improve service coordination and integration.

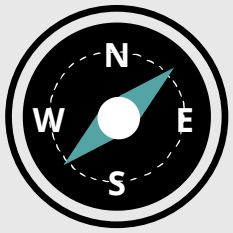
For the project, the integrated service delivery hubs were defined as a service delivery 'entity' that connects multiple, cross-sectoral community partners to increase access to mental health supports for youth ages 11-24. We worked in 13 different communities, which included three Indigenous communities and one Indigenous land base, spanning a geographic area of over 660,000 km2.

Project Approach

Developmental evaluation provides an examination of current emerging practices, while identifying potential areas where changes can be implemented. It is meant to promote the strengths of an initiative while identifying opportunities to develop greater capacity. Using developmental evaluation activities throughout the implementation process allowed PolicyWise to respond quickly to the needs of Indigenous communities and/or partner organizations. As with all communities that have been involved, the lessons learned throughout implementation have been reflected in the core elements of the provincial implementation and operational approach*. The direct focus of this document is to bring attention to specific considerations when supporting Indigenous communities and/or partner organizations to lead this work.

**For a detailed description of the provincial implementation and operational approach and evidence please contact PolicyWise.*

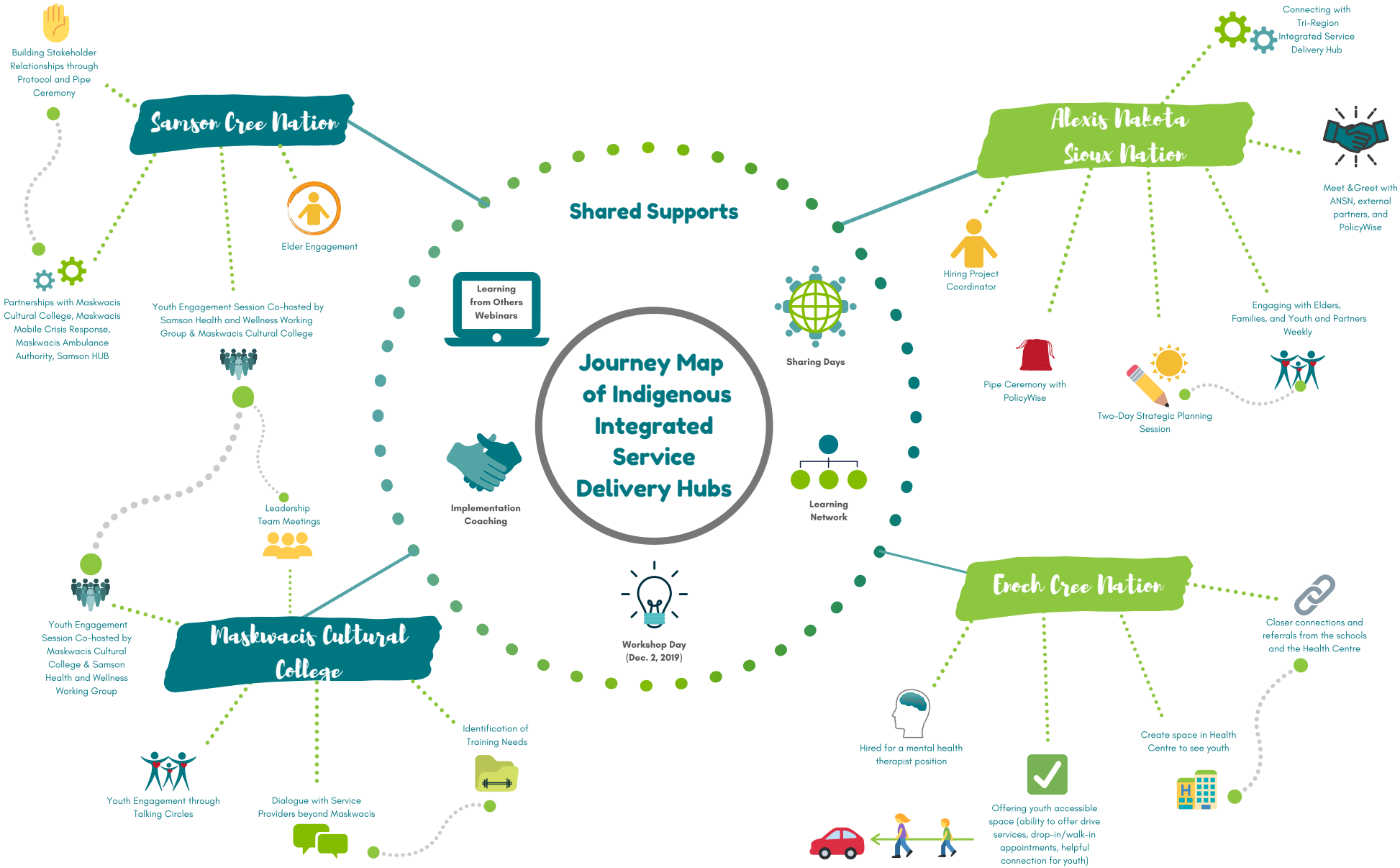
Journey Map



This journey map represents select milestones achieved from the start of the grant in May 2019 up until March 2020. PolicyWise supported the development of Indigenous integrated service delivery hubs through two types of grants to work through Phase 2: Capacity & Readiness or Phase 3: Plan & Prepare.

These grants facilitated momentum of work that was often already occurring in the Indigenous communities and/or partner organizations and offered a shared provincial approach that could be adapted to local context. The existing relationships and community practices enabled each Indigenous community and/or partner organization to apply the framework in ways that made sense to them to further promote accessibility and integration of youth services.

Please refer to the next page which illustrates highlights from the different Indigenous-led implementation experiences.



Legend: Capacity & Readiness | Plan & Prepare

Lessons Learned

When supporting Indigenous-led implementation of integrated service delivery hubs:

1. **Follow the lead of each Indigenous community and/or partner organization to ensure appropriate protocol and cultural practices are honoured.**
2. **Build meaningful relationships by getting to know each other.**
3. **Acknowledge the intergenerational historical trauma of residential schools and systemic barriers in order to begin reconciliation through collaborative dialogue.**
4. **Support the involvement of a cultural resource person to help bridge Indigenous and western practices.**
5. **Recognize that Indigenous people are always connected to their nation, regardless of where they reside.**
6. **Understand that youth are nested in circles of holistic support based on kinship practices.**

Please refer to the next six pages to read about what each of these lessons look like in practice and how the lesson is reflected in the core elements of the provincial implementation and operational approach.

Lessons Learned

1 Follow the lead of each Indigenous community and/or partner organization to ensure appropriate protocol and cultural practices are honoured.

All Indigenous communities and/or partner organizations shared with us the importance of Elder protocol. When an Elder is present in Indigenous work, a tobacco offering is made along with the request to open a meeting. Agenda items are presented to the Elder with the knowledge that their guidance will get the group to where they need to be, regardless of whether the agenda items are discussed or not. Once this request is made and tobacco is accepted, the Elder will offer their presence and may share teachings they carry to support or guide meeting outcomes. This lead must be followed out of respect and recognition of the wisdom Elders hold in their community.

Beyond engaging with Elders, each Indigenous community and/or partner organization may have different protocols and expectations that will guide the ways of working and communicating with external organizations. While a signed contract is the norm for western practices, some Indigenous communities and/or partner organizations may want to signify the start of the work by holding a pipe ceremony. For example, some Indigenous communities and/or partner organizations pray and smudge at the start of each meeting while others do not. Indigenous communities and/or partner organizations may also use a mix of western and Indigenous practices such as an agenda and sharing circles. The interactions PolicyWise had with each Indigenous community and/or partner organization were different and we learned quickly not to assume that a protocol followed in one meeting would happen at the next because the context could be different. This meant that PolicyWise checked in with primary contacts from each Indigenous community and/or partner organization regularly when developing support activities and followed their lead.

In-person Learning Network events such as Sharing Days open with prayer and smudge by an Elder. These practices are optional to participate in to demonstrate respect for the culture differences among Indigenous communities and/or partner organizations.

Lessons Learned

2 Build meaningful relationships by getting to know each other.

Relationships take time to build. As an organization external to the Indigenous community and/or partner organization, do not assume that you will be trusted. PolicyWise needed to slow the implementation process down to allow for building relationship. This was best accomplished by meeting in-person with the primary project contact over coffee or lunch to learn about each other's backgrounds, extending the professional relationship into a more personal one. Building rapport with a primary contact from each Indigenous community and/or partner organization resulted in an extension of trust within the community as PolicyWise could then be vouched for.

When building the relationship with Indigenous community and/or partner organization, it is important to take introductions beyond the typical statement about your profession. Begin by stating where you are from, where you grew up, who your parents and even grandparents are, and acknowledge your role as a settler if you are one. If possible, learn a greeting in their Indigenous language and ask for help with pronunciation. At each subsequent gathering, spend time talking without an agenda. These are often where the greatest moments of understanding will be revealed to create shared understanding. During the process mistakes will be made but by expressing humility, acknowledging what we do not know, and making the best effort to do what is right, mutual trust will form.

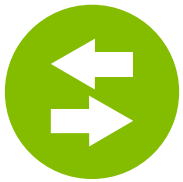
Implementation coaches are supported to do as much in-person work with Indigenous communities and/or partner organizations as possible, especially when initially beginning the work. There are no timelines imposed for any of the implementation phases to allow time for meaningful relationship building.

Lessons Learned

3 Acknowledge the historical intergenerational trauma of residential schools and systemic barriers in order to begin reconciliation through collaborative dialogue.

Implementation of integrated service delivery hubs is complex and this complexity is compounded in Indigenous communities and/or partner organizations by the intergenerational historical trauma of residential schools and systemic barriers. While communities are expected to knit together existing services, many Indigenous communities and/or partner organizations do not have sufficient funding for services to begin with. These inequities were often shared with PolicyWise through the safe spaces of talking circles during in-person sharing days.

Hosting regular, in-person sharing days was a large benefit to bring each Indigenous community and/or partner organization closer together as well as closer with PolicyWise. Talking circles created a safe space for everyone to discuss historical trauma and systemic barriers and begin thinking about ways to move forward with implementation of integrated service delivery hubs as an act of reconciliation. It is the responsibility of non-Indigenous stakeholders to become better allies and advocates through self-directed education. PolicyWise staff did this through familiarization with United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), Truth and Reconciliation Commission documents, and seeking out Indigenous-designed learning opportunities such as the University of Alberta's Indigenous Canada massive open online course (MOOC).



Indigenous sharing days are part of the Learning Network to provide a format for collaborative dialogue and deeper understanding of historical traumas that shape current realities. To protect against perpetuating barriers, the Evaluation Framework is adaptable to Indigenous methods of data collection and follows the principles of Ownership, Control, Access, and Possession (OCAP) to ensure raw and analyzed data are shared in full with Indigenous communities and/or partner organizations.

Lessons Learned

4 Support the involvement of a cultural resource person to bridge Indigenous and western practices.

It is important to find someone with Indigenous background who can lend support to the project. This person may be an Elder, cultural resource person, or knowledge keeper. Elder Sharon Pasula was recommended to PolicyWise for her ability to develop meaningful relationships through finding parallels that bridge Indigenous and western practices. This looked like adapting in person activities to use methods like sharing circles and working through how to respectfully adapt a sharing circle to allow for open discussion. A cultural resource person observes, offers guidance, insights, and suggestions to improve relationships and ways of working. It is understood that there is a spiritual component to all of the work. While PolicyWise worked under the best of intentions, we made mistakes along the way and were given genuine feedback from our cultural resource person that we responded to seriously. As an external organization, it was our responsibility to be accountable and work towards decolonizing practices in our role of facilitator and of learner.

Beyond bridging Indigenous and western practices, cultural resource persons help to build relationships within and across Indigenous communities. When working to find common ways of working across Indigenous communities and all integrated service delivery hub communities in Alberta, the purpose of a cultural resource person is significant. Elder Sharon helped to acknowledge individual practices among nations and sought to create an environment of acknowledging Creator at all times.

Implementation coaches and Indigenous communities and/or partner organizations are supported in building relationship through consultation with a cultural resource person. Recommendations are made in the collaborative governance structure to include the cultural and spiritual guidance of Elders for oversight of ongoing provincial implementation and operation of integrated service delivery hubs in Alberta.

Lessons Learned

5 Recognize that Indigenous people are always connected to their nation, regardless of where they reside.

While many integrated service delivery hubs are place-based, those that are Indigenous-led will serve an extended outreach focus to ensure supports for their people regardless of where they are located. This was not something that PolicyWise was aware of prior to beginning the project as eligible communities and/or land base areas were initially defined though parameters of small to medium population centres. For example, an Indigenous community may only have 500 people living on reserve, but their membership may actually put them in the category of a small population centre with over 1,000 people.

Whether a youth is urban or on reserve, they are always part of their nation and have rights to service access that fits their cultural and spiritual needs. This has implications for accessibility which must take into account the need for provincial level promotion of all integrated service delivery hubs through a common website and service directories so that communities who serve Indigenous youth are aware of cultural and spiritual supports through Indigenous-led integrated service delivery hubs.

The Implementation Framework emphasizes a variety of delivery modalities for integrated service delivery hubs which do not need to be place-based and can extend service reach through network, pop-up event, or mobile supports.

Lessons Learned

6 Understand that Indigenous youth are nested in circles of holistic support based on kinship practices.

In working with Indigenous communities and/or partner organizations, many expressed that the initial integrated service delivery hub age parameters of 11-24 did not fit with their care practices. Indigenous care is holistic and involves complex kinship networks that extend throughout the whole community. Western concepts of mental health do not always fit with this understanding. Many of the Indigenous language words used to describe kinship and care practices also do not adequately translate into English. This can result in tensions when trying to reach shared understanding of how to support Indigenous youth who live between traditional and western worlds.

The involvement of youth within Indigenous communities and/or partner organizations right from the start has provided clarity on this tension. Youth have made it clear that the inclusion of Elders and family support is crucial to their well-being as well as to the health of the community. Youth want greater family connection and awareness of mental health concerns, and this requires supporting family members across a spectrum of ages.

The 11-24 age parameter is not included as a required component of integrated service delivery hubs to reflect that it may be an arbitrary distinction in Indigenous communities and/or partner organizations. The language used in the Implementation Framework became less clinical and better represents holistic approaches to prevention and early intervention to support broader concepts of mental wellness.

Going Forward

We recognized through our collaborative work with Indigenous communities and/or partner organizations that intergenerational trauma, entrenched racism, systemic barriers, and local history have an impact on the implementation of integrated service delivery hubs. Each Indigenous community and/or partner organization takes a different approach to implementation of integrated service delivery hubs that works well within their context and continues to adapt their approaches accordingly. Throughout the project, PolicyWise has witnessed a tremendous amount of effort by all communities and/or partner organizations across the province to embrace integrated service delivery hubs while maintaining local and cultural context.

These lessons emerged through hundreds of hours of communication with Elders, youth and Indigenous partners over the course of one year. As integrated service delivery hubs continue to evolve, more lessons will be learned based on continued co-development of implementation and operational practices.

PolicyWise is honoured to have built meaningful relationships with the Indigenous communities and/or partner organizations throughout the integrated service delivery hub project. We have learned much from our Indigenous partners and hope to impart what we have taken away from the experience for continued implementation of integrated service delivery hubs that is Indigenous-led and provincially supported.

Primary Contributors

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Project Sponsor

Alberta Health, Addiction and Mental Health Branch

Suggested Citation

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Sharing Guidelines

It is the hope of all those who contributed to this project that these findings are shared and used to benefit others and inform policy and practice to improve relationships between Indigenous communities and/or partner organizations as well as stakeholders involved in integrated service delivery hubs in Alberta. All third party and general public communications relating to this journey map or Indigenous-led integrated service delivery hubs requires pre-approval from respective participants via PolicyWise for Children & Families.

Honouring Our Strengths:

A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada

THE NATIONAL NATIVE ADDICTIONS PARTNERSHIP FOUNDATION Inc.

Health Canada Santé Canada

Description of the Cover

The tipi is one cultural structure among many that holds our sacred knowledge and cultural Indigenous evidence base. It is a structure with meaning, which by its design, holds teachings about living life and reflects the values that guide the implementation and interpretation of this renewal framework and its elements. *Honouring Our Strengths*, like the tipi, communicates a comprehensive circle of elements, with a strong cultural base that requires partnerships, programs, services, and infrastructure to come together to support stronger connections to family and community. It also recognizes that collaboration amongst partners is necessary to address social determinants of health and the environment around and within our communities. These strengths and the sense of shared identity will help to ensure that we move forward and yet stand strong as we embrace change for the future.

Table of Contents

EXECUTIVE SUMMARY 1

INTRODUCTION 4

GUIDING PRINCIPLES 7

ENVIRONMENT 8

WHO IS AFFECTED? 10

OTHER CONSIDERATIONS 13

OVERVIEW OF THE SYSTEMS APPROACH 15

ELEMENTS OF CARE 18

- ELEMENT 1—COMMUNITY DEVELOPMENT, UNIVERSAL PREVENTION, AND HEALTH PROMOTION 20
- ELEMENT 2—EARLY IDENTIFICATION, BRIEF INTERVENTION AND AFTERCARE 30
- ELEMENT 3—SECONDARY RISK REDUCTION 36
- ELEMENT 4—ACTIVE TREATMENT 42
- ELEMENT 5—SPECIALIZED TREATMENT 54
- ELEMENT 6—CARE FACILITATION 60

SUPPORTING THE CONTINUUM OF CARE 64

- WORKFORCE DEVELOPMENT 66
- GOVERNANCE AND COORDINATION OF SYSTEMS 72
- ADDRESSING MENTAL HEALTH NEEDS 76
- PERFORMANCE MEASUREMENT AND RESEARCH 82
- PHARMACOLOGICAL APPROACHES 88
- ACCREDITATION 92

MOVING FORWARD 97

ENDNOTES 99

APPENDIX A – FIRST NATIONS ADDICTIONS ADVISORY PANEL 100

Executive Summary

First Nations people face major challenges such as high unemployment, poverty, poor access to education, poor housing, remote location from health services, the displacement of Indigenous language and culture, and social and economic marginalization; all of which continue to impact their health and well-being. In this context, substance use issues and associated mental health issues continue to be some of the more visible and dramatic symptoms of these underlying challenges. The use and abuse of substances has been consistently noted as a top priority by First Nations people and leadership. In fact, a national survey of First Nations communities (completed between 2008–2010) reported that alcohol and drug use and abuse was considered to be the number one challenge for community wellness faced by on-reserve communities (82.6% of respondents), followed by housing (70.7%) and employment (65.9%).[1]

The primary network in place to respond to First Nations substance use issues is the National Native Alcohol and Drug Abuse Program (NNADAP). NNADAP was one of the first programs developed in response to community needs. It evolved from the National Native Alcohol Abuse Program (a pilot project in 1974) to a Cabinet-approved program in 1982. This network of on-reserve addiction services has since evolved into 49 NNADAP alcohol and drug abuse treatment centres, more than 550 NNADAP community-based prevention programs, and since 1995, a network of National Youth Solvent Abuse Program (NYSAP) residential treatment centres which now includes 9 centres across Canada.[2] In the North, NNADAP funding is transferred to the Governments of Northwest Territories and Nunavut under the 1988 Northwest Territories Health Transfer Agreement and through the creation of Nunavut in 1999. Yukon First Nations receive funding for the prevention and treatment components of NNADAP, some through contribution agreements and some through their authority as self-governing First Nations. Northern First Nations and Inuit either attend an alcohol and drug treatment centre operated by the respective territorial government or are transported to the closest appropriate treatment centre South of 60, as per Non-Insured Health Benefits Program (NIHB) policy. In addition to NNADAP/NYSAP, First Nations also access substance use and mental health-related services from other sectors throughout the health care system both on- and off-reserve, as well as various other systems and sectors, including social services, child welfare, justice, housing, education, and employment.

These various systems of care are faced with increasingly complex needs: new drugs; more people reporting associated mental health issues; a rapidly growing First Nations youth population;[3] and growing prescription drug abuse concerns in some regions and communities. These factors have dramatically changed the landscape upon which systems were designed. With diverse systems and increasingly complex needs, a challenge for communities, regions, and all levels of government is to coordinate a broad range of services and supports to ensure First Nations have access to a comprehensive client-centred continuum of care.

In response to this need, in 2007, the Assembly of First Nations (AFN), the National Native Addiction Partnership Foundation (NNAPF), and the First Nations and Inuit Health Branch (FNIHB) of Health Canada oversaw a comprehensive, community-driven review of substance use-related services and supports for First Nations people in Canada. This review was led nationally by the First Nations Addictions Advisory Panel (see Appendix A for a list of Advisory Panel members), which was responsible for both guiding the process and developing a national framework. The review was also informed by the First Nations and Inuit Mental Wellness Advisory Committee's *Strategic Action Plan for First Nations and Inuit Mental Wellness*, which was developed in 2007 to provide national strategic advice on efforts related to First Nations and Inuit wellness. From 2007 to 2011, the review included a wide range of knowledge-gathering and consensus-building activities, including regional addiction needs assessments; a national forum; a series of research papers; regional workshops; and an Indigenous knowledge forum. These activities directly engaged community members, treatment centre workers, community-based addiction workers, health

administrators, First Nations leadership, Elders, provincial service providers, researchers, and policy makers to develop and shape a renewed approach for community, regional, and national responses to substance use issues among First Nations people in Canada. *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* was developed based on this process of engagement and feedback.

Honouring Our Strengths outlines a continuum of care in order to support strengthened community, regional, and national responses to substance use issues. It provides direction and identifies opportunities to ensure that individuals, families, and communities have access to appropriate, culturally-relevant services and supports based on their needs at any point in their healing process. This vision is intended to guide the delivery, design, and coordination of services at all levels of the program. This approach recognizes that responsibility for a strengthened system of care includes individual responsibility for managing one's own health, communal responsibility among First Nations people, and a system-wide responsibility that rests with individuals, organizations, government departments, and other partners. The focus of the framework is on addressing substance use issues; however, it also considers the important roles mental health and well-being play in all aspects of care, including prevention, early identification, intervention, and follow-up. In addition, it recognizes that community development and capacity building are central to more self-determined substance use and mental health services and supports.

The continuum of care outlined in this framework consists of six key elements of care. These six elements respond to the needs of individuals, families, and communities with a wide range of substance use issues. They are also designed to meet population needs throughout the life-span and across unique groups (e.g., women, youth, and those affected by mental health issues). These elements are as follows:

- **Element 1:** Community Development, Universal Prevention, and Health Promotion: Element 1 includes broad efforts that draw upon social and cultural systems and networks of support for people, families, and communities. These supports, including formal and informal community development, prevention, and health promotion measures, provide the basis for a healthy population and are accessible to the broader community.
- **Element 2:** Early Identification, Brief Intervention, and Aftercare: Element 2 is intended to respond to the needs of people with at least moderate levels of risk with respect to a substance use issue. Services and supports in this element help to identify, intervene, and support those in need of care with the goal of intervening before substance use issues become more severe. These services may also provide ongoing support to those who have completed more intensive services (such as active or specialized treatment).
- **Element 3:** Secondary Risk Reduction: Element 3 seeks to engage people and communities at high risk of harm due to substance use issues and who may not be receiving support (e.g., Personal: physical injuries, becoming a victim of sexual assault/abuse, domestic abuse, car accidents, suicide, and HIV and/or Hepatitis C infections; or Community: crime, lost productivity, increased needs with unmatched resources for health, child welfare, and enforcement). These services and supports seek to reduce the risk to individuals and communities through targeted activities that engage people at risk and connect them with care that is appropriate for their needs.
- **Elements 4:** Active Treatment: Element 4 is focused on people with substance use issues that are moderate to severe in their complexity. This element involves more intensive services than those found in the previous element, and may include a range of supports (e.g., withdrawal management, pre-treatment, treatment programming, aftercare, and case management) provided by various service providers. These can be community-based or they may be part of outpatient programs. Having an aftercare stage or a second phase of care that provides active support and structure makes it easier for clients to slowly return to the community for longer-term recovery work.
- **Element 5:** Specialized Treatment: In contrast to Element 4, Element 5 provides active treatment for people whose substance use issues are highly complex or severe. People who require care in this element often have highly acute and/or complex substance use issues, diagnosed mental health disorders, mental

illness, and other conditions like as Fetal Alcohol Spectrum Disorder (FASD). Specialized services usually required can include medically-based detoxification and psychiatric services, as well as culturally-based interventions.

- **Element 6:** Care Facilitation: Element 6 involves active and planned support for clients and families to find services in the right element, transition from one element to another, and connect with a broad range of services and supports to meet their health and social needs (e.g., cultural supports, housing, job training, jobs, education, and parenting skills). Whether through formal case management or other forms of community-based or professional support, care facilitation involves efforts to stay connected with clients, especially when various service components are not well integrated.

Six key supports to the continuum of care have also been identified in the framework. These include: workforce development; governance and coordination of and within the system; addressing mental health needs; performance measurement and research; pharmacological approaches; and accreditation.

While the framework is first intended to influence change in the current NNADAP and NYSAP programs, it is also an evidence-based framework to guide the design, delivery, and evaluation of substance use and mental health programs that serve First Nations populations in other jurisdictions. These include provinces, territories, First Nations self governments, and transferred health programs within First Nations communities. This framework benefits from extensive engagement with First Nations people across Canada through the

FIGURE 1: ELEMENTS OF CARE

ELEMENT OF CARE	ELEMENT 1 Community Development, Universal Prevention, and Health Promotion	ELEMENT 2 Early Identification, Brief Intervention, and Aftercare	ELEMENT 3 Secondary Risk Reduction	ELEMENT 4 Active Treatment	ELEMENT 5 Specialized Treatment
POPULATION SERVED	Everyone	People at moderate risk	People at high risk	People with moderate issues	People with severe issues
SERVICE & SUPPORT COMPONENTS	Community Development Universal Prevention Health Promotion	Early Identification Brief Intervention Referral & Case Management Risk Assessment & Pre-Treatment Support Aftercare	Community-based Supports Outreach Risk Assessment & Management Screening, Assessment, Referral & Case Management	Screening, Assessment & Referral Withdrawal Management & Stabilization Treatment Planning & Pre-Treatment Care Case Management Specialized Treatment Programming Discharge Planning & Aftercare	Coordination of Care Cultural Competency Community-Level Capacity & Support
ELEMENT 6: Care Facilitation					

networks of the three partners to this process: the AFN health technicians and First Nations political system; the NNAPF networks of NNADAP and NYSAP workers; and the Health Canada First Nations and Inuit Health Regional Program Advisors.

Honouring Our Strengths has the benefit of a team tasked with guiding, advocating, and supporting its implementation. The NNADAP Renewal Leadership Team is a national committee with broad, cross-Canada representation from areas such as prevention, treatment, culture, youth, policy, health, nursing, public health, and research who will guide the implementation of the framework's renewal opportunities. Facilitating and influencing change, where change is possible, is critical to maintaining the momentum that has been generated through the regional needs assessments and in the development of this framework.

Introduction

>> PROCESS OF RENEWAL

Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada outlines a comprehensive continuum of services and supports, inclusive of multiple jurisdictions and partners, to strengthen community, regional, and national responses to substance use and associated mental health issues among First Nations people in Canada.

There is currently a range of federally-funded mental health and addictions programs in place for First Nations and Inuit communities that are aimed at improving their physical, social, emotional, and spiritual well-being. These programs include: Building Healthy Communities; Brighter Futures; NNADAP—Residential Treatment; NNADAP—Community-based Services, and NYSAP. Other programs that were not included in the process of renewal are the Indian Residential Schools Resolution Health Support Program (IRS-RHSP); and the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS). These programs vary in their scope, application, and availability, but generally provide community-based services to First Nations people living on-reserve and Inuit living in the North.

First Nations substance abuse prevention and treatment services have continued to evolve throughout their history. In the beginning, NNADAP services were largely based on the Alcoholics Anonymous model, with the main difference being the infusion of First Nations cultures. Over time, many treatment centres have moved toward the use of other therapeutic interventions, such as cognitive behavioural approaches, while also strengthening their culturally-specific interventions and incorporating more mental health-focused services. In addition, since the NNADAP network was further expanded in 1995 to include NYSAP treatment centres, communities have had access to a range of highly innovative and effective treatment programming for First Nations youth.

NNADAP and NYSAP's many successes over the years can be largely attributed to First Nations ownership of the services, as well as the creativity, dedication, motivation, and innovation of NNADAP workers. NNADAP centres and workers have continued to show their commitment to strengthening the program by pursuing accreditation and certification, respectively. Through the creation of community NNADAP worker positions, NNADAP has contributed to the development of local leadership. In addition, many former NNADAP workers have gone on to pursue post secondary education and have moved into high level positions within the community, as well as taking on roles in the public and private sectors. The *NNADAP Storybook: Celebrating 25 Years* also demonstrates the significant impact NNADAP has had within First Nation communities.

NNADAP has been reviewed several times during its long history. Most recently, the *1998 NNADAP General Review* generated 37 recommendations, including the need for communities, regions, and all levels of government to better coordinate services and supports to meet the needs of First Nations communities. Since 1998, some of these recommendations have been addressed, while others are

informing current renewal efforts. Since the review, the urgency and complexity of issues facing communities have increased. Prescription drug abuse has emerged as a major issue in many communities, and the recognition of the unique treatment needs of certain populations (e.g., youth, women, and people with mental health issues), has also become more defined. Likewise, the number of people who specifically identify their trauma and associated substance use issues as being linked to Indian Residential Schools and child welfare experience has also increased. There is broad recognition of the need for strong health promotion, prevention, early identification and intervention services within the context of community development for the rapidly growing First Nations youth population.

Based on these and other emerging needs, the process of renewal developed as a result of a partnership between the AFN, NNAPF, and Health Canada. It has been led nationally by the First Nations Addictions Advisory Panel, which included addictions researchers, health professionals, Elders, and First Nations community representatives, who both guided the process and were tasked with developing this national framework. Significant guidance and support has also been received from regional networks including AFN Regional Health Technician Network, NNAPF regional networks, and Health Canada First Nations and Inuit Health Regions and their partners. Renewal officially began in 2007 and has involved a wide range of activities aimed at informing a strengthened systems approach to community, regional, and national service delivery. These activities have included regional addiction needs assessments; a national forum to identify key renewal directions; a series of research papers; and an Indigenous knowledge forum. Activities have involved community stakeholders and those most directly involved in providing services to clients at a local level.

Announced in 2007, the National Anti-Drug Strategy (NADS) represents the most significant investment in NNADAP since its creation in the 1980s. Under the NADS, the Government of Canada committed $30.5 million over five years, and $9.1 million ongoing, to improve the quality, accessibility, and effectiveness of addiction services for First Nations and Inuit. Funding provided by the NADS is supporting the development, enhancement, renewal, and validation of on-reserve addiction services, including NNADAP and NYSAP. NADS funding has provided an opportunity to support services in targeted areas to better respond to the current and emerging needs of First Nations individuals, families and communities.

More information on the renewal process, including the regional needs assessments, research papers, and NNADAP Renewal National Forum, is available on the NNADAP renewal website—http://www.nnadaprenewal.ca

>> PARALLEL INITIATIVES

Within Canada, mental health and addiction issues have gained considerable attention in recent years. Consequently, there are a number of parallel initiatives that have provided direction and support to the NNADAP Renewal Process. The ongoing implementation of *Honouring our Strengths* will benefit from co-ordinating with, and building upon, these parallel initiatives. These include but are not limited to:

The National Anti-Drug Strategy (2007):

The NADS encompasses prevention, treatment, and enforcement. In 2007, the Government of Canada committed $30.5 million over five years, and $9.1 million ongoing, under the Treatment Action Plan of NADS to enhance addiction services for First Nations and Inuit populations. The NADS investment provided the opportunity for renewal, as well as support for ongoing implementation efforts.

First Nations and Inuit Mental Wellness Advisory Committee's (MWAC) Strategic Action Plan (2007):

This action plan was developed by a national committee established to provide advice to Health Canada on issues relating to First Nations and Inuit mental wellness, including mental health, mental illness, suicide prevention, Indian Residential Schools, and substance use issues. MWAC's Strategic Action Plan advocates a holistic approach, recommending that individual and community efforts towards health and wellness should take into account the inter-relationship of mental, physical and social well-being. The NNADAP Renewal Process has been informed by, and is consistent with, this approach.

The National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada (2005):
This framework was developed following two years of Canada-wide consultations spearheaded by Health Canada, its federal partners—Public Safety and Emergency Preparedness Canada, and the Department of Justice Canada—and the Canadian Centre on Substance Abuse. It emphasizes that a range of approaches are necessary to address substance use issues, and identifies 13 priorities for action, including alcohol, treatment, youth, First Nations and Inuit, workforce development, Fetal Alcohol Spectrum Disorder, and offender-related issues.

Key Concepts

Three terms found throughout this report are defined here; however these definitions may not capture all realities for all people.

1) Substance Use Issues

"Substance use issues" is used to describe a broad range of issues and concerns related to, and resulting from, substance use. This includes problematic use (e.g., substance abuse and potentially harmful use, such as impaired driving, using a substance while pregnant, or heavy episodic/binge drinking) and substance addiction or dependence (e.g., substance use disorders, as defined by diagnostic classification systems, such as the DSM–IV). These issues are typically experienced by individuals, families, and communities alike, and their impact may be physical, psychological, emotional, behavioural, social, spiritual, familial, or legal in nature.

2) Services and Supports

"Services and supports" is used to convey a broad range of interventions or responses—provided by NNADAP/NYSAP, Elders, cultural practitioners, health care, public health, social service, justice or other sectors or providers—to address substance use issues or to reduce their associated risks. These interventions or responses include proactive responses to care provided from various systems, such as prevention, health promotion, intervention services, and aftercare, and also extends to a wide range of support functions and resources. It recognizes that both formal services and individual, family, community, and other cultural supports are often critical to supporting individuals throughout their healing journey. A fundamental challenge for any system of care is to integrate this broad range of interventions or responses.

3) Determinants of Health

"Determinants of health" are factors both connected to, and affecting health, which often fall outside the realm of health programming. They are sometimes described as the "root causes" of poor health, that include general social and economic factors, such as income, education, employment, living conditions, social support, and access to health services. Understanding the impact and relationship between these factors supports a more holistic view of health. However, in addition to social and economic factors, First Nations health is widely understood to also be affected by a range of historical and culturally-specific factors. These additional factors are sometimes referred to as First Nations or Aboriginal-specific determinants of health and include loss of language and connection to the land; residential school abuses; systemic racism; environmental destruction; and cultural, spiritual, emotional, and mental disconnectedness.

A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy (NTS) (2007):

This approach is the product of a cross-Canada working group established to improve the quality, accessibility, and options available to address harmful substance use—which is one of 13 priority areas identified by the National Framework for Action. The NTS provides general principles and key concepts for building a comprehensive continuum of care, and focuses on addressing risks and harms related to substance use including an emphasis on community-based prevention and treatment initiatives. Engagement of families and a continuum of care responding to the needs of all individuals adversely affected by substance use problems are also featured.

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada (2009):

This document establishes the framework for Canada's first ever mental health strategy. The report was developed by the Mental Health Commission of Canada, and sets out seven goals for what a transformed mental health system should look like: one enabling all Canadians the opportunity to achieve the best possible mental health and well-being. The NNADAP Renewal Process has been informed by, and is consistent with, the principles of this approach. It may also help to inform the Mental Health Commission's ongoing strategic planning efforts.

Guiding Principles

A systems approach depends not only on ensuring the system contains all the right "parts", but must be guided by a set of overall principles informed by the cultural realities of First Nations people. The following principles were established based on the guidance of cultural practitioners and Elders at the NNADAP Renewal Indigenous Knowledge Forum, and based on a series of regional confirmation workshops for the framework:

- **Spirit-Centred**—Culture is understood as the outward expression of spirit and revitalization of spirit is central to promoting health and well-being among First Nations people. System-wide recognition that ceremony, language and traditions are important in helping to focus on strengths and reconnecting people with themselves, the past, family, community and land.
- **Connected**—Strong connections are the basis for holistic and integrated services and supports. Healthy family, community, and systems are built on strong and lasting relationships. These connections exist between Indigenous people, the land, and their culture, as well as relationships between various sectors and jurisdictions responsible for care delivery.
- **Resiliency-focused**—While trauma contributes substantially to both addictions and mental health, there is a need to recognize, support, and foster the natural strength and resilience of individuals, families, and communities. These strengths provide the foundation upon which healthy services, supports, and policies are built.
- **Holistic Supports**—Services and supports that are holistic consider all potential factors contributing to well-being (e.g., physical, spiritual, mental, cultural, emotional, and social) over the lifespan, and seek to achieve balance within and across these areas. This involves recognition that individual well-being is strongly connected to family and community wellness; and that a comprehensive, integrated continuum of care is necessary to meet the needs of First Nations people.
- **Community-focused**—Community is viewed as its own best resource with respect to the direction, design, and delivery of services. Adopting a community-focused lens will help to both ensure that diversity within and across communities is respected, and enhance overall system responsiveness to factors that make each community unique.
- **Respectful**—Respect for clients, family, and community should be demonstrated through consistent engagement, at all levels, in the planning and delivery of services. This engagement must also

uphold an individual's freedom of choice to access care when they are ready to do so, as well as seek to balance their needs and strengths with the needs of their families and communities.

- **Balanced**—Inclusion of both Indigenous and Western forms of evidence and approaches to all aspects of care (e.g., service delivery, administration, planning and evaluation) demonstrates respect and balance. It is also important to maintain awareness that each is informed by unique assumptions about health and well-being and unique worldviews.
- **Shared Responsibility**—Recognition of the individual, shared, and collective levels of responsibility to promote health and well-being among First Nations people. This begins with individuals managing their own health and extends to families, communities, service providers, and governments who all have a shared responsibility to ensure services, supports, and systems are effective and accessible, both now and for future generations.
- **Culturally Competent**—Cultural competence requires that service providers, both on- and off-reserve, are aware of their own worldviews and attitudes towards cultural differences; and include both knowledge of, and openness to, the cultural realities and environments of the clients they serve. To achieve this, it is also necessary for indigenous knowledge to be translated into current realities to meaningfully inform and guide direction and delivery of health services and supports on an ongoing basis.
- **Culturally Safe**—Cultural safety extends beyond cultural awareness and sensitivity within services and includes reflecting upon cultural, historical, and structural differences and power relationships within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to First Nations people.

Environment

As of 2011, there are 630 First Nations communities in Canada. These communities vary considerably and range from larger reserves located close to major urban centres, to very small and remote reserves. Some of these communities are self-governing and exercise control over their health programs; are economically well off; enjoy general good health and high levels of participation in education and community life; and are continuing to pass on their cultural knowledge, language, and traditions to the next generation. However, many communities face major challenges, such as high unemployment, poverty, low levels of education, poor housing, and considerable distances from health and social services.

Substance use issues, including heavy drinking, drug use, and related harms (e.g., violence, injuries, and family disruptions) are consistently identified as priority health concerns by First Nations. Results from the 2008–10 First Nations Regional Longitudinal Health Survey indicated that respondents believed that alcohol and drug use and abuse was the number one challenge to community wellness faced by on-reserve communities (82.6% of respondents), followed by housing (70.7%) and employment (65.9%).[4]

For some First Nations, the use and abuse of substances offers a means of coping with, and providing a temporary escape from, difficult life circumstances and ongoing stressors. Many of these challenges are rooted in the history of colonization which has included: criminalization of culture and language; rapid cultural change; creation of the reserve system; the change from an active to a sedentary lifestyle; systemic racism; and forced assimilation through residential schools and child-welfare policies. These experiences have affected the health and well-being of communities, and have contributed to lower social and economic status, poorer nutrition, violence, crowded living conditions, and high rates of substance use issues. Regardless of their social, economic and/or geographic status, these issues and their historical contexts must be understood as ones faced by First Nations communities.

Several generations of First Nations children were sent to residential schools. Many of the approximately 80,000 former

students alive today are coping with disconnection from traditional languages, practices, and cultural teachings. Others suffer from the after-effects of trauma stemming from physical, sexual, and emotional abuse endured as children in residential schools or through the child welfare system that also removed First Nations children from their families and communities. Because they were removed from daily contact with their parents/family, community, and traditional lands at a young age; many lack a connection to a cultural identity and the parenting/family skills that would have allowed them to form healthy attachments with their own children.

Taking into account the legacy of colonization, a process of decolonization has emerged as a priority for First Nations communities and leadership. Decolonization refers to a process where First Nations people reclaim their traditional culture, redefine themselves as a people, and reassert their distinct identity. It has involved grieving and healing over the losses suffered through colonization; the renewal of cultural practices and improved access to mental wellness resources; and First Nations leaders and communities calling for healing, family restoration, and strengthened communities of care. There have also been calls for a parallel process of raising a consciousness within Canadian society so that stigma and discrimination against First Nations people can be eliminated, both on the personal and the structural levels of society. These efforts to provide effective healing programming and to reclaim cultural identity are recognized as keys to revitalizing communities and reducing the extent of alcohol and substance abuse.

Many First Nations communities aspire to achieve wellness, which is a holistic view of health that promotes balance between the mental, physical, emotional, and spiritual aspects of life. This view of health, sometimes referred to as mental wellness, includes a secure sense of self, personal dignity, cultural identity, and a feeling of being connected. Many First Nations people have reported little success with, and may in fact avoid, services that do not value their way of knowing, particularly with respect to health and wellness.

Likewise, there is a common view that culture is vital for healing, although how culture is defined and practiced varies across communities. Culture is intimately connected to community wellness and is often described as a way of being, knowing, perceiving, behaving, and living in the world. It is recognized as being dynamic because the beliefs, values, customs, and traditions that are passed

on between generations continue to be relevant to current realities. Expression of culture may take on many different forms including: language; methods of hunting, fishing and gathering foods; arts and crafts; ways of relating to each other; knowledge that informs family, community, and governance structures; the gathering and use of traditional medicines; traditional diets; as well as spiritual journeying, drumming, dancing, singing, and healing ceremonies. Within these various expressions of culture, some First Nations people see culture as distinct from spirituality. However, for others, traditional Creation Stories of First Nations people in Canada set out the primary foundation for defining culture with an understanding that spirit is the central and primary energy, cause, and motivator of all life. It follows then that the use of cultural practices to address substance use issues, and the role of spirituality within these practices, must be determined by individuals, families, and communities themselves.

Who is Affected?

>> INFANTS AND CHILDREN

Through the regional needs assessments, many First Nations communities expressed significant concern over how many First Nations children are exposed to alcohol and drugs at an early age. A Quebec-based survey on substance use patterns among First Nations revealed that one-third of the people surveyed who had used inhalants started using them at the age of 10 or younger and 58% began using them when they were aged 11 to 15. Alcohol and marijuana were also used at an early age compared with amphetamines, cocaine, heroin, and prescription medications. The first use generally occurred (about 60%) in the 11 to 15 age group and slightly more than 20% said they first used alcohol at the age of 10 or younger.[5] In addition, the regional needs assessments indicated that, while data is limited, Fetal Alcohol Spectrum Disorder (FASD) continues to be a concern in some First Nations communities.

The role of early childhood development in future health is well known.[6] During the early years of life, children develop important attitudes and resiliency skills. Thus, it makes sense to provide children with the tools and support they will need to make healthy lifestyle choices. There is a range of ways to use prevention and health promotion to help reduce the chance that children will develop a future substance use or mental health issue. The focus will be on lowering risk factors (e.g., problems at school, abuse, family neglect, psychological disorders, low degree of bonding with parents, and lack of connection with traditional culture and life ways), while promoting protective factors (e.g., pride in cultural identity, speaking a traditional language, school success, literacy skills, access to high school, recreational activities, and ties to a supportive adult or Elder). By dealing with these issues early in childhood, the risk of future problems will be lowered.[7]

>> YOUTH AND ADOLESCENTS

A high level of concern exists when it comes to youth. Aboriginal youth are the fastest growing population in Canada, with a projected annual birth rate growth that is nearly three times higher than non-Aboriginal Canadians. In 2006, the average age of Canada's Aboriginal population was 27 years, compared with 40 years for non-Aboriginal people, a gap of 13 years.[8] Between 2002–03, more than one in four (27.2%) First Nation youth reported sad, blue, or depressed feelings for two weeks in a row. This same study revealed that 21% of First Nations youths had thoughts of suicide, while 9.6% have attempted suicide.[9] According to the 2008–10 First Nations Regional Longitudinal Health Survey (RHS), 51.1% of First Nation youth (12–17) reported heavy drinking (five or more drinks on an occasion) at least once per month in the past 12 months, and 10.4 % of youth engaged in heavy drinking at a rate of at least once per week in this past 12 months.[10] Previous surveys have revealed that First Nations are more likely to both use all types of illegal drugs and to start using substances at a much younger age than non-Aboriginal Canadians. The highest risk group for both drinking and drug use among Aboriginal people is young males aged 18–29.[11]

There is a significant body of research that demonstrates the effectiveness of prevention, outreach, early identification and intervention services targeted at youth and adolescence as a cost-effective means for reducing substance use issues later on.[12] These approaches focus on lowering risk factors, while promoting protective factors. Because many services—especially mental health and addictions services—are not usually designed for youth, mental health and addiction health workers are seldom trained to specifically work with this population. In fact, youth are among the least-served segment of the population and rarely seek out formal mental health and addictions services that exist in their communities.

>> ADULTS

Among the First Nations adult population, alcohol is still the most common substance of abuse. Although abstinence from alcohol is common among First Nations, so is heavy drinking. The RHS 2002/2003 showed that almost three times as many First Nations adults reported heavy drinking on a weekly basis (16%) than did the general population (6.2%).[13, 14] The survey also found that 7.3% of the adults surveyed said they use illegal drugs, more than double the rate among mainstream Canadian adults. In addition, alcohol was a noted as a factor in 80% of suicide attempts and 60% of violent events.[15] While alcohol abuse among First Nations has been a concern for a long time, some communities are reporting increasing use of illegal and prescription drugs. Although the extent of prescription drug abuse is not well known, First Nations in some provinces have described it as a high priority issue, while others have said it is an emerging concern.

>> OLDER ADULTS/SENIORS

Older adults/seniors make up the smallest group of First Nations people, and are often one of the most under-served groups given that many services target the needs of younger adults. Although research data is very limited for this population, some regions have stated that more attention is required on this population, particularly with respect to alcohol and prescription drug abuse. This population may have a unique

set of risk factors for developing a substance use issue. For instance, older adults/seniors are significantly more likely to have direct experience with residential schools (as opposed to intergenerational) and to have lost a child due to removals through the respective child welfare system. The regional needs assessments revealed that many older adults still find talking about their residential school experience difficult. They also indicated that they did not easily recognize prescription drug abuse or gambling as problems.

>> FAMILIES

When children grow up in an environment where their cultural identity is oppressed and substances are abused frequently, they may come to see alcohol and other substance abuse as "normal" and therefore become more likely to repeat those behaviours in adulthood. A family environment characterized by intergenerational trauma, grief and loss will also be characterized by an erosion of cultural values visible through inadequate child rearing, disengagement from parental/family responsibilities, violence, abuse, and the problematic use of substances are all risk factors that contribute to alcohol and drug abuse. Parenting programs and other supports for families could help to address this need with a more holistic approach that would include child and parent well-being through the provision of family healing programs and traditional parenting programs for families and extended family members.

Families have a responsibility to provide children with an environment where they feel loved, nurtured, safe, and connected to their spirit, community, and culture. First Nations definition of family goes beyond the nuclear family and recognizes that children have a wide range of caregivers apart from parents (including older siblings, extended family, and clan family). For First Nations people, identity comes from family and, by extension, community and traditional land and clan systems. These supports and connections have the capacity to promote a secure sense of self pride in culture and fulfillment of cultural identity, and play a significant role in preventing or delaying the onset of substance use issues and mental health disorders.

>> GENDER

Many First Nations women's health issues are adversely affected by gender-based social status and roles imposed through colonization. First Nations women face high rates of family violence, single parenting, sexual harassment, inequality, sexual exploitation and poverty. The impacts of these issues contribute to their mental health and substance use issues and have a major impact on the lives of their children, families and communities.[16] Women also face unique barriers to accessing services and may be deterred from doing so due to stigma, discrimination, a fear of losing their children, or a lack of women-centred programs. Lack of childcare, housing, income support, and transportation are some of the more common barriers for women that need to inform service delivery and planning. In the past, many services were aimed mostly at the needs and realities of men. It is important that services and supports acknowledge the role of sex and gender, including the unique experiences of women with substance use and mental health issues, in service design and delivery. There is now a movement toward offering services that are women-specific, in consideration of past/current trauma and the barriers that many women seeking services face; or at the very least, services that are adapted to reflect the needs and realities of women.

While there is a need for women-centred services, it remains very important to continue to have programs that are designed and developed to address the needs of men of all ages. Men are also dealing with the impacts of poverty, violence, sexual abuse, and loss of culture and language, and require programming that supports them in addressing these underlying issues as part of their recovery. The stigma around various types of physical and sexual abuse can be just as significant for men as for women, making gender-specific programming critical for many individuals. As well, traditional cultural teachings may also play an important role in restoring gender defined strengths and purpose in family and community.

>> MENTAL HEALTH

Colonization and residential schools have contributed to First Nations experiencing mental health and substance use issues at much higher rates than the general population in Canada. In 2002–2003, 30% of First Nations people who

were surveyed said they had felt sad, blue, or depressed for two or more weeks in the past year.[17] Recent data also suggests that First Nations people are two times more likely to seek help for a mental health issue than other Canadians.[18] This number is likely to rise if more services become available in rural and remote communities. In 2005–2006, antidepressants were the number one type of therapeutic drug issued under Non-Insured Health Benefits Program (NIHB), at a cost of $17.5 million, while anti-anxiety medications ranked sixth, for a total of $5.5 million.[19] NIHB data also show that depression and anxiety are two of the more common mental health issues faced by First Nations.

The links between substance use and mental health issues are complex. It is generally known that someone with a mental health issue is more likely to use substances to self-medicate, just as a person with a substance use issue is more likely to have or develop a mental health issue. Likewise, it is generally recognized that people with co-occurring mental health conditions have poorer treatment outcomes; are at a higher risk for harm; and have the most unmet needs.

>> PEOPLE WITH UNIQUE NEEDS

Although anyone may be affected by substance use issues, the risk and course of these issues vary for different people. Services and supports must adapt or be targeted toward unique population needs to maximize their appropriateness and effectiveness. As well, some persons may also face additional risks and barriers. Examples of populations with unique service needs include, but are not limited to:

- two-spirited, gay, lesbian, bisexual, and transgendered people;
- people with disabilities;
- people with mental health issues;
- individuals living with HIV/AIDS or Hepatitis C;
- persons with cognitive impairments or acquired brain injuries;
- youth and adults who are FASD affected;
- marginalized individuals, such as those who are homeless; and
- persons in conflict with the law.

It is recognized that for these populations they may not be able to feel fully connected or engaged in community life. Due to this disconnect, they may not be the focus of prevention efforts, or have access to treatment services. In addition, they may experience distinct barriers that impact on their ability to access services; services may not be responsive to their unique needs; and their community may not be fully accepting or welcoming in supporting their recovery. In some cases, people belonging to these populations need to migrate to urban centres to obtain proper services or for the support and safety that may be lacking within their home community. A systems-wide goal to address the needs of all populations is required to remove barriers, combat stigma, and ensure proper services and full community participation.

Other Considerations

>> TOBACCO ABUSE

Tobacco-related illnesses and diseases are urgent issues in First Nations communities where smoking rates are more than double those for the rest of Canada. According to the 2008–10 First Nations Longitudinal Health Survey, 43% of First Nations adults are daily smokers, with an additional 13.7% self-identifying as occasional smokers.[20] In comparison, 17.1% of the larger Canadian population are daily smokers.[21] As well, over half of daily smokers are between the ages of 18–29,[22] and the majority of on-reserve First Nations people who smoke started between the ages of 13 and 16.[23]

Currently, stop smoking programs (tobacco cessation) within First Nations communities receive limited funding from various federal programs. Some funding support from provinces is also offered through community partnerships with provincial agencies. The focus of available community efforts have been on prevention, cessation, and education. Some communities have also chosen to promote smoke-free environments and have banned smoking in public spaces (e.g., health and social services offices, band offices and sometimes treatment centres). In addition, some treatment centres provide support for clients with tobacco cessation in addition

to overcoming other chemical addictions, although there is a common view within many other treatment centres that it is too much to expect from clients for them to abstain from everything all at once.

>> PROBLEM GAMBLING AND OTHER ADDICTIVE BEHAVIOURS

A process addiction can be defined as a process or activity that has become compulsive or destructive to a person's life. Process addictions differ from substance addictions because they are not a physical addiction in the way that alcohol or other substances can be. In contrast, process addictions involve a psychological addiction, which can still be very harmful and may require counselling, treatment, or other supports. There are a wide range of process addictions. The most common process addictions are sex addiction, compulsive gambling, internet addiction, shopping addiction, and compulsive eating.

For many Aboriginal communities, addictions to gambling are a growing concern across all age groups. Unfortunately, older adults seem to be more likely to get involved in problem gambling, often finding refuge from being lonely and isolated. During community focus groups, some people said that family members are often aware of problem gambling but feel helpless. Gambling can be seen as a way to fill a social void for many people because it provides a social outlet. As a result, many people are not keen to view gambling as a form of addiction. Gambling addictions are not usually part of current NNADAP programming. However, some treatment centres have chosen to provide specific programming for gambling addictions. Programming may include awareness, counselling, or support groups. Often these services are offered as an extra service rather than as part of the core program.

Overview of the Systems Approach

>>SUMMARY OF THE SYSTEMS APPROACH

This systems approach to addressing care is inclusive of the full range of services, supports, and partners who have a role in addressing substance use issues among First Nations people. This includes First Nations community-based services and supports (such as NNADAP, community cultural supports, and social support networks) but also other related partners and jurisdictions (e.g., housing, education, employment, and federal correctional services). It is recognized that no single sector or jurisdiction can support individuals and their families alone. A systems approach provides a framework through which all services, supports, and partners can enhance the overall coordination of responses to the full array of risks and harms associated with substance use among First Nations.

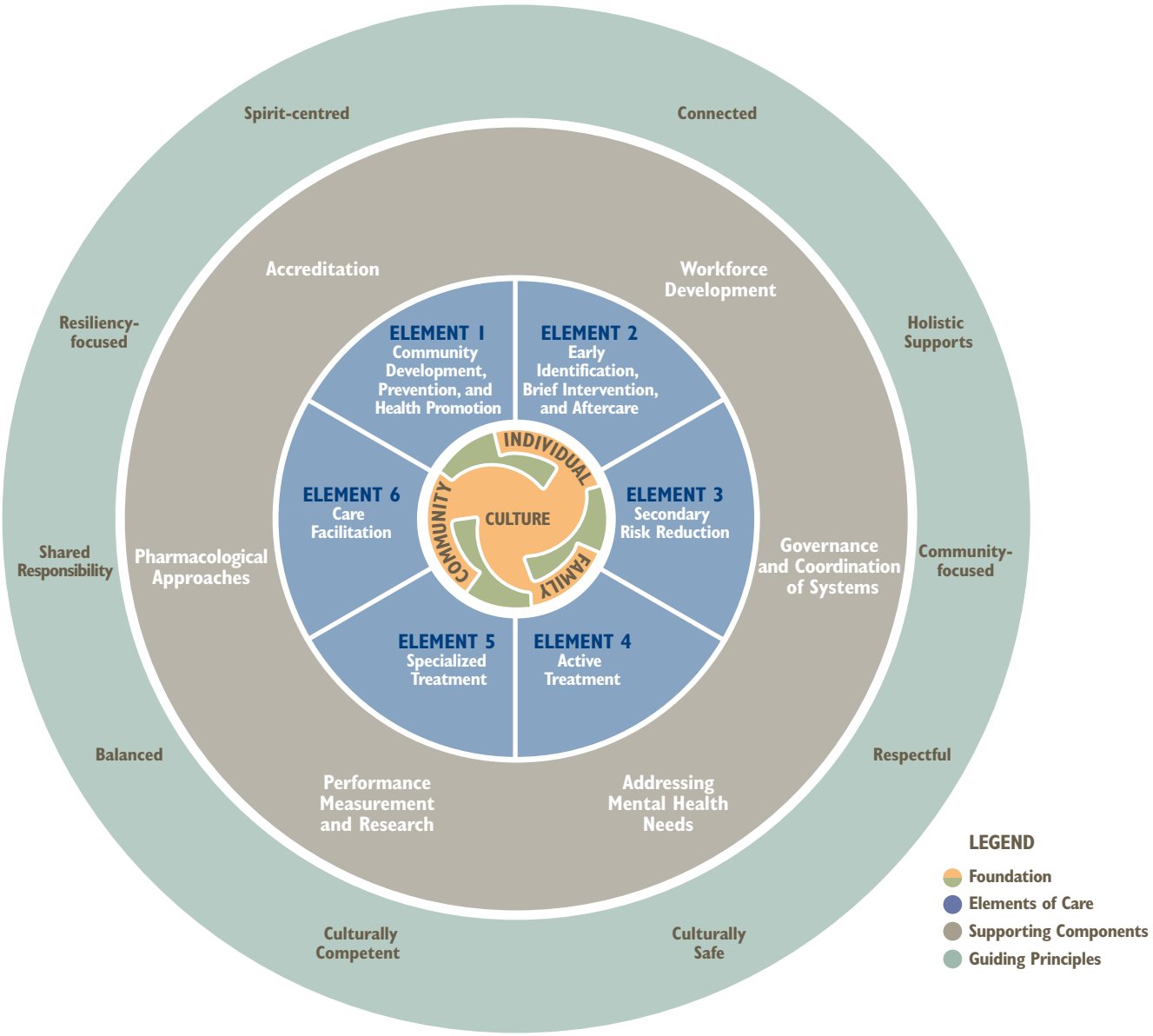
The elements of care described in *Honouring Our Strengths* reflect a continuum of care approach that considers a range of services, supports, and partners who have a role in addressing substance use issues among First Nations. This approach aims to support a strengthened, systems-wide response for First Nations communities and people who are at risk of, or directly affected by substance use issues throughout the lifespan. This approach focuses on:

- Matching people affected by substance use issues to the kinds of services and supports they need at any point in their care journeys; and
- Co-ordination among partners and sectors to provide effective, client-centred and culturally safe services and supports.

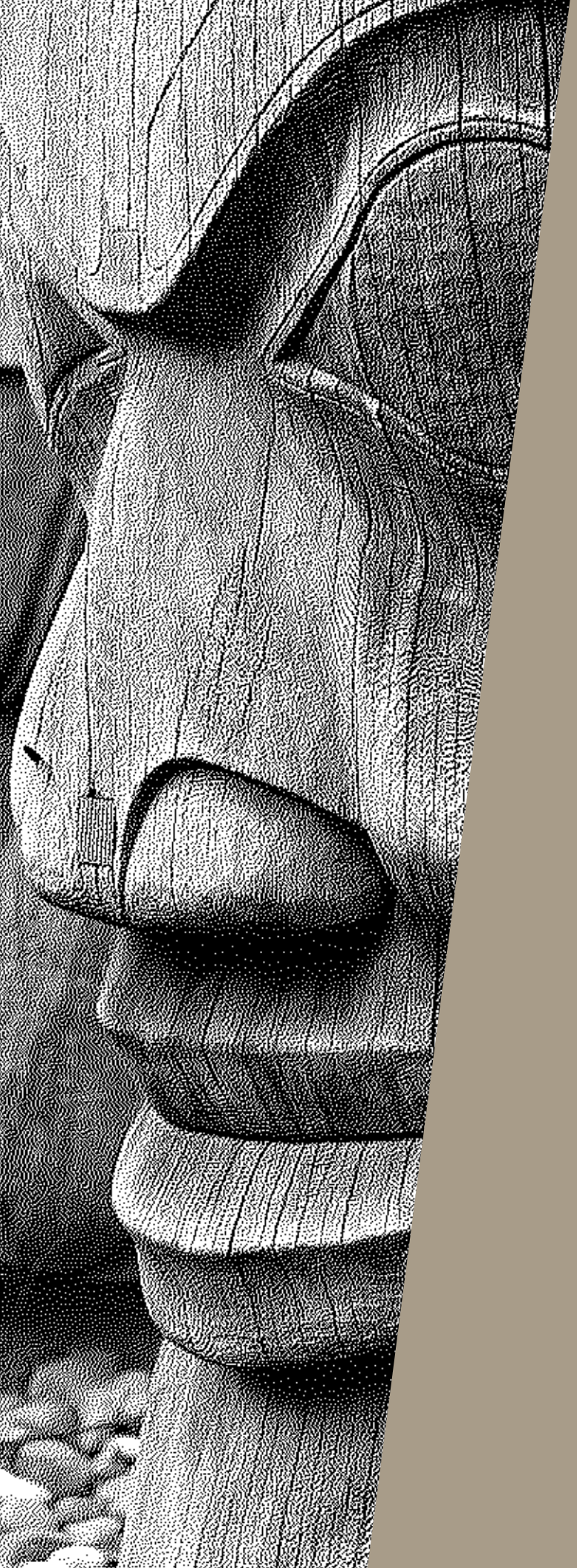
The six elements of a continuum of care are intended to respond to the needs of individuals, families, and communities with a range of substance use issues. The elements are also designed to meet the needs of specific population groups (e.g., women, youth, and people with co-occurring mental health issues). The elements of care are as follows: Community Development, Universal Prevention, and Health Promotion; Early Identification, Brief Intervention, and Aftercare; Secondary Risk Reduction; Active Treatment; Specialized Treatment; and Care Facilitation. Six key supports to the continuum of care have also been identified in the framework: workforce development; governance and coordination of and within the system; addressing mental health needs; performance measurement and research; pharmacological approaches; and accreditation. The elements and key supports outlined in this model are described in more detail in the sections that follow. Each of the sections is organized into four parts:

1. **Description:** providing a summary and rationale for the section, including a description of the target population, key components, and/or key partners. This outlines what services and supports would ideally look like.
2. **Key Components:** providing further definition of the key services and supports specific to each element.
3. **Current Status:** providing an overview of current services and supports available with an emphasis on strengths and challenges.
4. **Renewal Opportunities:** identifying opportunities to strengthen the current system in line with the description and key components while supporting identified strengths and targeting challenges within the current system.

FIGURE 2: SYSTEMS MODEL



ELEMENTS OF CARE



Health and well-being must be pursued in the context of the community in which First Nations people live and remain connected throughout their lives.

First Nations communities, with services and supports that are responsive to their needs and culture, are the primary means for promoting healthy connections between individuals, families, and communities.

Element 1

Community Development, Universal Prevention, and Health Promotion

>> DESCRIPTION

The services and supports in Element 1 are broad efforts focused on promoting and strengthening the well-being of individuals, families, and communities. A healthy community with strong social supports helps to establish a foundation for all aspects of the continuum of care. In periods of stress, where substance use issues mostly occur, social support networks can provide essential care and encouragement for personal, family, and collective healing.

The three main components of Element 1 involve:

- community development;
- universal prevention; and
- health promotion.

People who may provide Element 1 services and supports include but are not limited to community members such as parents, family, and friends; staff from all community programs; and leaders in the community, both formal and informal.

>> KEY COMPONENTS

Community Development

Community development describes the intentional actions taken by a community to increase their overall health and wellness. Community development strategies work best when they are community-driven, long-term, planned, empowerment-based, holistic, build ownership and capacity at the community level, and take into account the broader social and economic context. This context may include the influence of education levels, living and working conditions, poverty, awareness of culture and traditional language, social environments, history of colonization, and access to health and well-being services.

Capacity within community is an important foundation to effectively plan, implement, and evaluate community development activities. Community capacity includes the practical, team-building skills of facilitating community consensus; leadership skills; cultural resources and knowledge; health and wellness knowledge and expertise to provide mental health promotion, addictions treatment and prevention.

Universal Prevention

In harmony with community development, universal prevention approaches are aimed at the general public or a population within a region or a community (e.g., youth, pregnant women, or older adults) with the specific goal of promoting healthy behaviours and preventing, reducing, or delaying substance use or abuse. Effective prevention initiatives focus on strengthening protective factors and minimizing risk factors. These initiatives are positive, proactive and offered to everyone, no matter what their risk status.

Collaboration is required on these initiatives between various health and social services, departments, and agencies. Examples of universal prevention in action may include:

- drug education programs in schools;
- community-based cultural practices;
- parenting or family programs;
- media campaigns; and
- alcohol or drug policies and strategies within a community.

These efforts are often most effective when based on Indigenous value systems and culture, plan for future generations, and combined with other health and social strategies or frameworks at the community level.

Health Promotion

Health promotion is a process of empowering people to increase control and improve their health and its determinants. These efforts help people engage in safer and healthier lifestyles, create conditions that support such lifestyles, and restore healthy and supportive family and community dynamics. They can also advance skills, knowledge, changes in attitude, or community environment to help people engage in safer and healthier lifestyles.

Specific to substance use and mental health issues, health promotion may be paired with universal prevention programming in a variety of ways. This may include a range of approaches to build self-awareness, self-esteem, healthy boundaries, and effective assertiveness skills. These skills and approaches may serve as key protective factors among individuals, families, and communities to reduce, delay, or prevent future substance use or mental health issues. They may also build awareness among youth and families of cycles or patterns of behaviour (e.g., addiction, or physical, emotional, or sexual abuse) that are key risk factors for these issues. Awareness is often an important first step in breaking these patterns of behaviour, both in the present and intergenerationally.

Health promotion may also include long-term planning to ensure future generations are adequately supported. It can also contribute to healthy public policy development; help to create supportive environments; and, where appropriate, lead to re-orienting or re-focusing health services. Community health promotion can enhance community development efforts that are based on local needs identification and community- or region-wide inter-agency planning (e.g., needs assessments based on participatory approaches). This kind of community health promotion targets issues in a multi-dimensional, holistic fashion as communities become the focal point of decision making and operations for health services.

Alkali Lake (Esketemc First Nation) Community-based Holistic Healing

There are a number of examples of First Nations communities who have developed holistic approaches to community-based healing. One of the more dramatic examples is Alkali Lake (Esketemc First Nation) near Williams Lake, British Columbia. In reaction to high rates of alcohol addiction, with nearly all of the community seen as dependent, the community engaged in an ongoing healing process to transform health and social conditions, promote individual and community wellness, and revitalize traditional teachings and practices. Guided by continued leadership, commitment and support, this process started with one sober person and expanded to 95 percent of community members indicating that they were clean and sober. Throughout the process, sober community members worked to eliminate the bootlegging of alcohol through collaboration with the RCMP. As well, a voucher system was established with stores in Williams Lake for food and other necessities, where some of the community's heaviest drinkers received these in place of social assistance funds.

>> CURRENT STATUS

Community development efforts vary considerably from one community to the next. At present, a majority of First Nations community development efforts are focused on economic development. However, there is a growing recognition among government departments and communities that efforts benefit significantly from including a focus on mental health and well-being.

The intergenerational impacts of residential schools can sometimes contribute to mental health issues, which can hinder collective action. Despite these challenges, there are examples where communities, in partnership with their leaders, have implemented community development projects that target either mental health or addiction issues. These projects often focus on individual, family, and community well-being within the broader context of social determinants of health. Such projects promote community interconnectedness and

cultural identities through traditional teachings and ceremonies. However, the significance of this approach may not be recognized by the communities themselves or by research bodies and policy-makers.

A wide range of community workers, including NNADAP workers, Brighter Futures coordinators, suicide prevention workers, Community Health Representatives (CHRs), youth workers, and teachers, have a role in delivering prevention, health promotion, and community development in First Nations communities. As key parts of the health system, some of these individuals have a passion for, and understanding of, prevention work. That being said, many workers also find it hard to create time and space for prevention, health promotion, and community development activities as they are overwhelmed with crisis response, treatment needs, and other demands, which often take priority over these activities. Subsequently, workers tend to provide basic supports to clients in the form of counselling, as well as transportation to and from treatment facilities.

NNADAP community-based addiction workers vary in their capacity to carry out prevention roles. In some cases, workers are mostly qualified to do counselling but they may not have formal qualifications to develop or carry out prevention programs. As a result, an ongoing concern for NNADAP community-based addiction workers is that training and certification activities are not geared toward prevention. Instead, these actions focus on personal development in the field with little emphasis on population level responses, community development, and public health/prevention theory and practice. In general, NNADAP workers receive limited training each year to advance their knowledge of addiction issues and to enhance their prevention skills and approaches.

While workers in some communities clearly know what their roles are, well-developed resources and job descriptions are not common across the system. An additional challenge is the fact that community prevention funding for NNADAP is often used for wages, whereas Brighter Futures and Building Healthy Communities funding is often focused on program activity dollars. This has led to calls for strengthened collaboration at the community level and greater integration of program dollars at regional and national levels.

Current prevention efforts, where they exist, are mostly focused in schools. In many cases, school interventions are limited to public speakers, participatory events, and reading material distribution during National Native Addictions Awareness Week. As well, there are some examples of community awareness raising and support offered in the form of community workshops and events.

Many communities have raised concerns about the lack of support for prevention and health promotion, both in terms of leadership not acknowledging their importance, and funding limitations. For example, some communities support by-law policies that create dry communities. However, when such by-laws are passed, bootlegging is common and enforcement is a significant challenge. In general, by-laws are usually not effective unless they are coupled with a broader wellness approach which addresses the complex social and health conditions that lead to substance use and mental health issues.

The community context where prevention and health promotion activities occur can be affected by many challenges that threaten implementation. One of the main challenges is the difference in capacity of each community. While some communities have set up an integrated, comprehensive approach to prevention, many do not have the capacity to support a range of such activities. This is particularly the case in smaller, rural/remote communities that only have funding for one part-time addictions worker. The lack of more comprehensive prevention activities is often due to a lack of knowledge, resources, or a coordinated plan to support culturally relevant, community-based prevention and health promotion activities.

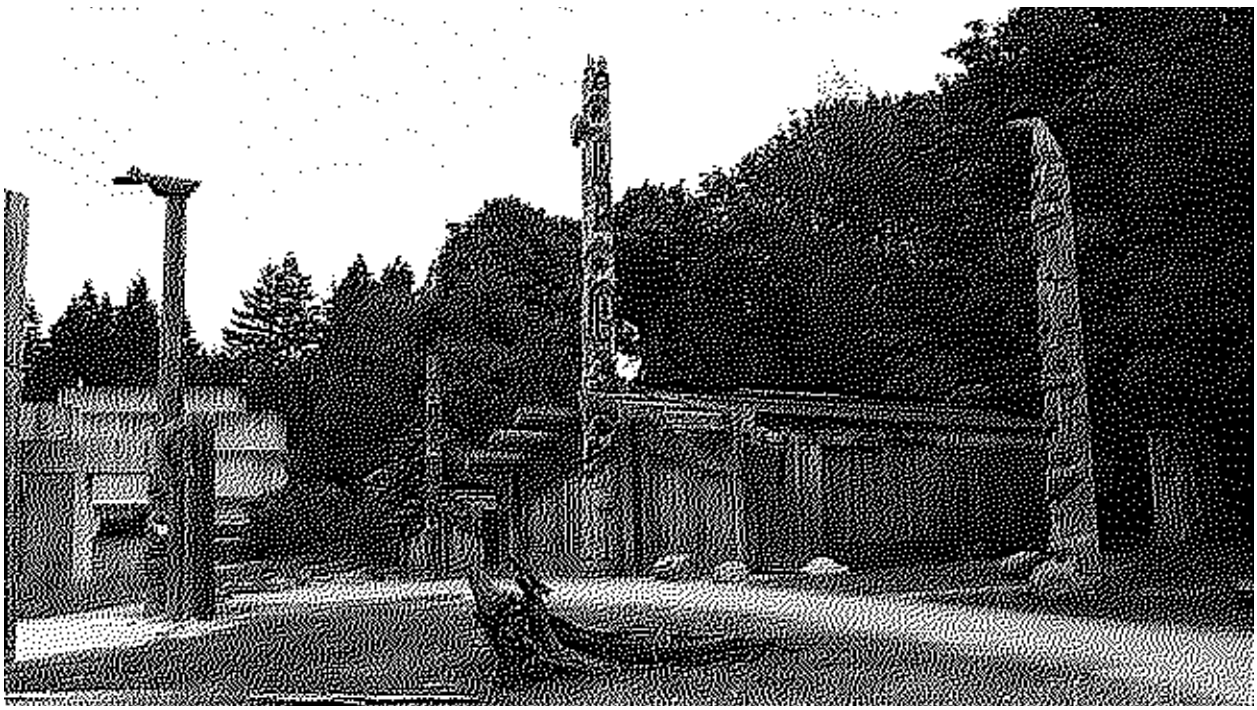
>> RENEWAL OPPORTUNITIES

Community Development

- A system-wide approach to community development to promote the local control of services and support and include a strong focus on mental wellness within communities. Such an approach would be designed and directed by community members

and leadership and include a focus on First Nations-specific social determinants of health. It would also focus on improved collaboration with other communities, community programs, as well as multiple levels of government and other federal departments (e.g., Aboriginal Affairs and Northern Development Canada, given its central role in supporting communities when it comes to many determinants of health).

- A process for collecting and sharing successes, challenges, and lessons learned from local community development activities. This would allow for useful regional knowledge exchanges to occur through the sharing of experiences, hopes, and needs across regions. Such an approach would take time and investment, but would be an effective way to build processes which can nurture and expand healthy community development.
- Coordination of services in the community, including partnerships with police, justice, child welfare, housing, education, job and training, social assistance, health, cultural programs and community governance, which would help to ensure a multi-faceted, community-wellness focused approach. Means to support this collaboration could vary and may include multidisciplinary mental wellness teams and leadership roundtables composed of local program managers.
- Ongoing community discussions about culture in order to define its role in service design and delivery and within broader community development efforts. These discussions could help to inform dialogue between a community and other individuals (e.g., service providers) and organizations (e.g., provincial and federal departments) directly involved in community wellness so as to ensure that cultural differences are respected in all dealings.
- Consider how to build a continuum of care beyond prevention and residential treatment. This approach could involve learning more about the kinds of mental health and addictions services which could be available in a given community, per this framework.
- Ongoing engagement and support of parents and families within communities, especially those who have school-age children. Parents and families need support and assistance from service providers, Elders and community leadership to maintain an environment of inter-generational wellness and support. Part of this would involve including more and better



activities for youth (e.g., sports and recreation activities) within the community. As well, school staff may require more training to work with parents, families, and health and social service providers in order to offer a network of observant and engaged role models for youth.

- Chances for youth to meet and engage with each other and with other generations through holistic outlets such as art, sports, dancing, drumming, or learning their Indigenous language. Intergenerational activities and sports have been found to be a good way to share values and ideas, as well as to promote healthy behaviours. Youth can be given support to develop and lead activities or programs they feel would benefit them.
- Mobilization and support of community volunteers to provide community development activities, including recreation, community events, and general activities that help to strengthen community support, promote wellness, and transmit knowledge.

Tribal Journeys—West Coast of British Columbia

Tribal Journeys has become a movement embraced by international coastal First Nations communities. For two weeks each summer, canoe families (all ages) from up and down the coast make a drug- and alcohol-free journey to a host community. The journey has profound therapeutic value and promotes a healthy lifestyle, not just during the journey, but in the months leading up to it. Spiritual, emotional, social, physical, cultural, and mental challenges are supported by Elders and knowledge keepers such as canoe builders, skippers, traditional food gatherers, cooks, and paddlers. Team meetings allow people to speak of their emotions during the trip. Skipper meetings recognize the skills of those who know the water and embrace the longing of others to learn. In each First Nations community, the visitors are fed as they rest overnight. The success of these tribal journeys is based on a strong cultural foundation that embraces both the past and a modern world. Family involvement allows for intergenerational healing, and relationship building that spans decades. Families and friends celebrate in sobriety, a practice that reflects strong ancestral processes.

Universal Prevention and Health Promotion

- A clearly stated strategy for universal prevention and health promotion, with defined outcomes and indicators that feed into ongoing policy and program development. This strategy would require a vision or indicators of community wellness and set out a vision for the types of services and supports required to achieve that vision. Key components of this approach would:
  - focus on preventing/reducing possible substance use issues through a whole community/multi-level approach, within a broader public health framework;
  - prevent multiple problem outcomes (e.g., substance use issues, suicide, and mental health issues) through a multi-component, community wellness-based approach (e.g., as school, policy, parent, and media programs or self-care/management tools);
  - reduce developmental risk factors and strengthen protective factors;
  - include a range of health promotion activities that seek to build healthy public policy, create supportive environments, strengthen community actions, develop personal skills, and, where appropriate, re-orient health services;
  - include a focus on addressing and de-normalizing the inherited effects of colonialism—lateral or community violence, guilt, shame, etc.—in fostering a transition to healthier lifestyles built on a strong cultural foundation;
  - draw on mainstream and Indigenous knowledge;

  - build capacity within communities, with an empahsis on supporting communities in need through shared learning and mentorship;
  - opportunities for communities to dialogue on effective strategies for prevention and health promotion;
  - harmonize or link existing addiction, prevention—related, and mental health promotion—based services and funding;
  - prioritize the health and well-being of children and youth;
  - target prevention activities for high-risk groups (see Element 2); and
  - include secondary risk reduction services and supports to people who are actively using alcohol and other drugs (see Element 3).
- Community-driven alcohol policies that focus on promoting health, regulating alcohol supply, reducing instances of driving while intoxicated, reducing environmental risk factors, and broad-based actions to change drinking-related norms and values. These policies will require continuous monitoring and must evolve with both the available evidence, and the values and norms within the community.
- Self-care and management tools and resources that help people manage their own health and wellness. This many include sharing information to help individuals and families make informed choices about health and wellness services and could also include a range of self-management tools (e.g., books, correspondence courses, computer programs and websites).
- Support for families and others who are either close to, or have been impacted by, someone with a substance use issue. This may include family based-programming, cultural supports, or "co-dependency"—focused mutual aid groups (e.g., Co-dependents Anonymous or Adult Children of Alcoholics). These forms of support can help individuals adopt healthier behaviours, set boundaries, build self-esteem, support a loved one's recovery from addiction, and help individuals and families recognize and break patterns of behaviour.
- Strengthened collaboration between prevention and health promotion approaches with treatment, pre- and post-treatment, and community-based intervention services at all levels. The goal would be to create a balance between the needs of community-wide prevention and treatment with support efforts to help promote and sustain healthy behaviours within communities.
- Coordination and cost sharing of prevention and health promotion activities with provincial services. This would support new ways of working at the provincial level and provide ways to exchange knowledge on prevention and health promotion models.

First Nations Health and Social Services Resource Center (FNHSSRC)—Kahnawake, Quebec

In the community of Kahnawake, Quebec the First Nations Health and Social Services Resource Center (FNHSSRC) was created with the objective of providing information to community caregivers promoting the health and well-being of Aboriginal families. Bilingual newsletters are published quarterly with information pertaining to the Native Alcohol and Drug Abuse Prevention Program (NNADAP) projects in the Quebec region. Among the many resources available are DVD documentaries, pamphlets, documents, and conference dates provided by outside agencies to the Centre. Subjects include mental health, bullying, child abuse, family violence, FASD, suicide, tobacco, AIDS and sexually transmitted infections, and teen pregnancy. An extensive data base lists the materials and clients are able to order on-line or by telephone. An extensive list of resources is available from the Center's catalogue found on their website.

Working to Prevent Prescription Drug Abuse

>> CURRENT STATUS

Prescription drug abuse (PDA) has emerged as a critical issue in many parts of Canada, both on- and off-reserve. The problem use of prescription drugs can be defined as the use of a drug for something other than its intended medical purpose. Often, abuse involves using a drug to get high and misuse is defined as not using a drug in the way it was prescribed.

There is limited surveillance data available to completely capture the extent of the use or prevalence of PDA in First Nations communities, particularly as it relates to illicit supply sources (thefts, organized crime, family members procuring or using another family member's prescription, and internet supply). However, First Nations in some regions have described prescription drug abuse as a high priority issue, and others have said it is an emerging concern. According to the 2002–03 First Nations Regional Longitudinal Health Survey the use of substances without a prescription (including codeine, morphine and opiates) had the second highest frequency of use, after marijuana, with 12.2% of the population reporting the use of these drugs over the past year.

The availability of prescription drugs in First Nations communities can be attributed to the following main sources: Non-Insured Health Benefits Program (NIHB); Provincial drug plans/cash payments; and illicit supply.

For this reason, while NIHB data is important in establishing the extent of PDA in First Nations communities, it has its limitations. For example, NIHB data does not capture drug claims paid through other provincial plans, paid by cash, or purchased on the Internet. In some communities, the issue is illicit supply of prescription drugs, either through organized crime or individual users.

Prescription drug abuse has been a target of both NNADAP and several community-based pilot projects funded by Health Canada. The pilot projects raised awareness of prescription drug abuse through various means, including promotional materials, workshops focusing on youth, community and cultural events, and social activities. Specific examples of community interventions to increase awareness of PDA include going door to door to educate community members about healthy prescription drug use and the disposal of unused or expired medications; a public notice in the health centre that medical doctors will not prescribe any form of narcotic drug, and that counselling, treatment plans, and referrals to resources would be offered to individuals seeking help with chemical dependencies; engaging elders to be champions in supporting young mothers with prescription drug misuse issues while teaching them how to prepare nutritional, traditional and affordable meals; and implementing "train-the-trainer" workshops to increase capacity within the community.

Results of the pilots showed that certain key elements are important for successful interventions at the community level; the development of steering or advisory committees to guide prevention efforts at a community/regional level; support from chiefs in council; collaboration with police, schools, family services and health centres; community consultations; use of the mass media; multidisciplinary team approaches; and showing people how much of a problem it is, using local data.

The evidence indicates that, as with all addictions, a comprehensive approach is needed to address prescription drug abuse. Current activities to address PDA are underway in five key areas:

1. Multi-sectoral collaboration—partnerships with addictions programming, policing, nursing, and schools.
2. Research and Surveillance—tracking patterns of use as well as research into best approaches to prevention and treatment.
3. Demand reduction—prevention initiatives to help reduce the demand for prescription drugs, particularly among youth. The work related to prevention

is very similar to that which is described in Element 1 for all substances, however it has been noted that often there is a need to highlight the risks associated with using prescription medication in ways other than how they were prescribed.

4. Supply reduction—prevention initiatives looking at both legitimate and illicit supply. To address supply reduction, NIHB has several strategies, including warning messages to pharmacists about repeat prescriptions; giving pharmacists details on a client's drug therapy history; trend analyses of both client and program level prescription drug use; and the creation of an independent advisory committee to provide input, evaluation, and recommendations for client safety.
5. Treatment—as described in Elements 4 and 5.

>> RENEWAL OPPORTUNITIES

Multi-sectoral collaboration

- A multi-faceted approach to address the issues of prescription drug abuse, including exploration of traditional medicine and alternative therapies; improving access to counselling services; reducing peer pressure; and putting in place education and prevention strategies aimed at youth, doctors, pharmacists, dentists, police and the general public.
- Focus on long-term success by linking prevention work with structural change at all levels to shift social norms from reliance on prescription drugs. The findings of community-based pilot projects provide a number of examples of approaches that have worked well in communities.
- Infrastructure to support collaboration among the First Nations and Inuit Health Branch staff, NNADAP staff, doctors, pharmacists, police and band councils to lessen "double doctoring." This includes raising awareness of First Nations health issues within bodies such as the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians, the Canadian Medical Association, and medical schools. It may also include development of an early warning system for prescription drugs use/abuse in First Nations communities.

Surveillance/Research

- Strengthened evidence base regarding the incidence and prevalence of PDA, including sources of illicit supply.

Prevention

- Partnering with justice, social, and other sectoral partners at the national level to coordinate development of community-based prevention programming for youth.
- Cooperative approaches with physicians and pharmacists to support appropriate prescribing at the community level.
- Set NIHB coverage limitations for clients identified with PDA problems.
- Expansion of NIHB Prescription Drug Monitoring for clients at risk.

Treatment

- Support for community-based workers, particularly specialized training and clinical supervision.
- Strengthened access to appropriate counselling services at the local level where possible, in partnership with doctors and pharmacists.
- Support for local health services and treatment centres to ensure appropriate use and collaborative approaches to pharmacological therapy, such as methadone.
- Development of alternate approaches to treatment for those who are uncomfortable with harm reduction practices (e.g., methadone) and for rural and remote areas.

Ongoing engagement and care for those who are either at risk of developing substance use issues or who have already accessed more intensive services is central to a system of care.

Reducing and preventing potential issues requires that care providers, associates across the social determinants of health families, and other community members, are equipped with the skills and knowledge to identify, briefly intervene, and support those in need of care.

Element 2

Early Identification, Brief Intervention and Aftercare

>> DESCRIPTION

The service and support components in Element 2 help to identify, intervene with, and support those who are either at risk of developing a substance use issue or who are currently engaged in problematic or risky substance use. Element 2 also provides ongoing support to individuals and families who have accessed more intensive services in the past (such as active or specialized treatment).

These approaches must be strongly tied to the services, supports, and activities described in Element 1, as they will assist in both identifying and supporting individuals who require help. The key components of Element 2 include:

- targeted prevention;
- early identification;
- brief intervention;
- referral and case management;
- risk assessment and pre-treatment support; and
- aftercare.

People who may be well placed to provide Element 2 services and supports include: primary care and emergency health staff (e.g., doctors, nurses, nutritionists, health centre staff, and CHRs); NNADAP community-based addiction workers; cultural practitioners; social service workers; maternal child health home visitors; FASD mentors; law enforcement or correctional workers; staff at urban Aboriginal friendship centres; an a range of community and social supports (e.g., family members, teachers and friends).

>> KEY COMPONENTS

Targeted Prevention

Targeted prevention is aimed at specific populations showing early signs of a substance use issue or at risk of developing a problem. These approaches reduce risk factors, promote protective factors, limit disability, prevent future addiction issues, and promote community and cultural connections.

Focusing on high risk populations will help to ensure funding can be targeted to those who are at the greatest risk for substance use, as well as a range of health, social and other problems, which may impact the general health and well-being of the community. There is a growing understanding of the importance of focussing on risk factors, particularly among young people. Key high-risk populations include individuals:

- with a mental health issue or disorder;
- with a parent who is or has been alcohol or drug addicted;
- who have been physically, sexually or emotionally abused;
- who are involved with a gang;
- who are lesbian, gay or bisexual; and
- who have experienced childhood traumas or family disturbances, including former residential school students and their families.

Examples of targeted prevention include community support programs targeting at-risk families or communities, youth specific interventions, targeted health education, and social marketing programs to reduce stigma and discrimination.

Early Identification

Early identification involves a range of approaches to screen people who have or may be at risk of having a substance use issue (and in some cases a mental health issue). Screening is a process for determining the possible presence of a substance use (or mental health) issue; the level of risk to an individual, family, or community; and whether or not a more comprehensive assessment is required (see Element 4 for more information on comprehensive assessments). Screening can be done by a wide range of individuals, such as primary care professionals, child welfare workers, police, friends and family, and in a range of settings (e.g., schools, recreation centres, or workplaces).

Early identification of substance use and mental health issues may lead to early treatment and self-management, and is important for reducing current or potential addiction or mental health issues.

Brief Intervention

Brief intervention is a time-limited supportive conversation between a substance user and someone they trust and respect. These conversations can be structured or unstructured in nature; vary from a five minute discussion with a friend to a series of hour-long, structured conversations with a health care professional or Elder; and aim to help the person set goals for healthier behaviours related to their substance use.

Key mechanisms for achieving this can include personalized feedback on substance use patterns and the effects they may be having in a client's health or life. Brief interventions are mostly offered by health or social service providers who know the person. It can also be used by others, in other settings, such as in nursing stations or emergency rooms, and by teachers, school counsellors, or parents and other family members. By dealing with substance use and mental health issues through early identification and brief interaction it may be possible to stop them before they become more severe and complex.

Referral and Case Management

It is important that care providers know where to refer clients when it is clear that the client's substance use issue requires more intensive support (see Elements 4 and 5). This may involve referring the client for a more comprehensive assessment or directly to treatment services should the situation warrant it. This may also require a care provider to take the role of a case manager or to provide linkages to case management services to ensure appropriate navigation of available services and supports. Case management is discussed in more detail in Element 6.

Risk Assessment and Pre-treatment Support

Risk assessment and pre-treatment support is necessary for many clients with moderate to high substance use issues who are in need of treatment. These services provide an opportunity for the provider to assess an individual's readiness and motivation for treatment, along with any potential risk factors or patterns of behaviour that may lead to future substance use involvement or issues.

Risk assessment and pre-treatment support can address potential barriers to participation in treatment and help enhance a client's motivation. Support may also help clients prepare for the upcoming treatment process and can involve looking at a client's holistic needs, working with other service providers and sectors, as well as the person's community and social supports. For example, a youth who is at risk of a substance use issue may be far more likely to accept support from a school teacher or sports coach than those of an unfamiliar NNADAP worker.

Aftercare

Many people who receive intensive treatment services may require life-long, holistic support from a range of service providers as well as community and social supports. This post-intervention support is often referred to

Nemi'simk, Seeing Oneself—Nova Scotia

"Nemi'simk, Seeing Oneself" was a community-based, collaborative project designed to provide adolescents in partnering Mi'kmaq communities in Nova Scotia with tailored, brief interventions for alcohol misuse. By integrating Aboriginal and Western scientific knowledge, the project developed a brief intervention for substance abuse among Aboriginal adolescents who were engaging in risky drinking behaviour. The interventions occurred across two 90-minute sessions and were delivered by trained school facilitators. Participants in the tailored interventions showed decreased rates of drinking frequency, binge drinking, alcohol-related problems, and increased rates of abstaining from alcohol.

as aftercare. The purpose of aftercare is to help people and their families or other loved ones along their healing journey and to return to positive community life. Aftercare services and supports may be provided by:

- a variety of health and other professionals (e.g., NNADAP workers, mental health, housing, human resources, and social service providers, cultural supports) working both on- and off-reserve;
- community-based support groups for both the person in recovery (e.g., Alcoholic Anonymous and Narcotics Anonymous, sweat lodge ceremonies, or other traditional ceremonies) and family members or other individuals close to people with a substance use issue (e.g., Co-dependents Anonymous or Adult Children of Alcoholics); and
- a wide range of approaches using technology (e.g., telephone/video conference calls, or Internet-based links to health professionals and support groups).

Effective aftercare involves being aware that an initial intervention, such as treatment, is a first step in a long-term recovery process. Adopting a long-term approach to care often requires a focus on relapse prevention and strong case management supports. This approach will help to ensure continued engagement with a client and use community, cultural and social supports, as well as services in key social determinant of health areas (e.g., housing, employment, education, and living conditions).

Support from family, peer networks, and friends, as well as access to housing, education, work, and opportunities to celebrate cultural identity, help support a person to be productive and connected to their community. Effective aftercare strategies could include follow up by treatment providers; additional supports for people with co-existing mental health conditions; "safe" living conditions to support recovery; and support for people moving to urban centres or other communities.

>> CURRENT STATUS

Increased access to targeted prevention, early identification, and intervention services is required within many First Nations communities. As with universal prevention and health promotion (see Element 1), those best

placed to provide these services and supports are often not appropriately trained or find it hard to create time and space to engage in activities with a preventive focus.

Services that reach out to people with, or at risk of developing, a substance use issue are recognized as necessary within all aspects of community life. It is also apparent that funding and training opportunities are needed to ensure service providers and community members are comfortable enough to provide these types of services and supports.

Many of the current screening and assessment tools have a narrow focus on limitations of the client and what is missing in their lives. Although there is a shift toward screening and assessment tools that focus on client strengths, to date, many of these tools have been used mostly with youth. People also recognize that in many cases, current screening, assessment, and referral processes are too

time-consuming, flawed, or restrictive. The NYSAP has developed a more comprehensive screening and assessment approach, as well as tools that take into account a person's own strengths based on cultural identity and resilience.

Aftercare services represent a significant gap within addictions programming, both on- and off-reserve. As with prevention, granting time and space for aftercare can be hard to do. What gets in the way for community workers are high workloads and other, often more pressing concerns. Sometimes a lack of available, accessible, and affordable training or cultural resources can be a barrier to the delivery of aftercare. In the absence of available services, many clients must rely on support groups, family, and community to stay on their healing journey. In some cases, someone returning to a community may not have these supports or may still need more support for a wide range of problems linked to substance use issues.

>> RENEWAL OPPORTUNITIES

Early Identification and Intervention

- In harmony with universal prevention activities (see Element 1) and secondary risk reduction services and supports (see Element 3), development of a coordinated, long-term approach to targeted prevention focussing on specific populations whose levels of risk are significantly higher than average, either immediately or over a lifetime. This may involve a wide range of approaches, including:
  - youth-specific interventions, such as programs for personal development; cultural ceremonies celebrating puberty and rites of passage; peer education and outreach initiatives; anti-gang initiatives; and school-based early identification and intervention;
  - targeted interventions for other key populations, including pregnant women, two-spirited, gay, lesbian, bisexual, and transgendered people;
  - home and community support programs targeting at-risk individuals or families, such as family trauma-based services, or services and supports for single parents;
  - targeted health education, such as information on specific substances of use or abuse, including the effects of heavy drinking, the identification of the impacts of colonization on health behaviours, and the promotion of culturally informed healthy living;
  - cultural ceremonies that help individuals to identify their spirit name and clan family; and
  - targeted social marketing programs, such as sobriety promotion or anti-drug campaigns.
- Screening tools for substance use and mental health issues that are basic, evidence-informed and culturally safe. These tools would provide a wide range of community members and health professionals with a series of screening questions that could be used with each client to find out whether a substance use issue is present and determine if a more comprehensive assessment is needed.
- Development of holistic and culturally safe early identification and brief intervention tools to support people with substance use issues. These tools may be standardized and should:
  - recognize client, family and community strengths;
  - be easily adapted to meet the needs of different regions and populations;
  - include consideration of associated mental health issues;
  - be flexible enough to meet the diverse needs of regions and communities; and
  - be supported by guidelines, training and/or workbooks that would help community members, service providers, and other care providers, both on- and off-reserve, to help clients set goals for substance use behaviours. For more discussion on screening and assessment, see Element 4.
- Development of such tools and approaches will require collaboration with a wide range of workers providing services to First Nations communities (e.g., NNADAP workers, community members, cultural practitioners and clinical consultants) in order to identify existing opportunities for new screening, assessment, and brief intervention tools. It may also require that support staff get the correct training to perform the data entry and quality assurance checks required in all data entry.
- Where possible, early identification services could be paired with case management (see Element 6) and

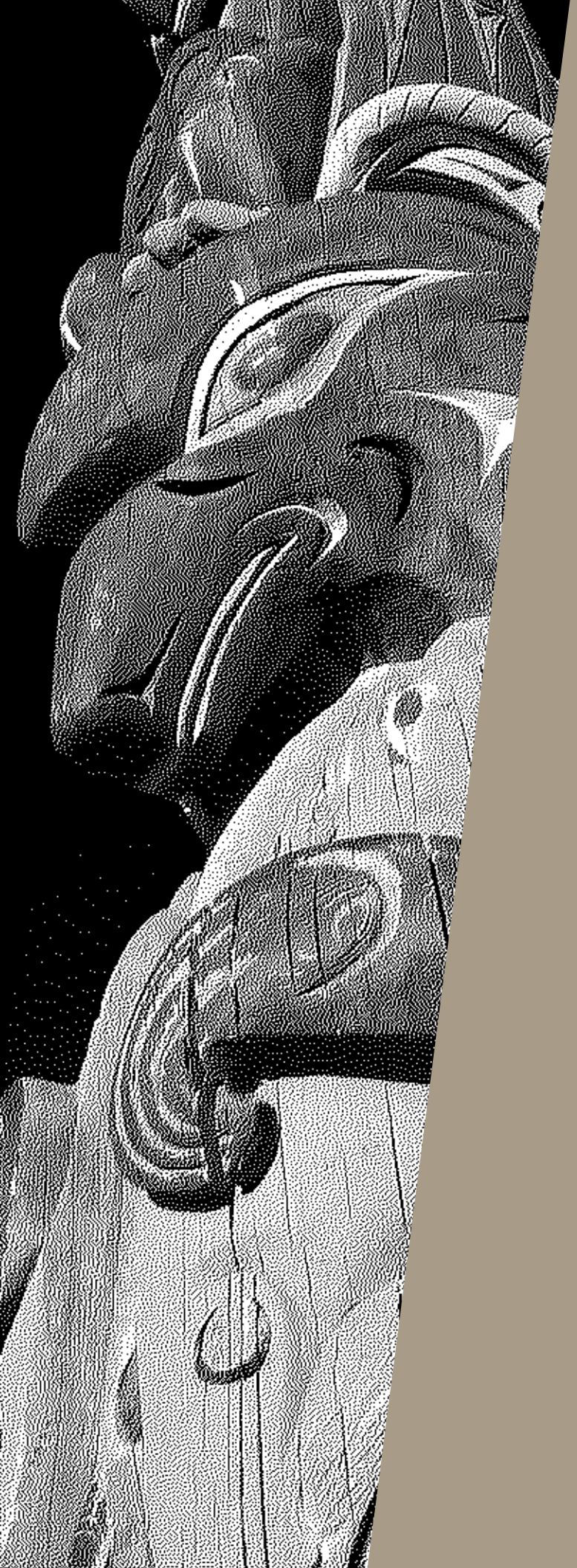
Video Conference AA Meetings—Shamattawa First Nation, Manitoba

Since June 2010, Shamattawa First Nation, with the support of Selkirk Hospital, has been hosting regular Alcoholics Anonymous (AA) meetings that are broadcast to a range of communities through video conference technology. These meetings provide ongoing support to the Thompson Addictions Foundation of Manitoba, along with many surrounding rural communities that do not have access to local support groups. The practice of video conference AA meetings has since expanded and there are now four other First Nations communities hosting meetings. These communities have made use of tele-health and video conferencing services in local nursing stations. This practice is being actively pursued in the Manitoba Region as a way of assisting community members to attend AA meetings without having to travel from their home communities.

secondary risk reduction supports (see Element 3). For example, when individuals with substance use issues are identified, basic assessment would also point out secondary harms and would provide guidance to case managers to make appropriate referrals. This may mean that coordination with a range of other services and supports will need to occur.

Aftercare

- Recognition of aftercare as a priority is an essential part of the overall continuum of services. Partnerships among communities, treatment centres and a wide range of health, justice and social service workers are required in order to collaborate on the development of a strategy to support an aftercare model at the community level. Such a model would recognize that recovery is an ongoing process and that clients require continued, holistic support.
- Ensuring community-based efforts have support from more specialized services and that referral guidelines are clear and well understood.
- An effective and comprehensive aftercare model could include the following:
  - training for community workers and community members in relapse prevention;
  - strong collaboration with other linked services (such as cultural and clinical services to treat psychiatric illness);
  - a focus on family members and other close to people with substance use issues;
  - flexible approaches that offer clients support both on- and off-reserve;
  - strong case management support to ensure easy access to services;
  - community and technology-based models of peer support (use of the internet, phone or video);
  - transitional, safe and recovery housing;
  - support for education, skill development, and employment;
  - ongoing check-ins (recovery management) by service providers and support networks; and
  - more access for clients to less intensive outpatient or community-based programs in support of both intervention and relapse prevention. For more information on aftercare (see Element 4).



People who are involved in substance use that may be putting themselves or others at risk (e.g., binge drinking, driving while intoxicated, and using substances in high risk environments) require a range of culturally safe services and supports.

These services and supports include actively engaging people in a wide range of settings and helping connect them with care responsive to their needs, priorities, and motivations to change. Meanwhile, other initiatives may involve community wide response to environmental factors.

Element 3

Secondary Risk Reduction

>> DESCRIPTION

The services and support components in Element 3 are intended to respond to the needs of people at a high risk for negative consequences linked to substance use. Their risky behaviours may put themselves or others at risk, and result in a range of negative consequences that include but are not limited to: violence, injuries, sexual victimization, school dropout, domestic abuse, gang involvement, driving while intoxicated, suicide, needle sharing, HIV infection, having a child with FASD, job loss, family break up, child apprehension, and community crime.

Services and supports in Element 3 seek to actively engage people in a wide range of settings and help connect them with care. Some individuals who have a substance use issue may not be willing, ready, or appropriate for certain more intensive services. Likewise, services may not be suited to the needs of these clients, particularly those services that require complete abstinence. Providing support and secondary risk reduction increases the chance that those at risk will experience some form of change and lower their levels of risk and harm.

The key components of an effective approach to secondary risk reduction include:

- community-based supports;
- outreach;
- risk assessment and management; and
- screening, assessment, referral and case management.

People who may be well placed to provide Element 3 services and supports include community-based mental health and addiction workers; cultural practitioners; social service workers; maternal child health home visitors; FASD mentors; law enforcement workers; correctional workers; off-reserve outreach workers; staff at urban Aboriginal friendship centres; and a wide range of community and social supports (e.g., family members, Elders, teachers and friends).

>> KEY COMPONENTS

Community-based Supports

The general community is in a good position to provide secondary risk reduction, whether through informal or formal means.

Within many communities, there is a great deal of knowledge and experience about well-being and recovery. Individuals who remain well-connected to their community through group events, (e.g., gatherings, feasts, and Indigenous ceremonies), and through connections to family and the land may be less likely to engage in risky substance use and therefore face fewer secondary risks.

Likewise, there are a number of formal risk reduction activities that a community can take on, such as drinking and driving reduction campaigns; alcohol and drug abuse screening by health professionals; and alcohol management or control policies. These approaches may be formalized in risk reduction plans that take into account the unique needs of a given community, and outline a range of services and supports to best meet the needs of those at risk.

Outreach

Outreach refers to a range of community-based activities that serve to improve health and reduce substance abuse risks for people and families that may not usually receive or access such services at fixed locations. Most of the time, outreach involves connecting with people who use substances, rather than waiting for them to come to the services. Effective outreach often involves helping a client determine what life changes they feel ready and able to make, and helping them connect with a wide range of health and social supports. This may include a range of approaches to provide/enhance skills, knowledge, resources, and support that individuals need to live safer, healthier lives.

Outreach may occur in a wide range of situations, including primary care, recreational activities, community gatherings, talking circles, cultural teaching events, or in a person's home.

Risk Assessment and Management

Risk assessment is a part of care planning. It involves engaging with clients and social and community supports, as well as sharing information and protocols among services. After risks have been identified, risk management plans are developed with clients and their supports, and put in place to prevent immediate harm. For example, if there are concerns about harm to children around a mother's substance use, social services would normally be involved in any further risk assessments. In this case, secondary risk reduction programs or services could create immediate outreach plans to meet the client's unique needs. This might involve screening, brief intervention, referral, (e.g., support offered through mentorship programs for mothers-at-risk or through social and cultural support networks).

Alcohol Regulatory Policies—Mattagami First Nation, Ontario

In some Aboriginal communities, alcohol regulatory policies have been designed to support moderate drinking practices and reduce problems related to alcohol misuse. For example, in 1993 the Mattagami First Nation in Ontario implemented a policy for serving alcohol that required a Special Occasion Permit and Band approval for the use of a designated building such as the community hall. It attempted to balance between a "wet" and "dry" approach by requiring that, in addition to alcohol beverages, non-alcohol and low-alcohol drinks be available on the premises. Further, it required that all staff be trained and signs posted in the facility to indicate that intoxicated people would be denied alcohol service, minors were not allowed (or only until a specified time), and there would be no "last call." An evaluation of the policy showed it was effective in reducing alcohol service to youth and the number of fights at community events.

Screening, Assessment, Referral, and Case Management

As with early identification, intervention, and aftercare (see Element 2), the desire to reduce the negative consequences linked to substance use requires an understanding of all the factors that play a role in the client's substance use behaviours. This can be done through screening, assessing, and referring clients to services and supports that match their needs, strengths, and readiness to change problem behaviours. There is also a need to respect each person's informed choice of what types of approaches may work best for them. A wide range of service providers and community members can provide such services, particularly when they have training and an awareness of available resources. As well, referrals may not always be to formal services. In some cases, they may connect people to cultural workers or other social supports. Coordination of these services and supports often requires a case manager to access the types of services needed and to ensure ongoing care (see Element 6 for more information on case management).

>> CURRENT STATUS

Substance use issues and their negative consequences generate high social and financial costs to First Nations individuals, families, communities and society as a whole.

Secondary risk reduction programs are currently limited within many communities. This is particularly true for more isolated or remote communities. Approaches, where available, are typically delivered by NNADAP community-based addiction workers. In many cases, these services are often delivered independently of one another and without much coordination.

Applying risk reduction activities may be challenging in some community settings. Many communities have a strict

focus on abstinence and prohibition with respect to any psychoactive substance use. Often these approaches do not support less risky or reduced substance use required for many secondary risk reduction approaches. The support for strict abstinence within many communities could be a barrier to exploring a wider range of risk reduction supports and may require further discussion, particularly given the persistence of alcohol and drug-related harms.

Other issues identified in regional needs assessments relate to staffing, training, role clarity, program-specific policies, and financial resources. All of these can affect the degree to which secondary risk reduction services are organized within a community. While there are debates about secondary risk reduction as an approach to substance use issues, communities seem to agree that services in this element are much needed and they are open to finding ways to discuss potential strategies for reducing secondary harms.

>> RENEWAL OPPORTUNITIES

A strengthened approach to secondary risk reduction services could include:

- Awareness of substance use-related costs and consequences of at the community level. This would help to support service delivery and planning at the community and regional levels in partnership with health units, nursing services, and provincial services.
- Completion of a community-based needs assessment on the services and supports for people with substance use issues. This may include finding out what kinds of services and supports exist for people at risk within a given community (e.g., people who are either not ready or not a good fit for treatment or those who have used services in the past and need more support), and what might need to be put in place.
- Development of a risk reduction plan based on findings from the needs assessment. These plans would be coordinated with universal prevention (see Element 1) and targeted prevention (see Element 2) activities and include an assessment of what is currently in place at the community level. These plans should include a wide range of partners such as primary care, police services, child and family services, schools, income support services, and the justice system. Examples of key risk reduction activities may include:

The Circle of Life Program—Terrace, British Columbia

The Circle of Life Program runs out of the Kermode Friendship Centre in Terrace, B.C. It is open to First Nations women of child-bearing age with a focus on women who are currently using alcohol and/or drugs, who have a history of alcohol or drug misuse, who have given birth to a child with Fetal Alcohol Spectrum Disorder (FASD), who are themselves affected by FASD, or have a family member who is affected. The program is designed to empower all First Nations women within their child-bearing years to make healthier lifestyle choices and decrease the number of alcohol and/or drug exposed births in the community. The approach is to have peer mentors who understand and support First Nations women in developing and maintaining healthy life choices, connecting them with their personal support systems as well as community services. By the end of the three-year mentoring program, women will have developed skills to maintain a healthy life plan for themselves and their families. Some skills may include budgeting, parenting, family planning, social skills, assertiveness and maintaining a recovery plan. Circle of Life is a replication of the successful Birth to Three Project developed in 1991 by the University of Washington School of Medicine, and adapted for use with Aboriginal women.

- culturally-appropriate media and social marketing campaigns where communities collaborate with a range of health professionals to positively influence community norms and individual behaviour;
- neighbourhood watch/outreach programming to identify and support substance users who are putting themselves or their community at risk;
- alcohol management policies to control the availability of alcohol, moderate consumption, and encourage safe drinking practices;
- public health approaches that pair substance-use related prevention and health promotion strategies with programs that address other risky behaviours (e.g., safe sex, tobacco cessation, and healthy eating);
- identification of role models within communities who maintain healthy lifestyles, which may include living alcohol and drug free;
- targeted approaches, such as screening and brief interventions, for heavy episodic drinking (i.e., binge drinking);
- youth-specific approaches such as school-based programs, increased recreation activities, anti-gang programs, and cultural activities; and
- injection drug use services, where appropriate, such as needle exchange programs, methadone maintenance programs, and anonymous HIV/AIDS testing.

- A wide range of workers with the training and skills to support people at risk of secondary harms, so that clients at risk of negative consequences may be identified in a timely way.
- Partnerships with existing organizations and between community programs that now provide risk reduction services to First Nations clients. While formal relationships are not required, agencies with secondary risk reduction mandates, particularly for First Nations clients, could be excellent supports to NNADAP-based programs. Some examples include the Canadian Aboriginal AIDS Network; the Ontario Aboriginal HIV/AIDS Strategy; and the Healing Our Spirit BC Aboriginal HIV/AIDS Society.

Supporting people with alcohol and drug addictions and those close to them requires that a range of client-centred, culturally competent approaches are available throughout the healing journey.

These services and supports build on individual, family, and community strengths; consider the holistic needs of clients; and are offered in a range of settings, such as communities, treatment centres, and on the land.

Element 4

Active Treatment

>> DESCRIPTION

The service and support components in Element 4 are intended to respond to the needs of people who are experiencing moderate to severe substance use issues. Element 4 includes a range of approaches, including counselling, education, group therapy and cultural approaches, which are often more intensive than those in other elements.

The goal of active treatment is to reduce the dependence on alcohol and drugs, as well as any negative health and social consequences linked to the use of such substances. Supporting people with alcohol and drug addictions and those close to them, active treatment also requires a range of client-centred, culturally competent approaches available throughout their healing journey. This often requires a range of treatment services and supports that assist individuals to achieve the ultimate goals of adopting healthier behaviours; enhancing their connection with family and community; and reducing addictive or compulsive behaviours and patterns.

Key components of an effective approach to active treatment include:

- Screening, assessment and referral;
- Withdrawal management (including medical management of withdrawal) and stabilization;
- Treatment planning and pre-treatment care;
- Case management;
- Specialized treatment programming; and
- Discharge planning and aftercare.

Services and supports for active treatment are generally provided in outpatient, day, evening, or residential settings, or on the land by health and social service professionals, as well as Elders and cultural practitioners. These individuals include but are not limited to addiction counsellors; NNADAP community-based workers; psychologists; social workers; case managers; cultural practitioners; staff at urban Aboriginal friendship centres; and for some services (e.g., withdrawal management) nurses and doctors.

>> KEY COMPONENTS

Screening, Assessment and Referral

Early identification and intervention through effective screening is an important first step in client care, and is typically done by a health professional or someone who has a trusting relationship with the individual. The goals of screening are to find out if someone has a substance use or mental health issue—including whether or not they are at risk—and to determine if a more comprehensive assessment is needed (see Element 2).

At the assessment stage, the client and health care worker work through a structured set of questions or criteria to define the nature and severity of the problem(s), as well as the client's strengths, supports, resources, readiness to change, and mental health status. Assessment is typically carried out by a trained professional at a community, regional, or treatment centre level. A primary goal of assessment is to determine if a client is in need of additional support and to refer them to the appropriate source. It is important to match the client's level of need with appropriate intervention options. Effective assessment is grounded in a therapeutic relationship that builds a rapport, enhances motivation, and develops a collaborative treatment plan. See Element 2 for more information on screening and assessment.

Withdrawal Management and Stabilization

When a person is addicted to drugs or alcohol and discontinues use, they will experience withdrawal symptoms that may be felt psychologically, physically, or, in some cases, both. Withdrawal symptoms vary considerably from one client to the next based on factors like the type of substance a person is addicted to; the length and frequency of use; and associated health issues. Whether or not medical support is required is often determined after an assessment by a qualified medical professional. For instance, people who have been taking large amounts of opioids (e.g., heroin, OxyContin®), pain medications, or alcohol either alone or together may need medically monitored withdrawal management services. In the

majority of cases, people with mild withdrawal symptoms from alcohol or drugs and people using cocaine, marijuana, opioids, or methamphetamine require little to no medical support and often do not need to be hospitalized for detoxification.

Withdrawal management (detoxification or "detox") and stabilization refer to processes of support that help people withdraw from the use of alcohol or other drugs. These services are an important first step in a long-term recovery process in which timely access to culturally appropriate services is necessary. Withdrawal management and stabilization services may include:

- Medical approaches (e.g., offered by provinces, typically either in hospitals or detoxification centres);
- Non-medical or minimally medical approaches, such as cultural, social, mobile, or home detoxification, which can be offered within communities, on the land, or within a home. Depending on symptoms, these may involve check-ins with primary care staff and medication; and
- Stabilization supports for people experiencing persistent psychological effects after successfully withdrawing from a substance (e.g., post-acute withdrawal syndrome). This may involve ongoing monitoring, assessment, case management, and treatment planning; and can be offered in a range of settings including recovery houses, residential treatment centres, or through outpatient, day or evening programming.

Treatment Planning and Pre-treatment Care

Treatment planning involves setting goals and objectives, and choosing a full set of staged, integrated treatments for each problem. The plan is matched to the client's needs, readiness, preferences and personal goals, and should be connected to broader care planning efforts (see Element 6). It should also consider their cultural, community, and family supports and relationships, and also involve developing hope and motivation, as well as focusing on non-chemical stress management techniques. It is crucial that the client takes an active role in this process and has a chance to be directly involved in setting their course for treatment. Access to community and agency

The Native Alcohol and Drug Abuse Counselling Association of Nova Scotia (NADACA)—Eskasoni, Nova Scotia

NADACA provides a wide range of services to 13 communities in Nova Scotia, as well as Labrador, Prince Edward Island and New Brunswick. Services include community outreach field workers, school-based education, and prevention programs. Within the province of Nova Scotia, NADACA offers treatment for drug and alcohol misuse at the 15-bed Mi'Kmaw Lodge, located in Eskasoni, and the 7-bed Eagle's Nest Recovery House in Shubenacadie. Eagle's Nest provides a transitional program to help recovering individuals continue in a substance-free environment beyond the first stages of treatment at Mi'Kmaw Lodge. One-on-one counselling is the basis of the NADACA programming, with upwards of 20 certified counsellors employed to cover the 12 Bands in Nova Scotia. As part of a total recovery program, NADACA introduces clients to a range of options, such as job training and counselling, AA, and skills upgrading. NADACA outreach workers provide opportunities for children and youth to engage in positive experiences in their communities through such activities as boys and girls clubs, martial arts, swimming and ballet. A diversion program is offered at both treatment centres, which help clients in post-treatment by providing many opportunities to engage in positive behaviours such as cultural programming, tickets to entertainment and other venues. Through programming, such as those for children and youth, the treatment centres have come to be viewed as places of healing, not of sickness.

supports and resources is necessary for pre-treatment care. It is essential for referral workers to work closely with community and treatment workers, and other available agencies and resources, in order to support the client's preparation for treatment.

Case Management

Case management is a client-centered approach where a service provider (such as a referral worker, Elder, or case manager) or a team of service providers coordinates various health and social services to meet the special needs of each client. It may also involve multidisciplinary partnerships to support the client from pre-treatment to aftercare. To learn more about case management, see Element 6.

Treatment Programming

Treatment programs offer clients a range of services and supports aimed at helping clients stop or reduce an addiction to alcohol and/or drugs, and to improve their overall quality of life. Treatment may occur in a variety of settings (e.g., residential centres, direct counselling in the community, outpatient, day, or evening programs), or land-based healing programs. It may also consist of a variety of approaches and models, and vary in its intensity, specialization, and duration.

Specific approaches to treatment need to include an awareness of, and sensitive responses to a client's needs, including possible mental health issues, age, gender, substance(s) of use and abuse, language, culture, and co-morbid conditions. The approach to treatment may involve the use of medications, behavioural therapy (such as individual or group counselling, cognitive behavioural therapy), or a range of culturally-based activities.

Discharge Planning and Aftercare

After a client has completed a treatment program, it is important to build on the strong foundation set by the treatment process. This process of continuing care and support is a period of less intensive treatment usually referred to as aftercare. Aftercare is often set up during discharge planning at a treatment centre, but may also be part of care planning efforts initiated at any point during a client or family's healing journey.

Discharge planning is a process that guides such things as a return to the community and family; access to case management services; connection with services in key social determinant of health areas (e.g., housing, employment, education, living conditions, and social support); or a referral to a more intensive and specialized program when a client is leaving a structured treatment experience. It is also important that discharge planning begins when a client first enters a treatment centre to provide time to arrange necessary post-treatment supports. It involves making sure that ongoing support networks exist in the form of peer groups (e.g., going to 12-Step meetings or linking to community resources) and, if necessary, transitional housing. For more information on aftercare, see Element 2.

>> CURRENT STATUS

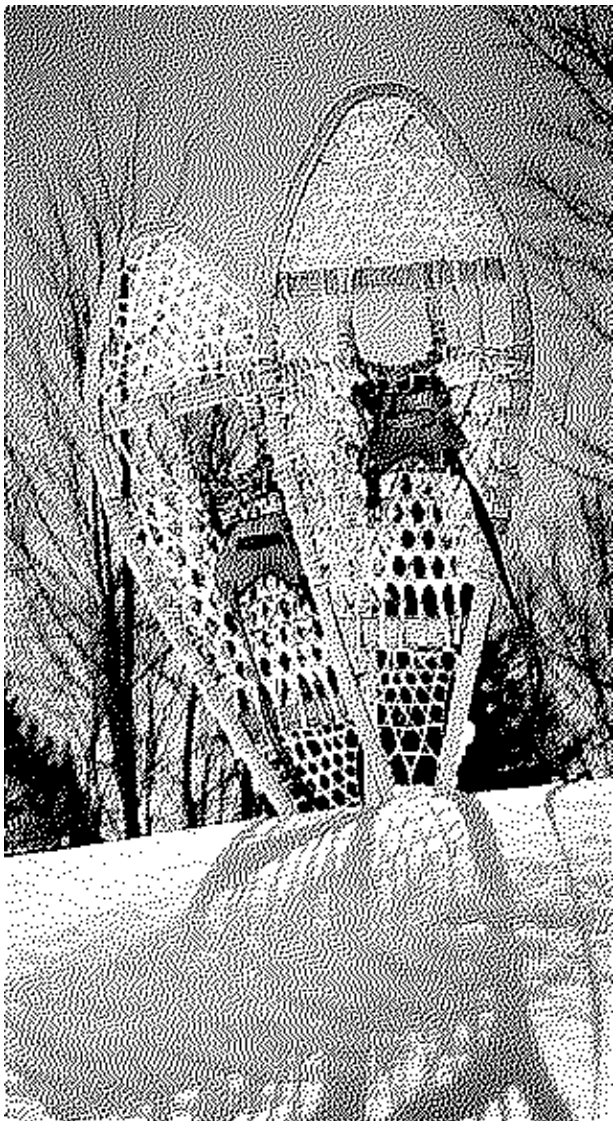
Addiction treatment services for First Nations populations are mainly provided through community-based addiction workers and a national network of treatment programs managed by First Nations organizations and communities. Residential treatment centres, while governed at the local level, are national resources and many centres accept referrals from all parts of Canada. There are also multi-disciplinary teams in some communities offering mental health and addiction services.

The extent to which workers are able to respond to the treatment needs of clients varies. There is also a growing complexity of client needs, which includes higher rates of concurrent disorders, illegal drug use, and prescription drug abuse. The ability and capacity of local workers to meet the complex needs of clients is directly linked to:

- Access to educational institutions where they can obtain and develop basic qualifications;
- Ongoing support and training;
- Clinical supervision; and
- Appropriate referral networks.

Other factors include high workloads, stressful working conditions, and low wages.

In all regions, factors that have an impact on workers' capacity and ability affect whether and how a client's needs can be met at the local level. This is most true



for youth or clients with more complex needs, such as those with complex mental health and addiction issues. Community-based addiction workers are the ones most likely to refer clients living on-reserve for treatment. However, the level of interaction and communication between community-based addiction workers and treatment centre workers before, during and after treatment is described as limited. A similar problem exists for off-reserve referral sources such as friendship centres, social workers, counsellors and psychologists.

The lack of a consistent and streamlined approach to client assessment and referral has been consistently recognized as a challenge by both communities and treatment centres. In some cases, different, and incompatible, assessment and referral tools are being used. As well, some assessment tools require training or fees for use, which create barriers to their consistent use. Through the regional needs assessments, both communities and treatment centres alike have called for a more standardized approach to reduce duplication of efforts and ensure that clients are matched with services appropriate to their needs and strengths.

In general, community-based addiction workers report that they devote large amounts of time to the referral process, while treatment centre staff report feeling frustrated by being sent "inappropriate" clients both from communities and provincial services.

All of the 58 First Nations addiction treatment centres provide culturally-relevant inpatient, outpatient, and day treatment services for alcohol and other drugs. Most of these use a number of treatment approaches—often a blend of cultural and mainstream—as well as life-skill and self-care techniques. Programs can vary in length but are usually between 29 and 42 days. At present, 10 programs provide specific programming for families while 12 are directed at youth. Nine focus mainly on solvent abuse and 17 are gender-based. These treatment centres are accessible either on an ongoing basis, or for certain clients, when needed.

Given the often chronic nature of addiction issues, characterized by high risk of relapse, one treatment episode is usually not enough. Most people who access treatment require multiple treatment attempts and ongoing post intervention support.

Limited access to provincially-based detoxification services has been a recognized barrier to effective client care. Where detoxification services are available, some communities have reported concerns with the cultural appropriateness of these services, as well as difficulties accessing them due to long wait lists.

In some cases, ensuring appropriate access requires clarification of funding responsibilities for these services between federal and provincial levels of government. In cases where medically based withdrawal management is not being offered by provinces, some communities

Caring for the Circle Within—Kwanlin Dün First Nation, Yukon

Caring for the Circle Within was a pilot project hosted by Kwanlin Dün First Nation at Jackson Lake Healing Centre in 2010 that is designed to address the spiritual, mental, emotional and physical needs of participants dealing with issues associated with substance abuse, the effects of Indian Residential Schools, grief and loss issues, violence, and trauma. The goal of Caring for the Circle Within is to provide a supportive, land-based, holistic, and compassionate environment, which includes both traditional and modern healing approaches, in order to foster balance and self-empowerment. This intensive land-based program offered a camp experience as a core part of its design and a central part of the healing process. Participants in the program have reported that the time on the land builds confidence, teaches them new skills, and fosters pride in local culture and traditional ways. A key success factor of the program is the participation of Elders and other community members in all aspects of programming.

have expressed interest in providing withdrawal management in their community. This is a highly complex area of service, requiring a comprehensive approach to ensure client safety.

As with community-based addiction workers, treatment centres are facing higher numbers of clients with ever more complex needs. Some centres have been working to set up specialized programs to respond to these needs, such as prescription drug abuse and mental health issues. The ability of treatment centres to respond to more complex client needs is directly related to their access to specialized training, clinical supervision, and often access to other psycho-medical supports. As long as difficulties accessing these specialized supports continue, the capacity to assume more complex cases will remain limited. The same is true at a community level.

For the most part, treatment programs for prescription drug abuse are based on what is known about addiction treatment in general where behavioural treatments combined with medications have proven effective. Although methadone is used in the treatment of prescription drug abuse, increased training, services and supports are needed. In some cases, tension exists in communities on the question of methadone as a treatment option. Often methadone is provided without complementary psychosocial services to address the other needs and goals of clients. In many communities, abstinence is seen as the only valid way to deal with addictions. Some of this resistance to methadone is based on a misperception of pharmacological approaches, along with examples of inappropriate assessment and prescribing and inadequate complementary supports. Many treatment centres do not take clients on methadone. When they do, the client needs to be stabilized on a specific dose and closely monitored. Reasons why some treatment centres do not take methadone clients include, but are not limited to:

- Limited access to a doctor who is authorized to prescribe the medicine;
- Limited access to a qualified pharmacist that can prepare and dispense methadone;
- Condition that the client must be stabilized enough to qualify for take-home doses or "carries", since this removes the need to travel every day for the daily dose of methadone;
- Uncertainty regarding the effect of methadone on treatment participation;
- Limits on the amount of "carries" that a pharmacy will dispense, so travel to the pharmacy must continue; and
- Client travel to medical services is not a service normally provided.

Unless treatment programs are able to provide medication for people in treatment, the coordination and provision of the necessary supports for dose management present a barrier to client participation in needed care.

Treatment centres range in size from 5 to 30 beds. The centres are based in remote, rural, and urban settings. The physical state of treatment centres has been flagged as a concern in many regions with some centres having limited funding to do basic maintenance, let alone major renovations. In recent years, some limited funding supported building maintenance. However, this funding was reported to be less than what was needed.

In some communities, inpatient facilities have been re-profiled to outpatient centres. This has been done in response to community needs. However, this has resulted in re-profiled programs becoming regional/local in scope, rather than national resources. In other regions, no shift to outpatient treatment centres has happened and "the centre" has been identified as a safe place for clients to go, especially when their communities are not.

Detailed information on how all the treatment centres are used is limited; available data shows major variations in bed occupancy rates, ranging from three-month long waiting lists to centres that are running well below capacity. Per bed costs also vary widely, particularly when economies of scale, travel costs and operating costs associated with treatment are included.

While treatment centres are consistently identified as important resources to support the wellness of the population, there is also growing recognition that this must be supported by effective services at the community level.

>> RENEWAL OPPORTUNITIES

Screening, Assessment and Referral

- Standardized mental health and addiction assessment tools. Such tools would be comprehensive, culturally safe, and easily adapted to meet the unique needs of different regions and populations.
- Cultural assessment tools developed to learn about a client's spiritual, community, or cultural needs. These tools would help to raise awareness and assess the strength of a client's spiritual connection to family, clan and community.
- Streamlined electronic referral systems that may include online bookings. This would help referral workers to quickly find out which programs have available beds/spots.
- Standardized referral packages that include screening tools, such as:
  - an observational checklist and ready-made screening questions about the client's emotional health, diagnosis, prescriptions, and ability to live in a group or be part of an intensive group process;
  - a form for the client to identify the mental, physical, emotional, and spiritual healing resources that are accessible in their home community;
  - a standardized medical form that includes vital statistics, dental care needs, as well as information on psychoactive medications (prescribed by a psychiatrist or doctor and approved by the centre before a client is admitted);
  - a brief mental health screening tool; and
  - cultural assessment tool(s).
- Basic information for community and referral workers on the correct way to offer pre-care services and supports, as well as treatment planning.
- Where available, a liaison with drug diversion courts and mental health diversion courts. Opportunities with these specialized referral routes include decreasing periods of incarceration. Liaisons should include "front end" interface with drug diversion courts as well as post-treatment planning and follow-up.

Withdrawal Management

- Collaboration with medically based withdrawal management (detoxification services) available off-reserve. This would include better coordination and information exchange between services, and a focus on key service gaps (e.g., for youth and women). Inter-agency memoranda of understanding and protocols for culturally safe withdrawal management may need to be developed.
- A system-wide approach to non-medical or minimally medical (e.g., visiting a doctor or accessing a nurse while home detoxing) withdrawal management within communities and treatment centres. This approach would include protocols that are easily adapted to each community's needs and resources. It would take into account problem severity, substance(s) being

used, health risks, and, as needed, culturally based medicines, ceremonies and supports. It would include the need for stabilization, pre-treatment supports and limited medical supports, where required.

- Consideration of stabilization services and supports for people experiencing persistent psychological effects after successfully withdrawing from a substance (e.g., post-acute withdrawal syndrome). This approach would look at including a variety of post-withdrawal management and pre-treatment programming for clients who are not able to or do not want to immediately access more intensive services, and could be offered in a range of settings, such as recovery houses or through outpatient, day or evening programming. These services are crucial for transitioning an individual from withdrawal management when appropriate services are not available.

Treatment Planning and Pre-treatment Care

- A coordinated approach to treatment planning and pre-treatment care for clients and their families. This approach would be linked to community-based resources, such as recovery houses or outpatient, day or evening programming, as well as stabilization and case management supports. Such an approach would seek to identify key people to support individuals in early recovery and to assist with strength-based treatment planning. It may also consider the needs and available supports for children or other dependents when their parent(s) or primary care provider(s) might need to leave home to access treatment.
- Pre-treatment check-ins for clients who are awaiting admission to a treatment facility. This type of support can make them more "treatment ready," and increase their likelihood of successfully treatment.

Case Management

- Community-centred case management approaches that involve multidisciplinary and multi-jurisdictional teams or partnerships to support clients from pre-treatment through to aftercare. For more information about case management see Element 6.

Treatment

Strengthened Care Approaches

- Standardized intake approaches at centres, aligned with the standardized universal referral packages discussed earlier, and including (as needed), medical and mental health screening and assessment.
- Approaches to care must be flexible and responsive to client needs at all levels of treatment. They must

also reflect a client's own Indigenous strengths and connections to culture. An emphasis on ways to strengthen the client's involvement in the treatment process will allow better outcomes to occur. Ways to do this include looking at how a client's involvement and treatment success are impacted by the design of the environment; the staffing model; cultural competencies; a focus on the client's strengths; and the support of family and community.

- A system-wide approach to clinical supervision, especially when it comes to co-occurring mental health issues, for both treatment centres and community-based workers. This approach could include in-person support on a rotating basis to First Nations communities and support through the use of technology (e.g., video conferencing, e-mail, or a 24-hour telephone line) for workers to receive clinical supervision, advice, and guidance.
- Exploration of opportunities to develop manual-based treatment approaches, based on clinical, best practice evidence that can be tailored to community or cultural needs.
- Treatment centre admission policies that support access for clients based on their stage of readiness for change, mental health or addiction pharmacological needs, or unresolved issues with the justice or child welfare systems.
- Recognition of the importance of family and the need to work with families before, during and after a client's stay in treatment to maximize successful outcomes. This is most relevant for youth, but is important for all clients.
- NIHB medical transportation policies, in line with practice-based evidence on client outcomes, to provide access to the services that are the best fit (not just the nearest), and that support a client's return home should they not complete treatment. Such policies would also support a return to treatment even where there has been a previous attempt, and provide support, where appropriate, for family to be involved in treatment.

Tsow-tun Le Lum Treatment Centre—British Columbia

Tsow-tun Le Lum Treatment Centre is a residential treatment centre on Vancouver Island in British Columbia that receives funding from both NNADAP and Corrections Canada. In addition to the centre's six-week addiction program, it also offers a five-week trauma program for individuals who have survived physical, emotional, and sexual abuse, including former residential school students and their families. The centre takes a client-centred and strength-based approach to services and is widely recognized for its use of both mainstream and traditional therapeutic models. Services include a mental health therapist, who provides services to clients and clinical supervision and support to staff; a resident Elder who provides traditional healing and counselling 24/7; and other traditional and spiritual approaches integrated into all aspects of care. The traditional spiritual supports are continually acknowledged by clients in post-treatment evaluations as a key strength and essential part of the program.

Enhanced Support for Cultural Practices

- A culturally competent system-wide approach that supports cultural practices within treatment programs, through policy, program design and service delivery.
- NIHB policies that support a cultural role in health and healing, by:
  - providing professional fees for cultural practitioners comparable to other approved NIHB service providers;
  - covering travel cost, including cultural practitioners and Elders visiting treatment centres to provide cultural support; and
  - acknowledging the community's right to define what a cultural practitioner is and "sanction" specific cultural practitioners.

- Further research on the extent and kinds of treatment approaches that are most likely to help First Nations people, families, and communities defeat prescription drug abuse, including research into non-drug, culturally based forms of treatment.
- Development of cultural protocols to guide relationships between cultural practitioners and communities/treatment programs. These protocols would focus on the dynamics between cultural practice and program requirements and between cultural practitioners and other program staff and clients. Protocols may set out the following:
  - what the treatment program expects and cultural practitioners expect, as well as the roles and responsibilities of each;
  - confirmation of the skill and knowledge base of cultural practitioners; to help create a better understanding of how their role parallels that of mental health professionals; and
  - standards of practice that set out such things as client rights, including the right to choose to be part of cultural practices; conflict resolution and grievance processes; scope or limitations of practice; named healing methods; diversity of practice; screening and assessment; resources and materials to support cultural practices; research, training, and information management; and record keeping and compensation.

Enhanced Collaboration and Knowledge Exchange

- Collaboration with primary care services to better serve clients with other health issues (such as chronic pain, tuberculosis, or diabetes as well as expectant mothers). This will include stronger relationships with nurses and doctors, and may also involve dieticians and other health workers.
- Knowledge exchange opportunities on effective approaches, as well as better access to details on practices from other parts of Canada or the world. This may include meetings or teleconferences among service providers; online discussion forums; a database tool that includes updates on clinical information about addictions which is accessible to the whole network; or development of a "community of practice."

Expanding and Strengthening the Continuum

- System-wide goals to address the needs of all populations are required to remove barriers, combat stigma, and ensure proper services and full community participation.
- Ongoing efforts to expand and strengthen the continuum of services and supports in First Nations communities, seeing residential treatment as just "a step" in a range of services. These efforts will require continued dialogue among communities, service providers, regional bodies, and national representative and funding organizations on questions of program design and configuring services. Key aspects of the discussions may include:
  - alternatives to residential treatment, including community-based approaches, land-based programs, outpatient services, day/evening programs;
  - lower threshold services to serve clients who either are not ready to abstain or have moderate substance use issues;
  - responsiveness of services to different language and cultural group needs;
  - community-based treatment options for rural and remote communities, including the use of mobile treatment or multidisciplinary teams; and
  - best use of existing resources, including a system-wide approach to addressing treatment centres that operate below capacity, as well as consideration of how to strengthen the capacity of programs in order to intake clients on a continuous basis.
- Strengthened approach to services and support for specific groups based on regional and national needs. Such an approach may include but is not limited to:
  - gender-specific services;
  - youth-specific services;
  - family-centred services; and
  - mental health-centred services
- Increase multidisciplinary support for NNADAP/NYSAP staff and provide specialized services more often. This would include case management processes and policy development, clinical supervision, direct service delivery, and training. It would also support strong links with crisis intervention and

centre-based addictions services, specialized mental health services, and justice services.
- Efforts to improve physical structures through more capital funding to treatment centres, and through spaces within buildings that allow for cultural practices, such as rooms with fans or vents so smoke can escape, larger group spaces, more offices, and areas for physical activity.

Discharge Planning and Aftercare

- Stronger relationships between treatment centres and referral workers (or communities) in all phases of client treatment, as defined and supported by policy development. Treatment centre counsellors could use tele/video conferencing to connect the client with the local care worker as part of the aftercare/discharge planning process. Other opportunities to support these linkages include networking forums for addiction workers each year and cross-training opportunities.
- Better recognition of social determinants of health in discharge planning and aftercare through greater collaboration with social services and an increased focus on life skills, emotional intelligence, or job training, both within programs and as a key aspect of aftercare planning.
- Stronger support for relapse prevention, especially as based on the Marlatt model within treatment that focuses on both immediate determinants of use (e.g., high-risk situations, outcome expectations, and coping skills), covert antecedents (e.g., lifestyle factors, urges, and cravings), and seeks to strengthen family, community and cultural supports.
- Development and support for community-based peer support programs to assist individuals and families in recovery.
- Using new electronic approaches to support clients (e.g., e-mail, social media, hotlines, an anonymous online discussion forum for aftercare), and providing "booster" or refresher programs for former clients at risk of relapse.

Nelson House Medicine Lodge—Culture and Ceremony

"Paving the red road to wellness," the vision of the Nelson House Medicine Lodge (NHML), truly guides the daily, weekly and seasonal resurgence of Cree culture and tradition to the benefit of clients, staff and community of this Northern Manitoban alcohol and drug treatment centre. Cultural activities include daily smudging observances, sacred songs and prayer, traditional teachings, weekly sweat lodge ceremonies and substantive seasonal undertakings, all drawing on the direction of Cree Elders. The NHML is a 17-week, 21-bed inpatient NNADAP alcohol and drug treatment program serving adult clients of either gender, most often native but occasionally non-native. Clients, staff, board members, and the community at large participate in spring, summer and fall fasting camps; medicine gathering; an annual winter round-dance which honours those who walk in sobriety; and the Sundance. The board, staff, and clients played a huge role in the reintroduction of the Sundance in Nelson House after a 130 year absence. By paving the red road to wellness, the NHML eases and enriches cultural and identity reclamation for their clients and community members as a primary means of promoting mental wellness as a way to a healthier, happier life.

People with highly complex service needs, including individuals with severe addiction and/or mental health or chronic health issues, require effective screening, assessment and referral; culturally competent services; and ongoing support and monitoring throughout their healing journey.

Those who access these care options, whether within or outside of the community, benefit from strong connections to support networks, such as family and community.

Element 5

Specialized Treatment

>> DESCRIPTION

The service and support components in Element 5 are intended to provide specialized treatment for people whose substance use issues are complex and severe. People with highly complex service needs, including individuals with severe addiction and/or mental health and chronic health issues, require effective screening; assessment and referral; culturally competent services; and ongoing support and monitoring. Those who access these care options, whether within or outside of the community, benefit from strong connections to their support networks, such as family and community.

The kinds of services provided in Element 5 are the same as those outlined in Element 4, but usually with significantly greater levels of intensity and professional specialization (e.g., psychiatric intervention and medically-based detoxification).

The key components needed to support an effective approach to specialized treatment are:

- coordination of care;
- cultural competency; and
- community-level capacity and support.

Services and supports for specialized treatment are generally provided in acute care or specialized care settings. Doctors, psychiatrists, psychologists, social workers, and cultural practitioners are the primary service providers, and often provide support through strong case management services and supports.

>> KEY COMPONENTS

Coordination of Care

Coordination of care efforts, such as case management and multi-disciplinary teams, that facilitate collaboration among care providers in a manner that is culturally competent are important for supporting clients with complex needs. This collaborative approach is essential given the range of services often required by clients in this element.

Cultural Competency

Cultural competence requires service providers to have knowledge of, and openness to, the cultural realities of the clients they serve. It also requires that service providers are aware of their own worldviews and attitudes toward cultural difference, including how these may influence the type of care that is provided.

To support cultural competence within the system, it is necessary for Indigenous knowledge to be translated into current realities so that cultural principles and knowledge meaningfully inform and guide the direction and delivery of health services and supports on an ongoing basis.

Community-level Capacity and Support

Capacity and support must be in place for community based workers to ensure that clients with highly complex needs get the support they need in time. This element allows trained service providers who have the required resources and tools to effectively screen and refer clients with complex needs to addiction and mental health assessments, specialized services and aftercare. This component also involves making sure that community members are aware of and understand the health problems that commonly occur along with substance use issues, and the types of supports that are available.

Collaboration among service sectors (e.g., the justice and education systems) and service providers is also important. A strong network that works together will make it easier for a client to move through the assessment, referral, treatment, and post-treatment phases of care. However, communities may need to find and use innovative ways to provide intensive services and supports. An example might be tele-psychiatry. It can be linked to primary health care services to effectively provide the client with the medical-based care needed, and a variety of cultural healing approaches and supports within communities.

>> CURRENT STATUS

Federal, provincial, and First Nations governments all play an important role in supporting First Nations people who require specialized services. Most of these services, however, are delivered and funded by provincial governments. As well, it is not uncommon for clients in need of specialized services to only get access to them when they are involved with the justice system.

When provinces shifted away from institutional care and towards community-based models of service, this impacted First Nations communities. The need for specialized, more intensive services remains a significant concern both within the NNADAP/NYSAP system and in other social and health systems across Canada. For example, limited beds in psychiatric hospitals mean that long waiting lists are often to be expected when attempting to find the appropriate services for someone with highly complex needs.

In many cases, clients with complex needs require support from a range of care providers, both within and outside their home community. This type of support often requires information exchange and coordination between various care providers and, in some cases, jurisdictions. Navigating through these separate systems of care is a challenge that those who provide services and supports to clients frequently face. As well, clients living in remote communities may suffer limits or delays in care if there is reduced access to primary health care and social service providers who play a critical role in assessing and referring people to specialized services.

Although community-level resources for people with complex needs are often inadequate, there are some communities with access to more specialized services. In general, however, most of these services are offered off-reserve. The concern with off-reserve services is that they may not be culturally safe and the client may lack the support that comes from community, family and cultural networks.

Keewaytinook Okimakanak Telemedicine and K-Net—Ontario

The Kuhkenah Network (K-Net) provides information and communication technologies, telecommunication infrastructure and application support to First Nations communities across north-western Ontario, as well as in other remote regions in Canada. K-Net recently partnered with Keewaytinook Okimakanak (KO) to provide First Nations access to the Ontario Telemedicine Network for clinical, educational, and administrative services. KO Telemedicine (KOTM) is a complete telemedicine program, connecting remote First Nations communities with health service providers. This technology has helped facilitate access to psychiatric services and supports. KOTM also includes an education program, which provides access to education sessions, training and support for community front-line workers and health staff, and supports the sharing of knowledge for and among addictions workers through online access. The service also includes Elder visitations, which feature an Elder presenting teachings such as traditional medicine and storytelling through video conferencing to community workers and members. K-Net is a program of Keewaytinook Okimakanak, a First Nations tribal council established by the leaderships of Deer Lake, Fort Severn, Keewaywin, McDowell Lake, North Spirit Lake and Poplar Hill bands to provide a variety of second level support services for their communities.

In addition, clients with complex needs are also referred to NNADAP/NYSAP centres when they should not be. Although this is not ideal, many centres do their best to manage clients' complex and concurrent needs so that the client will not be discharged before addiction treatment is complete.

>> RENEWAL OPPORTUNITIES

Coordination of Care

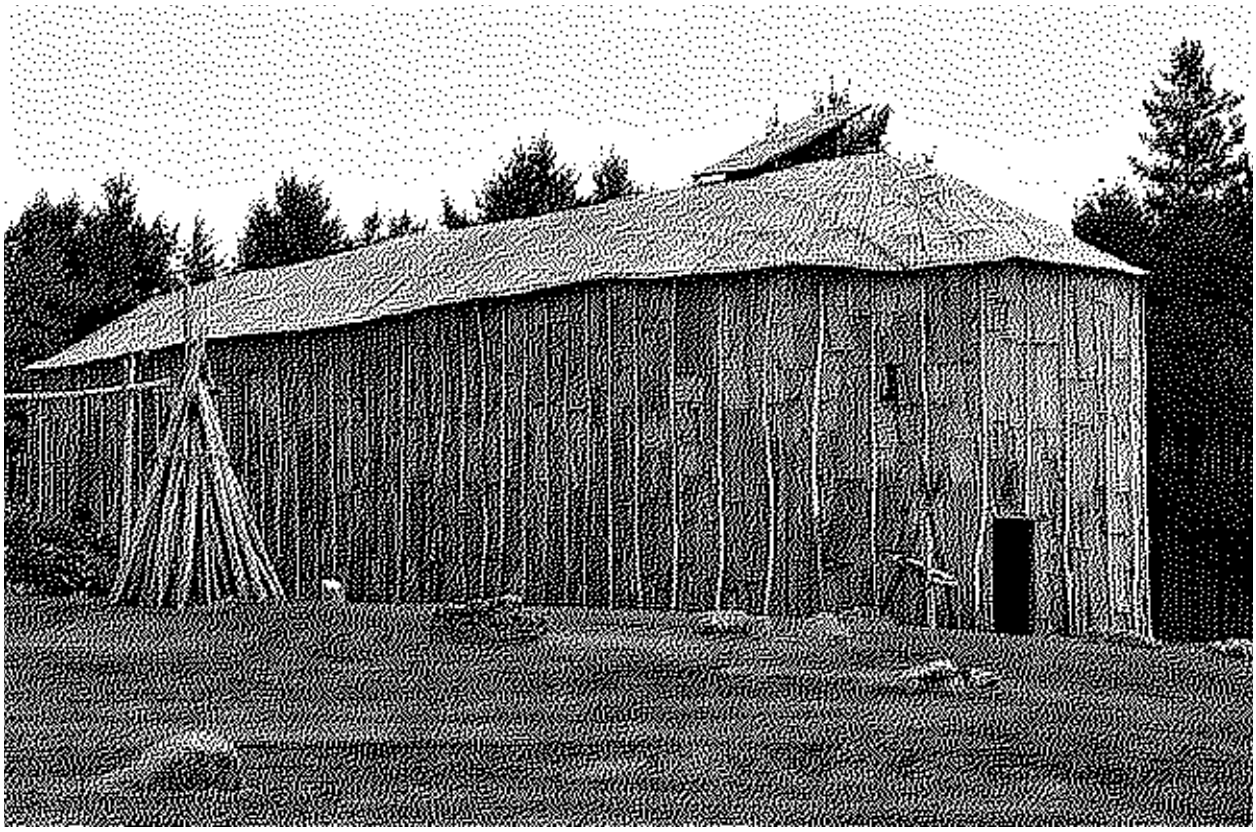
- Enhanced access to culturally safe and specialized services for clients within federal and provincial correction systems. Efforts could also be made to

link clients with appropriate community services and supports (e.g., family, community and cultural) when they are released. This will help to ensure continuity of care and successful reintegration into community life.

- Approaches to screening, assessment, referral and case management that ensure strong linkages between services and supports amongst communities and provincial and federal partners.
- Policies and formal agreements designed to coordinate the range of services and supports necessary for clients accessing specialized services across jurisdictions. These measures will help to reduce service gaps, make roles and responsibilities clear, and increase resources to meet client needs. Examples of such policy tools include inter-agency memoranda of understanding or agreements.

Cultural Competency

- First Nations' world views, an understanding of cultural practices and traditions, and the history of intergenerational trauma could be included in treatment and care plans. For example setting out the role of intergenerational trauma in concurrent mental illnesses. This would enhance both a client's comfort level when receiving care outside the community and treatment outcomes.
- Greater cultural competency among specialized service providers can lead to culturally safe care. For example, the Royal College of Physicians and Surgeons of Canada has a framework on cultural competencies that could be used or adapted to local contexts. It sets out core cultural competencies in a First Nations context for undergraduate, postgraduate, and continuing education medical studies.
- Cross-cultural training between NNADAP/NYSAP workers and mainstream service providers, with an emphasis on ensuring that the services and supports they provide are culturally competent and culturally safe. Training could be provided within provincial education services and through training courses in collaboration with NNADAP/NYSAP treatment centres and First Nations communities.

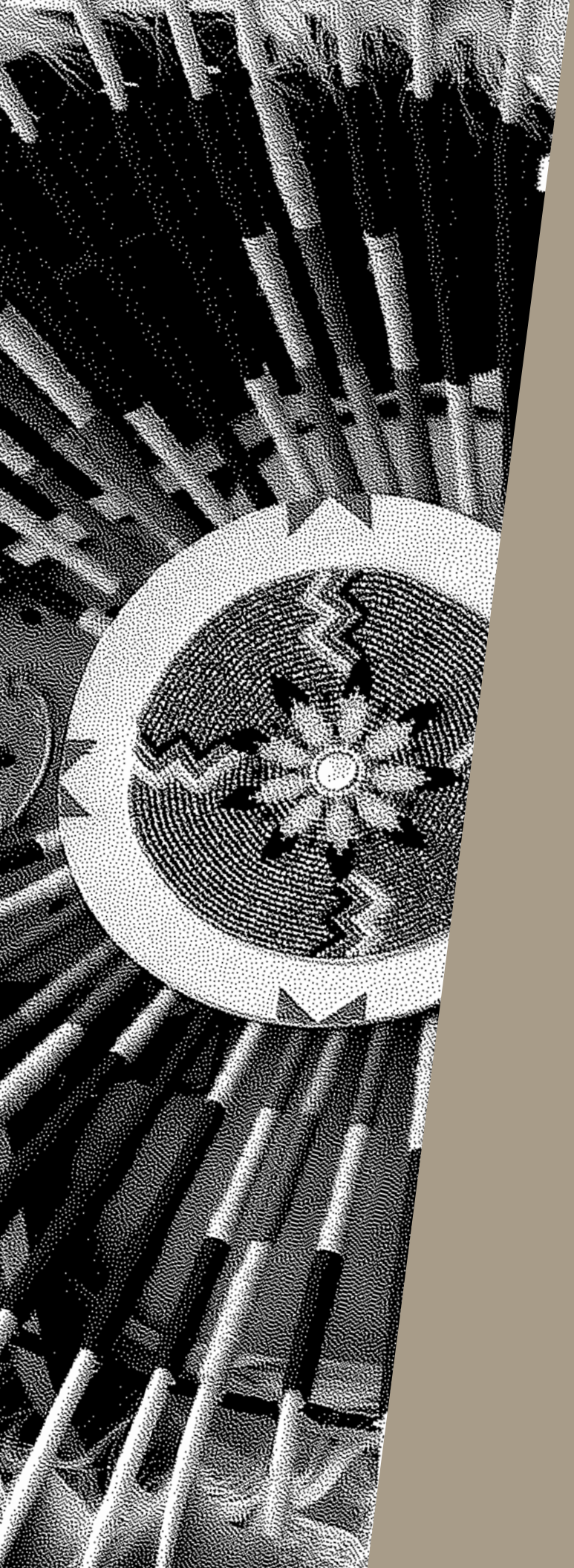


Community-level Capacity and Support

- The promotion of community awareness and education (with a focus on mental health and illness) in order to reduce stigma and to inform clients about how services can be accessed.
- The promotion of community-centred case management and the capacity for outreach that would involve multidisciplinary and multi-sectored teams or partnerships. Clients with complex, long-term needs and changing priorities require a team-based approach. It is most helpful to set up a long-term support system that draws on services from a number of sectors in a coordinated and strategic way. It would also help to use the limited care that can be provided within the community setting without fully exhausting it.
- Policies, services, and supports that foster culturally safe care for First Nations people who have highly complex needs. This may mean that funding and payment models would need to be adjusted to include Indigenous elements of care within care plans.
- The presence of primary health care services—and ideally specialized health services—within the community. This is very important, especially when it comes to effective assessment and referrals. Where a lack of resources limits services at the community level, solutions such as online, mobile, or teleservices (such as tele-psychiatry) could be explored.

Anishnawbe Health Toronto—Ontario

Anishnawbe Health Toronto offers specialized services to status and non-status First Nations, as well as Inuit and Métis people. Most of the clients are supported by social assistance and must have stable housing, including long-term shelter accommodation, to qualify. The walk-in intake is open five days a week, during which screening for substances, gambling and mental health issues is conducted. Referrals to detox, mental health services or a residential program are part of the intake service. A unique treatment plan is developed for each client, utilizing both individual and group counselling, and clients are able to choose among traditional healers or traditional counsellors. Culture plays a large role throughout treatment, such as traditional teachings and ceremonies as well as a traditional sweat lodge. Medication management is provided by an on-site psychiatrist, as well as a nurse for longer term injection medication. A psychologist performs assessments weekly. Clients participate in training and education sessions, such as life skills, cooking on a budget, self-care and self-esteem, art therapy, physical activity and healthy communication skills. To assist clients after their discharge from the program, an "aftercare circle group" is held once a week. All services are provided at no cost to the client and no provincial health identification is required.



An effective system of care requires coordination between a wide range of services and supports for individuals and families throughout the healing journey.

This system of care provides collaborative and consistent communication, as well as planning and monitoring among various care options specific to a client's holistic needs. It relies upon a range of individuals, including service providers, case managers, friends, or families to provide ongoing support to facilitate access to care.

Element 6

Care Facilitation

>> DESCRIPTION

People and families at higher risks of developing substance use issues may benefit from a range of services and supports during their lives. The types of services and supports will change over time but may include:

- Formal mental health and addiction services;
- Community and family supports;
- Cultural supports; and
- Services and supports to meet other needs such as housing, jobs, education and parenting skills.

Care facilitation can refer to formal case management or it can involve other forms of community-based, professional, or social support. No matter what it looks like, an effective system of care requires coordination between these various services and supports for individuals and families throughout the healing journey. This system of care provides collaborative and consistent communication, as well as planning and monitoring among various care options specific to a client's holistic needs. It relies upon a range of individuals to provide ongoing support to facilitate access to care.

Key components of effective care facilitation include:

- Social and cultural supports;
- Assessment and planning;
- Collaboration and information sharing;
- Advocacy; and
- Ongoing follow-up.

The people who are well-placed to provide care facilitation include any service provider involved in the client's care (such as NNADAP community-based addiction workers, case managers and staff at urban Aboriginal friendship centres), as well as community members (including Elders and cultural practitioners) who can support clients and their families in accessing the care they need during their healing journeys.

Tui'kn Case Management Model—Eskasoni First Nation, Nova Scotia

Eskasoni First Nation was the first Aboriginal community in Atlantic Canada to establish a multidisciplinary, multi-departmental case management team. Following a series of tragic events within the five Cape Breton First Nations communities, and with funding from both government and communities, these efforts were expanded to the surrounding communities of Membertou, Potlotek, Waycobah and Wagmatcook—known as the Tui'kn Partnership. The Tui'kn case management model is an approach to mental health and addictions that helps individuals, families and their communities restore and sustain balance and well-being. Through the creation of community-based multidisciplinary teams, the five communities have established a mechanism for the delivery of a streamlined, accessible, time efficient, coordinated, and gap reducing mental health/health/well-being/addiction service delivery model of holistic care. By creating these teams, what once would have taken individuals from multiple agencies several months to accomplish on behalf of their mutual clients can now be addressed in an efficient, coordinated, collaborative, and time sensitive manner.

>> KEY COMPONENTS

Social and Cultural Supports

Social and cultural supports are an essential component of an individual or family's healing journey. These supports can not only provide an essential source of encouragement and care but may also help identify care options, navigate services, and maintain connections between various other supports and care providers. This kind of support includes family, friends, and community members.

Assessment and Planning

Once a client has been screened and assessed (See Elements 2, 3 and 4), a range of individuals can help to develop a unique care plan grounded in the individual's or family's strengths, values, and goals, based on available resources and services. Care plans map out key services

and supports throughout an individual's care journey, which often take place at various stages. This plan may outline a range of formal and informal services and supports, including those care options that address key social determinant of health areas (e.g., housing, employment, education, living conditions, and social support). Care plans should be reviewed frequently with clients and adapted as their needs change (e.g., with the addition of an aftercare plan post-treatment).

Collaboration and Information Sharing

Through relationship-building and information/resource sharing with clients, their families, and other community services, this component makes it possible to establish meaningful partnerships within the community. It can allow providers to make the best use of limited resources and supports, enhance community and individual capacity, and remove or reduce delays and needless duplication. This approach may be something as simple as frequent meetings between health and social service providers or the identification of one worker within the community who is solely responsible for wellness-based case management. To support access to both on- and off-reserve services, it may be necessary to have regionally-based case management support as well.

Advocacy

This component involves speaking out on behalf of the clients and their families in order to enhance the continuity, accessibility, accountability, and efficiency of resources and services available to them. Advocacy can happen at individual and community levels. It can also have an impact on policy development to improve prevention, health promotion, early identification, and treatment services.

Ongoing Follow-up

This component provides ongoing review and recognition of what the client has achieved. It may involve adjustments to goals and changes to care plans, as needed, to serve and support the client during the healing process.

>> CURRENT STATUS

Mental health and addictions systems are fragmented and require enhanced coordination. Services and supports vary between communities and are offered by different levels of government, with often limited collaboration. Informal care facilitation is well-established in many communities. Often, community and family members assume key roles in supporting care. However, given the complex and fragmented nature of the services available and the limited awareness of available services, finding care for their family members can often be a challenge.

More formal care facilitation (e.g., case management) is not currently available in many communities or at the regional level. This often means clients are not aware of the services available to them including housing, job training, education, and community and cultural supports. Communities that do provide case management often find that the practice is uncoordinated and lacks effective communication and information sharing.

Workers often lose contact with clients after the client leaves a treatment centre. As well, uncoordinated service delivery can mean that clients must wait longer to get and benefit from services.

Sharing client information among service providers has raised concerns about privacy in First Nations communities. The proper ways to share information are often not in place. In smaller communities, where everyone knows each other, keeping information private can be hard to do.

>> RENEWAL OPPORTUNITIES

- A well-defined system-wide approach to care facilitation, available at both community and regional levels. These approaches should:
  - rely on evidence-based and culturally-relevant screening and assessment tools;
  - seek to coordinate with relevant health and social services, based on the needs of clients and their families;
  - respect existing confidentiality and privacy acts;
  - promote access to training and resources for individuals who provide care facilitation;
  - foster a system of support for the client within their social, family, and community;
  - promote the development of partnerships with specialized services from other communities, provinces, or other jurisdictions; and

Sakwatamo Lodge—Melfort, Saskatchewan

Sakwatamo Lodge has an Elder aftercare network to support the continuum of care for clients that complete their program and are returning home to their communities. Clients upon returning home are connected to their community NNADAP worker for access to various aftercare programs. Clients are also connected to this network of Elders to provide them additional support in the areas of culture, tradition and the transition to a healthy lifestyle. Elders provide the client with culturally sensitive knowledge, wisdom and participate in a variety of ceremonies to strengthen the client's resolve and decrease the likelihood of recidivism. These Elders have been trained in the various areas of addiction and have worked with Sakwatamo staff prior to becoming a part of the aftercare network.

  - include a focus on support for family members and other loved ones.
- Case managers from allied services who refer people to NNADAP services could receive cultural competency training, provided by a First Nations institute as this becomes increasingly more common across provincial health authorities.
- Standardized assessment tools and placement criteria would also contribute to increased information sharing and the use of available resources, such as referring people with the most severe issues to the most intensive treatment settings.
- A full and coordinated referral system that allows for referrals between on-reserve and off-reserve resources, and among mental health, addictions, and primary care services. This kind of system would also recognize the important role that community and family members play in care facilitation. The referrals would identify potential risks, drug use, client history (e.g., personal medical and impacts of colonization through intergenerational trauma), and other issues facing the client from a strengths-based perspective (especially cultural identity), to facilitate collaboration, information sharing, and care planning with all available supports.
- Increase awareness within communities of the range of available services and supports, including the eligibility criteria for accessing these services. Increased awareness of these services will help family and other social supports refer individuals to appropriate screening, assessment or intervention settings. This may involve something as simple as the development of a pamphlet that would be available within public areas.

SUPPORTING THE CONTINUUM OF CARE

The foundation of quality care for clients is: a qualified workforce with the appropriate skills and knowledge, supported by a healthy work environment, competitive wages and benefits, and opportunities for worker development.

Workforce Development

>> DESCRIPTION

A qualified workforce plays a vital role in the quality of care clients receive. A comprehensive strategy for human resource management supports hiring and recruitment and offers practical options for professional development. It sets the stage for employee satisfaction and retention. A strategy will help ensure the right mix of staff with appropriate qualifications and training is on hand to provide supports and services on an ongoing basis.

The key components of an effective approach to workforce development include:

- cultural knowledge and skills;
- recruitment;
- education and training;
- worker certification;
- worker retention;
- wages and benefits; and
- personal wellness.

>> KEY COMPONENTS

Cultural Knowledge and Skills

The skills and experience needed in a First Nations addictions system extend beyond clinical or counselling skills. The NNADAP and NYSAP programs were built upon the foundational belief that Indigenous-specific cultural practices drawn from an Indigenous worldview would provide the best route back to wellness. A strong basis in community and culture, and an understanding of cultural healing practices are important in both community and treatment centre settings.

Recruitment

Recruitment involves attracting, screening, and selecting qualified people for employment. The ability to attract qualified candidates is often directly linked to how a candidate views the organization and the pay and benefits provided. It is easier for organizations to recruit staff if: they have well-administered human resource policies and practices that balance recognition of western and traditional cultural qualifications; they have appropriate salaries and benefits; and the organization involves staff in decision making. Where the available pool of qualified candidates is limited (e.g., in rural and remote communities), ensuring staff have the capacity and opportunity to increase their qualifications over time through well planned recruitment and retention planning is essential.

Education and Training

Ongoing training and/or education is a requirement in the addictions field because of work complexity at the community level and the ongoing developments in the fields of prevention and treatment. With greater challenges and more diversity in services and programs, the capacity of service providers must also evolve. Specialized training, cultural competency, and multidisciplinary training are becoming more important if not necessary to help inform the workforce of emerging addiction and mental health issues. For specific or special needs groups, such as youth and women, workers often require targeted training and education to meet client needs.

Worker Certification

Certification is recognized as a key activity that enhances the skills of addiction workers. Certification involves an independent third-party assessing and acknowledging a person's level of knowledge and skill based on a set of pre-determined standards. Some advantages to being certified include better professional recognition and job mobility, as well as higher staff satisfaction and retention.

Worker Retention

Retention is the result of having appropriate human resource measures in place. It also depends on whether an organization can create a positive and supportive work environment. Although many factors can have a direct impact on retention rates, staff satisfaction with their job, a healthy relationship with a supervisor and competitive wages are often said to be the most important factors. For supervisors, both paying recognition to staff and engaging workers in policy development/decision making may also encourage retention.

Standardized Salary Grid—Alberta

In 2004, the Alberta region developed a standardized salary grid to provide First Nations communities and treatment centres with a streamlined approach to salaries within the addiction workforce. A committee composed of staff from FNIHB, NNADAP treatment centres, and community-based programs developed an incentive-based salary funding model by streamlining job descriptions into a single, standardized wage scale. As a result of this work, extra funds were given to treatment centres based on staffing levels and salaries, plus a remoteness factor. Funding to community-based programs was based on the Community Workload Information System (CWIS). Other groups/organizations, such as the Regional Addictions Partnership Committee of Manitoba, the Treatment Directors of British Columbia and the Youth Solvent Addiction Committee, have also developed standardized salary grids.

Wages and Benefits

Wages and benefits for the addictions workforce in communities and treatment centres are based on two factors: availability of funds and employer policies and practices (e.g., standardized job descriptions or salary grids). This is part of human resource management that is administered at the community level. In terms of benefits, an Employee Assistance Program can provide support that will help with the stresses of providing complex services at the community level and can reduce employee burnout.

Personal Wellness

Psychological Safety

Psychological safety refers to a workplace culture that promotes healthy mental wellness. Having healthy workplace policies, a trusting atmosphere, and resources for employee assistance will encourage psychological safety and allow employees to feel comfortable. Using employee surveys and feedback, addictions organizations can enhance employees' psychological safety.

Acknowledging and addressing vicarious trauma is one way an organization can promote and sustain the psychological safety of their staff. Vicarious trauma can be defined as a personal reaction to frequent exposure to the traumatic experiences of clients, especially when the discussions involve violence and physical abuse. Vicarious trauma generally happens over time and, if it is not addressed, can have a negative impact on the employee's work and personal life. Due to the nature of their work, helping professionals are at an increased risk of experiencing vicarious trauma. Common signs include anger, depression, fatigue, and problems with relationships.

Self-care

Both the employee and employer are responsible for self-care. It is critical for staff to manage stress and essential to have a self-care plan. A good self-care plan considers the physical, mental, emotional and spiritual needs of a worker.

Many centres within the NNADAP/NYSAP network use yearly personal wellness plans in annual performance appraisals to ensure that self-care is part of the workplace. Workshops, training events and professional development opportunities can promote self-care for staff.

>> CURRENT STATUS

The NNADAP/NYSAP workforce includes approximately 1,500 treatment centre and community workers. While they bring passion and dedication to their work, they can also be overlooked and not appreciated for the role they play in the system.

Community addiction workers are employed through their community. Their salary is generally set by funding authorities and available resources. Communities hire workers and set salaries using a variety of means, (e.g., wage scales and job descriptions). In most regional needs assessments, salaries were found to be one of the

most important barriers to hiring and retention. Limited resources and policy issues often make it hard for communities to set aside resources each year for salaries.

The on-reserve addictions workforce ranges from workers with formal education (like post-graduate degrees) to some staff with more limited addictions training and others still with cultural knowledge, skills and community sanctioning to conduct ceremonies with relevance to addictions treatment and prevention. All workers face the challenge of keeping up with emerging and complex addiction issues. During the last decade, both the addictions workforce and employers have acknowledged the importance of training and certification as a key way to meet standards and to provide effective, high-quality, culturally relevant addictions treatment and prevention services.

Training is a key requirement for workers to maintain certification. Unfortunately, prevention or treatment training does not occur in a systematic manner and is not consistent across all regions. Access to career development can be limited or lacking in smaller communities.

Despite differences across regions, most of the workforce at the community and treatment centre level has addictions training, certification training, a degree, or diploma. Treatment centre staff access to clinical supervision and support is also increasing.

In general, hiring and retention are common problems in addiction programs. Isolation and lack of community supports are also issues of concern. High staff turnover remains a significant problem, with skilled and experienced workers moving to the provincial system or leaving this work altogether. The reasons range from inadequate salaries and high workloads, to stressful working conditions and a lack of cultural supports.

>> RENEWAL OPPORTUNITIES

- A national addictions workforce strategy that respects local governance could provide guidance and support to employers for all aspects of human resources related to the addictions workforce.
- Competency-based job descriptions and training may help to support both worker development and better services for clients. Generic job descriptions can be a useful tool for multiple employers.
- The huge demands on addiction workers make it critical that a healthy work environment exists. A process for collecting and sharing strategies that promote worker wellness may provide additional support to both community and treatment centre staff. This process may include strategies for:
  - developing wellness plans for staff;
  - identifying opportunities for workers to voice their opinions on decisions;
  - developing and reviewing healthy workforce policies;
  - providing regular events/awards to recognize workers;
  - ensuring employees have formal ways to provide and receive feedback; and
  - creating plans for employee development.
- Enhanced networking among workers as a means for regional information exchange and networking forums to:
  - share effective approaches;
  - enhance service coordination; and
  - encourage formal and informal supportive professional networks.

Cultural Knowledge

- Identification of ways to link cultural knowledge, skills, and community-based cultural practices. This will be important for raising cultural competency within mental health and addiction services.
- Recognition of cultural knowledge and skills in qualifications for mental health and addictions services.
- Compensation of cultural knowledge and skills in setting salaries/wages.
- Provision of, or allowance for, cultural knowledge and skill development through culturally based professional development and psychological safety strategies.

Recruitment and Retention

- A key to longer term recruitment could be greater advancement opportunities through:
  - laddered approach to career building, which may lead to degrees or post-secondary education;
  - distance education programs;
  - support for education through bursaries or scholarships;
  - supervised clinical training;
  - activities to promote a psychologically safe workplace;
  - culturally appropriate professional support through an Employee Assistance Program, which includes access to Elders and cultural practitioners; and
  - orientation programming for new staff that is critical in supporting the engagement of new employees.

Education and Training

- An ongoing focus on education and training of workers, especially with respect to emerging issues (e.g., prescription drug abuse), target populations (e.g., women, youth, and people with co-occurring mental health issues), and essential skills and competencies (e.g., evidence-based prevention and health promotion strategies). This training can be supported through an approach to clinical supervision, either at community or regional levels, and may be enhanced through a mix of video-conferencing and distance education along with training and flexible work options.
- Emphasis on addiction and mental health training for a range of other care providers who may also be involved in client care. This may include family and community members, other community service providers, primary care and other medical staff (e.g., nutritionists and dental teams), and off-reserve service providers. This training could focus on signs of substance use or mental health issues; available services and supports; community and cultural considerations; and specific considerations for their area of practice.
- Partnerships between communities and cultural knowledge societies/Elders, regional training bodies, schools, universities, and provincial, territorial, or federal government agencies would help to ensure that supports are in place for workers seeking education. As well, training programs available within education institutions are required to provide courses and education necessary to complement workforce competencies.
- Partnerships with certifying bodies and schools/universities to ensure training and certification standards are accessible and culturally-relevant for the First Nations addictions workforce.

Certification

- Respond to the need and demand for culturally responsive certification standards for NNADAP and NYSAP workers.

Wages and Benefits

- More information and analysis are needed before regional and community salary scales and job descriptions endorsed by First Nations leadership can be applied to the addictions workforce. These scales could reflect both clinical and cultural competencies, and may draw upon certification data as key criteria within scale development.

Manitoba Clinical Supervision Approach

In response to a recommendation from the Manitoba Regional Needs Assessment, Health Canada's Manitoba Region, with the support of the Manitoba First Nation Addiction Committee, entered into a contract with a therapist for clinical support and training for the region's four NNADAP treatment centres. Since 2009, the therapist has provided both direct clinical supervision and training and has coordinated workshops and information sessions, all based on specific needs identified by each centre. Training and information has included such topics as the support of clients with prescription drug issues and children with FAS/FAE. Partnerships with related organizations have been facilitated as a result of these activities, leading to increased collaboration and information exchange.

The development and maintenance of holistic community-based addictions services and supports, which are informed by First Nations culture, values, and tradition, are central to a community's health and well-being.

These services and supports are enhanced when they are controlled and defined locally, and benefit from collaboration between and among governing bodies and service providers.

Governance and Coordination of Systems

>> DESCRIPTION

Strong governance and coordination among and within systems are vital to developing and maintaining a continuum of care in a First Nations community.

The responsibility for the governance of on-reserve addiction prevention and treatment services often rests with First Nations chiefs and councils, treatment centre boards of directors, tribal councils, and First Nations self-government structures. Specific to mental health and addictions, governing groups are responsible for two main functions: 1) making sure that needs are being met through systems design and policy; and 2) supporting accountability in all aspects of service delivery.

Key components that support both the governance and coordination of systems include:

- Community-driven addiction services;
- Inter-jurisdictional relationships and collaboration; and
- System level partnerships and linkages.

Alberta Region Co-Management Committee—Alberta Region

Since 1996, the Alberta Region Co-Management Committee has helped to ensure that Alberta First Nations are full partners with Health Canada with respect to community health administration. This group represents the majority of communities within the Region, and those without membership possess observer status at Committee meetings. The Co-Management Committee is comprised of six sub-committees which link to clusters of FNIH health programming: Non-Insured Health Benefits; Mental Health and Addictions (NNADAP and NYSAP); Children and Youth; Prevention Programs; Health Protection; and Governance and Capital. All sub-committees are co-chaired by a First Nation representative and FNIH ensuring full partnership and collaboration on all decisions. Through this committee, First Nation leadership and FNIH participate as equal partners in the administration of health programming for Alberta communities.

>> KEY COMPONENTS

Community-driven Addiction Services

A stable and progressive addictions service must be driven by First Nations communities and embody their cultures, values and traditions.

Inter-Jurisdictional Relationships and Collaboration

An effective addictions system requires the development/maintenance of inter-departmental and inter-jurisdictional relationships and collaboration. This kind of collaboration helps to understand:

- The impact of social determinants of health and their role in service delivery and continuity of care for clients (e.g., mental health, corrections, child welfare);
- Coordination and transition between services and supports (e.g., between provincial detox and community-based services); and
- How services can be responsive to the unique needs of First Nations people and communities (cultural competency).

It is important that the link between accountability and communication be clearly defined and actively supported. Collaboration requires a clear understanding of the roles and responsibilities of on-reserve governing bodies and service providers, as well as those of regional, provincial, and national service providers.

System-Level Partnerships and Linkages

Key opportunities for collaboration exist among governance bodies, health providers, and social service providers. In some cases, this collaboration is facilitated through community health boards or advisory committees that coordinate health services including NNADAP/NYSAP services or a regional NNADAP organization that represents all First Nations communities.

Establishing stronger links among addiction networks, community-based representatives, community-based programs and other key partners at the community level (e.g., research, political policy, and advocacy organizations) provides an opportunity to promote the interests of First Nations at regional and national levels. Regional and national networks can provide opportunities for knowledge development and exchange; a forum for contributing to the evolving addictions field; and ongoing advocacy for programming. All of these are vital in supporting community-based addictions systems.

>> CURRENT STATUS

Diversity exists in governance structures for First Nations people, at all levels. Depending on the community, these may include: band councils, self-government, regional tribal councils, and provincial/territorial organizations, as well as national Aboriginal organizations representing women, urban Aboriginals, addiction, and mental health. These issues can present unique challenges when adapting governance and service needs for such a diverse client base.

Community decision makers and leadership have significant roles in reducing substance use issues within a community. Without clearly defining governance structures, the roles can be unclear between a First Nations community governance body and the addictions or mental health service, especially with respect to who is responsible for setting policies and standards.

The level of integration and collaboration between community addictions services and off-reserve or provincial services varies widely. In some regions, collaboration is formal and well-established, while others have little or no collaboration. This is the case for detoxification services in particular.

Several regions currently have forums where regional working groups or committees may network, identify needs and challenges, and advise on regional and/or provincial actions. As well, the National Native Addictions Partnership Foundation serves as a national advocate in advancing First Nations and Inuit culturally based addictions services.

Summit on Addictions Among the First Nations of Quebec: Mobilizing Around Real Change—Trois Rivières, QC

From February 1–3, 2011, the Assembly of First Nations of Quebec and Labrador (AFNQL), and its regional commissions and organizations, held a summit that focused on ways to address substance abuse and addictions, with the theme "mobilizing for real change." Organizing this Summit was a priority for the First Nations of Quebec and Labrador chiefs, who had observed that their populations were poorly informed as to the magnitude of the situation and the available solutions. Faced with a real emergency that required action, the First Nations Chiefs chose to hold an event that would not only present the existing situation regarding addictions, but also encourage participants to explore possible solutions and make concrete commitments. The Summit brought together almost 400 First Nations people for the two-day gathering. In addition to workshops and plenary discussions, attendees participated in presentations by inspiring personalities who work in the fight against addictions.

NNADAP/NYSAP currently partner at the national level with the:

- Assembly of First Nations;
- Inuit Tapiriit Kanatami;
- National Native Addictions Partnership Foundation;
- First Nations and Inuit Mental Wellness Advisory Committee; and
- National Native Mental Health Association.

Some NNADAP representatives are part of mainstream addictions systems through the work of the *National Framework for Action* governed by the Canadian Centre on Substance Abuse and other partners (e.g., National Treatment Strategy Leadership Team, National Advisory Group for Workforce Development, and the National Treatment Indicators Working Group). There are, however, wide differences in the organization of, and support for, regional networks and mobilization. The way that each network informs national and federal policy and systems also varies.

>> RENEWAL OPPORTUNITIES

- Recognition, respect, and support for the idea that healing is connected to self-determination.
- Recognition of the major role that all aspects of governance, system coordination, and service delivery play in each client's or family's experience with accessing and using services, and ultimately, in positive client outcomes.
- Recognition of the important roles local control and cultural continuity play in community health and well-being. This may include:
  - indicators of how self-government is being achieved;
  - use of the courts to obtain First Nations title to lands;
  - degree of local control over health, education, and police services;
  - community facilities aimed at preserving culture;
  - local control over child welfare;
  - community capacity across determinants of health; and
  - women's involvement in governance.
- Recognition of Indigenous society, and support for communities (where desired) by promoting traditionally-based governance structures, customary land ownership, and internal reconciliation and healing. These are seen as vital to social cohesion based on the linked obligations and responsibilities that form the basis for Indigenous societies.
- Governance training for health boards and treatment centres. Such training would focus on good governance practices, workplan development and ways to enhance collaborative relationships among key partners (internally, as well as those that are inter-departmental, inter-jurisdictional, and system wide.)
- Networks for support, advocacy, knowledge development, and information exchange. These networks could also function within system-supports to ensure that changes to policies and laws truly reflect the needs of NNADAP/NYSAP addictions and mental health services and support issues around changing community needs.
- Active monitoring of changes to laws that have an impact on the addictions field (such as taxation, laws on illegal drugs, privacy laws, labour standards, Youth Criminal Justice Act, and Child Welfare).
- Clear and consistent communication should guide and then inform policy and service delivery, which may include measures to increase communication capacity both within and across communities.
- Promoting First Nations leadership involvement in reducing substance use issues by:
  - being role models for healthy living;
  - offering political/governance support to ensure competent staff with fair compensation in service delivery;
  - respecting and safeguarding treaty and Aboriginal rights, helping to set up links to multi-level services to ensure gaps are filled;
  - supporting the need for cultural competency in services both within and outside of First Nations communities and organizations; and
  - setting up methods to manage grievances and service complaints.

Serving clients and communities with mental health and addiction needs requires a range of community and medical supports which make use of both cultural and mainstream approaches to care.

The foundation of this approach includes worker competency with mental health issues, capacity to meet specialized needs, and strong connections among care providers.

Addressing Mental Health Needs

>> DESCRIPTION

It is generally understood that substance use and mental health issues are strongly linked and often occur together. For instance, mental health issues can lead to the use of substances as the person tries to cope with, or numb, distress. As well, substance use can lead to mental health issues, such as depression and anxiety.

The terms *concurrent disorders or co-occurring disorders* refer to a combination of a mental health disorder and a substance use disorder. Common mental health issues include mood, anxiety, and personality disorders, and post-traumatic stress. People with co-occurring issues tend to have poor general health (known as co-morbidity).

To prevent substance use issues, it is vital to take a holistic approach to mental wellness with a focus on strengths, resiliency and recovery. There are many system approaches to ensure that the mental health needs of clients with substance use issues can be addressed. Some are through referrals, cooperation, and collaboration among addiction and mental health services both on- and off-reserve; others involve using specialized mental health supports that are part of existing addiction services; and some comprehensive services exist to more fully address all of a client's and community's mental wellness needs.

An awareness of the frequent co-occurrence of mental health and addiction issues has significant implications for both addiction treatment and prevention. In many cases, it is best to address issues at the same time, through integrated or collaborative approaches.

Key components of an effective approach to addressing mental health needs within an addictions system include:

- strong referral and case management networks;
- centres able to deal with concurrent disorders;
- supports for community-based mental wellness;
- Indigenous approaches to mental health; and
- medical assessment and medication support when necessary.

>> KEY COMPONENTS

Strong Referral and Case Management Networks

For clients who require both mental health and addiction services, these services may not always be provided "under one roof." However, services and supports could also be made available through strong connections among services from various elements of care. For example:

- community-based mental health and addictions aftercare could follow intensive treatment at a provincial mental health facility or acute care services in a community;
- ongoing community-based mental health counselling, including family counselling, could follow NNADAP/NYSAP treatment;
- connections with primary care services could be made within and outside the community with respect to supporting and managing mental health issues; and
- a visiting Elder/psychologist and a NNADAP prevention worker could work along with a client and their family in a community.

In all of these examples, it is important to have mechanisms in place to support collaboration. Some of the mechanisms include culturally specific assessments, standardized assessments, well-defined protocols for case management, and a shared understanding of the relationship between the mental health and addiction issues for that client. As well, a shared understanding of the importance of culture and community as supports to well-being can help service providers work together to meet a client's needs. This can broaden the network of supports available for that client.

Centres able to Deal with Concurrent Disorders

Existing addiction services can safely and effectively meet the needs of some clients with concurrent disorders, particularly those that are less severe. This may be the case if the addiction service has well-trained staff with access to

clinical supervision and specialized cultural supports to provide support to individual client cases. Access to medical supports outside the centre is needed for cases using drug-based approaches to help a client manage a mental health condition. However, it may not be necessary or feasible for all centres to have the capacity to manage specialized concurrent disorders. What is more practical is for every centre to have some level of competency with respect to mental health issues, and to have specific centres within the regional and national continuum of services that can provide specialized concurrent disorder treatment, based on need.

Supports for Community-based Mental Wellness

Strong community-level supports designed to be flexible and to meet the mental wellness goals of a community can eliminate the need for more acute services for some clients. For instance, when it comes to diagnosis, research suggests that for youth, early diagnosis and intervention for a mental health issue can reduce its severity and thus reduce the chance that the client will develop a substance use issue later in life.

Community-level supports can also provide assistance to other clients before they access specialized services and/or help them with their well-being when they return home. The latter may involve in-community supports, (e.g., multi-disciplinary teams to help provide aftercare for families). For many people, stigma is often a major barrier to accessing services which reflects the need for trustful relationships. Mental health supports help to encourage community members to access counselling or specialized services.

Networks and links to provincial services are essential, especially for clients with concurrent disorders and other acute mental health issues. Access to community-based, culturally appropriate supports for mental wellness are just as important. This includes prevention, health promotion, early identification, intervention, and follow-up activities and supports that are connected to, and coordinated with community development efforts.

Indigenous Approaches to Mental Health

Providing cultural or Indigenous approaches along with mainstream clinical approaches is often necessary to reflect the diversity of client needs. The specific cultural approaches used and the right balance between the two must be determined by clients, families, or communities themselves. Consideration of these approaches must also respect diversity within the First Nations community and adapt to varied approaches to care. For instance, some cultural practitioners are trained in ceremonial practices for assessment and diagnoses, and in the use of natural medicines, which can be an important way to improve the well-being of those dealing with

Dilico Anishnabek Family Care—Ontario

In response to growing needs and demands, Dilico has conducted extensive research into how best to refine its services to meet the needs of those with concurrent disorders and prescription drug addictions, and to be able to offer gender-specific treatment services. This research has led the centre to make provisions for concurrent disorders in the centre's mission, screening, assessment, treatment planning, program content, discharge planning, staff competency and training in an effort to become a "concurrent disorder capable" program. Changes in service provision have included a strong case management focus; medication being accepted as part of the provision of care; and clinical support and consultations routinely accessed. It also included efforts to strengthen pre-treatment support services and aftercare to enhance the continuum of care to better support clients with more complex needs.

both addictions and mental health issues. Based on a client's preferences, their strengths, and their needs, the role of Indigenous medicines and ceremonies should be seen as part of, not separate from, other aspects of support and care.

Medical Assessment and Medication Support

For many clients a medical assessment is required to rule out physical illness that may cause or play a role in mental health symptoms, and to identify mental health issues. Key factors in knowing whether a mental health diagnosis is needed relate to the severity of a client's symptoms; the distress the symptoms cause; and the degree to which they affect how the person functions in the world. This can include being able to make and maintain relationships and friendships; to work in some way; and to take care of oneself and/or others. Based on a medical assessment, medication may be prescribed to manage symptoms of mental illness and improve client safety.

In addition to doctors, nurse practitioners can also play an important role in the administering and prescribing of medication. In some regions, they can renew prescription medications used to treat mental health issues (e.g., depression, anxiety disorders and schizophrenia), while in other regions they can both prescribe and renew medications. This can affect whether clients with mental health needs can get new prescriptions on-reserve. However, an ongoing concern for many communities, particularly those that are rural and remote, remains access to medical assessments, prescribed medication, and complementary psychological, social, and cultural support.

>> CURRENT STATUS

Mental health and addictions have historically been viewed and treated as separate conditions with separate systems of care. Sometimes integrating mental health and addiction systems has raised the concern that by trying to address mental health issues within addictions programming, the focus and expertise on addictions will be lost. Although structural issues related to systems integration may be complex, the need for stronger collaboration between mental health and addictions services is essential in addressing the needs of clients. This is consistent with client and community requests for more effective, holistic, and client-centred services.

The high co-occurrence of mental health and addiction issues requires strong collaboration between and within services, screening, referral, assessment, and treatment methods. Collaboration between addictions and mental health services is taking place in some First Nations communities. However, the supports needed for integrated treatment plans often do not exist. Some of those supports include culturally specific assessments, standardized assessments, protocols in place for case management and information sharing, and the correct screening tests for mental health conditions.

Currently there are limited specialized mental health services available. Mental health services are limited

and fragmented and often delivered by multiple sectors. These gaps in available mental health services can be found both on- and off-reserve. While an established system of on-reserve addiction services exists across the country, on-reserve mental health services are underdeveloped with little or no coordination existing between the two systems. In addition, access to provincial mental health services is limited due to long waiting lists. These services may not be culturally appropriate or safe, and may not exist at all for certain populations, such as youth.

A challenge within the system occurs when clients are not only unable to access more specialized services, but where there are no specialized mental health services, or when long waiting lists prevent access to treatment, the local supports available to clients are inadequate to meet their needs.

The number of addiction treatment centres that can address concurrent disorders is increasing. In all cases, this has involved staff receiving specialized training, clinical supervision, and access to other psycho-medical supports. Where there is limited access to these supports or difficulty in recruiting and retaining qualified staff, the capacity to work with more complex cases will remain a challenge. The same is true at the community level, where community-based prevention workers need more support and training to meet the needs of clients with concurrent disorders.

An emerging area that many centres and community workers have had to deal with is the use of mental health medication. There is a significant body of research supporting the idea that people with concurrent disorders have significantly better outcomes when they are *appropriately* medicated while receiving addiction interventions at the same time, and that medication or counselling alone is less effective. Determining the appropriateness of medication often requires monitoring by a qualified medical professional.

Currently, some NNADAP centres have policies restricting mental health medication; however, many others have adapted their services to accommodate clients taking mental health medication. These centres have reported that the accreditation process has been particularly helpful in providing guidance on protocols and policies for medication management.

There are examples of community mental wellness supports, funded through programs such as Brighter Futures or Building Healthy Communities; however, they are generally described as insufficient to fully address a community's needs or are not carried out in a systematic or deliberate fashion (see Element 1 for more information on community wellness approaches).

Multi-disciplinary, community-based mental wellness teams provide a variety of culturally safe mental health and addictions services and supports to First Nations communities, including mobile clinical services; access to specialized mental health services; community development; and traditional/cultural programs. The mental wellness team concept supports an integrated approach to service delivery (multi-jurisdictional, multi-sectoral) to build a network of mental wellness services for Aboriginal people living on and off reserve. Mental wellness teams are owned, defined and driven by the community and include traditional, cultural, and mainstream clinical approaches to mental wellness services, spanning the continuum of care.

>> RENEWAL OPPORTUNITIES

- Incorporating cultural or Indigenous approaches along with mainstream clinical approaches into mental health and addictions services is important to reflect the diversity of client needs.
- Mental health and addictions workers must be culturally competent and have cross-disciplinary training and access to networking. In particular, workers could be trained in basic counselling skills, case management, family counselling and basic knowledge of addiction and mental health issues.
- A long-term approach to community-based coordination of mental wellness services, supports, and workers. This may involve:
  - development of community-based wellness plans, inclusive of mental health, addictions, and community development;
  - implementation of multi-disciplinary teams, adapted to community needs and inclusive of

both mainstream and cultural practitioners, within and across communities; and
    - identification of a wellness coordinator within each community tasked with providing leadership on all mental health, addiction, and community development activities. Such a worker would require a range of skills and competencies and may also provide direct service delivery.
- Stronger screening and assessment to help addictions workers better identify client needs, and then find the "best fit" with available services. A key avenue for this may include standardized assessment tools or approaches, along with relevant training.
- Flexible funding options at a community level to support stronger mental health supports (both Indigenous and clinical), will help to meet the needs of clients with concurrent disorders, as well as their family's needs.
- A systematic approach is needed to support NNADAP and NYSAP treatment programs to become more capable in addressing the needs of clients with concurrent disorders. This will ensure a dual focus on mental health and addiction issues throughout the treatment process, in policies and procedures (e.g., for medication and psychiatric emergencies), as well as in screening, assessment and referral; intake procedures; and treatment sequencing and analysis.
- Access to appropriate services needs to be supported by referral networks that allow addiction workers and other community workers to easily refer clients to more specialized resources, such as physician services and acute mental health services. As well, having ongoing links to community resources will help workers better support clients when they return home.
- Specialized treatment services for youth who would benefit from more development and new approaches to care.
- Medical transportation policies that allow for access to the right kind of care based on the needs of the client and support a return to treatment, even where there has been a recent attempt at treatment.

Nuu-chah-nulth Tribal Council Mental Wellness Team—British Columbia

Nuu-chah-nulth Tribal Council provides multidisciplinary support to 14 First Nations communities on Vancouver Island. The Quu'asa Mental Wellness Team is a partnership between a range of health professionals and community support staff such as nurses, infant development workers, clinical counsellors, cultural healers, external support services, and the RCMP. The team coordinates client-driven, culturally sensitive, strength-based treatment for both mental health and addictions. Cultural healers and the multidisciplinary team coordinate ceremonies by working collaboratively with the community, and planning and consulting with health professionals about culturally sensitive healing approaches. The Quu'asa workers provide support, information, and mentorship on cultural healing and prevention in communities, at public urban centres, in the workplace, and on a one-to-one basis. Trained cultural healers lead gatherings and ceremonial and cultural healing events and are included in case conferencing. The program has been operating for several years and has shown positive results in reducing youth suicide, addictions and in promoting mental health.

Ensuring an effective system of care requires culturally-relevant research and ongoing tracking of program results, including not only data on individual substance use but also all factors which contribute to wellness for First Nations.

This approach combines opportunities to share knowledge and support addictions programs to better meet the needs of clients and communities.

Performance Measurement and Research

>> DESCRIPTION

Performance measurement and research are both relevant to the development and delivery of effective programs and services. They make it possible to develop approaches that best meet the needs of clients while getting the most value from available resources. Performance measurement is an important way to demonstrate to clients, communities, and stakeholders that the work being done in addictions programs is having a positive impact on the well-being of First Nations communities. Coordinated research activities are vital to building a stronger evidence base and understanding why what is being done works within particular contexts, from a First Nations perspective. It can also make a case for changes that may need to be introduced.

Key components of a strengthened approach to performance measurement and research in a First Nations addictions system are:

- population health information;
- integrated performance measurement system;
- research strategy; and
- knowledge exchange.

>> KEY COMPONENTS

Population Health Information

Population health information includes both health status (outcome measures) and indicators of the need for health care (socio-economic measures). Socio-economic measures include determinants of health data which can be used to conduct needs-based planning and inform future programming that focuses on improving overall health.

Integrated Performance Measurement System

Integrated performance measurements can be an effective way to determine where change may be needed within an organization. Key elements of an integrated performance measurement system include tracking and reporting of activity data (e.g., service availability and rates of use, results data, and client outcomes). This is generally done by using a systematic approach to record keeping, such as a case management or an electronic system. It is also important to observe this data alongside defined human resource indicators, such as staff turnover, staff grievances, staff attendance and staff satisfaction to link the impact on client care and service outcomes.

Research Strategy

A well-defined research plan identifies and funds research in areas most important for client and community wellness. Specific research is necessary for demonstrating the impact of cultural interventions. It is important that both the research plan and any research projects recognize cultural knowledge and the values of a community with respect to the principles of community-controlled and community-owned research.

Research may also support the development of new treatment approaches, or measures to improve care for the community (e.g., for certain kinds of addictions, or clients with specialized needs); or may include research on other variables that have an impact on access to and impact of care received. Meaningful program reviews usually address both performance measurement and research plans.

Knowledge Exchange

Knowledge exchange helps with the transfer and integration of research findings and information among the areas of research, policy, and practice at a community, regional, and national levels. Knowledge exchange supports the development of new approaches to care and helps to refine services at all of these levels through methods including face-to-face meetings, conferences and web-based forums.

Nimkee NupiGawagan Healing Centre (NNHC)—Ontario

NNHC partnered with the Canadian Centre on Substance Abuse (CCSA) and Carleton University to identify indicators of client length of stay. The research project confirmed the use of indicators to monitor client engagement in the four-month gender-based treatment program for youth aged 12 to17, with the goal of improving treatment outcomes. This research highlighted the many factors that influence client engagement, retention and completion of treatment. Further research is needed into program length and length of client stay to standardize the indicators and their meaning for making informed clinical decisions. This is important given that the average rate of completion of treatment nationally for youth is at approximately 50 percent, while Nimkee NupiGawagan Healing Centre has been able to achieve a client completion rate of 100 percent annually over three years and 90 percent ongoing.

>> CURRENT STATUS

Population-level data specific to First Nations in support of monitoring or addictions-related program planning is limited. Canadian population-level research on substance use often does not include on-reserve populations and often does not use large enough samples to identify First Nations living off-reserve.

Concerns identified during previous efforts to obtain population-level data on substance use among First Nations have included low levels of participation; lack of cultural sensitivity in the survey tools and interpretation of results; and culturally biased diagnostic tools. There are also sensitivities around the use of this type of data, especially about how to reflect a holistic understanding of wellness. The most credible source of population-level data available is through the First Nations Regional Longitudinal Health Survey, which is the only First Nations governed, national health survey in Canada. It collects information based on both Western and traditional understandings of health and well-being.

Research specific to First Nations addictions programs often includes partnering with local, regional, national and international bodies, and is guided by Ownership, Control, Access, and Possession (OCAP) principles. Community processes and cultural protocols must be respected with research providing a benefit to the community.

Some First Nations communities have developed indicators that focus on wellness rather than illness and they may develop health information at a collective level of family or community, rather than at the individual level.

Without complete data, it is difficult to make a correct assessment of service gaps, needs, and priorities, or to make recommendations on the best way to allocate resources.

There is no defined set of indicators to guide data collection and performance measurement within the on-reserve addictions system. In some cases, a lack of awareness exists when it comes to the benefits of data collection or the need for infrastructure to support it. A basic electronic system for data collection is under development but until it is fully implemented, a large gap in performance measurement data will remain both in treatment centres and in communities.

Many research and information gaps have been identified in the current renewal process. The Renewal Process recognizes the need for an improved evidence base to inform programming. Both the process, along with an emerging research base, has helped to validate Indigenous knowledge and traditional practices within addiction services. However, there are no consistent definitions for Indigenous knowledge or Indigenous evidence. Little has been written or documented within the NNADAP and NYSAP regarding the structure, process, and outcomes of culturally based

programming or culture's role in mental wellness. These areas require significant attention and support from the research community.

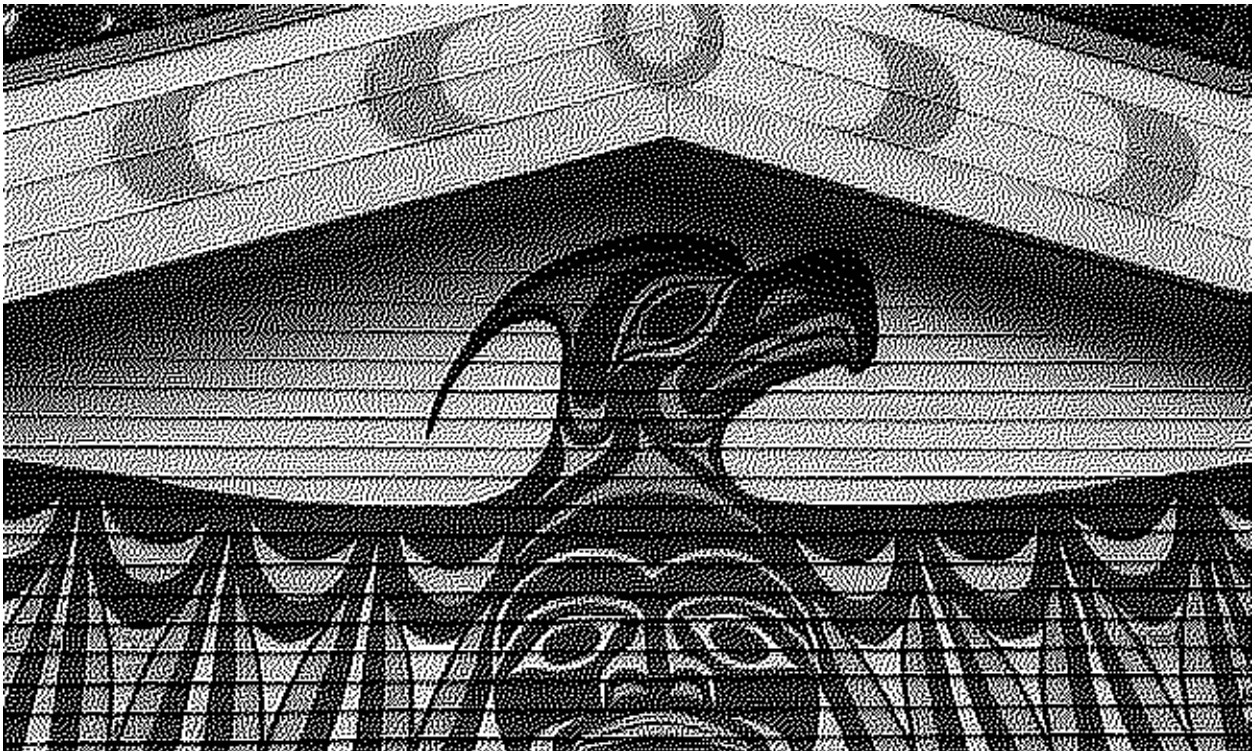
Wide-ranging research is needed for the development of a First Nations-specific evidence base and has been identified as a priority. There is a high level of interest in confirming the effectiveness of existing approaches through research. This will help to identify preferred treatment modalities for different populations (e.g., women and youth) and specific substances (e.g., methadone and prescription drugs) in a First Nations context. There has also been very limited research to date on substance use and abuse prevention in First Nations communities. Regional needs assessments and research forums revealed a high level of interest in research on culture's role in healing and on ways to integrate Indigenous and mainstream therapeutic approaches. Some communities have said they feel "researched to death," but the most common barriers to research that people named were access to funding, culturally competent researchers, and community involvement in defining research projects. The views on approaches to research in communities are as varied as the areas to be explored through research. For example, there is a need to define relevance and significance from a community perspective, not only from a clinical perspective.

Finally, opportunities for knowledge exchange to support the integration of evidence-based strategies are also viewed for the most part as limited. There is interest in having more opportunities for knowledge exchange where service providers can discuss and share what is working for their clients. There also seems to be interest in discussing research on certain programming areas, and receiving information on specific topics, such as clinical treatment information to support clients with prescription drug issues.

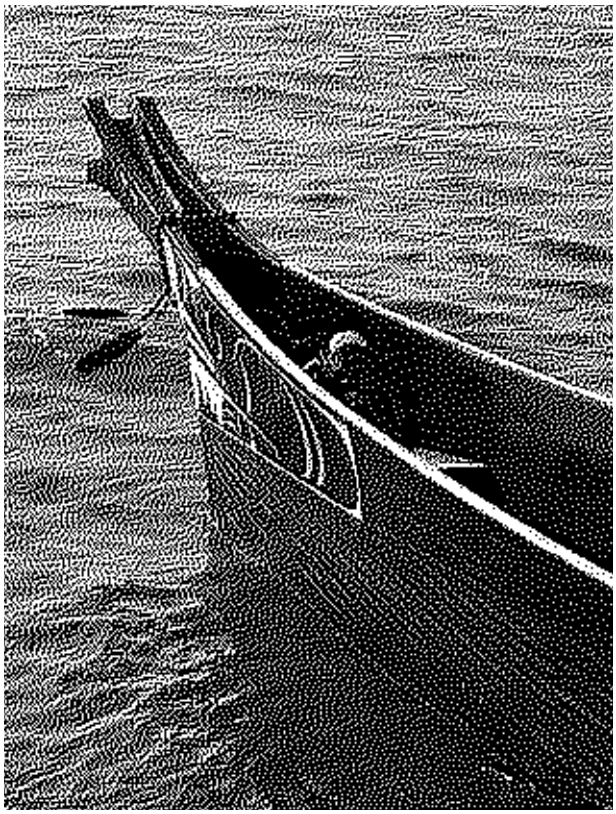
>> RENEWAL OPPORTUNITIES

Population Health Information

- A strengthened approach to gaining population level data is essential for understanding of the level of substance use issues, their patterns and changing demographics, and regional issues. This will help to support needs-based planning, improved national surveillance, and data sharing. The development and use of this data should build upon findings from available population-level information, such



as the *First Nations Regional Longitudinal Health Survey*, and must be done in partnership with communities.



Integrated Performance Measurement

- Well-designed and ongoing processes at the community/treatment centre level that support a systematic approach to collecting and managing client and program level information.
- A data management system or systems at the community/treatment centre levels, which supports the collection and reporting of key performance measurement information at the community, regional and national levels. As this system or systems evolve, there may be opportunities to coordinate with provincial data systems.
- Ongoing capacity development and training opportunities to ensure a robust system of performance measurement that is developed with and is meaningful to communities.
- Ongoing analysis of performance measurement data at all levels to inform system design and delivery.

Research Strategy

- A coordinated research strategy is needed to ensure that First Nations-specific research is conducted in a systematic and sustainable manner as part of the wider on-reserve addictions system. This strategy could help to improve:
  - understanding of "what works" for addiction prevention and treatment with First Nations;
  - planning, implementation and evaluation of programs;
  - workforce development;
  - policy areas, such as the integration between addictions and mental health programming; and
  - the identification of priority areas for research such as prevention strategies, treatment modalities, and research on specific populations, such as women and youth, with a focus on specific substances and the recipe for treatment "success."

  This strategy would draw upon priorities identified through the NNADAP Renewal Process, as well as research engagement activities carried out by the National Native Addictions Partnership Foundation (NNAPF), and seeks to partner with a wide range of research organizations, such as the Canadian Institute on Health Research.

- The approach to all research outlined in the strategy also needs to reflect indigenous cultures and values. Key components of this approach include:
  - making use of Indigenous research methods;
  - ensuring research is *founded* upon cultural knowledge with culturally relevant mainstream approaches *incorporated*, where appropriate;
  - developing Indigenous knowledge and models of practice;
  - building of Indigenous research partnerships and dissemination of results by Indigenous researchers;
  - ensuring research is informed by data from the First Nations Regional Longitudinal Health Survey; and
  - providing two-way knowledge exchange with communities.

- Strengthened community capacity to develop and support effective, evidence-based programming. This may involve shared learning and mentorship, support and training from regional networks, better research information from across the on-reserve addictions system, and greater incentives to work with best practices.

Knowledge Exchange

- Support for information sharing and mentorship between communities that are doing well and those that may have more challenges.
- A planned approach to knowledge exchange that supports networks and processes and that would review research and performance measurement data. The goal would be to improve program efficiency and effectiveness. Some networks could involve:
  - a wide cross-section of partners from both mainstream and cultural practitioners, while others could be Indigenous-only;
  - partners involved in all aspects of the system, such as universities, researchers, policy developers, private companies, mental health and addictions workers, program directors and Elders; and
  - support for knowledge translation to ensure that the results of research are shared and discuss how useful data could be made available to people.

The processes to support these networks could vary, and would likely include videos, websites, brief reports, and regional and national networking meetings, as well as conferences and specific training events. Priority areas for knowledge exchange are the same as with research, namely promising Indigenous and cultural approaches to addictions and wellness. Indigenous and cultural approaches to addictions and wellness.

- Peer reviews and external reviews, for example the accreditation process, can provide a snapshot of where an organization is in its quality improvement process.

Aboriginal Women Drug Users in Conflict with the Law: A Study of the Role of Self-Identity in the Healing Journey

There is limited research on how women's healing is impacted by the stigma linked with drug abuse, criminal involvement, and being of Aboriginal descent in Canada. Guided by the existing literature and practice-based expertise, the National Native Addictions Partnership Foundation, the Canadian Centre on Substance Abuse and the University of Saskatchewan undertook a collaborative study in this area. With initial funding from the Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health, over 100 narratives of women across the country were shared about their healing journeys at NNADAP treatment centres, including women who completed NNADAP treatment. The study established that healing from drug abuse must address the need for women to re-claim (and for some to claim for the first time), a healthy self-identity as an Aboriginal woman. This includes understanding the negative impacts of stigma. NNADAP treatment providers also offered insight on their roles in women's (re)constitution of their identity and its impact on healing. The goal of the study was to contribute original knowledge in the treatment field that can assist in improving the burden of ill health experienced by Aboriginal women in Canada. A key knowledge translation tool developed from the study's findings is a song and music video titled *From Stilettos to Moccasins* and a corresponding health intervention workshop. Prioritizing the often silenced voices of women with the lived experience, these products convey the interconnection between the negative impacts of stigma and the resilient benefits of a cultural identity.

Training, support, and information-sharing are central to ensuring a safe and appropriate approach to medication in support of addiction recovery in First Nations communities.

This approach places an emphasis on collaboration between a range of individuals, including clients, medical service providers addiction workers, and cultural supports to ensure that clients get the care they need.

Pharmacological Approaches

>> DESCRIPTION

Medications can be central to treating addiction issues and support addictions recovery. When appropriately prescribed and administered, they can increase the chance that a client with addictions will, over time, reduce their substance use or achieve sobriety. Prescription medications are sometimes used in the treatment of addictions either as a substitute for the substance of abuse, or to help the person reduce or stop their abuse. Medications can also be central to treating mental health issues (see the Addressing Mental Health Needs section of this chapter for more information on the use of medications for mental health issues).

The correct use of pharmacotherapy can be a valuable part of treatment for those clients who need to include medication in their healing journey. Key components of pharmacotherapy include:

- Medical assessment;
- Follow-up and monitoring;
- Coordination of care; and
- Multi-disciplinary team approaches.

Service providers include individuals qualified to prescribe medication such as physicians, and in the case of some medications, nurse practitioners. Non-prescription medications may be recommended by various health care providers, including nurses and pharmacists, or specialized cultural practitioners. Community-based addictions workers can also have an important role for clients on medication by providing routine follow-ups and monitoring side effects.

>> KEY COMPONENTS

Medical Assessment

The vast majority of assessments are done by primary care providers in the communities such as general physicians and nurse practitioners. A medical assessment is required to determine a client's need, suitability, and fitness for a particular medication. A client's need relates to a review of the client's symptoms and whether or not symptoms could be relieved or controlled by medication. Suitability relates to a person's tolerance of the medication given their condition or diagnosis, and their fitness relates to whether they can safely take the medication without severe physical side-effects.

Follow-up and Monitoring

A person who is being prescribed medication needs to have ongoing follow-up with the appropriate health care provider. Symptoms and side-effects must be monitored and it is vital to determine the client's tolerance level of medication to ensure proper dosage. This ongoing monitoring by a health professional may also be an opportunity to determine what additional services are necessary.

Coordination of Care

Some clients may need to be stabilized on a medication so that they can enter treatment (e.g., clients experiencing mental health issues). In these cases, community-based services may need to offer strong case management support to clients and link them with appropriate services, and assist them with making well-informed choices. Coordination of care includes physicians that provide pharmacological aspects of service working with the client and/or other health care providers.

Medication can be coordinated with the client's broader treatment plan to ensure they complement other approaches to healing such as traditional and complementary medicine.

Multidisciplinary Team Approaches

A multidisciplinary team approach to care is often most effective when addressing all aspects of the client's needs. This enables knowledge exchange between medical professionals and other service providers to ensure coordinated care plans, particularly for clients on medication. It facilitates long-term partnerships among physicians, advanced practice nurses, pharmacists, and communities in supporting addiction workers as part of a holistic approach. It links continuity of care, follow-up supports, supervision, and consultation for the person's day-to-day

Siksika Pain Management Approach—Alberta

Siksika First Nation represents an example of a successful model of collaboration through their Chronic Pain Clinic. This clinic brought together a multidisciplinary team (physician, counsellor, pharmacists, orthotist and Elder) to work collaboratively with community members struggling with chronic pain by assessing individuals and making recommendations for treatment options. This included assessing proper usage of medication and making recommendations such as the use of alternative methods to help clients manage their pain. Members of the multidisciplinary team identified feeling more comfortable and gaining skills in working with chronic pain and medication use through the strong support from Elders.

care providers. It can also ensure that prescribing physicians are aware if the client is using traditional medicines, so as to reduce possible drug interactions. A team approach also facilitates the inclusion of Elders and other cultural supports.

>> CURRENT STATUS

There is much sensitivity around the use of prescription medications in First Nations communities. Some is rooted in the history of colonization, dominance of medical thinking, language and treatment, and a poor understanding by the medical system of the complex issues faced by First Nations people, families, and communities; and the cultural processes needed to support and empower them. This reinforces the belief that pharmacotherapy services are not always culturally safe. There is also growing awareness of the preventative and curative treatment value of Indigenous and complementary medicines, (e.g., to ease stress, anxiety and depression, to help build coping skills, and build resilience). It is also recognized that not all approaches have to involve medication.

Pharmacotherapy, however, can be a useful addition to other forms of treatment, and certain prescription drugs can help people to resist urges during their first year of abstinence. Opiate replacement therapy, such as methadone and the buprenorphine/naloxone combination (Suboxone®), has been shown to be very helpful to clients, their families and their communities when there are clear management plans in place. A client's overall health can improve while on these medications because with symptoms or cravings controlled, clients may be more likely to access health services and live healthier lifestyles. Their risk for contracting diseases like Hepatitis C and HIV is lower and they are more likely to have better relationships with family and friends.

Both opiate replacement therapy, such as methadone and Suboxone®, and naltrexone (Revia®, lowers a person's craving for alcohol), can be very useful in helping clients to complete an addiction treatment program. Completing a treatment program is one of the most important factors for long-term sobriety. Medications such as those listed above help clients dealing with withdrawal symptoms, support them to enter treatment at an early stage, and may increase the chance that they will complete treatment. For these reasons, it is recognized that medication is important for managing the physical aspect of addictions. Other aspects of treatment can address the emotional, spiritual and mental health needs to ensure a holistic approach.

Supports are limited for clients who are using medications and who also wish to access NNADAP treatment services.

- Treatment staff lacks specific training in how to deal with clients using medications as part of their addiction recovery.
- Treatment staff needs more support from physicians who have knowledge regarding addiction medications.

>> RENEWAL OPPORTUNITIES

- Information on pharmacotherapy for service providers to provide more clarity about the scope of practice, screening, protocols, and when/how to seek assistance from a health professional and specialized cultural practitioner. Training and knowledge translation activities at all levels will help to build awareness of pharmacological and traditional medicine approaches to treatment, as needed.
- Training for addictions workers, nurses, doctors, and CHRs in mental health disorders would increase knowledge of the most up-to-date treatments (both behavioural and pharmacological). This will then allow NNADAP workers to inform physicians of a mental health or addiction issue that might require a pharmacological approach.
- Training for doctors and others able to prescribe medication on the factors that influence substance use and mental health issues among First Nations people, including potential cultural differences in understanding and treating these issues, as well as specific considerations for providing pharmacological support. This may involve coordination with professional and/or licensing organizations, in addition to other partners in prevention, provincial, and local health authorities.
- Recognition of the role and usefulness of team-based approaches including Elders and cultural supports as part of a multidisciplinary team. This would allow knowledge exchanges between medical professionals and other service providers to ensure coordinated care plans, and also promote information sharing, dialogue, and teamwork to address the stigma and fears linked to the use of medication.
- Involving clients themselves to be a part of the team and promote sharing and dialogue among physicians, communities, families, and clients with the goal of creating a safe setting for addressing challenges.
- Treatment centres' access to physicians, pharmacists and mental health professionals who are familiar with addictions so they can provide input into the development of policies and programming, as well offer support in the treatment of individual clients.

Oromocto First Nation Methadone Maintenance Treatment Program—Oromocto, New Brunswick

Oromocto First Nation could not even begin to heal until the epidemic drug abuse in the community had been addressed. Every household and program on the reserve was affected, as over 85 percent of the community was addicted to drugs, and most were injecting. The Oromocto First Nation was a community in crisis due to opiate addiction; however, the community recognized the situation and desperately wanted a methadone maintenance treatment (MMT) program on reserve. This pharmacological approach to the treatment of addictions was the first MMT program on any First Nation in Atlantic Canada. In addition, traditional culture, such as drum making, was integrated with Western medicine into this strategy. As well, individual counselling and primary health care were provided to the community.

National standards for treatment centres and community-based health services that reflect First Nations culture are essential to promoting quality services, and ensuring the safety of both clients and addiction workers.

This approach helps to meet and maintain standards of care, which encourage continuous quality improvement of addictions services.

Accreditation

>> DESCRIPTION

Accreditation is a quality improvement process focusing on client safety and quality of work life, whereby addiction treatment centres are assessed against national standards of excellence. These standards measure clinical, operational, and governance-based performance. They provide a clear picture of strengths, areas for improvement, and levels of risk within an organization. The accreditation process is based on how well an organization complies with national standards and it measures the quality of services that clients receive.

In general, most accreditation processes consist of a three-year cycle that begins with an organizational self-assessment against standards of excellence. The next step usually involves a peer review that is done by external reviewers. They interview staff at all levels of the organization/health service, including governance, management, staff and organizational partners, as well as clients and their family members.

Key components of a strong accreditation approach are:

- Assessing organizational readiness;
- Choosing an accreditation body/organization;
- Conducting self-assessment and evidence gathering;
- Peer review;
- Report and recommendations; and
- Follow-up and continuous improvement.

>> KEY COMPONENTS

Assessing Organizational Readiness

The first step in an accreditation process is to gather information to find out how ready the organization is for accreditation. This generally involves the organization's board of directors and staff having a discussion about the potential risks and benefits of accreditation. For accreditation to be successful, organizational consensus must exist at the very start of the process. Readiness also explores the organization's capacity related to policy, planning and measurement of specified indicators throughout the organization, defined processes for service delivery, and linkages with partners.

Choosing an Accreditation Body/ Organization

It is important to research all the options available for accreditation since many bodies may provide accreditation in a given field. Organizations need to seek out an accreditation body that will be responsive to their needs, as well as Health Canada accreditation policies. Some important factors are costs, level of detail in the standards, reporting time lines and the process requirements.

Conducting Self-assessment and Evidence Gathering

Once an organization selects an accreditation body, it will need to take some time to understand the standards structure and how processes will be measured within this structure. During this phase of the process, time is needed to gather policies, practices, and evidence that support organizational ratings based on a set of standards.

Peer Review

A peer review is generally set up after the organizational self-assessment has been sent to the accreditation body. One to three reviewers will visit the organization to gather more evidence. During this part of the process, they may conduct interviews with staff, board, clients, and former clients.

Report and Recommendations

Quality in addictions programming is assessed by examining structure, process, and outcomes. *Structure* involves having the resources and infrastructure that are needed to conduct tasks, such as having the human, financial and program resources to provide care, as well as the facilities, governance, standards, and policies in place. *Process* involves the delivery of health services, namely how it is done, inputs-tasks-outputs and the care itself. *Outcomes* involve the results, such as client satisfaction, staff satisfaction, effective care, efficient use of resources and measurement of the extent to which services impact client health.

Using information from the organization's self-assessment, combined with information gathered and verified during the peer review, the accreditation body provides a report on its findings. This report usually comes in the form of recommendations for continuous quality improvement. Depending on the accreditation body that is used, the time between peer review and the report can vary from a few days to many months.

Follow-up and Continuous Improvement

In this phase, an organization works to implement the recommendations and makes changes to policies, practices or environmental supports based on the recommendations of the report. The process may include a re-visit from the accreditation body or the submission of follow-up evidence of how the organization has worked to address certain recommendations.

>> CURRENT STATUS

Accreditation is being provided for treatment centres within NNADAP/NYSAP and community based health services inclusive of NNADAP by one of three main accreditation bodies:

- Accreditation Canada (AC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Canadian Accreditation Council (CAC))

Health Canada has an accreditation framework document that outlines some key features of accreditation. This outline informs programs for which accreditation is mostly voluntary, and provides details on incentive supports for programs that begin the accreditation process and meet the criteria.

The accreditation process is initiated by a First Nations treatment centre or community-based substance use-related service within a broader community health service and is managed by a non-government accrediting body. Centres may receive funding from Health Canada to engage in the accreditation process with an eligible accreditation body.

Among First Nations addictions programming, awareness of accreditation and its benefits has grown as more organizations feel proud of their success and have met standards of excellence. What started as a grassroots movement has gained force and is now seen as the model for many NNADAP/NYSAP treatment centres. The success of accreditation to date is largely due to the desire of First Nations services to provide a high level of quality health services to their clients.

Some of the challenges linked to accreditation relate to the higher costs and workload for centres and their staff during the accreditation process. Some centres question whether accreditation programs which are mostly focussed on health care services are relevant. For example, a focus on client safety within the context of a community health and residential addiction treatment centre is very different from in acute health care settings. If accreditation is going to be seen as useful, the standards must be relevant for community services. In addition, there are concerns about the fact that program funding for accreditation does not cover the entire cost of compliance with accreditation recommendations.

Although accreditation addresses all structures, it does not replace evaluation of specific programs. For example, accreditation does not prescribe the best approach to offering any health care service or to addiction treatment (namely the evaluation of a specific theory or of a cultural approach to health service delivery). It does, however, ask how the organization uses its knowledge of best practices to guide its service delivery and how the organization monitors and measures effectiveness.

>> RENEWAL OPPORTUNITIES

- Support for treatment centres to bear the costs of compliance with accreditation standards. This support must be fair, scalable, adaptable, and sustainable. It must include both the implementation of accreditation and compliance with recommendations stemming from this process.

- Accreditation standards that have meaning to First Nations culture can provide a holistic framework within the accreditation process, and cultural relevance needs to be integrated into assessments.
- Having standards that can accommodate First Nations holistic health and healing practice requires ongoing improvements to the accreditation processes and standards. This will help to ensure that these standards are more tuned into the operations and realities of First Nations addictions facilities and programs.
- Ongoing evolution of the accreditation process will ensure that the process meets the best standards possible in an ever-changing sector. The standards must be a benchmark of excellence.
- Support for knowledge exchange among centres specific to accreditation will help to ensure that practice-driven success can be shared broadly. This may include a national program resource centre or a centre of excellence that promotes accreditation champions. The goal would be to further support accreditation within First Nations communities and organizations.

Accreditation at Wanaki Centre, Quebec

The Wanaki Centre is an 11-bed adult inpatient treatment centre located in Maniwaki, Quebec. This Centre offers a culturally based residential treatment experience to First Nations speaking either English or French. Wanaki Centre has been accredited since 1999, and the accreditation experience has been a very positive one. Accreditation has helped to ensure staff continuously focuses on and assesses the quality of care being provided to their clients. The most significant change attributable to accreditation has been in the management and observation of client medications. This has included a pre-treatment contact component to services, during which an inventory of medications is made and the client is asked if they know what the medication is and why they are taking it. The medication inventory is updated when the client arrives at the centre, and all client medication becomes the responsibility of one member of the clinical team. Wanaki Centre has obtained the services of a pharmacist at no cost who meets with clients upon their arrival for treatment, reviews their medication and answers any questions. Reconciliation of client medication inventories is done continuously. Clients are also observed taking their medication and any reactions are noted and monitored. As well, an incident report process has been introduced to track errors in medication administration, resulting in improved quality in client medications. These reports are reviewed every morning by the clinical team members.

MOVING FORWARD

Moving Forward

Honouring Our Strengths outlines a vision for a comprehensive continuum of services and supports to guide community, regional, and national responses to substance use issues among First Nations people in Canada. This vision recognizes that a strengthened system of care is the shared responsibility of various jurisdictions (community, province, federal), as well as a wide range of care providers including family and community members, community service providers, primary care and other medical staff, and off-reserve service providers. Within this vision, the emphasis is on ensuring that people, families, and communities have access to a range of effective, culturally-relevant care options at any point in their healing journey. Culture, family, and community are seen as the foundation of this approach; along with the important role that First Nations-specific social determinants of health play in revitalizing communities and reducing the extent of substance use issues. This approach also recognizes the connection between mental health and addiction issues, and that an integrated approach to programming at a system level is required to best meet the needs of clients and communities.

Renewal presents a significant opportunity for partners at all levels to initiate discussion on the vision for change, as well as how to support and facilitate this change. These discussions must acknowledge the important roles not only of community, provincial, federal, and territorial governments but also of regional and national organizations. They must also acknowledge the important role individuals, families and communities have in supporting each other and implementing a strengthened, systems-based approach to care. Realization of this vision will require ongoing commitment, collaboration, and sustained partnerships. Commitment and collaboration will, in turn, depend upon effective leadership throughout the system.

The NNADAP Renewal Leadership Team was formed in 2010 to exercise leadership in guiding the implementation of *Honouring Our Strengths*. In support of this goal, the Leadership Team will work with various networks and jurisdictions to facilitate open dialogue on renewal; advocate for additional resources; establish linkages and help to inform related efforts; and oversee a range of implementation activities to support a system-wide, strengthened approach to service delivery and planning. Membership of the team includes broad, cross-Canada representation from areas such as prevention, treatment, culture, youth, policy, health, nursing, public health, and research. Similar to the First Nations Addictions Advisory Panel, the Leadership Team is supported by national renewal partners—AFN, NNAPF, and Health Canada. As guided by the Leadership Team, the national partners in renewal have a responsibility to work creatively within available mechanisms to: raise awareness and gather information on areas of need within the system; work strategically with a wide range of partners to enhance this system; advocate for the resources required to make the vision of the framework a reality; and track and communicate progress on implementation to partners.

While it is recognized that full implementation of all aspects of the system that the framework describes will depend on increased resources, there are existing opportunities to positively influence change; optimize the use of existing resources; and leverage partnerships to better meet the needs of First Nations. For instance, with direction from the regional needs assessments and support from the National Anti-Drug Strategy investment, many communities and regions have already begun strengthening their services and supports in response to community needs.

The strength of the renewal process to date has been its connection to a wide range of regional and national First Nation health and wellness networks. These networks have provided guidance to the renewal process, shaped the vision for the framework, and supported engagement with First Nations communities. Key networks include, but are not limited to: the AFN First Nations Health Technicians Network; the NNAPF Board of Directors and their regional networks; Regional Addiction Partnership Committees, including advisory groups, co-management committees, and tripartite organizations; the Youth Solvent Addiction Committee; and Health Canada First Nations and Inuit Health regional offices and regional addiction/wellness consultants. These networks will continue to be essential in their ongoing support and leadership of the process. This may include using the framework as a tool at both regional and national levels to initiate conversations with major healthcare providers, other service providers, and jurisdictional partners to

enhance collaboration and build partnerships in order to ensure the needs of First Nations people are being met.

While the Leadership Teams, regional networks, and national networks all play an important role in facilitating implementation, it is important to note that solutions for renewal must come from First Nations people, who own the vision of the framework. They must guide its implementation. Many First Nations people, service providers, Elders, youth, and cultural practitioners have already demonstrated that change is possible through their selfless acts and continued efforts to promote wellness within communities and among their people. Renewal provides an opportunity to build upon these efforts and begin changing systems. Such change often begins with a small group of people who create collective ownership for change and which then transforms into communities of solutions.

In accordance with the belief that change is everyone's responsibility, implementation of the framework must empower individuals, communities, and organizations to see their role and capacity in influencing this renewed approach to care. This will involve the development of tools or guides to support uptake of the renewal vision, including its use as a best-practice framework to guide the design, delivery, and coordination of addictions and mental health services at community and regional levels. It will also involve establishing ongoing feedback and engagement mechanisms facilitated through networks, the Leadership Team, and the renewal national partners—AFN, NNAPF and Health Canada.

While *Honouring Our Strengths* provides a comprehensive vision for the renewal of First Nations substance use-related services, it is recognized that the framework must be viewed as a living document, which can be adapted or revised based on the evolving Indigenous and mainstream evidence-base, as well as the changing needs and realities of First Nations people. Over time, this will require integrating programs for tobacco abuse, problem gambling, and other addictive behaviours. It will also involve efforts to expand and evolve a fully integrated mental wellness [24] continuum of services and supports, which will require additional resources and significant engagement with First Nations communities and leadership.

The opportunities that exist to strengthen the system of care are great. Many First Nations cultural teachings indicate that the Creator gave everyone tomorrow to make a difference, and with this promise of tomorrow comes responsibility. It follows then that everyone involved in the vision of this framework has a decision to make. How everyone chooses to manage the responsibility for "tomorrow" is dependent upon our answer to the question: "what difference will we collectively make?" Our shared vision for the future cannot be created with or bound by limitations, such as the lack of funding or barriers that may be encountered in facilitating change. The collective vision of the change we seek must be fuelled by courage to include all possibilities beyond our imagination. Courage is a vital characteristic of leadership, and is necessary to ensure we are ready when the timing is right: to be strategic in taking risks, to create new pathways, and to continuously seek answers to the unknown. In fact, it is in that which is yet unknown where we will find the answers that are there waiting for us. The vast numbers of youth which make up the First Nations population rely upon those in front of them on this path to the future to ensure the footprints we leave every day will lead them to their freedom from the harms of drugs, alcohol and the ongoing legacy of colonization. Every moment and every effort counts. We must "honour our strengths" with the belief that change is possible through our collective efforts.

Endnotes

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Appendix A:

First Nations Addictions Advisory Panel

The First Nations Addictions Advisory Panel (FNAAP) was a time-limited body of community, regional and national mental health and addiction representatives tasked with developing *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada*. The Panel included members of the AFN's Public Health Advisory Committee, and was supplemented by addictions researchers, health professionals, Elders and First Nations community representatives. In addition to developing the Framework, the Panel also provided support to regions to complete their regional needs assessments.

>> CO-CHAIRS

Carol Hopkins (co-chair)—National Native Addictions Partnership Foundation

Winona Polson-Lahache (co-chair)—Assembly of First Nations

>> ADVISORY PANEL

Jim Dumont—Elder

Dr. Malcolm King—Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health/ University of Alberta

Dr. Kim Barker—Assembly of First Nations

Dr. Peter Menzies—Centre for Addiction and Mental Health

Shannelle Alexander—Kitselas First Nation, NNADAP Community-Based Program

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Chris Mushquash—Dalhousie University

Rose Pittis—Dilico, Ojibway Health Services

Dr. Richard MacLachlan—Dalhousie University

Dr. Brian Rush—Centre for Addiction and Mental Health/University of Toronto

Dr. Rod McCormick—University of British Columbia

Dr. Christiane Poulin—First Nations and Inuit Health—Atlantic Region

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Marie Doyle—Health Canada

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Natalie Jock—Health Canada

Christine Wilson—Health Canada

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Certification

Honouring our Strengths - Continuum of Care - Workforce Development Series

Certification is one way to ensure that addiction workers have and maintain the skills and competencies necessary to effectively support individuals with substance use issues. The process to obtain certification requires a significant commitment by both employees and employers. Through certification, workers build awareness of the latest developments in the field of addictions and gain access to targeted training opportunities that strengthen their skills and competencies as a counsellor, community-based worker or clinical supervisor. This pamphlet will provide a brief overview of certification benefits for addictions workers serving First Nation communities.

What is certification?

"Certification is a process by which an independent third-party assesses and acknowledges an individual's level of knowledge and skill relative to a set of pre-determined standards. Unlike accreditation, which acknowledges compliance with standards at the program or organization level, certification concerns standards at the individual level. Certification is typically accomplished by collecting and presenting information related to educational background, work/life experience and specific skill sets. Membership fees, ethics codes, continuing education and periodic reviews are also a common part of the certification process."[1]

What are the key benefits of certification for addictions workers?

1. Certification demonstrates your expertise in the addictions field and promotes professional recognition with your peers, employers and other healthcare professionals.

2. Certification enhances your marketability, mobility and may lead to expanded career opportunities.

3. Certified addiction workers have transferable skills and competencies required for a range of service delivery positions (youth workers, family support workers, program Elders, Community Health Representatives, client support workers, Cultural Practitioners, Traditional Healers, etc.) and across service sectors (e.g., health, social, and justice services). In addition, many First Nations addiction workers have gone on to become the Health Director or Chief in their community, while maintaining their level of certification!

4. Certification is one way to ensure that you as an addictions worker have and maintain the necessary skills and competencies to provide the best and most appropriate services to First Nations clients. In addition, certification bodies like the First Nations Wellness/ Addictions Counsellor Certification Board (FNWACCB), extend the scope of their certification services to validate your specialized cultural knowledge and skills[2]

5. Certification increases your confidence as an addictions worker and provides you with personal sense of accomplishment as you know that you are contributing to better outcomes among the clients you serve by effectively applying your skills and competencies.

6. Training and certification may result in increased compensation, either within the community or through certification incentives provided by Health Canada with support from the National Anti-Drug Strategy. For instance, workers who submit proof of certification may be eligible to receive an annual certification incentive of $4,000.[3]

7. Fact is, provincial, federal and international agencies require certification, and certification with any of the main bodies places NNADAP and NYSAP Addictions Counsellors on par with their peers nationally and internationally, with equivalent job opportunities working with Indigenous and non-indigenous populations' world-wide where their certification is recognized.

What are the key benefits of certification for employers?

1. Ensures the employer meets the accreditation requirements of Canadian standards that speaks to staff attaining certification or licensure where available as a component of good HR Management practices (e.g. whether social worker, a childcare worker, and all staff with diplomas, degrees, and certification within their profession).

2. Certification minimizes risk to the employer in the provision of services to address substance use issues by ensuring the workforce has the core competencies required for quality and safe client services. This is because ALL certification standards require the workforce to have competency in tracking clients' progress in treatment services, for managing client suicide and aggressive behaviours.

3. Unique to NNADAP/NYSAP Counsellors, certification can serve to define the roles of Wellness or/and Addictions Counsellors within a First Nations community context that validates cultural knowledge, a critical element identified in Honouring our Strengths,4 and further validated at follow-up national forums.[5]

4. Certification options gives addiction workers regular access to the latest developments in the field and targeted training opportunities on-line for example (e.g. FNWACCB, Brown's University courses, NVIT, Tape Studies, etc.), without losing services to the community while staff are in training.

5. Certification demonstrates the employer's commitment to staff competence and developing staff expertise, and serves to promote professional development through certification incentives for all staff, even where funding may be limited. Certification incentives can include:

- Splitting the fee between the employer and employee for training and to maintain certification whether workshops, seminars, training programs, ad-hoc courses are offered externally or internally, registration at training events or conferences that support certification maintenance;

- providing the full benefit to the employee in one payment to compensate for the low wages;

- providing computer equipment to the employee if there is no such equipment currently; and,

- paying for the internet connection which will allow the employee to have access to on-line addictions courses, as examples.

6. Certification provides a measure of competence which will be recognized far beyond the First Nations community, and constitutes an important step to ensure the continuation of First Nations Wellness and Addiction Programs.

7. Certification increases the employees' confidence in their abilities. Certification may also contribute to increased safety for the clients and improved client satisfaction, trust and confidence in the professional abilities of your staff.

What are the main certification bodies?

There are three main organizations offering certification to addiction workers:

• First Nation Wellness/Addictions Counsellor Certification Board (FNWACCB)
• Website: www.fnwaccb.ca

• Canadian Addiction Counsellors Certification Federation (CACCF)
Website: www.caccf.ca

• Canadian Council of Professional Certification (CCPC)
Website: www.ccpcprofessionals.com

This pamphlet was developed by the National Native Addictions Partnership Foundation (NNAPF), with support from the Assembly of First Nations (AFN) and Health Canada. NNAPF, AFN and Health Canada are national partners supporting the ongoing efforts to implement Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada.

1 http://www.cnsaap.ca/ENG/EDUCATIONANDTRAINING/GETCERTIFIED/Pages/default.aspx

2 FNWACCB is the only certification body that has developed their own exam with First Nations input, and contains an essential component on Indigenous culture & healing with an oral component. This exam is required for Level 3 and above and entitles the registrant to international recognition of their credential, and the ability to work in other Indigenous communities around the world.

3 However, it should be noted that this payment is provided directly to communities, who have the final decision on whether or not the incentive payment goes directly to the worker or is used for other purposes within the community (worker training, salary increases for all mental health and addiction workers, etc.)

4 www.nnadaprenewal.ca

5 http://chiefs-of-ontario.org/Assets/NNADAP%20Renewal%20National%20Forum%20Summary%20FINAL%20April%202010.pdf

6 Full and summary versions of the framework are available at www.nnadaprenewal.ca

nnapf
national native addictions partnership foundation

fanpd
Fondation autochtone nationale de partenariat pour la lutte contre les dépendances

RCMP arrest wanted suspect in Bashaw

Arrest made in partnership with Stettler, Bashaw RCMP and Central Alberta Crime Reduction Unit

KEVIN SABO / Mar. 25, 2022 4:50 p.m. / LOCAL NEWS / NEWS

The Stettler RCMP partnership with the Central Alberta Crime Reduction Unit is already having success.

Operating in municipalities throughout central Alberta, the Crime Reduction Unit investigators were operating in Bashaw when they observed a male and female exit a residence.

Recognizing the male as being wanted on outstanding warrants, investigators moved in to make the arrest as the pair attempted to enter a nearby vehicle.

When the members approached, the male attempted to flee on foot but was ultimately taken into custody after a short foot chase.

After bringing the pair into custody, the members searched a backpack located at the scene and found a loaded revolver and just over 11 grams of “a substance believed to be Cocaine,” according to the media release.

Jesse James McDonald, 32, was arrested on outstanding warrants in Stettler and in Ponoka.

In addition to the outstanding warrants McDonald was charged with resisting a peace officer.

Jody Lill Sarasin, 30, was charged with possession of Cocaine and failure to comply with a condition of a release order.

The pair were jointly charged with four firearms related offences due to being in possession of the loaded handgun.

Sarasin was released from custody until her next court date.

McDonald was remanded into custody until his court date in Red Deer on March 24.

Any members of the public who suspect criminal or suspicious activity are encouraged to contact the local RCMP detachment.

If one wishes to remain anonymous, call Crime Stoppers at 1-800-222-TIPS (8477), contact Crime Stoppers online at www.p3tips.com or vie the P3 tips app available on the Google and Apple stores.

LOCAL NEWS | NEWS | RCMP

What to do before an emergency

Overview

We all have a role to play in emergency and disaster preparedness. By knowing your role, you can prepare for what is within your control.

Be prepared

Individuals and families should be prepared to take care of themselves for at least 72 hours. The following steps will assist you in building your preparedness plan.

- Know the risks: Knowing the risks and hazards can help you and your loved ones prepare for the unexpected.
- Make a plan: A plan will help you cope with the stress of an emergency or disaster.
- Build a kit: By taking a few simple steps you can become better prepared to face a range of emergencies. Be sure your kit includes a battery-powered/crank radio/flashlight or Weatheradio in case of a power outage.

Find out where your community will post information and updates during an emergency, and make sure to download the Alberta Emergency Alert app for critical, life-saving alerts.

When individuals are prepared to the best of their ability, this allows first responders, such as police, fire, and ambulance, to focus on the emergency and provide assistance to those who need the help most.

Community

Being prepared is not only about having the right supplies. Your ability to recover from unexpected situations also relies on your connections to others.

When these situations occur, it's often the people around you, such as neighbours, co-workers and friends that are first on-scene. It is easier to offer help, or ask for help, when you know who is there.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Know your insurance policy. Make sure your home, vehicle, business and belongings are protected.
- If possible, consider an emergency savings account to cover temporary expenses while you are out of your home.
- If you can, keep emergency cash handy in case banking services are unavailable.
- If you are evacuated, keep all receipts for additional expenses.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

The Insurance Bureau of Canada is ready to answer your questions. Connect with them by email at askibcwest@ibc.ca or by telephone 1-844-227-5422. For more information on insurance preparedness visit ibc.ca.

Hazards vary depending on where you live. Identify the hazards near you so you can create your own emergency plan.

The role of your local government

Your local government is responsible to make sure your community is prepared. The Local Authority Emergency Management Regulation (2018) legislates their responsibilities, which include:

- establishing an emergency management agency and an emergency plan
- appointing a director of emergency management
- providing training and exercises for those who have a role in emergency management

Your local government also leads the development of recovery plans and initiatives, with support from the provincial and federal government.

The role of the provincial government

Every province and territory has an emergency management organization to manage disasters and provide assistance to community response teams.

In Alberta, the Alberta Emergency Management Agency (AEMA) is the coordinating agency for emergency management activities and initiatives. AEMA monitors the province for potential emergencies and disasters on a 24/7 basis.

Be prepared: alberta.ca/emergency-preparedness.aspx

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Alberta

Other functions AEMA provides include:

- Emergency management training
- Public education on preparedness
- Emergency management conferences, workshops and forums
- Policy and legislation development
- Disaster Recovery Program delivery

The role of the federal government

Federal departments and agencies support provincial or territorial emergency management organizations.

Other roles they play are to manage emergencies that involve nuclear safety, national defence and border security.

We are all in this together

There are a number of industry, mutual aid and nongovernmental organization (NGO) partners that play important roles in preparing for emergencies in your community:

- Industry: Oil and gas or construction companies are responsible for training their staff and making plans to manage emergencies related to their operations to ensure that staff are trained and ready to respond appropriately.
- Mutual Aid: Partnerships made between nearby communities or organizations ensure they are able to assist one another when needed. For example, if a community needs additional security they can ask their mutual aid partner to supply officers to assist.
- NGO: Not-for-profit organizations that work with local and provincial governments offer services such as first-aid training and community preparedness support.

As of 2019, the partners of the NGO Council of Alberta are:

- Canadian Red Cross
- St. John Ambulance
- The Salvation Army
- Adventist Disaster Relief Agency
- Billy Graham Rapid Response Team Chaplaincy
- Canadian Global Response
- Mennonite Disaster Service
- Samaritan's Purse Canada
- Team Rubicon Canada
- World Renew
- Alberta SPCA

For more information

Read our other fact sheets on:

- During an emergency
- After an emergency

You can find more information about preparedness through **Alberta.ca**, or by contacting your community's Director of Emergency Management.

Be prepared: alberta.ca/emergency-preparedness.aspx

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What to do during an emergency

Overview

Emergencies have the potential to cause serious harm to people, property, the economy, and the environment. Make sure you know who to call and what to do during an emergency or disaster.

Protect yourself

How to protect yourself and your loved ones during an emergency or disaster will depend on the hazard.

Shelter-in-place

Authorities may direct you to shelter-in-place. If this happens, you should stay where you are and follow their instructions.

Community

When unexpected situations occur, the people around you, like your neighbours, co-workers, and friends are often the first ones on-scene. If something happens in your neighbourhood, ask yourself these questions:

- Who might need extra assistance?
- Who can you ask to check on your pets?
- Who is first aid-certified?

Getting to know the people in your community can help everyone. If you aren't already familiar with your neighbours, consider reaching out and making those connections.

Stay informed

- Ensure you are monitoring the Alberta Emergency Alert app so you are always up-to- date with the latest information.
- If you're able to, check your community's website or social media channels for updated information.

Evacuation alerts and orders

Some emergencies lead authorities to issue an evacuation alert or an evacuation order.

- **Evacuation alerts** warn the public of a potential or current threat. An evacuation alert can lead to an evacuation order. If an alert is issued, you should prepare to evacuate.
- **Evacuation orders** are used when the public must leave the area for their own safety.

Directions from authorities can vary based on the emergency, they can also change very quickly. Staying informed on what is happening in your community could save your life.

Protect your pets

Have a phone list of animal shelters, veterinarians, and kennel facilities that could house your pets if needed. It also helps to create a buddy system with a neighbour in case one of you are unable to return home to pick up your pet.

A pet carrier stocked with supplies for a quick grab- and-go ensures that your pet will have what it needs. Make sure to include a collar, leash, 2 weeks supply of food and water, and medications if required.

In the case of an evacuation, never leave your pet behind. More information on pet preparedness can be found on Alberta.ca.

If there is time…

Consider the following:

- Protect your home, in some cases authorities will give instructions depending on the emergency or disaster. They could ask you to shut off water, electricity or gas. Do not shut off your utilities unless directed to.
- Update your out-of-town contact on the situation in case you are separated from family and friends. They can assist with reconnecting you.
- Leave a note in your mailbox letting authorities know where you are going and how you can be reached.

The role of your local government

Your local government is responsible for public safety, situational awareness, and providing resources to combat the emergency. Special privileges and duties may be given to specific people, such as police, fire, medical, and your

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director of emergency management, so they can do their job effectively.

The role of the provincial government

In Alberta, the Alberta Emergency Management Agency (AEMA) is the coordinating agency for emergency management activities in the province.

During a major emergency or disaster, AEMA supports communities by leading the coordination of the response with all levels of government. This may include:

- additional response resources, such as personnel or equipment
- reception centers
- health services
- emergency relief funds

We are all in this together

There are a number of industry, mutual aid, and non-governmental organization (NGO) partners that play vital roles during disasters and emergencies.

NGOs work with community members, local, and provincial governments to help. A few of the services offered include:

- Emergency food, clothing, and shelter
- Emotional and spiritual support
- Health care services at reception centres

As of 2019, the partners of the NGO Council of Alberta are:

- Canadian Red Cross
- St. John Ambulance
- The Salvation Army
- Adventist Disaster Relief Agency
- Billy Graham Rapid Response Team Chaplaincy
- Canadian Global Response
- Mennonite Disaster Service
- Samaritan's Purse Canada
- Team Rubicon Canada
- World Renew
- Alberta SPCA

Financial preparedness

- If you are evacuated, keep all receipts for additional expenses.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

The Insurance Bureau of Canada is ready to answer your questions. Connect with them by email at askibcwest@ibc.ca or by telephone 1-844-227-5422. For more information on insurance preparedness visit ibc.ca.

For more information

Read our other fact sheets on:

- Before an emergency
- After an emergency

You can find more information about preparedness through **Alberta.ca**, or by contacting your community's Director of Emergency Management.

Be prepared: alberta.ca/emergency-preparedness.aspx

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What to do after an emergency

Overview

The lingering effects of unexpected emergencies and disasters are different for everyone. Knowing what to do after an emergency can help reduce stress and aid in a quicker recovery.

Recovery is a process

The recovery process includes the actions you take to repair and restore your life after an emergency or disaster. The process is not easy and takes time, flexibility, and patience. Examples of recovery can include:

- Removing waste and debris
- Contacting your insurance company
- Replacing lost or destroyed documentation
- Finding a new home
- Getting mental health support

Find out where your community will post information after an emergency. Information such as support and recovery services that may be available to you could be posted there.

Community

Having a sense of community and people you can lean on is an important part of recovery. Research shows that communities with strong relationships recover faster.

Reach out to your neighbours and friends to find out how you can support each other.

Re-entry

If you had to evacuate, you can't return home until authorities have told you it safe to do so.

In some cases, re-entry can involve a brief return home to inspect damages. If you have returned to inspect damages, please keep in mind the following:

Do not enter to your home or property if:

- an expert has not deemed it safe to do so
- any part of the structure has collapsed
- the structure is off its foundation
- the main power switch was not turned off prior to flooding

Use extreme caution at all times. This is especially true if there are holes in the floor, broken glass and dangerous debris.

Your mental health

Disasters can affect people in many ways. Sometimes we have emotional responses right away and sometimes they show up days, weeks, months or even years after. Feelings of stress are normal, but some people can experience more severe distress and may require help.

Monitor yourself and your loved ones for signs of distress, which could include:

- difficulty sleeping
- emotional outbursts
- anxiety
- depression or unexplained physical issues

If any of these signs appear, make sure to talk about them and seek advice from a professional.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

The Insurance Bureau of Canada is ready to answer your questions. Connect with them by email at askibcwest@ibc.ca or by telephone 1-844-227-5422. For more information on insurance preparedness visit ibc.ca.

Helpful resources

- Alberta Works and Alberta Supports Contact Centre
- Responding to a Disaster or Emergency
- Recovery After a Disaster or Emergency
- Taking Care of Ourselves, Our Families and Our Communities
- Helping Children Cope
- Helping Teens Cope

The role of your local government

After a disaster, your local government will focus on activities that support community building, such as:

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- conducting damage and loss assessments
- restoring public services
- providing emotional support service

Your local government also leads the development of recovery plans and initiatives, with support from the provincial and federal governments.

The role of the provincial government

The Government of Alberta has a responsibility to help recovery from a disaster or major emergency. Some examples of how the province provides support are:

- Programs, grants, and tax incentives that support reconstruction
- Financial assistance through programs such as the Disaster Recovery Program
- Arranges for insurance representation to be available to Albertans
- Work with the local community to provide advice and the coordination of provincial support

For more information on disaster recovery, visit Alberta.ca. Please note, provincial programs are never guaranteed and are not a supplement for private insurance.

We are all in this together

There are a number of non-governmental organizations (NGOs) committed to assisting those affected by a disaster or emergency. Examples include:

- Community clean up
- Psychological counseling
- Assistance with replacing lost items
- Paperwork, or other tasks as needed.

As of 2019, the partners of the NGO Council of Alberta are:

- Canadian Red Cross
- St. John Ambulance
- The Salvation Army
- Adventist Disaster Relief Agency
- Billy Graham Rapid Response Team Chaplaincy
- Canadian Global Response
- Mennonite Disaster Service
- Samaritan's Purse Canada
- Team Rubicon Canada
- World Renew
- Alberta SPCA

For more information

Read our other fact sheets on:

- Disaster Recovery Program information for Homeowners and residential tenants, Not-for-profit and cooperatives, and Agriculture and farming operations
- Before an emergency
- During an emergency

You can find more information about preparedness through **Alberta.ca**, or by contacting your community's Director of Emergency Management.

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Evacuation
What you need to know

Authorities will only ask you to leave your home if they have reason to believe you are in danger.

Evacuation alerts

- Plan to evacuate with enough items to keep your family comfortable for a minimum of 72 hours.
- Keep the radio on all day and tuned to a local station. Have a battery-powered radio ready in case of power failure.
- Download the Alberta Emergency Alert app to stay up-to-date.
- Keep in touch with absent household members and ensure that a plan is in place if evacuation orders are given.

Evacuation orders

- Vacate your home when authorities advise you to do so. Ignoring these instructions could jeopardize the safety of your family and/or those rescuing you.
- Take your emergency kit with you.
- Follow the routes specified by officials. Do not take shortcuts as they could lead to a blocked or dangerous area.
- Drive carefully with headlights on. Make way for pedestrians and emergency vehicles.
- Stop at the pre-determined marshaling point(s). Report to authorities and wait for further instructions. Do not leave again without informing officials.
- Do not return to your property until permitted to do so by authorities.
- If time permits, leave a note informing others when you left and where you went. If you have a mailbox, leave the note in there.
- Shut off water and electricity if you are asked to by an officials.
- Leave natural gas service on, unless officials tell you otherwise.
- If you turn off the gas, the gas company has to reconnect it. In a major emergency, it could take weeks for a professional to respond. You would be without gas for heating and cooking.
- If the evacuation occurs in the winter, take extra precautions.
    - Turn off the water and then drain the water from your plumbing system.
    - Starting at the top of the house, open all taps, and flush toilets several times.
    - Go to the basement and open the drain valve.
    - Drain your hot water tank by attaching a hose to the tank drain valve and running it to the basement floor (if you have a gas-fired tank, the pilot light should be turned out - call the local gas supplier to re-light it).
    - Protect the valve, inlet pipe, and meter or pump with blankets or insulation material.

Be prepared and have your:

- Emergency kit.
- Emergency plan.
- Essential medications and copies of prescriptions.
- Cell phone and charger.
- Pets. Plan in advance for a pet-friendly location as some shelters don’t allow animals and make sure you bring your pet carrier.

Be prepared: www.alberta.ca/emergency-preparedness.aspx

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Alberta

Shelter-in-place
What you need to know

If hazardous materials are released into the air, you may be asked to shelter-in-place. These situations usually last a few hours. Information on how to protect yourself will be shared on radio, TV, the Internet and the Alberta Emergency Alert app.

At home

- Lock windows and exterior doors.
- Close window shades, blinds, or curtains.
- Turn off fans, heating and air conditioning. Close the fireplace damper.
- Get your emergency kit and make sure the radio is working.
- If you don't have a hardwired phone, bring a cell phone and charger.
- Call your emergency contact.
- Go to an interior room above ground, without windows. Above-ground locations are safer as some chemicals are heavier than air and seep into basements even if windows are closed.
- Bring pets with you along with food and water.
- Use duct tape and plastic sheeting, or wet towels, to seal cracks around doors and vents.
- Listen to radio or TV and check the Alberta Emergency Alert app until you're told the danger has passed or you're told to evacuate.

Driving

- If you are close to your home, office or a public building, get inside immediately and follow recommendations above.
- If you can't get to a building, pull over and stop in the safest place possible. If it's sunny, stop in the shade to avoid overheating.
- Turn the engine off. Close windows and vents. If possible, seal them with duct tape.
- Listen to radio for updates and instructions.
- Stay where you are until it's safe to go.

At work

- Lock all doors, windows and openings. Close window shades, blinds or curtains.
- Keep customers/visitors inside with you.
- Ask everyone to call their emergency contacts.
- Turn on call-forwarding and answering systems. Change voicemail recordings to say the business is closed and everyone is staying inside until it's safe outside.
- Ensure employees know how to turn off fans, heating and air conditioning systems.
- Turn off systems that automatically exchange inside air with outside.
- Gather non-perishable food, bottled water, battery-powered radios, first-aid supplies, flashlights, batteries, duct tape, plastic sheeting, and garbage bags.
- Go to interior room(s) above ground floor, with the fewest windows or vents. Large rooms without exterior windows work well. Avoid rooms with mechanical equipment like ventilation blowers or pipes that may be difficult to seal off.
- If you don't have a hard wired phone, bring a cell phone and charger.
- Use duct tape and plastic sheeting, or wet towels, to seal cracks around the door(s) and vents into the room.
- Write down everyone's name and call your business's designated emergency contact.

Contact your community's Director of Emergency Management or the Alberta Emergency Management Agency at 780-422-9000 or dial 310-0000 for toll-free access outside Edmonton.

Be prepared: www.alberta.ca/emergency-preparedness.aspx

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Alberta

Helping children
During emergencies

Overview

Teaching your children how to act during emergencies can help reduce stress, minimize the risk of serious injuries and save lives. Be sure to have family emergency plan, and prepare an emergency kit together.

Helping kids cope

Children can feel the stress from a disaster and may react in different ways.

- Take their fears seriously and tell them it is okay to be scared.
- Explain the events as best you can and acknowledge what is frightening about what has happened.
- Tell your kids what you think and feel. Doing so helps them feel less alone if they know their feelings are similar to yours.
- Maintain familiar routines, like mealtimes and regular bedtime hours.
- It may be helpful to talk to a professional who can help children understand and cope with their emotions.

Using 9-1-1

Let you children know they can call this number if they think someone is in danger, or are seriously injured. Assessing this kind of situation may not be obvious to children, so they need concrete examples. If your children are young, use simple words and avoid medical terms.

If someone close to you has a particular health problem, you should explain it to your children. Describe the symptoms and tell them what to do in case this person is not feeling well.

What to do before calling 9-1-1

Your children must be able to determine whether or not it is safe to call 9-1-1 from where they are.

Explain to your children that calling 9-1-1 is not a game or a joke. Tell them that every second counts when someone is in danger. An unnecessary 9-1-1 call could prevent someone who is truly in danger from getting help.

What to say to 9-1-1

Talk to your children about what will happen when they call 9-1-1. Tell them they will be asked whether they need police, fire or an ambulance.

They will need to know how to answer the following:

- What is wrong
- Where they are
- Their phone number

Resources

For more information on Responding to Stressful Events refer to Alberta Health or Public Health Agency of Canada.

Practice by role playing!

Familiarize children with emergency situations to help reduce panic or anxiety in case of a real emergency.

For more information and for scenarios, visit Emergency Preparedness for Children.

Be prepared: https://www.alberta.ca/make-an-emergency-plan.aspx

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Alberta

Power and water outages

Overview

An outage is a short or long term loss of water or electric power. It can affect a single property, a building, or an entire community.

Many of Alberta's hazards, such as high winds, freezing rain, and flooding, can damage power lines causing power outages. Water outages are caused by extreme temperature fluctuations and pipe corrosion causing water main breaks, among other reasons.

Before an outage

Be prepared for an outage before it happens.

- Download the Alberta Emergency Alert app for critical, life-saving alerts.
- Find out where your community will post information and updates during an emergency.
- Develop and practise a preparedness plan for you and your loved ones.
- Maintain an emergency kit stocked with supplies such as food, battery-powered/crank radio/flashlight and extra batteries.
- Store water for your family (including pets) for drinking, cooking, and hygiene.
- Install a carbon monoxide alarm with backup battery power.
- Know your utility company phone number.
- Have a backup exit plan if you rely on an elevator.
- Sign up for a medical alert program if you have critical needs.
- Have back-up power in place for your generator, heat, and critical medical equipment.
- If you have a vehicle, keep the tank full in case fuel stations lose power or close down, and keep an emergency vehicle kit.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Know your insurance policy. Make sure your home, vehicle, business and belongings are protected.
- If possible, consider an emergency savings account to cover temporary expenses while you are out of your home.
- If you can, keep emergency cash handy in case banking services are unavailable.
- If you are evacuated, keep all receipts for additional expenses.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

The Insurance Bureau of Canada is ready to answer your questions. Connect with them by email at askibcwest@ibc.ca or by telephone 1-844-227-5422. For more information on insurance preparedness visit ibc.ca.

Carbon monoxide poisoning is preventable. Generators, camp stoves, or barbecues do not belong indoors; gas stoves and ovens are not a safe source of heat.

During an outage

Outages can leave you without heat, water, lights, air conditioning, information services, and vital communication channels. Services such as grocery stores, pharmacies, gas stations, banks, and ATMs may be closed during an extended outage.

Outage troubleshooting

- If the power is still on in your neighbourhood but not in your home, check your breaker.
- Call your utility provider to determine if the interruption is widespread or only affecting your property.
- Leave one light on inside and one light on outside so you and the utility worker will know when power has been restored.
- Don't use any household appliances that require water.

Know when to go

Extreme heat and cold can have a greater impact on older adults, young children or those with health issues. If it is too cold to stay where you are, and it is safe to leave, head to a shelter until it is safe to return.

Outage survival tips

- Head to the lowest level of the building. Heat is drawn from the ground so it will stay warm longer.
- Keep doors and blinds closed.

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- Have extra blankets and warm clothes on hand.
- Use a wood-burning or gas fireplace if you have one.
- Turn cell phones to battery-saving mode and only use them for emergency calls.
- Disconnect appliances and electronics.
- Keep freezer and refrigerator doors closed.

After an outage

Outages can create safety risks and cause property damage. Be aware of the risks and take caution when power and water returns.

Safety tips

- Do not enter a flooded basement unless you are sure the power is disconnected.
- Keep yourself, kids, and pets away from affected areas in your community.
- Never use water-damaged appliances, electrical outlets or fuse-breaker panels until they have been checked by a qualified electrician.
- Check all food for signs of spoilage and damage. When in doubt, throw it out.
- After 24 hours of no power, all refrigerated medication should be thrown out, unless the label says otherwise.
- Restock your emergency kit.

How to prevent further damage

- Unplug appliances and electronics before turning on the main power switch.
- Allow the power to stabilize and wait 15 minutes before reconnecting tools and appliances.
- Turn the essentials on first. Start with heat, followed by the refrigerator and freezer.
- Turn on the main water supply.
- Make sure the hot water heater is filled before turning it on.
- Connect with your utility provider for more information.

For more information

Read our other fact sheets on:

- Hazard specific preparedness information including severe weather, flooding and more.

You can find more information about preparedness through **Alberta.ca**, or by contacting your community's Director of Emergency Management.

Be prepared: alberta.ca/emergency-preparedness.aspx

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Severe weather

Overview

Thunderstorms, heavy rain, hail, high winds, blowing snow, blizzards, and ice storms can develop quickly and threaten life and property. Severe storms occur frequently across Alberta and can be unpredictable.

Before a storm

Having an emergency plan in place is valuable when severe weather strikes. Take the opportunity to choose the best location to shelter in the places you frequent most and share that location with people close to you. Talk to your friends, loved ones and co-workers about where you will go, how you will get there, and how to stay in touch if you are separated during a storm.

- Maintain an emergency kit stocked with supplies such as water, food, battery-powered/crank radio/flashlight or Weatheradio in case of a power outage.
- If you have a vehicle, keep the tank full in case fuel stations lose power or close down. Keep a vehicle kit and include an extra phone charger, with necessary adapters.
- If you are outdoors, secure everything that might be blown around or torn loose. Trim dead branches and cut down dead trees to reduce injuries and damages.
- If you are indoors, close your windows, blinds, and curtains.
- If you are in a vehicle, park away from trees or power lines that might fall on you.

Find out where your community will post information and updates during an emergency, and make sure to download the Alberta Emergency Alert app for critical, life-saving alerts.

When individuals are prepared to the best of their ability, this allows first responders, such as police, fire, and ambulance, to focus on the emergency and provide assistance to those who need the help most.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Know your insurance policy. Make sure your home, vehicle, business and belongings are protected.
- If possible, consider an emergency savings account to cover temporary expenses while you are out of your home.
- If you can, keep emergency cash handy in case banking services are unavailable.
- If you are evacuated, keep all receipts for additional expenses.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

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Evacuation alerts and orders

Some emergencies lead authorities to issue an evacuation alert or an evacuation order.

- **Evacuation alerts** warn the public of a potential or current threat. An evacuation alert can lead to an evacuation order. If an alert is issued, you should prepare to evacuate.
- **Evacuation ord**ers are used when the public must leave the area for their own safety.

When building a kit, remember to include items for children, individuals with specific needs, and pets.

During a storm

- In extreme high winds, go to the basement or to a small interior room in the center of the building on the lowest floor, such as a closet, bathroom, or hallway. If this is not an option, take cover under a stairway or sturdy table and use a soft item, such as a cushion or mattress, to protect your head.
- Stay away from windows, doors, exterior walls and fireplaces. Avoid buildings with large, unsupported roofs like arenas, supermarkets, and barns.
- You may want to go to the sheltered area that you and your loved ones have chosen in your emergency plan.
- Stay up to date on the situation by listening to updates from local authorities.
- If you are on water and see bad weather approaching, head for shore immediately.

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Community

When unexpected situations occur, the people around you, like your neighbours, co-workers, and friends are often the first ones on-scene. If something happens in your neighbourhood, ask yourself these questions:

- Who might need extra assistance?
- Who can you ask to check on your pets?
- Who is first aid-certified?

Getting to know the people in your community can help everyone. If you aren't already familiar with your neighbours, consider reaching out and making those connections.

After a storm

Severe weather can have a significant impact on people and property. The steps you take after a storm are as important as what you do before and during it.

- If you have been evacuated, do not return until advised that it is safe to do so.
- If you have experienced flooding due to rainfall and the main power switch was not turned off, do not re-enter until a qualified electrician has determined it is safe to do so.
- If you suspect structural damage, get a professional opinion to ensure it is safe before re-entering.
- Damaged buildings, such as homes and workplaces, should be restored as soon as possible to protect human health and prevent further damage.
- Depending on where you are, your local or provincial inspection authority may be responsible for issuing the necessary permits before certain utilities can be reconnected.
- Reflect on the impact of the storm and take steps to be better prepared for the next one.

For more information

Read our other fact sheets on:

- Blizzards, freezing rain, and ice storms
- Thunderstorms, lightning, and hail
- Hazard specific preparedness information including wildfire, flooding, power and water outage, and more.

You can find more information about preparedness through **Alberta.ca**, and **Environment and Climate Change Canada**.

Be prepared: alberta.ca/emergency-preparedness.aspx

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Thunderstorms, lightning, and hail

Overview

Seasonal weather such as thunderstorms, lightning and hail can develop quickly and threaten life and property. Severe storms occur across Alberta in all seasons.

Be prepared

Individuals and families should be prepared to take care of themselves for at least 72 hours. The following steps will assist you in building your preparedness plan.

- Build a kit: By taking a few simple steps you can become better prepared to face a range of emergencies. Be sure your kit includes a battery-powered/crank radio/flashlight or Weatheradio in case of a power outage.

Find out where your community will post information and updates during an emergency, and make sure to download the Alberta Emergency Alert app for critical, life-saving alerts.

When individuals are prepared to the best of their ability, this allows first responders, such as police, fire, and ambulance, to focus on the emergency and provide assistance to those who need the help most.

Heavy rain

There are two types of summer heavy rains: Large- scale weather systems with long-term rainfall, and short thunderstorms with heavy rainfall.

Heavy rain facts

- Large weather systems can often last several days.
- Heavy rainfall can cause floods in a short period of time, especially when the ground is frozen or already wet.

Heavy rain survival tips

- Avoid roadway underpasses, drainage ditches, low lying, and water collection areas because they can flood or overflow.
- Stay away from power lines or electrical wires.
- Check the drainage around your house to reduce the possibility of basement flooding.

Thunderstorms

Thunder is the noise created when the air suddenly expands from the heat of a lightning discharge. All thunderstorms are potentially deadly electrical storms, whether or not there is severe weather.

Thunderstorm facts

- Severe thunderstorms could bring damaging conditions such as strong winds, hail, lightning, heavy rain, and tornadoes.
- A series of thunderstorms can last for several hours.
- Straight-line winds cause most thunderstorm wind damage. These winds move horizontally along the ground away from the storm.

Thunderstorm survival tips

- Before any thunderstorm, unplug radios and televisions.
- During a thunderstorm, stay away from shattered glass and tall objects that could topple.

Lightning

Lightning is an electrical discharge caused by a buildup of static electricity, which can deliver up to 100 million volts of electricity.

Lightning facts

- Each year lightning kills approximately 10 Canadians and injures even more.
- On average, lighting causes more fatalities in Canada annually than hail, rain, flooding, wind, tornados and hurricanes combined.
- If you can hear thunder, consider it a threat.
- Rubber footwear and tires do not offer any significant protection from lightning.

Lightning survival tips

- Seek shelter in fully enclosed building with wiring and plumbing.
- Stay away from anything that has an electrical cord, and avoid doors, windows, fireplaces, sinks, tubs, and showers.

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- If you are caught outside, do not stand near tall objects or anything made of metal, and avoid open water. Take shelter in a low lying area.
- Wait 30 minutes after you hear the last rumble of thunder before going outside.

Hail

Hail forms in storm clouds and is most common in summer, but can also occur during colder times of the year. Large hail occurs more in the warmer seasons and requires specific conditions. Nearly all areas of Alberta can be affected by large hail.

Hail facts

- Hailstorms occur mostly from May to October.
- Hailstones can be as small as peas or as big as grapefruits.
- A hailstorm can be a financial disaster because of damage to homes and property (including crops).
- Hail can fall to the ground at speeds of 100 km/h or more.
- When combined with heavy rain, hail can clog storm drains and create unexpected local flooding.

Hail survival tips

- Take cover when hail begins to fall. Do not go out to cover plants, cars, or to rescue animals.
- Keep yourself and your pets away from windows, glass doors, and skylights, which can shatter.
- If outdoors without shelter, crouch down with your face away from the wind. Protect your head and neck with your hands.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Know your insurance policy. Make sure your home, vehicle, business and belongings are protected.
- If possible, consider an emergency savings account to cover temporary expenses while you are out of your home.
- If you can, keep emergency cash handy in case banking services are unavailable.
- If you are evacuated, keep all receipts for additional expenses.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

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For more information

Read our other fact sheets on:

- Tornadoes
- Hazard specific preparedness information including wildfire, flooding, power and water outage, and more.

You can find more information about preparedness through **Alberta.ca**, or and **Environment and Climate Change Canada**.

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Blizzards, freezing rain, and ice storms

Overview

Blizzards, ice storms, high winds and blowing snow can develop quickly and threaten life and property. Severe storms occur frequently across Alberta and can be unpredictable when they happen outside of their regular season.

Be prepared

Individuals and families should be prepared to take care of themselves for at least 72 hours. The following steps will assist you in building your preparedness plan.

- Know the risks: Knowing the risks and hazards can help you and your loved ones prepare for the unexpected.
- Make a plan: A plan will help you cope with the stress of an emergency or disaster.
- Build a kit: By taking a few simple steps you can become better prepared to face a range of emergencies. Be sure your kit includes a battery-powered/crank radio/flashlight or Weatheradio in case of a power outage.

Find out where your community will post information and updates during an emergency, and make sure to download the Alberta Emergency Alert app for critical, life-saving alerts.

When individuals are prepared to the best of their ability, this allows first responders, such as police, fire, and ambulance, to focus on the emergency and provide assistance to those who need the help most.

Blizzards and blowing snow

A blizzard warning is issued when falling or blowing snow, combined with 40 km/h winds, is expected for 4 hours or longer. Visibility is usually reduced to 400 metres or less.

A blowing snow advisory is issued when blowing snow combined with 30 km/h winds are expected for 3 hours or longer and visibility is reduced to 800 metres or less.

Blizzard facts

- Blizzards can occur when there are clear skies.
- In wide open areas, blowing snow or a blizzard can mean zero visibility!

Blizzard survival tips

- If you live in a rural area and a blizzard or blowing snow is forecast, you may want to string a guideline between your house and any other buildings you might have to go to during the storm.
- Restrict travel to daytime hours and let someone know your route and arrival time.

If you find yourself stuck in a vehicle during a severe storm, remain calm! Stay inside the vehicle, run the engine every once in a while, and beware of fumes. Ensure the exhaust pipe is not blocked, and continually allow fresh air in.

Freezing rain and ice storms

Freezing rain is rain that falls through a layer of warm air into a layer of freezing cold air below (below 0°C), freezing onto any surfaces or objects in the cold air and creating a buildup of what is called “glaze ice” on everything it touches.

An **ice storm** occurs when large amounts of freezing rain continue for several hours. They can also include wind, ice fog, and cold temperatures.

Freezing rain and ice storm facts

- Freezing rain can cause damage by creating a heavy load wherever the ice forms. During an ice storm, freezing rain damage can be severe.
- Even a small amount of freezing rain can make roads extremely slippery.
- Ice from freezing rain can build-up on any surface making sidewalks and pathways dangerous for falls and slips.
- In an ice storm, the risks from freezing rain may still be present hours or even days after the rain stops falling.

Freezing rain and ice storm survival tips

- Avoid driving when freezing rain is forecast.
- Wait several hours after the storm ends so that road crews have enough time to address poor road conditions.
- If possible, avoid going outdoors. If it’s unavoidable, use extreme caution.

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  - Pay attention to wires, large sheets of ice on buildings, tree branches, or power lines above you that could break or fall without warning.
- Never touch a power line – you could be electrocuted.

Extreme cold

In Alberta, an extreme cold warning is issued for expectations of air temperature minus 40°C or colder, or the wind chill index is minus 40°C or colder.

Extreme cold facts

- Temperatures this low could occur throughout the winter months, especially from early December to late February.
- Extreme cold may occur with other weather, such as blizzards, ice storms or ice fog, and pose a risk of hypothermia or frostbite.
- Ice fog can occur in temperatures lower than minus 30°C due to tiny ice particles in the air. Ice fog forms quickly and can reduce visibility to near zero.

Extreme cold survival tips

- During extreme cold, stay indoors, and try to stay warm.
- If you must go outside, wear proper clothing, and take care not to overexert yourself.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Know your insurance policy. Make sure your home, vehicle, business and belongings are protected.
- If possible, consider an emergency savings account to cover temporary expenses while you are out of your home.
- If you can, keep emergency cash handy in case banking services are unavailable.
- If you are evacuated, keep all receipts for additional expenses.
- Prepare a detailed list of all your belongings.
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For more information

Read our other fact sheets on:

- Severe weather
- Tornadoes
- Thunderstorms, lightning, and hail

You can find more information about preparedness through **Alberta.ca**, or and **Environment and Climate Change Canada**.

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Tornadoes and extreme winds

Overview

Seasonal weather, such as winds, hail, and tornadoes, can develop quickly and threaten life and property. Severe storms occur across Alberta in all seasons. It is important to know what to do to protect lives and property.

Winds

In most of Alberta, a wind warning is given for winds expected to reach at least 70 km/h, or gust to at least 90 km/h.

Wind facts

- Extreme, strong or gusting winds can cause injury or property damage.
- Winds of this speed can cause difficulty walking or loss of control while operating a vehicle.

Wind survival tips

If possible:

- Secure loose objects around your property as they can become dangerous projectiles.
- Shelter your livestock.
- Shelter-in-place until the storm has passed.

Tornadoes

A **tornado** is a violently rotating column of air extending between a thundercloud and the ground.

Tornado facts

- Tornadoes can come with extreme wind speeds, in rare cases over 400 km/h.
- Most tornadoes develop in the late afternoon and early evening.
- Tornadoes are often hard to see from far away.
- Not all tornadoes have a visible funnel cloud.
- Tornadoes usually come from the south or west, but can come from any direction and can change direction quickly.

Tornado survival tips

- Large hailstones are often present during tornadoes. Take cover when hail begins and do not go outside.
- May through September is tornado and hail season in Alberta. Mid-June through early August is the peak time.

Find out where your community will post information and updates during an emergency, and make sure to download the Alberta Emergency Alert app for critical, life-saving alerts.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Know your insurance policy. Make sure your home, vehicle, business and belongings are protected.
- If possible, consider an emergency savings account to cover temporary expenses while you are out of your home.
- If you can, keep emergency cash handy in case banking services are unavailable.
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For more information

Read our other fact sheets on:

- Blizzards, freezing rain, and ice storms
- Thunderstorms, lightning, and hail
- Severe weather

You can find more information about preparedness through **Alberta.ca**, or and **Environment and Climate Change Canada**.

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TAKING SHELTER IN EXTREME WINDS

How to protect yourself from extreme winds (90 km/h or more) depending on the type of building you are in

Structure	Safety tips
All cases	• Get down, protect your head and watch out for flying debris. • Do not chase tornadoes. They are unpredictable and can change course abruptly. • A tornado is deceptive, it may appear to be standing still when it is moving toward you. • Keep your radio on to find out what areas are affected, what roads are safe, where to go, and what to do if you have been directed to evacuate. • Keep your emergency kit close by. • Follow instructions from authorities. Remember, disobeying an order puts lives at risk.
Detached-home	• Go to the basement or underground shelter, if available. • Otherwise, take shelter in a small interior ground floor room such as a bathroom, closet or hallway. • Make sure windows and doors are closed and secured, then stay away from them.
Farm	• Shelter in your home, as above. Do not try to rescue livestock unless you feel it is safe to do so.
Office or apartment	• Take shelter in an inner hallway or room, ideally in the basement or on the ground floor. • Do not use the elevator. Stay away from windows.
Large building	• Buildings such as an arena or shopping mall may collapse if a tornado hits. • If possible, find shelter in another building. • If trapped inside, take cover under a sturdy object such as a table or desk.
Mobile home or vehicle	• Mobile homes or vehicles are not safe during tornadoes or any extreme wind storms. • More than half of tornado-related deaths occur in or near mobile homes or in vehicles. • Seek shelter in a sturdy building immediately. • Ensure your emergency plan includes a nearby safe place to evacuate to.
Driving	• If in a rural area and the threat is visible in the distance, you may be able to avoid a tornado by moving at right angles to its path. Otherwise, seek sturdy shelter immediately. • If the threat is near and shelter is not available, get out of your car and take cover in a low- lying area, such as a ditch, but beware of flooding. • Never try to outrun a nearby tornado. • Avoid hiding under bridges or overpasses.

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Wildfires

Overview

Wildfire season officially starts March 1 and runs until October 31 annually. Wildfires can affect communities in forested or grassland areas; including urban green spaces like ravines and parks. If a fire is near, protect yourself and loved ones by following directions from authorities, and be prepared to evacuate.

Before a wildfire

How to prepare

Individuals and families should be prepared to take care of themselves for at least 72 hours. Prepare for an emergency by:

- Downloading the Alberta Wildfire app, or visiting alberta.wildfire.ca website for more information.
- Building and maintaining an emergency kit stocked with supplies such as water, food, battery-powered/crank radio/flashlight, extra batteries or Weatheradio in case of a power outage.
- Collecting important documents such as passports, birth certificates, banking information, and insurance papers and store them in a safe place in an above ground location.
- If you have a vehicle, keep the tank full in case fuel stations lose power or close down. Keep a vehicle kit and include an extra phone charger, with necessary adapters.

Find out where your community will post information and updates during an emergency, and make sure to download the Alberta Emergency Alert app for critical, life-saving alerts.

Protect your property and belongings

- Learn FireSmart methods and share them with members of your community.
- Remove items that can burn from within 1.5 metres (5 feet) of your home, such as: dried branches, leaves, lawn furniture, firewood and debris.
- Install smoke detectors and carbon monoxide alarms on every floor and near sleeping areas.
- Keep a sprinkler in an easy to access location.
- Be careful when smoking outside, extinguish fire pits and burn barrels, and obey local fire bans.

Safeguard pets and livestock

- Have a pet and livestock plan in case of evacuation. Include where they will go and how they will get there.
- In the case of an evacuation, never leave your pet behind. More information on pet preparedness can be found on Alberta.ca.
- Use FireSmart methods to protect livestock enclosures and barns.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Know your insurance policy. Make sure your home, vehicle, business and belongings are protected.
- If possible, consider an emergency savings account to cover temporary expenses while you are out of your home.
- If you can, keep emergency cash handy in case banking services are unavailable.
- If you are evacuated, keep all receipts for additional expenses.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

The Insurance Bureau of Canada is ready to answer your questions. Connect with them by email at askibcwest@ibc.ca or by telephone 1-844-227-5422. For more information on insurance preparedness visit ibc.ca.

Community

Get to know your neighbours!

Being prepared is not only about having the right supplies. When an unexpected situation occurs, the people around you, such as neighbours, co-workers and friends, are often first on-scene. It's easier to offer help, or ask for help, when you know who is there.

If you see a wildfire, report it immediately by calling 310-FIRE. If the fire is in your community, call 9-1-1.

During a wildfire

If there is a threat of fire in your area:

Be prepared: alberta.ca/emergency-preparedness.aspx

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- Listen for updates from authorities.
- Be prepared to evacuate at a moment's notice.
- Have your vehicle stocked with supplies and ready to go.

Safeguard pets and livestock

- Bring your pets indoors and move grazing animals to a central, safe refuge.
- Avoid locking farm animals in enclosures such as barns as they could get trapped.

Safety first

Wildfires are extremely dangerous. If a wildfire enters your community, the following steps can help:

- Report it, and get to a safe place.
- Never attempt to fight a fire yourself. Wildfires move rapidly and are unpredictable.
- Smoke from fires can be harmful. Monitor air quality through Alberta Health Services.ca.
- Children, elderly, and those with heart and lung related health issues are at the greatest risk from smoke inhalation.
- If you experience any difficulty in breathing, seek medical attention immediately.
- Paper masks do not provide protection from smoke.
- Ensure all windows and doors are closed. Cover vents and other openings with duct tape or other adhesive to help keep smoke out.
- Always obey an evacuation order if issued by an authority; failing to do so puts lives at risk!

Evacuation alerts and orders

Some emergencies lead authorities to issue an evacuation alert or an evacuation order.

- **Evacuation alerts** warn the public of a potential or current threat. An evacuation alert can lead to an evacuation order. If an alert is issued, you should prepare to evacuate.
- **Evacuation orders** are used when the public must leave the area for their own safety.

After a Wildfire

If you are ordered to evacuate, you cannot return until authorities have declared it is safe to do so.

You should not re-enter your property if:

- the authority has not deemed it safe to do so.
- any part of the structure has collapsed.

Use extreme caution, especially if there are holes in the floor, broken glass or dangerous debris.

Prevent fires from restarting

- Check for hot spots, like smoldering stumps and vegetation. Saturate these spots with water and monitor them closely.
- Check the roof and all exterior areas for sparks and embers.
- Check the attic and the house for hidden burning, sparks and embers.
- Monitor problem areas for several days.

For more information

Read our other fact sheets on:

- Hazard specific preparedness information including severe weather, flooding and more.

You can find more information about preparedness through **Alberta.ca**, or by contacting your community's Director of Emergency Management.

Be prepared: alberta.ca/emergency-preparedness.aspx

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Flood preparedness

Overview

Floods are a frequent hazard in Canada, and have devastated many areas of Alberta. High-risk flood zones are in low-lying areas along river banks, called flood plains. These areas naturally flood when water levels rise.

Flood facts

Flooding can occur at any time of year and can result from:

- Heavy rainfall, particularly when the ground is still frozen or already wet
- Ice jams
- Rapid melting of glaciers or snow packs
- Natural or man-made dam failures

Low-lying areas along rivers or in ravines have a high risk of flooding. Heavy rainfall or dam failures can cause flash floods, which happen quickly and with no warning.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Know your insurance policy. Make sure your home, vehicle, business and belongings are protected.
- If possible, consider an emergency savings account to cover temporary expenses while you are out of your home.
- If you can, keep emergency cash handy in case banking services are unavailable.
- If you are evacuated, keep all receipts for additional expenses.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

The Insurance Bureau of Canada is ready to answer your questions. Connect with them by email at askibcwest@ibc.ca or by telephone 1-844-227-5422. For more information on insurance preparedness visit ibc.ca.

Before the flood

The potential for flood damage is high in the flood plains. If possible, avoid building or buying properties located there. Because flooding is not limited to these areas and can happen anywhere, here are a few things you can do to prepare:

How to prepare

Individuals and families should be prepared to take care of themselves for at least 72 hours. The following steps will assist you in building your preparedness plan.

- Download the Alberta Rivers: Data and advisories app, or visit rivers.alberta.ca website for more information.
- Maintain an emergency kit stocked with supplies such as water, food, battery-powered/crank radio/flashlight, extra batteries or Weatheradio.
- Collect any important documents such as passports, birth certificates, banking information, and insurance papers and store them in a safe place in an above ground location.
- If you have a vehicle, keep the tank full in case fuel stations lose power or close down. Keep a vehicle kit and include an extra phone charger, with necessary adapters.

Find out where your community will post information and updates during an emergency, and make sure to download the Alberta Emergency Alert app for critical, life-saving alerts

Protect your home and belongings

- Use weather protection sealant around basement windows and the base of ground-level doors.
- Ensure downspout drainage moves water away from the property.
- Install a sump pump and zero reverse flow valves in basement floor drains.

Safeguard pets and livestock

- Have a pet plan in case of evacuation. Include where they will go and how they will get there.

Water is powerful. It only takes 6 inches of moving water to knock over an adult, 12 inches to carry away a car, and 2 feet to move an SUV. Never attempt to cross a flooded area.

During a flood

If there is a threat of flooding in your area, prepare to leave. Consider the following:

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Prepare to leave

- Stay informed on the situation by listening to updates from authorities. Be sure to follow all directions and instructions from authorities.
- Have your emergency kit, including your important documents, ready to go.

Protect your home and belongings

- Consult your electricity or fuel supplier for instructions on how to safeguard electrical, natural gas or propane equipment.
- Do not shut off electricity if any water is present.
- Move furniture, electrical appliances and other belongings to floors above ground level.
- Remove toxic substances such as pesticides and insecticides from the flood area to prevent pollution.
- Remove toilet bowls and plug basement sewer drains and toilet connections with a wooden stopper.
- Disconnect eavestroughs if they are connected to the house sewer.
- Properties can be protected with sandbags or other barriers. This approach requires specific instructions from authorities.

Safeguard pets and livestock

- Avoid locking farm animals in enclosures, such as barns. They could drown if they are trapped.

Evacuation alerts and orders

Some emergencies lead authorities to issue an evacuation alert or an evacuation order.

- **Evacuation alerts** warn the public of a potential or current threat. An evacuation alert can lead to an evacuation order. If an alert is issued, you should prepare to evacuate.
- **Evacuation orders** are used when the public must leave the area for their own safety.

Evacuation survival tips

- Avoid low-lying areas, such as ravines or underpasses that could flood quickly.
- If you are caught in fast-rising waters and your vehicle stalls, abandon it to save yourself and your passengers.
- Follow evacuation routes specified by authorities. Do not take shortcuts. They could lead you to blocked or dangerous areas.
- Drive carefully with headlights on. Make way for pedestrians and emergency vehicles.
- Stop at the marshaling point(s), report in at the checkpoints, and wait for directions.

For more information

Read our other fact sheets on:

- What to do after a flood
- Hazard specific information including severe weather, wildfire, power and water outage, and more

You can find more information about preparedness through **Alberta.ca**, or by contacting your community's Director of Emergency Management.

Be prepared: alberta.ca/emergency-preparedness.aspx

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What to do after a flood

Overview

After flood waters are gone, there could be substantial damage to a community and hazards to be aware of when you return.

Re-entry

If you are ordered to evacuate, you aren't allowed to return until authorities have declared it is safe to do so.

You should not re-enter your property if:

- an authority has not deemed it safe to do so
- any part of the structure has collapsed
- the structure is off its foundation
- the main power switch was not turned off prior to flooding

Remember to use extreme caution, especially if there are holes in the floor, broken glass and dangerous debris.

Clean-up

It is important to clean and dry your property after a flood as soon as possible to prevent further damage and reduce risks to your health. Here are some helpful tips:

- Maintain good hygiene during flood cleanup by:
  - Reducing contact with floodwater or anything that may have been in contact with it.
  - Wearing protective clothing like rubber boots, safety glasses, and hard hats.
  - Never use water that may be contaminated, and wash your hands often.
- Keep children and pets away from contaminated areas during clean-up.
- Dry carpets within the first two days, and replace if carpets are deeply penetrated or damaged.
- Clean all interior wall and floor cavities with a solution of water and unscented detergent.
- Mud can be dried and brushed off.
- Move damp items to a cool, dry area as soon as possible. Set up fans to minimize mold growth.

Mold

Mold spores are often invisible, and can cause long term illness. Symptoms include persistent headaches, sudden nosebleeds, or colds. Mold is identifiable by signs of brown, grey or black growth on surfaces; not all mold damage is visible though.

- Wear a dust mask and rubber gloves.
- Dispose of all insulation material, particleboard, furniture, mattresses, box springs, stuffed toys, pillows, padding, cushions and furniture coverings that show signs of mold.
- Freeze important textiles and documents until you have time to treat them.

Plastic and hardwood items may be saved. Let wet mold dry, then brush it off outdoors, and disinfect. Washable items can also be saved. Disinfect by lightly misting each item with a cleaner (e.g. rubbing alcohol or chlorine bleach; use 1 part cleaner to 4 parts water).

Supplies

- Protective gear
- Pails, mops and squeegees
- Plastic garbage bags and large containers
- Unscented detergent, chlorine bleach or rubbing alcohol
- Equipment such as extension cords, water pumps, shop vacuums, carbon monoxide detectors, dehumidifiers, fans, and heaters

If your property has signs of mold, stay safe by finding alternate housing.

Water usage

- Check local water advisories. Do not use water from the local supply unless it is declared safe by authorities.
- Do not drink water if it shows signs of contamination, such as colour, odour, or taste.
- Standing water should be drained slowly and in stages. Use pumps or pails to remove, then a wet/dry shop vacuum to clean up the rest.
- Contact your local or provincial health authority for instructions on how to disinfect and restore wells and cisterns.

Property assessment

Heating and appliances

- Do not heat your property to more than 4°C/40°F until after all the water is gone.

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- Do not use any appliances or electrical systems, or touch electric panels, until all components have been thoroughly cleaned, dried and inspected by a qualified electrician.
- Buy and install a carbon monoxide sensor if you plan to use pumps or heaters powered by gasoline, kerosene or propane during clean up.
- Clean or replace soaked or damaged parts, such as filters, ducts, and electrical components, in the furnace and hot water tank.

Food and medicine

- Thoroughly wash and disinfect all undamaged food, medicine, and supplies.
- Dispose of all food, medicine, cosmetics and toiletries that made contact with flood water.

Financial preparedness

- Speak to an insurance agent about your specific needs.
- Prepare a detailed list of all your belongings.
- Know the 7 steps for making a home insurance claim.

The Insurance Bureau of Canada is ready to answer your questions. Connect with them by email at askibcwest@ibc.ca or by telephone 1-844-227-5422. For more information on insurance preparedness visit ibc.ca.

Recovery assistance

The Government of Alberta and your local government have a responsibility to help a community through recovery from a disaster or major emergency. Some examples of support are:

- Programs, grants, and tax incentives that support reconstruction
- Financial assistance through programs such as the Disaster Recovery Program
- Arrange for the availability of insurance services
- Work with the local community to provide advice and the coordination of provincial support

Your local government is responsible for administering provincial recovery funds, and for ensuring overall support after a disaster.

For more information on disaster recovery, visit Alberta.ca. Please note, provincial programs are never guaranteed and are not a supplement for private insurance.

For more information

Read our other fact sheets on:

- Disaster Recovery Program information for Homeowners and residential tenants, not-for-profit and cooperatives, and Agriculture and farming operations
- Flood preparedness

You can find more information about preparedness through **Alberta.ca**, or by contacting your community's Director of Emergency Management.

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Government of Alberta emergency preparedness toolkit for seniors

Alberta

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Emergency Preparedness Toolkit | Municipal Affairs

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Contents

AEMA Overview **4**
Know the risks **5**
Hazards 5
Emergency preparedness 5
Get informed **5**
Stay informed 5
Create financial resiliency **6**
Security threats 6
Build an emergency kit and gather supplies **6**
Start a conversation **7**
Make community connections **7**
Make an emergency plan **8**
Health 8
Communication 8
Power dependent 8
Routine maintenance 9
Evacuation 9
Become a Resilience Builder **9**
Join the campaign **9**
Go virtual **10**
Get Prepared: 60 Second Emergency Tips **10**
Scan to Prepare QR posters **10**
QR code overview **10**
Who we are **10**
Resources **11**

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Alberta Emergency Management Agency (AEMA)

AEMA Overview

The AEMA, under the authority of the *Emergency Management Act*, leads the coordination and co-operation of all organizations involved in emergencies and disasters. This includes emergency and disaster prevention, preparedness, response and recovery.

Emergency preparedness

When the people living, working, and travelling in Alberta are prepared, they can better navigate disruptions, which allows them to protect themselves and their loved ones. At a minimum, individuals should be prepared to be self-sufficient for 72 hours as it can take several hours or even days for help to arrive.

We all have a responsibility to raise awareness about being prepared for disasters, emergencies and unexpected situations; together we can strengthen the call to action and inspire Albertan's to become better prepared.

Protecting lives and livelihoods

Emergencies often happen suddenly and can leave devastating impacts long after the emergency is over. Seniors can be especially vulnerable to these types of situations.

Common factors that contribute to increased vulnerability include mobility limitations, decreased physical strength and sensory awareness as well as a reduced ability to respond to sudden change. It is essential for seniors and caregivers to have an emergency plan to ensure they are ready to respond and supports in place to assist their recovery.

Small steps every day

Preparedness is a challenge for us all, but by breaking it down into simple steps and making preparedness a habit, you can become better prepared without investing a lot of time or money.

Take action with one-step today!

Know the risks

Get informed

Create financial resiliency

Build an emergency kit and gather supplies

Start a conversation

Make community connections

Make an emergency plan

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Know the risks

Understanding your risk to the hazards in your community can help you prepare for them. Each of the links below leads to a hazard specific web page with tips to assist your preparedness efforts.

Hazards

- Wildfires
- Tornadoes and extreme winds
- Floods
- Power and water outages
- Thunderstorms, lightning, heavy rain and hail
- Blizzards, freezing rain, ice storms and extreme cold
- Pandemic influenza

Extreme heat is another hazard to include in your emergency planning; heatwaves are a common occurrence during the summer months. As individuals age, their sense of thirst is reduced putting them at an increased risk of dehydration and heat stroke.

Before a heatwave occurs, ensure you have the following:

- Sufficient amount of water available to keep you and your pets hydrated
- Back up cooling devices in the event of a power outage

Emergency preparedness

- What to do before, during and after an emergency
- Evacuation
- Emergency preparedness for your pets
- Farm animal and livestock preparedness

Get informed

Information helps us to better prepare for emergencies, disasters, and unexpected situations. When we know what is happening we can make more informed and timely decisions during times of stress.

Before an emergency occurs, identify information sources that you can rely on for updates.

- Do you know where your trusted sources of information post their emergency updates?
  - Social media, television, radio, website, community bulletins, email, automated phone messages
- At the facilities where you spend your time, do you know how staff provide emergency notifications?
  - Door to door notification, email or phone notification
- Do you have dedicated emergency contacts who will provide updates?
  - Family, friends or caregivers, community groups, organizations, neighbours or facility staff
- Do you have a backup plan to ensure you receive emergency updates and can call for help?
  - Battery-powered or crank radio, landline or cellular phone, and medical alert devices

Stay informed

Download and follow along on these platforms to keep informed and up to date.

- Alberta Emergency Alert app – Alberta issues alerts to provide critical information and actions needed to stay safe
- Wildfire app – See where wildfires are burning in Alberta and how they impact you
- WeatherCan app – Receive weather alert notifications in your area and your saved locations across Canada

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- Local, provincial and federal alerts through your mobile phone
- Government of Alberta social media
    - Instagram: youralberta
    - Facebook: YourAlberta (Government of Alberta)
    - Twitter: @YourAlberta
    - LinkedIn: Government of Alberta
    - YouTube: @YourAlberta
- Public Safety Canada social media
    - Facebook: Emergency Ready in Canada
    - Twitter: Public Safety
    - Twitter: GetPrepared
    - Youtube: Public Safety

Directions from authorities can change quickly based on the emergency.

Knowing what is happening in your community could save your life.

Create financial resiliency

Being financially prepared is about more than just having money in the bank. To help you create financial resiliency, consider the tips below.

- Ensure you have adequate insurance and keep a detailed list, including photographs of all your valuables
- Keep cash on hand, as ATMs and debit services may become unavailable
- Keep receipts for all expenses incurred during an emergency or disaster
- Know the 7 steps for making a property claim
- If possible, create an emergency savings account to cover expenses during an emergency

Understanding insurable vs. non-insurable disaster financial assistance can also help protect your property. The Government of Alberta's Disaster Recovery Program offers information and resources that can help.

Security threats

Seniors are at an increased risk of financial scams during emergencies and disasters. Through awareness that fraudulent activity increases at this time, you can reduce your fraud risk.

Do not provide any personal information over the phone, through email or to door-to-door visitors that you are not able to verify as legitimate organizations. If you are unsure of the authenticity of the request, ask a loved one, neighbour or caregiver to verify the information. Service Alberta is also available to assist at 1-877-427-4088. Being cautious is crucial to avoid becoming a victim of scams.

Build an emergency kit and gather supplies

There are many ways you can become more prepared. You can build emergency kits that you can grab and go during an evacuation, or you can make sure you have enough supplies at home in case you have to take shelter. In either case, your goal will be to have enough supplies to keep you safe, warm, and comfortable.

Below you will find links to printable emergency checklists to help get you started. Ensure your kit is specific to your needs.

- Gather supplies - Having the supplies you need on hand can help keep you, your household, and pets safe
- Emergency kit checklist - When an unexpected situation occurs, it is easier to prioritize your safety and well-being if you have an emergency kit you can grab and go at a moment's notice
- Emergency kit checklist for your pets - reduce the stress of making important decisions in urgent situations

  Emergency kit checklist for your vehicle - Situations such as a vehicle breakdown, poor weather, and traffic accidents are easier to manage when you are prepared

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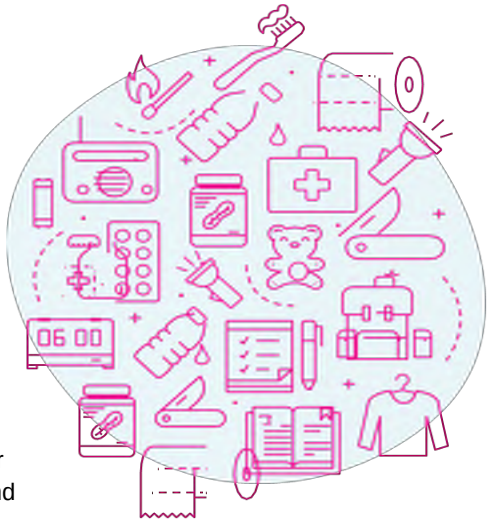
Additional items to consider:



- A spare set of dentures and contact lenses
- Incontinence undergarments
- Extra medical supplies, including catheters, syringes for insulin, and feeding tubes
- List of medications taken – to provide to pharmacy for emergency refill if required
- Ice packs or a cooler for refrigerated medications
- Entertainment items such as books, playing cards, or cross-word puzzles
- Spare set of keys for your car and house
- Batteries for hearing aids or other devices such as wheelchairs
- Equipment such as oxygen tanks or walkers – label all items with your contact information
- Medical ID bracelet (includes your name, allergies, serious medical conditions, your caregiver's name and phone number)
- Copies of important documents stored in a waterproof bag, including copies of your Green Sleeve contents, contact information for utility providers, a list of allergies and dietary items, and instructions for medical devices

Start a conversation

Talk to loved ones, neighbours, and caregivers about what you can do to manage disruptions before they occur. Talking often leads to action and can be the first step to making your emergency plan.

Senior centres, Family and Community Support Services, and community organizations provide opportunities to have coffee and chat sessions where emergency preparedness can be a topic of discussion. In many cases, you can ask your local seniors organization to host information sessions to facilitate conversations and provide support.

Current events are also a great way to start a conversation, ask: "What would you do if that happened to you?" or "Do you have a plan for that?"

- Create community resilience – This 60-Second Emergency Tip video is a reminder that neighbours are often the first around when an emergency, disaster or unexpected situation occurs
- Raise awareness in your community – This web page provides tools and materials to assist community efforts in raising awareness, such as #PrepareYourSelfie campaign and the Get Prepared: 60-second Emergency Tip video library

When starting the conversation consider asking a neighbour to be your buddy. The buddy system can help when you might need someone to check on your property or pets if you are away or unable to return home.

Make community connections

Community connections contribute to the development of healthy support networks and can improve your health and emotional well-being.

Take steps to get to know the people around you by waving a friendly hello, or joining a local community association, committee or group program.

Once you have built a support network, identify those who would be willing and able to help you and those to whom you could offer help. When people work together, it can reduce stress and recovery time.

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Make an emergency plan

Disasters often cause confusion and distress. An emergency plan can help you cope with the stress and navigate the situation better.

Make an emergency plan – Being prepared is different for everyone, create an emergency plan that works for you.

Caregivers are in a unique position to provide support to seniors in regards to physical health. They also know who may need extra assistance to prepare for potential disasters.

The sections below can help get you started with creating your own personal emergency plan.

Health

Medical passport, commonly referred to as a Green Sleeve, should be stored on or near the fridge for emergency services personnel. This folder contains advanced care planning documents and forms specific to your healthcare goals. Familiarize those involved in your emergency plan with your medications, medical supplies and devices. Ensure they know where to find your important supplies and how to use them.

If you require routine treatments at a clinic or hospital, talk to your service providers to find out how you can still receive care during an emergency. Consider all impairments and plan for them, such as:

- Sense of smell
- Vision
- Hearing
- Mobility
- Chronic conditions
- Cognitive

These factors, and others, can put you at a greater risk if not prepared for in advance.

Communication

Create a communications plan that will outline who you will contact and who will check in on you during emergencies. These contacts may be caregivers, loved ones or community-based organizations and agencies who serve seniors.

Communication systems can often become overloaded and unavailable during emergencies and disasters.

- Do you have an alternative method for contacting your family or neighbours?
- If you have communication challenges, ensure you note the best way for people to communicate with you

Power dependent

If you use medical devices, equipment, and medications that rely on power:

- Contact the medical equipment company to find out about emergency options
- Consider how you store medications that require refrigeration in a power outage
- Talk to your doctor or pharmacist to see what options are available during an emergency
- Consider looking into back up power supply options if your need for power is essential

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Shelter in place

Consider the following to help you plan for sheltering in place:

- Have you identified safe locations to take shelter if authorities advise you to shelter in place?
- Is there room for you, your emergency supplies, and essential medical equipment?
- Will the location keep you and your pets or service animals comfortable for several hours or days?
- If you have limited reach, battery-operated touch lamps are a good alternative for light sources

Routine maintenance

Do you perform routine maintenance on your home so it can withstand severe weather?

- Check that window caulking and seals are intact, repair if necessary
- Renew insulation, if needed, to keep your home warm during winter months
- Add reflective window coverings to keep your home cool during the summer months
- Consider installing a sump pump
- Keep downspouts and gutters clean

Evacuation

Consider the following to help you plan for an evacuation:

- Do you have reliable transportation if an emergency or disaster required you to evacuate your home and neighbourhood?
- Do you have mobility limitations and require assistance to leave safely and quickly?
- Do you have a place to go, if you are unable to return home?

Pet Preparedness – this web page includes tools and resources to help keep pets safe and comfortable, before, during and after an emergency.

Farm animals and livestock – this web page includes tools and resources to help keep farm animals and livestock safe if you need to shelter in place or evacuate.

Get involved

Become a Resilience Builder

Our team, Strategic Partnerships and Public Education, shares quarterly updates with a network of people who have an interest in building resilience in their community. These updates keep you informed of what's new in our program and provide information to help you raise awareness, build resilience and contribute to disaster risk reduction behaviours.

On occasion, a Prepare to Respond email to this same network will be sent. Prepare to Respond provides timely information on ways to prepare for a potential threat. These emails include a general preparedness message that ties to current events. They can be quickly edited by you and shared with your network so you can keep them informed and motivate preparedness action. If you would like to be added to the Resilience Builder's network, please email aema.stakeholders@gov.ab.ca

Join the campaign

Emergency Preparedness Week (EP Week) is a national event that takes place annually during the first full week of May. The event promotes individual preparedness and encourages Canadians to learn about the risks they face in their communities and to take action to prevent, mitigate, and prepare for these risks.

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Every year, Public Safety Canada coordinates this event in close collaboration with the provinces, territories, and other partners; and together, with community leaders, first responders, all levels of government and non-government organizations, we have an opportunity to create community resilience and help Albertans who face disruptions return to their lives and livelihoods sooner. Visit our web page to learn how you can participate.

Go virtual

To help raise awareness all year long, here are some ideas on how you can share preparedness materials, tools, and information with your networks using social media and other communication channels.

- Share links to the printable emergency kit checklists through email
- Share information about the hazards in your community with links to the Alberta.ca hazard pages for more information
- Share the *Get Prepared: 60-second Emergency Tip* videos on your social media platforms
- Download and print the *Scan to Prepare* touchless QR code posters and post them in public areas allowing individuals to scan them with their smartphones to watch the *60-second Emergency Tips*
- Create a preparedness presentation and share it with your community members online
- Check out GetPrepared for additional tools and materials
- Listen to a subject matter expert talk about emergency preparedness with the EPIC podcast team

Of note, Factsheets and checklists are available in Arabic, Traditional and Simplified Chinese, Punjabi, Spanish and Tagalog. To access the translated materials, click on the “Resources and translations” link on the web pages listed throughout this toolkit. French translations are underway, but if you need French resources now refer to Get prepared federal website.

Get Prepared: 60 Second Emergency Tips

The *'Get Prepared: 60 Second Emergency Tips'* video series delivers simple steps that anyone can take to become better prepared for an emergency or disaster.

Take a minute today to learn about what you can do to become better prepared and share the videos online and within your community.

Scan to Prepare QR posters

This is a touch-free way to share preparedness information with community members through their smartphones. The posters use an embedded QR code you scan with your smartphone’s camera app to display content directly on the device. Download the QR Code Posters to print and display in common areas to encourage community members to take small steps towards becoming more prepared.

QR code overview

Unique QR Codes (Quick Response Coding) can be created using a third party web service. QR codes can link to pre-existing materials by connecting users with materials that are posted online, such as videos, pictures, guides or websites, but they can also be used to display documents that are not published on the web. Most smartphones have the ability to scan a QR code with their camera, but in some cases, a mobile app is required.

Who we are

Strategic Partnerships and Public Education is a team within the Alberta Emergency Management Agency, a department of the Ministry of Municipal Affairs. Our work involves collaboration with Ministry and community partners to develop inclusive resilience building programming to meet the diverse needs of all people living, working and travelling in Alberta. Through research and partnerships, we create public education tools and materials for anyone looking to encourage and motivate their communities to become more resilient to disasters, emergencies and disruptions.

Classification: Public

Resources

Alberta Emergency Management Agency (AEMA) https://www.alberta.ca/alberta-emergency-management-agency.aspx.	Learn more about what the AEMA does and how it is involved in emergencies and disasters.
Emergency Preparedness https://www.alberta.ca/emergency-preparedness.aspx	Learn how you and your loved ones can prepare yourselves for an emergency or disaster.
Alberta 211 https://ab.211.ca	211 is a helpline and online database of Alberta's community and social services. Search by topic or location to find programs or services in your community.
Alberta 511 app https://511.alberta.ca/about/mobileapp	Stay informed by downloading the 511 smartphone app.
Alberta Emergency Alert app https://emergencyalert.alberta.ca/content/about/signup.html	Stay informed by downloading the AEA smartphone app.
Alberta Rivers app https://open.alberta.ca/blog/?page_id=197	Stay informed by downloading the data and advisories smartphone app.
Alberta Wildfire https://wildfire.alberta.ca/prevention/default.aspx	Wildfire prevention is a responsibility we all share and it is important to understand safe fire practices so that everyone can enjoy Alberta's forests.
Alberta Fire Bans app https://open.alberta.ca/blog/?page_id=327	The Alberta Fire Bans application will help you find the most current and reliable information on all active fire advisories, fire restrictions, fire bans, and off-highway vehicle (OHV) restrictions in Alberta
The Alberta Wildfire app https://open.alberta.ca/interact/alberta-wildfire	See where wildfires are burning in Alberta. Get up-to-date information on wildfire conditions and hazards or report a fire.
Government of Canada: Cyber Security https://www.getcybersafe.gc.ca	A web page dedicated to how older adults can protect themselves from the most common cyber security threats.
Government of Canada https://weather.gc.ca/warnings/index_e.html?prov=ab	Monitor public Weather Alerts for Alberta.
Alert Ready https://www.alertready.ca/#faq	Stay informed through Canada's emergency alert system.
Government of Alberta Minimum Housing and Health Standards	The standards are used to protect and promote the health and well-being of occupants of rental housing.

Classification: Public

Notifications

COVID-19 Updates: Taking steps to return to normal.

- Public health restrictions: Alberta entered Step 2 on March 1.
- Book your vaccine: Albertans 5+ can get it now. Get third dose when eligible.

Alberta.ca

Resources for your community

60 second videos, fact sheets, posters and more material you can share on how to be better prepared for emergencies and disasters.

On this page:

- Overview
- New social media challenge
- Tips to follow year round
- Videos
- Checklists and translations
- Fact sheets
- Toolkits
- QR code posters
- Infographics
- Contact
- Related

Overview

Incorporate the following resources into local efforts to help community leaders raise awareness about personal preparedness and help build resilience at the local level. These materials complement existing preparedness programming or used in the absence of an existing program. Some examples of how the information can be used include sharing on social media, publishing in newsletters, incorporating into presentations or printed and displayed in public spaces.

New social media challenge

While the emergency management community is preparing for wildfires and other hazards, Albertans should be taking steps to prepare too. To help, the Alberta Emergency Management Agency kicked off the #BePrepared challenge.

Interested in championing the #BePrepared challenge in your community? Send us an email at beprepared@gov.ab.ca to receive the weekly message. You can start the #BePrepared challenge in your community at anytime. Launch the challenge in your community and encourage others to join you in becoming more prepared too.

Tips to follow year round

Preparedness is a challenge for us all.

Here are a few things you can do to make readiness a part of your routine.

Start a conversation

Start the conversation with those around you. Talking about emergencies often leads to action and can be the first step in making your emergency plan.

Know the risks

Know your risk to the hazards in your community so you can plan for them.

Make a plan

Disasters often cause confusion and distress. An emergency plan can help you cope with the stress and navigate the situation better. Create an emergency plan that works for you and your family.

Get informed

Get informed by signing up to your local emergency warning system and through identification of trusted sources of information before an emergency occurs. Download the Alberta Emergency Alert app

Build a kit and gather supplies

Build an emergency kit and gather supplies, including water, non-perishable snacks and a battery or crank-powered radio in case of power outages. Your goal will be to have enough supplies to keep you safe, warm and comfortable.

Create financial resilience

Being financially prepared is about more than just having money in the bank. Having the right insurance for your property and belongings can reduce financial hardship and your recovery time.

Make connections

Building relationships with the people around you can reduce stress and create community resilience. Neighbours are often nearby when an emergency, disaster or unexpected situations occur. Knowing your neighbours makes it easier to ask for help when you need it, or offer help to those who need it most.

Updates

To receive regular updates on new programming join the Resilience Builders Network by sending an email to beprepared@gov.ab.ca.

Videos

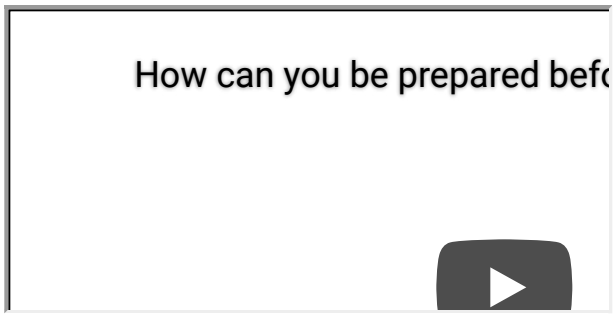
The 'Get Prepared: 60 Second Emergency Tips' video series delivers simple steps that anyone can take to become better prepared for an emergency or disaster.

Take a minute today to learn about what you can do to become better prepared, and share the videos online and within your community.

To view the video in full screen, click on the title of the video or the YouTube icon.

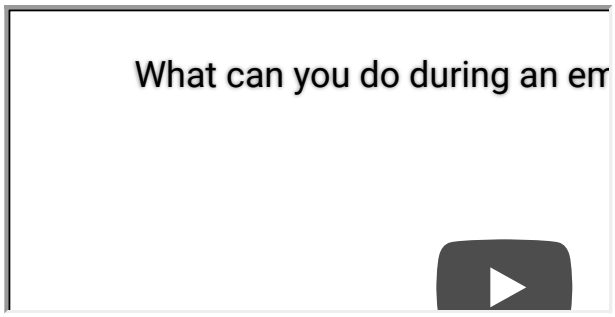
How can you be prepared before an emergency?

Emergencies affect us all differently and help is not always available in the way we expect. Learn what steps you can take to ensure your needs are met when it matters most.



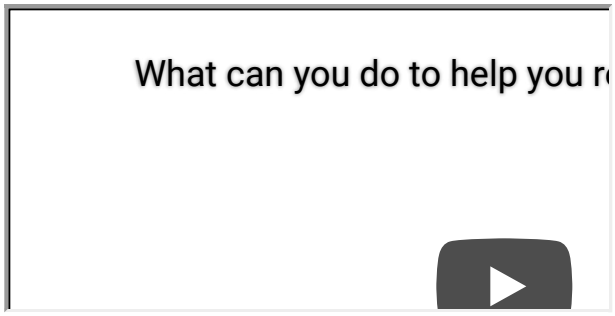
What can you do during an emergency to stay safe?

Protecting yourself and your loved ones will depend on the hazard, but these tips can help you manage emergencies and disasters safely.



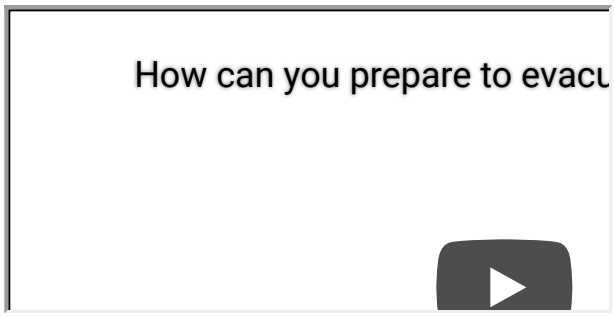
What can you do to help you recover after an emergency?

Being prepared can help speed up your recovery time so you can get back to your life and work sooner.



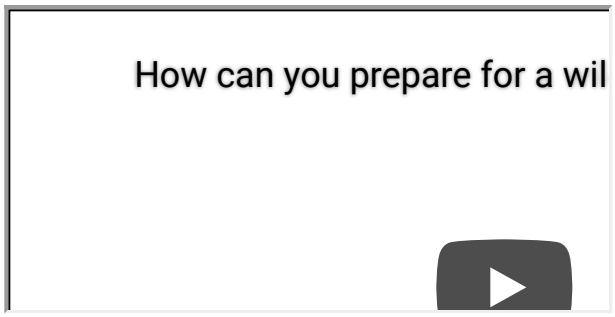
How can you prepare to evacuate?

Authorities may evacuate your community if lives are at risk. Learn how to plan for an evacuation alert or evacuation order.



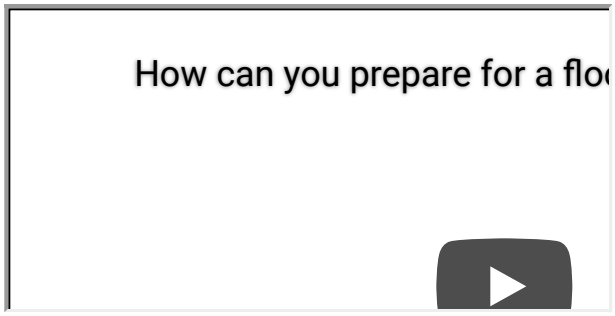
How can you prepare for a wildfire?

Alberta's wildfire season runs from March 1 to October 31 every year. Find out how you can become better prepared.



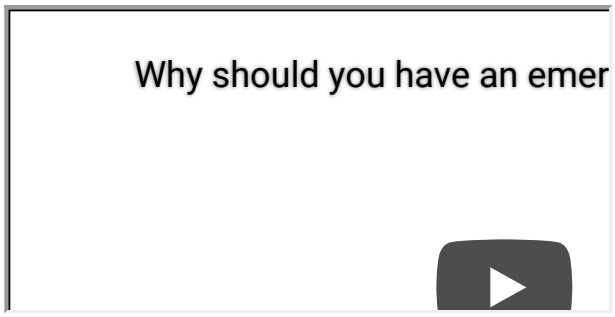
How can you prepare for a flood?

Floods are a common hazard in Alberta, and are known to have devastating effects. Find out how you can become better prepared.



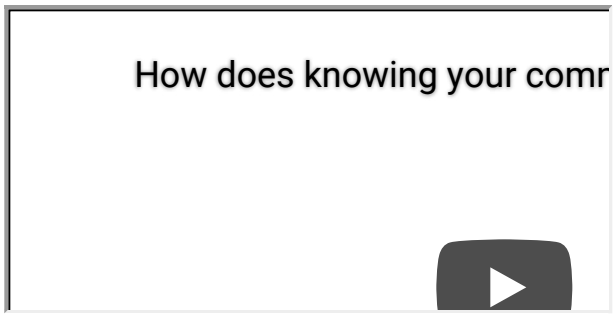
Why should you have an emergency kit?

Unexpected situations can happen to any of us. Having an emergency kit is one step to being more prepared.



How does knowing your community help you become more prepared?

Knowing your neighbours makes it easier to ask for help when you need it most. Learn ways to safely connect with your community.



More videos on being prepared

Farm animals and livestock

[Do you have an emergency plan for your farm animals and livestock?]

You may need to shelter in place or evacuate with your farm animals and livestock in an emergency. Make a plan for both situations.

Emergency kits

[What goes inside your emergency kit?]

Start building your emergency kit with these basic supplies. What else would you add to your kit?

Low cost ways to prepare for an emergency

[How can you prepare for an emergency or disaster without spending a lot of money?]

Being prepared doesn't have to be costly. Learn how you can prepare without spending a lot of money.

Preparing financially for a disaster

[How can you be financially prepared for a disaster?]

Emergencies and disasters can result in financial hardship and stress. Learn how to be better financially prepared for the unexpected.

Keeping you pets safe

[How can you ensure your pets are safe when an emergency occurs?]

Pets are part of many families, and need to be included in all family emergency plans. Learn how you can ensure their safety in an emergency.

Winter driving

[How can you prepare for winter driving?]

Cold, snow and ice can make winter driving dangerous. Learn how you can prepare for road conditions in the winter months.

Extreme cold

[How can you prepare for extreme cold?]

Learn how to stay safe when the temperature drops below -40°C or wind chill makes it feel that cold.

Tornadoes

[How you can prepare for a tornado?]

Tornadoes are common in Alberta. Find out what steps you can take to protect yourself.

Hazards

[What are hazards and how can they affect you?]

Learn about some of the most common hazards in Alberta, and how you can become better prepared.

Losing power and water

[How can you prepare for an outage?]

A power or water outage can create dangerous situations. Learn steps you can take to become better prepared.

Difference between emergencies and disasters

[What is the difference between emergencies and disasters?]

Emergencies and disasters have distinct qualities that make them different from each other. Do you know the difference?

Disaster Recovery Program changes

The Government of Alberta has made changes to the Disaster Recovery Program (DRP). For more information, visit Disaster financial assistance and recovery support.

3 reasons why you should prepare your home or property from flooding

3 reasons why you should prepare your home or property from flooding

Floods are common in Alberta year-round. Learn 3 reasons why it's important to prepare your home or property.

Checklists and translations

Use the following checklists to build specific emergency kits. Translated versions are also available in عربي (Arabic), 简体中文 (Simplified Chinese), 繁體中文 (Traditional Chinese), ਪੰਜਾਬੀ (Punjabi), Deutsch (High German), Plautdietsch (Low German), Español (Spanish), Français (French) and Tagalog (Tagalog).

Emergency kit checklist

- Emergency kit checklist (printable brochure) Printing instructions: use double-sided print setting and flip on short edge.
- عربي
- 简体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

Emergency kit checklist for your pets

- Emergency kit checklist for your pets (printable brochure) Printing instructions: use double-sided print setting and flip on short edge.

- عربي
- 简体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

Emergency kit checklist for your vehicle(s)

- Emergency kit checklist for your vehicle(s)
- عربي
- 简体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

Fact sheets

Helpful materials you can read, download, print and share online and within your community. Translated versions are also available in عربي (Arabic), 简体中文 (Simplified Chinese), 繁體中文 (Traditional Chinese), ਪੰਜਾਬੀ (Punjabi), Deutsch (High German), Plautdietsch (Low German), Español (Spanish), Français (French) and Tagalog (Tagalog).

Flood preparedness

- Flood preparedness
- عربي
- 简体中文

- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

What to do after a flood

- What to do after a flood
- عربي
- 简体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

Wildfires

- Wildfires
- عربي
- 简体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

Power and water outages

- Power and water outages
- عربي
- 簡体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

Severe weather

- Severe weather
- عربي
- 簡体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

Thunderstorms, lightning, and hail

- Thunderstorms, lightning, and hail
- عربي
- 簡体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français

- Tagalog

Blizzards, freezing rain, and ice storms

- Blizzards, freezing rain, and ice storms
- عربي
- 简体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

Tornadoes and extreme winds

- Tornadoes and extreme winds
- عربي
- 简体中文
- 繁體中文
- ਪੰਜਾਬੀ
- Español
- Deutsch
- Plautdietsch
- Français
- Tagalog

What to do before, during and after an emergency

- What to do before an emergency
- عربي
- 简体中文
- 繁體中文
- ਪੰਜਾਬੀ

DISPELLING COMMON MYTHS *ABOUT* INDIGENOUS PEOPLES

9 MYTHS & REALITIES

INDIGENOUS CORPORATE TRAINING INC.

About the author

Bob Joseph, President, Indigenous Corporate Training

Hi there, I'm **Bob Joseph**, a certified Master Trainer and founder of **Indigenous Corporate Training Inc**. Through my courses I have been helping organizations, all levels of government, and individuals work more effectively with Indigenous Peoples for over 20 years.

I believe that by sharing knowledge and information through our training, blog, and free resources, such as this ebook, we can make the world a better place for Indigenous and non-Indigenous people.

Please note, the materials on our **website** are provided for informational and educational purposes only and do not constitute legal advice. We expect you will learn from our educational materials and obtain legal advice as you need.

For permission to reproduce, please contact us at **info@ictinc.ca**.

Foreword

A Note on Terminology

This eBook is titled *Dispelling Myths about Indigenous Peoples* so before we get going we should talk about terminology. This ebook could have easily been about Aboriginal peoples or Indians or First Nations but we chose Indigenous Peoples because the federal government is now using this term.

The constitutional correct terminology in Canada is Aboriginal Peoples and this includes Indian, Inuit and Métis. Indian can be synonymous with First Nation, First Nations or even Nations. Indian can also be broken up into status Indian and non status Indian. The Inuit are different from Indians as are Métis.

We will use those terms accordingly depending on the myth we are talking about. Most of the myths (taxes, housing, education) regarding Indigenous Peoples in Canada relate to Indians (status) or First Nations.

For the purposes of this ebook, we use First Nation. Although the ebook is called *Dispelling Common Myths About Indigenous Peoples*, you will see a shift in terminology. And the last word on terminology, in addition to the Indigenous Peoples in Canada - First Nations, Inuit and Métis - you can also have Indigenous Peoples from other countries such as Peru, Mexico or Argentina living in Canada. They are still Indigenous persons, but are not covered by the ***Indian Act*** or eligible for tax exemptions for example.

Ways to share this eBook

Here are a few suggestions on how you could share this eBook with colleagues and/or visitors to your office:

- print a copy and leave it on the table in your break room
- pin it to a notice board
- post it to your website internet and intranet
- add it to the reading material in your waiting room
- take a copy with you if you are working remotely or visiting a field office

Definition of a myth

There are many myths out there about Indigenous Peoples in Canada. We call them myths because, although they may contain an element of truth, they also contain some "wide of the mark" information. Some of these myths are deeply rooted in the minds of some Canadians.

In this eBook we take a look at some of the common myths and then provide a snapshot of the reality for Indigenous Peoples. And it is just a snapshot as the background to these myths is long and complex.

Myths surrounding Indigenous Peoples cover many aspects. These myths, which have endured for generations and continue to do so, often paint a distorted picture that does not represent reality for many Indigenous People in Canada.

Myth #1

Indigenous Peoples are all the same

REALITY:

One the popular myths is that the Indigenous community is one homogeneous group. This disregards the reality that hundreds of individual Indigenous communities have their own unique history, culture, traditions and economies.

> *Anishinaabe, Métis, Coastal Salish, Cree, Cherokee. We have nothing much in common. We're all aboriginal and we have the drum. That's about it.*

The quote is from Thomas King and he's writing about a drum circle in *"The Inconvenient Indian: A Curious Account of Native People in North America."* I like the quote because King has neatly summed up the crux of this myth.

Not recognizing the cultural diversity of Indigenous Peoples in Canada is one of the most common mistakes non-Indigenous people make when working with people and communities. See this short video on name dropping for example.

Respect for cultural diversity is an aspect of Canadian society that is of great appeal to people from other countries who want to move here and is supported by the *Multiculturalism Act of 1988*. The average Canadian would proudly say they respect cultural diversity.

Myth #1

Indigenous Peoples are all the same cont'd

REALITY:

There are three distinct groups of Indigenous (Aboriginal) Peoples - First Nation or Indian, Métis and Inuit as defined by the *Constitution Act, 1982*.

Let's take a look at the largest group - First Nations (also known as Indians).

There are over 600 bands and over 2,000 reserves - each one with a distinct history that shaped their particular cultural identity. They each have distinct languages, cultures, economies, capacities, challenges, stories, teachings and worldviews.

In BC alone there is an amazing diversity of First Nation culture and language - there are over 200 First Nation communities in the province - each with its own unique culture, traditions and history. These 200 communities represent 60% of the First Nation languages spoken in Canada.

Speaking of language, did you know that outside of Quebec, English is becoming the common language of Aboriginal people in Canada?

Myth #1

Indigenous Peoples are all the same cont'd

REALITY:

Recognition of the uniqueness of each community is a fundamental first step non-Indigenous Canadians can take to respect Indigenous Peoples. If, for example, readers believe First Nation people should all be equal then they are not respecting and recognizing that this is the opposite of recognition of the uniqueness of individual First Nation communities.

In terms of an extractive company, an educator, a government representative, or average Joe or Josephine (to be respectful) time spent researching and developing an understanding of the unique background of each community will increase your understanding of what is important to that community, what they are proud of, and what they will fight to protect.

Myth #2

Indigenous Peoples already have ample reserve lands and resources

REALITY:

There are a number of wrongs about this myth, the first being that not all Indigenous Peoples have reserves.

> *"Except for the far north (including northern Quebec), where comprehensive land claims settlements have improved the situation, the present land base of First Nations is inadequate. Lands acknowledged as First Nation south of the sixtieth parallel (mainly reserves) make up less than one half of 1% of the Canadian land mass. Much of this land is of marginal value. In the United States (excluding Alaska) – where Aboriginal people are a much smaller percentage of the total population – the comparable figure is 3%." [1]*

Myth #2

Indigenous Peoples already have ample reserve lands and resources cont'd

REALITY:

Some reserves are tiny, some are vast distances from urban centres, education facilities, and employment opportunities. Don't make the mistake of equating reserves with traditional or treaty territories which can be vast.

As designated in the *Indian Act*:

> *"Reserves are held by Her Majesty for the use and benefit of the respective bands for which they were set apart, and subject to this Act and to the terms of any treaty or surrender, the Governor in Council may determine whether any purpose for which lands in a reserve are used or are to be used is for the use and benefit of the band." [2]*

Traditional lands refer to an area that a Nation has occupied and used for many generations, long before reserve borders were imposed by the *Indian Act*. When reserves were designated, traditional usage and ceremonial sites were not always considered. Some Nations were relocated to reserves in areas that were completely alien to their traditional lands.

[1] Report of the Royal Commission on Aboriginal Peoples

[2] Indian Act 18.

Myth #3

Indigenous Peoples can do whatever they want with their reserve lands and resources

REALITY:

For this myth to be true, all Indigenous Peoples in Canada would live on **reserves**. In reality, a reserve is a tract of land set aside under the Indian Act and treaty agreements for the exclusive use of an Indian band (First Nation). Métis and Inuit have no reserves. The ultimate title to reserve lands is vested in "Her Majesty."

Section 28 of the *Indian Act* states:

"Reserve lands are not subject to seizure under legal process."

Section 32(1) of the *Indian Act* provides:

> *"A transaction of any kind whereby a band or a member thereof purports to sell, barter, exchange, give or otherwise dispose of cattle or other animals, grain or hay, whether wild or cultivated, or root crops or plants or their products from a reserve in Manitoba, Saskatchewan or Alberta, to a person other than a member of that band, is void unless the superintendent approves the transaction in writing."*

Myth #3

Indigenous Peoples can do whatever they want with their reserve lands and resources cont'd

REALITY:

The Canadian government passed legislation in the late 19th and early 20th centuries allowing the government to expropriate portions of reserve land to provide land for public utilities rights-of-ways (railways, transmission lines and highways) - often done without the consent of the Nation and without compensation. It is this expropriation that has resulted in the fragmentation and disruption of many reserves.

In many cases, the province or Crown further retains subsoil rights on the reserve, which means band members do not 'own' the minerals found there.

Coastal waters and tidal lands do not form part of the reserve either in most cases. Although colonists tried to justify the small sizes of many reserves along coastal British Columbia by their access to waterways, Indigenous fishing grounds and their resources have been restricted by provincial and federal regulations.

Myth #4

Indigenous people living on reserves get free housing!

REALITY:

The Canada Mortgage and Housing Corporation (CMHC) offers many programs to assist both Indigenous and non-Indigenous people meet their housing needs. For Indigenous people, the assistance programs are only applicable for dwellings on reserve lands. First Nations (or Indians, depending on their preference) people can apply for social housing programs offered by the CMHC.

The housing programs for Indigenous people are mainly designed to give low-income families access to rental housing. Bands and First Nations that meet CMHC lending criteria apply to a bank for conventional mortgage funds to finance the social housing construction, usually with CMHC providing loan insurance. The band rents the housing units to its members and maintains the mortgage.

On many reserves, except some that have developed **self-government** agreements, the house is owned but the land is not – therefore it cannot be sold - which makes it impossible to build up equity in your home, as is possible for non-Indigenous people. Additionally, the reality for most people is that they need to take out a loan in order buy a house and loans require collateral.

Myth #4

Indigenous people living on reserves get free housing! cont'd

REALITY:

The *Indian Act* limitations to seizing property on-reserve, make it extremely difficult to secure financing for anything, whether you intend to buy, build or renovate a house, start a business, or what have you. To be extremely clear, this is not an endorsement of attempts to unilaterally impose private property regimes on reserve, I'm just explaining things.

Reserves are of a finite size, and on some urban reserves, there is no room for expansion - when the space available for housing reaches its maximum capacity, that's it, which makes accommodating population growth a challenge. As Indigenous people are the fastest-growing segment of Canada's population, with more than half the population under the age of 25, this means the additional challenge of available building space will become an issue for some reserves.

Myth #4

Indigenous people living on reserves get free housing! cont'd

REALITY:

The housing shortage on-reserve is estimated at "35,000 and 85,000 units across the country." [1] The population growth rate coupled with the shortage of adequate housing results in thousands of people living in unhealthy and overcrowded conditions.

Maintenance is also a huge factor. Many reserves are situated long distances from hardware stores or have fly-in access only so have to bring in building supplies by air. "An estimated 37% of housing units on reserve are in need of major repairs." [2]

The struggles of the Attawapiskat First Nation in Ontario that hit the media in late December 2011 are a clear example of some of the unhealthy and overcrowded living conditions that exist on reserves in Canada today.

[1] Standing Senate Committee on Aboriginal Peoples

[2] ibid

Myth #5

Indigenous Peoples don't pay taxes in Canada

REALITY:

This myth is proclaimed frequently, and is presented as a testament that Indigenous People in Canada have a massive tax advantage over other people in Canada.

In order for this myth to be true, it would have to be all Indigenous people are exempt from paying taxes but the reality is that it is only the status Indians who are exempt from paying taxes. All other Indigenous people – Inuit, Métis and non-status Indians - pay taxes on the same footing as non-Indigenous people. However, in January 2015 the Supreme Court of Canada ruled that Métis and non-status Indians are "Indians" under the *Constitution Act*. This could mean in future that Métis and non-status Indians will also be eligible for the same tax exemptions but it is unclear yet. The federal government is considering its options in terms of appealing the decision. Indigenous Peoples from other countries such as Mexico or Peru, living in Canada pay taxes.

Federal tax exemptions for status Indians have existed at least since the consolidation of the *Indian Act* in 1876, but only apply in very specific and limited conditions. Under sections 87 and 90 of the *Indian Act*, status Indians do not pay federal or provincial taxes on their personal and real property that is on a reserve. Personal property includes goods, services and income as defined under the Canada Customs and Revenue Agency policies. As income is considered personal property, status Indians who work on a reserve do not pay federal or provincial taxes on their employment income.

Myth #5

Indigenous Peoples don't pay taxes in Canada cont'd

REALITY:

Initially the purpose of the exemption was to preserve the entitlements of status Indians to their reserve lands and to ensure that the use of their property on their reserve lands is not eroded by taxes.

Section 87 also exempts from the federal Goods and Services Tax (GST) the goods and services bought by status Indians at businesses located on-reserve. Goods and services purchased off-reserve by status Indians but delivered to the reserve are also tax exempt. Most provincial sales taxes are similarly applied. In some provinces, there are certain exemptions such as automobiles which must be registered to an address on a reserve in order to be tax exempt.

Most income, sales and property tax exemptions only apply to status Indians (637,660) who live or work on a reserve. Less than half of all registered status Indians live on reserve so the number who are actually eligible for tax exemptions amounts to about 314,000 people. [1] To put it in perspective, somewhat less than half of all registered status Indians live on reserve so less than 1% of the total population of Canada are exempt from paying certain taxes.

Myth #5

Indigenous Peoples don't pay taxes in Canada cont'd

REALITY:

The Court has indicated that this tax exemption is not intended to remedy the economically disadvantaged position of Indigenous people in Canada or bring economic benefits to them. Also, based on Supreme Court decisions, Indian property not situated on a reserve will generally be subject to tax just like property held by other Canadians.

Status Indians do pay income tax Income earned on a reserve is exempt, whether or not the employed status Indian person lives on or off reserve. Income earned off reserve is taxed on par with non-Indigenous taxpayers.

So, in terms of how many status Indians are receiving income tax exemptions:

- "The employment rate for working-age status Indians was 55% in 2011, over 20 percentage points lower than the rate for non-Aboriginal persons of working age (76%).
- The unemployment rate for working-age status Indians was 17%. The proportion was even higher for those living on-reserve at 22%." [2]

Myth #5

Indigenous Peoples don't pay taxes in Canada cont'd

REALITY:

So, some points to further clarify the reality of the myth that Indigenous people don’t pay taxes in Canada: Personal property tax exemption facts:

- "A tax exemption for Indian property situated on reserves has existed since before Confederation.
- The Supreme Court of Canada has stated that this exemption is linked to the protection of reserve land and property.
- The Court has concluded that the purpose of the exemption is to make sure tax does not erode the use of Indian property on reserves." [3]

Myth #5

Indigenous Peoples don't pay taxes in Canada cont'd

REALITY:

Sorry, Justin, there's no free gas!

In 2012, Justin Bieber infamously stated in an interview for Rolling Stone magazine:

> *"I'm actually part Indian. I think Inuit or something? I'm enough percent that in Canada I can get free gas."*

Reality check – status Indians who present their status card when purchasing gas on reserve are tax exempt. This does not apply to gas purchased off reserve.

So there's some clarification for you. Now when you hear the statement "Indigenous Peoples don't pay taxes" you will know differently.

We also would like to point out that not paying taxes is practically a national pastime - consider all the non-Indigenous Canadians and corporations who actively look for loopholes to avoid paying taxes and are entitled to do so...

[1] 2011 National Household Survey: Aboriginal Peoples in Canada: First Nations People, Métis and Inuit

[2] ibid

[3] Canada Revenue Agency website

Myth #6

Indigenous Peoples receive free postsecondary education

REALITY:

To say that all Indigenous Peoples receive free post-secondary funding is misleading because it implies all Indigenous Peoples are eligible for funding. This is not the case. Only status Indians are eligible to receive funding for post-secondary education through Indigenous Services Canada funding - non status Indians, Inuit and Métis are not eligible for this funding.

Eligibility is just one criteria. The student has to apply to the band office of their home community. The number of applications for funding frequently exceeds the available. Some communities have waiting lists and those on the lists will probably never be funded. Some communities require the student to be a resident in the community which eliminates the students who live in urban centres. So, while in some communities the rate of high school graduation is increasing, the graduates often step off the path to higher education at that point due to the lack of available funds.

In order to create additional opportunities for their members some bands set aside funding within their budgets to assist their members in obtaining a post-secondary education. These programs are similar to scholarship programs established by post-secondary institutions and other organizations who want to see the advancement of youth.

Myth #7

Residential schools are ancient history

REALITY:

It is a common and convenient myth that **residential schools** are part of Canada's ancient history. In reality the last school closed in 1996 which is 166 years after the first school, the Mohawk Indian Residential School, opened in 1830. As recently as 1979, 12 residential schools were still operating. Over the 166 years there were 139 schools operating across Canada except Prince Edward Island New Brunswick and Newfoundland (in Newfoundland the Indigenous population, the Beothuk, became extinct 350 years after European contact).

Beginning in the late 1800s, Indigenous children (150,000) were removed from their homes and placed in state funded and church-run schools - they were not allowed to attend public schools. Programs offered in the Indian Residential Schools system emphasized 'Christianizing' Indians (at that time there was no distinction between Indians, Inuit or Métis) and provided training for jobs in agriculture and as domestic help - not with a goal of obtaining a post secondary education.

Myth #7

Residential schools are ancient history cont'd

REALITY:

The policy behind the schools has now been acknowledged as "cultural genocide".

> *"I want to get rid of the Indian problem. I do not think as a matter of fact, that the country ought to continuously protect a class of people who are able to stand alone... Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian Department." [1]*

The impact of the residential school system is multi-generational, current, and is considered one of the primary contributors to the social problems of many survivors, their families, and communities. There are approximately 80,000 former students, or survivors, alive today.

According to the Truth and Reconciliation Commission an approximate 6,000 children died in or due to residential schools.

[1] Duncan Campbell Scott, 1920, Deputy Minister, Indian Affairs in Canada

Myth #8

There's no connection between Indigenous unemployment and Indigenous health and social problems

REALITY:

Employment opportunities and rates on reserves vary considerably due to general economic circumstances in a particular region and the presence or absence of on-reserve resource bases that can generate employment.

Given that in many circumstances incomes are low and employment prospects poor, it is not surprising that a large proportion of the Indigenous population is unemployed and lives in poverty.

Going back to Myth#4, poor and scarce housing leads to too many people living in housing units that are frequently riddled with mold, not weatherproof, and insufficiently heated - the ideal incubation setting for respiratory conditions.

Myth #9

Missing and murdered Indigenous women brought it upon themselves

REALITY:

Decades of government policies have wreaked havoc on traditional Indigenous family relations and destroyed communities, leaving many Indigenous women and girls impoverished, demoralized, and extremely vulnerable to exploitation and attack. Prevailing antagonism and enduring racial stereotypes that sexualize Indigenous women and girls denigrate their dignity and self-worth and sets the environment for some men to feel they can get away with violent acts of hatred against them.

Stats Canada's report Violent victimization of Aboriginal women in the Canadian provinces, 2009 shows that:

> *"close to 67,000 or 13% of all Aboriginal women aged 15 and older living in the provinces stated that they had been violently victimized. Overall, Aboriginal women reported experiencing close to 138,000 incidents of violence and were almost three times more likely than non-Aboriginal women to report having been a victim of a violent crime. This was true regardless if the violence occurred between strangers or acquaintances, or within a spousal relationship."*

Myth #9

Missing and murdered Indigenous women brought it upon themselves cont'd

REALITY:

In 2014, the RCMP released a report that marked the first time that police in Canada have attempted, at the national level, to identify how many Indigenous women and girls have been murdered or gone missing.

According to the report, 1,017 women and girls identified as Indigenous were murdered between 1980 and 2012–a homicide rate roughly 4.5 times higher than that of all other women in Canada. In addition, as of November 2013, at least 164 Indigenous women and girls remained missing under suspicious circumstances or for undetermined reasons.

Indigenous women and girls in Canada, on and off reserves, in major cities, in every region in the country are at risk of experiencing violence. The perpetrators include Indigenous and non-Indigenous men alike.

The 1,107 murdered Indigenous women and the additional 164 who are missing under suspicious circumstances did not bring it upon themselves.

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8 First Nation reserve FAQs

March 06, 2015

A First Nation reserve is a tract of land set aside under the ***Indian Act*** and treaty agreements for the exclusive use of an Indian band (First Nation). Earliest examples of reserves date back to attempts by French missionaries in 1637 to encourage Aboriginal Peoples to settle in one spot and embrace both agriculture and Christianity. As more and more Europeans settled in Canada and encroached on lands of Indigenous Peoples, it became apparent to the authorities that an effective means to ensuring the most fertile land was available to European farmers was needed. The development of the reserve system met this need.

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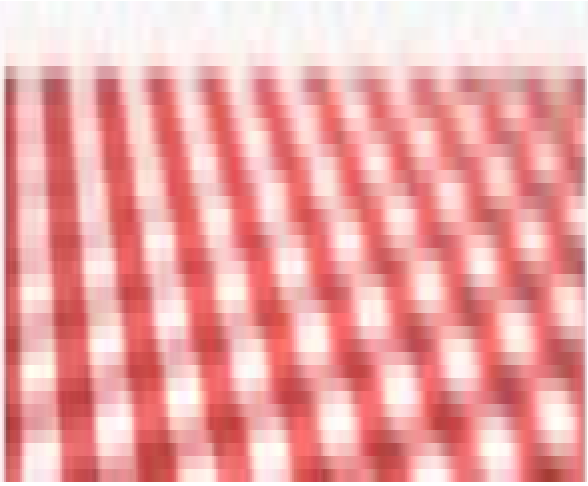

1) How many reserves are there in Canada? According to the 2011 National Household Survey (**NHS 2011**), there are 3,100 reserves.

2) How many First Nations live on reserves? 637,660 First Nations people reported being Registered Indians (First Nations) in the NHS 2011 and of that number nearly one-half (49.3%) lived on an Indian reserve. Here's a deeper look: **8 Things You Need to Know About On-Reserve Housing Issues**

3) Do Metis and Inuit have reserves? Not usually, although many live in communities that are governed by **land-claim decisions** or **self-government agreements**.

4) Are reserves the same as traditional lands? No. As designated in the ***Indian Act***,

> "Reserves are held by Her Majesty for the use and benefit of the respective bands for which they were set apart, and subject to this Act and to the terms of any treaty or surrender in Council may determine whether any purpose for a reserve are used or are to be used is for the the band. " [1]

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Traditional lands refer to an area that a Nation has occupied and used for many generations, long before reserve borders were imposed by the *Indian Act.* When reserves were designated, traditional usage and ceremonial sites were not always considered. Some Nations were relocated to reserves in areas that were completely alien to their traditional lands.

5) Can one Chief and Council administer more than one reserve? Yes, some reserves are shared by more than one Nation, and smaller neighboring bands often share ceremonial facilities.

6) On what basis was reserve land allocated? There wasn't a consistent formula for designating land to a Nation. For example, Treaties 1 and 2 used the ratio of 160 acres per family of five; Treaties 3 – 11 allocated 640 acres per family of five. In British Columbia, the ratio was an average of 20 acres granted per family. A Nation may have more than one reserve, and they may or may not all be contiguous.

Here are two starkly opposing perspectives on the size of land allocated to each band.

> . . .This Government does not desire to see apportioned any unnecessarily large Reserves such as would interfere with the progress of white Settlement . . . [2]
>
> ———
>
> Mr. O'Reilly came in 1881 to lay off reserves, and w
> at this; and he measured off just a small piece, whi
> us; but it was too small, not large enough for us, no
> live on, only a little from our houses; we told how much we wanted, but he only shook his head. Only a small part of hat he measured is

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> good. My heart is sick, and so are all our people, because the land is so large outside of what he measured for us, and our berry trees, our salmon streams, and hour hunting grounds are in this land that is taken from us. These are not in what Mr. O'Reilly measured for us . . . I want to see the Government do right by us, and the officers to treat us all alike, not help one village different from another, and then we shall have confidence in their work. We want sufficient land for ourselves, to be our own; we do not want it as a reserve; and give us a treaty, and something for the outside, our hearts will then be satisfied. [3]

7) Are all reserves occupied? No, not all reserves are populated, especially some of the smaller, remote reserves. Some reserves may solely be used for traditional seasonal pursuits such as trapping, berry picking, or fishing.

8) Can anyone live on a reserve? Generally, reserve residents are members of the Nation where they reside. According to the *Indian Act*, only registered Nation members may live permanently on a reserve unless the Nation has adopted a residency bylaw that regulates who has the right to live on the reserve. In 2010, according to Aboriginal Affairs and Northern Development (now called Indigenous and Northern Affairs Canada), 230 bands controlled their own membership lists, while a further 31 controlled membership under self-government legislation.

And no, reserves are not the same as reservations. Reservation is the term used in the United States. In Canada, reservations can be sought at hotels, airlines and restaurants. Reserve is the proper legal term.

[1] *Indian Act 18. (1)*

[2] Instructions to Indian Reserve Commissioner Alexander McKinley, 1876

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[3] Statement of George Gibson, Naas River November 19, 1888

Here's an article on **Urban Reserves**

If you are interested in learning more terminology such as "reserve" versus "reservation", please download our *Indigenous Peoples: A Guide to Terminology*.

Topics: **Indian Act**, **First Nations**

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Please Visit

http://www.aema.alberta.ca/personal-emergency-preparedness

The Alberta provincial website for more tips on personal emergency preparedness, and how the province has prepared to react to any disasters in the area.

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Emergency Preparedness Supply List

If there was an emergency right now, what would you do? Have a plan.

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Recommended Items to Include in a Basic Emergency Supply Kit:

- ☑ WATER; 4 liters of water per person per day, for at least three days, for drinking & sanitation
- ☑ FOOD; at least a three-day supply of non-perishable food
- ☑ Battery-powered RADIO and a Weather Radio with tone alert and extra batteries for both
- ☑ FLASHLIGHT & extra BATTERIES
- ☑ FIRST AID KIT
- ☑ Whistle and signal for help
- ☑ Dust mask, to help filter contaminated air, and, plastic sheeting and duct tape to shelter-in-place
- ☑ Moist towelettes, garbage bags and plastic ties for personal sanitation
- ☑ Basic TOOLS needed to turn off utilities (wrench, pliers, etc.)
- ☑ Can opener for food
- ☑ Local MAPS

Additional Items to Consider Adding to an Emergency Preparedness Supply Kit:

- ☑ Prescription medications & glasses
- ☑ Infant formula and diapers
- ☑ Pet food & water for your pet
- ☑ Important family documents (copies of insurance policies, ID, & bank account records in a waterproof & portable container
- ☑ Cash or traveler's checks
- ☑ Sleeping bag or warm blanket for each person
- ☑ Complete change of clothing including a long sleeved shirt, long pants, & comfortable shoes
- ☑ Household chlorine bleach & medicine dropper – When diluted 9 parts water to 1 part bleach, bleach can be used as a disinfectant. Or in an emergency, you can use it to treat water by using 16 drops of regular household liquid bleach per gallon of water. Do not use scented, color safe or bleaches with added cleaners.
- ☑ Fire Extinguisher

Cont'd

- ☑ Matches in a waterproof container
- ☑ Feminine supplies and personal hygiene items
- ☑ Mess kits, paper towels, paper cups, plates & plastic utensils
- ☑ Paper & pen/ pencil
- ☑ Books, games, puzzles or other activities for your family

Appendix B to Ministerial Order No. A: A:001/21

Alberta Private Sector Disaster Assistance Guidelines

Effective upon signing of Ministerial Order No. A:001/21 until superseded by a subsequent version.

Alberta Government

Classification: Public

Ministry of Municipal Affairs, Government of Alberta

February 25, 2021

Alberta Private Sector Disaster Assistance Guidelines

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The Guidelines are not a substitute for the *Emergency Management Act* or its regulations. To the extent, there is any inconsistency between the Guidelines and the *Emergency Management Act* or its regulations, or any other applicable legislation, the legislation is paramount.

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ALBERTA PRIVATE SECTOR DISASTER ASSISTANCE GUIDELINES

In the event of a disaster, the Government of Alberta (GoA) may provide financial assistance to private sector applicants through a Disaster Recovery Program (DRP) administered by the AEMA.

These Alberta Private Sector Disaster Assistance Guidelines come into effect upon signing of Ministerial Order No. A:001/21.

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Table of Contents

Introduction 4
Part 1 – Purpose and Principles 5
1.1 Interpretative Principles and Purpose 5
1.2 Exclusions for Specified Events 5
1.3 Assessment of Applications 5
Part 2 – Application Process 6
2.1 Limit on Assistance 6
2.2 Applications for Assistance 7
2.3 Notification 7
2.4 Evaluation of Losses and Damages 7
2.5 Reconstruction Permissions 8
2.6 Supporting Documentation 8
2.7 Auditing Applications 9
2.8 Determination of Exceptional Circumstances 9
Part 3 – Payment and Program Completion 10
3.1 Payment 10
3.2 Program Completion 10
3.3 Repayment Requirements 11
Part 4 – General Program Eligibility Criteria 11
4.1 Insurance 11
4.2 Rate Schedules 12
4.3 Consequences of Providing False Information 12
4.4 Pre-emptive Actions 13
4.5 Response 13
4.6 Innovative Recovery Solutions 13
4.7 Mould 14
4.8 Costs Eligible for Assistance 14
4.9 Costs Ineligible for Assistance 15
Part 5 – Residential Eligibility Criteria 15
5.1 Residential Applicants 15
5.2 Costs Eligible for Assistance 17

Classification: Public

5.3 Costs Ineligible for Assistance 18
Part 6 – Small Business Eligibility Criteria 18
6.1 Small Business Applicants 18
6.2 Costs Eligible for Assistance 19
6.3 Costs Ineligible for Assistance 19
Part 7 – Agricultural Operation Eligibility Criteria 19
7.1 Agricultural Operation Applicants 19
7.2 Costs Eligible for Assistance 20
7.3 Costs Ineligible for Assistance 22
7.4 Woodlots 22
Part 8 – Not-for-profit Eligibility Criteria 23
8.1 Not-for-profit Organization Applicants 23
8.2 Not-for-Profit Cooperative Applicants 23
8.3 Government Sales Tax 23
Schedule 1 - Glossary 255

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Introduction

The Alberta Emergency Management Agency (AEMA) has developed the Alberta Private Sector Disaster Assistance Guidelines (Guidelines) for the administration of disaster financial assistance through the province's Disaster Recovery Program (DRP). These Guidelines have the force of law under the Disaster Recovery Regulation, AR 51/94, when approved by Order of the Minister of Municipal Affairs.

These Guidelines are designed and developed to provide fair, consistent and transparent financial assistance to private sector applicants for uninsurable loss and damage caused by disasters. These Guidelines apply to private sector applicants, including homeowners, residential tenants, small business owners, landlords, agriculture operations, condominium associations and not-for-profit organizations and cooperatives.

Separate guidelines are established for public sector applicants, under the Alberta Public Sector Disaster Assistance Guidelines.

Assistance provided under these Guidelines may be reimbursed to the AEMA in part by the Government of Canada pursuant to the federal Disaster Financial Assistance Arrangements (DFAA). The DFAA is a federal grant program that allows for federal and provincial cost-sharing of disaster recovery programs. Any discrepancies between these Guidelines and the DFAA, or any other federal programs, have no legal effect: only Guidelines made under the Disaster Recovery Regulation apply to disaster assistance applications under Alberta's *Emergency Management Act*.

Many terms in these Guidelines are defined terms. Refer to Schedule 1, Glossary, to find out what these terms mean. If you have not read these Guidelines before, read the Glossary first.

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Part 1 – Purpose and Principles

1.1 Interpretative Principles and Purpose

1.1.1 The purpose of disaster assistance is to:

(a) contribute to a ready and resilient Alberta by providing financial assistance for uninsurable disaster events and emergencies;

(b) provide or reinstate the basic essentials of life to individuals, including financial assistance to help repair and restore damaged principal residences to their pre-disaster functional condition;

(c) re-establish or maintain the viability of small business and agricultural operations;

(d) help return property to a basic level of functionality, but not be a full cost property replacement program, like some forms of insurance; and

(e) be a financial assistance program of last resort in response to a widespread disaster or emergency.

When navigating these Guidelines references to the largest headers are “Parts”, the smaller headers are “Divisions”, and then the points underneath are sections (e.g. Part 1, Division 1.1, Section 1.1.2).

1.1.2 The definitions contained in Schedule 1 apply to the interpretation of these Guidelines.

1.1.3 These Guidelines must be interpreted:

(a) consistently within the scope of the Minister’s authority under section 2 of the Disaster Recovery Regulation, and

(b) in accordance with the *Interpretation Act*.

1.1.4 Unnumbered text boxes are for information only.

1.2 Exclusions for Specified Events

1.2.1 No assistance may be provided under these Guidelines where a disaster or emergency event consists of or originates from:

(a) public or civil disorder including a riot, criminal or terrorist acts, or domestic or international armed conflict;

(b) construction or development deficiencies that result in damages to property not directly caused by a natural disaster; or

(c) forest, prairie, grass or another type of wildfire, except where the fire poses a threat to urban and commercial developments, and actions taken in response to the fire are primarily for pre-emptive actions, including evacuation, and damaged infrastructure restoration.

1.3 Assessment of Applications

1.3.1 The AEMA is responsible to determine eligibility for assistance under these Guidelines, including decisions of what costs of recovery of damage or losses may be compensated, and the limits on

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assistance that may be provided to an applicant.

1.3.2 The AEMA is responsible for determining the total amount of assistance that an applicant is eligible to receive under these Guidelines, including the determination that an applicant is or is not eligible for any assistance.

1.3.3 Where a DRP is established, no applicant is eligible for assistance if they are located outside of the affected geographical area or where the AEMA determines that damages and losses to property were not due to the disaster event described in the applicable Ministerial Order (MO), or for the disaster event in a localized disaster, if a MO is not required.

Part 2 – Application Process

2.1 Limit on Assistance

2.1.1 No applicant is eligible for assistance under these Guidelines if the applicant does not:

(a) apply for assistance in accordance with this Part,
(b) comply in good faith with the processes and requirements of this Part,
(c) meet the limitation periods established by this Part, subject to any applicable exceptions to limitation periods in this Part, and
(d) meet all of the other criteria for eligibility for assistance under these Guidelines.

Any references to "days" in these Guidelines is counted as calendar days.

2.1.2 An applicant is ineligible for assistance under these Guidelines where assistance may be recovered from another source or under any other program existing at the time of the disaster, whether or not the applicant accessed the program or source. This is duplicate assistance and is subject to repayment under Division 3.3.

2.1.3 The AEMA may deny assistance to homeowner applicants, even if the applicant is otherwise eligible, unless the applicant consents to allowing the AEMA to make publicly available the physical location address and legal land description where damage or loss occurred and assistance was provided.

2.1.4 Where an applicant is eligible for assistance under these Guidelines, the amount payable to the applicant is limited to 90 per cent of the total amount of assistance deemed eligible by the AEMA.

2.1.5 Assistance may not be paid to any applicant who is otherwise eligible for assistance, where assistance was previously paid to a homeowner applicant under these Guidelines for damage or loss to property at that same physical location.

(a) Assistance may only be paid for damages or loss to a homeowner property once; if the property ownership changes it will remain ineligible for future assistance for any private sector applicant type.
(b) This section only applies to assistance provided for disaster events, occurring after signing of MO No. A:001/21.

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2.1.6 Where a homeowner applicant is eligible for assistance under these Guidelines, the maximum assistance payable to the applicant may not exceed $500,000.

2.2 Applications for Assistance

2.2.1 Applicants cannot apply for assistance until their local authority is approved under a DRP.

2.2.2 Applications for assistance must be submitted to the AEMA within 90 days from the program approval date.

Disaster event start date and program approval date are different. See the glossary for definitions.

2.2.3 The deadline stated in section 2.2.2 does not apply where the Managing Director chooses to accept an application:

(a) where there has been a change in the policy of the DRP program which would make an applicant eligible who was not eligible prior to the change in policy;
(b) where an applicant was unaware of the eligibility criteria or deadline due to the applicant being hospitalized, functionally illiterate, or away from the Province; or
(c) for any other reason for which the Managing Director is of the opinion would be just and reasonable in the circumstances.

2.3 Notification

2.3.1 When a DRP is approved, the AEMA notifies the local authority applicant. The local authority is then responsible for notifying the impacted population within the local authority's boundary.

For details on local authority responsibilities refer to the Alberta Public Sector Disaster Assistance Guidelines.

2.4 Evaluation of Losses and Damages

2.4.1 The AEMA facilitates evaluations of losses and damages for which assistance may be eligible under the Disaster Recovery Regulation.

2.4.2 Where specialists are required to evaluate losses or damages, only professionals whom the AEMA determines to be qualified may provide evaluations to determine eligibility under these Guidelines.

2.4.3 On request from the AEMA, the applicant must provide all relevant records to determine the pre-disaster functional condition of any type of damaged property.

Property may include land, buildings, structures, equipment and contents.

2.4.4 For the purposes of determining the applicant's eligibility for assistance, the AEMA has sole discretion to determine:

(a) the pre-disaster functional condition of property, and
(b) the state of the pre-disaster event property, including the degree of pre-existing event wear, tear, and damage to the property as compared to the property's replacement cost.

Classification: Public

2.5 Reconstruction Permissions

2.5.1 Where a permit, authorization, or approval requires supporting documentation, including plans, drawings, technical reports and assessments, the applicant must determine and obtain all required permits, authorizations, and approvals necessary before carrying out repairs or restoration activities.

2.6 Supporting Documentation

2.6.1 Supporting documents required under these Guidelines must be submitted to the AEMA by the deadline set by the AEMA.

2.6.2 Upon request from the AEMA, the applicant must demonstrate that reasonable efforts were taken to prevent further damages to the applicant's property following the disaster event.

2.6.3 All applicants must:

(a) keep accounts and records of related financial estimates and expenditures of damages before, throughout, and after the clean-up and repairs; and

(b) not submit documentation to the AEMA that includes costs for property maintenance or routine non-disaster related work, or if documentation for work includes maintenance or routine non-disaster related work costs, then clearly identify the cost as excluded.

2.6.4 Where an applicant applies for assistance that allow the applicant to rebuild or replace property to a condition that exceeds the pre-disaster functional condition of the property, the applicant must demonstrate to the AEMA that this is required by law.

2.6.5 The applicant is responsible for any cost to rebuild or replace property to a condition, which exceed the pre-disaster functional condition of the property that is not required by law, by-laws or building codes. Assistance is only eligible for repairs and replacement up to a basic standard.

(a) An applicant is not eligible to receive assistance for private or neighbourhood architectural design controls that are above the basic level of construction and finishing.

(b) The applicant is responsible for meeting additional private or neighbourhood architectural design controls (including landscaping) for the property above the basic level of construction and finishing.

2.6.6 An applicant must submit records to the AEMA to verify their identity and name; the following documents are acceptable:

(a) driver's license;

(b) passport;

(c) legal documents (e.g., Marriage/Divorce/ Death certificate);

(d) statutory declaration; or

(e) other GoA standards outlined at www.servicealberta.ca/2135.cfm.

Classification: Public

2.6.7 An applicant must submit records to the AEMA to verify property ownership; the following documents are acceptable:

(a) land title certificate;
(b) property tax assessment;
(c) mortgage statement;
(d) letter from the Government of Alberta;
(e) corporate registry;
(f) legal agreement;
(g) letter from lawyer;
(h) legal document (e.g., Marriage/Divorce/ Death certificate); or
(i) statutory declaration.

Proof of repair is required to ensure that assistance was used for the purposes for which it was intended.

2.6.8 Proof of repair is required for applications from small business owners, landlords, agricultural operations, condominium corporations, not-for-profit organizations, institutions, co-operatives and residential applications for items not identified in the AEMA published Rate Schedules.

(a) For an expense requiring proof of repair, the applicant must submit to the AEMA an invoice or receipt and an explanation of the reason for the expense.

2.6.9 For residential applications, proof of loss or damage, rather than proof of repair, is generally the basis for determining eligibility. This includes loss and/or damage to contents, essential assets, and non-structural property damages.

2.6.10 Despite section 2.6.9 when requested by the AEMA an applicant must provide records to determine the eligibility of essential items where the replacement cost is not identified on the AEMA published rates schedules.

2.6.11 Despite section 2.6.8, the Director may waive the proof of repair requirement for an applicant due to exceptional circumstances under Division 2.8.

2.7 Auditing Applications

2.7.1 Applicants must keep all records related to disaster event costs for not less than two years from the date of the closure of their application indicated in the File Closure Letter.

2.7.2 Applicants must make accounts and records described in section 2.7.1 available to the AEMA upon request.

2.7.3 The AEMA is not bound by supporting documentation provided by an applicant. The AEMA may reject any information or documentation provided by an applicant where the AEMA determines the information or documentation is, or may be, insufficient or unreliable.

2.8 Determination of Exceptional Circumstances

2.8.1 Only the person holding the position of Director may determine whether an applicant's situation constitutes exceptional circumstances for the purposes of these Guidelines.

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2.8.2 A determination that an applicant's situation constitutes exceptional circumstances is only applicable to the provisions of these Guidelines that the Director determines it applies to.

2.8.3 An applicant must provide any information requested by the AEMA to determine that exceptional circumstances apply.

Part 3 – Payment and Program Completion

3.1 Payment

3.1.1 An applicant may be paid assistance, only where:

(a) the applicant incurs a cost that is eligible for assistance under these Guidelines,

(b) the applicant meets all of the criteria contained in these Guidelines to be eligible for assistance, and

(c) no provisions in these Guidelines make the applicant ineligible for assistance.

3.1.2 Subject to the exceptions stated in Division 3.1, the AEMA may make a payment to an applicant for eligible assistance only after the AEMA has reviewed the applicant's application and determined the appropriate amount of assistance eligible to be paid.

3.1.3 Upon the province establishing a DRP, an applicant may request, in writing, an advance payment of anticipated eligible expenses. The AEMA may provide an applicant with an advance payment of assistance representing up to 90 per cent of the amount of eligible expenses.

3.1.4 In the applicant's request for an advance, the applicant must submit supporting documentation, including receipts for actual interim expenditures and projected estimates to the AEMA.

3.1.5 The applicant must complete one of the following documents and submit it to the AEMA prior to receiving their payment:

(a) the Advance Payment Acknowledgement Letter for advances less than $10,000, or

(b) the Advance Payment Agreement for advances $10,000 or greater.

3.1.6 The AEMA may make a payment for eligible assistance directly to a third party excluding contractors and vendors, on behalf of an applicant, if the AEMA determines that exceptional circumstances in accordance with Division 2.8 apply.

(a) An applicant is required to complete a Direction to Pay which must be approved by Municipal Affairs' Legal Services prior to AEMA assigning assistance directly to the third party.

3.2 Program Completion

3.2.1 The program completion date is the three-year anniversary of the disaster event program approval date and any extensions granted under these Guidelines.

3.2.2 Despite section 3.2.1, for a localized disaster where no MO is approved, the program completion date for applicants is established by the Director, but may not exceed more than two years from the date of the localized disaster event start date.

Classification: Public

3.3 Repayment Requirements

3.3.1 All assistance payments are subject to being returned to the AEMA, if the AEMA determines an applicant was ineligible for, or otherwise paid an amount in excess of the assistance eligible under these Guidelines.

3.3.2 An applicant must inform the AEMA where any of the costs in their application for assistance is paid for by any other source.

3.3.3 Where an applicant receives assistance under these Guidelines, and receives duplicate assistance from another source, the AEMA may require the applicant to repay the amount of the duplicate assistance to the AEMA.

Examples of duplicate assistance include, but are not limited to, insurance, payments of damages by court order or settlement agreement, other government programs, or a form of assistance from a non-governmental entity (including a charity or other non-profit organization).

3.3.4 The limitation period for the AEMA to provide written notice to an applicant that a repayment is required under this Division (3.3) is seven years from the program completion date.

Part 4 – General Program Eligibility Criteria

4.1 Insurance

4.1.1 Uninsurable is where insurance coverage for a property that suffered damage or loss, from the peril that occurred in the disaster event, was not readily available in the area affected by the disaster event, at a reasonable cost prior to the event; uninsurable is determined by the AEMA.

4.1.2 Subject to these Guidelines, assistance for damage and loss is eligible only where the property was uninsurable at the time of the event.

"Uninsurable" should not be confused with "uninsured". Eligibility criteria is assessed by the AEMA based on insurability. Albertans are expected to assess their risk and purchase adequate insurance.

4.1.3 An applicant's cost of insurable property damaged or loss due to the disaster event is not eligible for assistance.

4.1.4 Section 4.1.2 applies to a situation where the applicant did not obtain sufficient insurance to cover the full costs of recovery for damage or losses to the property due to the disaster event (i.e., is underinsured).

4.1.5 Upon request by the AEMA, an applicant must provide records to demonstrate that prior to the disaster event a property damaged or lost in the disaster event was uninsurable, by the deadline set by the AEMA.

4.1.6 If an applicant is requested by the AEMA to demonstrate that a property was uninsurable, and the applicant fails to demonstrate that the property was uninsurable by the deadline, then the

Classification: Public

applicant is ineligible for assistance for the costs of the lost or damaged property.

4.1.7 Insurance policy premiums, or deductibles, or both, are not eligible for assistance.

4.1.8 If insurance coverage on buildings owned by landlords, agricultural operations, condominium corporations and not-for-profit institutions, can only be purchased for up to a designated fraction of the appraised value of the building, a portion of the uninsured losses may be eligible for assistance as determined by AEMA (principal residents are excluded).

4.2 Rate Schedules

4.2.1 The following rate schedules, amended annually by the Managing Director, apply to the assistance provided under these Guidelines:

(a) *Contents Rate Schedule Per Room*, AEMA
(b) *Repairs Rate Schedule*, AEMA
(c) *Agricultural Rate Schedule*, AEMA
(d) *Rebuild Rate Schedule,* AEMA

The Rate Schedules outline the maximum eligible assistance amounts for restoring or repairing assets, furnishings, appliances and clothing of an essential nature to individuals, families and small businesses. Rate Schedules are available online at www.aema.alberta.ca , and by contacting AEMA at 780-422-9000 (Dial 310-0000 for toll-free access).

4.3 Consequences of Providing False Information

4.3.1 No applicant is eligible for assistance where the applicant provided false information to the AEMA, including where the information was provided by fraud, willful blindness, recklessness, or negligence.

4.3.2 No applicant is eligible for assistance where the applicant did not provide to the AEMA information relevant to the determination that would have had the effect of reducing the applicant's amount of eligible assistance, including where the information was omitted by fraud, willful blindness, recklessness, or negligence.

4.3.3 Where an applicant is otherwise eligible for assistance under these Guidelines, the applicant is disqualified from eligibility for any assistance under these Guidelines whatsoever by the applicant's provision of false information to the AEMA or failure to provide relevant information to the AEMA.

4.3.4 The AEMA may in its sole discretion waive the application of section 4.3.2 only where the applicant unintentionally provided false or incomplete information to the AEMA, and upon discovery that the information was false or incomplete, immediately advised the AEMA and

Classification: Public

provided correct and complete information.

4.4 Pre-emptive Actions

4.4.1 Where, due to the disaster event, a danger to life, property or the environment reasonably appeared to be imminent, and where instructions or orders were made by a public authority to the applicant to take one or more pre-emptive actions, the applicant's cost of taking those pre-emptive actions is eligible for assistance.

4.4.2 Activities performed as a normal part of preparations to avoid or reduce the effects of a disaster are not eligible for assistance.

Albertans are expected to take reasonable measures, including the purchase of insurance, and absorb reasonable related costs, to protect themselves and their property.

Examples of eligible pre-emptive measures include material costs of sandbagging in the event of a flood and measures taken to protect life and property when a forest fire threatens an urban area.

4.4.3 Despite section 4.4.1, the cost of a pre-emptive action is not eligible for assistance, if a DRP is not approved for the disaster event.

4.5 Response

4.5.1 Subject to this Part (4), the costs of an applicant's disaster response activities incurred within six months of the disaster event start date, but not after that, are eligible for assistance.

4.5.2 If requested by the applicant, in writing, the Director may extend the time limit in section 4.5.1 for a period of up to one year from the disaster event start date, when the Director determines under Division 2.8, that the applicant's situation constitutes exceptional circumstances.

4.5.3 The following expenses necessary for the applicant's disaster response activities, are eligible for assistance:

(a) out-of-pocket costs for measures taken based on direction from AEMA approved authorities to reduce the extent of possible damage. Such precautions may include the removal of valuable chattels and hazardous materials from the area of immediate risk, the provision of storage space, transportation and special protective measures; and

(b) incremental costs for any uninsurable shelter and feeding of affected livestock from eligible agricultural operations, including the provision of facilities for these purposes and transportation costs to bring livestock to market prematurely and/or to transport for protection.

4.6 Innovative Recovery Solutions

4.6.1 An "innovative recovery solution" means a repair, rebuild or replacement of property with a different design or version of the property, or with one or more new features that exceeds the pre-disaster functional condition, where the different design, version or new feature is likely to reduce

Classification: Public

the risk of or prevent recurrence of damage or loss in a future disaster event.

4.6.2 The costs of an innovative recovery solution, up to an equivalent of the eligible cost of repair, rebuilding or replacement of original damaged or lost property may be eligible for assistance at the sole discretion of the AEMA. Such solutions may include relocation assistance to less disaster-prone areas, or permanent removal of structures on vulnerable properties.

4.6.3 An applicant who proposes an innovative recovery solution of equal cost must provide information respecting the cost of both property restoration options, the proposed innovative recovery solution and the rebuild to original functional condition to the AEMA.

4.7 Mould

4.7.1 Damage related to mould is ineligible for assistance, as the occurrence of mould is preventable through timely action.

4.7.2 In exceptional circumstances under Division 2.8, loss and damage due to mould amplification may be considered eligible for assistance by the AEMA, if an applicant has been denied access to their property by a designated authority for an extended period.

4.7.3 The AEMA may waive the requirement for an applicant to clean up immediately after a disaster event where there are identified safety concerns. Once re-entry is approved, safety concerns such as mould growth or unsafe structures must be addressed before clean up can begin.

(a) Clean up and protection efforts of the property and contents must begin immediately upon the applicant being granted re-entry to the property by the appropriate authority.
(b) If outstanding clean up and protection issues continue to exist after initial efforts by an applicant, the issues can be addressed on a case-by-case basis by an AEMA approved authority.

4.8 Costs Eligible for Assistance

4.8.1 An applicant's cost of repair and restoration of previously existing, constructed riverbank stabilization works, including wooden bulwarks, rock gabions, placed-boulder embankments, rip-rap and similar protection works, revetments and concrete walls, are eligible for assistance subject to Division 2.5.

4.8.2 Costs associated with restoring roads, including associated guardrails, signage, signaling devices, sidewalks, bridges, tunnels, overpasses, underpasses, causeways, culverts, verges and drainage systems to their pre-disaster functional condition are eligible for assistance in the following categories:

(a) roads essential to the operations of a small business or agricultural operation;
(b) trails, informal dirt paths or tracks that are essential to the operation of a small business or agricultural operation; and
(c) driveway repairs for access or safety.

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4.9 Costs Ineligible for Assistance

4.9.1 The following costs incurred by an applicant are not eligible for assistance:

(a) loss of income, profits and/or revenue, loss of production or productivity, loss of opportunity, inconvenience, loss of asset market value, loss of market share, reduction or loss of yield (e.g., crops, livestock or wood), loss of rent revenue, rent obligations, utility charges, taxes, and normal enterprise operating expenses;
(b) losses or damages that are an ordinary or normal risk of a trade, calling or enterprise;
(c) legal and other costs associated with the settlements of estates due to disaster fatalities;
(d) damage awards by courts, including punitive damages, or out-of-court claim settlements;
(e) assistance for any costs originating outside of the area affected by the disaster event;
(f) interest on loans obtained for financing of recovery activities or any other purpose;
(g) late payment fees and interest owing to contractors;
(h) costs associated with damage or losses to land due to erosion or channel course changes;
(i) post-event inquiries, commissions or other studies;
(j) decorative or ornamental landscaping to property;
(k) damages or loss of rental or leased items;
(l) costs to repair or replace personal vehicles;
(m) costs to repair or replace secondary residences, recreational trailers, recreational property or cottages;
(n) theft or vandalism of any assets (e.g., equipment, tools) owned by the applicant; and
(o) any other expenditures, which in the opinion of the AEMA, were not reasonably or prudently incurred.

4.9.2 Costs of repairs to fences not part of an agricultural operation are not eligible unless required for safety or by a government bylaw, or code.

Part 5 – Residential Eligibility Criteria

5.1 Residential Applicants

5.1.1 For a homeowner or tenant applicant to be eligible for assistance, an applicant must demonstrate their application is for their principal residence under section 5.1.2.

5.1.2 A principal residence must be:

(a) a specific property that is a housing unit, or a leasehold interest in a housing unit inhabited by the owner/occupant for more than six months a year;
(b) the true, fixed and permanent home and the principal establishment to which the owner, if absent, has every intention of returning; and
(c) either a house, condominium, winterized cottage or a fixed-in-place mobile home.

5.1.3 Eligibility for assistance as a beneficial owner situation is determined by the AEMA and occurs if the applicant demonstrates that:

(a) the housing unit is the principal residence of the individual, but legal ownership is with

Classification: Public

another party, such as a family member or trustee;

(b) rent is not paid by the resident (beneficiary) to the owner of the housing unit;

(c) control of use and benefit of the property is with the resident (beneficiary) and not the legal owner; and

(d) the risks associated with the property are the responsibility of the trustee for the benefit of the resident (e.g., insurance and repairs).

5.1.4 Eligibility for assistance as a family homestead situation is determined by the AEMA and occurs if the applicant demonstrates that:

(a) one or more separate home(s) are located on a single parcel of land under the same title (e.g., owned by one property holder);

(b) family members share the homestead land and live in separate homes or suites on it;

(c) the applicant is related to the owner;

(d) the building is their principal residence per section 5.1.2; and

(e) the applicant does not pay rent for the building they are using for a home to the actual landowner, nor perform the equivalent value in labour for the landowner.

5.1.5 Repair, restoration and replacement of condominium, strata and cooperative apartment buildings, row-type housing and similar situations where there is individual ownership of units and group ownership of common elements is eligible for assistance if they are operated as a not-for-profit and the following criteria is demonstrated by the applicant:

(a) planned allocations to establish and maintain a reasonable level of operations and reserve funds are not considered profit;

(b) individual strata/owner-occupier's unit damages are treated in the same manner as a principal residence; and

(c) the condominium/strata corporation is considered equivalent to a cooperative with respect to the condominium's common elements and reasonable repair or replacement expenses made by the corporation (exclusive of incremental administrative fee or profit allowance).

5.1.6 A tenant living in a rental accommodation is only eligible for assistance for contents they own, subject to these Guidelines.

5.1.7 When an applicant is not living at their principal residence at the time of a disaster event due to an exceptional circumstance, on request by an applicant to the Director, the time limit in section 5.1.2(a) may be waived, when the Director determines under Division 2.8 that the applicant's situation constitutes exceptional circumstances.

Examples of exceptional circumstances can include (but are not limited to) the event taking place during a move from one home to another, when a domestic situation is considered unsafe, when an applicant has been removed by a legal authority, or when a long-term medical situation makes living in the home temporarily not possible.

5.1.8 If a residence is considered a historical property by a recognized municipal source, an applicant

Classification: Public

must advise the AEMA of this designation, and seek financial assistance from the historical society before requesting assistance from the AEMA.

5.1.9 Costs related to unoccupied homes under construction, involving an applicant building a home which they were planning to move into, are treated as follows:

(a) Where both the home being lived in and the one under construction is damaged, only one home is eligible for assistance, typically the principal residence defined in section 5.1.2.

(b) Where only the home under construction is damaged, and the individual did not lose their principal residence; the dwelling under construction is not eligible for assistance.

5.2 Costs Eligible for Assistance

5.2.1 The AEMA reimburses for the cost of Goods and Services Tax (GST) to residential and tenant applicants as identified in the Contents and Repair Rate Schedules described in section 4.2.1 (a).

5.2.2 The following costs are eligible for assistance:

(a) financial assistance at the provincial minimum wage at the time of the disaster event, to a maximum of 200 hours, for property clean up by owners or occupants of the principal residence if documented with dates, times and tasks performed;

(b) debris clean up, removal of hazardous material and waste disposal for accessibility and safe occupancy of a residence;

(c) restoration, repair or replacement for assets of an essential nature;

(d) replacing uninsurable equipment, required for a vocation or trade, such as reference books, tools and informatics devices;

(e) meal and accommodation expenses incurred in the immediate post-disaster evacuation period, as directed by appropriate authorities;

(f) a maximum of 10 days of short-term evacuation assistance unless the Managing Director considers exceptions to the evacuation assistance limit on a per-program basis;

(g) assistance for meal and accommodation rates are the per diem rates for the Government of Alberta at the time the disaster event occurred;

(h) reasonable temporary accommodation costs, including those incurred when major repairs are underway for damage caused by the disaster; and

(i) displaced homeowners with ongoing mortgage obligations who are repairing or rebuilding their homes may be eligible for long-term evacuation assistance up to a maximum of six months, unless the Managing Director considers exceptions are required.

Applicants are required to check with their insurance provider to determine which costs are covered under their plan. Most home insurance policies have coverage for evacuation expenses. Insurable costs are not eligible for assistance and any duplication of assistance is required to be paid back to the AEMA; see Division 3.3 for details on repayment requirements.

Classification: Public

5.3 Costs Ineligible for Assistance

5.3.1 The following expenses are not eligible for assistance:

(a) utility expenses for repairs, either incremental, or incurred at the time of recovery;
(b) costs associated with replacing any item determined by AEMA to be non-basic or luxury;
(c) beverages (including beer, wine, liquor, soft drinks, empty bottles and containers);
(d) cameras;
(e) documents and books (except reference or text books by students with current student status);
(f) fur clothing, including, but not limited to, coats, muffs, or stoles;
(g) jewelry, including, but not limited to fine, costume, loose gemstones, or precious metals;
(h) works of art and home decorations;
(i) recreation items;
(j) electronic entertainment equipment (e.g., stereos, DVD players, videogame consoles or videogames);
(k) stored building materials (e.g., plywood, lumber, roofing materials, paint, etc.);
(l) boats, docks, boat sheds, and restoring water access; and
(m) replacement of foodstuffs.

Part 6 – Small Business Eligibility Criteria

6.1 Small Business Applicants

6.1.1 To qualify for assistance as a small business an applicant must:

(a) be an enterprise with yearly gross revenues, as reported on income tax documents or financial statements from the fiscal year immediately prior to the DRP, of between $6,000 and $15,000,000;
(b) provide to the AEMA the yearly gross revenues, as reported to the Canada Revenue Agency on behalf of the small business;
(c) employ not more than the equivalent of 20 full-time employees;
(d) be an owner-operated enterprise, where the individual owner(s)-operator(s) is/are a day-to-day manager(s);
(e) have the individual owner(s)-operator(s), or a family of owner(s)-operator(s) own at least 50 per cent of the business;
(f) not be a hobby business; and
(g) re-establish operations in the community they were located in at the time of the disaster event.

6.1.2 To verify an applicant's eligibility for assistance as a small business, upon request from the AEMA an applicant must submit the following documentation:

(a) taxable capital gains earned by the business from the sale of real estate tied directly to the business and disaster-affected rental income of the business is included in the revenue calculation (only applicable to real estate and landlord businesses);

Classification: Public

(b) payroll records of full-time equivalent employees by number of hours worked; and
(c) records, such as legal contracts and/or tax documents, demonstrating the structure of the business where the owner-operator(s) is/are acting as a day-to-day manager(s).

6.1.3 Despite section 6.1.1(a), for extenuating circumstances pursuant to Division 2.9, the AEMA may consider yearly gross revenues based on a three-year average from income tax documents or financial statements from the three fiscal years immediately prior to the disaster event.

6.2 Costs Eligible for Assistance

6.2.1 A small business applicant is eligible for assistance for the following:
(a) incremental compensation paid by a business, to non-salaried employees or a contractor, to clean a place of business and prepare it to re-open, including debris clean up, removal of hazardous material and waste disposal;
(b) non-operational costs related to commercially operated apartment buildings and roads servicing the apartment building; and
(f) landscaping that is an essential element of the function of the business such as a botanical garden or a golf course.

6.2.2 The AEMA reimburses the cost of GST for eligible expenses incurred by small businesses who have gross revenues of less than $30,000, in the year immediately prior to the disaster event, and do not have a registered GST account (e.g., residential landlords and daycare), unless required to register under Canada Revenue Agency criteria.

6.3 Costs Ineligible for Assistance

6.3.1 A small business applicant is not eligible for assistance for the following:
(a) maintenance and utility costs; and
(b) costs for repair or replacement of items not essential to the restoration of a small business to a viable state (e.g., works of art, decorations, and furnishings).

6.3.2 Small businesses with gross revenues in excess of $30,000, from the year immediately prior to the disaster event are not eligible to receive assistance for GST and must submit their GST number to the AEMA.

Part 7 – Agricultural Operation Eligibility Criteria

7.1 Agricultural Operation Applicants

7.1.1 For an applicant to be eligible for assistance as an agricultural operation the applicant must:
(a) be an enterprise with yearly gross revenues, as reported for income tax purposes, of between $6,000 and $15,000,000;
(b) not be a hobby farm;
(c) be an owner-operated enterprise, where the individual owner(s)-operator(s) is/are acting as a

Classification: Public

day-to-day manager(s), and own(s) at least 50 per cent of the business;

(d) have the individual owner(s)-operator(s), or a family of owner(s)-operator(s) own at least 50 per cent of the business; and

(e) re-establish operations in the community they were located in at the time of the disaster event.

7.1.2 For an agricultural community to be eligible for assistance as an agricultural operation applicant, the applicant must meet the criteria in section 7.1.1 (a), (b), (d) and (e) but not (c).

7.1.3 For an applicant to be considered eligible for assistance as an agricultural operation, they must meet the definition in section 7.1.1 or 7.1.2 and be engaged in one or more of the following activities:

(a) aquaculture operations;
(b) beekeeping;
(c) cultivating crops in soil, compost, water or through hydroponics;
(d) animal husbandry;
(e) managed woodlots; and/or
(f) any agricultural business activity deemed eligible by the AEMA.

Agricultural community members do not normally take individual ownership, they generally own the agriculture operation collectively, and community leadership acts as day-to-day managers.

Examples of agricultural communities include settlements, colonies, communes, sects, and faith groups.

7.2 Costs Eligible for Assistance

7.2.1 Costs to repair or replace the following items must contribute directly to the agricultural operation and be uninsurable to be considered eligible for assistance at the appraised value or rates determined by the AEMA:

(a) small tools;
(b) saddles and tack;
(c) residences that provide accommodation to non-family workers;
(d) fixed equipment, such as permanently fixed electrical panels and switchgear;
(e) agricultural operation-owned rental properties, located on land that is part of the operation where rent is declared as income for the agricultural operation;
(f) water wells (cleaning, repair or replacement) and/or septic systems (not residential);
(g) fences, including fences around farmhouses where livestock is kept or trespass and crop pilferage are deterred;
(h) crops already harvested prior to the disaster event, and located in secured storage;
(i) harvested hay and straw (bales or stacked) at the value per ton recommended by Alberta Agriculture and Forestry at the time of the disaster event and adjusted to percentage loss, as evaluated by the AEMA;
(j) tame pasture and hay reseeding where verification that foraging sources are dead is provided and the acreage is cultivated prior to payment (assistance is based on market conditions as determined by Alberta Agriculture and Forestry at the time of the disaster event);
(k) losses of other business inventory while held in storage, including feed, seed, bedding or

Classification: Public

fertilizer, are eligible for assistance;

(l) fuel tanks or receptacles (excluding the fuel itself) based on receipts for replacement; and

(m) losses to livestock inventory which are not insurable, where an independent veterinary doctor verifies that the loss is a direct result of the disaster event.

7.2.2 A farmhouse is eligible for assistance as a principal residence if it meets the requirements set out in section 5.1.1 and a separate residential application is submitted to the AEMA.

7.2.3 Where the area of agricultural land is proven to be in production and is damaged from a flood, costs eligible for assistance may include:

(a) leveling the agricultural land to workable condition; and

(b) removal of excessive silt deposits to clear the land to workable condition.

Agricultural land left fallow in a demonstrable cycle of crop rotation, is considered to be in production.

Cost effectiveness of restoration of agricultural land is measured by the market value of the agricultural property, versus the value of the crops produced on that land.

7.2.4 Assistance for the costs outlined in section 7.2.3 cannot exceed its pre-disaster market value based on the Canadian Land Inventory (CLI) value per acre and is subject to the following limitations:

(a) contracted clean up requires prior approval from the AEMA; and

(b) clean up or repairs by a farmer or a family member are limited to the provincial minimum wage per hour and applicants must maintain an hourly record of all labour, where assistance may be subject to a limit determined by the AEMA.

7.2.5 An applicant is eligible for the cost of operating its owned equipment where assistance may not exceed:

(a) 50 per cent of the amount of the rate for renting the equipment in the most recent publication of the Alberta Roadbuilders and Heavy Construction Association Equipment Rental Rates Guide or the Alberta Agriculture Farm Operations Cost Guide for farm machinery costs; and

(b) an operator's actual hourly wage paid by the applicant.

7.2.6 No applicant is eligible for assistance described in section 7.2.5 unless the applicant submits to the AEMA an hourly record of all equipment, labour and operating time, where assistance may be subject to a limit determined by the AEMA.

7.2.7 Pumping costs to protect non-land assets are eligible for assistance when the applicant provides a detailed record of hours of labour and equipment according to the following limitations:

(a) labour costs are calculated at the rate of the provincial minimum wage per hour when the work is being completed;

(b) equipment costs are reimbursed using the lesser of the most recent publication of the Alberta Roadbuilders and Heavy Construction Association Equipment Rental Rates Guide or invoices; and

(c) pumping costs to protect agricultural land cannot exceed the land's pre-disaster market value

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based on the CLI value established in the disaster event year.

7.3 Costs Ineligible for Assistance

7.3.1 The following expenses are not eligible for assistance:

(a) repairs or replacement of machinery and vehicles;
(b) losses of sowed seed, fertilizer, and topsoil, or of soil fertility and the application of weed control measures;
(c) loss or damage to perennial crops and sowed annual crops in the field that are insurable under the crop insurance program of the Alberta Agriculture Financial Services Corporation or other insurers;
(d) shelterbelts;
(e) livestock losses attributable to a disease outbreak handled in accordance with Canada's *Health of Animals Act*;
(f) fuel; and
(g) tools, equipment and tack for hobby activities or recreational purposes.

7.4 Woodlots

7.4.1 For a woodlot to be eligible for assistance as an agricultural operation applicant, it must:

(a) be land covered with trees and held primarily as a source of fuel, posts, logs or trees;
(b) the trees must be grown with active management; and
(c) meet the criteria defined in section 7.1.1 for an agricultural operation.

7.4.2 For an applicant to be eligible for assistance under section 7.4.1 (b) the applicant must demonstrate active management under one or more of the following conditions:

(a) the woodlot is operated with a reasonable expectation of profit;
(b) the main focus of the woodlot is planting, nurturing and harvesting trees pursuant to a forestry management plan, and significant attention is paid to manage the growth, health, quality and composition of the stand;
(c) there is evidence of active management (e.g., a forest operational plan, significant investment, or evidence of revenue from timber sales in the last five years);
(d) there is extensive forest product utilization as an integral part of the overall agricultural operation; or
(e) there is proof of participation in one or more provincial programs dealing with any relevant aspects of forest/woodlot management (e.g., conservation, incentive and improvement programs).

7.4.3 Costs eligible for assistance for applicants who are woodlot or orchard owners is limited to costs to repair and restore damaged land up to its pre-disaster market value based on CLI rates.

7.4.4 Costs eligible for assistance for applicants who own nurseries and tree farms include replacement

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of damaged trees, shrubs or plants that are inventory.

Part 8 – Not-for-profit Eligibility Criteria

8.1 Not-for-profit Organization Applicants

8.1.1 Repairs, restoration, rebuilding and/or replacement of damaged property owned by a public organization such as a church, charity, community service club or volunteer agency are eligible for assistance if:

(a) the organization contributes to the fabric and sustainability of the community, and a basic or essential service in the interest of the community as a whole is provided in the facility of the organization;
(b) church property, must be a facility essential to the secular needs of the community;
(c) public access to the facility is allowed for all members of the community. Limitations on assistance based on the proportion of public access apply;
(d) they meet the small business eligibility criteria under Division 6.1, or allow for public access to facilities; and
(e) they re-establish operations in the community they were located in at the time of the disaster event.

8.2 Not-for-Profit Cooperative Applicants

8.2.1 Repairs, restoration, rebuilding and/or replacement of damaged property owned by a not-for-profit cooperative, are eligible for assistance if the cooperative:

(a) contributes significantly to the fabric and sustainability of the community, and a basic or essential service is provided in the facility of the cooperative;
(b) is not-for-profit;
(c) is in accord with the cooperative principles set out in Section 2(1) of Alberta's *Cooperatives Act*; and
(d) re-establishes operations in the community they were located in at the time of the disaster event.

8.2.2 For the purposes of these Guidelines, an Irrigation District, established under the *Irrigation Districts Act,* is considered a not-for-profit cooperative applicant, but is exempt from meeting the criteria in section 8.2.1 (c).

8.3 Goods and Services Tax

8.3.1 Not-for-profit organization and cooperative applicants must provide documents that confirm registration of a GST account, registration as a not-for-profit and evidence that establishes that the organization contributes to the community as a not-for-profit or charity.

8.3.2 Not-for-profit organization and cooperative applicants may be eligible to receive assistance for 50

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per cent of GST funds if they have a registered GST account.

8.3.3 Not-for-profit organization and cooperative applicants may be eligible to receive assistance for 100 per cent of GST funds if they do not have a registered GST account.

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Schedule 1 - Glossary

In these Guidelines,

(a) "AEMA" means the Alberta Emergency Management Agency as set out in section 3.1(1) of the *Emergency Management Act*;

(b) "animal husbandry" means the branch of agriculture concerned with animals raised for meat, fibre, milk, eggs, or other products. It includes day-to-day care, selective breeding and the raising of livestock;

(c) "applicant" means private sector applicants for disaster assistance who are homeowners, residential tenants, small business owners, landlords, agricultural operations, condominium corporations and not-for-profit organizations and cooperatives;

(d) "architectural controls" means the design guidelines used to harmonize and enhance the exterior presentation of homes and buildings with the general scheme of civic design. They often include materials, colors, styles, massing, textures, and scales;

(e) "assistance" means compensation by payment or in another form for damage or loss caused by a widespread or a localized disaster, or a payment for costs incurred by a local authority or the Government of Alberta in conducting emergency operations as defined in Section 1 (a) of the Disaster Recovery Regulation;

(f) "Church" or "Church Property" means churches, church camps, mosques, synagogues and other registered religious institutions;

(g) "Crown" means Her Majesty the Queen in Right of Alberta;

(h) "Director" means a person holding the position entitled Director of the Disaster Recovery Branch of the AEMA;

(i) "disaster event" means either the event that led to the issuance of a MO, or an event described in section 1.5.1(a), where the Director determines that the three clauses in section 1.5.1 apply, whichever is applicable;

(j) "disaster event start date" means either the disaster event start date determined by the AEMA and stated in the applicable MO, or the date on which the event described in section 1.5.1(a) began, where the Director determines that the three clauses in section 1.5.1 apply, whichever is applicable;

(k) "driveway" means a primary vehicle path from a public roadway to a private or a public building or parking area;

(l) "family unit" means the applicant and those other persons with whom they normally reside including their spouse/partner and dependents;

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(m) “hobby business” or “hobby farm” means an undertaking or activity that operates without a reasonable expectation of profit; reasonable expectation of profit is determined by the Canada Revenue Agency’s criteria.

(n) “local authority” means a local authority as defined in the *Emergency Management Act* and a public authority as referred to in the federal Disaster Financial Assistance Arrangements;

(o) “Managing Director” means the person holding the position entitled Managing Director of the AEMA;

(p) “municipally controlled corporations” means corporations where a municipality (or group of municipalities) holds more than 50 per cent ownership and votes in electing directors of the corporation, they are separate entities from a municipality and not eligible for assistance as a public sector applicant. Eligibility for municipally controlled corporations is determined under the small business criteria in these Guidelines;

Under the *Emergency Management Act*, municipal councils, Metis Settlement councils, a park superintendent of a national park and the band council of an Indian band are examples of local authorities. A park superintendent and a band council of an Indian Band are only a local authority if the province has entered into an agreement with the Government of Canada under section 9(b) of the *Emergency Management Act*.

(q) “program approval date” means the date the MO for the disaster event is approved or if there is no MO, the date determined by the Director;

(r) “program completion date” means the date that is the three-year anniversary of the disaster event program approval date.

(s) “public sector applicant” means a local authority, an Indian Band within the meaning of the *Indian Act* (Canada), Ministries of the Crown, and agencies, boards and commissions established by provincial law or other public authority;

(t) “third party” means any individual, corporation, or other form of organization that is neither an applicant nor bound by contract with the AEMA, but was hired or otherwise retained by an applicant to provide a service to assist them with eligible disaster related activities;

(u) “recovery” means activities that are intended to bring the applicant’s property to its pre-disaster functional condition, and includes remediating, repairing, rebuilding, replacing and otherwise restoring property; and

(v) “response” means the early coordination of resources and support to stabilize an incident, alleviate suffering and limit further impacts to people, property, the economy and environment.

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GOVERNMENT OF ALBERTA
BE PREPARED

Emergency Preparedness Week toolkit 2022
Be ready for anything

May 1 - 7, 2022

Alberta

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Emergency Preparedness Week Toolkit | Municipal Affairs

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Contents

AEMA Overview 4
Emergency Preparedness Week Overview 4
Know the risks 5
Get informed and stay informed 5
Alberta Emergency Alert Test 5
Create financial resilience 6
Start a conversation 7
Make an emergency plan 7
MyAlberta Digital ID 8
Alberta Emergency Alert Test 8
Go virtual 8
Translated materials 9
Get Prepared: 60 Second Emergency Tips 9
Toolkit 9
Scan to Prepare QR code posters 9
Social media challenge 10
#BePrepared 10
EP Week Communication Plan 11
Resources 13
Apps and alerts 14

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Alberta Emergency Management Agency (AEMA)

AEMA Overview

AEMA's mission is to build a safer, more disaster-resilient Alberta. Under the authority of the *Emergency Management Act*, AEMA leads the coordination and cooperation of all organizations involved in emergencies and disasters. This includes emergency and disaster prevention, preparedness, response and recovery. AEMA also works to ensure vital public services, such as government services and first responders, are available during a crisis.

Emergency Preparedness Week Overview

Emergency Preparedness Week (EP Week) is a national event that has run for more than 25 years in Canada and takes place annually during the first full week of May. Public Safety Canada coordinates this event in close collaboration with the provinces, territories and other partners. Together, with community leaders, first responders, all levels of government and non-government organizations, we have an opportunity to encourage the people in our communities to invest a few minutes of their time to become better prepared to face a range of emergencies.

Be Ready for Anything

This year's EP Week theme: Be Ready for Anything, is a reminder that preparedness isn't just about being ready for the next big disaster. It's about making preparedness a part of our regular routine so we are better able to navigate disruptions, big or small.

More than two years of living with a pandemic has forced many of us to develop our own preparedness habits without even realizing it. Building a network of people you can rely on in case of quarantine, and stocking up on supplies, are all preparedness habits that we can use for more than a pandemic. Being prepared is a challenge for us all. By breaking it down into small steps and making it a part of our routine, over time we can be ready for anything.

We all have a role to play

Disasters affect us all. While local and provincial governments take steps to prepare for wildfires and other hazards, the people living and working in Alberta should be taking steps to prepare as well. When the people in our communities are prepared, it makes communities stronger and more resilient. When community members are ready for disruptions, it creates a stronger foundation for emergency management overall, allowing emergency resources to be better used to respond to the actual event and support vulnerable populations.

The results of the 2021 Preparedness Survey of Albertans reflect a shared responsibility for all of us. By working together, we can help the people in our communities take steps towards preparedness.

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Know the risks

If you know what the hazards are in your community, you know what to prepare for. The 2021 Preparedness Survey of Albertans shows only 38% of Albertans are aware of the risks in their community. Common hazards, like severe weather and fire, can quickly lead to large disruptions. Being aware of the hazards in your community can help you take the right steps to reduce your risk.

Want to increase your risk awareness? Check out these resources to help get you started.

- Before, during and after an emergency
- Blizzards, freezing rain, and ice storms
- Emergency preparedness for your pets
- Evacuation
- Farm animal and livestock preparedness
- Flood preparedness
- Helping children during emergencies
- Power and water outages
- Severe weather
- Shelter-in-place
- Thunderstorms, lightning, and hail
- Tornadoes and extreme winds
- What to do after a flood
- Wildfires
- Cybersecurity

Scan to get information on the largest disasters that occurred in Alberta over a 20 year period.

Get informed and stay informed

The 2021 Preparedness Survey of Albertans confirmed that 61% of Albertans have signed up to receive public alerts and emergency messaging. Get informed by signing up to your local emergency warning system and through identification of trusted sources of information before an emergency occurs. When we know what is happening we can make more informed and timely decisions during times of stress.

Alberta Emergency Alert Test

On May 4, 2022 at 1:55 p.m. (MT), Alberta Emergency Alert will send out a test alert using the wireless public alerting system. Wireless public alerting is done through a national system that sends life-saving emergency alert messages directly to compatible smartphones.

During the test, an alert sound will go off with a message to the cellphone user confirming there is no need for concern. The test is not just a test of the Alberta Emergency Alert system. It is an opportunity for all of us to test our own readiness to respond.

This year, consider using the test alert to prompt your community members to have a conversation about preparedness with their household.

Tips to get informed and stay informed:

- Download the Alberta Emergency Alert (AEA) mobile app – Alberta issues alerts to provide critical information and what action you need to take to stay safe.
- Follow Alberta Emergency Alerts on Twitter at @AB_EmergAlert and on Facebook.
- Download other apps to help keep you safe like Wildfire, and Wethercan.
- Sign up for local, provincial and federal alerts through your mobile phone.
- Only use trusted information sources such as your community's social media pages, official websites and television/radio.

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If possible, keep a battery-powered or crank radio on hand in case of a power outage.

Sign up and follow along on these social media platforms:

- Government of Alberta
  - Instagram: Youralberta
  - Facebook: YourAlberta (Government of Alberta)
  - Twitter: @YourAlberta
  - YouTube: @YourAlberta
- Public Safety Campaign
  - Advertising campaign launched
  - Video ad Get Prepared
  - Public Safety Twitter
  - GetPrepared Twitter
  - Emergency Ready in Canada Facebook
  - Public Safety YouTube

Directions from authorities can vary based on the emergency and can change quickly.

Knowing what is happening in your community could save your life.

Create financial resilience

The 2021 Survey of Albertans shows only 54% of Albertans have the proper insurance and fewer have an emergency fund. Being financially prepared is about more than just having money in the bank. Insurance is a financial safety net. When you have the right coverage, it can help you and your loved ones recover when something bad happens.

- Understand the difference between insurable vs. non-insurable and speak with your insurance provider about your needs.
- Keep a detailed list of all property, including photographs, in case you have to file a claim.
- Keep cash on hand, as ATMs and debit services may become unavailable.
- If possible, create an emergency savings account to cover expenses during an emergency.
- Keep receipts for all expenses incurred during an emergency.
- Know the 7 steps for making a home insurance claim. For more information, see Claims Management tips from the Insurance Bureau of Canada.

As a last resort, the Government of Alberta's disaster recovery program may be an option, but it's important to note it does not cover all types of damage or loss and may not cover the full cost of replacement. Visit Disaster Recovery Program to learn more.

Make community connections

The 2021 Survey of Albertans shows only 10% of Albertans have made a neighbourhood contact list. Building relationships with the people around you can reduce stress and create community resilience. Neighbours and community members are often nearby when an emergency, disaster or unexpected situation occurs. Get to know those around you before an emergency. It makes it easier to ask for help when you need it, or offer help to those who need it most.

- Create community resilience – build strength in your community by getting to know one another.
- Raise awareness in your community – visit this web page for tools and materials to help you raise awareness, such as the Get Prepared: 60-second Emergency Tip video library.

Start a conversation

The 2021 Survey of Albertans shows only 34% of Albertans have started to discuss emergency preparedness with their networks. Start the conversation with those around you. Talking about emergencies often leads to action and can be the first step in making your emergency plan.

- On May 4 at 1:55 p.m. when you hear the Alberta Emergency Alert test, please take a moment to consider how prepared you would be if that alert were real.
- Use current events. They can be excellent conversation starters and can prompt others to think about their level of preparedness and what steps they can take to prepare for similar situations.
- Listen to a subject matter expert talk about emergency preparedness with the EPIC podcast team.

Build an emergency kit and gather supplies

The 2021 Survey of Albertans shows only 51% of Albertans have gathered enough supplies to stay safe during disruptions and only 26% of Albertans have an emergency kit. Emergencies and disasters can impact grocery stores, pharmacies, and even gas stations and banking services. Having supplies is one thing you can do to help your household manage unexpected situations, whether they are big or small.

There are many ways you and your loved ones can become more prepared. You can build emergency kits to help you grab and go. You can make sure you have enough supplies at home so you can stay safe. In either case, your goal will be to have enough supplies to keep everyone safe, warm and comfortable.

Emergency supplies and kit checklists:

- Build an emergency kit - having the supplies you need on hand can help keep you, your loved ones and pets safe and provide peace of mind, even if service disruptions occur.
- Emergency kit checklist - when an unexpected situation occurs, it is easier to prioritize your safety and well-being if you have an emergency kit you can grab and go with at a moment's notice.
- Emergency kit checklist for your pets - provides information about emergency preparedness for your pets.
- Emergency kit checklist for your vehicle - create a vehicle emergency kit to help keep you and your family comfortable and safe during times of emergency.

Make an emergency plan

The 2021 Survey of Albertans shows only 27% of Albertans have a household emergency plan, and less are aware of the emergency plans at their loved ones facilities (such as their children's school or a family member's care home). Disasters often cause confusion and distress. An emergency plan will help you cope with the stress of an emergency or disaster. Being prepared is different for everyone. Think about your personal needs to create an emergency plan that works for you. Being ready can reduce the disruption to your daily life.

- Make an emergency plan – this web page has information to help with planning. Being ready can reduce the disruption to your daily life.
- Pet Preparedness – this web page includes tools and resources to help keep pets safe and comfortable, before, during and after an emergency.

  Farm animals and livestock – this web page includes tools and resources to help keep farm animals and livestock safe if you need to shelter in place or evacuate.
- Make an emergency plan with Public Safety Canada's Get Prepared fillable plan.

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MyAlberta Digital ID

This free account lets you prove who you are online without paper documents or face-to-face visits. Creating and verifying an account before an emergency occurs can help you navigate disruptions by getting you access to information on supports and services you may be eligible for.

You can use your verified account to access provincial services that were previously considered too sensitive to offer online, including MyHealth Records and MyAlberta Emergency Benefits System, as well as Alberta Student Aid and the Canada Revenue Agency My Account for Individuals.

Get access to supports and services when you need them most by creating your MyAlberta Digital ID.

To create you ID, visit account.alberta.ca. For support, call 1-844-643-2789 between 8:15 am and 4:30 pm, Monday to Friday.

Practice preparedness

Alberta Emergency Alert Test

This year, consider using the test alert to prompt your community members to have a conversation about preparedness with the people around them. Ask “how prepared would you have been if this alert had been real?” and encourage them to visit Alberta.ca/BePrepared to learn more about what they can do to be ready for anything.

Alberta Emergency Alert test alerts are an ideal teaching moment. Not just in households, but in schools, businesses, in government…everywhere. Here are some ideas on who you can reach out to, to get the conversation started:

- **Organizational leaders** can use the test alert to demonstrate their commitment to preparedness. It is not just a test of the system. It is a test of an individual’s ability to adequately respond to a range of hazards.
- **Schools** can use the test alert to practice one of their drills and send students home with preparedness materials so they can talk to their households about building their own emergency plan.
- **Families** can use the test alert to prompt a conversation. That evening, have a conversation about what you would have done if the test alert were real and take steps so you are ready for anything.
- **Employers** can test their emergency response and business continuity plans. Run an exercise prompted by the test alert or practice a drill, then provide staff with organization specific emergency plans, and preparedness materials (e.g. build an emergency kit checklist). When employees are prepared for disruption, it helps them continue to come to work while they deal with the disruption. This builds organizational resilience too.

Think about how you can use the test alert as an opportunity to build resilience.

Go virtual

Here are some ideas on how you can help raise awareness using social media and other communication channels. These are opportunities for you to champion preparedness all year long.

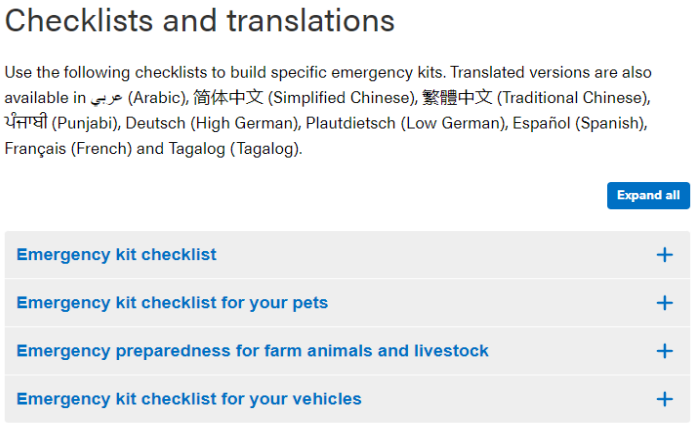
- Share links to the printable emergency kit checklists with community members through email.
- Share information about the hazards in your community with links to the Alberta.ca/hazards web page for more information.
- Post the *Get Prepared: 60-second Emergency Tip* videos on social media.
- Download and print the *Scan to Prepare* touchless QR posters and post them in public areas allowing individuals to scan them with their smartphones to watch *60-second Emergency Tips.*
- Create a preparedness presentation and share it with your community members online.
- Check out the Public Safety Canada’s GetPrepared for additional tools and materials.

Translated materials

The Government of Alberta emergency preparedness materials are updated regularly and are designed for sharing virtually or in-person. Additionally, a number of materials are have been translated with more underway.

Translations available:

- Arabic عربي
- Simplified Chinese 简体中文
- Traditional Chinese 繁體中文
- Spanish Español
- Punjabi ਪੰਜਾਬੀ
- French Français
- Tagalog
- High German Deutsch
- Low German Plautdietsch



To access the translated checklists and factsheets, visit the Resources for your community web page, select your desired language then read, download, print or share with your community and networks.

Get Prepared: 60 Second Emergency Tips

There are now 19 videos in the *Get Prepared: 60 Second Emergency Tips* video series that deliver simple steps that anyone can take to become better prepared for an emergency or disaster. Need help deciding where to start? Consider a few of these questions.

- Do you know the difference between emergencies and disasters?
- Did you know you can prepare for an emergency or disaster without spending a lot of money?
- Wildfire season in Alberta started March 1 and runs till October 31. Are you prepared for a wildfire?
- Don't forget to plan for your pets. Do you have a plan to keep them safe when an emergency occurs?
- Summer heat is coming which means more demand on the power grid. Are you prepared for an outage?

Toolkit

The Emergency Preparedness Toolkit for Seniors provides information on how to reduce the impact and recovery time to you and those you care for. If you rely on others for assistance or provide care and services for a senior, use this toolkit to learn how you can become more prepared for emergencies and disasters.

Scan to Prepare QR code posters

This is a touch-free way to share preparedness information with community members through their smartphones.

Download the QR Code Posters to print and display in common areas to encourage community members to take small steps towards becoming more prepared.

⇦ **Grab your phone and test the QR code!**

Infographics

Download and share infographics with your community through communication channels available to you.

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Winter preparedness – If you have lived in Alberta for a while this infographic won't share anything new. But for anyone new to Alberta winters (or if you know someone who is) or even if you know how to be prepared for winter hazards, you can share this with your friends and family to help make sure we all stay safe in winter.

Survey of Albertans – In May 2021, the Government of Alberta issued a survey to Albertans on emergency preparedness awareness, attitudes and behaviours to inform program development that will improve individual and community resilience across the province. Summarized results can be found in this infographic.

Disaster History in Alberta – A timeline of Alberta's largest disasters over the past 20 years.

Social media challenge

#BePrepared

Interested in championing the #BePrepared challenge in your community? Send us an email at BePrepared@gov.ab.ca to receive 8 weeks of preparedness messages that you can copy, edit, and share with your communities as you see fit.

#PrepareYourSelfie:

The #PrepareYourSelfie challenge uses social media to help you become better prepared. You can share each step you take with others through the #PrepareYourSelfie hashtag and create conversations with your community, invite local leaders and social media influencers to share the message and challenge businesses and neighbouring communities to take another step towards being prepared and to share the journey on social media.

Send us an email at BePrepared@gov.ab.ca to receive information to support your #PrepareYourSelfie challenge.

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EP Week Communication Plan

EP Week provides us a unique opportunity to come together to spotlight emergency preparedness and pull more people into the conversation. In an effort to amplify the message, a seven day communication plan has been provided. Please take what works for you and share it, adding local context to make it meaningful for the people in your community.

Together, using the same voice, we can strengthen the message and motivate preparedness action.

May 1, 2022	The Preparedness Survey of Albertans confirms that 41% of people feel unprepared. There are many reasons not to be prepared, but if you break it down into simple steps and make it a part of your routine, over time you can be prepared for anything. Here are some easy ways you can make preparedness a habit: • Buy a case of water on your next tip to the grocery store. • Keep your phone charged by carrying a phone charger with you. • Contribute as little as $5 a paycheck to a dedicated emergency savings account. Being prepared can help you and your loved ones recover when something bad happens. Challenge yourself to add a new preparedness habit to your routine each week or month. Over time, preparedness will become a part of your day-to-day life. To learn more about emergency preparedness visit alberta.ca/BePrepared.
May 2, 2022	Did you know that signing up for MyAlberta Digital ID can help you be prepared for emergencies or disasters? MyAlberta Digital ID is a free account that lets you prove who you are online without paper documents or face-to-face visits. Creating and verifying an account before an emergency occurs can help you navigate disruptions, help you prove who you are and get you quick access to information on supports and services you may be eligible for. Create yours now so it's ready if you need it: account.alberta.ca To learn more about emergency preparedness visit alberta.ca/BePrepared.
May 3, 2022	Did you know that you can protect your livestock, poultry and other farm animals by applying to the Premises Identification (PID) program, which is used as an early warning system for natural disasters such as floods or wildfires? Emergencies and disasters can affect the well-being of your animals and operations. The PID program is used as an effective emergency response tool to help keep your animals safe. Apply to Alberta's PID program and keep your information current as part of your emergency plan and take one minute to watch this video to learn more. What can you do to protect your livestock, poultry and other farm animals during emergencies or disasters?

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May 4, 2022	Today at 1:55 p.m., the wireless public alerting system will send out a test alert across Alberta. During the test, an alert sound will go off with a message to the cellphone user confirming there is no need for concern. The test is not just a test of the Alberta Emergency Alert system. It is an opportunity for all of us to test our own readiness to respond. When you receive the alert, take a moment to reflect on how prepared you would have been if that alert were real. Tonight, go home and ask your household about where they were when the alert went off and how ready they would have been. Having a conversation about preparedness is one step to becoming more prepared. Want to Be Prepared? Visit Alberta.ca/BePrepared to learn more.
May 5, 2022	Hazards such as flooding, wildfire, and extreme temperatures are typical throughout Alberta and can pose a significant risk to you, your loved ones, and your property if not prepared for. Knowing your risk to the hazards in your community can help you reduce their impact when an emergency or disaster occurs. When looking to develop or buy property, avoid high-risk areas if possible. If you aren't looking to move, assess your property and take steps to reduce your risk. Take one step today by speaking with your insurance provider to make sure your policies fully protect you, your property, and belongings. Take two minutes to learn 3 reasons why you should prepare your home or property from flooding and visit Alberta.ca/BePrepared to learn more. How can you reduce your risk to the hazards in your community?
May 6, 2022	Wildfires can affect communities in forested or grassland areas, including urban green spaces like ravines and parks. The 2021 Survey of Albertans shows that 53% of Albertans are concerned about wildfires. If your location is at risk from wildfire, you may be ordered to evacuate. #BePrepared by: • Make an emergency plan so you know where to go. • Start an emergency kit for your home and vehicle(s). • Keep vehicle fuel tanks more than half-full, and if you don't have a vehicle reach out to your network to make a plan. For more tips to prepare watch this 60 second video and visit alberta.ca/MakeAPlan to learn more. https://youtu.be/FzGJNC-eb6I What steps can you take to help your household be prepared to evacuate at a moments notice?
May 7, 2022	Cyber attacks are becoming increasingly common and putting many Albertans at risk. As part of your emergency preparedness routine, make it a habit to regularly update passwords, back up data and ensure security software is up to date. By protecting yourself against cyber threats, you can keep information like your identity, finances and other personal information safe. Visit alberta.ca/Cybersecurity for tips. Learn more about emergency preparedness Alberta.ca/BePrepared.

Classification: Public

Resources

Alberta Emergency Management Agency (AEMA) https://www.alberta.ca/alberta-emergency-management-agency.aspx.	Learn more about what AEMA does and how they are involved in emergencies and disasters.
Alberta Disaster Recovery Programs https://www.alberta.ca/disaster-recovery-programs.aspx	Financial recovery available for municipalities affected by disasters.
Emergency Preparedness https://www.alberta.ca/emergency-preparedness.aspx	Learn how you and your loved ones can prepare yourselves for an emergency or disaster.
Healthy Aging CORE https://corealberta.ca/	The knowledge hub for Community-Based Seniors Serving organizations and allied agencies and individuals in Alberta
Emergency Preparedness Training (E-Prep) https://public.3.basecamp.com/p/hr3XMSwXe2HG6EKCeVVm2TnQ	An interactive and educational workshop, developed by Alberta Health Services and Carya, uses a step-by-step plan for participants to develop their own personalized preparedness kit. Email to sign up or for more information: HPDIP.MH.EarlyID@albertahealthservices.ca
Psychosocial Disaster Network (PDN) newsletter Previous newsletters: https://public.3.basecamp.com/p/LVRB51V5haBV5Xw7qTnc99AT	A virtual hub for psychosocial disaster preparedness and recovery Email to sign up or for more information: HPDIP.MH.EarlyID@albertahealthservices.ca
Psychosocial Disaster Network (PDN) online community https://3.basecamp.com/4684623/join/K4X4iSQQ1yza	Join the PDNs online community on Basecamp
Government of Canada: Get Prepared https://www.getprepared.gc.ca/index-eng.aspx	A web page dedicated to emergency preparedness that allows Canadians to learn about hazards and how they can prepare for them.
Government of Canada: Cyber Security https://www.getcybersafe.gc.ca/en	Get Cyber Safe is a national public awareness campaign created to inform Canadians about cyber security and the simple steps they can take to protect themselves online.
Government of Canada: Cyber Security (seniors) https://www.getcybersafe.gc.ca/en/blogs/how-older-adults-can-protect-themselves-most-common-cyber-security-threats	How older adults can protect themselves from the most common cyber security threats.
BlueSky Canada https://www.alberta.ca/bluesky-canada.aspx	This system is a collaboration between Alberta and British Columbia combining forest fire information with weather forecast computer models.

Apps and alerts

Alberta.ca apps https://open.alberta.ca/blog/?page_id=115	Listing of available Apps through the Government of Alberta.
Alberta Emergency Alert app https://emergencyalert.alberta.ca/content/about/signup.html	Stay informed by downloading the AEA smartphone app.
Alberta 511 app https://511.alberta.ca/about/mobileapp	Stay informed by downloading the 511 smartphone app.
Alberta Rivers app https://open.alberta.ca/blog/?page_id=197	Stay informed by downloading data and advisories smartphone app.
Alberta Wildfire https://wildfire.alberta.ca/prevention/default.aspx	Wildfire prevention is a responsibility we all share and it is important to understand safe fire practices so that everyone can enjoy Alberta's forests.
Alberta Fire Bans app https://open.alberta.ca/blog/?page_id=327	The Alberta Fire Bans application will help you find the most current and reliable information on all active fire advisories, fire restrictions, fire bans, and Off-highway vehicle (OHV) restrictions in Alberta
The Alberta Wildfire app https://open.alberta.ca/interact/alberta-wildfire	See where wildfires are burning in Alberta. Get up-to-date information on wildfire conditions and hazards or report a fire.
Alberta 211 https://ab.211.ca	211 is a helpline and online database of Alberta's community and social services. Search by topic or location to find programs or services in your community.
Government of Canada https://weather.gc.ca/warnings/index_e.html?prov=ab	Monitor public Weather Alerts for Alberta.
Alert Ready https://www.alertready.ca/#faq	Stay informed through Canada's emergency alerting system.

Winter Hazards

Severe winter weather can be dangerous without a plan.

Blizzards

bring snow, cold temperatures, strong winds and low visibility.

Effects include blowing snow and difficulty seeing your surroundings

Prepare by staying inside

Freezing rain

freezes on impact and creates a layer of ice on surfaces.

Effects include falling branches and slippery roads and sidewalks

Prepare by avoiding travel

Extreme cold warnings

are issued when the temperature drops below -40°C.

Effects include sore red skin that can freeze within minutes and a quick drop in body temperature

Prepare by dressing warmly and wearing layers of clothing

Being prepared can help.

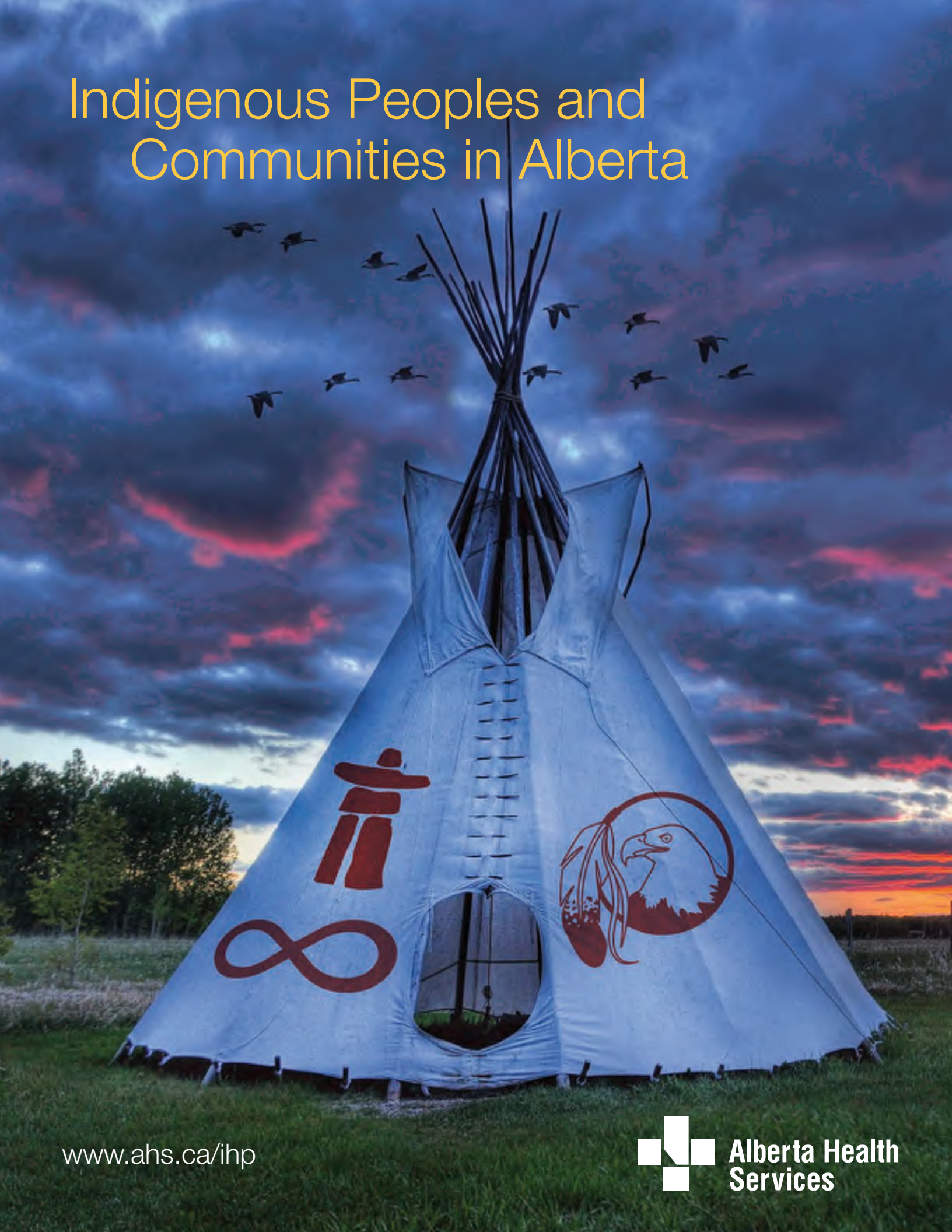
Protect yourself and others by knowing the risks of winter hazards and make a plan.

Visit **alberta.ca** to learn how you can become better prepared.

Alberta

Security Classification: PUBLIC

Indigenous Peoples and Communities in Alberta



www.ahs.ca/ihp

Alberta Health Services

Table of Contents

Introduction 3

Our People 4
- First Nations of Alberta 6
- Métis People 7
- Inuit People 9
- Indigenous Diversity 10
- Urban Indigenous Populations 10
- Indigenous People and History 11
- How did contact with European settlers impact Indigenous peoples? 11
- The Indian Act 11
- The Indian Treaties 12
- Tribal Councils 12
- Residential Schools 13
- The 60s Scoop 13
- The Truth and Reconciliation Commission of Canada 14
- UNDRIP 14

Our Culture 15

Our Wellness 18
- Caring for Indigenous People – 10 Tips to Keep in Mind 23

Indigenous Health Program services 24

Online Resources 26

References 27

Introduction

Purpose

The purpose of this booklet is to provide information about Alberta's Indigenous peoples including demographic details, Indigenous identities, cultural practices, historical events, wellness approaches and social determinants of health.

The goals:

- *Improve cultural competency for AHS staff, contractors and volunteers.*
- *Provide culturally appropriate service delivery for Indigenous patients, clients and families.*
- *Positively affect interactions with Indigenous patients and clients.*
- *Contribute to improved health outcomes for Indigenous Albertans.*

Information Sources and Selection:

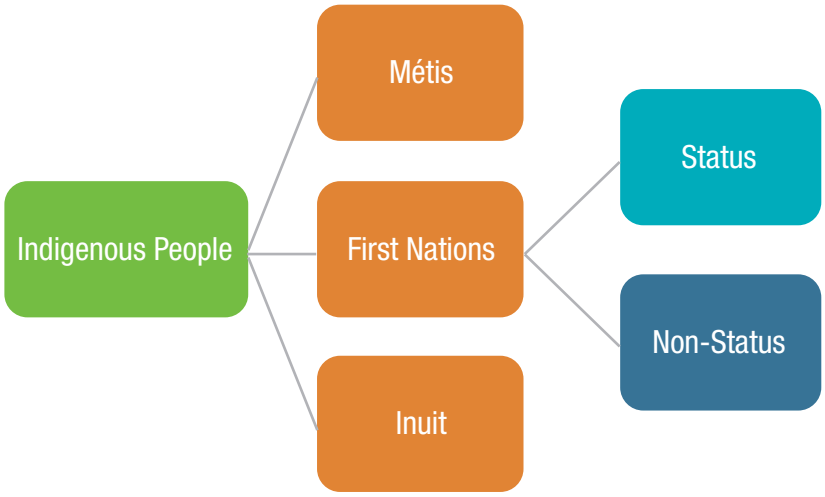
The sources of information used for this report include Statistics Canada, Indigenous and Northern Affairs Canada,* First Nations Inuit Health Branch,* First Nations Profile, Alberta Health and Wellness and other sources noted in the references section. This report is a compilation of existing information from government and community sources; no new research was undertaken for this document.

*First Nations Inuit Health Branch and Indigenous and Northern Affairs have recently been incorporated formally within one body and are now known as Indigenous Services Canada.

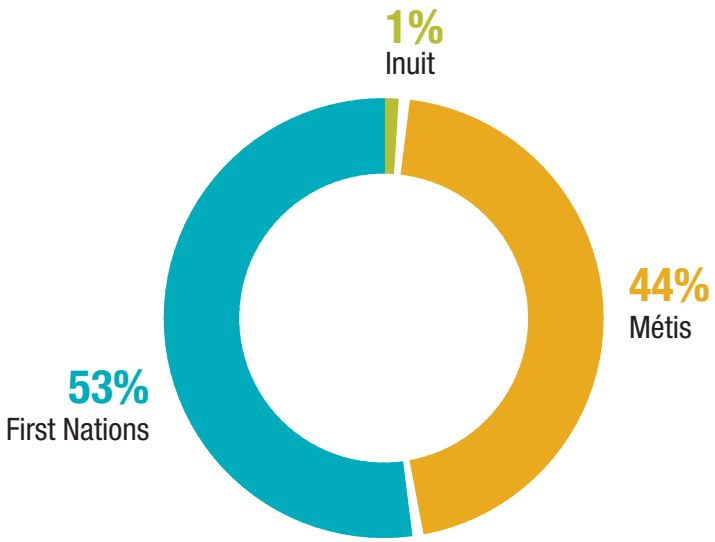
This resource is divided into three main sections:

Our People

There are three groups who are classified as Indigenous (Aboriginal*) people under the Canadian Constitution:



There are about 260,000 Indigenous peoples living in Alberta, comprising 6.5% of the provincial population.



*The Government of Alberta, Government of Canada and Alberta Health Services have adopted the term Indigenous in reference to Canada's original inhabitants, replacing the name Aboriginal. Some older resources or documents referenced in this resource may still use the term Aboriginal, however it should be noted that both terms refer to the same group of people. Indigenous is now widely accepted as the preferred term, as it is considered to be more inclusive.

Indigenous Peoples: The descendants of the original inhabitants of North America. The Canadian Constitution recognizes three groups of Indigenous peoples — Indians, Métis and Inuit.

First Nation: A term to replace the word "Indian," which some people find offensive. Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term "First Nations peoples" refers to the Indian people in Canada, both Status and non-Status. Some Indian people have also adopted the term "First Nation" or "tribe" to replace the word "band" in the name of their community.

Indian: Indian people are one of three cultural groups, along with Inuit and Métis, recognized as Indigenous people under section 35 of the Constitution Act. Such terminology is recognized in the Indian Act and is used by the Government of Canada when making reference to this particular group of Indigenous people.

Status Indian: A person who is registered as an Indian under the Indian Act. The Act sets out the requirements for determining who is an Indian for the purposes of the Indian Act.

Non-Status Indian: An Indian person who identifies as an "Indian"/First Nations individual, but who is not registered as an Indian under the Indian Act.

Treaty Indian: A Status Indian who is registered to a First Nation that signed a treaty with the Crown.

Indian. The term used in the *Indian Act*, the legal term used by the Government of Canada

- **Status Indian**. A person who is registered as an Indian under the *Indian Act*.
- **Non-Status Indian**. An Indian person who is not registered under the *Indian Act*.
- **Treaty Indian**. A Status Indian, part of a nation that signed a treaty with the government.

First Nations

- A term replacing the word 'Indian,' which some people find offensive
- Not a legal definition, but refers to both Status and Non-Status Indians
- Some nations use this term to replace the word 'band' in the name of their community.

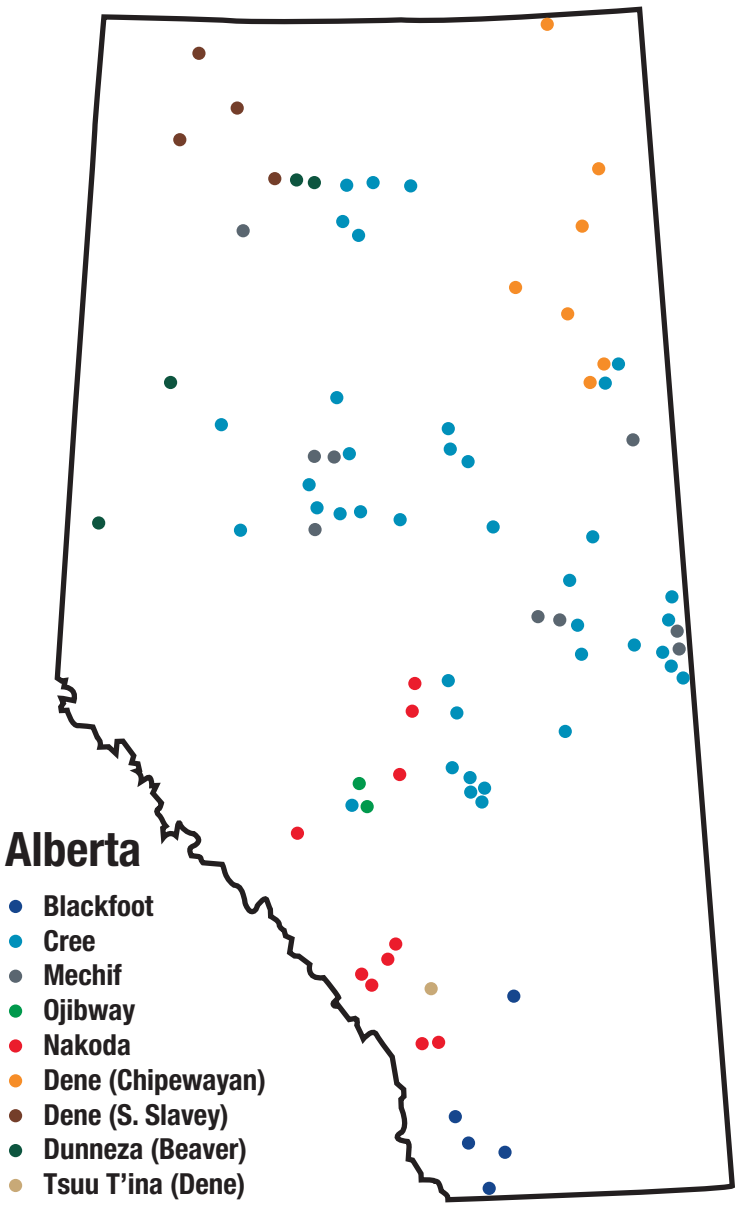
First Nations of Alberta

Who are First Nations People in Alberta?

North
- Dene (Chipewyan)
- Dunne-za (Beaver)
- Dene Tha (Slavey)

Central
- Plains and Woodland Cree
- Nakoda (Stoney)

South
- Blackfoot Confederacy
  – Siksika (Blackfoot)
  – Piikani (Peigan)
  – Kainai (Blood)
- Tsuut'ina (Dene)
- Nakoda (Stoney)



The 48 First Nations communities of Alberta are diverse in size, culture, and character. There are eight main First Nations cultural/language groups in Alberta today. The contemporary names of the cultural/language groups are included here, as well as former or alternative names in brackets. Cree is the language of 32 of the 48 First Nations communities, mostly those in central and northern Alberta. In northern Alberta, there are a number of communities that speak Dunne-za (Beaver), Dene Suliné (Chipewyan), and Dené Tha (Slavey). West of Edmonton and Calgary are several Nakoda (Assiniboine/Stoney) communities. The O'Chiese First Nation near Rocky Mountain House is Anishnabé (Saulteaux, Western Ojibway). In southern Alberta, there are three Blackfoot communities (Kainai, Piikani, and Siksika). The First Nation located adjacent to the City of Calgary is Tsuu T'ina (Dene).

Métis People

The Métis are one of the three distinct Indigenous people of Canada recognized in the Constitution. According to the Métis Nation of Alberta, “Métis means a person who self-identifies as a Métis, is distinct from other Indigenous people, is of historic Métis Nation ancestry, and is accepted by the Métis Nation.” The Métis Homeland encompasses parts of present-day Ontario, Manitoba, Saskatchewan, Alberta, British Columbia, and the Northwest Territories. Individual provinces may use different criteria to establish Métis ancestry.

The word Métis comes from the Latin “miscere” to mix, and was used originally to describe the children of Indigenous women and European settlers. Other terms for these children were Country-born, Black Scots, and “half-breeds.”

The Métis were intermediaries between European and Indigenous cultures, working as guides, interpreters, and workers at the forts and trading companies.

Métis culture is a blend of French, English, and Indigenous influences. The Métis developed a unique language called Michif, that combines Cree and French words. Their fiddlers combined jigs and reels into their music. Métis attire included woven sashes, embroidered gun sheaths, deer hide caps, and quilled and beaded pipe bags. The Métis developed technologies such as the Red River Cart.

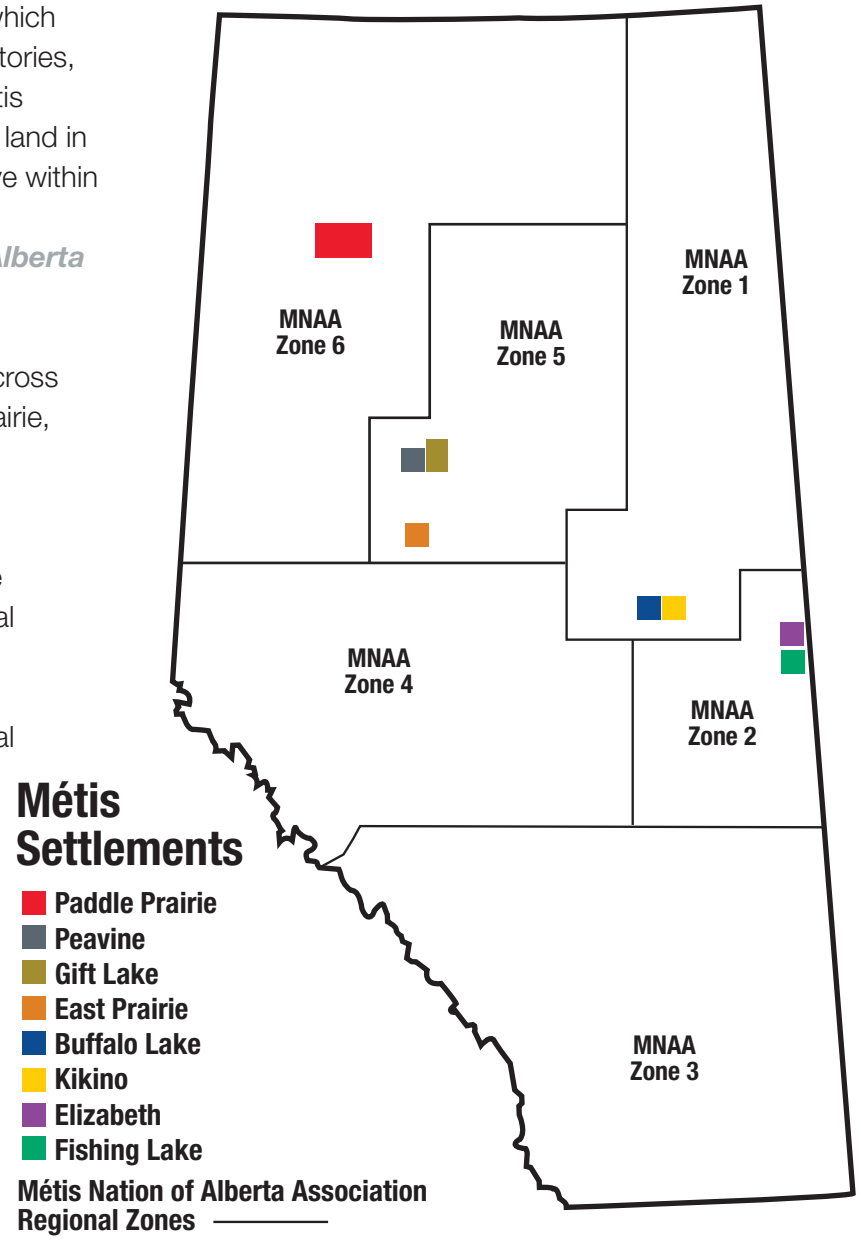
The Métis are primarily located on the Prairies but also live in other provinces and territories across the country. In 2011, just over 450,000 people identified as Métis. They represented 32% of the total Indigenous population in Canada and 1.4% of the total Canadian population.
~Statistics Canada, 2011.

In 2016, over 80% of Canada's Métis population lived in Ontario, making it the province with the highest proportion of Métis residents. Alberta had the largest Métis population in the western provinces, accounting for 19.5% of the total Métis population.

Alberta is the only province in Canada in which Métis people have rights over specific territories, the Métis Settlements. There are eight Métis Settlements covering 512,121 hectares of land in northern Alberta. Close to 5,000 people live within the eight Métis Settlements.
~2012 Métis Settlements Census via Alberta Indigenous Relations.

The eight Métis Settlements recognized across northern Alberta are Buffalo Lake, East Prairie, Elizabeth, Fishing Lake, Gift Lake, Kikino, Paddle Prairie and Peavine.

Please note: The 8 Métis Settlements are governed by the Métis Settlements General Council (MSGC) and the 6 Métis Regional Zones are under governance of the Métis Nation of Alberta (MNA). They are individual entities. For simplicity, this map shows both.



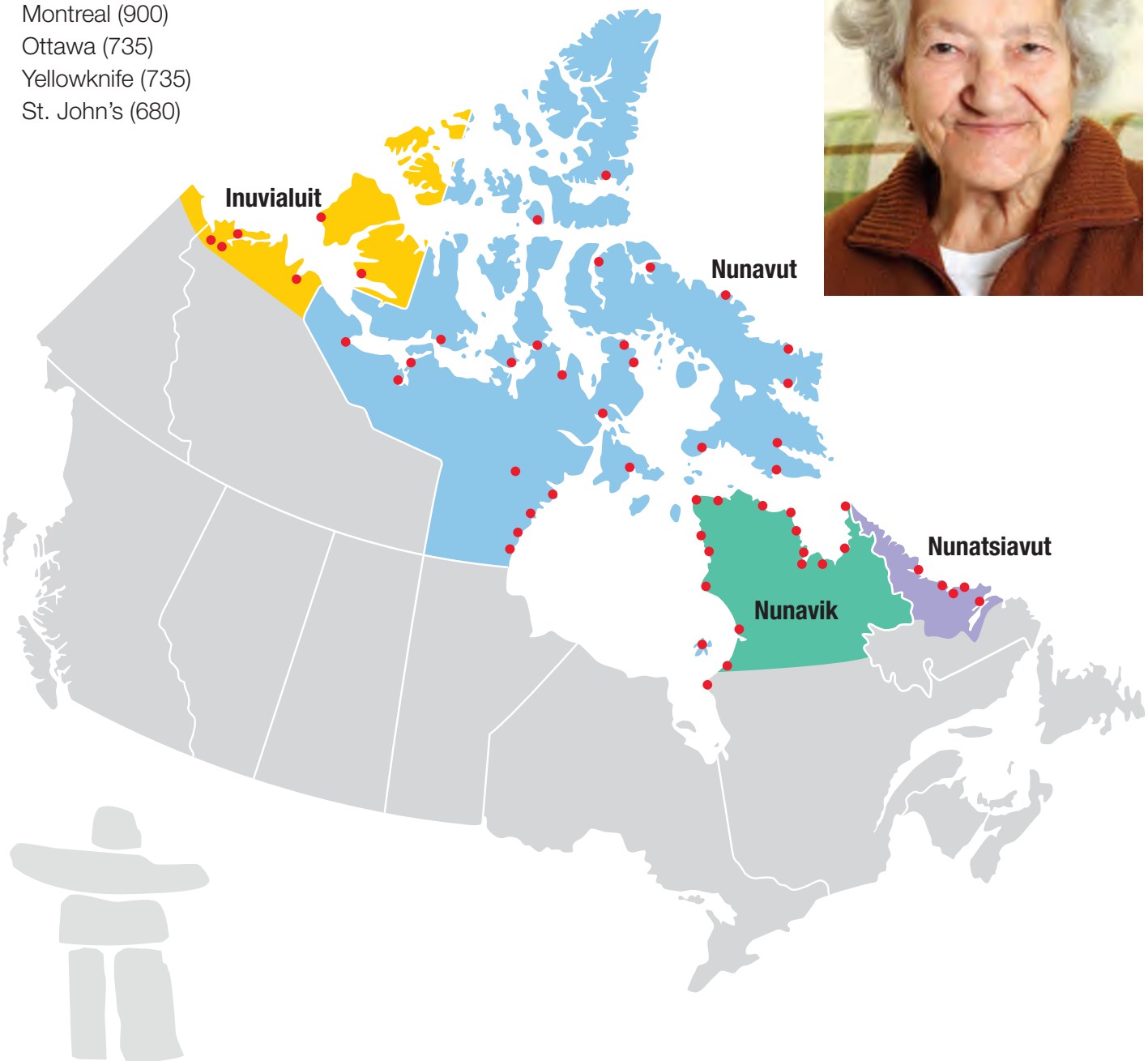
Inuit People

Inuit people are Indigenous people who reside mostly in the Northwest Territories, Nunavut, Northern Quebec and Northern Newfoundland/Labrador. There are approximately 2,500 Inuit people living in Alberta, mainly in urban centres in the northern part of the province.

The word Inuit means ‘people’ in the Inuit language (Inuktitut). This Indigenous language has been one of the most widely retained in Canada and about 60% of Inuit people can conduct a conversation in Inuktitut.

Inuit Population by Large Urban Centres:

Edmonton (1,115)
Montreal (900)
Ottawa (735)
Yellowknife (735)
St. John’s (680)



Indigenous Diversity

It is important to note that not all Indigenous people are the same. There is much diversity between Indigenous groups in terms of the way people identify (Status, Non-Status, First Nations, Métis, Inuit), with regard to language and history and the individual treaty rights that were negotiated with the government.

Within Indigenous groups there are differences in language, access to resources, socio-economic status, access to services and other social factors. Indigenous communities can also be very diverse, with some people practicing Christian religions and others following traditional belief systems. There are generational differences as well.

Urban Indigenous Populations

While much of the information in this resource pertains to supports and structures existing within First Nation communities on-Reserve, the distinction between Alberta's urban and rural Indigenous populations is an important one. Urban indigenous people are those who have migrated to the cities from rural First Nations, Métis, and Inuit communities. In 2016, over half (51.8%) of the Indigenous population in Canada lived in a metropolitan area of at least 30,000 people. From 2006 to 2016, the number of Indigenous people living in a metropolitan area of this size increased by 59.7%. First Nations people account for 50 percent of the urban population and Metis people comprise 43 percent. Five percent of the population of Edmonton and three percent of Calgary's population are Indigenous people.
~Aboriginal Peoples in Canada: key results from the 2016 Census, Statistics Canada.

The residential patterns of Indigenous people living in urban centres is affected by environmental, cultural and social factors. These factors include the availability and location of community resources, schools, subsidized day cares, affordable housing, public transportation, family closeness, job opportunities and First Nations or Métis ownership of apartments or townhouse complexes.

The Indigenous population in Edmonton is distributed mainly in central, north, and northeast areas of the city, as well as in pockets in west and southeast Edmonton. The neighborhoods with the highest proportion of Indigenous people are Queen Mary Park, Eastwood, Rundle Park, Albert Venue, Inglewood, and McCauley.
~City of Edmonton, Aboriginal Relations office (2009). Urban Aboriginal Population: A statistical profile of Aboriginal people in the City of Edmonton.

The Indigenous population of Calgary is widely distributed throughout the city and contributes to the city's growing ethnic and cultural diversity. There are no neighbourhoods in Calgary in which the Indigenous population exceeds 12 per cent.
~The City of Calgary Population Profiles, Aboriginal Identity, 2011.

Indigenous People and History

How did contact with European settlers impact Indigenous peoples?

European contact changed the course of history for Indigenous populations forever. Canada's Indigenous peoples were exposed to new infectious diseases to which they had no immunity. Outbreaks were numerous and were exacerbated by social, political and economic disruptions such as being forced to live together in large groups. Indigenous populations drastically declined. Indigenous people lost their traditional sources of food and livelihood as a result of Eurpoean contact and starvation was commonplace when the buffalo numbers declined and the fur trade made traditional hunting and trapping more difficult.

The Indian Act

For over 300 years, First Nations peoples and Europeans regarded one another as distinct nations. They traded and formed alliances in war. Things changed in 1876 when the Indian Act was signed.

The Indian Act was a wide-ranging piece of legislation covering governance, land use, health care, education and other areas of life for Indigenous people. It was devised by the Government of Canada in an effort to "get rid of the Indian problem" and allow the government to gain access to land and resources. The plan focused on assimilation for all Indigenous peoples.

As a result of the Indian Act, First Nations people were forbidden from speaking their native languages and/or practicing sacred ceremonies in their communities. They were forced onto reserves, assigned European names, had western forms of government imposed upon them and were not permitted to form their own political organizations. First Nations people could not vote, they could not leave their reserves without a permit or "pass" from an Indian Agent and their children were sent away to residential schools.

Many people also lost their Indian status because they joined the clergy or military or chose to pursue a university education. Indigenous women lost their status if they married a non-Indigenous man and female Elders were removed from all positions of leadership.

The Indian Treaties

Historically, Indian treaties in Canada were constitutionally recognized agreements between the Crown and original Indigenous people. The First Nations people were allocated land reserves and the right to schooling, agricultural equipment, training, gifts and annuities.

Between 1871 and 1921, the Canadian government signed 11 numbered treaties with Indigenous people. In the province of Alberta there are 48 First Nations that are situated in three treaty areas: Treaties 6, 7 and 8. The three treaties include 134 reserves (separate parcels of land) with a total of approximately 700,537 hectares of land.
~Treaties with Indigenous Peoples in Canada (2017), The Canadian Encyclopedia.

Treaty 6

- was signed at Fort Carlton and Fort Pitt in 1876. This treaty covers central Alberta and Saskatchewan. There are 17 Alberta First Nations located in Treaty 6. Treaty 6 is the only treaty to include a specific "medicine chest clause," which was negotiated by First Nations people to ensure that the government had a role in providing health care for its people. This has been interpreted as an ongoing responsibility for the Canadian government to provide health care to First Nations people.

Treaty 7

- was signed at Blackfoot Crossing, about 100 kilometres east of Calgary, in 1877. This treaty covers southern Alberta and includes seven First Nations.

Treaty 8

- was signed at Lesser Slave Lake in 1899. This treaty area covers portions of northern Alberta, British Columbia, Saskatchewan and parts of the Northwest Territories. There are 24 First Nations in Treaty 8.

Tribal Councils

Tribal Councils are formal organizations of several First Nations, representing the joint interests of member communities and undertaking collective projects and services. Tribal Councils are usually formed by a group of First Nations that are located close to each other and have common political, treaty, cultural and/or linguistic links. Tribal Councils in Treaty 6 and Treaty 8 include: Athabasca Tribal Council, North Peace Tribal Council, Lesser Slave Lake Indian Regional Council, Confederacy of Treaty 6, Kee Tas Kee Now Tribal Council, Western Cree Tribal Council, Tribal Chiefs Ventures Inc, Yellowhead Tribal Development, Treaty 8 First Nations of Alberta and Maskwacis (Four Nations Administration).

Residential Schools

Indigenous children were taken from their communities at very young ages and sent to church-operated boarding schools. The Government of Canada made attendance at Indian Residential Schools compulsory for every First Nations child as of 1894 and there were 150 of them across the country. At the height of operations, Alberta had 25 residential schools, the most of any province or territory in Canada. These schools were used as a tool of assimilation by the Canadian Government and churches and they were often overcrowded and underfunded.

Residential schools officially operated in Canada between 1831 (Mohawk Indian Residential School, Brantford, Ontario) and the late 1990s. The last federally administered residential school closed in 1996 (Gordon's Indian Residential School, Punnichy, Saskatchewan). Over 150,000 children attended these schools. Many never returned. Thousands of students suffered physical and sexual abuse. All suffered from loneliness and a longing to be home with their families. The damages inflicted by these schools continue to this day. It is now well recognized that the residential school system resulted in severe and negative intergenerational impacts on many Indigenous children, families and communities.

~Legacy of Hope Foundation and Aboriginal Healing Foundation – The Legacy of Residential Schools (2010).

~National Centre for Truth and Reconciliation – The University of Manitoba.

The 60s Scoop

The term 60s Scoop refers to the practice of Indigenous children being apprehended by child welfare workers between the mid-1960s and 1980s, often without the knowledge or consent of their families or bands. During this time, it is estimated that over 20,000 children were taken from their homes, "scooped" from parental care and moved into foster placements and adoptive homes. Approximately 70% of 60s Scoop kids were adopted into non-Indigenous homes in Canada, the United States and Europe. Neglect was the most commonly cited reason for the government's decision to remove these children. Contributing to perceptions of child neglect, however, was the fact that many residential school survivors returned home and became parents without ever being given the opportunity to connect with their own caregivers, parents and communities. Transfer of traditional knowledge about childbirth and child-rearing was also impacted by the residential school system, as was information about ways to give and receive affection and create a nurturing family environment.

Sadly, Indigenous children are still overrepresented in government care. Today, there are 3 times more Indigenous children in the child welfare system than there were at the height of the residential school era or during the 60s Scoop.

~Blackstock, 2003

The Truth and Reconciliation Commission of Canada

In 2009, the Truth and Reconciliation Commission of Canada (TRC) began a multi-year process to listen to Survivors, communities and others affected by the residential school system. As a result of this endeavour, the commission issued a document identifying 94 "Calls to Action" to "redress the legacy of the residential schools and advance the process of Canadian reconciliation."

~Truth and Reconciliation Commission of Canada: Calls to Action.

7 of the TRC's Calls to Action pertain specifically to health:

TRC Call to Action
#18: Acknowledgment; recognize and implement health care rights
#19: Establish measurable goals and surveillance of health indicators; close gaps in health outcomes
#20: Address distinct health needs of Métis, Inuit and off-reserve First Nations
#21: Provide sustainable funding for existing and new healing centres
#22: Incorporate traditional healing practices with Indigenous healers and Elders
#23: Increase Indigenous representation in the health care field; ensure retention; provide cultural competency training
#24: Medical and nursing schools in Canada to offer mandatory course dealing with Indigenous health issues.

United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) recognizes Indigenous peoples' basic human rights, as well as rights to self-determination, language, equality and land, among others. Unqualified support was given by the Federal Government in May, 2016.

- Many of the articles in the UNDRIP suggest how states can work in conjunction with Indigenous peoples.The main types of measures suggested are:
  - To return land (article 26), ceremonial objects (article 12) and human remains (article 12)
  - To place "programs for monitoring, maintaining and restoring the health of Indigenous peoples" (article 29)
  - To protect and uphold the rights of Indigenous individuals and peoples

- Article 24.2 states, "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health."

~The United Nations, 2008.

Our Culture

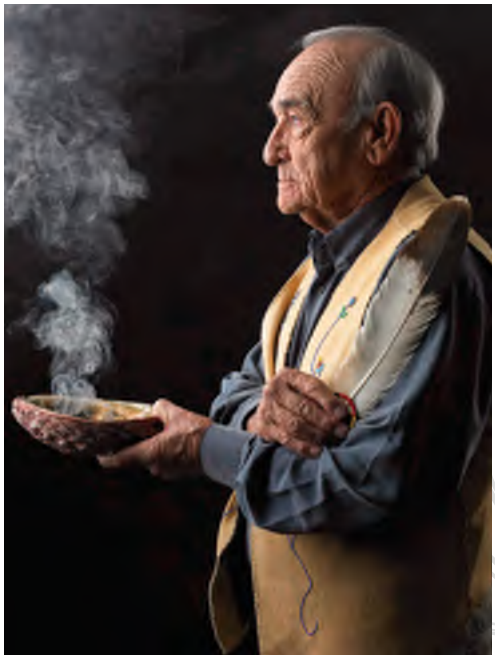
Indigenous people are very diverse in terms of cultures, beliefs, languages, spiritual practices and traditions. These variations are the result of the geographic differences between communities and the ways in which landscape and access to resources influence the day to day lives of different groups of people. There are also different approaches to culture as it relates to belief systems. Many Indigenous people believe in a Creator. Some Indigenous people follow Christian religions, some practice traditional Indigenous belief systems and others have adopted a blend of Christian and traditional ways of being.

Tobacco

Commonly used as an offering (protocol) to an Elder in exchange for prayers, advice or ceremonial services. The offering and acceptance of tobacco is considered by some to be a binding contract.

Protocol

The act of offering an Elder tobacco when requesting her/his services communicates respect to the Elder and places value upon their time and knowledge. The formal Protocol may change depending on the Elder who is performing the service and the type of work that is being requested from her/him. If you are unsure, it is best to ask the Elder what his/her protocol expectations are in advance.



Smudge

Smudging involves the burning of traditional herbs for spiritual practice. During a smudge, the smoke from the smouldering plants is cupped in one's hands, drawn over the body and may be brought to the head, eyes, mouth, ears, down the arms, down the front of the body, to the heart and down to the feet. The act of smudging is used for prayer and helps to cleanse. Smudge is also used to purify houses or spaces, bless objects and is utilized in ceremony. People will often smudge to begin or end the day, to begin a ceremony or open a meeting.

Many Alberta Health Services hospitals across the province host regular Smudge ceremonies. If you are interested in learning more about the Smudge schedule, please consult your hospital's Spiritual Services department or ask an Indigenous Hospital Liaison.

Sweat Lodge

Sweat lodges have been a tradition for First Nations since time immemorial and they still serve many functions for Indigenous people today. The sweat lodge ceremony cleans and heals the body. Although usually associated with healing, each sweat lodge has a different purpose and each Elder or spiritual leader leads their ceremony differently. Sweat lodges are dome-like structures made of branches and a variety of rugs, furs and blankets are used to completely enclose the lodge.

~The Sweat Lodge – An Aboriginal Healing Experience (Indigenous Tourism, BC).

~Sweat Lodge Function, Owlcation Social Sciences.

Sweats are available at the Alberta Hospital in Edmonton and may be available to patients in other areas. Please consult the Indigenous Health Program office in your zone for information.

Alberta Health Services tipi and sweat lodge, Alberta Hospital, Edmonton.

Pow Wows

Pow Wows are First Nations peoples' way of meeting together to join in dancing, singing, drumming, visiting, renewing old friendships and making new ones. This is a time to renew culture and preserve the rich heritage of First Nations people. Most Pow Wows are open to the public.

~Pow Wows.com

Harvesting

Something most Indigenous people share is the importance of harvesting of raw materials from nature. Harvesting may include hunting, gathering, trapping, fishing, gardening and farming, as well as drying and processing hides and animals and obtaining natural resources for various uses. Sometimes harvests are accompanied by ceremonies and feasts.

Storytelling and Creation Stories

Storytelling is a central element of most Indigenous cultures. Oral tradition and wisdom is passed on by Elders to younger generations as a way to connect to morality, explain natural phenomena and help with problem solving. Some stories are for entertainment, some are humourous and some teach lessons. Indigenous patients may use storytelling as a way to explain their illnesses or ailments to a health care provider. Many Indigenous cultures also have their own creation stories. Some are based around characters or cultural heroes. Creation stories provide a narrative about how things in the natural world came to be.

Métis Culture

Métis people participate in a wide range of First Nations cultural and ceremonial practices, including those listed above. They may be Christian, Traditional or a blend of both. Métis culture is commonly characterized by fiddle music and a traditional dance known as the Red River Jig or "Jigging." It is a very structured competition dance between two partners. The dance involves hardly any movement of the body above the knees, and all the work is done with the feet. Furniture used to be moved aside and cleared out in order to make room for jigging contests at gatherings.

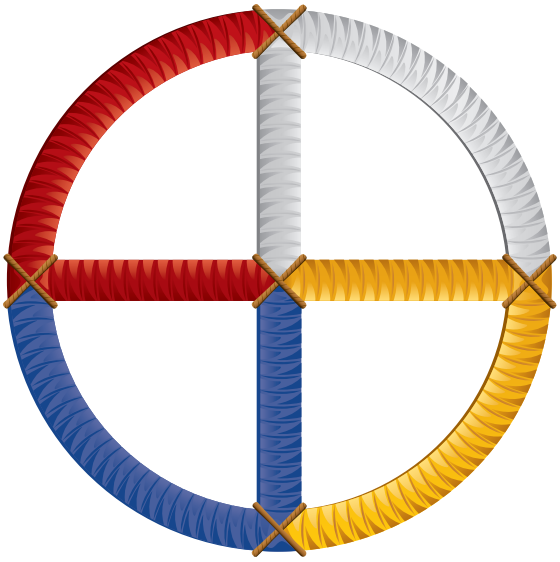
~Métis Nation of Alberta, 2018

Inuit Culture

Inuit people practice many of their own cultural traditions and ceremonies. Much of the Inuit way of life is focused around survival in extreme weather conditions, as the population resides solely in the north where access to resources is scarce. Hunting, trapping and fishing are extremely important parts of Inuit life. Throat singing is a form of traditional music that is unique to the Inuit, using breath control and no instruments.

The Medicine Wheel

Many traditional Indigenous people use a circle (known as a Medicine Wheel) to conceptualize health and illness. The roundness of the circle represents the sacred cycle of life. The circle represents the four aspects of human nature: physical, mental, emotional, and spiritual. Often, specific colours, animals or natural elements are associated with each of the four quadrants.



Each aspect must be in balance with the others in order for an individual to be healthy. In contrast to Western bio-medicine, traditional Indigenous health perspectives stress the close relationship between the spiritual and physical worlds.

While not all Indigenous people use a medicine wheel to understand health, many health care providers, community leaders and traditional Elders are now using these concepts to help their communities understand and address Indigenous health issues. It is important to note that there are many different medicine wheels; the quadrants may vary, the colours may change and the meanings may differ depending on the geographical area, the Indigenous group and the teachings that have been shared by Elders and traditional knowledge holders. The diagram provides an example of a medicine wheel.

Our Wellness

Indigenous concepts of health focus on a holistic approach. The Circle of Life is a philosophy of wellness that reminds us of the continuum of life through which people travel from childhood to youth, adulthood and, in some cases, Elder status. Within the circle it is recognized that, like the components of health, people themselves cannot be separated or considered in isolation of their age or their connection to others, the land and their ancestors. The Circle of Life is forever changing and different for each individual. It cannot be written in stone – the ideal "model" exists within each of us. The Circle of Life is a guide for us to be centred in our own lives.

The Circle of Life is one of the foundations of the Indigenous Health Program. The Circle represents the holistic components of health and well-being – physical, mental, emotional and spiritual – that exists within each individual, family, community and nation.

Wayne Burnstick, 1956-2018

Indigenous concepts of health vary depending on the patient, family and community of origin. Many Indigenous people believe strongly in the power of their traditional medicines. Traditional concepts of wellness differ in many ways from the Western medical model of health that is practiced by physicians.

Traditional Medicines

Traditional medicines have been used for centuries by Indigenous people throughout the world. These medicines are derived from natural sources and have been adapted for a number of medicinal and therapeutic uses. Common traditional medicines include tobacco, sage, sweetgrass, willow bark fungus, rat root/bitter root and cedar, however this is not an exhaustive list. These medicines vary by region and are utilized in a number of oral and topical applications. Administration of traditional medicines is dependent upon the Healer or Knowledge Holder who is advising on their use and there may be ceremonial considerations as well.

Population Health Data

There are some definite disparities between Indigenous people and their non-Indigenous counterparts in terms of health status. Life expectancy and infant mortality rates for First Nations Canadians have improved significantly in the last few decades, but they are still trailing those of the non-First Nations population. While the majority of Canadians who die in any given year are 65 and over, that age group is underrepresented in the deaths among First Nations people; injury is the leading cause of death for First Nations individuals between the ages of 0 and 44.

The prevalence of major chronic diseases including diabetes, heart disease, cancer, hypertension, arthritis/rheumatism and tuberculosis is significantly higher in the First Nations population. For example, First Nations people are 3-5 times more likely to be diabetic and 5-10 times more likely to contract tuberculosis than non-First Nations people, or other Canadians.

First Nations adults are more than twice as likely to smoke cigarettes than other adults in Canada. First Nations people are also twice as likely to be overweight or obese. While alcohol addiction is problematic for many First Nations families and communities, First Nations people are more likely to abstain from alcohol use than non-First Nations Canadians.

For current statistical data, please visit the Statistics Canada website at www.statcan.gc.ca

Access to Health Services

First Nations communities with reasonable access to health services in nearby towns or urban centres have health centres. These centres operate similarly to other clinics off reserve, open weekdays during business hours and closed evenings, weekends and statutory holidays. More geographically isolated First Nations communities may have health centres which provide 24/7 service for emergency health care, however access to provincial /territorial health care and hospital services must be provided by air or ground ambulance. Remote and isolated communities commonly experience difficulties recruiting and retaining nurses and physicians and access to targeted health care can be complicated depending on location.

NIHB

Non-Insured Health Benefits (NIHB) is a health benefit program that provides financial support for health related supplies and services to eligible First Nations and Inuit people. Similar to other health insurance programs, NIHB covers the health supplies and services which are not covered through the provincial health care system or private health care plans. To be eligible, the person must be a registered/status First Nation or a registered Inuit residing in Canada and be registered with a provincial or territorial health care system. The benefits provided under this program include limited prescription drugs, medical supplies, medical equipment, dental care, vision care, medical transportation and crisis intervention counselling. In order to access these benefits a person must have a Treaty/Status number or NWT health care card.

There are NIHB Navigators assigned by Treaty area who work to improve access to supports for clients and patients. These navigators work with community health workers, service providers and a network of regional policy analysts. Navigators are mandated by their regional health organization.

Métis Health Services

Métis health services are provided by Alberta Health Services. There are no unique health benefits or services for Métis people in Alberta like those available to First Nations and Inuit people. Métis people receive health care services like all other Albertans.

Jordan's Principle

Jordan's Principle is a child-first principle named in memory of Jordan River Anderson, a First Nations child from Norway House Cree Nation in Manitoba. Born with complex medical needs, Jordan spent more than two years unnecessarily in hospital while the Province of Manitoba and the Federal Government argued over who should pay for his at-home care. Jordan died in the hospital at the age of five years old, never having spent a day in his family home. Jordan's Principle aims to make sure First Nations children can access all public services in a way that is reflective of their distinct cultural needs, takes full account of the historical disadvantage linked to colonization, and without experiencing any service denials, delays or disruptions because they are First Nations.

Payment disputes within and between federal and provincial governments over services for First Nations children are not uncommon. First Nations children are frequently left waiting for services they desperately need, or are denied services that are available to other children. This includes services in education, health, childcare, recreation, and culture and language. Jordan's Principle calls on the government of first contact to pay for the services and seek reimbursement later so the child does not get tragically caught in the middle of government red tape. In a landmark ruling on January 26, 2016, the Canadian Human Rights Tribunal ordered the Federal Government to immediately stop applying a limited and discriminatory definition of Jordan's Principle, and to immediately take measures to implement the full meaning and scope of the principle.

How to access public services and support through Jordan's Principle (as of June, 2018):

- Call the Jordan's Principle call centre at 1-855-572-453.
- You will be asked to provide basic information including the child's name and medical needs.
- If approved, Canada will arrange service provision and payment.
- If the request is denied, you will have one year to appeal the decision.

~First Nations Child & Family Caring Society of Canada.

Social Determinants of Health

The social determinants of health (SDOH) are the social and economic factors that influence peoples' health. These are apparent in the living and working conditions that people experience every day. Due to various SDOH and the ways in which they influence overall wellness, Indigenous people in Canada have generally lower health statuses than non-Indigenous Canadians.

The following is a list of 13 social determinants of health:

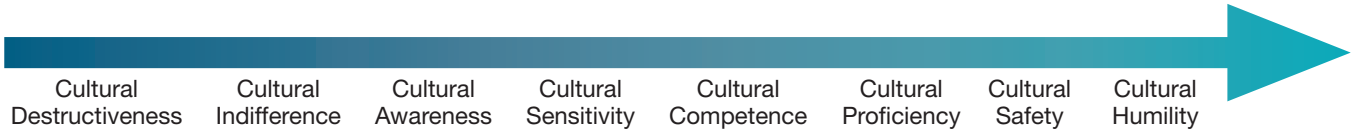
- Income and Income Distribution
- Education
- Unemployment and Job Security
- Employment and Working Conditions
- Early Childhood Development
- Food Insecurity
- Housing
- Social Exclusion
- Social Safety Networks
- Health Services
- Gender
- Race
- Disability

Indigenous People and the Health Care System

"It is well documented that many underlying factors negatively affect the health of Aboriginal people in Canada, including poverty and the intergenerational effects of colonization and residential schools. But one barrier to good health lies squarely in the lap of the health care system itself. Many Aboriginal people don't trust—and therefore don't use—mainstream health care services because they don't feel safe from stereotyping and racism, and because the Western approach to health care can feel alienating and intimidating."
-Health Council of Canada, 2012.

Cultural Competency

Cultural competency is a set of behaviours, attitudes, and policies that come together in a system, agency, or among professionals which enables that system, agency, or those professionals to work effectively in cross-cultural situations. Indigenous cultural competency within Alberta Health Services will contribute to Indigenous patients, clients and families feeling respected and being treated with sensitivity. When staff, volunteers and contractors work towards providing more culturally competent care, they will approach their interactions with Indigenous patients from a place that is mindful of cultural considerations and is informed by an understanding of factors such as intergenerational trauma, social determinants of health and historically negative interactions with the health system.



Cultural safety and cultural competency go hand in hand. Cultural safety is the recognition that each of us as humans and as professionals carry our own concepts of culture into any relationship. We need to be conscious of – and consistently challenge – the unequal power relations that exist between individuals, communities, and within society. Individuals and organizations each operate at various points on the continuum, between cultural destructiveness and cultural humility.

Cultural safety and cultural humility are not skills that can be taught. They are ongoing processes and require individuals and organizations to continuously strive to integrate culturally competent practices into their daily work. Most importantly, cultural safety can be defined only by the patient, client or individual who is receiving services.

Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.

Why are Cultural Safety/Humility Important?

People who experience culturally safe care are more likely to access care earlier and more likely to feel at ease and empowered throughout the process of receiving care.

It is believed that culturally safe care will result in patients, clients and families who are:

- more inclined to share details about their illnesses, concerns and care preferences
- more willing to return and to follow treatment plans recommended by professionals
- more likely to see improved health outcomes

Caring for Indigenous People – 10 Tips to Keep in Mind

1. **People first** – personal relationships are very important; your professional function comes second. It is helpful to establish rapport and trust as respectful human beings before entering into a professional relationship. Even a few friendly sentences before beginning the clinical interaction can help. Be genuine in your approach.

2. **Greet and shake hands** – a personal greeting and handshake is highly appreciated by most Indigenous people as a sign of respect and acceptance. Shaking hands is also a way to say thank you. Many Indigenous people have a soft handshake so as not to appear confrontational.

3. **Recognize the diversity of Indigenous people** – do not make assumptions. Not all Indigenous people have the same beliefs, customs or traditions. Ask individuals for their preferences; asking is always better than assuming.

4. **Apologize if you are rushed** – hurrying is considered disrespectful; apologizing can help. Explaining that you are short for time, but will be able to spend more time later can help.

5. **Be sensitive to eye contact** – direct eye contact may be viewed by some Indigenous people as disrespectful or insulting. Some Elders have also indicated that an aversion to eye contact is a direct result of attending residential schools, as children in these schools were afraid of making direct eye contact with school staff. Take your cue on this from the patient.

6. **Listen carefully and non-judgmentally** – allow Indigenous people time to explain their situation and tell their story. Consider how past experiences of discrimination or abuse within institutions may affect the patient's current experience and behaviour.

7. **Explain what you are doing and why** – assist the Indigenous person to understand what is happening rather than treating or providing care without any explanations.

8. **Ask permission before touching** – this demonstrates respect for the individual and takes into consideration possible sensitivities or past negative experiences.

9. **Appreciate the importance of extended families** – extended family and friends provide very important supports for an ill Indigenous person. If there are many visitors, try to accommodate them as you are able, or find a place for them. Ask the family to identify one person to be the spokesperson and contact for the family.

10. **A holistic health approach** – traditional Indigenous health perspectives are often holistic: encompassing physical, mental, emotional and spiritual well-being. Facilitate requests for spiritual and cultural practices that promote health and healing when appropriate.

The Indigenous Health Program

The Indigenous Health Program partners with Indigenous peoples, communities and key stakeholders to provide accessible, culturally appropriate health services for First Nations, Métis and Inuit peoples in Alberta.

Alberta Health Services is committed to improving health outcomes and the health care experiences for Indigenous peoples in Alberta through the appropriate allocation of resources and support, and a culturally competent, diverse and inclusive workforce.

As our vision states, we focus on achieving "Healthy Albertans. Healthy Communities. Together." As an organization, we must focus on stripping away racism and dispelling biases against Indigenous peoples that stand in the way of caring for all Albertans. We must work together on a common agenda, across services and sectors, within the organization and beyond, to achieve a collective impact in improving physical, mental, emotional and spiritual well-being and social outcomes for Indigenous peoples in Alberta. Together, we will work to acknowledge the traumas of the past for Indigenous peoples in order to create a common space for reconciliation and healing.

Wisdom Council

Wisdom Council provides guidance and recommendations to ensure AHS develops and implements culturally appropriate and innovative health service delivery for Indigenous people. Council focuses on Indigenous health priorities, services, and resources, and is made up of public members from across treaty areas and Alberta's health zones.

Traditional Wellness Services

The Indigenous Health Program offers traditional wellness services in each AHS zone. The goal is to provide an effective, patient-centred approach for improving care to First Nations, Métis and Inuit peoples and communities through provision of specific services. Traditional wellness aims to support clients at AHS facilities and connect clients to regional Indigenous organizations and resources. Examples of such services include support for accessing insured and non-insured health benefit coverage, assistance with basic needs, connections to community resources and other hospital-based services, help with discharge planning, case management, patient advocacy, health literacy support and, in some cases, patient/client language interpretation. Cultural supports such as smudge and sweat ceremonies, spiritual practices, Elder services and other ceremonies are also provided, as appropriate/able. Services may vary by location.

Indigenous Wellness Clinic

Located in Edmonton at Anderson Hall (across the street from the Royal Alex Hospital), this diabetes education program combines western medicine with Indigenous traditional teachings. The Indigenous Wellness Clinic provides diabetes education using a holistic and cultural approach for First Nations (Status and Non-status), Métis and Inuit patients and families. Within a chronic disease mandate, this clinic provides a four day, culturally-based, holistic diabetes education program (meals and accommodation included), as well as 1 day follow-up appointments with the wellness team. Patients of the program are encouraged to bring a support person. The Indigenous Wellness Clinic offers a full range of primary care services, including Indigenous physicians that specialize in palliative care, family medicine, women's health and opioid dependency. Nurses, mental health practitioners, cultural helpers, health coordinators and physiotherapists are also available. All clinical services utilize a client centred approach to help work towards cultural safety.

Elbow River Healing Lodge

The Elbow River Healing Lodge is located in Calgary in the Sheldon M. Chumir Health Centre and offers a full range of primary care and visiting specialists to First Nations (Status and Non-Status), Métis, and Inuit peoples and their families. Services provided include traditional healing approaches, health promotion, disease prevention, curative care, rehabilitative care and social resource advocacy (supportive care). Primary care services include assessments and examinations, onsite Elders, traditional wellness and healing (spiritual, cultural, and ceremonial supports), family focused care, prenatal care, traditional midwifery, nutrition and traditional dietary services, immunizations, social resource referral and advocacy (Community Liaison), outreach (in community, acute sites and Calgary Zone) and foot clinics and foot health. The clinic also offers specialized services such as general internal medicine, nephrology, neurology, traditional midwifery, rheumatology, access to psychiatry, physical and rehabilitation medicine and obstetrics and gynecological care.

Honouring Life

This is an Indigenous youth suicide prevention program (formerly known as the Aboriginal Youth and Community Empowerment Strategy or AYCES) developed to support First Nation and Métis communities by building capacity in mental wellness, resiliency, and healthy lifestyle promotion. The vision for Honouring Life is that Alberta's Indigenous youth are balanced, healthy, and hopeful about their life journeys, proud of their cultural identities, and confident in pursuing success in their lives and communities.

To locate Indigenous Health Program services in your zone, please refer to the Alberta Health Services Indigenous Health page online at https://www.albertahealthservices.ca/info/Page11949.aspx

For further information:

General Inquiries:
Indigenous.Health@ahs.ca

Cultural Competency Education Inquiries:
Indigenous.Education@ahs.ca

Honouring Life Inquiries:
HonouringLife@ahs.ca

YouTube:
https://www.youtube.com/user/AHSChannel (go to the Indigenous Health Program playlist)

Online Resources:

Alberta First Nations Health Consortium
www.abfnhc.com

Alberta First Nations Information Governance Centre
www.afnigc.ca

Alberta Health Services – Indigenous Health
www.albertahealthserivces.ca/info/Page11949.aspx

Assembly of First Nations
www.afn.ca

City of Calgary – First Nations, Metis and Inuit Peoples
http://www.calgary.ca/CSPS/CNS/Pages/First-Nations-Metis-and-Inuit-Peoples/First-Nations-Metis-Inuit-Peoples.aspx#

City of Edmonton – Indigenous Relations
https://www.edmonton.ca/city_government/initiatives_innovation/indigenous-relations.aspx

First Nations Child and Family Caring Society
www.fncaringsociety.com

Government of Alberta – Metis settlements and First Nations in Alberta: Community Profiles
Provides and overview of the eight Metis settlements and 48 First Nations in Alberta, including information on population, land base, location and community contacts, as well as quick facts on Metis Settlements and First Nations.
https://open.alberta.ca/publications/1925-5209

Indigenous Relations – Government of Alberta
www.indigenous.alberta.ca

Indigenous Services Canada: Government of Canada
https://www.canada.ca/en/indigenous-services-canada.html

Jordan's Principle
www.canada.ca/en/indigenous-services-canada/services/jordans-principle.html

Metis Nation of Alberta
www.metis.org

Metis Settlements General Council
www.msgc.ca

National Collaborating Centre for Aboriginal Health
www.nccah-ccnsa.ca

The Confederacy of Treaty Six First Nations
www.treatysix.org

Treaty Eight First Nations of Alberta
www.treaty8.ca

Truth and Reconciliation Commission of Canada
www.trc.ca

United Nations Declaration on the Rights of Indigenous People
www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

Provincial Resources (External to Alberta)

All Nations' Healing Hospital (Fort Qu'Appelle, Saskatchewan)
http://www.rqhealth.ca/facilities/all-nations-healing-hospital

First Nations Health Authority
www.fnha.ca/

Thunderbird Partnership Foundation - Document Library (Bothwell, Ontario)
www.thunderbirdpf.org/nnapf-document-library/

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Alberta Health
Services

COVID-19 Info: For Albertans | For Health Professionals | Vaccine | Assessment & Testing | Results | Visitation

A CMOH order remains in effect that requires continuous masking at all AHS, APL and Covenant facilities provincewide.

811 Health Link

COVID-19: Information about vaccines, selfcare, recovery and more.

One Number.

All your trusted health advice.

For health advice or information, call Health Link 24/7 by dialing 811 or visit MyHealth.Alberta.ca. For more ways to reach Health Link, visit our Contact section.

For help navigating the health system, please visit Navigation Services.

Health Advice

Primary Care Providers

Addiction & Mental Health

Dementia Advice

Rehabilitation Advice Line

Nutrition Information

Health Advice

Do you have health concerns about you or your child? Call Health Link and you have options to speak with a variety of health care professionals including registered nurses, dieticians, dementia specialists and mental health and rehabilitation clinicians. We will help determine the best care for your individual situation.

Did You Know?

The top three reasons people called Health Link last year:

1. COVID-19 Related Health
2. Testing or Vaccine Related Questions
3. Booking & Advice

Primary Care Providers

Health Link works with different doctors and other health care providers to help figure out the best type of care for you. We are able to offer referrals to after-hours clinics and services, including some Primary Care Networks (PCN's).

For more information on PCNs, or to find a family doctor please go to Alberta Find a Doctor.

Addiction & Mental Health

Do you have a question or concern about an addiction or mental health issue? The Addiction Helpline and the Mental Health Helpline are both answered 24/7 by a team of registered mental health professionals (Social Workers, Psychologists, Nurses, Occupational Therapists) at Health Link. You can now dial 811 to easily reach our team.

Whether you are concerned about yourself or someone else, our team can give you advice, support (even during a crisis), and information about mental health and addiction resources anywhere in Alberta.

AlbertaQuits Helpline

The AlbertaQuits Helpline is a free, confidential, non-judgmental support service to help people cut back or quit using tobacco products. Our business hours are 8 a.m. to 8 p.m., 7 days a week. Staffed with trained cessation counselors, who can give you information about quitting tobacco use, help you make a quit plan, help you deal with cravings and triggers, and give you ongoing support to help you stay motivated. If your first language isn't English, we can access the language line to get an interpreter to join the call—over 240 languages are available.

AlbertaQuits has many programs and services through groups, text, and online. To learn more, go to albertaquits.healthiertogether.ca. You can use the resources on your own or with phone counselling —whatever works best for you.

Call 1-866-710-QUIT (7848) or by calling Health Link at 811.

Dementia Advice

A dementia diagnosis can be an overwhelming experience for both patients and their families. Dementia Advice through Health Link, helps ease the stress by providing compassionate advice about living with dementia.

Dementia Advice can:

- Listen to Your Story
- Suggest Strategies to Help Manage Dementia-Related Challenges
- Recommend Supports & Assistance
- Facilitate Long Term Support
- Provide Self-Care Tips For Caregivers

For more information, please visit Dementia Advice.

Rehabilitation Advice Line

Do you have questions about a new or chronic bone or joint condition? Do you have questions about managing a neurological condition for yourself or someone else? Do you need help with recovering from COVID-19? Looking for in person rehabilitation services or clinics in your community?

Speak with an occupational therapist or physiotherapist about:

- Pain Management
- Exercises to Help with Physical Concerns
- Strategies to Help Manage Day To Day Activities
- Navigation Support to Available Rehabilitation Services & Community Organizations

For more information, visit ahs.ca/ral.

Did You Know?

Over 90% of the callers to the Rehabilitation Advice Line are looking for ways to manage their pain.

Nutrition Information

Do you have a nutrition question? Health Link has Registered Dietitians available to answer nutrition questions about:

- Healthy Eating
- Pregnancy
- Breastfeeding Or Infant Formula
- Feeding Your Toddler Or Young Child
- Health Conditions Including: Diabetes, High Cholesterol, High Triglycerides, Kidney Disease, Celiac Disease, Irritable Bowel Disease, Irritable Bowel Syndrome, Pancreatitis, Cancer, Obesity, Malnutrition, Long COVID-19
- Eating After Discharge From Hospital
- Weight Gain Or Loss
- Digestive Symptoms Including Heart Burn, Constipation, Diarrhea, Or Vomiting
- Nutrition Supplements Including Extra Protein and Calories
- Vitamin And Mineral Supplements
- Food Allergies
- Other

If you have a nutrition question, call 811 and ask to talk to a Dietitian.

Find out how to access a dietitian in your area and more information.

Let Us Help You Find Your Way

Need help finding the nearest immunization clinic? Wondering how to find a family doctor? Looking for a program to manage chronic disease or need to sign up for prenatal classes? Call Health Link for all your questions around where to go for health care and help navigating the health system.

Health Link experts will help guide you to the right care provider, at the right time, in the right place.

For more information, please visit Navigation Services.

Your Health Link Video Series

New Parent Supports

Language Support

Calling for Someone Else

Alberta Quits

Additional Supports

Dementia Advice

What Questions Will I Be Asked?

What is Health Link?

Contact

If you need health advice or information call Health Link 24/7 by dialing 811 or visit MyHealth.Alberta.ca.

To access Health Link within Alberta, call 811. If you are unable to dial 811 from your phone, please call 403-943-5465 for Calgary or 780-408-5465 for Edmonton. For internet phone users, call 1-866-408-5465.

Health Link support is available in more than 240 languages.

We offer a number of translated resources in some of the more common languages in Alberta. Get Health System Information in Your Language.

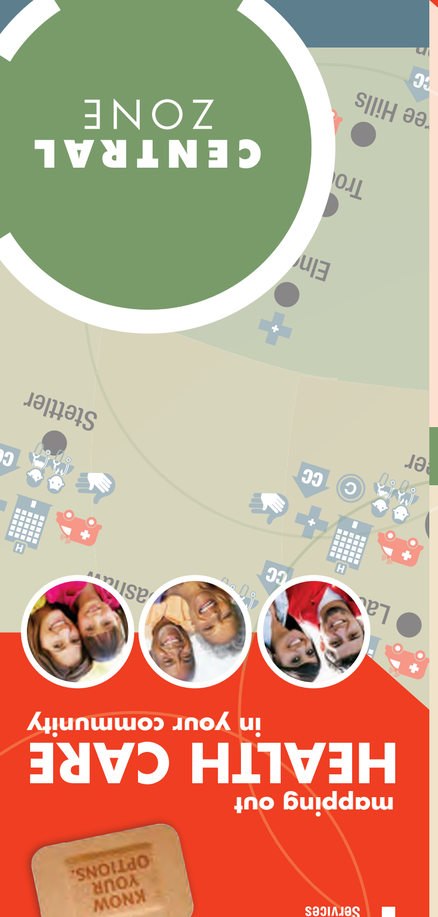
Those who have difficulty with hearing or speech - and use a Teletypewriter (TTY) to communicate with regular telephone users - can contact Health Link 24 hours a day, 7 days a week using the TELUS RELAY Service (TRS).

If you would like more information about the Health Link service please email us healthlink@ahs.ca.

Quick Reference

The following Health Link posters are available to download and print:

- Call Health Link
- Concerned About Your Baby?
- Feeling Sick?
- Find Your Way



mapping out
HEALTH CARE
in your community

Alberta Health Services

IMPORTANT CONTACTS

HEALTH LINK 811

AHS ONLINE
www.ahs.ca is your online source for health care information, services, news and more.

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Alberta Health Services

CENTRAL ZONE

CENTRAL ZONE

ZONE STATS...

Population 470,490
Life Expectancy 80.1 years
Hospitals 30
Physicians 707
AHS Employees 12,631
Volunteers 3,292
Size 95,000 km²
Meals Served 2.4 M per year

DID YOU KNOW...

- More than 300 new spaces, providing a variety of continuing care and supportive living options, have opened in the Central Zone since 2012.
- The Two Hills Health Centre is home to just the second rehabilitation unit in Alberta to use the ReTouch system, a therapeutic screen system that helps patients on the stroke and geriatric empowerment unit regain mobility and strength.
- Residents in Rocky Mountain House are now able to be screened for colorectal cancer at the Rocky Mountain House Health Centre, following the addition of a state-of-the-art endoscopy system, which helps physicians screen and diagnose colorectal cancer and other bowel disease.
- The Pediatric Weight Management Program, which can help families plan for healthy and nutritious eating habits for children, is now available in person in Camrose, Red Deer, Vegreville and Vermilion, as well as remotely through Telehealth, making it accessible across the Zone while reducing travel for families in outlying communities.

ALPHABETICAL LISTING OF SERVICES BY COMMUNITY • CENTRAL ZONE

For more information about health care options, programs and services, contact your local facility at the numbers provided below. Many programs and services, such as Addiction & Mental Health and Public Health, are available through your local health centre.

ANDREW
Laboratory Services 780-656-3034

BASHAW
Bashaw Community Health Centre 780-372-3731
Bashaw Home Care/Palliative Care 780-372-4155

CAMROSE
Camrose Addiction and Mental Health
Addiction Services 780-672-1181
Mental Health Services 780-679-1241
Camrose and Area Mammography Centre 780-679-6146
Camrose Community Cancer Centre 780-679-2822
Camrose Community Health Centre/Public Health 780-679-2980
Camrose Home Care 780-679-2900
Camrose Professional Centre
Pediatric Specialty Clinic 780-608-8611
Camrose St. Mary's Hospital 780-679-6100
Healthy Living Centre 780-608-8683
MSK (hip and knee) Clinic 780-678-3400

CASTOR
Castor Community Health Centre 403-882-3404
Castor Our Lady of the Rosary Hospital 403-882-3434

CONSORT
Consort Community Health Centre 403-577-3770
Consort Hospital and Care Centre 403-577-3555
Consort Mental Health Services 403-577-3770

CORONATION
Coronation Community Health Centre 403-578-3200
Coronation Hospital and Care Centre 403-578-3803

DAYSLAND
Daysland Health Centre 780-374-3746

DRAYTON VALLEY
Drayton Valley Community Cancer Centre 780-621-4888
Drayton Valley Community Health Centre 780-542-4415
Drayton Valley Hospital and Care Centre 780-542-5321
Drayton Valley Addiction and Mental Health Services 780-542-3140

DRUMHELLER
Drumheller Addiction and Mental Health Services - 403-820-7863
Drumheller Community Cancer Centre 403-820-7985
Drumheller Environmental Health and Support Services 403-823-3341
Drumheller Health Centre 403-823-6500

ECKVILLE
Eckville Community Health Centre 403-746-2201

ELNORA
Elnora Community Health Centre 403-773-3636

HANNA
Hanna Addiction Services 403-820-7863
Hanna Health Centre 403-854-3331
Hanna Mental Health Services 403-854-5276

HARDISTY
Hardisty Health Centre 780-888-3742

INNISFAIL
Innisfail Health Centre 403-227-7800
Innisfail Mental Health Services 403-227-4601

KILLAM
Killam Addiction Services 780-672-1181
Killam Health Care Centre 780-385-3741
Killam Mental Health Services 780-385-7161

KITSCOTY
Kitscoty Public Health/Rehab 780-846-2824

LACOMBE
Lacombe Community Health Centre 403-782-3218
Lacombe Addiction and Mental Health Services 403-782-3413
Lacombe Hospital and Care Centre 403-782-3336

LAMONT
Lamont Health Care Centre 780-895-2211

LLOYDMINSTER
Lloydminster Community Cancer Centre 306-820-6144
Lloydminster Public Health Services 306-820-6225
Lloydminster Home Care 306-820-6200
Lloydminster Hospital (Saskatchewan) 306-820-6000
Lloydminster Mental Health Services 306-820-6250
Lloydminster Patient Care Centre
Laboratory Services 780-875-1590

OLDS
Olds Campus Community Health Centre 403-559-2150
Olds Community Health Centre 403-556-8441
Olds Hospital and Care Centre 403-556-3381
Olds Addiction and Mental Health Services 403-507-8174

PONOKA
Centennial Centre for Mental Health and Brain Injury 403-783-7600
Ponoka Community Health Centre 403-783-4491
Ponoka Hospital and Care Centre 403-783-3341
Ponoka Addiction and Mental Health Services 403-783-7903

PROVOST
Provost Addiction and Mental Health
Provost Addiction Services 780-753-6958
Provost Mental Health Services 780-753-2575
Provost Community Health Centres 780-753-6180
Provost Health Centre 780-753-2291

RED DEER
Central Alberta Cancer Centre 403-343-4526
Red Deer Addiction Services 403-340-5274
Red Deer 49 Street Community Health Centre 403-314-5225
Red Deer 49 Street Community Health Centre - Mental Health Services 403-340-5466
Red Deer Bremner Avenue Community Health Centre 403-341-2100
Red Deer Johnstone Crossing Community Health Centre 403-356-6300
Red Deer Regional Hospital Centre 403-343-4422

RIMBEY
Rimbey Addiction and Mental Health Services 403-843-2406
Rimbey Adult Day Support 403-843-2030
Rimbey Community Health Centre 403-843-2288
Rimbey Hospital and Care Centre 403-843-2271

ROCKY MOUNTAIN HOUSE
Rocky Addiction and Mental Health Services 403-844-5235
Rocky Mountain House Health Centre 844-846-3347

SEDGEWICK
Sedgewick Home Care/Public Health/Rehab 780-384-3652

STETTLER
Stettler Addiction Services 403-742-7523
Stettler Community Health Centre 403-742-3326
Stettler Hospital and Care Centre 403-742-7400
Stettler Mental Health Services 403-743-2000

SUNDRE
Sundre Community Health Centre 403-638-4063
Sundre Hospital and Care Centre 403-638-3033
Sundre Mental Health Services 403-636-6278

SYLVAN LAKE
Sylvan Lake Community Health Centre 403-887-2241
Sylvan Lake Addiction and Mental Health Services 403-887-6777

THREE HILLS
Three Hills Addiction Services 403-820-7863
Three Hills Health Centre 403-443-2444
Three Hills Mental Health Services 403-443-8532

TOFIELD
Tofield Addiction Services 780-672-1181
Tofield Health Centre 780-662-3263

TROCHU
St. Mary's Health Centre 403-442-3955

TWO HILLS
Two Hills Health Centre 780-657-3344

VEGREVILLE
St. Joseph's General Hospital 780-632-2811
Vegreville Addiction Services 780-632-6617
Vegreville Home Care/Public Health/Rehab 780-632-3331
Vegreville Mental Health Services 780-632-2714

VERMILION
Vermilion Addiction Services 780-842-7619
Vermilion Community Health Centre 780-853-5270
Vermilion Health Centre 780-853-5305
Vermilion Mental Health Services 780-581-8000

VIKING
Viking Health Centre 780-336-4786
Viking Home Care/Public Health/Rehab 780-336-4782

WAINWRIGHT
Wainwright Addiction and Mental Health
Addiction Services 780-842-7619
Wainwright Mental Health Services 780-842-7522
Wainwright Community Health Centre 780-842-4077
Wainwright Health Centre 780-842-3324

WETASKIWIN
Wetaskiwin Addiction Services 780-361-1358
Wetaskiwin Community Health Centre 780-361-4333
Wetaskiwin Hospital and Care Centre 780-361-7100
Wetaskiwin Mental Health Services 780-361-1245

WINFIELD
Winfield Community Health Centre 780-682-4755

CONTINUING CARE ACCESS IN CENTRAL ZONE
1-855-371-4122

CONTINUING CARE FACILITIES

Continuing care in Alberta includes home care, supportive living, long-term care, hospice and end of life care. Alberta Health Services has programs, services and supports to help Albertans of all ages lead active and fulfilling lives, close to home.

HOME CARE provides health care services and supports to help people remain in their own homes for as long as possible.

SUPPORTIVE LIVING facilities provide care to help people live with as much independence as their abilities allow. AHS works with the sites to ensure the client's health care needs are met.

LONG-TERM CARE provides services for people with complex health care needs who can no longer be safely cared for at home or in a supportive living facility.

NEED HELP? HAVE CONCERNS?
Call Health Link at 811 or visit
www.ahs.ca/continuingcare

PRIMARY CARE NETWORKS

PROVOST PCN 780-753-2271 Serves Provost and surrounding area

BIG COUNTRY PCN 403-442-2252
www.bigcountrypcn.com Serving Three Hills, Trochu, Hanna, Drumheller, Stettler, Coronation, Consort and surrounding area

DRAYTON VALLEY PCN 587-982-7307
www.draytonvalleypcn.ca Serving Drayton Valley, Breton and Winfield

KALYNA COUNTRY PCN 780-603-4455
www.kalynapcn.ca Serving Vegreville, Viking and surrounding area

LLOYDMINSTER PCN 780-874-0490
www.lloydpcn.ca Serving Lloydminster and surrounding area

PEAKS TO PRAIRIES PCN 587-796-0765
www.peakstoprairiespcn.com Serving Olds, Sundre, and surrounding area

CAMROSE PCN 780-608-4927 **www.camrosepcn.com** Serving Camrose, Bashaw, Tofield, Daysland, Killam, Forestburg, Hardisty

RED DEER PCN 403-343-9100 **www.reddeerpcn.com** Serving Red Deer and surrounding area, including: Red Deer County, Blackfalds, Delburne, Penhold and Springbrook

ROCKY MOUNTAIN HOUSE PCN 403-845-3050
www.rockypcn.com Serving Rocky Mountain House, Caroline, County of Clearwater, Sunchild First Nations Reserve, O'Chiese First Nations Reserve and Bighorn First Nations Reserve

WAINWRIGHT PCN 780-842-6676 Serving Wainwright and surrounding area, including: Chauvin, Edgerton, Irma, Denwood, Fabyan, Kinsella, Lougheed, Hardisty, Amisk, Hughenden, Czar, Metiskow, Ribstone and Heath

WETASKIWIN PCN 780-312-2500
www.wetaskiwinpcn.ca Serving City and County of Wetaskiwin, including: Maskwacis, Millet, Gwynne, Ma Me O Beach and surrounding area

WOLF CREEK PCN 403-782-1408
www.wolfcreekpcn.com Serving Lacombe, Ponoka, Rimbey, Sylvan Lake and surrounding area

ALBERTA HEARTLAND PCN* 780-895-2022
www.wolfcreekpcn.com Serves Lamont

LAKELAND PCN* 780-645-1188
http://www.lakelandpcn.com Serves Two Hills

**Indicates PCN located outside of Central Zone but serving a Central Zone community*

KNOW YOUR OPTIONS

When you need health care, you have many options. Knowing your options will help you get the care that's best for you.

Alberta Health Services offers programs and services at over 400 facilities throughout the province, including hospitals, clinics, continuing care facilities, mental health facilities and community health centres. Our skilled and dedicated health professionals promote wellness and provide health care every day to over four million Albertans.

Find out what Alberta Health Services offers in your local area and how you support your health.

www.ahs.ca/options

HEALTH CARE OPTIONS AND INFORMATION

811 Health Link Health Advice 24/7 Call Health Link at 811 for health advice and information across Alberta. Access is 24-hours, 7days a week and provides support by experienced registered nurses and other healthcare professionals.

FAMILY DOCTOR
Your best option for on-going health needs. Family Doctors can diagnose and treat most medical issues, and can help manage chronic illness and mental health issues.

URGENT CARE CENTRES
Extended hour access for unexpected, non-life-threatening health concerns, such as broken bones, pain, infections and cuts.

FAMILY CARE CLINICS
Extended hours care, especially for those who need a family physician, have chronic diseases, or addiction or mental health needs.

WALK-IN CLINICS
Some communities have walk-in clinics that often don't require an appointment. Many offer extended hours.

PHARMACISTS
Renew prescriptions, assess minor condition symptoms, offer treatment or refer you to the most appropriate treatment location.

MyHealth.Alberta.ca
This website has trustworthy health information and useful health tools, including a symptom checker.

AHS apps for iPhone and Android
Use your phone to find hospitals, facilities, programs & services in your area. Emergency wait times are available for the Calgary and Edmonton areas.

ALBERTA HEALTH SERVICES **CENTRAL ZONE**

LEGEND OF SERVICES

Emergency Departments. 24-hour care – If you are concerned that you are seriously ill or injured, go to the nearest emergency department. **Patients with potentially life-threatening conditions should immediately phone 911.**

Emergency Limited Hours. These communities have emergency health care services available within limited hours. Please contact the facility in your community to confirm the hours for emergency care. Please refer to the back of this map for contact numbers in your community.

Hospitals. These are AHS and AHS partner facilities for treating urgent, complex or other health needs on an inpatient basis. Some sites may provide hospital care, continuing care or community health care from one site, called a Health Centre. (Partner facilities are denoted in **brown**.)

Community and Public Health Services. These facilities provide a wide range of health services which may include prenatal, postpartum, health promotion/disease and injury prevention, bereavement services, communicable disease and school health, and many other community care, public health and wellness programs.

Primary Care Networks. Many family physicians in Alberta are part of a Primary Care Network (PCN) – a group of family doctors working together with a team of other health professionals such as nurses, dietitians and pharmacists to provide care to a defined group of patients.

Addiction and Mental Health Services. These facilities and programs are for the treatment and care of people with mental health or addiction challenges.

Cancer Care Centres. AHS offers a variety of programs, services and facilities that work with those affected by cancer, as well as provide programs to help Albertans reduce their risk of developing cancer. For more information on the services available in your community, call Central Alberta Cancer Centre (in Red Deer) 403-343-4526.

Continuing Care. These are AHS or AHS partner sites offering long term and/or supportive living options in

0 10 20 30 40 50

SCALE PROVIDES APPROXIMATE DISTANCE IN KILOMETRES.

Lamont
Andrew
Willingdon
Two Hills
Mundare
Vegreville
Tofield
Mannville
Vermilion
Islay
Kitscoty
Lloydminster
Drayton Valley
Breton
Winfield
Wetaskiwin
Camrose
Viking
Daysland
Killam
Sedgewick
Wainwright
Hardisty
Rimbey
Ponoka
Bashaw
Galahad
Provost
Bentley
Lacombe
Stettler
Rocky Mountain House
Eckville
Sylvan Lake
Red Deer
Castor
Coronation
Consort
Innisfail
Elnora
Sundre
Olds
Trochu
Three Hills
Linden
Drumheller
Hanna

Passion for Health

We have a passion for your health. It's why we do what we do. We know that you are passionate about good health, too. Your opinions, concerns and questions matter.

So, we've launched a project called Passion for Health where we can have face-to-face conversations with Albertans; share information on the health topics that interest you; and help you find the resources you need to be healthy.

Through our Passion for Health project, we are attending your community events, inviting you in to our facilities through open houses to see what happens behind the scenes, hosting information sessions called "Apple Talks" and we are provicing health information through a blog.

We also have a series of "Because You Cared" videos that have given Albertans a way to say thank you to the health providers who have made a significant difference in their lives.

Look for AHS staff and physicians in our Passion for Health booths at festivals and community events, and at Apple Talk forums, near you.

Share your passion for health with us and visit our Passion for Health website at **www.ahs.ca/passionforhealth** to find out more.

If you are experiencing a life-threatening emergency, call 911 or go immediately to the nearest emergency department.

HEALTH ADVISORY COUNCILS

Health Advisory Councils (HACs) are focused on one thing: listening to your thoughts and ideas on health care in Alberta. Yellowhead East and David Thompson are the two councils located in central Alberta. Councils act as a channel for information and feedback, and provide advice to Alberta Health Services. The Yellowhead East Health Advisory Council includes communities from Lloydminster to Camrose and Andrew to Provost. The David Thompson Health Advisory Council includes communities from Consort to Rocky Mountain House and Drayton Valley to Drumheller. For more information about the councils, please visit **www.ahs.ca/hac.asp**

FOUNDATIONS AND TRUSTS

Local health foundations work in your communities, raising funds to improve health care delivery where you live. To support your local foundation, email **FoundationRelations@ahs.ca**, or visit **www.ahs.ca/give**

PATIENTS AND THEIR FAMILIES ARE THE CENTRE OF EVERYTHING WE DO AND EVERY DECISION WE MAKE.

COVID-19 Info: For Albertans | For Health Professionals | Vaccine | Assessment & Testing | Results | Visitation

A CMOH order remains in effect that requires continuous masking at all AHS, APL and Covenant facilities provincewide.

Wisdom Council

Advisory Councils

Building a Better Health System with the Voice of Our Community

Wisdom Council provides guidance and recommendations to ensure AHS develops and implements culturally appropriate and innovative health service delivery for Indigenous Peoples. Council focuses on Indigenous health priorities, services, and resources, and is made up of public members from across treaty areas and Alberta's health zones.

Wisdom Council Recruitment

Until March 31, 2022, Alberta Health Services (AHS) is accepting expressions of interest from individuals who wish to sit on the Wisdom Council.

The Wisdom Council is an advisory board of dedicated people who speak as an Indigenous person to share their experiences to ensure AHS is providing culturally safe, accessible care for Indigenous peoples.

Indigenous specific services are delivered throughout the province in partnership with Indigenous peoples and organizations to provide high quality, culturally safe, accessible health care.

Participating in the Wisdom Council will allow you to have a voice in how healthcare is delivered to Indigenous peoples in Alberta.

AHS continues to explore how best to integrate advice and feedback into our health policies and practices to better serve Indigenous peoples in a culturally safe and appropriate way to rebuild trust and remove barriers within the system.

Interested people will be screened, interviewed and selected by current members of the Wisdom Council. For more information or to submit an expression of interest, please email wisdomcouncil@ahs.ca.

Quick Reference

- Expression of Interest
- Frequently Asked Questions
- Share Your Wisdom Poster
- Terms of Reference
- Three Year Commitments

Annual Reports

- 2019/20
- 2018/19
- 2015/16

Contact Us

Email: wisdomcouncil@ahs.ca

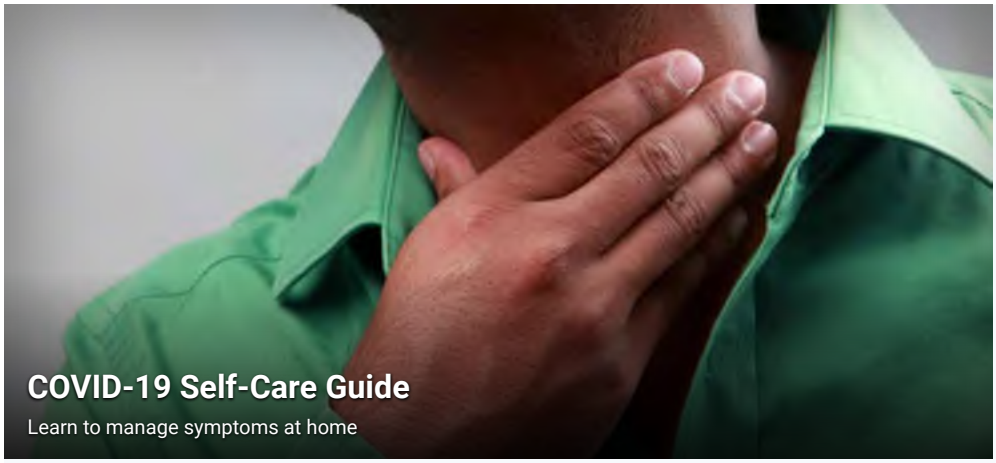
NEW: Express access to COVID-19 vaccine record is now available.

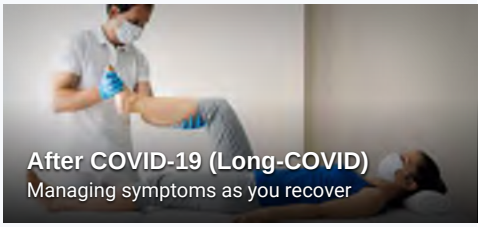
MyHealth.Alberta.ca Network

Home | Health Information and Tools | MyHealth Videos | Find Healthcare | About MyHealth.Alberta.ca | Healthier Together | MyHealth Records

MyHealth.Alberta.ca

All MyHealth.Alberta.ca Search...





Know Your Options: Learn Where to Get the Care You Need

Find Healthcare: Find a Service or Facility

Emergency Department Wait Times

IMPORTANT PHONE NUMBERS

Health Link - Health Advice 24/7
811

Family Violence Info Line
310-1818

Poison & Drug Information Service
1-800-332-1414

Kids Help Phone (Youth Counselling Line)
1-800-668-6868

Addiction Services Helpline
1-866-332-2322

Mental Health Helpline
1-877-303-2642

Rehabilitation Advice Line: Open M - F
1-833-379-0563

Show more

HEALTHCARE PROVIDERS

Find contact information to healthcare providers and practitioners

Health Information and Tools

Check your symptoms, learn more about a health condition or medicine. Take charge of your health.

Symptom Checker

Health A - Z

MyHealth Records

Patient Care Handouts

Medications

Tests & Treatments

NEW: Express access to COVID-19 vaccine record is now available.

MyHealth.Alberta.ca Network

Home | Health Information and Tools | MyHealth Videos | Find Healthcare | About MyHealth.Alberta.ca | Healthier Together | MyHealth Records

Have you Registered?

Did you know? Just 1 organ and tissue donor can save up to 8 lives and make life better for up to 75 other people.

Alberta Organ and Tissue Donation Registry

HOT TOPICS

What's New for MyHealth.Alberta.ca?

MyHealth.Alberta.ca is growing by adding new content and functions that will help more Albertans to manage their own health. Here are some of the exciting new additions and future plans.

View all News

ADVISORIES

- Alberta Health Services advisories
- Latest information on COVID-19 in Alberta
- Travel health advisories
- Restaurant inspections

SPOTLIGHT

Spotlight

- Coronavirus (COVID-19)
- COVID-19 vaccines
- MyHealth Records
- Syphilis
- Opioids

Home | About MyHealth.Alberta.ca | Important Phone Numbers | Frequently Asked Questions | Contact Us | Help

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Terms & Conditions | Accessibility | Privacy

811 Health Link Health Advice 24/7

Alberta Health Services

COVID-19 Info: For Albertans | For Health Professionals | Vaccine | Assessment & Testing | Results | Visitation

A CMOH order remains in effect that requires continuous masking at all AHS, APL and Covenant facilities provincewide.

About AHS

Who We Are

- Alberta Health Services (AHS) is proud to be part of Canada's first and largest provincewide, fully integrated health system, responsible for delivering health services to more than 4.4 million people living in Alberta, as well as to some residents of Saskatchewan, B.C. and the Northwest Territories.
- AHS has more than 108,600 direct AHS employees (excluding Covenant Health and other contracted service providers) and more than 12,500 staff working in AHS' wholly-owned subsidiaries such as Alberta Precision Laboratories, Carewest and CapitalCare Group. AHS is also supported by approximately 12,200 volunteers and more than 10,900 physicians practicing in Alberta, approximately 9,000 of whom are members of the AHS medical staff (including active, temporary and community appointments).
- Students from Alberta's universities and colleges, as well as from universities and colleges outside of Alberta, receive clinical education in AHS facilities and community locations.
- AHS has 106 acute care hospitals, five stand-alone psychiatric facilities, 8,513 acute care beds, 27,973 continuing care beds/spaces including 257 community palliative and hospice beds/spaces, 2,840 addiction and mental health beds/spaces, plus equity partnership in 40 primary care networks.
- Programs and services are offered at more than 900 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities

and community health sites.
- The province also has an extensive network of community-based services designed to assist Albertans in maintaining and improving their overall health status.

Our History

- Canada’s first provincewide, fully integrated health system, announced on May 15, 2008, by Ron Liepert, Minister of Health and Wellness.
- We bring together 12 formerly separate health entities in the province including three geographically based health authorities, Alberta Alcohol and Drug Abuse Commission (AADAC), Alberta Mental Health Board and Alberta Cancer Board. Ground ambulance service was added to the responsibilities of AHS in an announcement from Alberta Health and Wellness on May 30, 2008. The services were moved from municipalities to AHS effective April 1, 2009.

AHS Board

Meetings, contact, governance, committees.

More ›

Get to Know Us - Quick Facts About Your Health System

Canada

Royal Canadian Mounted Police (/en)

Home ➜ Find a detachment ➜ Alberta ➜ Maskwacis detachment

Maskwacis detachment Alberta

Hobbema, Montana First Nation, Pigeon Lake First Nation, Samson First Nation, Louis Bull First Nation and Ermineskin First Nation.

Maskwacis (Hobbema)

RCMP response to Coronavirus disease (COVID-19)

There has been no change to the RCMP's response to critical and emergency matters. RCMP detachments remain open and your local police officers continue to be present in your community to ensure community safety. Out of respect for social distancing, and in consultation with local authorities and health professionals, we have made the following changes:

- Some RCMP detachments across Canada are reducing or suspending certain front-counter/in-detachment services.
- Members of the public are encouraged to check with their local RCMP detachment for more information on services currently available.

These measures are being taken to protect the safety of our employees and the citizens we serve.

During an emergency, dial

9-1-1

Contact information

1 Mile Rd and Highway 611 E, Samson Townsite
Maskwacis AB T0C 1N0

Telephone: 780-585-4600 - Administration
Telephone: 780-585-3767 - Non-emergency
Fax: 780-585-4610
English only
Your nearest bilingual detachment is Edmonton International Airport (/detach/en/d/520#Edmonton%20International%20Airport)

Mailing address

P.O. Box 490
Maskwacis AB T0C 1N0

Hours of operation

General services

Monday to Friday
7:30 am to 4:30 pm

Report a crime online here (https://ocre-sielc.rcmp-grc.gc.ca/alberta)

Services available

- ✔ Criminal records check
- ✔ General information
- ✔ Non emergency complaints
- ✔ Police certificate
- ✔ Report a crime
- ✔ Vulnerable sector check

Please be advised: Information is subject to change without notice.

Canada

Royal Canadian Mounted Police (/en)

Home ➜ Find a detachment ➜ Alberta ➜ Bashaw detachment

Bashaw detachment Alberta

Alix, Bashaw, Buffalo Lake Estates, Donalda, Dorenlee, Edberg, Ferintosh, Meeting Creek, Mirror, Pelican Point and Tees.

Bashaw

RCMP response to Coronavirus disease (COVID-19)

There has been no change to the RCMP's response to critical and emergency matters. RCMP detachments remain open and your local police officers continue to be present in your community to ensure community safety. Out of respect for social distancing, and in consultation with local authorities and health professionals, we have made the following changes:

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- Members of the public are encouraged to check with their local RCMP detachment for more information on services currently available.

These measures are being taken to protect the safety of our employees and the citizens we serve.

During an emergency, dial

9-1-1

Contact information

5017 52nd St
Bashaw AB T0B 0H0

Telephone: 780-372-3793 - Administration
Telephone: 780-372-3593 - Non-emergency
Fax: 780-372-2121
English only
Your nearest bilingual detachment is Red Deer City (/detach/en/d/492#Red%20Deer%20City)

Mailing address

P.O. Box 248
Bashaw AB T0B 0H0

Hours of operation

General services

Monday to Friday
8:30 am to 4 pm

Report a crime online here (https://ocre-sielc.rcmp-grc.gc.ca/alberta)

Services available

- Criminal records check
- General information
- Non emergency complaints
- Police certificate
- Report a crime
- Vulnerable sector check

Please be advised: Information is subject to change without notice.

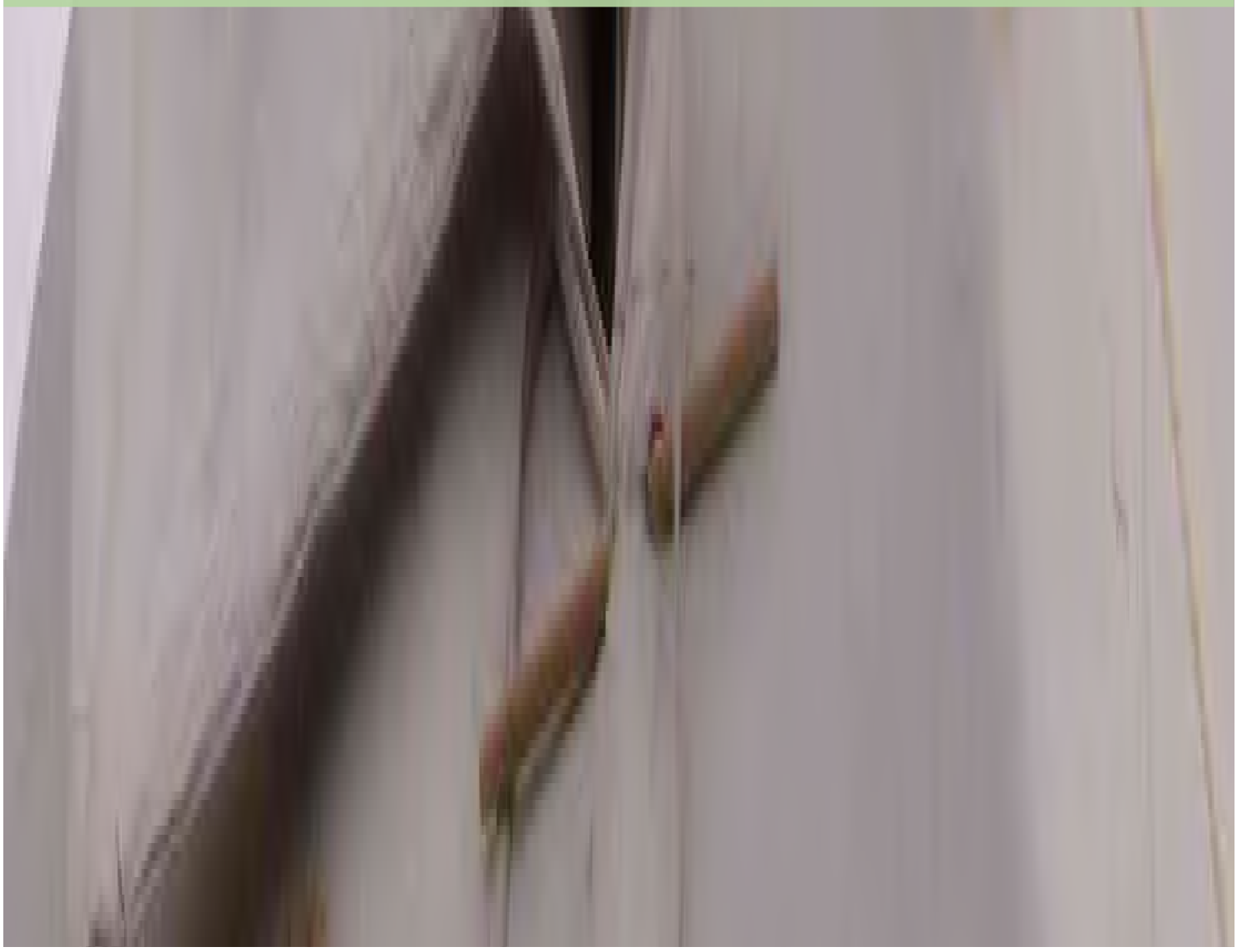
Covid-19 Information Click Here

Hours of Operation

MHS will be open to the general public from 9:00 am – 3:00 pm

TAWÂW

WELCOME



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MASKWACIS MOBILE MENTAL HEALTH

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- Kicehtowin (Respect) – We honor and respect ourselves and all who we serve.
- Kitimakehitowin (Caring) – We provide the ultimate care and compassion to all that we serve.

MASKWACIS MOBILE MENTAL HEALTH

MENU

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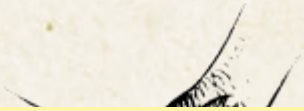
- Nehiyawatisiwin (Thought and Way of Life) -We are mindful of the Cree thought and the way of life in all that we do.



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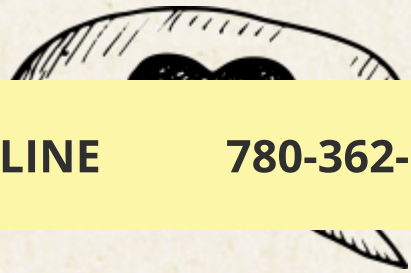
We are committed to body, mind & spirit well-being of the Maskwacis peoples.



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A compassionate & caring voice will focus on your immediate crisis or need.

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HOTLINE 780-362-2150

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January 11, 2021

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HOTLINE 780-362-2150

780-372-3911 | 780-372-2335 | admin@townofbashaw.com

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Bashaw Community Health Centre

Find up-to-date information here.

Bashaw Medical Centre

For more information, please call
Phone 780.372.3740
Fax 780.372.3741

Other Health Service Contacts

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Town of Bashaw
5011 – 52 Ave., Box 510
Bashaw Alberta, Canada T0B 0H0

Hours
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8:30 am – 4:30 pm
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780-372-3911
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Alberta Health Services

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On April 1, 2009, AHS brought together 12 formerly separate health entities in the province: nine geographically based health authorities (Chinook Health, Palliser Health Region, Calgary Health Region, David Thompson Health Region, East Central Health, Capital Health, Aspen Regional Health, Peace Country Health and Northern Lights Health Region) and three provincial entities working specifically in the areas of mental health (Alberta Mental Health Board), addiction (Alberta Alcohol and Drug Abuse Commission) and cancer (Alberta Cancer Board).

ABORIGINAL MENTAL HEALTH: A FRAMEWORK FOR ALBERTA

Healthy Aboriginal People in Healthy Communities

AMHB
ALBERTA MENTAL HEALTH BOARD
. . . Advancing Mental Health

ACKNOWLEDGEMENTS

The Alberta Mental Health Board would specifically like to thank the members of the AMHB Wisdom Committee and the current and past staff of the AMHB for the research and stimulation of collaborative efforts that contributed to the development of this Framework. It is also acknowledged that there were many others, too numerous to mention, who contributed their time, knowledge and experience to support the development of this important document.

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ALBERTA MENTAL HEALTH BOARD WISDOM COMMITTEE DECLARATION 2004

The following is a declaration that reflects the worldview of the Alberta Mental Health Board Wisdom Committee as guiding principles in their work to guide and support the mental wellness of Aboriginal people in Alberta.

We, the Original Peoples of this land, know the Creator put us here.

The Creator gave us laws that govern all our relationships to live in harmony with nature and mankind.

The Laws of the Creator defined our rights and responsibilities.

The Creator gave us our spiritual beliefs, our languages, our culture, and a place on Mother Earth, which provided us with all our needs.

We have maintained our Freedom, our Languages, and our Traditions from time immemorial.

We continue to exercise the rights and fulfill the responsibilities and obligations given to us by the Creator for the land upon which we were placed.

The Creator has given us the right to govern ourselves, and the right to self -determination.

The rights and responsibilities given to us by the Creator cannot be altered or taken away by any other Nation.

"This declaration remains as long as the sun shines, river flows and the grass grows."

Adapted from the Assembly of First Nations 2001

TABLE OF CONTENTS

AMHB WISDOM COMMITTEE DECLARATION 1

TABLE OF CONTENTS 2

INTRODUCTION 3

- AMHB and the Purpose of the Aboriginal Mental Health Framework 6
- Vision for Aboriginal Mental Health in Alberta 7
- Beliefs and Principles 8

BACKGROUND 11

- Aboriginal Perspectives on Mental Health 12
- Historical Legacy of Aboriginal Peoples 13
- Socio-demographic Characteristics and the Diversity of Aboriginal Peoples 14
- Environmental Impact on Aboriginal Peoples 18
- Socio-economic Influences 19

ABORIGINAL MENTAL HEALTH 21

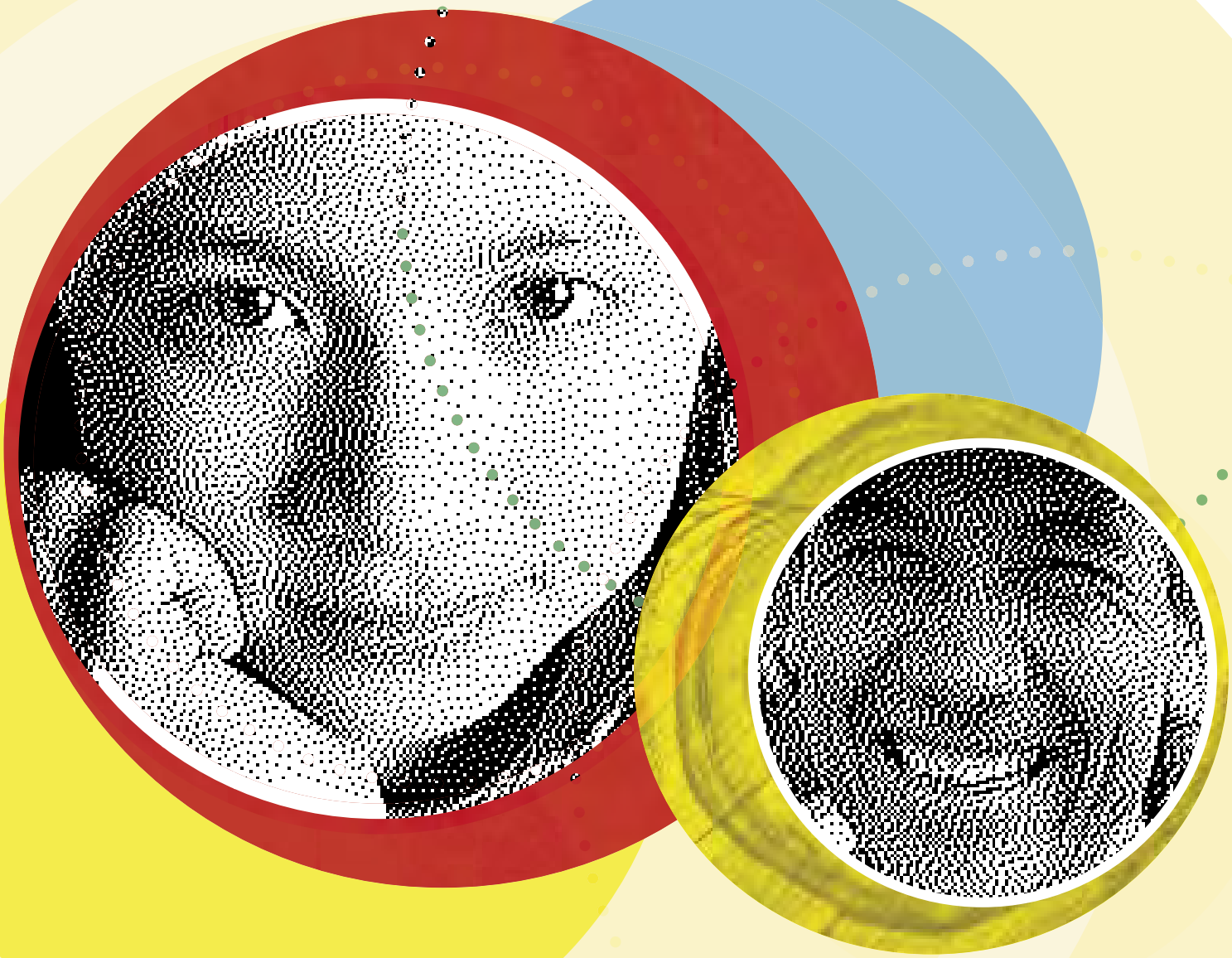
- Key Mental Health Issues of Aboriginal Peoples: A Review of the Literature 22
- Considerations for Program Development 26

STRATEGIC DIRECTIONS FOR ACTION 29

- Proposed Conceptual Model 30
- Strategic Directions 32
- What Next? A Framework for Action 33

GLOSSARY AND REFERENCES 35

- Glossary 36
- References 37
- List of Reports Reviewed 38



INTRODUCTION

INTRODUCTION

The Provincial Mental Health Plan for Alberta (PMHP) released in 2004 was developed through the collaborative effort of the Alberta Mental Health Board (AMHB), Alberta's nine regional health authorities, the Alberta Alliance on Mental Illness and Mental Health, the Alberta Medical Association, the Alberta Psychiatric Association, and Alberta Health and Wellness. The PMHP is one of the key initiatives in moving forward significant changes to Alberta's health system based on the recommendations of the *A Framework for Reform Report of the Premier's Advisory Council on Health (2001)* which recommended that mental health services be fully integrated with other health services available in regions and be close to where people live (PMHP, 2004).

The AMHB has been given the mandate through the PMHP to lead and facilitate the development of an *Aboriginal Mental Health Framework* in collaboration with provincial ministries, regional health authorities, Health Canada, Aboriginal communities and other service providers. The *Aboriginal Mental Health Framework* will be a framework for action in the development and implementation of regional mental health supports and services for Aboriginal peoples in Alberta.

The development of the PMHP for Alberta engaged Aboriginal stakeholders in providing information on the needs and services of Aboriginal peoples in Alberta. ***Aboriginal*** in this document is defined according to the *Canadian Constitution Act* (1982) as "Indian (First Nations), Inuit and Métis peoples of Canada." The following are definitions specific to each Aboriginal group:

FIRST NATIONS: **Descendants of the original inhabitants of North America. Although the term "First Nation" is now widely used, there is no legal definition for it. (INAC,2005).**

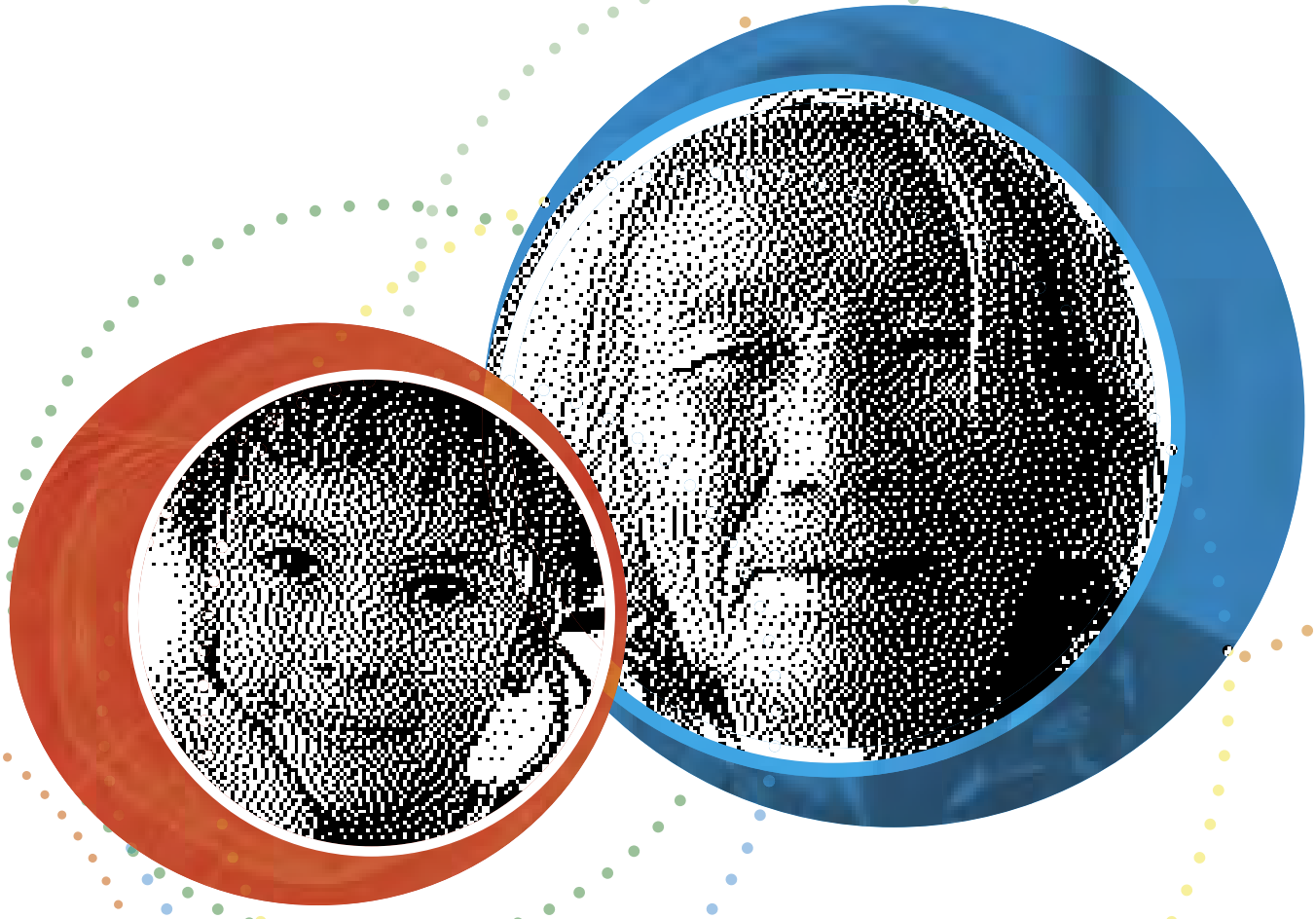
MÉTIS: **Métis means a person who self-identifies as Métis, is of historic Métis Nation Ancestry, is distinct from other Aboriginal Peoples and is accepted by the Métis Nation (Métis National Council, 2002).**

INUIT: **Inuit are the Aboriginal people of Arctic Canada. They live primarily in Nunavut, the Northwest Territories, Labrador, and Northern Quebec. Inuit means "the people" in Inuktitut, the Inuit language. (INAC, 2005).**

The AMHB Wisdom Committee, Health Canada, Aboriginal Affairs and Northern Development and other Aboriginal stakeholders participated in various focus groups across the province to discuss key areas of mental health for Aboriginal peoples (PMHP, 2004).

The primary concerns identified by Aboriginal stakeholders were:

- Improved mental health outcomes for Aboriginal people depend on the creation of culturally based options for the full range of mental health services.
- Concerns of Aboriginal people relate to the availability and delivery of mental health services.
- Our present mental health system struggles with how to meet the mental health needs of Aboriginal people. Research demonstrates that the present level of programming and services does not evidentially impact the continued overrepresentation of Aboriginal people within our health and social systems. Yet, considerable Aboriginal expertise and best practices in Aboriginal mental health are available as a potential foundation for appropriate mental health services strategies.
- Planning and management of effective Aboriginal mental health services requires both formal and informal inter-governmental and inter-Ministerial, Health Canada and Aboriginal collaboration. Health Canada and Aboriginal governments need to be engaged "without abrogating or derogating from Treaty and Aboriginal rights" in providing services to First Nations people (PMHP, Appendix 2, p.1).



AMHB AND THE PURPOSE OF THE ABORIGINAL MENTAL HEALTH FRAMEWORK

The Government of Alberta's Aboriginal Policy Framework (APF) requires that Alberta Ministries demonstrate their ability to 'strengthen relationships' and address issues relating to Aboriginal peoples in Alberta. The Alberta Mental Health Board (AMHB) strives to support the APF by identifying outcomes that speak to the mental wellness of Aboriginal peoples in Alberta. For example, the AMHB potential targets for 2005-06 address a number of objectives to support the well being of Aboriginal peoples, including the Aboriginal Mental Health Framework. The Alberta Aboriginal Policy Framework provides rationale to all involved ministries and it is important that Aboriginal communities determine what is required to achieve 'wellness'. Aboriginal participation in all aspects of planning will be essential for any programming to succeed. The Provincial Mental Health Plan states "the mental health needs of Aboriginal people will be better served by a province-wide framework" (PMHP, p.16).

The purpose of the *Aboriginal Mental Health Framework is*

1. To provide background information and described factors that influence the unique and complex needs for mental health services and supports that will serve the various Aboriginal groups in the province of Alberta.
2. To develop a document in Mental Health that reinforces and reflects the Aboriginal Policy Initiative.
3. To provide strategic direction for service providers that will be beneficial in the development of services to the Aboriginal communities of Alberta.
4. To coordinate and facilitate joint service planning, service delivery, capacity building, innovation, research and evaluation. (PMHP, p.16).

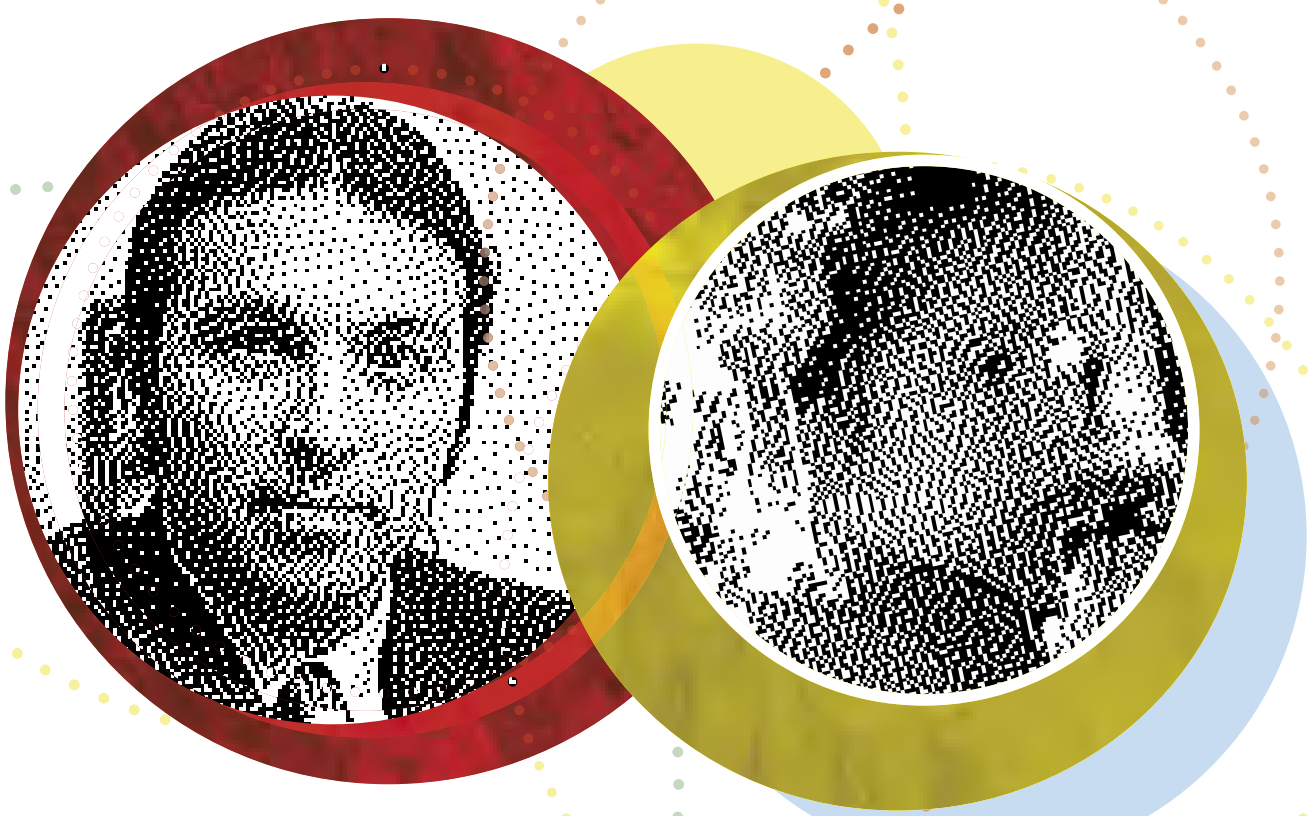
VISION FOR ABORIGINAL MENTAL HEALTH IN ALBERTA

The PMHP (2004) proposes a number of statements as part of its 'vision' including clients as a first priority having access to services through effective partnerships which support their mental health needs. From an Aboriginal perspective, this means that a holistic approach to service development and delivery will be embraced and respected. This principle has been endorsed by the AMHB Wisdom Committee whose goals include the following:

> **"To promote the improvement of the well being of the mind, body, spirit and emotions of Aboriginal children, adults, families and communities through Aboriginal culturally appropriate promotion, prevention and treatment services within the mental health system in Alberta" (AMHB Wisdom Committee, 2004).**

This statement supports the following proposed ***Vision*** for Aboriginal mental health in Alberta:

> **A responsive and accountable mental health system, that is recognized as a provincial and national leader, actively supports First Nations, Métis and Inuit individuals, families and communities in pursuit of their aspirations for health and well-being.**



BELIEFS AND PRINCIPLES

The *Aboriginal Mental Health Framework* is based on the following beliefs and principles that support an effective and holistic approach to the delivery of mental health services to Aboriginal people.

AMHB Wisdom Committee Statement of Beliefs

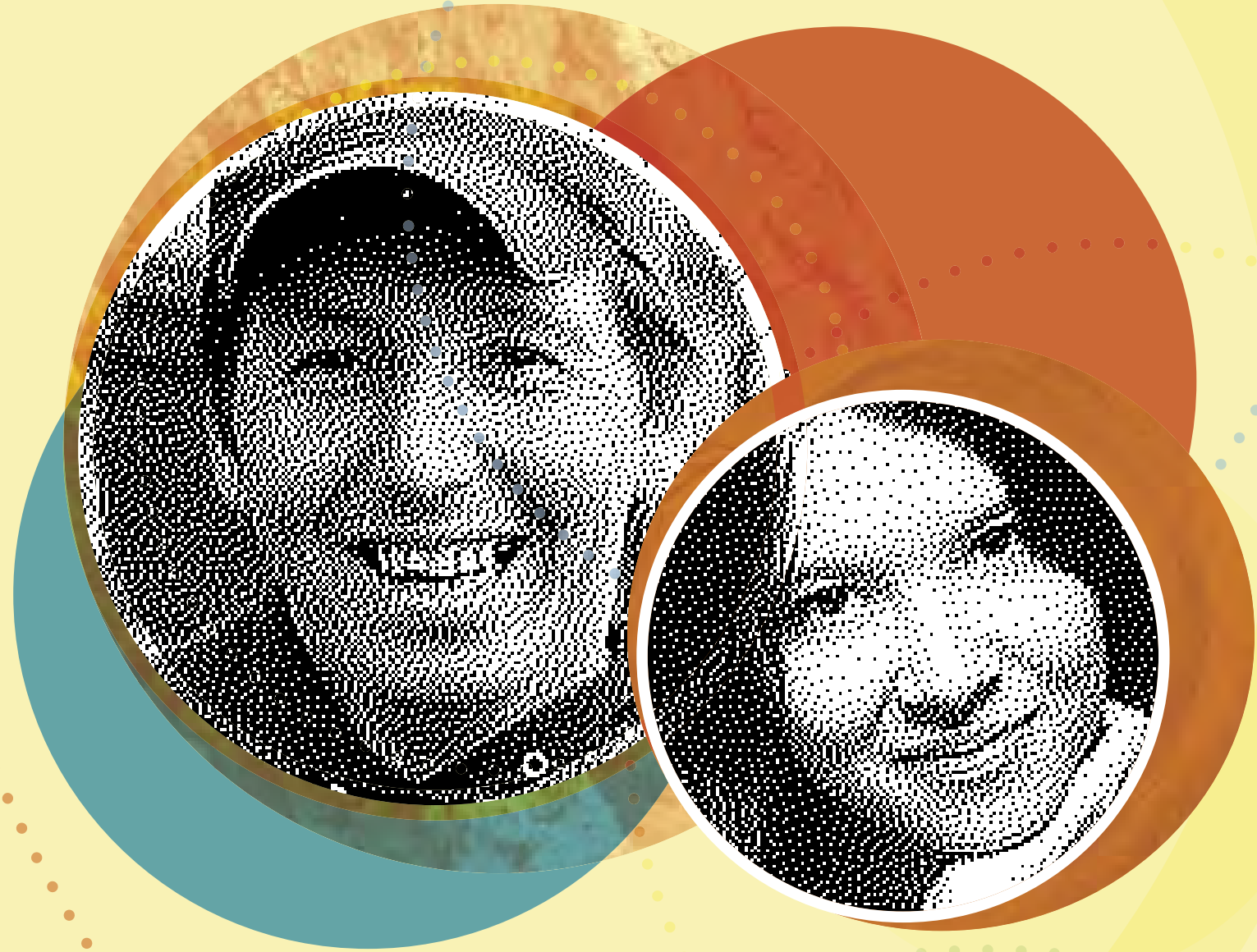
- **We Believe in the Laws of the Creator: The Creator is Almighty.**
- **We believe in the principle of holistic healing: Spiritual, Emotional, Mental and Physical. Traditional medicine – gives the spirit and power back to the individual by empowering them and gives them the responsibility to take care of their life.**
- **We believe that we need to have relationships and accept that we are all related and we all come from the same source.**
- **We believe that we need to go back to our traditional values and beliefs.**
- **We believe in a holistic approach: sharing, honesty, trust, respect, honour, love, caring and support.**
- **We believe that our declaration reflects what we do; the important role of our Elders and Traditional Healers are what we need to keep us on track and bring us comfort in the work we do.**
- **We believe that the declaration identifies who we are.**
- **We believe in the traditional ways of our people.**
- **We believe we began this work with the original ways of our people through prayer, involving the Elders, Healers, from the very beginning.**

The beliefs of the AMHB Wisdom Committee are acknowledged and shared by the World Health Organization (2001), which promotes a balanced continuum of care based on continuing relationships. It is to be noted, however, that this worldview is not shared by all Aboriginal people. There are Aboriginal people who may have chosen other ways of expressing their beliefs and way of life. A number of reports and studies suggest that a holistic and inclusive approach is best when developing services for Aboriginal people.

The National Aboriginal Health Organization (NAHO, 2003) supports the importance of a holistic approach in the healing journey. The Government of Alberta, Health and Wellness (2004) also advocates for balanced care in Aboriginal health services; and Alberta Agriculture, Food and Rural Development has developed *Principles of Aboriginal Involvement* (2004) which supports the need for Aboriginal people to be involved in the design and delivery of Aboriginal services.

Principles

1. Based on common goals, all necessary partners will support the health and well-being for Aboriginal peoples in Alberta through a coordinated, holistic approach.
2. The respect for the diversity of the Aboriginal population in Alberta will be demonstrated in the development and implementation of mental health programs and services for Aboriginal peoples.
3. Services will reflect community needs and protocols.
4. Efforts will be made to engage Aboriginal peoples in defining priorities for Aboriginal well-being in Alberta.



BACKGROUND

BACKGROUND

ABORIGINAL PERSPECTIVES ON MENTAL HEALTH

The concept of mental health as narrowly defined by western medical science is not easily translated among Aboriginal cultures. Inherent in the philosophies of many Aboriginal peoples are the beliefs and teachings about creation, life, spiritual practices, the maintenance of one's well-being, and relationships with all aspects of creation. At the core of Aboriginal philosophies is the concept of Spirit, the eternal force from which all aspects of creation evolve. On a human level, Spirit is the foundation of being and subsequently well-being. Nourishing and honouring of Spirit fosters the balance and harmony of the body, mind, and emotions. Neglect of one affects all. Within an Aboriginal perspective health is viewed inclusive of the health and well-being of the individual and family and the community. To become imbalanced or ill in body can lead to an imbalance in emotions and mind.

The World Health Organization defines traditional medicine and healing as "the sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness" (Martin Hill, 2003 p.3). Traditional healing has also been defined as "practices designed to promote mental, physical, and spiritual well-being that are based on beliefs which go back to the time before the spread of western 'scientific' bio-medicine" (Martin Hill, 2003 p.7). When Aboriginal people discuss the elements of traditional healing, "they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counseling and the accumulated wisdom of elders" (Martin Hill, 2003, p.7).

On comparison with western medicine that typically has the goal 'to cure', the goal of traditional medicine is 'to improve the quality of life with an emphasis on the healing journey' (NAHO, 2002, p.9). As NAHO (2002) states, a basic principle of the scientific method is "to separate parts from the whole and to concentrate on the parts that need the most attention. In the traditional model, the approach is to consider the whole of the person's being. Quality of life is the focus, with an emphasis on achieving balance in all aspects" (Ibid, p.9).

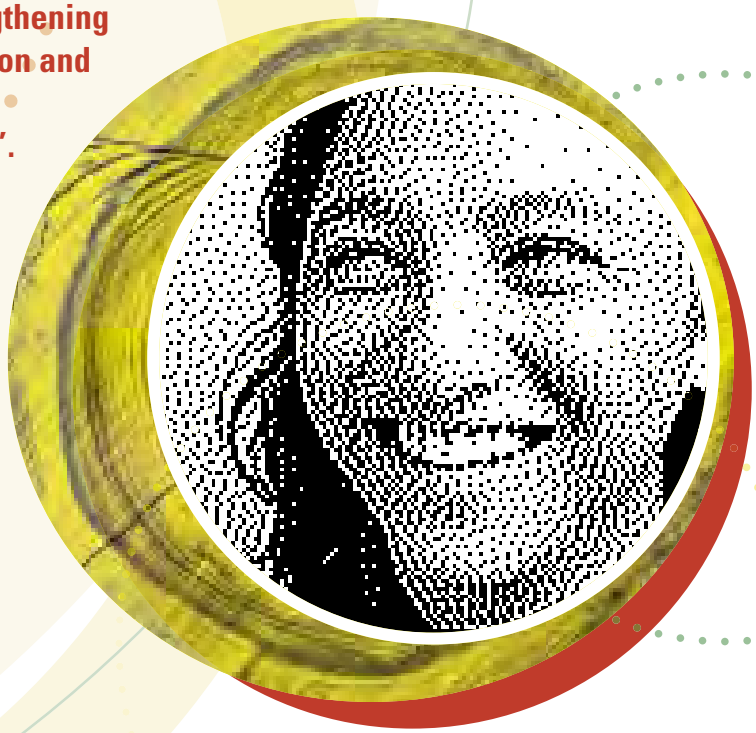
HISTORICAL LEGACY OF ABORIGINAL PEOPLES

Among the various groups of Aboriginal peoples in Canada and Alberta it is a common held belief that Aboriginal people have been here since time immemorial. Their unique histories predate contact with Europeans, which over the past few centuries has provided strengths and challenges to Aboriginal people. Strengths include the acquisition of new skills and tools for development through economic and educational processes. Challenges, however, include the erosion of Aboriginal cultures through colonialism and assimilation including policies that have attempted to erode Aboriginal forms of governance, language, and education. In addition, loss of traditional lands and the exploitation of the land's economic resources have resulted from these practices.

The impact of western European contact and colonization of Aboriginal peoples is also evident today in the diversity of spiritual practices. Many Aboriginal people follow and practice Aboriginal ways, others uphold Christian beliefs, and still others practice either a combination of both or neither. It has been stated that this historical context sets the stage to examine the contemporary health and well-being of Canada's Aboriginal people (CIHI, 2004, p. 75).

The aforementioned historical factors have had major impacts on all aspects of the lives of Aboriginal peoples including their individual, family, and communal health and well-being. These factors will be key issues to acknowledge in the planning and delivery of mental health services to Aboriginal consumers. As Kirmayer, Simpson, and Cargo (2003, p.15) state:

"There is clear and compelling evidence that the long history of cultural oppression and marginalization has contributed to the high levels of mental health problems found in many (Aboriginal) communities. There is evidence that strengthening ethnocultural identity, community integration and political empowerment can contribute to improving mental health in this population".



SOCIO-DEMOGRAPHIC CHARACTERISTICS AND THE DIVERSITY OF ABORIGINAL PEOPLES

According to the 2001 Census, approximately 156,000, or 5% of Alberta's population are Aboriginal people defined in Alberta as First Nations, Métis, and Inuit. Of these, 84,995 are identified as North American Indian, 66,060 as Métis, and 1,090 as Inuit. Approximately 65,130 of Aboriginal people live in Edmonton, Calgary, or Lethbridge with about 62,840 living in the two largest centres. The remaining individuals reside either on reserves within the three treaty areas, on Métis settlements, or in other urban and rural areas within the province (Statistics Canada, 2001).

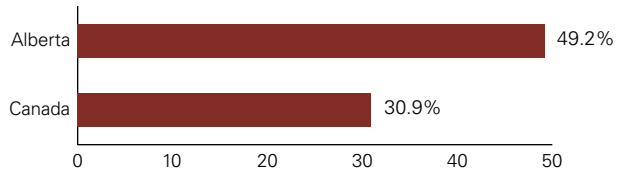
The Department of Indian and Northern Affairs, Canada, keep its own data on those First Nation members who are registered according to the Indian Act. As a result, the department's figures are slightly different from those of Statistics Canada. Based on the 2001 Indian and Northern Affairs Register, there are 87,703 registered First Nations people in Alberta with 29,657 living off-reserve (INAC, 2003).

According to the 2001 Census, approximately 976,305 people, or 3.3% of the total population of Canada, identify themselves as Aboriginal, that is, either North American Indian (including First Nations), Métis or Inuit. Of the 976,305 individuals who identify themselves as Aboriginal, 62% (608,850) report that they are North American Indian/First Nations, 30% (292,305) identify themselves as Métis, and 5% (45,075) identify themselves as Inuit. Nationally, 47% of those who identify themselves as North American Indian live on reserve, 68% of Métis population live in urban areas, and half of the Inuit population live in Nunavut.

There are eight Aboriginal languages spoken by the various First Nations in Alberta. Michif and Cree are the First Nation languages spoken among the Métis, and Inuktitut is spoken by the Inuit.

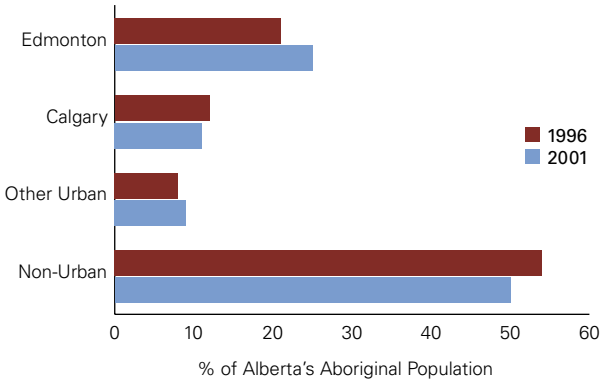
There is also some recent data which suggests the importance of examining the urban Aboriginal story. The following tables exemplify how this is an important area for consideration in service planning and delivery of mental health services with Aboriginal peoples in Alberta:

Aboriginal Population Resident in Major Urban Centres – Canada and Alberta (2001)



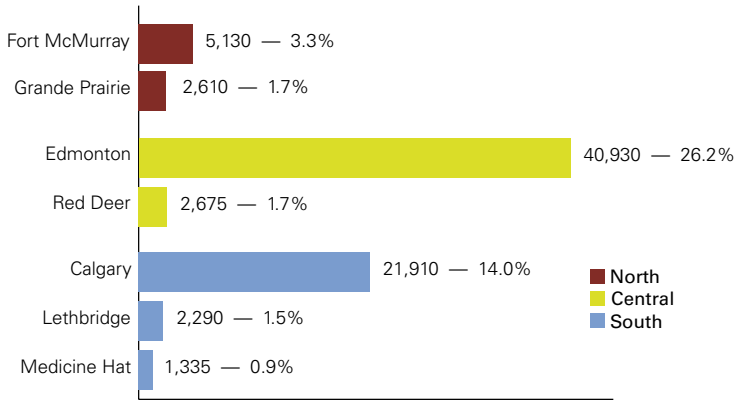
Source: Statistics Canada, 1996 & 2001 Census of Canada

Aboriginal Urbanization Trend – Alberta



Source: Statistics Canada, 1996 & 2001 Census of Canada

Aboriginal Population of Alberta's Major Urban Centres
Total = 76,880



First Nations

In Alberta, there are 44 First Nations within the three Treaty areas. They are situated on 124 reserves. Combined, these reserves cover 700,500 hectares of land, which is an area slightly larger than Banff National Park (approximately 664,000 hectares).

Métis

Most Métis live in western Canada in both rural and urban settings but primarily Métis and/or mixed communities. Presently, there are over 300 Métis communities, most of which are English speaking. However, some northern communities primarily speak Cree or Michif (Métis National Council, 2003).

Metropolitan areas with the largest Métis populations include Winnipeg (31,395), Edmonton (21,065), Vancouver (12,505), and Calgary (10,575) (Statistics Canada, 2001). Alberta has the largest Métis population (66,050), of which approximately 6% (4,200) live on the eight Métis Settlements of Buffalo Lake, East Prairie, Elizabeth, Fishing Lake, Gift Lake, Kikino, Paddle Prairie, and Peavine. Forty thousand Métis people live outside the settlements, of which 55% reside in Alberta cities. There are also non-recognized Métis settlements which include the Métis communities of Marlboro and Grande Cache. The largest Métis urban populations within Alberta reside in Edmonton and Calgary (Métis National Council, 2003).

Inuit

Most Canadians view Inuit people as the Aboriginal people of Arctic Canada. The word 'Inuit' means 'the people' in Inuktitut, the Inuit language, and is the term the Inuit use to refer to themselves. The Inuit population is largely situated north of the 60th parallel. However, according to the 2001 Census, there were 1,090 individuals who identified themselves as Inuit living in Alberta.

Statistics Canada (2004) reports that "although the Inuit birth rate has declined in recent years, it is still twice as high as the overall non-Aboriginal birth rate". Compared to other Aboriginal groups, the Inuit have the youngest population. This and other factors related to mobility and lifestyle changes create some unique needs in the area of mental health services for the Inuit people (Statistics Canada, 2004, p.16).

Aboriginal Children and Youth

It has been said that 'Children are Gifts from the Creator'; however, historically there have been a high number of Aboriginal children in the care of the Ministry of Children's Services in Alberta. In February 2005, there were over 5,000 Aboriginal children in the child welfare system with a large number having the status of permanent wards and being over the age of twelve (Alberta Children's Services, 2005). These children and their families require the assistance of a responsive mental health system.

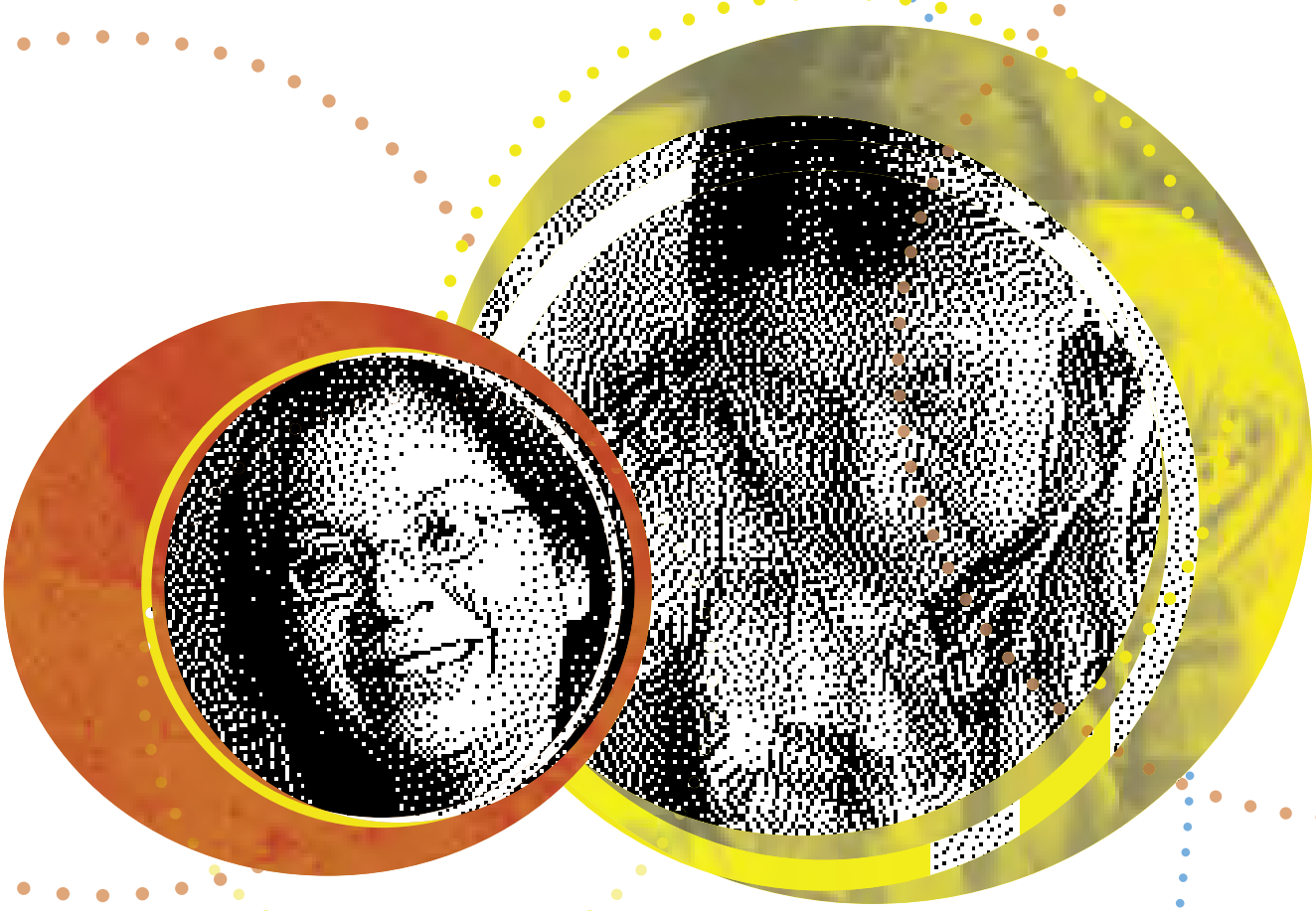
Overall, the Aboriginal population is young, both at a national and provincial level. The national statistics indicate 50% of those identified as North American Indian are less than 23 years of age. Fifty per cent of the Métis population are under 27 years of age, and the youngest Aboriginal population are the Inuit with 50 per cent younger than 20 years of age.

Learning about Aboriginal children and youth living in Alberta might lead to a better understanding of their situation. One of the growing concerns for Aboriginal youth in Alberta, for instance, is the influence of drugs such as crystal meth, known to be extremely addictive and easy to obtain (AADAC, 2005). Other activities such as gang involvement and warfare, violence in schools or exposure to racism and stereotypes can impact the self-development of Aboriginal youth. Although there is a lack of empirical studies which address these concerns, a recent report from the Aboriginal Health Program in Calgary Health Region (2005, p.12) states that the initial data on mental health suggests that Aboriginal youth are more likely to visit a doctor with mental health concerns than their non-Aboriginal peers.

The Centre for Suicide Prevention in Calgary (2004) states that although the daily realities of many Aboriginal youth may be grim, Aboriginal people have shown an incredible resiliency and ability to survive. The organization claims that this is the starting point in making change and for other organizations devoted to enhancing the well- being of Aboriginal youth, these can be viewed as words of encouragement.

ENVIRONMENTAL IMPACT ON ABORIGINAL PEOPLES

There have been a number of environmental impacts in various geographic locations that have altered the lifestyle and well-being of Aboriginal populations in those regions. Chadakrant (2004, p.270) describes risk factors for Aboriginal health including poor housing conditions and environmental contaminants. This is heightened in traditional diets where the animals have been exposed to contaminants and later ingested by Aboriginal peoples. He describes this factor as complex because game meat and fish are a healthier diet than processed foods and contributes to the cultural and spiritual bonds for Aboriginal peoples. Alberta Health and Wellness and the University of Alberta (2004, p.48) predict an increase in chronic respiratory disease in the future. Risk factors for conditions such as asthma and other respiratory tract infections include environmental factors such as air pollution e.g., gaseous pollutants. There are a number of Aboriginal communities located within close range of major industrial development sites in Alberta. Communities near development projects in Fort McMurray or Swan Hills for example may be at risk for health problems associated with these living environments. Health services need to consider these factors in developing local services.



SOCIO-ECONOMIC INFLUENCES

A number of socio-economic factors have influenced the characteristics of the diverse Aboriginal communities in Alberta. Although there are other variables that are unique to each Aboriginal community, some of the general factors include the following:

Political Context

There are political diversities in Alberta's Aboriginal communities that are influenced by jurisdictional issues, mandates, resource allocations, and cultural and historical factors. These political diversities have implications for the formation of partnerships and for collaboration with Aboriginal peoples in the development of mental health services (Aboriginal Affairs and Northern Development, 2001).

Demographic Influences

The Department of Indian Affairs and Northern Development (1997) reported that First Nations populations will increase at a rate of 1.7% compared with 1.1% for the general population (White, Maxim, & Beavon, 2003, p.10). The Royal Commission on Aboriginal Peoples (RCAP, 1996) projected growth rates for Aboriginal people 58% higher than the 1991 Census, at an estimated rate of 52% from 1991 to 2016 (White, Maxim, & Beavon, 2003, p.3).

However, demographic studies have used various methods to identify Aboriginal peoples in Canada. These studies are often based on projection models that do not address influences on demographic changes affecting Aboriginal populations. For example, marriage and fertility estimates are based on models that may not consider how ethnicity may change from birth to death. In other words, Aboriginal peoples may have their identity altered through factors such as status inheritance rules, self-reporting mechanisms, and reinstatements of status (White, Maxim & Beavon, 2003, p.55).

ABORIGINAL MENTAL HEALTH

ABORIGINAL MENTAL HEALTH

KEY MENTAL HEALTH ISSUES FACED BY ABORIGINAL PEOPLES: A REVIEW OF THE LITERATURE

A cursory review of the literature on the health of First Nations, Métis, and Inuit peoples resulted in the identification of seven themes linked to Aboriginal mental health and well-being:

1. **Health must be viewed from a holistic perspective.**
2. **Health determinants are key in addressing and analysing the health of Aboriginal peoples.**
3. **Information needs of Aboriginal peoples are not being met.**
4. **Knowledge and service gaps exist.**
5. **Aboriginal people have unique mental health challenges and needs.**
6. **Jurisdictional issues impact service.**
7. **There are policy gaps and programs and services access concerns.**

1. Health must be Viewed from a Holistic Perspective

National Aboriginal Health Organization (NAHO) identified five key factors that are considered contributors to positive change in Aboriginal health systems (CIHI, 2004, p.95).

- Aboriginal ownership and control
- Focus on primary care
- Links with the provincial health system
- Integrated service delivery
- A holistic focus and integration of traditional approaches with mainstream care

2. Health Determinants are Key in Addressing and Analysing the Health of Aboriginal Peoples

Five key health determinants identified by the Canadian Population Health Initiative (CIHI, 2004, p.75) as affecting the health of Aboriginal Peoples are:

- Ongoing impacts of colonialism
- Relationship between housing and health
- Legacy of the residential school system
- Climate change and environmental contaminants that impact Inuit health
- Community control and self-determination

3. Information Needs of Aboriginal Peoples are Not Being Met

The National Aboriginal Health Organization (NAHO) identified five priority information needs that are currently not being met (CIHI, 2004, p.98).

- Development of health information systems for Métis
- Estimates of current and projected demographic changes of all Aboriginal peoples
- Information about the ongoing incidence and prevalence of the full range of identified diseases and conditions (there is currently an emphasis on communicable and some chronic diseases)
- Investigation of new trends and emerging issues
- Monitoring of environmental quality (water, air, land and food sources)

The data for Aboriginal peoples in the area of health is predominantly on First Nations and Inuit people. However, this health data, contains little, if any information on mental health. Recent data released by

Alberta Health and Wellness and the University of Alberta Public Health Sciences (2004) indicate that First Nations people were seeking help at higher rates than the general population for mental health problems primarily through physicians, emergency rooms, and hospital admissions rather than mental health outpatient clinics. This data also disclosed that one of the greatest challenges for Aboriginal mental health in Alberta is to "balance the needs of diverse populations of Aboriginal clients accessing mental health" (Alberta Health and Wellness, 2004, p.25).

There is very little health or mental health data that is specific to Métis. Research conducted by the Canadian Institute of Health Research made an attempt to include Métis health issues but found minimal health indicators due to the void of an identifier. As well, there is limited mental health information for First Nations, Métis and Inuit peoples in the *Aboriginal People's Survey* (Statistics Canada, 1994, 1996, 2001) and lack of information specific to regional diversity within the *First Nations and Inuit Regional Health Survey* (1997). It is also important to note that there is a small population of Inuit people in Alberta whose needs must be identified and addressed.

4. Knowledge and Service Gaps Exist

Knowledge in Aboriginal mental health, appropriate funding models, and the availability of mental health services and an Aboriginal mental health workforce pose ongoing challenges to the mental health system. Research and data on all aspects of Aboriginal mental health, including best practice models, are limited and in some instances non-existent. Mental health services specific to Aboriginal populations, and the availability of Aboriginal people trained in mental health and working in the mental health system are also very limited.

5. Aboriginal People have Unique Mental Health Challenges and Needs

Family violence, suicide, and substance abuse problems are common among Aboriginal peoples in Alberta. Many of the mental health issues facing Aboriginal peoples today are rooted in historical and socio-economic factors. Family violence, including physical and sexual abuse, is often the reason for referrals to mental health centres and hospitals and can be directly related to the historical legacy of Aboriginal people, such as the residential school system. Suicide among Aboriginal peoples, but more specifically among Aboriginal youth, is of major concern provincially and nationally. Various studies estimate the average rate of youth suicide in some Aboriginal communities is eight times higher than the national average.

The Canadian Population Health Initiative (2004) states "the social, economic and environmental conditions of Aboriginal people are worse than those of non-Aboriginal people. These include education, work status, income, housing, water and sewage systems and nutritional options that are readily available and affordable"

(CIHI, p.90). These conditions impact the ability of Aboriginal communities to meet many of the social determinants of health, which in turn impacts the health of the people. Cultural safety needs to be assured and cultural awareness and positive imaging needs to be promoted. For example, First Nations may have concerns around giving others access to their mental health service information for fear the information will be used to steer program dollars away from the community.

6. Jurisdictional Issues Impact Service

Mental health programming for First Nations and Inuit is divided between federal and provincial governments. However, there is limited funding and continuity of services that cause barriers to the health and mental health of Aboriginal people. Mental health programs and services are the responsibility of each First Nation and the First Nation and Inuit Health Branch (FNIHB); therefore, the issue of jurisdiction is a significant policy initiative where discussions with all these stakeholders must be processed in order to determine how provincial mental health services can create a relationship that enhances change and improves existing services. FNIHB funds mental health activities and services in the form of short-term crisis intervention, counselling, treatment and prevention programming through the following four initiatives and programs:

- Brighter Futures Initiative
- Building Healthy Communities Initiative
- Non-Insured Health Benefits Program
- National Native Alcohol and Drug Abuse Program

7. There are Policy Gaps and Program and Services Access Concerns

There is no national mental health policy for First Nations, Métis, and Inuit peoples. The influence of the national gap is that provincial mental health programs have no Aboriginal mental health policy. Although Aboriginal peoples in Alberta are eligible to access mental health services that are outside First Nation reserves and Métis settlements such as in community mental health clinics, hospitals, and psychiatric institutions provided through the regional health authorities, there are significant concerns regarding access to these services. These concerns include whether services are geographically easy to access, welcoming, and culturally appropriate; and if the professionals providing these services are aware of the unique needs of Aboriginal people. Services to Aboriginal children and youth are also an important area for program and policy development.

CONSIDERATIONS FOR PROGRAM DEVELOPMENT

Culturally appropriate mental health programming for Aboriginal people means acknowledging and understanding the historical, political, economic, social, cultural, linguistic, and community factors that influence and continue to impact the well-being of Aboriginal peoples in Alberta. It is crucial for the success of any Aboriginal mental health program to incorporate traditional Aboriginal approaches to healing as an option. Furthermore, programming must be holistic in focus and use the expertise and knowledge of Aboriginal peoples and their communities (PMHP, p. 30).

Currently, the diagnosis of mental illness and mental disorders of individuals are completed by physicians, psychiatrists, and other mental health professionals using the Diagnostic Statistical Manual – 4th Edition (DSM-IV-TR) developed by the American Psychiatric Association. The manual is grounded in western science and is based on a disease-oriented model that focuses on the individual. Mental illness cannot be viewed only from this western medical model if a holistic approach is a viable option in the mental health of Alberta's Aboriginal peoples. It is recognized, however, that although mental health services in Alberta have a history of following a medical model, new advances in treatment modalities and innovative service delivery practices such as solution-focused and narrative therapies and single-session brief therapy models are leading the way for strength-based and holistic models of mental health practice in western models of health care.

It is also important to note that what is culturally appropriate mental health programming for one group of Aboriginal peoples is not necessarily appropriate for another group. As previously described, there is much diversity of Aboriginal peoples in this province, which can be addressed through a decentralization of service planning.

Beliefs are complex systems with any group of people and encompass many areas including spiritual practices and beliefs about human life. Although diversity in cultural practices, languages, values, and belief systems is considerable among the Aboriginal peoples in Canada and in Alberta, there are many commonalities including a belief system based on the concept of holism. Simply stated, holism is the belief that all forms of life and all elements of creation are inter-connected, with each aspect affecting the others. Holism is evident in Aboriginal peoples' belief systems relating to life, health, and well-being.

Even though there is diversity among Aboriginal groups, the most common feedback received from the Aboriginal focus groups in the development of the PMHP (2004) was that Aboriginal people want the option to use and have available culturally appropriate mental health services that acknowledge the historical, colonial, and assimilative factors that impact them. More importantly, it is critical to validate Aboriginal practices on healing by making traditional healers and medicine available as a viable option in seeking help for mental health problems.

Traditional Concepts

The four traditional concepts of holism, history, spirituality, and relations must guide program development for Aboriginal mental health.

Holism Working within the context of the Aboriginal worldview, nature is qualitative and subjective rather than quantitative and objective. Holism is the guide to determining preparedness for task, timing, and balance of other factors. Holism is the medium for communication.

History Where it becomes more than longitudinal chronology, history is a major process of understanding. The analysis of history provides the perspective from which one examines Aboriginal and non-Aboriginal relationships formed, solutions sought, methods tried, and opportunities made for new developments.

Spirituality Spirituality is honoured in all life, and begins, exists within, without, and throughout all relationships.

Relations The Aboriginal concept of relatedness demands that every entity in the universe seeks and sustains personal relationships, and that the spiritual aspect of knowledge teaches that relationships are not left incomplete. This gives life to the traditional protocols that support the honouring of relations (adapted from Indian Association, Native Child Welfare, 1988).

Other Considerations

Other considerations include some of the following program components that have an integral place in service development and delivery related to Aboriginal people:

Accountability In the Aboriginal community, accountability is defined differently than the process within government and non-Aboriginal organizations. Communication with community members is based on protocols and procedures to ensure all partners are involved and consulted as initiatives are developed and implemented internal and external to the organization (For example, see Appendix A: *AMHB Aboriginal Research Protocols*).

Research, Evaluation and Service Delivery Projects Integral to any research, evaluation or service implementation project is the principle that Aboriginal people assume a leading role. In addition, a research guide needs to be developed or identified for the design, implementation, and dissemination of information. This guide should acknowledge Aboriginal cultural approaches and protocols that are identified and maintained within specific Aboriginal communities. Outcomes, indicators, and measures that relate to Aboriginal programs and services need to be developed in collaboration with affected Aboriginal communities.

Human Resource Capacity The development of a culturally competent workforce ensures that a comprehensive workforce plan reflects strategic priorities that encompass the unique needs of Aboriginal staff and consumers/clients. It recognizes the opportunities and benefits to the mental health system in training, hiring, retaining, and supporting a workforce that reflects the cultural diversity of local communities. Aboriginal staffing at every service level, including traditional healers and elders, is part of integrated service provision. Cultural awareness training and orientation is vital for mental health staff as well as other service providers (education, police, social services, children's services, etc.) in both facilitating access to mental health services and in providing services that support mental health/wellness.

Financial Resource Capacity Funding development requires strategies based on level of need for services equitable to non-Aboriginal peoples and communities. Issues of access, delivery, and capacity will inform the necessary level of resources required. Collaboration with existing partners such as health regions, Alberta Health and Wellness, Health Canada or local wellness centres can produce some creative strategies reflective of local needs and customs.

Integrated Community-based Service Delivery

Integrated community-based service delivery strategies to address the determinants of health and ensure that services are available and accessible in the communities where Aboriginal people reside are integral to successful mental health service provision. It also requires that an integrated, community-based service delivery strategies and systems are developed with culturally based mental health/wellness service providers who are educated to become culturally competent to serve Aboriginal people. Mental health providers can only create an environment of "cultural safety" for Aboriginal people if they have been trained to understand and accept the cultural, linguistic, tribal, geographical, economic, political, and community context of the various Aboriginal communities. Failure to grasp the significance of these contextual factors often leads to stigmatization, misdiagnosis, and inappropriate treatment. Capacity building approaches must identify the strengths and recognize the expertise within each Aboriginal family and community.

Unique Approaches Required

The above factors demonstrate the need for innovative and unique approaches to service development and delivery in addressing the mental wellness of Aboriginal peoples in Alberta. Jurisdictional complexity influenced by mobility and migration creates challenges in reducing and serving the Aboriginal community. A historical legacy which includes linguistic and cultural diversity creates unique regional dynamics for service provision. The importance of relationships with service providers and Aboriginal stakeholders is therefore critical. Strategic Directions focused on relevant action are required.

STRATEGIC DIRECTIONS FOR ACTION

STRATEGIC DIRECTIONS FOR ACTION

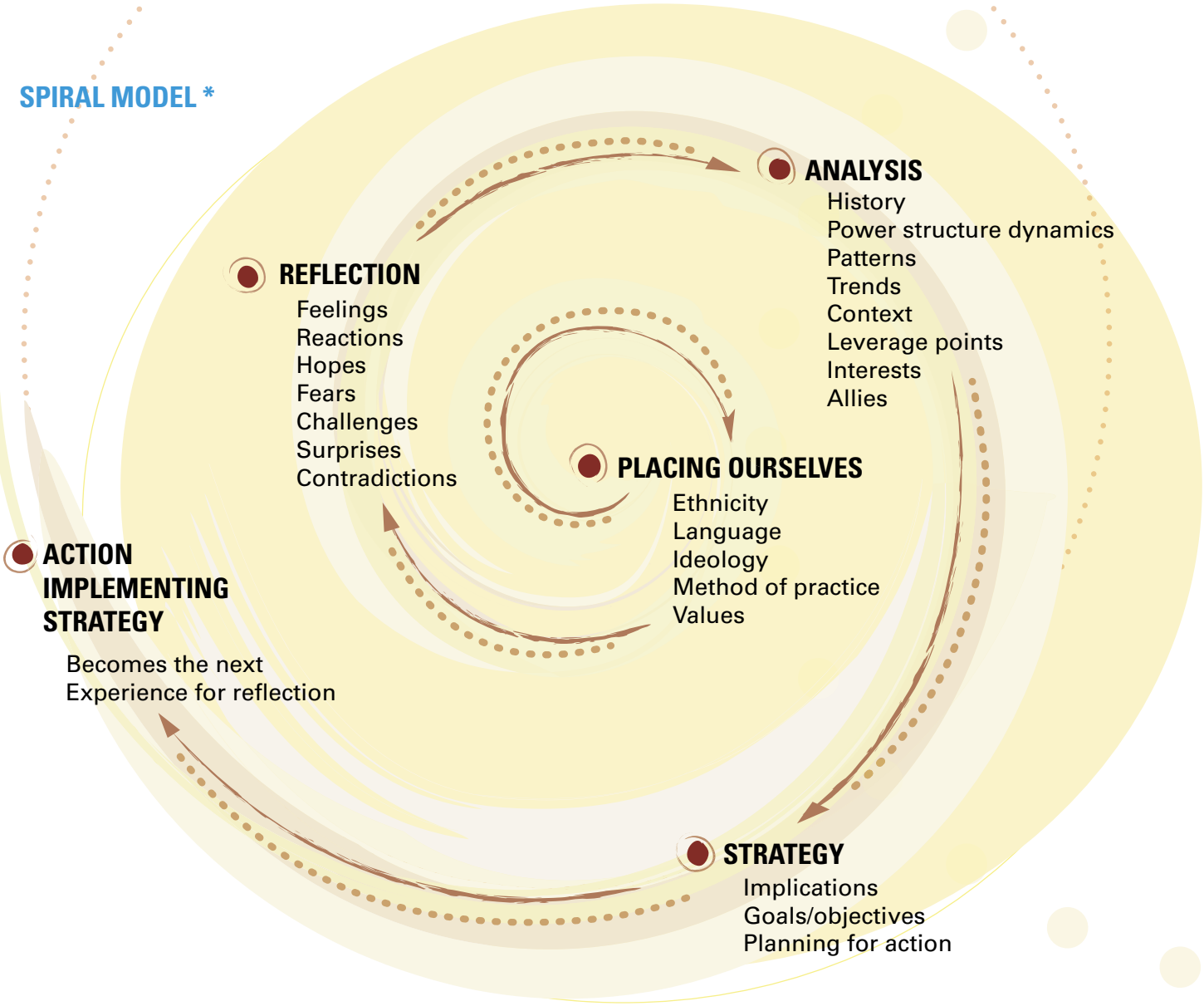
PROPOSED CONCEPTUAL MODEL

Mental health, as defined by Aboriginal people, is not separate from physical, emotional or spiritual health. The conceptual model presented is an integrated model of two conceptual models.

The medicine wheel or the life cycle is borrowed from the teachings of the medicine wheel or the circle of life in which balance and harmony must prevail. The model represents the unity which prevails on the AMHB Wisdom Committee by including representatives from First Nations, Inuit, and Métis peoples on the committee. This concept also facilitates the understanding of the purpose of the *Aboriginal Mental Health Framework*, in which the circle can be used as a conceptual guide for the development of mental health programs and services.

The Circle of Life can be conceptualized in various ways. The important elements are the components of *spiritual, emotional, physical and mental* aspects of planning and service delivery. which are reflected in each domain of the Spiral Model.

SPIRAL MODEL *



*The Spiral Model is adapted from Becoming an Ally Breaking the Cycle of Oppression by Anne Bishop, 2002, Fernwood Publishing, Halifax. Also called the Action-Reflection Model or the Conscientization Model Adapted from: The "Core Model" of Learning, Centre for Christian Studies, Toronto, Ontario CUSO Education Department, *Basics and Tools: A Collection o/Popular Education Resources and Activities* (Ottawa: CUSO, 1988) Arnold, Burke, James, Martin, Thomas, *Educating for a Change* (Toronto: Between the Lines, 1991)

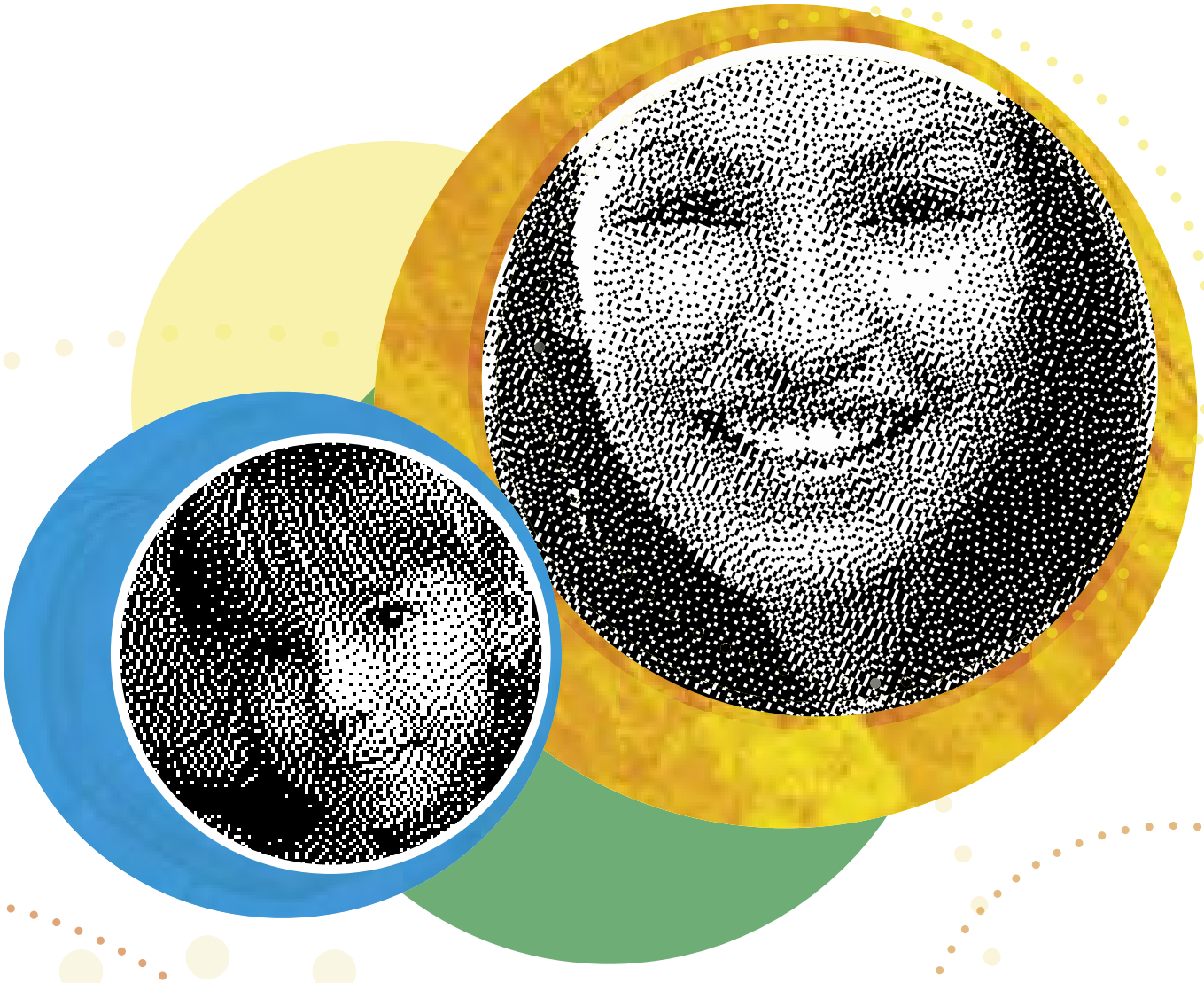
STRATEGIC DIRECTIONS

Strategic Directions were identified during focus group discussion for the development of the Provincial Mental Health Plan in 2003. They are captured as key points in the PMHP Appendix A (pp 34-35). The following strategic directions serve as a foundation for joint action planning to advance Aboriginal mental health.

1. **Service Development**
   - Integrated, community based service delivery
   - Culturally based wellness workers
   - Capacity building approaches
2. **Human Resources**
   - Comprehensive workforce to meet the cultural diversity of Aboriginal peoples and their unique needs
   - Cultural Awareness training for mental health professionals serving Aboriginal peoples
3. **Research and Evaluation**
   - Aboriginal people take a lead role in research, evaluation and planning
   - Develop a research guide (plan) that acknowledges Aboriginal cultural approaches and protocols
4. **Funding**
   - Equitable funding
5. **Data Collection and Information**
   - Need for more accurate data specific to the Aboriginal peoples (First Nations, Métis & Inuit) in health/mental health
   - Need to establish a system to monitor mechanisms to identify, monitor and reduce barriers to the mental health system used by Aboriginal Peoples

WHAT NEXT? A FRAMEWORK FOR ACTION

The next step for the AMHB Aboriginal Mental Health team is to bring this Framework to the Aboriginal communities and agencies, federal and provincial stakeholders, and the Regional Health Authorities. Dialogue will be facilitated with each stakeholder regarding the action steps needed to implement the strategic directions mentioned in the Framework. Each stakeholder needs to evaluate what their needs are for their region or community in terms of this Framework and its implementation process.



GLOSSARY AND REFERENCES

GLOSSARY

National Aboriginal Health Organization (NAHO)

- Created in 2000
- "Designed and controlled by Aboriginal people. Its mandate is to influence and advance the health and well-being of Aboriginal peoples through knowledge based strategies" (CIHI p.92).
- In 2001, Three Centres of Excellence specializing in the health of First Nations, Métis and Inuit were established.

Institute of Aboriginal Peoples Health (IAPH)

- One of 13 institutes of the Canadian Institutes of Health Research
- Established in 2000
- Its mandate "supports research to address the special health needs of Canada's Aboriginal Peoples" (CIHI, p.92).

Aboriginal Healing Foundation (AHF)

- Established in 1998 in response to the Royal Commission on Aboriginal Peoples (RCAP) report regarding the impact of the residential schools system. The federal government provided 350 million dollars to Aboriginal peoples towards the healing of the intergenerational impact of the physical and sexual abuse that occurred in these schools. All monies were to be dispersed by March 2003 and funded projects to be monitored and evaluated until 2008. No new dollars have been set up to continue with the healing (CIHI, p.92).

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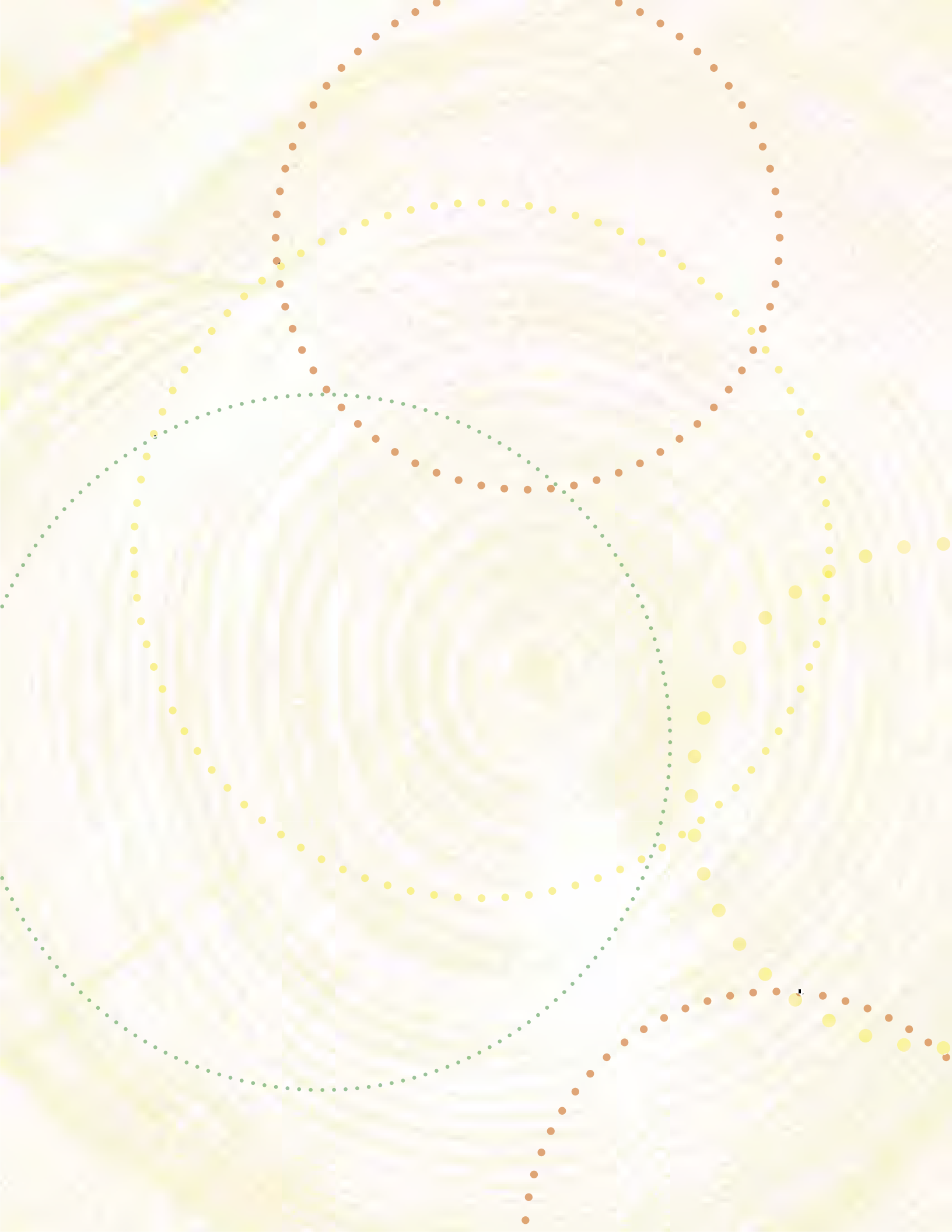


AMHB

ALBERTA MENTAL HEALTH BOARD

. . . Advancing Mental Health

MENTAL HEALTH STIGMA
IN CANADA

Mental health conditions are common in Canada.

1 in 4

Canadians have been diagnosed with a mental health condition

1 in 3

had a mental health concern disrupt their life in the past year

» took medication to cope

» missed social or family events

» missed work or school

2018 Ipsos Canadian Mental Health Checkup

Stigma can be worse than the condition itself.

stigma
/ˈstiɡmə/
noun

A set of **negative** and often **unfair beliefs** that a society or group of people have about something, which affect that group's attitudes, feelings, and behaviours.

Takes the form of:

- Discrimination
- Distrust
- Stereotypes
- Fear
- Embarrassment
- Anger
- Avoidance

> **Stigma affects us all. We are all vulnerable to the slow and insidious practice of dehumanizing others and we are all responsible for stopping it.**
>
> **Dr. Theresa Tam**
> **Chief Public Health Officer of Canada**

Stigma prevents people from seeking help.

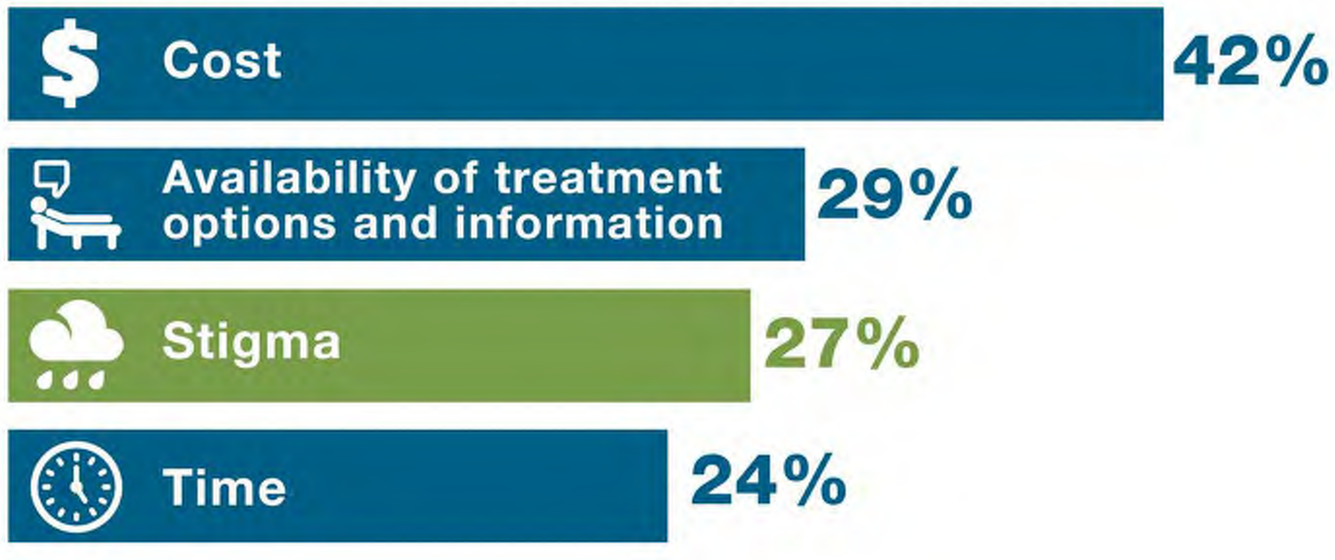
1 in 4 Canadians say

stigma is a barrier

to seeking help for mental health issues.

2018 Ipsos Canadian Mental Health Checkup

Top reported barriers to dealing with mental health issues



Stigma works at three levels.

Self stigma

People may believe the negative ideas about their condition, leading to:

- Shame
- Self-blame
- Hiding the truth

Public stigma

Society expresses their prejudices toward people who have the condition. This often takes the form of fear, blame, and unfair treatment.

Structural stigma

Prejudices within larger systems reinforce negative perceptions through things like insufficient resources and unfair laws and policies.

There are ways to fight stigma.

Learn about mental illness, addiction, and recovery.

Two good places to start are the Centre for Addiction and Mental Health tutorial **Mental Health and Addiction 101** and online course **Understanding Stigma**.

Choose your words carefully.

The words we use can affect others' attitudes, and reinforce negative and unfair beliefs.

Learn about stigmatizing language and what you can say instead.

Person-centric Language Guide
Stamp Out Stigma

Harm Reduction: Reducing Stigma
Alberta Health Services

Changing the Language of Addiction
Canadian Centre on Substance Use and Addiction

Treat everyone with dignity and respect.

Remember that **no one is defined by their condition.** Recognize that recovery is not a linear process, and looks different for everyone. **Support and encouragement go a long way toward recovery.**

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Alberta Health Services

Harm Reduction

Reducing Stigma

Two key strategies for addressing harmful, high-risk substance use or substance-use disorder include reducing stigma and harm reduction. People will continue to experience harm from substance use if stigma prevents them from seeking help.

What is stigma?

- A complex social process of labeling, stereotyping, devaluing, and discrimination
- Occurs on multiple levels:
  - intrapersonal (self-stigma)
  - interpersonal (relations with others)
  - structural (discriminatory or exclusionary policies, laws, and systems)
- Includes negative attitudes and the negative behaviours that result from those attitudes

The impact of stigma

- Stigma impacts care, treatment, and recovery from a mental health condition or substance use disorder.
- People living with mental illness or substance use say the stigma they face is often worse than the illness itself.
- People are dying alone because of the shame and stigma of substance use.

What does stigma look like?

- Biases
- Distrust, anger, or fear
- Stereotyping
- Labeling
- Avoiding
- Discriminating
- Shaming

Myths that contribute to stigma

- People living with a mental health condition or substance use disorder are dangerous.
- People who use substances are lawbreakers.
- Addiction is just a lack of self-control.
- Addiction is a moral failure.
- Stigma does no harm.

> Negative attitudes (prejudice) and negative behaviour (discrimination). These attitudes and judgments can affect how we think about, behave and provide care to clients.
>
> **Alberta Health Services**

Stigma prevents people from seeking help.

The role of healthcare providers

Small things can make a big difference and help a person feel hopeful and supported.

- Listen.
- Show compassion.
- Be understanding.
- Be kind.

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Alberta Health Services

Approaches to reduce stigma

- **Think of the patient as a person first.** Recognize the courage it took for them to seek help. Separate the person from the condition that brought them to you for care.
- **Know the facts.** Educate yourself and others about mental illness and addiction.
- **Be aware of your attitudes and behaviours.** We can change the way we think and act. See people as individuals, not as labels or stereotypes.
- **Focus on the positive.** Recognize and applaud people who are making positive changes despite their challenges.
- **Advocate for patients and their families.** Treat people with dignity and respect.
- **Include everyone.** Ensure people with mental health and substance use problems are given equal opportunities to take part in their own care.

Choose your words carefully

One way to reduce stigma is to change the way we speak about people who use substances and substance use itself.

- **Use people-first language.** Refer to the person before describing their behaviour or condition.
- **Use language that reflects the medical nature of substance use disorders.** Avoid terms that suggest that addiction is a moral or personality failure, rather than a medical issue.
- **Use language that promotes recovery.** Be optimistic, supportive, and respectful of people's autonomy.
- **Avoid slang and idioms.** These terms can have negative meanings and be stigmatizing.

Instead of saying this:	Say this:	Rationale:
• Substance/drug abuse • Problematic use • Misuse	• Substance/drug use • Substance/drug dependence • Substance/drug consumption • Substance use disorder (if diagnosed)	• Does not imply judgment
• Substance/drug user • Addict • Junkie • Druggie • Abuser	• Person who uses substances/drugs • Person with substance use disorder (if diagnosed) • Person with lived/living experience with substance use	• Refer to people as people first, not their use • Literal and neutral terms
• Person who is clean • Person who has been clean • Former addict • Former abuser • Former junkie • Former druggie	• Person in recovery • Person who is sober • Person who is abstinent • Person who has lived experience with substance use • Person no longer using substances	• Literal and neutral terms that do not imply judgment (for example, if someone is "clean" when sober, they must be "dirty" when using)
• Relapse	• Return to use	• Does not imply judgment
• Clean drug screen • Dirty drug screen	• Negative drug screen • Positive drug screen	• Medically accurate and neutral • Avoids slang

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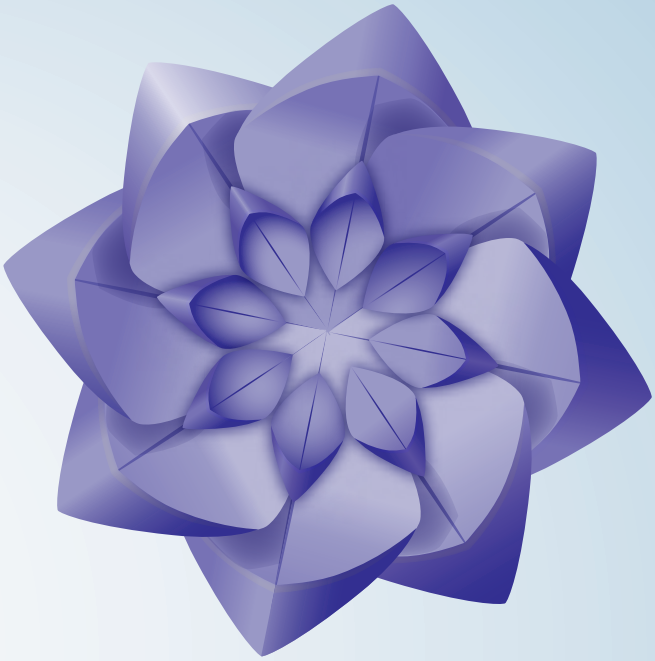

Opening Minds

Interim Report

November 18, 2013

www.mentalhealthcommission.ca

Mental Health Commission of Canada

Commission de la santé mentale du Canada

Acknowledgements

This report was prepared by the *Opening Minds* team, with contributions from principal investigators (in alphabetical order): Carolyn Dewa, Keith Dobson, Bonnie Kirsh, Terry Krupa, Bianca Lauria-Horner, Scott Patten, Heather Stuart, and Robert Whitley, and Mental Health Commission of Canada researchers and staff. The report summarizes the work of four research teams, as well as additional work being carried out by, or in conjunction with, *Opening Minds* to reduce stigma toward mental illnesses in Canada.

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Contents

Introduction 1

- Purpose 1
- About *Opening Minds* 1
- What is stigma? 2

Developing an Approach 3

- Program evaluations 3
- Choosing target groups 4
- Development of measures 5
- Forging partnerships 6
- Building networks of practice 7

Target Group: Youth 9

- Activities and findings to date 9
- Future directions 14

Target Group: Health Care Providers 15

- Activities and findings to date 15
- Future directions 18

Target Group: News Media 20

- Activities and findings to date 20
- Future directions 23

Target Group: Workforce 24

- Activities and findings to date 24
- Future directions 29

Development of a Rapid Response Stigma Module 30

Knowledge Exchange 32

Together Against Stigma International Conference 32
Global Alliance Against Stigma 33
Justice Symposia and Projects 33
Cafés Scientifique 33
Reports and Publications 34

Future Directions 35

Project Teams 38

References 40

Appendices

Appendix A – Youth Program Questionnaire 41
Appendix B – Health Care Providers Program Questionnaire 43
Appendix C – Workforce Program Questionnaire 44
Appendix D – *Opening Minds'* Partners 46
Appendix E – Logic Model For Youth Anti-Stigma Programs 49

Introduction

PURPOSE

This interim report on the activities of the Mental Health Commission of Canada's *Opening Minds* anti-stigma initiative, is intended to summarize activities to date, comment on lessons learned, and identify future work and challenges.

ABOUT *OPENING MINDS*

In 2006, Canada's Standing Senate Committee on Social Affairs, Science and Technology completed a national review of mental health and addiction services in Canada. It was the most extensive study of the mental health system ever undertaken in Canadian history. One of the key observations in its final report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness, And Addiction Services in Canada,* was that there was a lack of national focus on mental health issues. To address this gap, the Committee recommended that the Government of Canada create a Mental Health Commission.

The Mental Health Commission of Canada was then established in 2007 with the support of all federal parties. Funded through Health Canada, the Commission has a 10-year mandate to act as a catalyst for improving mental health systems and changing the attitudes and behaviours of Canadians with respect to mental health issues. In its role as a catalyst, the Commission has created partnerships to focus on key projects and make recommendations to governments, service providers, community leaders, and more.

In 2001, the World Health Organization declared stigma as the "single most important barrier to overcome." *Opening Minds*, one of the Commission's major initiatives, was created in response to the knowledge that stigma is also a major barrier to people seeking help. Many describe stigma as more life-limiting and disabling than the illness itself.

Opening Minds recognizes that stigma is primarily a problem of behaviours resulting in the unfair and inequitable treatment of people with a mental illness and their family members. Thus, the goal of the initiative is to effect change that will result in tangible improvements in the day-to-day lives of those living with a mental illness.

The Hallway Group

To truly understand how harmful stigma can be, you need to talk to the people who have experienced it. And to really beat stigma, you need to go back to those same people for help.

Opening Minds knew its work to reduce stigma could never succeed unless it regularly consulted directly with the people it was doing this work for — Canadians living with mental illnesses and their families.

For that purpose, *Opening Minds* led the development of the Hallway Group. It consists of 10 people from across Canada with lived experience of a mental illness. Together, they provide us with feedback and suggestions about the work we are doing. Their support and advice is of incredible value to us.

The group is named for the informal conversations that continue in the hallways between formal meetings. Not surprisingly, those casual chats are often considered to be the most productive, and they happen around the table when the Hallway Group meets.

Additionally, our initiative is helping Canada to meet international obligations. The United Nations Convention on the Rights of Persons with Disabilities, to which Canada is a signatory, requires parties to raise awareness about the rights of people with disabilities, foster respect, combat stereotypes, prejudices, and harmful practices. *Opening Minds*, through its anti-stigma activities, helps Canada meet its obligations under that Convention.

WHAT IS STIGMA?

Opening Minds identifies stigma as a complex social process involving many parts, all of which work together to marginalize and disenfranchise people with a mental illness and their family members. Based on the recognition that stigma is primarily a problem of behaviours resulting in unfair and inequitable treatment, *Opening Minds* is working in part to cultivate an environment in which those living with a mental illness feel comfortable seeking help, treatment, and support on their journey toward recovery.

Stigma is enacted at three levels: self-stigma; public stigma; and structural stigma[2].

Self-stigma occurs when people with a mental illness accept and agree with negative cultural stereotypes. They feel ashamed, blameworthy, and try to conceal their illness from others. This may include avoiding situations that may elicit stigmatizing responses. Stigma avoidance is thought to be one of the key reasons why the majority of people who meet the criteria for a mental illness do not seek care[3].

Public stigma encompasses the prejudicial attitudes and discriminatory behaviours expressed toward people with a mental illness by members of the public. Public stigma is based on deeply held prejudices that are, by definition, resistant to change. Cultural attributions that fuel public stigma include the ideas that people with a mental illness can never recover; they are violent and unpredictable; they are blameworthy and could control their illness.

Structural stigma occurs at the level of institutions, policies, and laws. It creates situations in which people with a mental illness are treated inequitably and unfairly, for example when they are denied their basic human rights, or when policy agendas do not give mental health issues high priority.

Developing an Approach

Where and how does one begin to tackle such a pervasive and challenging problem as stigma?

If *Opening Minds* was to follow in the footsteps of a number of countries, the answer would have been to launch a large, expensive social marketing campaign. And yet, such campaigns often end up with little in the way of results to show for their hard work and many dollars spent.

When the Mental Health Commission was first developing the *Opening Minds* initiative, it planned to incorporate a media campaign in its efforts, and began with a small, public education campaign launched in 2009. During this campaign, *Opening Minds* reached out to a variety of media sources to transmit positive messages concerning people who have a mental illness.

The results were disappointing and we knew it would not be cost-effective to undertake a larger, long-term media campaign when there was no hint from our data that we would achieve positive results. In the interim, we had discovered there are already hundreds of anti-stigma programs being delivered in communities across the country. Few of these had ever been formally evaluated to see if they were actually working, and in that we recognized a tremendous opportunity. We knew what *Opening Minds* needed to do; identify these programs, evaluate their effectiveness, develop anti-stigma program tool kits based on these findings, and work with partners to replicate these programs across the country. There is also evidence suggesting that anti-stigma initiatives need to be tailored to the audience being targeted — and we have incorporated this finding into our work.

In comparison with social marketing and public awareness campaigning, our more focused, grass-roots approach is much more cost-effective and sustainable over time. And unlike the former, this approach is actually capable of getting the results needed — changes in Canadians' attitudes and behaviours toward people with a mental illness.

PROGRAM EVALUATIONS

In order to build on these existing programs, *Opening Minds* has coordinated and is funding a series of evaluation projects. These projects evaluate anti-stigma programs aimed at one of three target groups: youth, health care providers, and the workforce. The goal is to understand the best or promising practices in the field, then create resources and toolkits that could be made available on a national (or international) scale to other communities and stakeholders who wish to begin their own anti-stigma efforts. In this way, the central operating tenet of the *Opening Minds* initiative has been to identify, document, and disseminate leading practices in stigma reduction using networks of existing programs as community leaders.

Opening Minds recruited principal academic investigators for each target group and assigned research associates to support the evaluation activities. Program representatives agreed that projects delivering similar interventions would use similar evaluation strategies with common assessment tools (questionnaires). In this way, outcomes could be compared across settings to help determine which program activities would yield the greatest effects.

Participants would be tested before and after their exposure to the anti-stigma intervention being evaluated. In some cases, they were tested again a few months after participating in the program to determine if the changes were sustained.

CHOOSING TARGET GROUPS

The stigma surrounding mental illnesses touches Canadians in every demographic and in every corner of the country. Anyone can stigmatize and anyone can experience stigma. *Opening Minds* had the challenge of deciding which of these many individual groups to begin targeting with its anti-stigma work, while keeping in mind the goal of effecting positive change in the lives of all Canadians with mental illnesses.

Based on feedback received in the 2006 national consultation undertaken by the Senate Committee on Social Affairs, Science and Technology, the Mental Health Commission of Canada identified youth and health care providers as key audiences for anti-stigma efforts. Two more groups were later added, resulting in these four initial target groups:

Youth 12-18

The majority of adults living with a mental illness say their symptoms developed before they were 18 years old. Young people are at a high risk of being stigmatized and the fear of stigma often delays diagnosis and treatment; therefore, early intervention can make an enormous difference in the quality of life of an individual. A major survey conducted by *Opening Minds* in partnership with Statistics Canada found that youth are the group in the Canadian population most affected by stigma. Nearly 60% of youth 25 years of age and under, treated for a mental illness in the past year, reported being affected by the impact of stigma compared to fewer than 20% of adults 45 years of age and over.

It has been estimated that one in five Ontario youth will meet the criteria for a mental disorder each year[4]. There is also some evidence that Canadian youth may experience higher levels of emotional distress than youth in other countries. In a multi-country study conducted by the World Health Organization, Canadian students were among the most likely to report feeling depressed for a week or more, with estimates ranging from a quarter to over one third, depending on age and gender[5].

In our work to identify, evaluate, and then replicate successful anti-stigma programs for young people, we are hoping to create help-seeking and supportive environments for our youth in their schools and among their peers.

Health Care Providers

People who seek help for mental health problems report that they often experience some of the most deeply felt stigma from front–line health care personnel. Research shows stigma and discrimination in health care to be a major barrier to access, quality care, treatment, and recovery. For example, people using mental health services often say they feel "patronized, punished or humiliated" in their interactions with health professionals[6].

This stigmatizing behaviour is often unintentional, as many health care providers are unaware that the language they use or the actions they take can be harmful to people with lived experience of mental illness. Negative attitudes and stereotypes, prognostic negativity (pessimism about a person's chance of recovery), diagnostic overshadowing (the tendency to misattribute unrelated symptoms and complaints to the person's mental illness), marginalization (not wanting to treat psychiatric symptoms in a medical setting), lack of training and insufficient skills are among the key concerns for this target group[6,7,8,9,10].

The News Media

Research from across the western world indicates that the public relies on the media as one of its main sources of information about mental health and mental illnesses[11]. This includes newspaper articles, television broadcasts, radio broadcasts, and internet sites.

The accumulated findings of this research suggest that the news media play an important role in creating and maintaining some of the popular stereotypes that are associated with

people with a mental illness. Such stereotypes can influence societal reactions to people with a mental illness[12]. On the one hand, a glut of articles about crime and violence vis-a-vis mental illnesses may lead to fear and avoidance of people living with a mental illness by the general public. On the other hand, a series of articles that focus on recovery and rehabilitation of people with a mental illness may lead to a more kindly and compassionate reaction.

The Workforce

One out of every four or five employees is affected by a mental health problem every year. Many individuals may experience anxiety, depression, and other mental health problems during their prime working years[13], resulting in sick leave and limited productivity. And many workers choose to go untreated rather than risk being labeled as "unreliable, unproductive, and untrustworthy".

In concert with the toll that mental illnesses have on individuals and their families, their effects on the Canadian economy are enormous, estimated to be at least $50 billion per year. Short-term and long-term disability claims related to mental health account for 30% of all work-related disability claims[14] and cost organizations approximately double the average ($18,000 vs. $9,000) of a non-mental health related disability claim.

The Mental Health Commission of Canada recently identified improving mental health in the workforce as one of its key priorities moving forward in its mandate. This year, it launched the *National Standard of Canada for Psychological Health and Safety in the Workplace*, a voluntary standard to help employers foster healthier work environments. Additionally, the Commission's Mental Health First Aid program continues to expand its reach into more businesses and organizations to train employers and employees how to recognize emerging mental health problems or crises and provide early help. *Opening Minds* works in collaboration with these and other initiatives targeting the workforce to help ensure stigma is considered in every aspect of our approach.

DEVELOPMENT OF MEASURES

As a building block to evaluation, one of *Opening Minds*' first major tasks was to develop reliable and valid methods of testing peoples' attitudes and behavioural intentions toward people with a mental illness before and after exposure to an anti-stigma program.

Researchers collected and studied many of the homegrown questionnaires that grassroots anti-stigma programs were already using, as well as those reported in scientific literature, when available. Each research team (health care, youth, and workforce) developed and strategically tested a number of different assessment measures (questionnaires).

Youth: The youth research team developed two 11-item scales. The first measured stereotypic attributions (controllability of the illness, potential for recovery, and potential for violence and unpredictability) and the other measured behavioural intentions related to social acceptance (desire for social distance and feelings of social responsibility for mental health issues). Questions were worded to be accessible to a grade six reading level.

Health Care Providers: In developing a questionnaire for this target group, it was important that we would be able to capture attitudes and behavioural intentions in relation to phenomena unique to that target group, such as diagnostic overshadowing and prognostic negativity, as mentioned previously. It was also important to be able to learn their perceptions of competence and personal control among people living with mental illnesses, and the extent to which the health care providers feel they have a role or responsibility as advocates for such.

Workforce: In the case of the workforce, two separate questionnaires were ultimately developed and used. The first is a 23-item questionnaire to assess employees' stigmatizing attitudes, beliefs, and behaviours in the workplace towards co-workers who may have a mental illness. The second questionnaire was derived from existing items from various studies[15,16,17] and assesses stigma-related attitudes specific to the supervisor role. The latter was considered necessary as a separate questionnaire, as supervisors have distinct duties and challenges when dealing with an employee with mental health issues.

A questionnaire for each target group is included as an appendix in this document.

FORGING PARTNERSHIPS

Opening Minds identified potential partner programs targeting youth and health care professionals by issuing a Request for Interest (RFI). In 2009, the RFI was distributed widely through various mental health networks, institutions, associations, and individuals. We received nearly 250 requests; 44% were programs focusing on youth audiences and 56% focused on health care professionals.

To review the applications, *Opening Minds* formed an impartial selection committee comprised of national and international experts, including people with lived experience of a mental illness, family members, researchers, policy makers, mental health advocates, and anti-stigma experts. Based on knowledge of promising practices in the literature, priority was given to programs that:

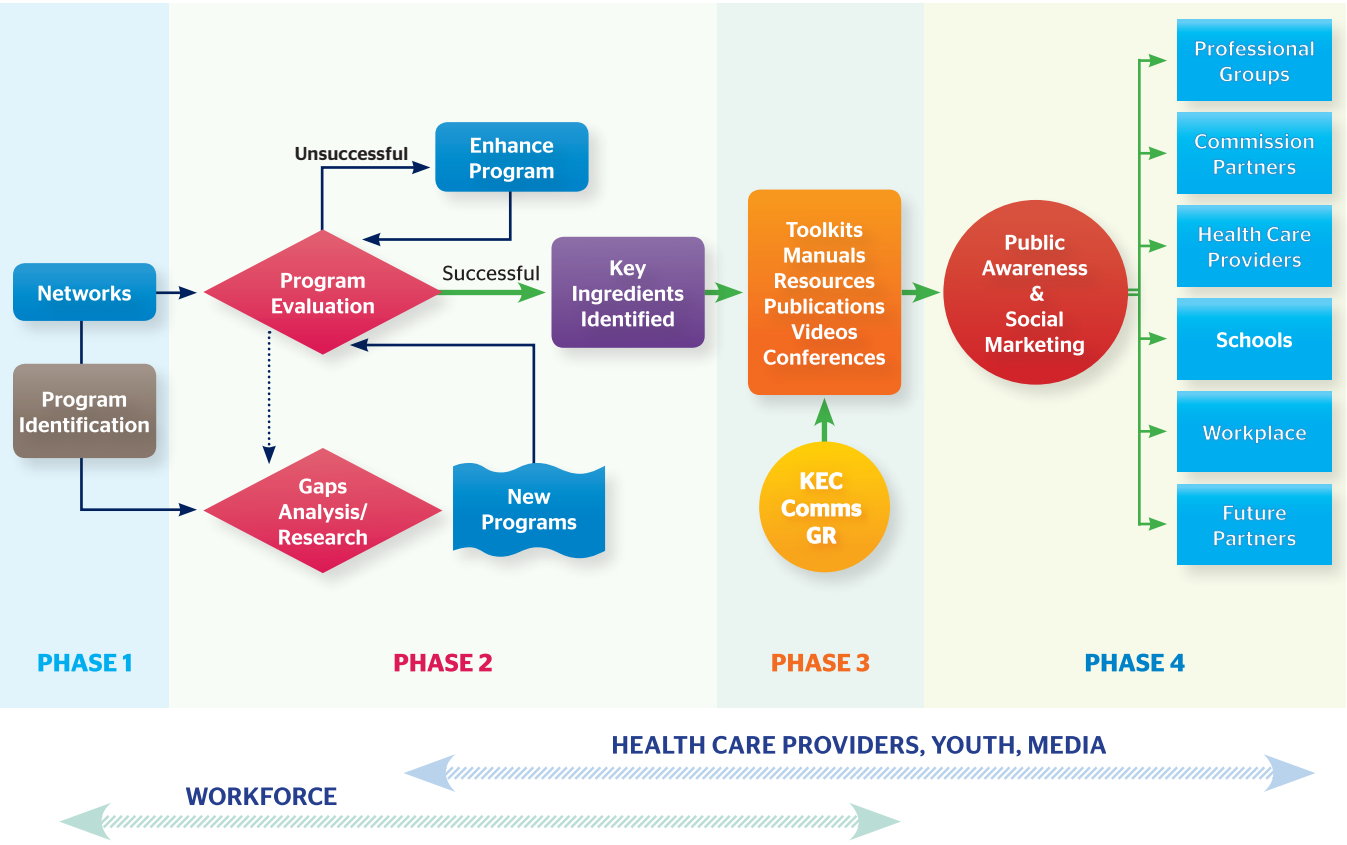
- Were contact-based interventions in which people with lived experience of a mental illness were involved in the delivery of the program. Typically, contact-based education involves trained speakers who share their personal story of recovery and engage audiences in active discussion.
- Had stable funding so that the program would not be in jeopardy of closing during the life of the *Opening Minds* initiative. Just over half (54%) of the youth programs and 57% of the health care provider programs indicated they had stable funding.
- Had been evaluated and shown to be effective. Unfortunately, less than half of the programs responding to the RFI indicated they had been evaluated. Of the programs that had undergone evaluation, the majority had examined customer satisfaction rather than changes in stigma.
- Had the potential to be widely disseminated if demonstrated to be effective.

In terms of forging partnerships with the media over a three year period, we tried numerous approaches, including owners, publishers, associations, and unions. We finally made a connection with the Canadian Journalism Forum, which was doing related work with journalists in the area of looking at post-traumatic stress disorder.

Forging partnerships with businesses and organizations to evaluate workforce anti-stigma programs proved to be considerably slower and much more challenging. We have largely developed partnerships with employers through existing partners, for example Alberta Health Services, or by directly canvasing groups and employers we knew had an interest.

The *Opening Minds* process model in Figure 1 below summarizes the phased-in approach taken.

Figure 1: *Opening Minds* Process Model



In Phase 1, programs are identified.

In Phase 2, evaluations are conducted and work undertaken to enhance programs. This phase in the process also enables us to identify potential gaps and difficult-to-reach groups. Ingredients key to the success of programs are identified.

In Phase 3, toolkits, manuals, and other resources are developed based on the most successful approaches identified in the evaluations.

In Phase 4, when successful products are available, we will use techniques such as social marketing and public awareness campaigns to make these products widely available and to assist in replicating successful programs throughout Canada.

BUILDING NETWORKS OF PRACTICE

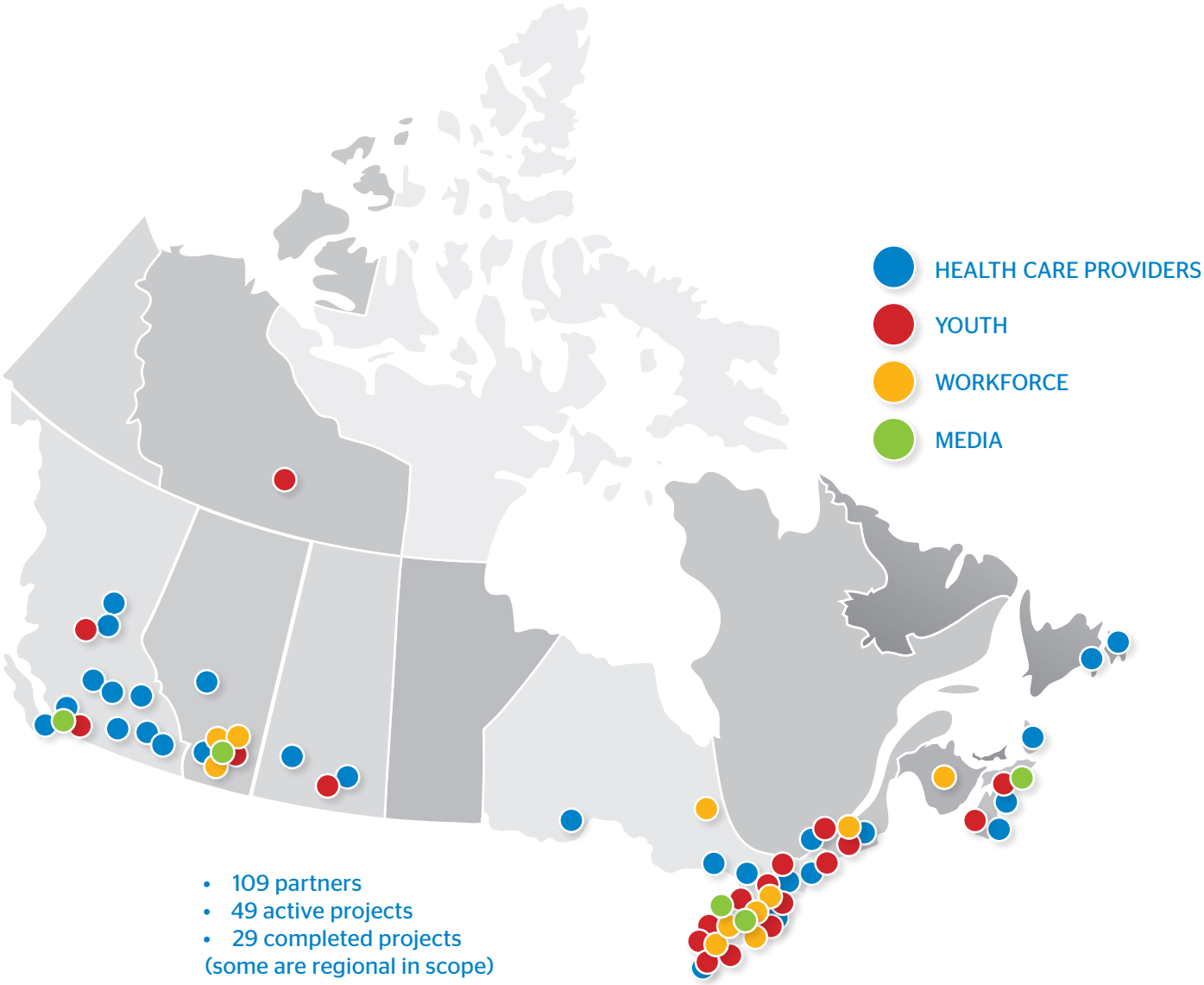
Opening Minds determined that a key element of its approach would be to foster networks of practice, so local programs that were demonstrated to be effective could develop a wider reach and contribute to a national effort, and program leaders could act as mentors to newly developing programs.

Opening Minds is now working with more than 100 partner organizations. At least half of those partners are or have been involved in developing and evaluating contact-based anti-stigma programs that have the potential to be broadly disseminated once they have been demonstrated to be effective.

Fostering grassroots initiatives and working with university-affiliated researchers to develop evaluation networks are key components of the *Opening Minds* strategy. We have partnered with a multi-disciplinary team of junior and senior academics at The University of Calgary, Queen's University, the University of Toronto, McGill University, and Dalhousie University. This is the only anti-stigma program worldwide with such a broad base of academic support. For a list of all of *Opening Minds*' more than 100 partner organizations, please refer to Appendix D.

Figure 2 below illustrates the dozens of program partnerships occurring across the country. A list of all of the programs and the status of their evaluations can be found online at **http://www.MentalHealthCommission.ca/English/OM-Programs-by-Province**

Figure 2: Geographical Breakdown of *Opening Minds* Projects



Target Group: Youth

ACTIVITIES AND FINDINGS TO DATE

The *Opening Minds*' youth research team is nearing completion or has completed evaluation and data analyses of more than 20 anti-stigma programs and surveys of 10,000 Canadian youth. The researchers have identified a number of programs that have shown positive results, and *Opening Minds* has already begun work on replicating some of these programs in other communities.

COMMUNITY DEVELOPMENT APPROACH

Opening Minds has partnered with programs that are currently in the field delivering anti-stigma messages to students. By involving them in an evaluation network, we have encouraged them to critically reflect on their evaluation data in a way that will strengthen their interventions. Based on their findings, two programs discontinued their approach, another made important changes to the speaker selection and training, and the remaining programs deliberately tried to improve areas where they considered they were not achieving the desired level of improvement. Based on their experiences, program personnel have become leaders for their peers. This approach promotes sustainable development.

LARGEST EVALUATION DATASET

Our evaluation work is based on the largest dataset of its kind for this work, with more than 10,000 students from across Canada represented. This means that results are more generalizable than results from smaller, local efforts.

All programs are implementing similar interventions (contact-based education), but are doing it in slightly different ways. The variation that is visible by using the same questionnaire for each program has allowed us to begin to understand what activities and supports are needed to maximize positive outcomes.

HIGH LEVEL RESULTS

Figure 3 on the next page shows the results on the Stereotype scale for 15 programs. It shows the proportion of students who received an A-grade (reflecting 80% of the questionnaire items correct) on the pre- and the post-test. The difference between the bars illustrates the amount of improvement. It shows that large changes (25-30%) occurred for several programs, which highlights them as the best in class. It also shows that several programs did quite poorly with little or no change.

70% of adults living with a mental illness say the onset occurred before age 18

Early intervention can make a dramatic difference in a child's quality of life

Only one in six children diagnosed with a mental health problem will get treatment

40% of parents say they would not admit to anyone, not even their doctor, that they had a child with a mental illness

Figure 3: Proportion of Students Who Received an A-Grade (80% correct) on the Stereotype Questionnaire by Program

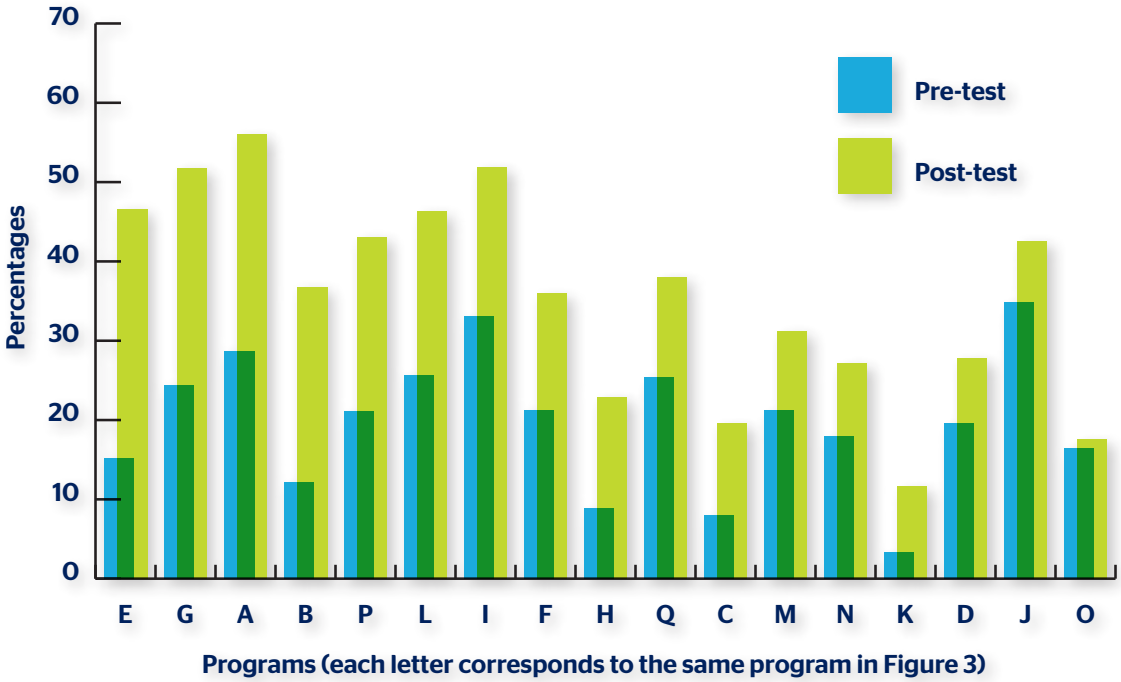
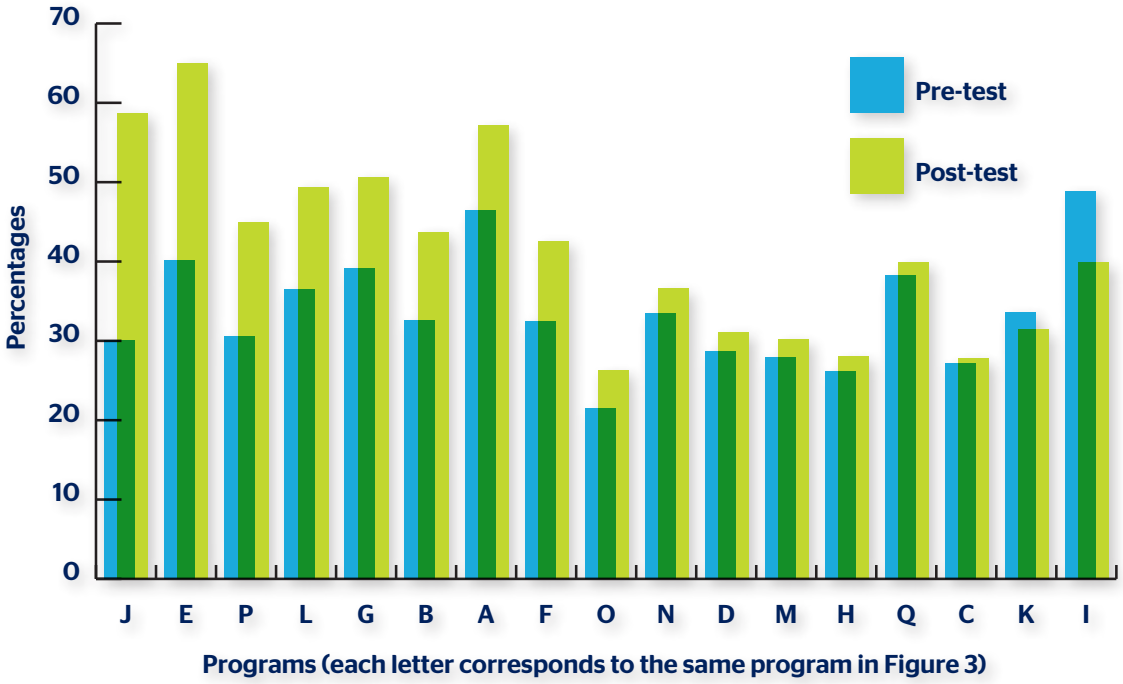


Figure 4 on the following page shows the results on the Social Acceptance Questionnaire for the same 15 programs. It shows that, on average, the changes in social acceptance were smaller than the previous measure. It also shows that two programs were able to create large changes, in the order of 25% to 30%. These programs were also the ones that showed the largest change in the Stereotype Questionnaire, making them the most effective, overall, in reducing stigma. It also shows that several programs were unable to improve social acceptance.

> "...when [students] see us and when they meet us ... they can see that we're just like everyday average citizens. They have a live example in front of them of what is ... a person with mental health issues. We just need to tell them that stigma is wrong, you know, it's morally wrong."
>
> **Speaker with lived experience of mental illness**

Figure 4: Proportion of Students Who Received an A-Grade (80% correct) on the Social Acceptance Questionnaire by Program



IDENTIFYING A NEED FOR SUPPLEMENTAL PROGRAMS

Though we have been unable to collect follow-up data, we have every reason to believe that effects of individual programs will dwindle over time. For this reason, the research team has recommended that, in addition to a solid foundation of contact-based education, schools should consider implementing additional 'booster' activities that occur at regular intervals throughout the year to consolidate and improve effects.

ROLLING OUT SUCCESSFUL PRODUCTS AND REPLICATING PROGRAMS

Opening Minds is already disseminating its research on youth anti-stigma programs so that other groups and organizations may benefit from what we are learning. We are also planning to roll out some of the most successful products and replicating some of the most promising programs in communities across the country.

Below are examples of just some of the high-performing programs that have been identified by the *Opening Minds* research team, along with information about how we are helping to expand their reach into other communities across the country.

1. **Durham Talking About Mental Illness (TAMI) Coalition –** While this multi-faceted program was originally developed by the Centre for Addiction and Mental Health in Toronto more than a decade ago, this particular version has been enhanced over the years by the Ontario Shores Centre for Mental Health Sciences in Whitby, Ontario, with help from a strong local coalition of organizations. One part is a five class learning curriculum for grades 7-12, that includes a professional development workshop for teachers. Another program is a stigma summit, a one-day event bringing together students and teachers from various high schools to receive education and experiential exercises. Contact-based education with speakers who have lived experience of mental illness is central to all program components.

Our activities – *Opening Minds* has replicated the Durham TAMI five class curriculum program in elementary and high schools in Yellowknife and Winnipeg. Plans are in development for a major national summit to facilitate the upscaling and replication of this model. We are also working to incorporate the best elements from other TAMI/contact-based education programs (such as CMHA Champlain East and Beautiful Minds) into our overall process model and toolkits.

2. ***Iris the Dragon*** **Series –** *He Shoots. He Scores* is one of the *Iris* books for children that were created in Perth, Ontario, to address children's mental health challenges in a non-threatening and supportive way. It uses the personal story of the main character to simulate contact with someone who has had a mental health challenge (termed 'indirect contact'). It showed positive results in reducing stigma among students. The *Iris* books help educate readers about mental health and wellness, at the same time showing how a caring community can support children to reach their potential, tackling several topics, including Bipolar, Anxiety Disorder, ADHD, and Asperger's Syndrome.

   Our activities – *He Shoots. He Scores* is now available online and free of charge, so *Opening Minds* is beginning to promote and share it with schools across the country.

3. **Partnership Program –** This is a panel presentation for high school students in Saskatoon and Regina, Saskatchewan, that aims to reduce the stigma and misconceptions associated with mental illness. Teams of three people — a person living with schizophrenia, depression or bipolar disorder, a family member who has an ill relative, and a mental health professional — share their personal stories. The mental health professional also provides a clinical overview of the illness. A discussion follows.

   Our activities – *Opening Minds* will share the successful results of the Partnership Program with other Schizophrenia Societies across Canada, and other similar stakeholder organizations.

4. **Dream Team –** This Ontario-based program is delivered by a group of people with lived experience in mental health and addictions issues. Dream Team members take their message to youth in schools and universities, as well as other populations, to increase awareness about the lives of people with mental health issues and their contributions to the community.

   Our activities – Dream Team is a program that is unique to Toronto, but one that could serve as a model to other community groups in Canada. *Opening Minds* will connect any interested group directly with the Dream Team.

5. **mindyourmind –** This youth website based in London, Ontario, developed an online program for Grade 11 students that provides information about mental illness, resources, first person stories, and interactive coping tools. The objective is to improve knowledge about mental health and reduce stigma and other barriers to youth seeking help.

   Our activities – There are proprietary challenges surrounding this program, but we are working with mindyourmind to determine how it can be shared broadly. The program will be incredibly useful to schools throughout the country; students in any school can do it and the content can be easily tailored for different youth populations and school requirements.

Detailed reports on each of these programs are available at **http://www.mentalhealthcommission.ca/English/initiatives-and-projects/opening-minds**

SOME LESSONS LEARNED SO FAR

The research team has already identified some key lessons from its evaluations and data analysis. Some of these lessons are listed below.

- Not every program is successful and some can do harm by concretizing negative stereotypes and provoking negative change.
- Short one-off interventions don't allow for the engagement and the active participation that is needed to maximize change. Programs need to think about sustainable change using the in-class portion as one component of a whole-school anti-stigma strategy, including booster sessions and other student-led activities.
- A cornerstone of contact-based education is a story told by someone who has experienced a mental illness, but we have learned that not every story is a good story. Stories have to have a consistent theme of hope and recovery.
- Not every person is a good storyteller. The best storytellers can engage their audience and allow for active participation through questions and discussion. They are psychologically ready to share their experiences and open to discussion. This takes considerable training and support.

These and other lessons learned with respect to mounting a successful school-based anti-stigma program are summarized in a logic model, an example of which appears in Appendix E. It was developed following detailed qualitative inquiry of 18 programs from across Canada, and in-depth interviews with three speakers with lived experience and one family member. The logic model will be further developed to create a set of quantitatively-verified criteria that can be used by new and existing programs to assess their fidelity to the best or promising practice in contact-based education. This work is expected to be completed in the fall of 2013. The model and toolkits will be made available on the *Opening Minds* website.

In both youth surveys, students are presented with a number of statements and asked to indicate whether they agree or disagree, and to what degree.

Sample statements from the Stereotype Questionnaire:

- People with serious mental illnesses need to be locked away.
- You can't rely on someone with a mental illness.
- Most people with a mental illness get what they deserve.

Sample statements from the Social Acceptance Questionnaire:

- I would be upset if someone with a mental illness always sat next to me in class.
- I would not be close friends with someone I knew had a mental illness.
- I would try to avoid someone with a mental illness.

FUTURE DIRECTIONS

The logic model and large database of program outcomes make it possible for the research team to use quantitative analysis to better identify the key characteristics that make a successful anti-stigma youth program. The resulting criteria can assist new and existing programs to ensure that they are in line with best or promising practices.

As *Opening Minds* helps to further replicate successful programs, we have an opportunity to work with schools to collect comparative data. This will allow us to strengthen our inferences regarding program effects. One school district in Winnipeg has already agreed in principle to let the program staff collect data on children who have not received the intervention (a wait list control).

We don't know why some students change more than others (and some not at all). In future work, it will be important to isolate predictors of change so that programs may be more precisely targeted to students' learning needs.

Now that we have identified successful program approaches, it will be important to assess the business case. This means we will have to be able to document the cost of presenting a successful program, as well as the return on investment for students and schools. *Opening Minds* has an economist on its team, so the major challenge will be finding a school that will let us access its student data in order to determine costs and returns.

The research team has not had much opportunity to study primary school students, but believes it is important to reach children as early as possible, before stereotypes become concretized. We need to think about how contact-based principles could be incorporated into elementary schools in age-appropriate ways.

We have also identified a number of additional populations for which specific and tailored interventions do not exist (including Aboriginal youth and multi-cultural youth). Future work will need to translate the successful contact-based approaches so that they are appropriate for these additional populations.

Target Group: Health Care Providers

ACTIVITIES AND FINDINGS TO DATE

Opening Minds' health care providers research team is nearing completion or has completed evaluation and data analyses of more than two dozen anti-stigma programs targeting this group. The researchers have identified many programs that have shown positive results in reducing stigma within this group. *Opening Minds* has already begun work on replicating some of these proven programs in other communities.

The researchers have incorporated a qualitative component into their evaluation to examine anti-stigma programs in greater depth and detail. So in addition to the questionnaires given to participants before and after their exposure to a program, researchers are conducting in-depth interviews with the program facilitators, program developers, people with lived experience of a mental illness, and more. This is enabling us to better identify best or promising practices and processes, and to gain further theoretical understanding of the process of building a successful anti-stigma program for health care providers.

PROGRAMS SHOW POSITIVE RESULTS OVERALL

There is strong overall evidence of positive change for the health care provider programs we are evaluating. Thirteen of the programs have shown to have led to statistically significant improvements in participants' intended behaviours. All but two programs have demonstrated some level of positive change from pre-to post-program.

Among the programs evaluated to date, those which emphasize social contact with people with lived experience of a mental illness, as well as programs emphasizing skills training for health care providers in treating and interacting with people who use mental health services, have both been shown to be effective. Skills training might work well with other groups, for example, teachers, police, and leaders in the workplace, but, as yet, we have no data to support this theory.

Stigma is one of the key barriers preventing many people from getting help

Many say living with stigma is worse than the illness itself

Some of the most deeply felt stigma comes from front line health care professionals

Many people who seek help for mental health concerns feel disrespected and discriminated against by them

Some Other Key Findings

Short programs can work just as well as longer programs, if designed and delivered properly.

Programs may be more likely to be successful if they make use of multiple forms of contact-based education, such as live personal testimony, as well as video.

"One-off" programs are unlikely to sustain the positive change, so programs should hold additional sessions over time.

Successful programs tend to have some type of incentive or expectation for participation, such as education credits, paid-for time, or position back-filling.

Preliminary findings from our qualitative research provide some possible key factors for successful program design, regardless of whether the program is focused primarily on contact-based education or skills training. Some of these emerging key factors include the following:

Put the person ahead of the illness. Combating stigma requires health care providers to make the connection and see the person behind the diagnosis.

Demonstrate recovery and competence. If anti-stigma programs are to be effective, they need to highlight that recovery is both possible and probable. One way to do this is through social contact with people with lived experience of a mental illness who can speak about their own journey of recovery.

Teach health care providers what to do. Another emerging theme is that health care providers often feel ill-trained in the field of mental illness; they don't know how to help. Healthcare providers' sense of helplessness is likely to contribute to stigma[9].

Find a passionate champion who models anti-stigma. A program's success may also have something to do with the champion(s) designing and delivering the program.

PROGRAMS MAY HAVE GREATER IMPACT IF FOCUSED ON A SPECIFIC ILLNESS

Programs targeting a specific type of mental illness may see a greater reduction in stigma towards that specific illness rather than towards mental illness in general. For a program on borderline personality disorder, researchers used both the original questionnaire they had created for health care providers, and a second version in which each instance of the term 'mental illness' was replaced with the term 'borderline personality disorder'. The program showed a statistically significant positive effect on both versions of the questionnaire. However, the amount of change after exposure to the program was much greater for the specific illness of borderline personality disorder than it was for mental illness in general.

DISCOVERING DIFFERENCES AMONG PROGRAMS

The research team is finding considerable differences among the various programs being evaluated, such as their amount or type of social contact provided. This diversity provides a valuable opportunity to learn about what contributes to successful programs and initiatives.

REACHING SOME ADDITIONAL POPULATIONS

To begin to reach additional populations we are partnering with three large Community Health Centres (CHCs) in Toronto, which are developing and implementing an anti-stigma and pro-recovery intervention, with particular focus on immigrant populations from Africa, Latin America, the Caribbean, and other minority

populations including Asian and South Asian. The CHCs will clarify the stigma of mental health problems and substance use issues among these populations, and use their findings when developing the program which *Opening Minds* will evaluate.

REACHING PHYSICIANS

Physicians in particular have been a challenging group to reach. The researchers have observed that many of the anti-stigma programs designed for health care providers in hospitals and/or community health care settings are not well attended by physicians. As such, we have had to seek out partners specifically interested in designing, delivering, and evaluating programs targeting this particular group.

As an example of how well that can work, *Opening Minds* is collaborating on a randomized control study of a special program designed for family physicians in Nova Scotia. Originally developed in British Columbia, the Practice Support Program has been shown to reduce stigma and increase the skills and confidence of doctors treating patients with mental health problems. The study will look at stigma reduction, effect on emergency room visits, visits to specialists, pharmaceutical costs, and other economic factors. The partnership includes the Nova Scotia Department of Health, Nova Scotia College of Family Physicians, Doctors Nova Scotia, and the British Columbia Medical Association.

ROLLING OUT AND REPLICATING SUCCESSFUL PROGRAMS

Below are just a few examples of some of the high-performing programs that have been identified by the *Opening Minds* research team, along with information about how we are helping to expand their reach into other communities across the country.

1. **Central Local Health Integrated Network (LHIN) Program –** The Central LHIN, north of Toronto, created and delivered this program to hospital workers and support staff in its region. During the two-hour program, people with lived experience of a mental illness talk to frontline workers about their illness, the impact stigma plays on their recovery and what helps to make a positive difference. These firsthand stories complement and reinforce other content of the training course, such as a PowerPoint presentation, a video/DVD, interactive activities, and a discussion with people with lived experience.

   Our activities – *Opening Minds* has already replicated the program in seven community hospital emergency rooms in Interior British Columbia, as well at the IWK Children's Hospital in Halifax, Nova Scotia, three other LHINs in Ontario, and in an Alberta Health Services webinar for all mental health care providers in Alberta. In fall 2013, we are replicating the program for the Vancouver Island Health Authority, following a day-long workshop we supported to train facilitators to deliver the program. The DVD we helped to create is being used as a discussion tool by program facilitators around the country to reduce stigma.

2. **University Programs –** We have identified a number of promising programs already being delivered in universities. These include the University of Alberta Occupational Therapy curriculum, Brandon University Psychiatric Nursing Program, Pharmacy Curriculum (the universities of Dalhousie, Memorial and Saskatchewan), and the Mind Course at the University of Calgary's School of Medicine.

   Our activities – *Opening Minds* will be contacting other universities throughout Canada that offer health care training in these areas, with the hope of sharing these potential tools and promising programs to reduce stigma among even more students.

3. **Practice Support Program (PSP) Mental Health Module and Cognitive Behavioural Interpersonal Skills (CBIS) –** The in-depth PSP Program was created in British Columbia to help increase the knowledge and skill level among family doctors. Research by *Opening Minds* shows it also reduces stigma. CBIS is one section of the PSP Module which provides physicians, as well as other health care providers, with skills and tools to help treat people with lived experience of mental illness. These result in individuals becoming more empowered, more active, and more relaxed with improved cognition. Physicians are also taught interviewing and assessment skills.

   Our activities – *Opening Minds* has helped to bring a scaled-down, day-long version of the PSP program to a family physicians conference in Montréal. We will also be replicating the full PSP training program in Nova Scotia, where it will undergo a randomized control study. Additionally, parts of the PSP program have been used in the online continuing medical education program for family physicians, created with support by *Opening Minds* in partnership with several organizations including the Canadian Medical Association and the Mood Disorders Society of Canada. We have also replicated CBIS as a webinar for Alberta Health Services mental health employees.

Detailed reports on each of these programs are available at **http://www.mentalhealthcommission.ca/English/initiatives-and-projects/opening-minds**

FUTURE DIRECTIONS

Opening Minds' next main priority is to further understand what exactly makes some anti-stigma programs for health care providers and health care providers-in-training more effective than others. Researchers will be looking for answers to the following questions:

- What are the main differences and similarities between programs that have shown more positive evaluation results and those that have shown less positive results?
- What are the critical components of effective anti-stigma programs aimed at health care providers/health care providers-in-training?
- Do critical components differ depending on health care provider type (e.g., student versus practicing professional; physicians versus nurses, etc.) and/or institutional context (e.g., hospital versus university; ER department versus other hospital department)?
- What are the underlying processes responsible for bringing about changes in mental illness attitudes and/or behavioural intentions?

Additional themes regarding the key components for effective anti-stigma programming for health care providers will continue to emerge and be refined as the *Opening Minds*' health care research team furthers its work.

Upon completion of remaining evaluations and data analysis, researchers will create a logic model for developing effective anti-stigma programs for health care providers and health care providers-in-training.

The next step is building a full toolkit for successful anti-stigma programming for health care providers, including the logic model, whole programs proven to be effective, facilitator guides and other relevant resources. The completed logic model — and its accompanying report — will become one of the core tools in the health care provider anti-stigma toolbox. This research is approximately halfway to completion. Draft results will be delivered in 2014. *Opening Minds* will help to disseminate the findings and toolkit, making knowledge, tools, and resources available and accessible as widely as possible.

Our network of health care partners is steadily growing. Universities, health regions, hospitals, and other health care provider partners are approaching us looking for opportunities to collaborate and co-operate. This is a great strength for *Opening Minds*' ability to replicate successful programs in other jurisdictions and contexts, to continue to build our evidence-based approach, and to help identify the most important policy goals/legislative changes in the area of stigma aimed at changing behaviours, and promote the value of these changes.

Another key strength is our partners. Many of our health care partners are willing to freely share their anti-stigma programs, tools, and resources. Most partners are also enthusiastic evaluation collaborators, using the evaluation results provided to them to further improve and refine their programs and/or to promoting their programs for greater sustainability or growth.

The media has considerable influence on shaping public opinion

Words have power – they have the power to soothe or hurt, honour or insult, inform or misinform

The media is the public's main source of information on mental health and mental illnesses

More than 40% of Canadian news stories about mental health focus on murder and violent crimes

Target Group: News Media

ACTIVITIES AND FINDINGS TO DATE

Opening Minds is taking an approach with the news media that differs from the work it is doing with its other three target groups. We are trying to better inform current and future journalists about mental health, mental illnesses, and stigma, so they can avoid using stigmatizing language and assumptions in their reporting that can perpetuate the many misconceptions surrounding these issues.

We're also studying exactly how, and how often, the news media in Canada portrays people living with mental illnesses in its coverage. The preliminary findings indicate there is much need for improvement.

MEDIA RESOURCE GUIDE

Opening Minds has contracted The Canadian Journalism Forum on Violence and Trauma to research and write a new media resource guide. It is called *Mindset, Reporting on Mental Health*. Also partnering on the project is the Canadian Broadcasting Corporation (CBC).

The Media Resource Guide will include information about:

- the problems created by stigma and discrimination
- statistics and information about mental illnesses
- symptoms of different kinds of mental health issues
- myths perpetuated about mental illnesses
- research findings about stigma in Canadian news stories
- suggestions on how to cover stories about violence
- language use in news stories
- contacts who can help journalists preparing news stories
- references
- examples of stories that help reduce stigma

Journalists as a whole strongly resist being told how to cover the news by outsiders. *Opening Minds* has worked diligently to get senior journalistic leaders onside, who would be willing to create the guide. Once the guide is completed it will be tested at CBC for its effectiveness.

The guide will be available in a print and digital form, and will be ready for dissemination in early 2014. An internet site will be created to house the downloadable guide, with extensive links to other resources and in-depth case studies. This website will be updated regularly and contain a blog and forum for journalists and editors.

JOURNALISM SCHOOL SYMPOSIA/NEW JOURNALISM SCHOOL CURRICULUM

Over the last few years, *Opening Minds* has held symposia at a number of university journalism schools, taking the message about stigma to journalists-in-training. The media research team completed an evaluation on the pilot symposium at Mount Royal University and a comparison evaluation conducted at King's College School of Journalism at Dalhousie University. Results from both show symposia are effective at reducing stigma.

Delivering live programs each year to journalism students at the 14 university and 25 college journalism programs in Canada is not feasible, so *Opening Minds* is now turning its attention to creating an online curriculum for use by faculty and students that will include video, discussion topics, and suggested assignments. Some videos already exist for a toolbox, and early in 2013 *Opening Minds* held one additional symposium at Mount Royal University to videotape speakers to augment and update the curriculum. Speakers include a reporter who specializes in heath policy, a Canadian news media research expert, a forensic psychologist/lawyer with experience dealing with media, two young people with lived experience of a mental illness, and a family member.

Because no Canadian research was available for the first "pilot" journalism symposium, a media expert from the United States illustrated stigmatizing news stories from that country. Some members of the faculty and the student body took offence to Canada being compared to American news coverage, unconvinced that Canadian news reporters were stigmatizing. The need for Canadian data was clear, prompting *Opening Minds* to establish the media monitoring project.

"It really did change my perception of mental illness. A lot of the stuff like misconceptions I really didn't know about."

Journalism student after an *Opening Minds* symposium

MEDIA MONITORING PROJECT

Given the lack of research regarding the media's coverage of mental illnesses in Canada, *Opening Minds* established a media monitoring study with researchers at McGill University to examine trends in such coverage in Canada from 2005 to the present. This ongoing study is the largest of its kind in the world, and will extend to 2015, giving us more than 10 years of data to compare and contrast.

So far, researchers have collected and analyzed more than 11,000 French and English language newspaper articles from 2005-2011 and are in the process of analyzing more from 2012-2013. The time frame is interesting inasmuch as the Mental Health Commission of Canada was launched during this period (September 2007),

with an aim of promoting mental health and reducing stigma. This means we will be able to compare and contrast media coverage before and after the creation of the Commission, and *Opening Minds*, in order to assess the impact on media coverage of mental illnesses.

WHAT THE MEDIA MONITORING PROJECT IS TELLING US

Because of the previous literature on the topic, and the risk of stereotyping, the researchers considered danger, violence and criminality the key message to focus on in their analyses of the articles. They found that this was a direct theme in many newspaper articles.

When examined in detail, mental illnesses in these articles are frequently presented in the context of crime, prisons, police, deviant behaviours, and the courts. In a few cases, journalists wrote openly sensationalized and titillating accounts of events or people that they directly associated with a mental illness. Stigmatizing language such as 'crazy' and 'psycho' were used in these articles to describe people living with a mental illness. The researchers also noted that psychiatric labels were quickly assigned to people suspected of shocking crimes without any solid evidence that these people actually had a mental illness.

These figures are similar to those found in other countries, and the Canadian media appears to share the characteristics of British and American media when representing mental illness.

Among the findings so far:

- 40% of Canadian newspaper articles negatively associated crime, violence, and danger with mental illness
- only 17% of articles included the voice of someone living with a mental illness
- only 25% include the voice of an expert
- treatment is only discussed in 19% of articles
- only 18% discuss recovery or rehabilitation

The findings give cause for concern because they do not accurately reflect the realities of life for people with a mental illness. For example, much research shows that people with a mental illness are much more likely to be a victim of crime and violence rather than a perpetrator. Factors such as crime and violence are being over-reported, while those factors which are frequently associated with mental illnesses, such as recovery and rehabilitation, are being considerably underreported.

When considering all this information, it is vital to note the existence of much variation between individual newspapers and individual journalists. The researchers are currently conducting a sub-analysis, comparing individual newspapers regarding the quality and accuracy of their reporting. They are seeing that some newspapers, and individual journalists, are taking a progressive and balanced stance regarding mental illnesses, while others continue to use mental illnesses as an opportunity to dramatize, sensationalize, and titillate, in the process buttressing stigma and negative stereotypes about people with a mental illness.

Examples of some of the articles commonly seen are given in Table 1 on the following page.

Table 1: Examples

OVERT STIGMATIZATION	"Henderson — who is mentally ill and requires medication to manage his condition — went on a sex-tinged spree which saw several city women inappropriately groped in very public places. In one case, Henderson took pictures of a woman with his phone as she bent over a produce display at a grocery."
IMPLIED STIGMATIZATION	"Det. John Campbell asked anyone with information to come forward and warned the public to be vigilant in case there is a 'mentally ill person out there with a knife, arbitrarily stabbing anyone.' "
POSITIVE WRITING	"Rachel Scott-Mignon, 28, stood in front of a crowd of 600 strangers and gently hammered them with a dark secret: She suffers from bipolar disorder. 'I know first-hand what it is like to be in pieces, sometimes broken … to be sad,' she said. 'But I also know what it is like to be whole, hopeful, to be in the moment, to be happy, to be in love. Sometimes this happiness gets out of control and it's like a carnival in my head. Everything's fast and out of control. That's what living with bipolar disorder is all about.' "

FUTURE DIRECTIONS

The media monitoring project indicates that there is currently scope for improvement in coverage of mental health issues in Canada. We are trying to disseminate this message through academic papers, workshops at journalism schools, online videos, and public outreach events (Cafés Scientifique), as well as other related events.

In comparing media coverage between 2005 and 2010, the researchers have not observed any improvement in reporting. This might be expected, given that the Mental Health Commission of Canada has a 10-year mandate, and much of its anti-stigma work is being progressively implemented over time, with the more visible work of the Commission (for example, its national mental health strategy) launched more recently. It might be that the impact of the Commission will only be felt a few years down the line. Indeed, previous studies of changing attitudes regarding factors such as race suggest that a time period of around 10 years is necessary to effect positive industry-level change in tone and content.

As the project proceeds, we hope to see changes in coverage of mental health in the media. Indeed there is a proud tradition of social justice journalism in the Canadian media, for example the role it has played in bringing to light the difficult conditions faced in certain First Nations communities.

It is hoped that newspapers, broadcasters, and journalists take an active role in championing the cause of people with a mental illness, and join the broad front that is working to bring mental illness out of the shadows, forever.

Target Group: Workforce

Every day, half a million Canadians are absent from work for psychiatric reasons

One out of every four to five employees is affected by mental health issues every year

Every year mental illnesses cost the Canadian economy an estimated $50 billion (at least) annually in absenteeism, disability claims, and medical services used

Many workers choose to go untreated rather than risk being labeled as "unreliable, unproductive, and untrustworthy"

"Stigma affected me in the workplace in what to me was the worst way possible; I got fired from a job I absolutely loved and was fantastic at."

Person with lived experience of mental illness

ACTIVITIES AND FINDINGS TO DATE

The *Opening Minds* workforce research team is partnering with programs and workplaces across Canada to identify and evaluate existing anti-stigma programs targeting the workplace, with the goal of determining the effectiveness of these programs and their potential to be rolled out nationally.

The Mental Health Commission of Canada has recently identified the workforce as a key focus area moving forward, and *Opening Minds*' work is complementary to other Commission programs and initiatives aimed at this target group. One example is Mental Health First Aid Canada, a program designed to train people to respond to mental health problems that is also believed to reduce stigma (see page 26). Another example is the *National Standard of Canada for Psychological Health and Safety in the Workplace*, which in part encourages organizations to understand and respond to the nature and dynamics of stigma.

PARTNERSHIPS TAKE TIME

Workplace anti-stigma programs have the potential to alleviate the heavy personal and financial costs associated with mental illness, benefitting both employee and employer. We have now been able to form strategic partnerships with more than a dozen organizations, such as Alberta Health Services and the Nova Scotia Public Service Commission. Evaluations of anti-stigma programs within these organizations are all at varying stages.

Forging these kinds of partnerships has taken more time than with other target groups. Several levels of approval within the organizations are often required, and the implementation of anti-stigma programs is often delayed due to competing priorities. We have also noted that one of the largest factors affecting uptake by a company or organization is the extent to which the executive level acknowledges the potential impact of the stigma of mental illness and psychological health and safety in the workplace.

VARIETY OF WORKFORCE PROGRAMS

Given the vast number of workforce settings and the enormous variety of workforce cultures, *Opening Minds* set out to try to create a wide range of workforce and program partnerships. This would allow us to better understand how stigma occurs and how it can be prevented in different workplaces — for example, a private corporation as opposed to a public organization.

Following are three examples of programs which illustrate the variety of the evaluation work being undertaken with this target group.

Program for government employees: Mental Health Works (MHW) is a national initiative of the Canadian Mental Health Association dedicated to workplace skills enhancement, awareness, education, and stigma reduction.

A version of the MHW program was customized for management training at the Peel Region municipal government in Ontario. The program involved three modules and was offered to more than 500 supervisors of the organization throughout 2011. Our program evaluation included assessment of changes in attitudes, knowledge, behaviour, and self-confidence of supervisors.

Participant scores on our general workplace stigma questionnaire indicated low levels of stigmatizing opinions to start. As a result, there was not much room for big improvements, or statistically significant findings to be seen. There were, however, specific items on the questionnaire where attitudes seemed to become even more positive (i.e., less stigmatizing) over time. Statistically significant changes in attitudes were seen on the workplace attitudes questionnaire, specific to the supervisory role.

With the positive response to the training program and feedback from managers that the program needed to be delivered to all employees, the employer made it available to the entire staff of approximately 5,000 people. The staff training program was modified to consist of just one 45-minute module, and group discussion sessions are facilitated by a supervisor who has previously received training. Data collection is underway for this piece of the evaluation.

Program for business leaders: *Mind Matters* is a full-day workshop developed by the Mood Disorders Association of Ontario (MDAO). The program focuses on steps business leaders can take to create healthy workplace environments and implement practices fundamental to managing mental health problems in the workplace. The program can also be tailor-made to the organization.

Opening Minds' evaluation results of a 2011 workshop indicated a significant decrease in stigmatizing attitudes. Participants also increased their knowledge about mental illnesses as indicated by the significant increase in the number of correct responses on the knowledge quiz. Since our evaluation, the *Mind Matters* program has evolved, and we are currently in discussions with the MDAO regarding an evaluation of the modified program potentially being delivered to a large organization in the fall of 2013.

Program for managers and employees: The Department of National Defence's (DND) Road To Mental Readiness (R2MR) program was developed to increase resiliency and mental health in its soldiers and civilian staff. It categorizes signs, symptoms, and behaviours of good to poor mental health under a four colour continuum: green (healthy), yellow (reacting), orange (ill), and red (injured). This continuum model bypasses the need for labels and the stigma attached with these labels.

The RCMP in New Brunswick are participating in an evaluation of the program specially tailored for their use. The RCMP in Nova Scotia, Prince Edward Island, and Newfoundland have expressed an interest in using the program and will also become test sites.

The Calgary Police Service, working in collaboration with *Opening Minds*, Alberta Health Services, and DND, has developed an adaptation of R2MR for municipal police forces. Training is scheduled to begin fall 2013. A number of police forces across Canada have expressed an interest in using this version of the program. These include the Ontario Provincial Police, Peel Regional Police, Vancouver Police Department, and Ontario Police College.

Opening Minds decided it would be more efficient to adapt the already successful R2MR program for a general workplace audience. That adaptation, being carried out by researchers and a person with lived experience, is called *The Working Mind* program and it is geared towards managers and employees.

Thirty trainers working for three major employers successfully completed training in Halifax in September 2013, and will begin delivering *The Working Mind* to managers and employees. The organizations that participated in the program include the Nova Scotia Public Service Commission, the Capital District Health Authority, and Nova Scotia Community College. The University of Calgary is next in line to take the training in fall 2013.

Mental Health First Aid Canada

Mental Health First Aid (MHFA) is a program of the Mental Health Commission of Canada. It trains people to recognize the early signs of a mental health problem or crisis in themselves or others, and to provide initial help.

MHFA training is being held just about everywhere in Canada, including in businesses and organizations, and for both employees and employers.

The program is also believed to help reduce stigma among training participants, and *Opening Minds* will soon be evaluating MHFA to determine its effectiveness in this area.

SOME EARLY FEEDBACK AND LESSONS

While these are still early days in our evaluations of workforce programs and quantitative data is under analysis, we are already gaining valuable feedback from our qualitative data about some of the characteristics necessary for developing successful anti-stigma programs for this target group. For example, participants in one program suggested higher levels of interaction amongst group members, case scenarios specific to their workplace, and the need to make videos engaging and exciting. One of the most important lessons gleaned so far is that there needs to be not only general approval from senior executives, but also actual endorsement of any anti-stigma initiative; the message must be that the program is valued and that participation is expected. If this precursor is not present, the researchers and program providers need to obtain executive-level endorsement so that the partnership and subsequent actions progress more smoothly. Lack of 'buy-in' from management, and organizational or personnel changes, may also apply after a partnership has formed.

ECONOMIC ANALYSIS OF THE IMPACT OF MENTAL ILLNESS IN THE WORKPLACE

Mental health problems present a significant societal cost in terms of health care service use, lost work days, and work disruptions – estimated to be at least $50 billion per year. About 35% of the societal cost of mental illnesses is related to work disruptions.

While there has been growing awareness of the staggering social and economic costs of mental disorders in the workplace, there is little information about the magnitude of these costs to businesses. One of the challenges researchers face is the lack of data to pursue these inquiries.

Estimating costs and rates of disability for mental illnesses for various groups of workers requires data that not only contain information about workers who have a specific type of disability claim, but also those who are healthy and do not.

The purpose of this study is to build the 'business case' for addressing the stigma surrounding mental illness in the workplace. Through economic analyses, we will estimate the return on investment (ROI) that small-, medium- and large-size organizations can realize through the implementation of anti-stigma and mental illness awareness programs. The main idea is that stigma reduction may lead to more effective reduction of a major source of disability costs (i.e., those from mental illness).

This year, one of the steps toward building the business case involved developing an economic model to estimate the breakeven point for workplace-based anti-stigma programs. These types of economic models can be used to understand how much a company should invest in an anti-stigma program given its effectiveness. The estimates from the model can be used as a launching point to discuss how organizations can think about investing in an anti-stigma program (e.g., when is it economically worthwhile for them).

The economic model building activity involves using administrative data from the organizations participating in *Opening Minds* to further enhance the model and understand the differences in the returns on investment for the different types of organizations. The model is flexible enough to incorporate 'contextual evidence' (e.g., a company's specific ratio of managers to non-managers). After the model has been fully specified, different assumptions can be explored to determine under what circumstances mental health or anti-stigma programs are cost-effective. In addition, the results can be explored to see how sensitive they are to various assumptions. In this way, economic modeling can be used to make the business case that mental health and anti-stigma programs are not only good for health, they are also good for business.

STIGMA AND SOCIAL BUSINESS STUDY

Social businesses (or social firms) are businesses that combine conventional market activities with a social purpose. In the case of mental illnesses, the social business approach has been applied widely in Canada, particularly for individuals who have experienced long-term detachment from the community labour market. In addition to improving employment prospects, social businesses have the potential to reduce stigma in a variety of ways.

This study has the following objectives: 1) to explore social business processes that influence stigma, and 2) test whether employment in a social business for a person who has a mental illness, influences how employers rate hireability.

The first objective is being addressed by a multiple case study design that is exploring stigma in the context of social businesses located in three Canadian communities. Analysis is expected to be completed in early 2014.

The second objective is being addressed by the vignette technique to elicit survey data. Participants will be employers who will each view employment résumés and letters of reference for two job candidates, followed by short videos involving these candidates in a job interview. One employee will have recent experience working in a social business. Employers will be asked to rate each job candidate on three aspects of perceived hireability. Open ended questions related to the perceived hireability of characters depicted in the vignettes will also be used. Data collection for this study is expected to be complete by the end of 2013, with findings available by the spring of 2014.

Supporting The Aspiring Workforce

The Aspiring Workforce are people who, due to a mental illness, have been unable to enter or re-enter the workforce, or who are in and out of the workforce due to episodic illness. In many cases, stigma and discrimination are among the major barriers keeping them from gaining employment.

The Mental Health Commission of Canada has recently identified improving mental health in the workforce as a priority, and as part of its efforts, the Commission is collaborating with its partners to help the Aspiring Workforce achieve its right to work.

In collaboration with the Centre for Mental Health and Addiction, the University of Toronto, and Queen's University, the Commission recently produced a series of reports called *The Aspiring Workforce: Employment and Income for People with Serious Mental Illness.* Among the recommendations is developing, implementing, and promoting anti-stigma initiatives in workplaces.

Opening Minds is helping to support this recommendation through its evaluation and replication of anti-stigma programs aimed at employers and employees.

FUTURE DIRECTIONS

Conducting evaluations in a workplace setting can be a difficult endeavour as barriers exist at each part of the process. Applied research, as opposed to experimental lab research, generally involves an added layer of complexity as researchers have to accommodate and be flexible to the context where the research takes place. Despite this, future *Opening Minds* evaluations, and workplace evaluation research more generally, should move beyond current procedures and methods, adding another layer of complexity to the research.

All *Opening Minds* workplace evaluations involve the measurement of attitudes and social distance towards people with mental illnesses as the standard indication of stigma. Although this method is clearly the most popular in the research literature, there is a need to move beyond measuring attitudes to measure behavioural indications of stigma and discrimination[18,19,20]. Put otherwise, evaluations need to move beyond asking people what they will do, to observing what steps they actually will undertake to reduce stigma.

It will also be important to understand more fully how problems related to mental health and mental illness are expressed in the workplace specifically, the meaning of these situations for the workplace and the individual, and strategies to address these issues while positively contributing to attitudes and opinions.

Evaluations should also examine the financial ramifications of anti-stigma programs, through administrative data sets, such as short- and long-term disability claims, absenteeism, and benefits utilization. These types of analyses can show the financial impact and the return on investment (ROI) of interventions in companies and organizations. Currently, *Opening Minds'* workplace evaluations at a number of sites are utilizing this type of administrative data analyses. However, more evaluations of this type would add to the literature and potentially make an even more compelling argument for companies and organizations to institute anti-stigma programs.

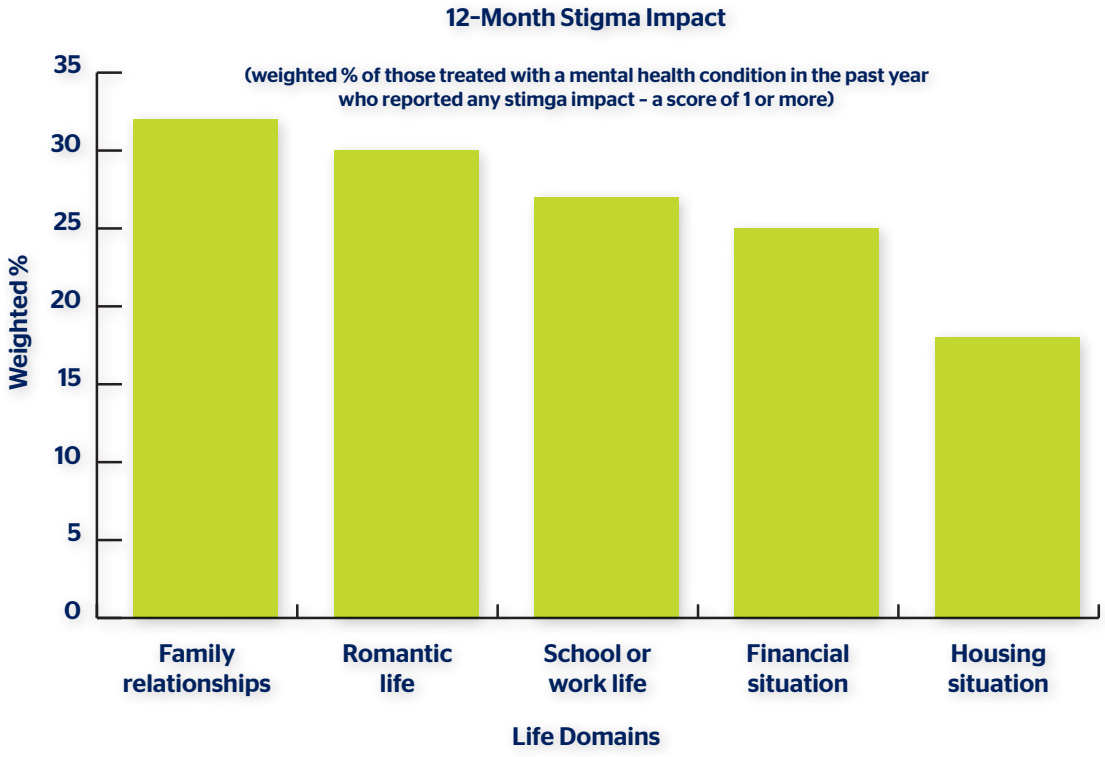
Development of a Rapid Response Stigma Module

The importance of evaluating and replicating successful programs cannot be understated. However, to understand whether these efforts are making a difference to people who have a mental illness on a population level requires a different approach. What we need to know is whether the stigma experienced by people living with a mental illness reduces over time.

Opening Minds collaborated with Statistics Canada to develop and test a stigma module that could be included in national population surveys. The three-minute module consists of six questions and was based on work completed at Queen's University[21]. The module measures the frequency and impact of stigma experienced by people who have received treatment for a mental illness along several important life domains.

In 2010, *Opening Minds* funded a Rapid Response survey to be conducted by Statistics Canada, which allowed us to piggyback the stigma module on the annual component of the Canadian Community Health Survey. The rapid response portion was conducted in May/June 2010 and provided data on approximately 10,000 Canadians. Figure 5 shows the domains that were used in the Rapid Response module (an additional domain pertaining to health care has since been added). It shows the per cent of respondents who reported some stigma in the prior 12 months (defined as having been treated negatively or unfairly because of a past or current mental health condition). Analyses of these data are continuing.

FIGURE 5: DOMAINS USED IN RAPID RESPONSE MODULE



Statistics Canada has since incorporated the stigma module into the Canadian Community Health Survey (Mental Health) focusing on some 35,000 Canadians. While we don't expect there to have been any change in stigma experiences since the 2010 Rapid Response survey, the availability of these data will allow us to better understand how to target anti-stigma programs to groups in highest need, and will provide an opportunity to examine factors that may be associated with stigma resilience.

To our knowledge, this is the first nationally representative survey of personal experiences with stigma and it reflects an important structural improvement in the way national data are collected. It also helps Canada fulfill its monitoring obligations under the UN Convention on the Rights of Persons with Disabilities, as this module can be used repeatedly to determine whether stigma is being reduced over time.

One interesting preliminary finding is that older Canadians reported the lowest levels of personal stigma, while youth reported the highest. It may be that older Canadians develop better coping mechanisms over time. This finding is indicative of the rich data being provided from this module. We expect that as more information becomes available, it will spawn significant additional research into stigma, not just within *Opening Minds*, but among academics and post-secondary students across Canada. In its role as a catalyst, the Mental Health Commission of Canada is engaged in projects and initiatives that spark positive changes within systems, be they organizational or policy improvements. Successfully encouraging Statistics Canada to not only test, but to also embrace this module is a significant achievement regarding systems change.

Knowledge Exchange

The Mental Health Commission of Canada believes knowledge can be a catalyst for action and change, and ensuring that knowledge and information about mental health is conducted and shared is a key part of the Commission's mandate.

Each program and initiative of the Commission includes a strategic focus on getting its research into the hands of the people who can put it to use and accelerate change.

To that end, *Opening Minds* continues to undertake a number of activities to ensure our knowledge about stigma reduction is shared with a broad audience, which includes policy makers, mental health and health care professionals, advocacy groups, support workers, governments and academics, to name a few.

Below are just some of *Opening Minds'* activities in knowledge exchange.

Together Against Stigma International Conference

Opening Minds and the World Psychiatric Association co-hosted the *Together Against Stigma International Conference* in Ottawa in 2012. It was the largest event of its kind ever organized, more than three times larger than the last international stigma convention held in London, England in 2009.

The conference drew close to 700 delegates from 29 countries and attracted researchers, scientists, mental health professionals, policy makers, and people with lived experience of a mental illness. About one-third of the participants and a number of the principal speakers were people with lived experience, which greatly added to the positive atmosphere and success of the event.

The Honourable Lisa Raitt, then Minister of Labour, opened the conference with welcoming remarks from the Government of Canada and shared her own personal mental health story. Keynote presenters included actor Glenn Close and former CTV broadcaster Lloyd Robertson. Leading international stigma experts also presented during the plenaries, including Professor Heather Stuart, Queen's University, the Senior Consultant to *Opening Minds* and the Bell Canada Mental Health and Anti-stigma Research Chair.

The conference was an overwhelming success on many levels. This was reflected in comments from attendees and post-conference survey results. Delegates described it as "the best conference ever" and "life changing". It spawned extensive media coverage and led to the formation of a new international association of anti-stigma organizations, the *Global Alliance Against Stigma*.

The conference also generated considerable national and international interest in the work of the Mental Health Commission of Canada (MHCC) and *Opening Minds*. The MHCC, in collaboration with the Canadian Human Rights Commission, produced a book called, *Together Against Stigma: Changing How We See Mental Illness* summarizing the keynote presentations, breakout sessions, and posters. It also contains a collection of the most current stigma research taking place around the globe. To experience the online flipbook, please visit **http://files.mentalhealthcommission.ca/antistigma**

Global Alliance Against Stigma

One of the major outcomes of the *Together Against Stigma International Conference* was the formation of a new international association of anti-stigma organizations, whose working name is the *Global Alliance Against Stigma*. Micheal Pietrus, the Director of *Opening Minds*, is the current Chair.

The Alliance's steering committee held its inaugural meeting in June 2012, and a steady flow of information and research is already being shared among members. In September 2013, the Alliance held its second meeting in London, UK, and *Opening Minds* presented updates on its most recent findings to the more than 50 participants gathered from around the world.

Justice Symposia and Projects

Opening Minds has co-sponsored three symposia with the provincial criminal justice associations, and will present at the national Canadian Criminal Justice Association conference during the fall of 2013. These symposia explain the issue of stigma related to mental illnesses in the criminal justice system and introduce police, corrections and court officers, lawyers, judges, and more to research and first-person stories of people living with a mental illness who have been negatively impacted by stigma in the justice system.

Opening Minds is also partnering with and assisting organizations that are creating anti-stigma programs for individuals working in the legal area. Work began this summer on an education program and resources for Legal Aid Ontario, which is expected to have national relevance.

Cafés Scientifique

Opening Minds' media researchers at McGill University obtained two separate grants from the Canadian Institutes of Health Research to hold Cafés Scientifique in Montréal to discuss mental illness, stigma, and the media. Cafés bring people to a small, public venue to hear a panel discussion, with the intent of extending scientific discourse to the wider community, and these particular events put the spotlight on *Opening Minds'* research. Both were well attended and well received. Members of *Opening Minds* participated in the panel discussion and fielded questions from attendees.

Reports and Publications

Opening Minds' researchers are actively publishing their work in peer-reviewed journals and books. In addition to the list of publications that follows, they have also written reports about each of the dozens of anti-stigma programs evaluated.

General

Does Labeling Matter? An Examination of Attitudes and Perceptions of Labels for Mental Disorders
Szeto, A. C. H., Luong, D., & Dobson, K. S.
Published April 2013 in the journal *Social Psychiatry and Psychiatric Epidemiology*.

Paradigms Lost: Fighting Stigma and the Lessons Learned
Stuart, H., Arboleda-Flórez, J., Sartorius, N.
Published in May 2012 by Oxford University Press. The authors provided a free copy of this book to all of the attendees of the International Anti-stigma Conference.

Workplace

Reducing the Stigma of Mental Disorders at Work: A Review of Current Workplace Anti-Stigma Intervention Programs
Szeto, A. C. H., & Dobson, K. S.
Published April 2012 in the journal *Applied and Preventive Psychology*.

Malachowski, C. & Kirsh, B. *Workplace Anti-Stigma Initiatives: A Scoping Study*. *Psychiatric Services*. 2013 Jul 1;64(7):694-702. doi: 10.1176/appi.ps.201200409.

Mental disorders and their association with perceived work stress: An investigation of the 2010 Canadian Community Health Survey
Szeto, A. C. H., & Dobson, K. S.
Published April 2013 in the *Journal of Occupational Health Psychology*.

Health Care

The Development and Psychometric Properties of a New Scale to Measure Mental Illness Related Stigma by Health Care Providers: The Opening Minds Scale for Health Care Providers (OMS-HC)
Kassam, A., Papish, A., Modgill, G., & Patten, S. B.
Published June 2012 in the journal *BMC Psychiatry*.

Perceived discrimination among people with self-reported emotional, psychological, or psychiatric conditions in a population-based sample of Canadians reporting a disability
Kassam, A., Williams, J., & Patten, S. B.
Published February 2012 in the *Canadian Journal of Psychiatry*.

Effectiveness of Contact-based Education for Reducing Mental Illness-related Stigma in Pharmacy Students
Patten, S. B., Remillard, A., Phillips, L., Modgill, G., Szeto, A. C. H., Kassam, A., & Gardner, D. M.
Published December 2012 in the journal *BMC Medical Education*.

The Hidden Medical Logic of Mental Health Stigma
Ungar, T. & Knaak, S.
Published February 2013 in the *Australian and New Zealand Journal of Psychiatry*.

Mental health stigma and the mind-body problem: Making the case for strategic collusion
Ungar, T. & Knaak, S.
Published July 2013 in the *Australian and New Zealand Journal of Psychiatry*.

News Media

Trends in Newspaper Coverage of Mental Illness in Canada: 2005-2010
Whitley, R. & Berry, S.
Published February 2013 in the *Canadian Journal of Psychiatry*.

Book Chapter: "Stigmatizing Representations: Criminality, Violence and Mental Illness in Canadian Mainstream Media"
Whitley, R. & Berry, S.
In press, spring/ summer 2013, publisher University of Toronto.

Analyzing Media Representations of Mental Illness: Lessons Learnt from a National Project
Whitley, R. & Berry, S.
Published January 2013 in the *Journal of Mental Health*.

Reducing Mental Health Stigma: A Case Study
Stuart, H., Koller, M., Christie, R., Pietrus, M.
Healthcare Quarterly, 2011, 14(April Special Issue), 41-49.

Future Directions

Opening Minds is taking a novel approach to reduce stigma in Canada, a method that is both achieving positive results and attracting attention. Having learned from previous anti-stigma efforts undertaken worldwide, *Opening Minds* is now being recognized as a leader both nationally and globally. We have begun replicating programs and sharing leading practices which we have identified as being effective. Still, there is much more work to do.

We have demonstrated on an unprecedented scale that contact-based education is a key to successful anti-stigma programs. That comes with its own set of challenges: *Opening Minds* must now help develop a network of speakers along with appropriate video and web-based content that can be used in place of live presentations. This work is needed if we are to succeed in a national roll-out of the most proven effective programs.

To successfully reduce stigma, we know that programs must be tailored to each particular target group and that is what we are doing for health care providers, youth, news media and the workforce. However, we have identified many additional populations, such as Canada's indigenous populations and other minority groups, that may require an even more tailored approach than the ones currently in use within our existing target groups. Creating programs specifically for these additional populations will require more time and more resources.

There are also growing opportunities to work on cultural and organizational change. For example, we've identified some highly effective programs targeting youth, but their potential will be limited if we cannot convince ministries and boards of education to put these programs in their schools' health curricula. As another example, we have legislation to protect peoples' rights in the workplace, yet they continue to be stigmatized. Now that we have workplace voluntary psychological safety standards and anti-stigma programs that work, we can reach out to employers to encourage them to make the organizational changes necessary to help create stigma-free workplaces.

"The Mental Health Commission of Canada is very wisely viewing the stigma issue as one small battle and one small victory at a time."

Patrick Corrigan, PhD
World-renowned international expert on mental health stigma

When *Opening Minds* began, there were no leading practices to reduce stigma among the general population, let alone Canada's smaller minority group populations, and there was little research to guide our choice of best practices; thus, our initial emphasis on evaluation and knowledge creation. *Opening Minds* will now focus our efforts on completing research and developing models that can help improve existing programs or create new ones. At the same time, we will continue to promote and replicate programs we have shown to be effective. We will also create a business case for anti-stigma programs among the different target groups, to demonstrate the economic benefits of stigma reduction in hopes of encouraging greater program uptake.

Opening Minds is creating models which can be used in the future to reach additional populations. Stigma related to mental illnesses will continue to flourish in Canadian society unless efforts are made to reach every demographic and reach into every corner of the country.

Opening Minds has identified the following goals going forward:

Further position the Commission as an international leader in stigma reduction.

Our evidence-based approach is already garnering attention from organizations at home and abroad that are seeking our advice about dealing with stigma. This interest will only increase as we continue to identify the key components of successful anti-stigma programs, develop toolkits, and expand our reach among the target groups. The goal is to put research into action to promote greater positive change on the ground.

Opening Minds is disseminating the findings from its research while also acting upon it. We will continue to take what we are learning and translate that into projects, toolkits, programs, partnerships, and more.

One example of putting our research into action will be seen on a very large scale next year. In 2014, students and teachers from across Canada will meet for a large youth anti-stigma event in a Canadian city which is yet to be determined. The event will be based on an Ontario-based program that our evaluations showed to be successful at reducing stigma among young people. The participants will then return to their own communities and construct activities to reduce stigma, encourage help-seeking and foster a more supportive environment.

On the health care front, we will continue to reach out to universities and colleges across Canada to promote the incorporation of effective anti-stigma methods into their curricula, and will share programs we have shown to be successful in hospital settings and with professional associations.

Make Canadian workplaces a mentally healthier environment for all employees.

Given how much of our daily lives we spend at work, it is critical that our places of employment be mentally healthy and as free of stigma as possible. Workers need know their employers will support them, whether they experience a mental illness or are confronted with stigmatizing behaviours from their colleagues. *Opening Minds* will continue to reach this key target group through its evaluation and replication of anti-stigma programs, while supporting other Commission initiatives aimed at improving mental health among the workforce, including the Mental Health First Aid program, and the *National Standard of Canada for Psychological Health and Safety in the Workplace*.

Additional strategic goals

Additional strategic goals include:

- dissemination of an interim findings/leading practices report on knowledge acquired to date on “what works” and communicate this to the community;
- completion of the research on current programs;
- allowing the research to drive action going forward, by designing and implementing a phased rollout of successful programs and findings; and,
- replication of anti-stigma programs focused on youth, health care professionals, media, and workforce in 10 jurisdictions (to include at least 100 program replications).

Project Teams

The principal investigators listed below lead project teams that are supported by other researchers and work in collaboration with *Opening Minds* staff.

Heather Stuart: Senior Consultant for *Opening Minds* and Principal Investigator for Youth

Heather is a Professor at Queen's University and the Bell Canada Mental Health and Anti-stigma and Research Chair. Her main research interests are in the areas of psychiatric epidemiology and mental health services evaluations. Her main goals have been to undertake applied research that helps policy makers and planners solve day-to-day problems and make evidence-informed decisions. Heather has worked in both hospital- and community-based mental health treatment systems and on international projects with the World Health Organization, the Pan American Health Organization, and the World Psychiatric Association.

Carolyn Dewa: Principal Investigator for Workplace Mental Health Economics

Carolyn is a Professor at the University of Toronto in the Department of Psychiatry, as well as the Department of Health Policy, Management and Evaluation. She also heads the Centre for Addiction and Mental Health's Centre for Research on Employment and Workplace Health. Carolyn currently holds a Canadian Institutes of Health Research/Public Health Agency of Canada Applied Public Health Chair.

Keith Dobson: Co-Principal Investigator for the Workforce (West)

Keith is a Professor of Clinical Psychology at the University of Calgary. His research interests include psychological models of and treatments for various disorders, particularly depression. In addition, Keith has written about ethical and professional issues in mental health treatment.

Bonnie Kirsh: Co-Principal Investigator for the Workforce (East)

An Associate Professor in the Department of Occupational Science and Occupational Therapy at the University of Toronto, Bonnie's primary research focuses on community and work integration for persons with mental illnesses. Another area of research is workplace mental health, including trajectories of persons who experience depression at work and related issues of disability management and return to work.

Terry Krupa: Co-Principal Investigator for the Workforce (East)

Terry is a Professor in the School of Rehabilitation Therapy at Queen's University in Kingston. Her research, teaching, and practice have focused on ensuring the full and meaningful community participation of people who experience mental illnesses.

Bianca Lauria-Horner: Co-Principal Investigator for Health Care Providers

Bianca is a psychiatrist and assistant professor of psychiatry at Dalhousie University's Department of Psychiatry. Her interests include teaching and leading research projects, particularly the design and evaluation of community-based mental health awareness and promotion programs.

Scott Patten: Principal Investigator for Health Care Providers

Scott is a Professor at the University of Calgary. Scott teaches in the Department of Community Health Sciences. The focus of his work is on the longitudinal epidemiology of major depression, with the main goal of integrating epidemiologic estimates of incidence, recurrence, prevalence, episode duration, and mortality into a comprehensive epidemiologic picture. He also has expertise in methodological approaches to the analysis of longitudinal data.

Robert Whitley: Principal Investigator for Mental Illness and Media Project

Rob is an Assistant Professor in the Department of Psychiatry at McGill University and at the Douglas University Mental Health Institute. Rob has a particular interest in recovery from severe mental illness and the role of stigma and religiosity in enhancing or impeding recovery. He is conducting a systematic analysis of media coverage of mental illness in Canada in order to discern whether the media is taking a more positive approach to mental health.

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Appendix A – Youth Program Questionnaire

Pretest

YOUTH OPINION SURVEY

In preparation for an upcoming class, we are going to ask you a few questions about mental illnesses. This will help us in developing our class materials and allow us to meet your learning needs. Please answer the following questions to help us.

SOME GENERAL INFO ABOUT YOU:

Year of birth : _____ Month of birth : _____ Day of birth: _____ Female ( ) Male ( ) What grade are you in? _____

WHAT WORDS OR PHRASES COME TO YOUR MIND TO DESCRIBE SOMEONE WITH A MENTAL ILLNESS ?

1. _____ 2. _____ 3. _____

THE NEXT FEW QUESTIONS ASK YOU TO AGREE OR DISAGREE WITH A SERIES OF STATEMENTS. PLEASE CHECK THE BOX THAT BEST FITS YOUR OPINION.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Most people with a mental illness are too disabled to work.	O	O	O	O	O
People with a mental illness tend to bring it on themselves.	O	O	O	O	O
People with mental illnesses often don't try hard enough to get better.	O	O	O	O	O
People with a mental illness could snap out of it if they wanted to.	O	O	O	O	O
People with a mental illness are often more dangerous than the average person.	O	O	O	O	O
People with a mental illness often become violent if not treated.	O	O	O	O	O
Most violent crimes are committed by people with a mental illness.	O	O	O	O	O
You can't rely on someone with a mental illness.	O	O	O	O	O
You can never know what someone with a mental illness is going to do.	O	O	O	O	O
Most people with a mental illness get what they deserve.	O	O	O	O	O
People with serious mental illnesses need to be locked away.	O	O	O	O	O

PLEASE TELL US WHAT YOU THINK YOU WOULD DO IN THESE DIFFERENT CIRCUMSTANCES.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I would be upset if someone with a mental illness always sat next to me in class.	O	O	O	O	O
I would not be close friends with someone I knew had a mental illness.	O	O	O	O	O
I would visit a classmate in hospital if they had a mental illness.	O	O	O	O	O
I would try to avoid someone with a mental illness.	O	O	O	O	O
I would not mind it if someone with a mental illness lived next door to me.	O	O	O	O	O
If I knew someone had a mental illness I would not date them.	O	O	O	O	O
I would not want to be taught by a teacher who had been treated for a mental illness.	O	O	O	O	O
I would tell a teacher if a student was being bullied because of their mental illness.	O	O	O	O	O
I would stick up for someone who had a mental illness if they were being teased.	O	O	O	O	O
I would tutor a classmate who got behind in their studies because of their mental illness.	O	O	O	O	O
I would volunteer my time to work in a program for people with a mental illness.	O	O	O	O	O

DO YOU, OR DOES SOMEONE YOU KNOW, HAVE A MENTAL ILLNESS?

- o No
- o Uncertain
- o Yes, a close friend
- o Yes, a close family member
- o Yes, someone other than a close friend or family member
- o Yes, I do

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

Used with permission from Koller, M., Stuart, H., and the Opening Minds Anti-stigma Initiative of the Mental Health Commission of Canada.

Appendix B – Health Care Providers Program Questionnaire

Mental Health Commission of Canada / Commission de la santé mentale du Canada

***OPENING MINDS* SCALE FOR HEALTH CARE PROVIDERS (OMS-HC)**

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1.	I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	☐	☐	☐	☐	☐
2.	If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain or headache), I would likely attribute this to their mental illness.	☐	☐	☐	☐	☐
3.	If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her.	☐	☐	☐	☐	☐
4.	If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	☐	☐	☐	☐	☐
5.	I would be more inclined to seek help for a mental illness if my treating health care provider was not associated with my workplace.	☐	☐	☐	☐	☐
6.	I would see myself as weak if I had a mental illness and could not fix it myself.	☐	☐	☐	☐	☐
7.	I would be reluctant to seek help if I had a mental illness.	☐	☐	☐	☐	☐
8.	Employers should hire a person with a managed mental illness if he/she is the best person for the job.	☐	☐	☐	☐	☐
9.	I would still go to a physician if I knew that the physician had been treated for a mental illness.	☐	☐	☐	☐	☐
10.	If I had a mental illness, I would tell my friends.	☐	☐	☐	☐	☐
11.	It is the responsibility of health care providers to inspire hope in people with mental illness.	☐	☐	☐	☐	☐
12.	Despite my professional beliefs, I have negative reactions towards people who have mental illness.	☐	☐	☐	☐	☐
13.	There is little I can do to help people with mental illness.	☐	☐	☐	☐	☐
14.	More than half of people with mental illness don't try hard enough to get better.	☐	☐	☐	☐	☐
15.	People with mental illness seldom pose a risk to the public.	☐	☐	☐	☐	☐
16.	The best treatment for mental illness is medication.	☐	☐	☐	☐	☐
17.	I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	☐	☐	☐	☐	☐
18.	Healthcare providers do not need to be advocates for people with mental illness.	☐	☐	☐	☐	☐
19.	I would not mind if a person with a mental illness lived next door to me.	☐	☐	☐	☐	☐
20.	I struggle to feel compassion for a person with mental illness.	☐	☐	☐	☐	☐

The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: the Opening Minds Scale for Health Care Providers (OMS-HC).
Authors: Kassam A, Papish A, Modgill G, Patten S.
Journal: BMC Psychiatry. 2012 Jun 13;12:62.
doi: 10.1186/1471-244X-12-62.

Appendix C – Workforce Program Questionnaire

OPENING MINDS SURVEY FOR WORKPLACE ATTITUDES

Mental Health Commission of Canada | Commission de la santé mentale du Canada

This survey was developed as part of the *Opening Minds* Initiative of the Mental Health Commission of Canada to assess opinions in the workplace towards co-workers who may have a mental illness. There are no right or wrong answers to these questions, as everyone will have different attitudes and opinions, based on their own experiences in life.

Please read each of the following statements carefully and decide how much you agree or disagree with each statement. Place an "X" in the correct column for each statement to indicate your response.

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1.	I would be upset if a co-worker with a mental illness always sat next to me at work.	☐	☐	☐	☐	☐
2.	Most employees with a mental illness are too disabled to work.	☐	☐	☐	☐	☐
3.	I would not want to be supervised by someone who had been treated for a mental illness.	☐	☐	☐	☐	☐
4.	I would not be close friends with a co-worker who I knew had a mental illness.	☐	☐	☐	☐	☐
5.	Employees with a mental illness tend to bring it on themselves.	☐	☐	☐	☐	☐
6.	The quality of the work performed by employees with a mental illness is unlikely to meet the expectations of the job.	☐	☐	☐	☐	☐
7.	Jobs with tight deadlines and high demands are harmful to employees with mental illnesses.	☐	☐	☐	☐	☐
8.	I would try to avoid a co-worker with a mental illness.	☐	☐	☐	☐	☐
9.	Employees with a mental illness could snap out of it if they wanted to.	☐	☐	☐	☐	☐
10.	Employees with a mental illness are often more dangerous than the average employee.	☐	☐	☐	☐	☐
11.	It would be better for employees with mental illnesses to participate in work activities that are outside of the paid labour force.	☐	☐	☐	☐	☐
12.	If I knew a co-worker who had a mental illness, I would not date them.	☐	☐	☐	☐	☐

13.	Employees with a mental illness often become violent if not treated.	☐	☐	☐	☐	☐
14.	I would not want to work with a co-worker who had been treated for a mental illness.	☐	☐	☐	☐	☐
15.	Most violent crimes in the workplace are committed by employees with mental illness.	☐	☐	☐	☐	☐
16.	I would tell my supervisor if a co-worker was being bullied because of their mental illness.	☐	☐	☐	☐	☐
17.	You can't rely on an employee with a mental illness.	☐	☐	☐	☐	☐
18.	I would stick up for a co-worker who had a mental illness if they were being teased.	☐	☐	☐	☐	☐
19.	You can never know what an employee with a mental illness is going to do.	☐	☐	☐	☐	☐
20.	I would help a co-worker who got behind in their work because of their mental illness.	☐	☐	☐	☐	☐
21.	Most employees with a mental illness get what they deserve.	☐	☐	☐	☐	☐
22	I would volunteer my time to work in a program for a co-worker with a mental illness.	☐	☐	☐	☐	☐
23.	Employees with serious mental illnesses need to be locked away.	☐	☐	☐	☐	☐

Szeto, A. C. H., Luong, D., & Dobson, K. S. (2013). Does labelling matter?: An examination of attitudes and perceptions of labels for mental disorders. *Social Psychiatry and Psychiatric Epidemiology, 48,* 659-671.

Appendix D – *Opening Minds'* Partners

PROFESSIONAL ASSOCIATIONS

Alberta Medical Association

British Columbia Medical Association

Canadian Medical Association

Canadian Psychiatric Association

College of Family Physicians of Canada

Royal College of Physicians and Surgeons

Nova Scotia College of Family Physicians

Doctors Nova Scotia

Canadian Journalism Forum on Trauma and Violence

PROGRAM PROVIDERS

Canadian Mental Health Association
- Calgary
- Champlain East Branch, Cornwall/Ottawa
- Grand River Branch, Guelph
- Hamilton
- Ontario
- Thunder Bay Branch
- Toronto
- Winnipeg

Centre for Addiction and Mental Health, Hamilton, Ontario

Canadian Mental Health Association, Ontario

Centre for Building a Culture of Recovery, Penetanguishene, Ontario

Children's Mental Health Ontario

Digby Clare Mental Health Volunteers Association, Digby, Nova Scotia

Dream Team/Houselink, Toronto, Ontario

Elevated Grounds, Toronto, Ontario

Family Outreach and Response, Toronto, Ontario

Family Service Thames Valley, London, Ontario

Hands – TheFamilyHelpNetwork.ca

Healthy Aboriginal Network, Vancouver, British Columbia

Iris the Dragon (Charity), Perth, Ontario

Laing House, Halifax, Nova Scotia

Mental Illness Foundation, Montréal, Québec

Mike's Story, Montréal, Québec

mindyourmind, London, Ontario

Mood Disorders Association of British Columbia, Vancouver

Mood Disorders Society of Canada

Mood Disorders Association of Ontario, Toronto

Progress Place and the University Health Network (UHN), Toronto, Ontario

Provincial Centre of Excellence for Child and Youth Mental Health, CHEO

Schizophrenia Society of Alberta, Calgary Chapter

Schizophrenia Society of Saskatchewan, Regina Chapter

Schizophrenia Society of Saskatchewan, Saskatoon Chapter

Self Help Alliance, Guelph, Ontario

Stand Up For Mental Health, Vancouver, British Columbia

Workman Arts, Toronto, Ontario

HEALTH SERVICE PROVIDERS

Alberta Health Services, Alberta

British Columbia Interior Health, Castlegar, Kelowna, Williams Lake, Penticton, Cranbrook, Kamloops, and Salmon Arm, British Columbia

CAMH – Centre for Addiction and Mental Health, Toronto, Ontario

Capital District Health Authority, Halifax and area

Central East Local Health Integration Network (LHIN), Oshawa, Ontario

Central LHIN, Markham, Ontario

Centre hospitalier universitaire, Sherbrooke, Québec

Children's Hospital of Eastern Ontario, Ottawa, Ontario

Community Health Centres in Ontario: South Riverdale, Central Toronto, Unison

Izaak Walton Killam (IWK) Health Centre, Halifax, Nova Scotia

Lakeridge Health, Oshawa, Ontario

Louis H. Lafontaine Hospital, Montréal, Québec

North Bay Regional Health Centre, North Bay, Ontario

Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario

South East LHIN, Belleville, Ontario

St. Joseph's Healthcare, Hamilton, Ontario

Toronto Western Hospital, Ontario

United Health Network, Toronto, Ontario

Vancouver Island Health Authority, British Columbia

UNIVERSITIES/COLLEGES

Algonquin College, Ottawa, Ontario

Brandon University, Brandon, Manitoba

Carleton University, Ottawa, Ontario

Dalhousie University, Halifax, Nova Scotia

McGill University, Montréal, Québec

Mount Royal University, Calgary, Alberta

Memorial University, St. John's, Newfoundland

Nova Scotia Community College, Sydney, Nova Scotia

Queen's University, Kingston, Ontario

Ryerson University, Toronto, Ontario

University of Alberta, Edmonton, Alberta

University of British Columbia, Vancouver, British Columbia

University of Calgary, Calgary, Alberta

University of King's College Journalism School, Halifax, Nova Scotia

University of Saskatchewan, Saskatoon, Saskatchewan

University of Toronto, Toronto, Ontario

University of Winnipeg, Winnipeg, Manitoba

York University, School of Social Work, Faculty of Liberal Arts and Professional Studies, Toronto, Ontario

CORPORATIONS – PRIVATE

Husky Energy, Calgary, Alberta

Standen's Ltd., Calgary, Alberta

TELUS, Barrie and Scarborough, Ontario

GOVERNMENT AND PUBLIC ORGANIZATIONS

Alberta Environment and Sustainable Resource Development

Alberta Health Services

Calgary Police Service

Canadian Broadcasting Corporation

Canadian Forces

Department of National Defence

Government of Northwest Territories: Department of Health and Social Services, and Child and Family Services

Government of Ontario: Ministry of Education; Ministry of Colleges and Universities; Ministry of Government Services; Ministry of Community and Social Services

Health Canada, Alberta

Nova Scotia Department of Health

Nova Scotia Public Service Commission

Royal Canadian Mounted Police

Region of Peel, Ontario

Toronto District School Board, Ontario

OTHER

Alberta Criminal Justice Association

Bell Canada

Canadian Criminal Justice Association

Canadian Human Rights Commission

Manitoba Criminal Justice Association

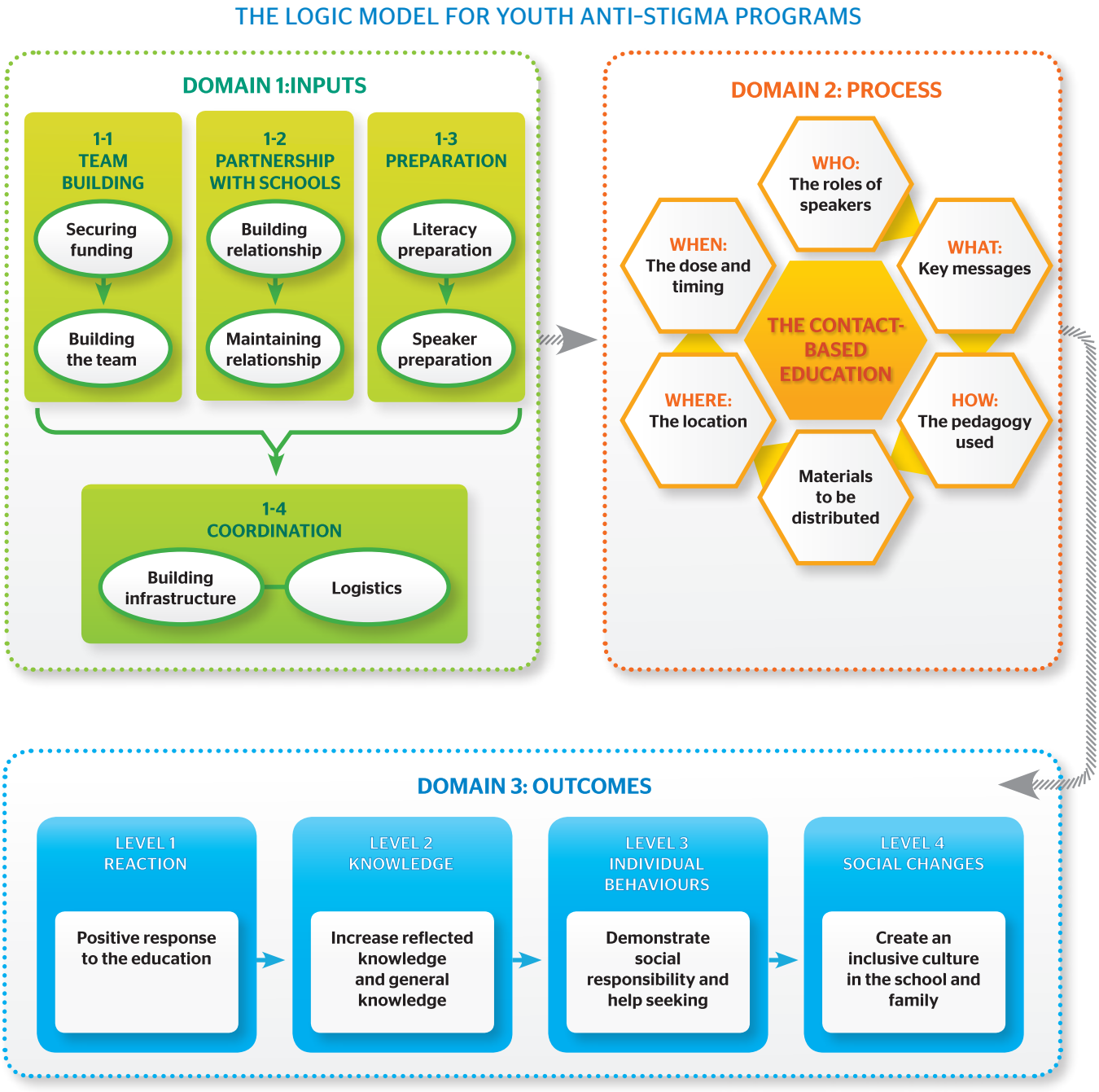
Statistics Canada

INTERNATIONAL

Global Alliance Against Stigma (examples: Time to Change, England; see me, Scotland; beyondblue, Australia)

World Psychiatric Association

Appendix E –
Logic Model For Youth Anti-Stigma Programs



Logic Model by Chen, Koller, Krupa, and Stuart, 2013

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Mental Health Commission of Canada

Commission de la santé mentale du Canada

Addressing Stigma

Towards a More Inclusive Health System

The Chief Public Health Officer's Report on the State of Public Health in Canada 2019

Canada

Également disponible en français sous le titre :
Rapport de l'administratrice en chef de la santé publique
sur l'état de la santé publique au Canada 2019

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Table of Contents

Message from the Chief Public Health Officer of Canada 4

About this Report 7

CHAPTER 1

Describing the Health of Canadians 8

Introduction 8
Health Trend Highlights 8

CHAPTER 2

Stigma is a Public Health Issue 20

The Experience of Stigma 20
The Pathways of Stigma to Health Outcomes 22
Why a New Stigma Model is Needed 24
Practical Application of the Model 25
Resisting the Impacts of Stigma 36

CHAPTER 3

Building an Inclusive Health System 38

The Experience of Stigma Revisited 38
An Action Framework for Building an Inclusive Health System 40
Principles to Guide Anti-stigma Interventions 53

Way Forward 55

APPENDIX A

Chief Public Health Officer's Health Status Dashboard 57

Acknowledgements 66

References 67

Message from the Chief Public Health Officer of Canada

By and large, we are a healthy nation. We can be proud of Canada's health and social systems that contribute to this status. From this position of strength, we have an even greater opportunity to lead the world in health status and to ensure all Canadians can achieve optimal health. This year, my annual report provides a snapshot of key public health trends and shines a light on one of the drivers of health inequities: stigma.

I am pleased to report on some important positive health trends this year like the lower incidence of certain chronic and other non-infectious diseases. Some social factors that lead to good health in Canada are also improving; more people are achieving post-secondary education, and poverty rates, especially childhood poverty, are decreasing.

I do continue to be concerned about worrying trends. With the dramatic rise in global measles cases this year, the risk of importation and domestic spread has increased. If we do not improve our vaccine coverage, we may lose our hard-earned measles elimination status. Sexually transmitted infections such as syphilis are also making a comeback with the additional challenge of antibiotic-resistant bacteria causing gonorrhoea. Youth vaping rates are increasing and we do not fully understand the related harms, from potential impacts on the respiratory system to the incidence of youth cigarette smoking. The opioid crisis continues, and claimed more than 12 deaths per day in 2018. The harms may have been much greater if a range of preventive, harm reduction, and treatment measures had not been implemented.

All of these trends are reversible. We know what to do but need to re-engineer how we implement proven public health measures in today's context. This includes getting trusted, evidence-based information to Canadians in the age of misinformation and disinformation.

Although public health policies and programs should benefit all, persistent health inequities prevent many from being able to achieve their full potential. Often these differences can only be explained by how people are treated. That is why I focused this annual report on stigma and health.

Stigma affects us all. We are all vulnerable to the slow and insidious practice of dehumanizing others and we are all responsible for recognizing and stopping it.

This is what we know. Stigma is associated with poorer physical and mental health outcomes. Stigma and discrimination towards persons with health conditions, such as mental illness, substance use disorders, and HIV, cannot be understood or treated separately from stigma related to other characteristics such as race, gender, sexual orientation, age, and income.

These many forms of stigma, that intersect in complex ways, are very much present in our health system, driving those most in need from getting effective care and accessing services. It means that we, as health system leaders and practitioners, are contributing to negative health outcomes.

This report offers a way forward.

We can build on our Canadian multicultural and inclusive way of life, while at the same time openly recognize and name racism, homophobia, transphobia, and other stigmas related to social identities. We can stop using dehumanizing language, examine our own assumptions, and implement policies and education programs, while also measuring our progress towards stigma elimination across the health system. By understanding the common drivers, practices, and experiences of multiple stigmas, we may find more collaborative and effective interventions.

It is hard to face our vulnerabilities as individuals and organizations who set out to care for others but fall short on providing the safe, effective, and compassionate health system that puts people first. However, with a dose of humility and a deepened connection to people who experience stigma, we can deconstruct the “us versus them” narrative and develop the most inclusive health system in the world.

Dr. Theresa Tam
Chief Public Health Officer of Canada

We would like to respectfully acknowledge that the land on which we developed this report is in traditional First Nations, Inuit, and Métis territory, and we acknowledge their diverse histories and cultures. We strive for respectful partnerships with Indigenous peoples as we search for collective healing and true reconciliation.

We would also like to acknowledge the territories in which we conducted discussion groups that contributed to this report:

- We acknowledge that the discussion group in Ottawa took place on the traditional unceded territory of the Algonquin people.
- We acknowledge that the discussion group in Toronto took place on the traditional territory of the Wendat, the Anishnaabeg, Haudenosaunee, Métis, and the Mississaugas of the New Credit First Nation.
- We acknowledge that the discussion group in Montréal took place on the traditional unceded territory of the Mohawk people.
- We acknowledge that the discussion group in Vancouver took place on the traditional unceded territory of the Coast Salish peoples, including the territories of the Musqueam, Squamish, Stó:lō, and Tsleil-Waututh Nations.

"Greater attention needs to be paid to stigma as a social determinant of population health."[1]

About this Report

Every year, the Chief Public Health Officer writes a report on the state of public health in Canada. These reports raise the profile of public health issues and stimulate dialogue. They can also lead to action in improving and protecting the health of Canadians.

This year's report first provides a summary of the overall health of Canadians, including how different populations experience poorer health. The rest of the report focuses on stigma, one of the reasons for these differences.

Health of Canadians

Chapter One draws on indicators from the Chief Public Health Officer's Health Status Dashboard (Appendix A), as well as other national data on the health of Canadians. Some health inequalities are highlighted by the use of key examples. The dashboard provides a breakdown of national indicators by sex where possible. In the past year, some new data have been released and indicator values have been updated. In other areas, the indicator values from last year remain the same.

Stigma and Health

Chapter Two presents a stigma and health model that highlights the pathways from stigma to poor health outcomes and how different stigmas intersect. This new model illustrates how stigma drivers and practices, including those in the health system, can lead to health inequities. Chapter Three presents an action framework with a range of evidence-based actions that can be implemented simultaneously to reduce stigma across the health system. These sections examine a range of health-related stigmas as well as stigmas associated with social identities.

The information presented in the stigma chapters was synthesized from an evidence review conducted in social and health science databases.

When synthetizing the evidence, systematic reviews were prioritized and complemented by primary studies. The strongest evidence found through the review was prioritized. Where available, Canadian research has been highlighted. Emerging and promising practices were identified through the evidence review, environmental scan, and stakeholder engagement.

Throughout the stigma chapters, quotes have been included to reflect the lived experiences of stigma and broader input on solutions for developing an inclusive health system. These quotes were gathered during five discussion groups and eight interviews with a range of people with expertise in stigma across Canada. Participants included health professionals, representatives from community-based organizations, service providers, policymakers, researchers, individuals with lived and living experience, and others working to improve the health of their communities. The areas of focus included stigma experienced by First Nations, Inuit, and Métis peoples, African, Caribbean, and Black Canadians, seniors, and LGBTQ2+ people, and across health issues such as mental illness, substance use, tuberculosis, HIV, and obesity.

More information about the themes from the discussion groups and interviews can be found in the What We Heard report.

CHAPTER 1

Describing the Health of Canadians

Introduction

Canadians are among the healthiest people in the world. In general, we live long lives in good health. Nevertheless, there are some concerning public health trends and health inequities.

The content of this chapter is based on indicator data derived from the Chief Public Health Officer's Health Status Dashboard (Appendix A), as well as other national data sources and scientific literature exploring the health of Canadians. Dashboard changes compared to the previous version that was published as part of the *Chief Public Health Officer's Report on the State of Public Health in Canada 2018: Preventing Problematic Substance Use in Youth*, include indicator value updates and breakdowns per sex, where available. In the event that no new indicator results were available, last year's published results are used. It is important to note, however, that national-level data can mask the health status of some groups in Canada. This chapter offers some examples of these persistent health inequities.

Health Trend Highlights

Life Expectancy is Changing

In 2017,[i] life expectancy at birth for women was 84 years, while for men it was 80 years.[2] Life expectancy is affected by both the number of deaths in a population, as well as the age at which those deaths occur.

For years, life expectancy at birth has steadily increased in Canada for both sexes, but recent data suggest this may be starting to change. From 2016 to 2017, for the first time in four decades, there was no year-to-year increase in life expectancy at birth for either males or females.[2]

Despite this, some encouraging trends in life expectancy have been observed. Over the course of the previous three decades, male life expectancy at birth has increasingly approached the life expectancy of females, so the gap between the sexes has decreased.[2] Life expectancy at birth has been positively influenced by fewer deaths or later deaths related to cancer or circulatory diseases from 2016 to 2017.[2]

Life expectancy is changing across age groups. Older people benefitted from improved mortality rates in 2017, meaning that they are dying at a slower rate than in 2016. However, gains in life expectancy at birth, due to these improved mortality rates for older Canadians, are being largely offset by increased mortality rates among younger adults. This is especially true for males (Figure 1).[2]

i Respective life expectancy data is based on reference period 2015–2017.

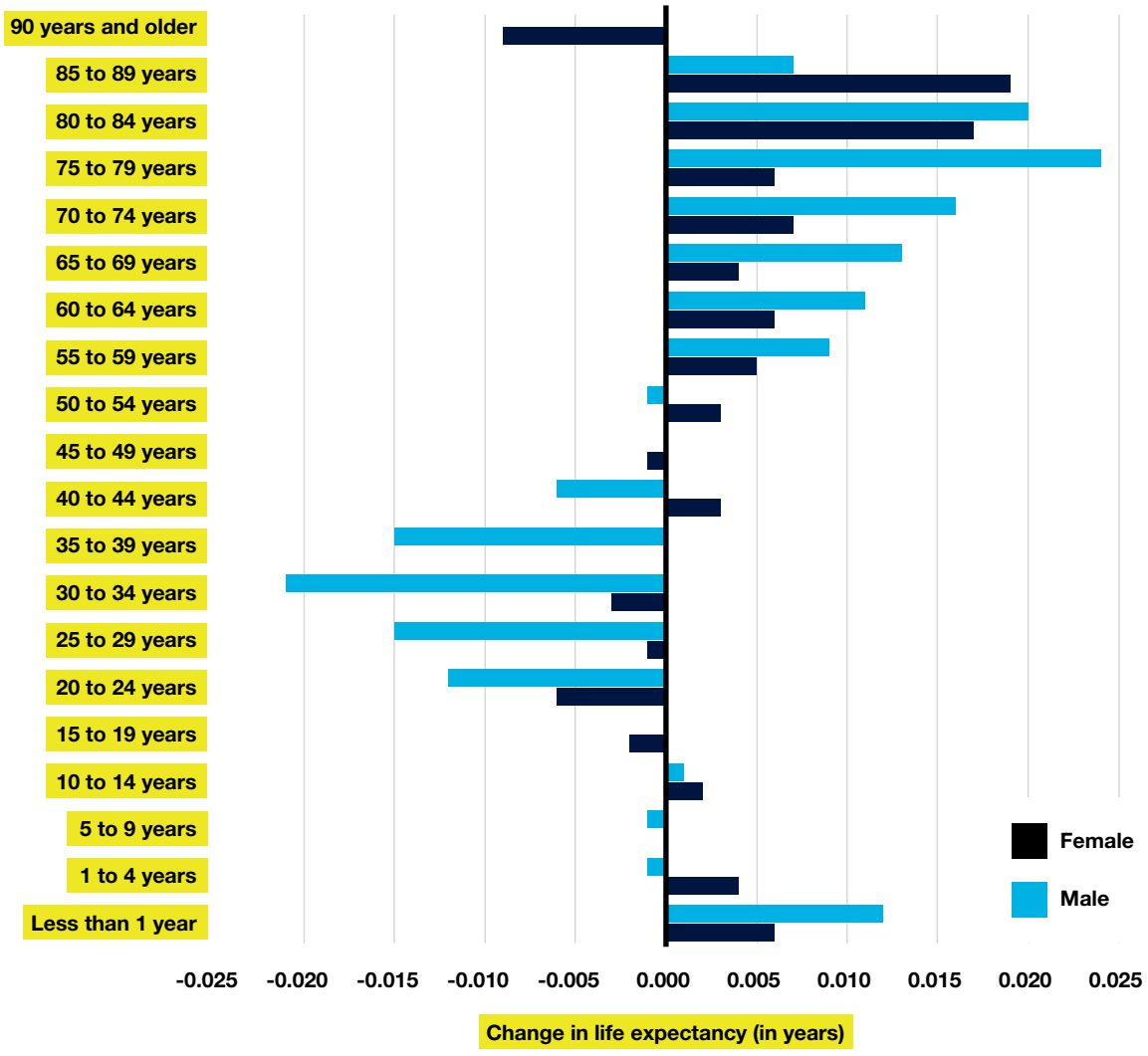
Health Inequalities and Inequities in Context

Health inequalities reflect differences in health outcomes. When these differences are related to unfair conditions, they are called health inequities. When reporting on populations that experience a disproportionate burden of poor health outcomes, it is critical to understand the context of these data.

For instance, First Nations, Inuit, and Métis peoples have had to overcome stigmatizing and catastrophic experiences throughout history, such as colonization, the loss of traditional lands and political institutions, and attempts at cultural assimilation. Poor health outcomes related to substance use and mental health are examples of the lasting impacts of intergenerational trauma (i.e., passing on the negative effects from one generation to the next) that have influenced the health of Indigenous peoples in Canada.

Unique contexts also exist for other populations, which need to be contextualized within historical, political, social, and economic conditions. Not all of these situations may be referred to in this chapter due to data and space limitations. To further explore differences in health outcomes, please refer to the report Key Health Inequalities in Canada.

FIGURE 1: Contribution of Age-specific Mortality Rates to the Change in Life Expectancy at Birth (by Sex, 2016 to 2017, Canada)



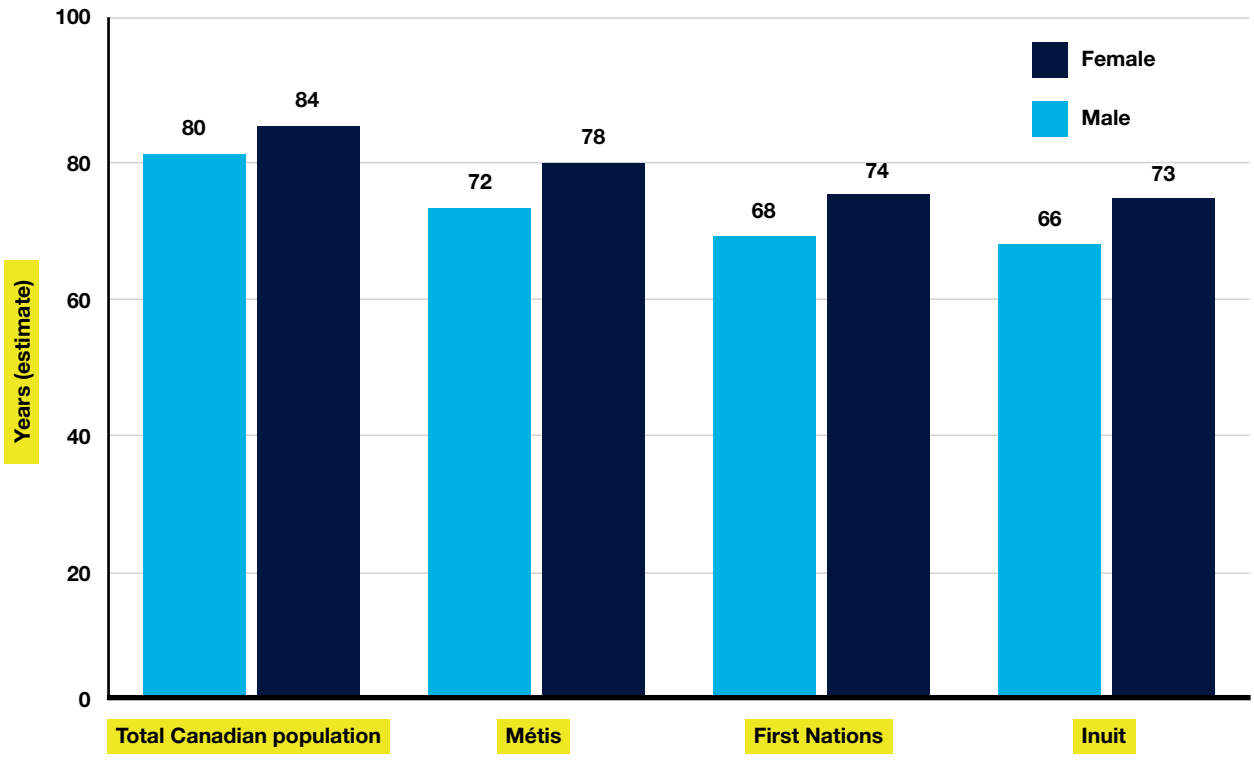
Source: Statistics Canada. Changes in life expectancy by selected causes of death, 2017.

The increase in deaths in young adults has been primarily attributed to the increase in opioid-related overdose deaths, particularly among young and middle-aged men. Opioid-related deaths have had a serious impact on life expectancy for both sexes, but more so for males in British Columbia and Alberta, contributing to decreases in life expectancy in both provinces from 2016 to 2017.[2]

When examining different groups in Canada, life expectancy is consistently lower among First Nations, Inuit, and Métis peoples. Other differences in life expectancies are consistent with what is known on the social determinants of health, like those living with lower income have a lower life expectancy than the general population. There are also populations for which we have very limited data. For example, life expectancy data for some populations, like other racial groups or LGBTQ2+ people, is not known.[3]

As seen in Figure 2, with respect to Indigenous peoples, Inuit were estimated to have a shorter life expectancy at birth, up to 14 years shorter for males, and up to 11 years shorter for females, compared to the overall Canadian population.[4] It is important to see these data in context; the lasting legacy of colonization and intergenerational trauma have led to systemic health inequities for First Nations, Inuit, and Métis peoples.[5]

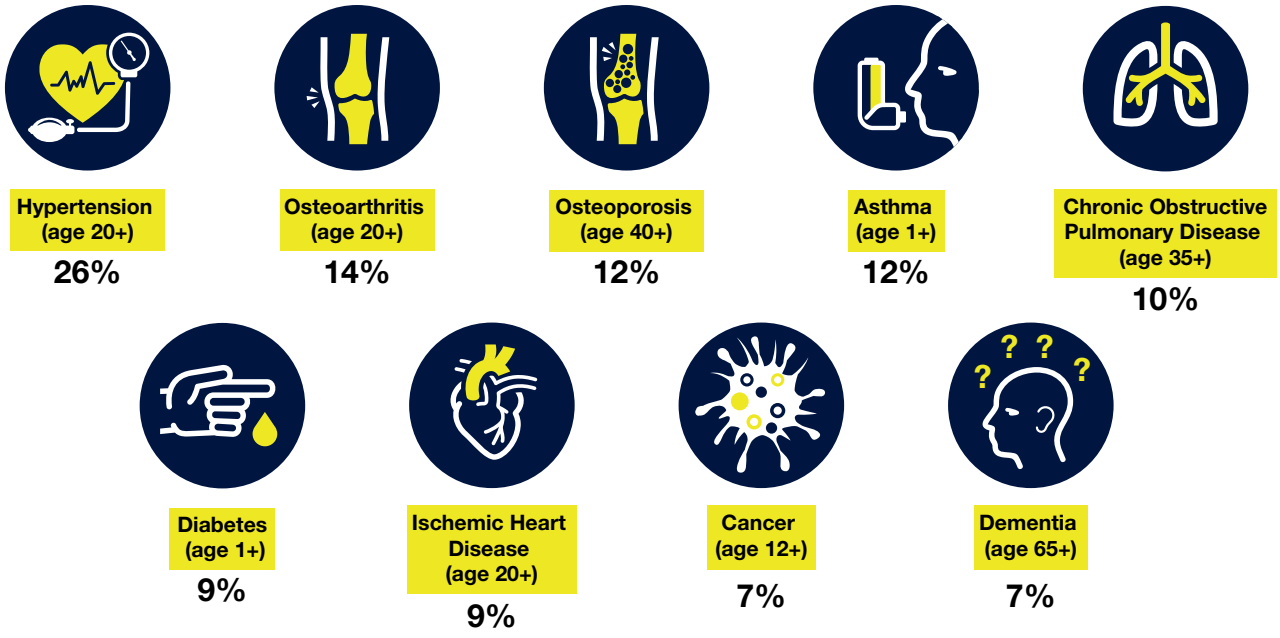
FIGURE 2: Life Expectancy at Birth by Indigenous Identity and Sex (Canada, 2009–2011)



Source: Pan-Canadian Health Inequalities Data Tool, 2017 Edition.

FIGURE 3: Prevalence Rates of Common Chronic Conditions

The prevalence[ii] rates of the most common chronic conditions[iii] are:



Note that although mood disorders are among the most common chronic conditions, they are described separately in a subsequent section.

Source: Public Health Agency of Canada. Canadian Chronic Disease Indicators, Quick Stats, 2018 Edition.

Chronic Diseases Continue to be the Major Disease Burden

Chronic disease continues to be the biggest cause of disease burden in Canada. Close to half of Canadian adults over the age of 20 years report that they are living with at least one of ten common chronic diseases or conditions (Figure 3).[7]

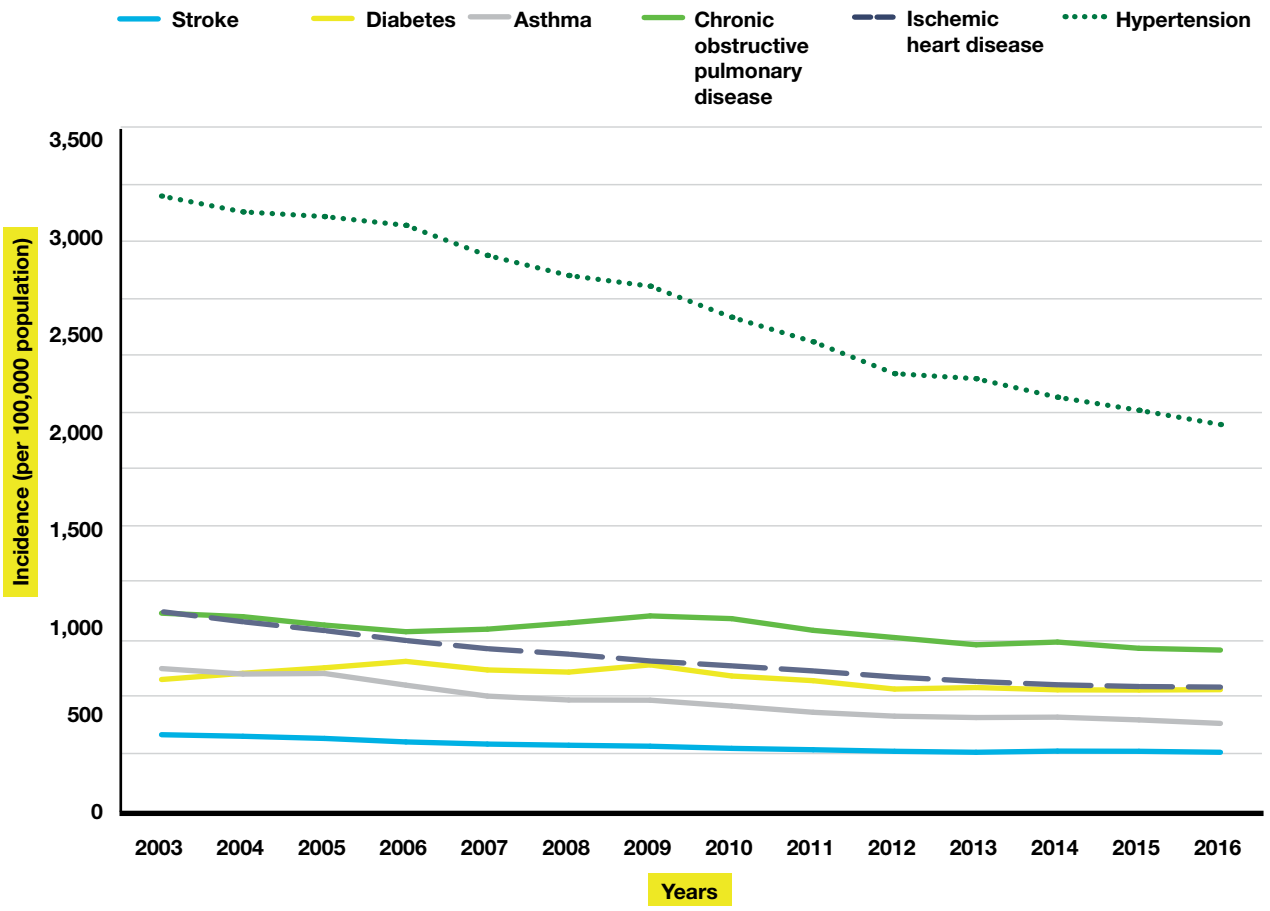
On a positive note, recent data suggest declining incidence[iv] rates for a number of chronic diseases in Canada (Figure 4).[7] A report analyzing national data over the period of 1999 to 2012 from the Canadian Chronic Disease Surveillance System (CCDSS) identified decreasing overall incidence trends for diagnosed asthma, chronic obstructive pulmonary disease, hypertension, ischemic heart disease, and stroke.[6] More recent data from CCDSS reiterates the continuation of these trends between 2003 and 2016 for all described chronic diseases and points to a declining incidence rate for diabetes starting in 2006.[7, 8] The observed decrease in chronic disease incidence rates may be influenced by factors such as varying strategies used to diagnose, manage, and report chronic diseases across the country. Further investigations are needed to fully understand these observations.

ii The term "prevalence" is used when referring to the number of people living with an existing medical condition in a given time period.

iii Many chronic conditions are influenced by modifiable risk factors which were not addressed in this report. Please refer to the CPHO 2018 annual report.

iv The term "incidence" is used when referring to the number of people newly diagnosed with a medical condition in a given year.

FIGURE 4: **Age-standardized Chronic Disease Incidence Estimates (2003–2016, Canada)**



Source: Canadian Chronic Disease Surveillance System data files (as of August 2019).[7]

Canadian data also suggest a possible decline in the incidence rates of newly diagnosed cases of dementia, including Alzheimer's disease (Appendix A).[9, 10] A recent Lancet commission examined lifestyle factors which might influence an individual's risk of developing dementia. Evidence shows that healthy living and higher education levels may contribute to preventing or delaying dementia.[11] While the incidence rate may be decreasing in Canada, the burden of Alzheimer's disease and dementia is expected to continue to increase, due to factors such as a growing and aging population, and possibly improved survival. Accordingly, between 2005 and 2016, the age-standardized prevalence rate of dementia increased by 12%.[7]

There are health inequalities across chronic diseases. For example, South Asian as well as African, Caribbean, and Black Canadian adults are more than twice as likely to live with diabetes than White adults.[3] Evidence suggests that dementia rates are rising more rapidly among First Nations populations compared to the general Canadian population, including earlier disease onset.[10, 12]

Poor Mental Health Continues to Impact Canadians

The good news is that 69% of Canadians aged 12 years and older reported their mental health status as very good or excellent in 2018. At the same time, the percentage of Canadians aged 12 years and older who indicated that they have been diagnosed by a health professional as having a mood disorder, such as depression, bipolar disorder, mania, or dysthymia (i.e., persistent depressive disorder) was 9% in 2018.[13]

Mental health varies considerably among Canadians, with some sub-populations being much more likely to report low self-rated mental health. For example, for the period of 2010 to 2013, adults who identified as bisexual were close to three times more likely, and adults who identified as gay or lesbian, were approximately twice more likely, to report low self-rated mental health than adults who identified as heterosexual. These higher rates could be linked to internalized stress related to gender expectations and experienced discrimination.[3]

In Canada, suicide rates remained stable from 2000 to 2017. On average, 11 Canadians die by suicide every day.[14] In 2017, the suicide rate among males was three times higher than the rate among females. Suicide rates were highest among middle-aged males.[14] Some Indigenous communities are disproportionally affected. Areas with a relatively high Inuit population had a 6.5 times higher suicide rate than areas with a low concentration of Indigenous peoples.[3] Suicide rates in areas primarily inhabited by First Nations and Métis peoples were also significantly higher (four and three times, respectively) than in areas with a non-Indigenous peoples majority.[3] The impacts of intergenerational trauma can ultimately manifest in poor mental health and practices that may place individuals at risk for suicide. However, it is important to note that not all Indigenous communities experience high suicide rates. For example, over 60% of First Nations bands had a suicide rate of zero.[15] Protective factors can include opportunities to speak and learn one's traditional language, cultural identity, and connection to the land.[16, 17]

Substance Use

Substance use and its related harms remain a concerning public health issue and a national priority. Street drugs contaminated with highly toxic fentanyl and fentanyl analogues continue to drive the current epidemic of opioid related deaths.[18] In addition, reducing or preventing alcohol-related harm is a persistent challenge, alongside addressing emerging concerns such as tobacco use and nicotine vaping among youth.

High Rates of Opioid-related Deaths Continue

Nationally, more than 12 apparent opioid-related deaths occurred on average every day in 2018.[18] In early 2019, 82% of accidental opioid-related deaths involved fentanyl or fentanyl analogues.[19] Regional variations continue to be observed and some provinces and territories (British Columbia and Alberta, in particular) have been impacted more than others. Data for 2018 show that overall, men accounted for three quarters of accidental apparent opioid-related deaths in Canada.[18] Likewise, in 2018, young and middle-aged adults accounted for the most accidental apparent opioid-related deaths overall, with 27% of deaths reported among those aged 30 to 39 years, followed by 22% in those aged 40 to 49 years, 21% aged 50 to 59 years, and 20% aged 20 to 29 years.[18] Although complete national information on opioid-related harms in Indigenous peoples is lacking, available data suggest higher opioid use and associated harms, including higher rates of hospitalization, accidents, and death in some but not all Indigenous communities, compared to the general Canadian population.[20] In this context, it is important to note that First Nations, Inuit, and Métis peoples have experienced intergenerational trauma, abuse and systemic racism, which directly or indirectly contribute to elevated levels of substance use rates.[21, 22]

Vaping Increases Among Youth

Vaping is the inhaling of a vapour created by an electronic cigarette (e-cigarette) or other vaping device. In 2017, the use of e-cigarettes as a cessation aid in the past two years was reported by 32% of current or former smokers.[23] Among the 3% of Canadians aged 15 years and older who used a vaping product in the past 30 days in 2017, 65% were current smokers, 20% were former smokers, and 15% reported having never smoked cigarettes.[23]

The increased use of vaping products by youth represents an emerging and serious health trend. Vaping can increase the risk of nicotine addiction and could alter brain development in youth.[24] The long-term effect of exposure to a range of harmful chemicals such as formaldehyde, acrolein, metals, and other contaminants through vaping remains unknown. Emerging evidence points to increased risk of respiratory disease in vaping device users, highlighting the need for further studies.[25, 26] In 2017, approximately 15% of Canadians aged 15 years and older had ever tried a vaping product, with the greatest likelihood among youth aged 15 to 19 years (23%) and young adults aged 20 to 24 years (29%).[23] A recent meta-analysis indicates that adolescents and young adults who had ever used e-cigarettes had close to four times higher odds of initiating cigarette smoking than those who had never used e-cigarettes.[27] Accordingly, from 2017 to 2018, the percentage of Canadian youth aged 16 to 19 years who reported vaping in the last month increased substantially by 74%.[28] More research is required to better understand the association between vaping and smoking behaviour in Canada, and the related health impacts.

Cannabis Use Rises in Adults 25+

In 2017, the prevalence of past-year cannabis use was 15%, a 3% increase compared to 2015.[23] Frequent cannabis use did not change between 2015 and 2017, with approximately 3% of Canadians aged 15 years and older reporting daily or almost daily cannabis use in the previous three months. It is important to note that most of the available data on cannabis consumption pre-dates cannabis legalization in Canada in 2018.[29] Consequently, cannabis use reporting was strengthened with the implementation of the *Cannabis Stats Hub* in 2018, which now monitors cannabis use every three months.[30]

Cannabis use varies by age. In 2017, past-year use of cannabis was highest among youth aged 15 to 19 years (19%) and young adults aged 20 to 24 years (33%) compared to adults aged 25 years and older (13%). Compared to 2017, past-year cannabis use among adults aged 25 years and older increased from 10% in 2015, though there were no changes reported for other age groups.[23] National and regional studies identified differences in cannabis use by race in youth, with Indigenous youth being the most likely group reporting lifetime and recent cannabis use.[31, 32]

By the end of 2018, the cannabis sources accessed by users largely depended on their reasons for using it. Eighty-six percent of medical users with documentation acquired cannabis from legally authorized retailers or licensed online producers, in contrast to 26% of non-medical users.[33] Forty-two percent of non-medical users declared obtaining cannabis from illegal sources and 54% from friends or family.[33]

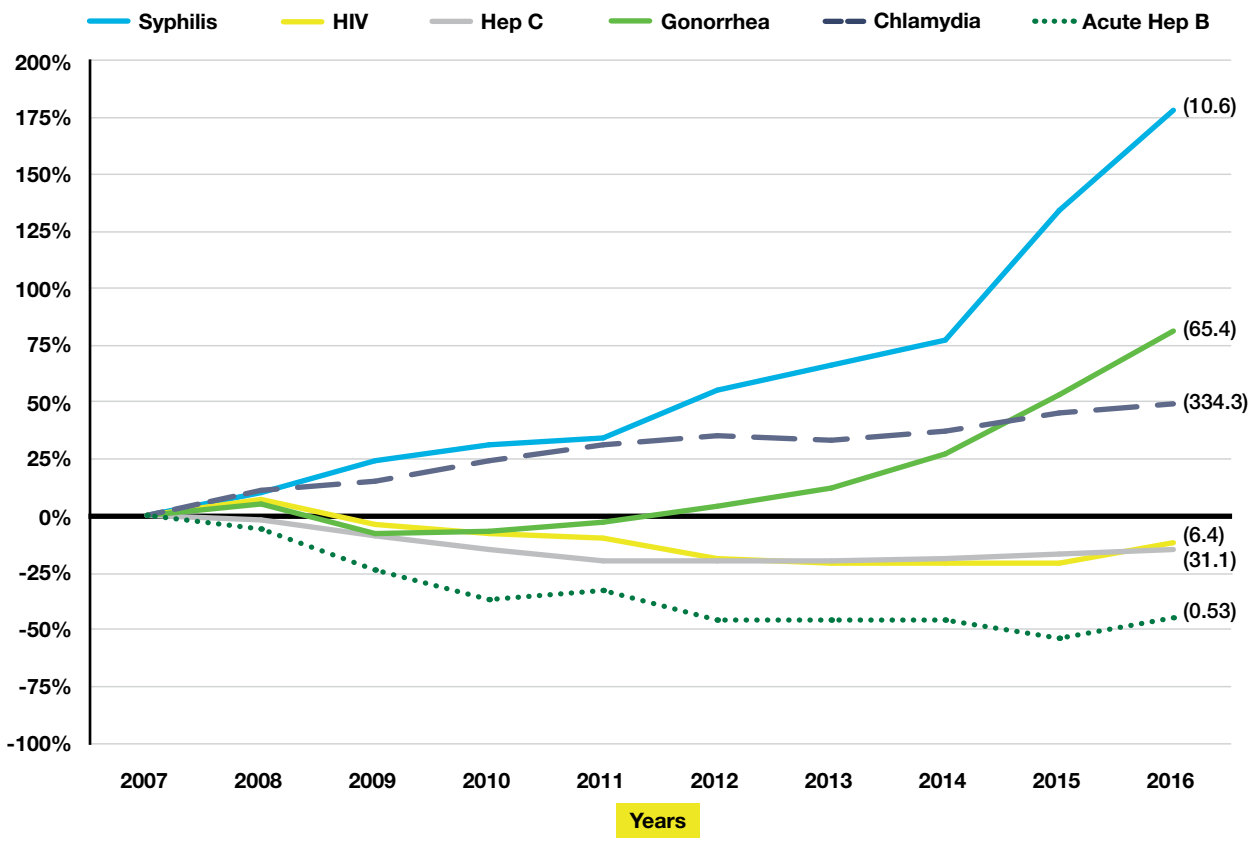
One important contributor for harms related to cannabis use is the increased risk of motor vehicle collisions when driving under the influence of cannabis.[34] Among cannabis users with a valid driver's licence, 14% admitted to driving within two hours of using cannabis. This practice was nearly twice as common in males compared to females.[35]

Heavy Drinking Rates Remain Harmfully High

Alcohol continues to be the most used psychoactive substance amongst adults and youth. In 2017, 78% of the population over 15 years of age reported drinking alcohol in the last year.[23] In 2017, past-year alcohol use among youth aged 15 to 19 years was 57%.[23] These figures were all unchanged from 2015.

Heavy drinking rates remained stable from 2017 to 2018, with 19% of Canadians aged 12 years and older reporting heavy drinking in 2018.[13] Heavy drinking means having five or more standard drinks for men or four or more standard drinks for women, on one occasion, at least once a month in the past year.[36]

FIGURE 5: Percentage Change in Reported Rates of Selected STBBI in Canada (2007–2016)



The percentages on the left represent the percent change relative to the reference year of 2007. The values in brackets represent the 2016 infection rates per 100,000 population.

Source: Adapted from *Accelerating our Response: Government of Canada Five-year Action Plan on Sexually Transmitted and Blood-borne Infections*.[38]

The rate of alcohol-related hospitalizations has increased faster for women than for men. More than 25,000 women had alcohol-related hospitalizations, representing a 3% increase from 2015–16 to 2016–17. In contrast, the increase for men was 0.6%.[37] Differences in heavy drinking behaviour exist across populations. For instance, close to 22% of White adults reported heavy drinking between 2010 and 2012, which is greater than the approximate 7% of heavy drinking among African, Caribbean, and Black, Asian, and Arab adults. Bisexual women and lesbians were almost twice as likely to declare high alcohol consumption as heterosexual women.[3]

Sexually Transmitted and Blood-borne Infections are on the Rise

Concerning increases for some sexually transmitted and blood-borne infections (STBBI) have been observed in Canada. From 2007 to 2016, the reported rates for chlamydia, gonorrhea, and syphilis increased by 49%, 81% and 178%, respectively (Figure 5).[38] Moreover, six cases of congenital syphilis were reported in Canada in 2015, reversing the previous downward trend observed from 2011 to 2014.[39] This result is disquieting as it coincides with a rise in syphilis cases in women of childbearing age. There are numerous factors that may contribute to some extent to the

observed trends, other than a true rise in incidence, such as improved diagnostic tools, contact tracing, and case detection.[40]

While the number of newly diagnosed HIV infections remained relatively stable in Canada, 14% of people living with HIV were estimated to be unaware of their status in 2016.[41] Similarly, as of 2016, national Hepatitis C infection rates remained stable over the course of previous years.[42] An estimated 44% of Canadians living with Hepatitis C are thought to be unaware of their status.[43]

Some communities are disproportionally affected. For example, gay, bisexual and other men who have sex with men accounted for more than 50% of new HIV infections in 2016, although they represented approximately 3% of the male population in Canada. Indigenous peoples accounted for 11% of new HIV infections in 2016, but represented only 5% of the general population.[41]

Certain sub-populations are at high risk for Hepatitis C infections, such as people who inject drugs and people who are incarcerated.[43]

Current Vaccination Rates are Not Reaching National Targets

For many decades, vaccines have helped prevent and control the spread of serious infectious diseases in Canada and abroad. However, effective vaccine protection at the population level requires establishing and maintaining high vaccination rates across the country. Since 2011, little progress has been made towards reaching national childhood vaccination targets for several vaccine preventable diseases, such as measles and polio (Appendix A).[44]

In the case of measles, for example, the disease was declared eliminated from Canada in 1998. This was shortly after introducing a routine second dose of the measles vaccine to the childhood immunization schedule, prior to school entry.[45] In spite of this success, the national estimated measles vaccine coverage rate among two-year-olds was only 90% in 2017, which is below the minimum 95% vaccination coverage needed at the population level to maintain measles elimination.[46] Over the past two decades, measles cases and outbreaks have occurred intermittently in Canada, ranging from a few secondary cases to over 680 cases per outbreak (Figure 6).[47–51] They have been linked to individuals who acquired measles during international travel.

Antimicrobial Resistance and Unnecessary Antibiotic Use is an Emerging Threat

Antimicrobial resistance (AMR) describes the capability of disease-causing microorganisms to withstand antimicrobial treatments such as antibiotics, thereby limiting available treatment options. AMR has been identified by the World Health Organization as one of the ten most significant threats to global health. Globalization, travel, and medical tourism mean that Canada shares this threat.[52, 53] If left unchecked, it is estimated that AMR could cause 10 million deaths a year worldwide by 2050.[54]

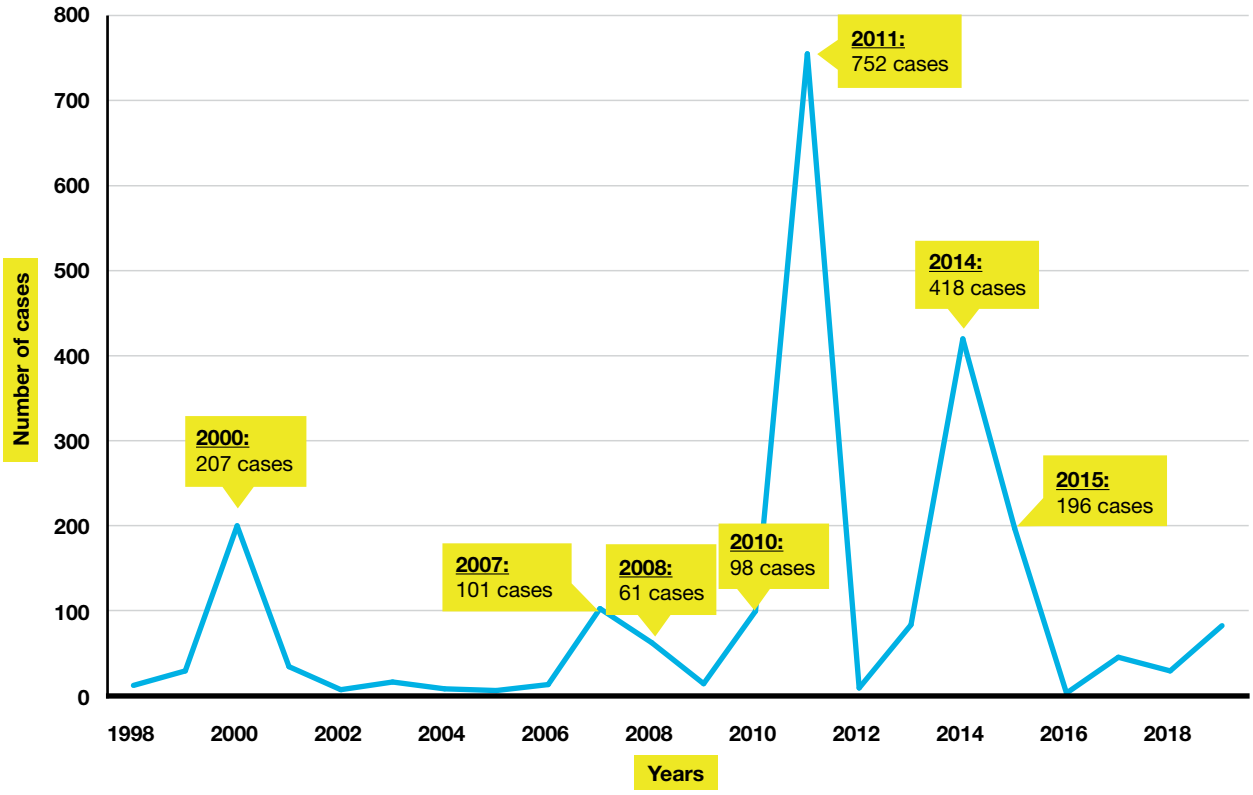
Concerning national AMR trends were observed for several infectious diseases. For example, rates of community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) infections increased by 62% between 2012 and 2017; *Neisseria gonorrhoeae* infections resistant to azithromycin increased by 50% from 2015 to 2016.[53] While infection rates of some of the most resistant organisms, carbapenem-resistant Enterobactericeae (CRE), have been stable, a very worrisome trend can be found in the five-fold increase, between 2014 and 2017, in the number of people who are carriers of these bacteria.[55] However, some progress has been made in Canada to reduce AMR, primarily in hospital settings. For example, healthcare-associated *Clostridioides difficile* and healthcare-associated MRSA infections decreased respectively by 36% and 6% from 2012 to 2017.[55]

Threats from AMR are not restricted to those coming from bacterial infections. For example, multidrug-resistant fungal infections caused by *Candida auris* are also a concern. Initially reported in Japan in 2009, the first imported case described in Canada was in 2017.[56] As of July 2019, there have been 20 cases of *C. auris* reported in Canada.[8]

Antibiotics are used widely in both human and veterinary medicine as well as in the agricultural industry. The prevalence of AMR is strongly associated with antibiotic use, and lowering antibiotic use can reduce the development of AMR.[57] In Canada, 92% of all antibiotics dedicated to human health care are prescribed in the community, primarily by general practitioners (65%), followed by dentists, nurses, and pharmacists (22%), as well as other specialists (13%).[58]

Greater efforts are required to reduce the unnecessary use of antibiotics.[59] In many cases, antibiotics are prescribed for indications where they are ineffective, such as for viral infections.[57, 60] Not only does this accelerate the development of AMR, it puts the patient at risk of side effects without offering them benefit. In some studies, it is estimated that 30–50% of all antibiotic prescriptions in outpatient settings are inappropriate.[61, 62]

FIGURE 6: Annual Number of Confirmed Measles Cases (1998–2019, Canada)[v]



v 75% or more of all confirmed annual measles cases were linked to one single outbreak that occurred the same year.

Climate Change is Impacting Health and Well-being

Our climate is changing. Canada is warming at about double the global rate, and northern Canada has already warmed to almost three times the global rate.[63–65] *Canada's Top Climate Change Risk*s report (2019) has identified health and well-being as one of the key areas of climate change risk facing Canada, while pointing out that such risks can be meaningfully reduced through adaptation measures that lessen vulnerability and/or exposure.[66]

Climate change is having an impact on health and well-being both directly and indirectly. Extreme weather events such as flooding, wildland fires, and heatwaves can result in death, injury, and illness. For example, more than 90 people in Quebec died as a result of the July 2018 heatwave.[67] Changes in precipitation and temperature have also influenced the spread of climate-driven infectious diseases.

Social determinants of health such as housing, working conditions, and food security will be affected by climate change. Extreme weather events not only increase the risk of direct negative health impacts, but also pose challenges to health systems and health care facilities with consequences for patient care, safety, and healthcare costs.[65]

The impacts of climate change on health and well-being will also vary by region. In northern Canada, the consequences of climate change are significant and widespread. For example, loss of sea ice is associated with food insecurity and mental health impacts for populations that rely on ice to access hunting grounds and traditional sites, and to bring food and supplies from the South.[65] In Rigolet, Nunatsiavut community members have reported feelings of displacement due to the disruption of hunting, fishing, foraging, trapping, and travelling from climate change impacts.[68]

Climate-driven Infectious Diseases

Changes in precipitation and temperature can increase the spread of climate-driven infectious diseases, specifically, zoonoses (i.e., diseases that can spread between animals and people), vector-, food- and water-borne diseases:

- Changing climate has facilitated the spread of the tick responsible for Lyme disease, contributing in part to an increase in cases from 144 in 2009 to 2025 in 2017.[69, 70] Other tick-borne diseases have also started to emerge in Canada including, for example, anaplasmosis and Powassan virus.[69]
- Four out of the five bacteria that account for over 90% of foodborne illness in Canada are influenced by climate change.[71]
- Over the last 20 years, the incidence rates of endemic mosquito-borne diseases, such as West Nile virus and Californian serogroup virus, have increased in Canada.[72]

Highlights of Other Factors Impacting Health

The health of individuals and populations is determined by a number of personal, social, economic, and environmental factors. These factors influence someone's place and position of power in society, and the access they have to the building blocks of good health. Examining key trends in the determinants of health is important to our understanding of public health and health inequities.

Strong Sense of Community Belonging

Community belonging has an important role in shaping mental health and a number of indicators related to community connectedness are included in the Public Health Agency of Canada's *Positive Mental Health Surveillance Framework*.[73] In 2018, 68% of the population aged 12 years and older reported a somewhat strong or very strong sense of belonging to the local community.[13] Some Indigenous peoples rate their sense of community belonging much higher than the national average. For example, close to 81% of First Nations peoples declared a somewhat strong or very strong sense of belonging to their local community in 2015–2016.[74] A strong sense of community belonging can be an asset for fostering resilience and mitigating the impact of societal inequities.

Higher Education Attainment and Less Poverty

Income and education are two key social determinants of health exerting an influence on many important health measures such as overall life expectancy. In the period from 2009 to 2011, Canadians living in the lowest-income neighbourhoods had a life expectancy at birth that was approximately four years lower than those living in the highest income neighbourhoods. Similarly, Canadians living in areas with the highest proportion of people having less than a high school education had close to three years lower life expectancy at birth compared to those living in areas with the highest proportion of university graduates.[4]

This year, important and encouraging trends are being reported for income and education.

The proportion of Canadians aged 25 to 54 years[vi] without a certificate, diploma or degree has decreased by 51%, from 14% in 2003 to 7% in 2018.[75] This trend may be influenced by a generational shift in the likelihood of completing postsecondary education.

There have also been considerable decreases in the proportion of Canadians living below Canada's Official Poverty Line, which is a measure of low income (based on the Market Basket Measure[vii]). In 2017, 10% of Canadians were living below the poverty line compared to 16% in 2006.[76] This represents a decrease of 39%. The change was even more pronounced among children living below the poverty line, with a decrease of 53% from 19% in 2006 to 9% in 2017.[76] Despite this encouraging trend, childhood poverty remains a concern in some populations. For example, in 2015, high childhood poverty rates were reported for Indigenous children, ranging from an average of 47% for First Nations children to 25% and 22% for Inuit and Métis children, respectively. Moreover, data on non-Indigenous children indicate that recent immigrant and non-Caucasian children had poverty rates of 35% and 22% respectively, compared to 12% for all children in the remaining group.[77]

vi Note that the CPHO Health Status Dashboard reports on educational certification for persons 25 years old and older. A narrower age range was chosen here to minimize the risk of possible misleading effects from including older Canadians in analysis.

vii The Market Basket Measure (MBM) is a measure of low income based on the cost of a specified basket of goods and services representing a modest, basic standard of living.

CHAPTER 2

Stigma is a Public Health Issue

Some Canadians experience worse social and health outcomes than others. The evidence tells us this is, in part, due to how we treat each other. When we stigmatize people, we affect their chances for a long and healthy life.

Stigma affects health through stress and other physical pathways. Many people are exposed to multiple stigmas, preventing them from attaining the resources they need to achieve optimal health such as education, employment, housing, and health services.

These stigma chapters will focus on the health system, which includes health care, public health, and other allied health services. Stigma in the health system can be particularly harmful, as people are prevented from accessing the health information services and resources they need, creating mistrust and further exclusion.

The Experience of Stigma

Here we introduce you to Charles and Cynthia, fictional people who experience multiple and intersecting stigmas. They face stigma in society and the health system, which affects their well-being and health. We revisit Charles and Cynthia in the next chapter, to see how things could have worked out differently.[viii]

Charles

Charles recently moved to a mid-sized town in Ontario. He feels people staring at him and has even seen people crossing to the other side of the street when he walks by. He wonders whether this is because he is Black. Charles has been with his partner David for most of his adult life. During the AIDS epidemic of the 1980's, he contracted HIV. Thanks to current treatments, the virus is undetectable in his body. However, recently he has been experiencing some symptoms that he thinks may have something to do with cardiovascular disease, just like his parents had. He knows that he needs to go see his new doctor and get this checked out, but he is hesitant because he had been treated with disrespect before by healthcare providers.

Charles attends an appointment with his new doctor to discuss his symptoms; however, she seems dismissive of his concerns. She instead asks Charles several questions about his HIV status and whether he is practising safe sex. At the end of the appointment, she only suggests that Charles change his diet, and she does not refer him for any further testing. Charles leaves feeling frustrated and ignored. He does not seek further care as he is worried that

viii We recognize that these stories may be disconcerting. The purpose is to use these fictional characters to highlight how stereotypes and stigma are often attached to individuals and communities because of their racial or sexual identity background.

he will not be taken seriously again. Several months later, Charles suffers a heart attack and is rushed to the hospital. While recovering, Charles feels the hospital staff are apprehensive to touch him and he notices that they put on gloves to perform routine tests, such as taking his blood pressure, which they do not do with other patients. Charles overhears two nurses whispering about his HIV status. Charles feels unsettled about the care he received and is worried about his future health.

Cynthia

Cynthia is a Cree woman living in Saskatchewan with her two young children and is pregnant with her third baby. She is connected with members of her First Nations community and has been receiving health care in a First Nations health centre. She has just learned that she will need to be admitted to a large hospital to receive treatment for complications related to her pregnancy. She is afraid of going into the hospital because during her first pregnancy, her non-Indigenous doctor kept asking her questions about drug and alcohol use and insinuating that she may not be capable of providing for her child. She has delayed going to the hospital because she does not want to face those kinds of questions or risk losing her children. The stress of worrying is causing her to not sleep or eat properly.

Due to her previous negative experiences, Cynthia avoids going to the hospital for treatment. Cynthia experiences severe complications during the seventh month of her pregnancy, and is rushed to the hospital, where she has an emergency C-section. Her baby is born with an extremely low birth weight and will need to stay in the neo-natal intensive care unit for at least one month. As she is recovering, the doctors and nurses repeatedly ask Cynthia why she did not get treatment to avoid these complications. Cynthia feels that they are implying she is a bad mother, and they are blaming her for the outcome of the pregnancy. Cynthia feels alone and is worried about the next steps for herself and her new baby. She is unsure how she can visit her new baby at the hospital without adequate childcare for her other children. Despite voicing her concerns, the hospital staff tell Cynthia these are “normal” emotions after having a baby, and they do not refer her to a hospital social worker or provide her with additional resources for support. Cynthia leaves the hospital feeling helpless and stressed, which adds to her existing eating and sleeping problems.

INTERVIEW QUOTE

“There are so, so many ways stigma stops people from reaching their full potential. And we as a society are poorer for that.”

The Pathways of Stigma to Health Outcomes

Stigma begins with the labeling of differences and negative stereotyping of people, creating a separation between "us" and "them." Those who are stigmatized are devalued and subjected to discrimination, which is unjust treatment. This can lead to disadvantage and inequitable social and health outcomes.[ix] Stigma happens in institutions (e.g., healthcare organizations), at a population level (e.g., norms and values), through interpersonal relationships (e.g., mistreatment), and internally (e.g., self-worth and value).

Stigma can be seen as both a cause and effect; it continues to justify the devaluing of people through stereotypes and exclusion.[78] Unless this cycle is actively stopped, the separation into "us" and "them" is reinforced by unequal power dynamics in society. People and institutions with resources and power, including health organizations, shape laws and social norms that can influence what is considered to be "normal" and "acceptable." In the health system, this power dynamic also exists between healthcare providers and patients.

Stigma can target different identities, characteristics, behaviours, practices, or health conditions.[79] For example, stigma can be based on race, gender and gender identity, sexual orientation, language, age, substance use, ability, and social class. Stigma related to health conditions can include obesity, substance use disorders, mental illness, dementia, tuberculosis, and HIV infection. When stigmas intersect, they can exacerbate negative health outcomes.

Stigma includes discrimination, as "enacted" stigma.[81, 82] While there is little data measuring stigma in Canada, discrimination is more commonly measured. The following section summarizes available self-reported discrimination data for some key populations. It is important to note that there is still limited data in this area and that experiences of discrimination may be underreported.

Stigma can benefit those in power in several ways:[80]

By keeping people "in", that is, by enforcing preferred social norms and values

By keeping people "down", which maintains one's group advantage in society

By keeping people "away", in order to avoid disease or a perceived threat

Discrimination in Canada

Over one in four Canadians have reported experiencing at least one form of discrimination in their lifetime.[83] Many Canadians experience discrimination based on race, religion, ethnic origin, gender, or sexual orientation. The most common type of discrimination reported by Canadians is racial discrimination.[83] African, Caribbean, and Black Canadians are the most likely to report discrimination in Canada, followed by Indigenous peoples.[84] Alarmingly, hate crimes, one of the most extreme forms of discrimination, have been on the rise in Canada, primarily against people who are part of Arab, Muslim, Jewish, and Black communities.[85]

ix Stigma definition adapted from Bruce G. Link and Jo C. Phelan, 2001.[81]

New analyses of the 2013 Canadian Community Health Survey Rapid Response Discrimination Module, the only national discrimination survey in Canada, support these findings. Lesbian, gay, bisexual (LGB) participants (note that transgender identities were not included in the survey), African, Caribbean, and Black Canadians and Indigenous peoples in Canada were more likely to report being unfairly treated than the general population. More specifically, LGB community members were almost three times more likely, and African, Caribbean, and Black Canadians and Indigenous peoples were twice as likely, to report having faced discrimination than their general population counterparts.[8]

In a national Canadian survey, the majority of youth who identified as transgender (ages 19 to 25 years) reported having experienced discrimination in the last year based on their gender identity (70%), sex (63%), physical appearance (60%) or sexual orientation (59%).[86]

In 2012, 20% of Canadians with a mental health illness reported being affected by negative opinions or unfair treatment due to their poor mental health.[87] In 2014, 10% of Canadians with mental health disabilities[x] reported violent victimization in the 12 months prior to the survey, which was more than double the general population.[88]

In an online Canadian survey in 2016, 49% of people currently in recovery from addiction reported experiencing stigma or discrimination during their active addiction.[89]

DISCUSSION GROUP QUOTE

"I think there are actually two groups that are impacted by stigma, those groups who are negatively impacted… [and] another group that we don't think about very often, and that's the group that benefits from stigma, and benefits from the perpetuation of those mainstream ideologies that continue to maintain that settlers, people with European background, as being better."

The Costs of Stigma

Stigma imposes significant costs on society, although quantifying the direct economic cost of stigma remains a challenge. Researchers have examined productivity loss and the consumption of resources from experiencing stigma.[90] On an individual level, stigma is a significant barrier to housing, employment, income improvement, and health care.[91–94] By reducing the accessibility and quality of health care, stigma can drive avoidance or delay of health care and non-disclosure of health conditions. This can increase the severity of symptoms and result in higher rates of hospitalization, emergency room visits, and healthcare-related costs.[92, 95–97] As an example of stigma's economic impact, mental health stigma increases absenteeism and productivity loss in the workplace.[98, 99] It also discourages affected people from seeking health care and treatment, which increases costs to the healthcare system.[95, 99]

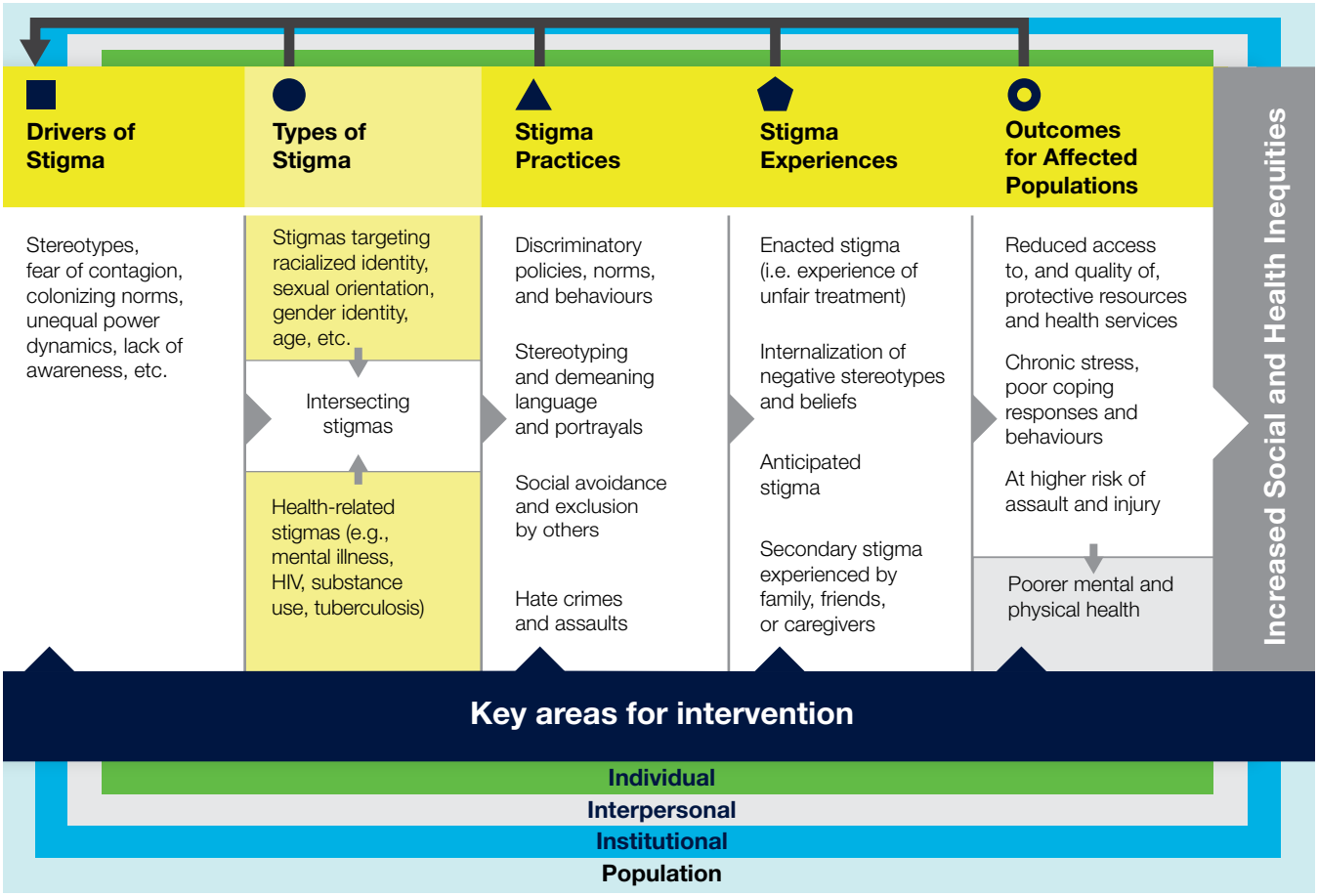
x A mental health disability refers to conditions that limit daily activities, including anxiety, depression, bipolar disorder, anorexia, and substance use disorders.

Why a New Stigma Model is Needed

The following Stigma Pathways to Health Outcomes Model (Stigma Model) provides a new way to think about stigma and how it undermines health for individuals and contributes to population health inequities (Figure 7).[xi] It builds on recent efforts to understand the full impact and significance of stigma on health, including the experience of multiple and intersecting stigmas that many people experience.[82, 100–102]

Although stigma has been studied in social and health sciences for decades, the research is generally focused on isolated health conditions or social identities.[82] This Stigma Model can be used to understand individual stigmas while also considering how different stigmas inevitably intersect to create worse outcomes for some people. The Stigma Model also offers the opportunity to understand the impact of stigma on different health outcomes simultaneously.

FIGURE 7: Stigma Pathways to Health Outcomes Model



xi This model has been adapted from the novel *Health Stigma and Discrimination Framework* recently commissioned by the National Institutes of Health.[100]

Stigmas Intersect Differently to Affect Health

Different types of stigma can intersect and work interactively to affect health.[103] Researchers use the term "intersectionality" to understand the complex connections, outcomes, and opportunities that can arise when people are subjected to multiple forms of stigma.[104] For example, the discrimination experienced by a racialized gay man living with HIV could produce poorer health outcomes because of the stigmas that arise from being racialized, identifying as gay, and living with HIV. Poorer outcomes might also result for an Indigenous, two-spirited person living with a mental illness. The reality is that many Canadians live with multiple stigmas. A key benefit of an intersectional approach is that it embeds an understanding of this complexity in our understanding of stigma's impact on health, and can therefore lead to a more complete and impactful response in addressing health consequences.

Importantly, the Stigma Model can be used by policy leaders, researchers, practitioners, and service providers to identify drivers of stigma and stigma practices in the health system that cut across areas of stigma. Interventions to address these broader issues are explored in Chapter Three and through the proposed Action Framework for Building an Inclusive Health System.

The Stigma Model works from left to right, but the components also influence one another. Applying the model to a particular stigma offers a way to understand how certain drivers lead to the "marking" and labelling of targeted groups. Once marked, people are then vulnerable to a variety of stigmatizing practices and discriminatory actions from other people, institutions, and society in general. Experiencing stigma can then lead to adverse health outcomes for individuals and increased inequities for populations.[100]

Practical Application of the Model

To illustrate how the model can be used to explore stigma pathways in detail and identify both cross-cutting and unique issues for different stigmas, seven examples are presented below (Table 1):

1. **Racism as experienced by First Nations, Inuit, and Métis peoples**
2. **Racism as experienced by African, Caribbean, and Black Canadians**
3. **Stigmas as experienced by LGBTQ2+ people (sexual stigma and gender identity stigma)**
4. **Mental illness stigma**
5. **Substance use stigma**
6. **HIV stigma**
7. **Obesity stigma**

Although the content for these examples has been drawn from the evidence, this is not a full examination of all possible pathways or the varied experiences within stigmas. Rather, the examples offer some areas for intervention across the health system. The Stigma Model can be used to further explore these stigmas as well as examine additional stigmas related to racial identities, religion, age, disability, and other characteristics or behaviours.

A detailed list of references for each stigma topic in Table 1 will be available on the 2019 CPHO annual report web page.

TABLE 1: Examples of How the Stigma Pathways to Health Outcomes Model Can be Applied to Different Stigmas

Drivers of Stigma	Intersecting Stigmas	Stigma Practices	Experiences of Stigma	Outcomes and Impacts for Affected Populations
Racialized identities: First Nations, Inuit, and Métis peoples (Racism)				
Unequal racial power dynamics created by colonization and reinforced by ongoing colonialism; forced removal from traditional lands and creation of reservation system; the residential school system; historical and current disproportionate rates of apprehension by child welfare agencies (e.g., Sixties Scoop); race-based stereotypes	Other social identity stigmas (e.g., sexual stigma, gender identity stigma, ageism) and health-related stigmas (e.g., mental illness stigma, substance use stigma, HIV stigma)	Abolishing or not recognizing traditional language and culture; social avoidance and exclusion by others; hate crimes and assaults; negative media portrayals; demeaning language (e.g., racial slurs); discrimination in employment, education, criminal justice, and housing sectors creating health vulnerabilities **Health system:** Discriminatory interpersonal behaviour of health professionals; Eurocentric health professional training (e.g., rejection of traditional knowledge, medicine, and healing practices)	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Overcrowded or inadequate housing; barriers to accessing post-secondary education; reduced economic resources due to employment barriers; increased risk of food insecurity; disconnection from family, community and culture; exposure to violence, particularly against Indigenous women and girls; reduced seeking, or avoidance of healthcare services and poorer quality of services received Chronic stress leading to health harming coping strategies (e.g., smoking, alcohol and substance use) **Health outcomes:** Increased risk of adverse physical health (e.g., lower life expectancy, tuberculosis) and mental health outcomes (e.g., intergenerational trauma, post-traumatic stress disorder, suicide and suicide attempts)
Racialized identities: African, Caribbean, and Black Canadians (Racism)				
Unequal racial power dynamics from slavery and colonization; forced removal from traditional lands; social, educational, residential, and occupational segregation; race-based stereotypes	Other social identity stigmas (e.g., sexual stigma, gender identity stigma, ageism) and health-related stigmas (e.g., mental illness stigma, substance use stigma, HIV stigma)	Social avoidance and exclusion by others; hate crimes and assaults; negative media portrayals; demeaning language (e.g., racial slurs); discrimination in employment, education, criminal justice, and housing sectors creating health vulnerabilities **Health system:** Discriminatory interpersonal behaviour of health professionals; Eurocentric health professional training	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Barriers to accessing post-secondary education; overcrowded or inadequate housing; reduced economic resources due to employment barriers; increased risk of food insecurity; exposure to violence; reduced seeking, or avoidance of healthcare services and poorer quality of services received Chronic stress leading to health harming coping strategies (e.g., smoking, alcohol and substance use) **Health outcomes:** Increased risk of adverse physical health (e.g., hypertension, diabetes) and mental health outcomes (e.g., intergenerational trauma, depression and anxiety)

Drivers of Stigma	Intersecting Stigmas	Stigma Practices	Experiences of Stigma	Outcomes and Impacts for Affected Populations
LGBTQ2+ (sexual stigma and gender identity stigma)				
Heteronormativity (expected sexual orientation is heterosexual); historical criminalization of same-sex relationships and sexual practices; societal expectation that gender identity matches biological sex at birth; gender bias that values men over women; historical medical diagnosis of alternative sexual orientation or gender identity as disordered; stereotypes based on sexual orientation	Other social identity stigmas (e.g., racism, sexual stigma, gender identity stigma, ageism) and health-related stigmas (e.g., mental illness stigma, substance use stigma, HIV stigma)	Assumptions of an individual's sexual orientation or gender identity; rejection and exclusion from family, peers, and/or community; lack of alternative gender identities on identification documents; hate crimes and assaults; negative media portrayals; demeaning language Health system: Discriminatory interpersonal behaviour of health professionals (e.g., incorrect use of gender pronouns); insufficient training of health professionals pertaining to LGBTQ2+ health; inappropriate practices such as conversion therapy; insufficient tailored health information, resources, and services	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Decreased social participation; concealment or denial of identity; increased risk of homelessness; reduced employment and income opportunities; exposure to violence; reduced seeking, or avoidance of healthcare services and poorer quality of services received Chronic stress leading to health harming coping strategies (e.g., self-harm, disordered eating, smoking, alcohol and substance use) Health outcomes: Increased risk of adverse physical health (e.g., sexually transmitted and blood-borne infections) and mental health outcomes (e.g., depression, anxiety and suicide ideation and attempts)
Mental illness stigma				
Beliefs that mental illness is caused by "bad genes," behavioural problems, or social skills deficits; divergent perceptions and understanding about the meaning of [mental] health; beliefs that people with mental illness are dangerous; negative perceptions about prognosis of recovery	Social identity stigmas (e.g., racism, sexual stigma, gender identity stigma, ageism) and other health-related stigmas (e.g., substance use stigma, HIV stigma, obesity stigma)	Low investment in research and education; negative media portrayals; demeaning language; violence and assault; distrust and avoidance of people living with mental illness; failure to accommodate employees with mental illness Health system: Limited training of health professionals to meet the needs of people with mental illness; using labels instead of person-first language (e.g., "schizophrenic" instead of "person living with schizophrenia"); low investment in mental health services	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Decreased social participation; concealment of illness; limited access to and loss of work or advancement opportunities; decreased use of health and social services and poorer quality of services received Health harming coping strategies (e.g., denial, self-isolation, substance use) Health outcomes: Increased risks of poorer physical health, quality of life, and psychological outcomes (e.g., lower self-efficacy, self-esteem and hopeless); decreased patient safety when stigma prevents health professionals from seeking care for their own mental health problems

Drivers of Stigma	Intersecting Stigmas	Stigma Practices	Experiences of Stigma	Outcomes and Impacts for Affected Populations
Substance use stigma[xii]				
Belief that substance use is a reflection of poor willpower or moral failure, and that people are to blame for their condition; belief that people who use substances are dangerous and reckless; belief that substance use is not a real illness and people "could choose to stop"	Social identity stigmas (e.g., racism, sexual stigma, gender identity stigma, ageism) and other health-related stigmas (e.g., mental illness stigma, HIV stigma)	Negative media portrayals; social avoidance and exclusion by others; discrimination in housing (e.g., denial of applications, eviction), failure to accommodate employees with substance use disorders **Health system:** Use of demeaning or inappropriate language; reduced empathy from professionals and less motivation to meet the needs of people who use substances; lack of training in harm reduction	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Decreased use of health and social services and poorer quality of services received; concealment of substance use disorder; loss of work and limited access to leadership positions; increased risk of homelessness Health harming coping strategies (e.g., isolation, social withdrawal and avoidance, further substance use) and behaviours (e.g., needle sharing) **Health outcomes:** Increased risks of poorer physical health, quality of life and psychological outcomes (e.g., lower self-efficacy, self-esteem and hopelessness); limited uptake of opioid agonist therapy; poorer outcomes for substance use disorder treatment
HIV stigma				
Fear of infection or contagion; misinformation about transmission of HIV; incorrect assumptions about prognosis and treatment	Social identity stigmas (e.g., racism, ageism) and other health-related stigmas (e.g., mental illness stigma, substance use stigma)	Criminalization of non-disclosure; forced disclosure; social distancing and avoidance; negative media portrayals **Health system:** Taking unnecessary precautions when interacting with people living with HIV; compartmentalized care (focus on HIV and not seeing the whole person); restrictions on blood and organ donations from gay, bisexual, and other men who have sex with men	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Delayed or decreased use of health and social services and poorer quality of services received; concealment of HIV status; self isolation; limited access to employment Health harming coping strategies (e.g., social withdrawal, substance use, denial, non-adherence to medications) **Health outcomes:** Increased risks of poorer physical health, quality of life, and psychological outcomes (e.g., depression, loneliness, suicidal ideation); lower self-rated health

xii The extent to which substance use is stigmatized varies by the particular substance and context of use. Much of the literature on substance use stigma focuses on substance use-related health conditions (e.g., substance use disorders) or use of substances in ways that might be harmful (e.g., drinking alcohol during pregnancy), though other contexts of substance use are also subject to stigma.

Drivers of Stigma	Intersecting Stigmas	Stigma Practices	Experiences of Stigma	Outcomes and Impacts for Affected Populations
Obesity stigma				
Belief that individuals are to blame for their weight due to lifestyle choices; stereotypes related to the behaviour or character of people living with obesity	Social identity stigmas (e.g., racism, sexual stigma, gender identity stigma, ageism) and other health-related stigmas (e.g., mental illness stigma, substance use stigma, HIV stigma)	Physical avoidance and exclusion by others; bullying; exclusion from the workforce; negative media portrayals Health system: Refusal of care, or low quality of care from service providers; healthcare environment not adapted to larger bodies; lack of empathy from health professionals; use of demeaning language	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Reduced seeking of care and use of health and social services and poorer quality of services received; decreased social participation; socioeconomic consequences (lower personal income) Health harming coping strategies (e.g., disordered eating) Health outcomes: Higher acute and chronic stress and related physiological responses; maintenance of excess weight, poorer mental and physical health outcomes (e.g., anxiety, depression, decreased motivation for physical activity)

Implicit Bias

Implicit bias refers to attitudes and stereotypes that occur unconsciously and inform our thinking, beliefs, and behaviours about social groups. Implicit bias occurs involuntarily and beneath the level of conscious awareness.[115]

Understanding Stigma Drivers and Practices in the Health System

Understanding how stigma drivers and practices manifest in everyday practices in the health system can inform the development of system-wide interventions. Below is a description of interrelated key drivers and practices that foster and sustain stigma in the health system.

The Language We Use

Language is a powerful tool that reflects and perpetuates biases in society. Words communicate assumptions, values, judgements, and stereotypes that create and reinforce negative portrayals of devalued groups. The way language is used in media, popular culture, health promotion initiatives, education, research, and policy shapes how people understand the world.

The use of outdated or incorrect language in the health system, such as an inaccurate pronoun or the negative labelling of a particular group, perpetuates stigma and can influence healthcare providers' perceptions of patients.[105, 106] For example, labelling people who use drugs as "addicts" or "junkies" marks them as less worthy of care and promotes fear.[107] In another example, describing the illness ahead of the person (e.g., using "schizophrenic" instead of "person living with schizophrenia") contributes to dismissive or demeaning behaviours by healthcare providers during treatment.[108] These types of labels also do not allow for other identities a person may have and suggest that everyone within that group has the same wants, needs, and challenges.

Implicit and Conscious Biases

Stigmatizing practices by health professionals may be a result of implicit or conscious bias.[22, 106, 109] Conscious bias occurs when an individual believes and reproduces negative stereotypes and myths about particular groups or individuals, resulting in discriminatory language or practices.[106, 109] For example, a health professional may use demeaning,

DISCUSSION GROUP QUOTE

"So in order to address that root cause of stigma, we absolutely need everybody to hold that mirror up and ask themselves that really important question, of how am I implicated in these systems and structures that discriminate, that stereotype, that hurt people. How can I be an agent of change, what can I do to arrest and disrupt those practices and policies that are so harmful to many of us?"

offensive, or incorrect language in reference to a patient's identity or condition, even after the patient has previously stated their preferred terminology.[106]

Implicit bias occurs when professionals are unaware that their actions or language is stigmatizing.[22, 106] Commonly held beliefs, stereotypes, and assumptions that pervade society make bias difficult to recognize. For example, many Canadians believe there are only two genders, and this assumption is widely reflected in everyday practices such as washroom signage, clothing labels, and healthcare intake forms. Assumptions are generally based on misperceptions or misinformation about certain groups, and may influence how a professional examines, treats, and assesses a patient. For example, patients with chronic pain may be denied medication on the assumption that they may be displaying "drug seeking" behaviour.[110, 111] Lack of training on appropriate care for health conditions or traditional cultural approaches to healing may contribute to the implicit bias of health professionals.[22, 106, 112–114] Although the avoidance of learning appropriate care is an example of conscious bias.

Lack of Respect and Understanding of People's Lives

Colonization and subsequent colonialism have been defining factors for Indigenous peoples and racialized populations. Colonialism has driven unjust attempts to erase cultural identity and practices, and has contributed to loss of language, exclusion from social and health institutions, and continued spatial segregation.[22, 109, 114, 116] The influence of colonialism is reflected in medical curricula that often do not incorporate or reflect the experiences of Indigenous peoples and other

DISCUSSION GROUP QUOTE

"We need to acknowledge that it [slavery] happened in Canada—if you don't ever acknowledge it, you leave us out there wondering if it even happened. You need to validate our reality."

The Death of Brian Sinclair

In 2009, Brian Sinclair, a 45-year old Indigenous man, died of preventable and treatable sepsis in an emergency room (ER). He was referred to the ER by a community physician for a bladder infection. Once he arrived, he did not get properly triaged and was told to wait in the waiting room. There he stayed for 34 hours before someone else let ER staff know that Brian did not seem to be breathing. The Winnipeg Regional Health Authority publicly apologized to his family for the preventable tragedy and has accepted all recommendations from a judicial inquest into this death. Recommendations include improving cultural safety for all staff at regional health authorities and recruitment of Elders for improved care in health centres. Indigenous leaders have asked the judicial inquest to seriously consider the ways in which Brian Sinclair's race, disability, and class led to his death.[22]

racialized populations, including diverse ways of knowing and understanding health and well-being.[22, 113, 114, 118, 119] The exclusion of these perspectives and ways of knowing shapes health professionals' practices and leads to culturally inappropriate treatment or care, which leads to further exclusion from health settings.[106]

Relatedly, healthcare providers are traditionally trained to focus on individual agency and lifestyle factors, without acknowledging the other factors that impact a person's life (e.g., the social determinants of health).[121] Patients have reported a lack of empathy and compassion from healthcare providers, as they feel they are blamed for their circumstances while the systemic barriers that have contributed to these are ignored.[111, 122–124]

Fear of Danger and of Contagion

Fear is a significant driver of stigmas relating to infectious diseases.[125, 126] Quarantine-related policies, mandatory immigration screening, and notifiable disease frameworks can have unintended stigmatizing effects.[127, 128] For example, people with tuberculosis may be stigmatized due to their perceived incurable and contagious state.[129] In a low-disease incidence country like Canada, specific population groups such as migrants can be portrayed as a public health threat and blamed for being carriers of infectious diseases such as HIV.[130, 131] Fear can also drive stigmatization of other health conditions, such as mental illness, where affected people may be seen as dangerous, unpredictable, or aggressive.[132]

Stigmatizing Organizational Cultures

Organizational cultures influence whether stigmatizing practices are acceptable and how health providers interact with patients.[108, 133–136] The above drivers and practices can become embedded in the culture of health organizations and reinforced by clinical and non-clinical staff (e.g., administrative, management and support staff). This can manifest in stigmatizing language, making assumptions, breaching confidentiality, using unnecessary precautions, and even, in some cases, denying care or access to treatment.[22, 106, 112, 113, 137] For example, transgender women have been denied access to women-only services for appearing too masculine[138] and "flagging" files to distinguish particular medical records may also promote stigmatization.[113] Burnout and compassion fatigue of providers can further contribute to these practices.[108]

Service providers may convey power and distance through the utilization of unnecessary protection, their way of delivering diagnoses, and their reactions to diagnoses.[108, 131, 139] This may also be seen through the imposing of rules and policies that shape treatment and recovery opportunities for individuals seeking help for conditions such as mental

DISCUSSION GROUP QUOTE

"You need education throughout your career. Not one day on cultural sensitivity, or mental health sensitivity."

DISCUSSION GROUP QUOTE

"People often struggle with the idea that people can be different than them."

DISCUSSION GROUP QUOTE

"When you challenge [cultural norms] in your practice, you can get boxed in…. For example, when I talk about race, religion, gender, there is a defense mechanism that kicks in."

health problems, substance use disorders, and HIV infection.[107, 140, 141] These practices include refusing mental health care to people who use drugs or restricting treatment for recurrent drug use, and denying access to treatment because of particular sexual practices or gender nonconformity.[107, 134, 138, 141–143]

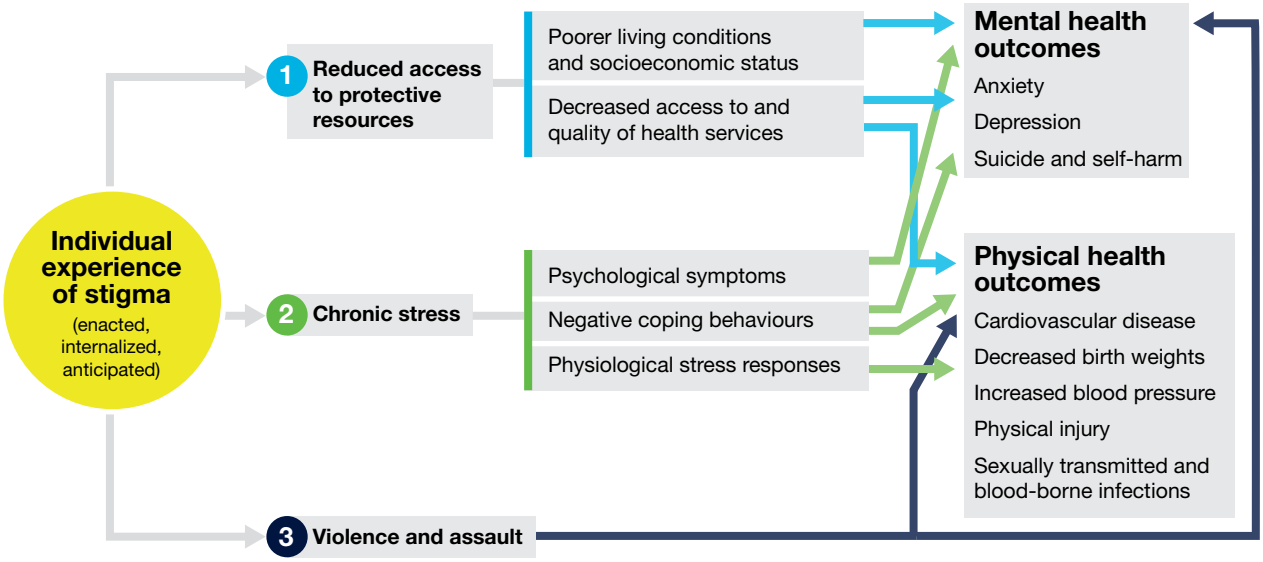
Stigma in organizational cultures may also have an impact on the health and well-being of staff. Healthcare providers may be reluctant to acknowledge or disclose their own stigmatized conditions, such as mental illness, in workplaces where stigma is persistent. This may result in self-treatment and a lack of peer support.[108]

How Stigma Leads to Adverse Health Outcomes

The following more fully unpacks how the experience of stigma leads to poorer outcomes and impacts overall health. Emerging research indicates that stigma affects health in **three key ways**:[xiii]

1. **It reduces access to and quality of protective resources and health services**
2. **It increases the risk of chronic stress and poor coping responses**
3. **It puts stigmatized people at higher risk of assault and injury**

FIGURE 8: How Stigma Affects an Individual's Health



While this is not a comprehensive list of all possible outcomes or mechanisms, it does summarize many of the proposed associations.[144]

Source: Adapted from Paradies *et al*. 2013[155]

xiii These data generally comes from self-reported experiences of stigma in relation to health outcomes. Additionally, many of these studies were conducted in the US. Caution should be taken regarding the generalizability of the findings.

1 *Stigma Reduces Access to and Quality of Protective Resources and Health Services*

Stigma can be a barrier to accessing essential resources and opportunities in life, such as housing, jobs, education, interpersonal relationships, and health care. These barriers may be the result of direct and active exclusion through discrimination by gatekeepers (e.g., landlords, employers, teachers, and healthcare professionals) or may arise internally from one's anticipation of facing stigma and mistreatment based on previous exposure to negative environments or discriminatory practices.[22, 106, 109, 111, 112, 123, 145] When people are excluded from these opportunities in life, they are exposed to more health risk factors and fewer protective factors.[109, 145–148] Importantly, once accessed, the services may be culturally inappropriate or of poorer quality.[118, 146]

2 *Stigma Causes Chronic Stress and Poor Coping Responses and Behaviours*

Stigma is a major source of psychological stress, whether it is enacted, internalized or anticipated. Because of their stigmatized status, people from stigmatized groups may experience shame, low self-worth, and blame, and are at increased risk of exposure to stressful and unfair conditions and situations.[106, 112, 152] Excessive and ongoing stress can affect the body in a negative way throughout the life course and can be particularly damaging for developing children.[153, 154] This repeated activation of stress responses can lead to an impaired immune system and interfere with the body's repair processes. It can also elevate blood pressure, heart rate, and stress hormones, which may have an effect on health over time.[120, 156, 157]

3 *Stigma Can Expose People to Violence and Assault*

Certain groups of people are feared or seen as less worthy of respect or dignity because of stigma. In combination with other social inequities, groups that are stigmatized are targets for explicit hatred and violence, including physical assault or abuse, sexual assault, bullying, harassment, and hate crimes. Verbal, physical and sexual violence against individuals or groups can occur at home, in school, in the workplace, in the community, or online.[106, 116, 149–151]

DISCUSSION GROUP QUOTE

"We're kind of scared, when I say "we're" I'm speaking as a Black woman, we fear not being understood, and most times ... I find it more manageable for me to just handle it on my own, or to maybe seek out a friend or family. Where really, I should feel comfortable to go and seek help in these facilities."

DISCUSSION GROUP QUOTE

"Well I think for people it [stigma] sort of affects their self-worth, their self-confidence, even though they might be skilled, or very educated, or informed, that it creates the self-doubt in them."

The effort required to deal with stigma reduces a person's psychological resources and resilience. It creates challenges in managing emotions and the ability to self-regulate, and an increased likelihood of having poor sleep habits, using substances, risky sexual behaviour, and unhealthy eating.[145, 158–161] These can place stigmatized people at even higher risk of acquiring further stigmatizing conditions (e.g., HIV infection, obesity). Although the outcomes may be harmful, these behaviours can be coping strategies and a way to survive challenging or even traumatizing events and experiences.[155] Through this lens, these responses can be understood as normal or expected responses to unjust and traumatic situations.

Through These Three Avenues, Stigma Can Lead to Adverse Mental and Physical Health Outcomes

Measuring the health impacts specifically due to stigma is methodologically difficult; however, research indicates that poor mental health is often associated with many types of stigma. Adverse outcomes include anxiety, depression and depressive symptoms, post-traumatic stress disorder (PTSD), suicidal ideation and behaviours, self-harm, and low self-esteem and self-worth.[100, 146] Poor cardiovascular health has also been linked to discrimination and chronic stress, and is a major cause of morbidity and mortality.[146,188] For example, recent research has focused on examining how systemic racism can have an impact on hypertension, cardiovascular health, and diabetes.[162, 163] In other research, experiencing stigma and discrimination while pregnant has been associated with pre-term birth, low birth weight, and higher rates of infant mortality.[164, 192] Discrimination has also been associated with increased rates of diabetes, cancer, tuberculosis, increased Body Mass Index and obesity, and increased risk of sexually transmitted and blood-borne infections.[112, 125, 146, 188]

DISCUSSION GROUP QUOTES

("Living while Black") "There isn't a moment when we are not calculating what does this mean, how will this be seen, how are they going to react, how am I going to react—it takes a lot of energy."

"Often I find people don't hear, listen to or see me."

DISCUSSION GROUP QUOTE

"When you kind of zoom out a little bit and realize that our social structures create situations in which people are silenced and can't get the resources they need to reach their full potential, then we see all kinds of poorer health outcomes."

Resisting the Impacts of Stigma

Building Resilience

Many people living with stigma resist devaluation and discrimination and build strength, resilience, and strategies to ward off stressors.[165, 166] These strategies can include invalidating the negative beliefs associated with stigma, attributing prejudices to ignorance and not to themselves, and drawing upon their identities (such as LGBTQ2+) or social roles for protection.[165, 166]

Others may disclose their stigmatized status and educate others on their health condition. Disclosure can lead to having more informal and formal support.[172, 233] Although disclosure can be empowering, not everyone may feel comfortable or safe to do so. Resilience can mean choosing not to disclose in order to feel safe.[167] In recent years, many people from stigmatized groups have come forward and publicly disclosed experiences of stigma and discrimination (for example, women who experienced violence and sexual assault).

When groups mobilize, there can be psychological and social benefits, such as social support, that buffer them from some negative health consequences.[165] For example, Black Canadian women are less likely to self-report poor mental health compared to White Canadian women.[168, 169] Research from the US demonstrates that African Americans may develop resiliency strategies, such as strong family and community ties, to cope with and challenge racism and discrimination.[170] These strategies and strengths may act as buffers and help prevent mental health issues.[169, 170] Although this has not yet been researched in a Canadian setting, similar dynamics may be at play.[168, 169]

Community Connection

Community culture and connection can play a protective role in supporting individuals who face stigma and discrimination. Among Indigenous peoples in Canada, cultural continuity has been associated with lower youth suicide rates.[171] Cultural continuity is measured in different ways, and can include factors such as self-government, community-level Indigenous language knowledge, and control over education, community, social or health services. As emphasized in the First Nations Mental Wellness Continuum Framework, culture—including values, sacred knowledge, language and cultural practices—is the foundation of health and wellness.[16]

DISCUSSION GROUP QUOTE

"…we have to get back to finding our kindness, and our humanness, and recognizing that if we were all the same it would be a very boring place to be and that the difference is what makes us strong and what keeps us going."

Collectively Changing the Health System

Populations subjected to stigma and oppression for generations have responded by engaging in collective responses and self-determination, and displaying profound group resilience. For example, despite a history of cultural genocide, assimilation, intergenerational trauma, and colonial policies, Indigenous peoples have survived and preserved their cultures and ways of being.[22] Learning about and incorporating traditional Indigenous health practices can build resilience and a sense of ownership over one's health.[22, 173, 174] First Nations, Inuit and Métis peoples in Canada have engaged in collective resistance to health system stigma by advocating for Indigenous education programs, promoting public education against negative stereotyping, and developing Indigenous-run governing health bodies and holistic approaches to health that respect and build on traditional ways of knowing.[22]

People living with HIV mobilized early in the AIDS epidemic to form a powerful social movement that helped to mitigate the stigma associated with HIV and AIDS and change the health system response by improving the patient-provider relationship, challenging stereotypes, and ensuring the meaningful participation of people living with HIV in research and health practices.[175, 176]

The call for meaningful representation has been echoed across other movements and communities, such as the disability movement that initiated the slogan "Nothing about us without us" as an act of resistance to the under-representation of people living with disabilities in research and in the media.[177] Similarly, Indigenous peoples have emphasized the importance of telling their own stories about Indigenous health and well-being, and leading the way forward through Indigenous-directed health and community services.[22]

The mental health movement in Canada contributed to normalizing mental health, the deinstitutionalization of mental health services and the shift towards having mental health and social supports available in the community, which can all reduce stigmatization.[178, 179] More recently, there has been a shift in approaches within the substance use movement in Canada. Utilizing a strengths-based and resilience approach instead of a risk-based perspective has led to increased availability and accessibility of harm reduction services and initiatives for reducing substance-related harms, such as supervised consumption sites, naloxone distribution and training, educational initiatives related to lower-risk substance use, and drug contamination testing.[180]

DISCUSSION GROUP QUOTE

"Being Indigenous doesn't make you more prone to HIV. Living without hope does."

DISCUSSION GROUP QUOTE

"Members of communities who are affected by stigma should be involved. [They] should be leading the conversation."

DISCUSSION GROUP QUOTE

"What has happened to us, is not who we are! If you look at who we are, there in lies the solution."

CHAPTER 3

Building an Inclusive Health System

The Stigma Pathways to Health Outcomes Model (Stigma Model) offers a comprehensive approach to understanding stigma and the real and measurable impact it has on physical and mental health outcomes. The Stigma Model also demonstrates that stigma is not simply an interaction between people but a process influenced by larger social, cultural, political, and economic forces.

Responding to stigma in the health system requires an equally comprehensive approach, through system-wide interventions in education, training, practice, and policy. This chapter presents a new **Action Framework for Building an Inclusive Health System** (Action Framework), developed for this report. Whereas the Stigma Model helps to understand the nature and extent of the problem of stigma, the Action Framework explores where and how it can be addressed.

The Experience of Stigma Revisited

Let's revisit Charles and Cynthia, who we met in Chapter Two. Previously, we examined the ways in which Charles and Cynthia experienced stigma in the health system and how this negatively impacted their overall health. Now, let's see how their experiences could have been different if they had been treated in inclusive environments that met their needs.

Charles

Charles, a Black, gay man who is living with HIV, recently moved to a mid-sized town in Ontario and believes he may have signs of heart disease. Charles books an appointment with his new doctor regarding his symptoms. At the appointment, his doctor takes the time to review his social and family history. As a routine part of getting to know each patient, his new doctor always asks patients for their preferred name and pronoun. When Charles sees how much his new doctor prioritizes patient trust, he feels comfortable sharing that he is gay. She knows that Charles is at higher risk of heart troubles because of his age and family history, and also due to social determinants such as his

racialized identity status. Charles' doctor determines that the best course of action is to refer him to a specialist at the hospital for further testing. Charles feels heard and respected by his doctor and appreciates her thoroughness. Charles is nervous about the tests with the specialist but when he arrives, he is treated with respect and dignity by the hospital staff. He also notices that the specialist and some of the other health professionals look like him. The specialist focuses on Charles' presenting symptoms and does not ask questions about his HIV status or sexual orientation when it is inappropriate to do so. Even when doing more diagnostic testing, the specialist and other health professionals do not take unnecessary precautions. The results of the tests show that Charles has early stage heart disease; however, because the disease was detected early, Charles' prognosis is good. Charles will continue to have follow-up appointments periodically with the specialist to monitor his health. Charles feels comfortable attending these appointments due to the excellent care he has received and the trust he has in his doctors.

Cynthia

Cynthia is a Cree woman living in Saskatchewan with her two young children. She is pregnant with her third child and has recently learned of complications with her pregnancy. Cynthia has been receiving care at a First Nations health centre in her community but needs specialist care at a large hospital. A nurse from the health centre refers her to the hospital's new Indigenous Health Program, where an Elder is available to provide guidance and cultural and spiritual support to Cynthia before, during, and after her treatments.

When it is time for her treatment, Cynthia's doctor introduces herself. She asks Cynthia about her experience and her priorities before thoroughly explaining the treatment, timelines, and next steps. Cynthia's doctor talks to Cynthia and encourages Cynthia to ask questions so they can make decisions together. The doctor began the appointment with this approach because the hospital recently implemented an institutional policy requiring and supporting all health professionals to learn and implement a cultural safety model of practice. Cynthia feels respected and the introduction eases her anxiety about the appointment. The Elder collaborates with Cynthia's healthcare team to facilitate communication and cultural understanding to create and maintain a culturally safe care plan. Cynthia continues to meet with the Elder during future treatments who also connects her to an appropriate, funded childcare facility where she can take her two children while she attends her ongoing appointments. Cynthia feels well supported by the Elder and her healthcare team at the hospital who successfully manage her pregnancy complications while providing culturally relevant care. Cynthia carries her baby to term and gives birth to a healthy baby.

An Action Framework for Building an Inclusive Health System

The complex and reinforcing processes that fuel stigma drivers and practices require system-wide responses. Using a public health lens, it is important to prioritize broad interventions that can have the most benefit to the greatest number of people.[181] Population- and institution-level interventions to address stigma drivers and to prevent stigma practices are most aligned with this approach. To mitigate individual-level harms, it is also necessary to implement interventions to better support individuals who have experienced stigma.

While actions have been organized according to various levels, complementary and synergistic interventions will need to be implemented across all levels to achieve the most impact. Though much of the research in this field has explored the impact of one intervention at one level, researchers increasingly emphasize the importance of working at multiple levels to reinforce and sustain change.[91, 100, 106, 113, 182–187] Additionally, attention to using de-stigmatizing language is important at all levels and in all interventions.

Policy leaders, researchers, practitioners, and service providers are encouraged to use the Stigma Model to understand different stigmas. The Action Framework then provides direction on developing multi-level and comprehensive approaches that respect differences across stigma experiences while offering the potential for lasting effects across stigmas (Table 2). The Action Framework can also serve as a starting point for other stigmas not summarized in this report, such as those related to age, class, and other health conditions.

An evidence summary on interventions to address stigma in the health system will be available on the 2019 CPHO annual report web page.

INTERVIEW QUOTE

"One of the things that gives me hope about addressing stigma is that first off, we're starting to realize that it needs to be addressed. That we're starting to recognize that this is one of those fundamental issues that is... that impacts everybody in society. Because if we don't name it, if we don't start to take action, if we don't start to see this as a problem, we can't move forward."

TABLE 2: **Action Framework for Building an Inclusive Health System**

How stigma operates across levels (examples)	Interventions to address stigma across levels (examples)	Potential outcomes (examples)
Individual		
Level of Stigma: person who experiences stigma		
• Enacted stigma (i.e., unfair treatment) (e.g., psychological stress) • Internalized stigma (e.g., low self-esteem and feelings of shame) • Anticipated stigma (e.g.,does not access support)	• Group-based supports to change stigmatizing beliefs, improve coping skills, support empowerment, and build social support	• Reduction in internalized stigma • Improved psychological well-being and mental health
Interpersonal (person-to-person)		
Level of Stigma: family, friends, social and work networks, healthcare and service providers		
• Language (e.g., using derogatory terms or dehumanizing labels; refusing to use preferred name and/or pronoun) • Intrusive attention and questions • Hate crimes and assault	• Education interventions to target myths and lack of knowledge. Include components that encourage examining personal values, biases, and beliefs • Contact interventions, including sharing personal stories, to target stigmatizing beliefs and attitudes	• Better understanding of the facts about stigmatized health conditions • Increased understanding of diverse perspectives and experiences of stigma • Growing social acceptance • Reduction in stereotyping
Institutional		
Level of Stigma: health system organizations, medical and health training schools, community sector organizations, social service organizations		
• Being made to feel "less than" (e.g., having to wait longer than others to be seen; lack of empathy from staff) • Physical environment is not inclusive (e.g., washrooms are single-sex; undersized chairs in public areas) • Institutional policies that cause harm (e.g., unnecessary drug tests; low investment of services)	• Ongoing and continued training targeting conscious and implicit bias • Implementation of cultural safety and cultural humility models • Safe and inclusive physical environments • Workforce diversity initiatives • Institutional collaboration with community; policies that support and fund meaningful engagement with people with lived experience of stigma • Implement trauma- and violence-informed care models • Accountability and monitoring frameworks that include stigma reduction indicators	• Institutional environment is inclusive, welcoming and diverse • Organizations are able to meet the needs of all populations • Reduction in stigmatizing beliefs and attitudes among staff • Improved patient/client ratings of care, satisfaction and trust • Patient/client outcomes improve
Population		
Level of Stigma: mass media, policies, and law		
• Widely held stereotypes • Negative portrayals in film and television (e.g., people with mental illness portrayed as violent) • Discriminatory policies and laws • Inadequate legal protections, or lack of enforcement of these protections	• Mass media campaigns to challenge stereotypes and prejudice • Guidelines to reduce stigma in media reports • Protective laws and policies • Addressing discrimination within existing laws and policies	• Reduction in stigmatizing beliefs, attitudes, and intended behaviour among the public • Reduction in discrimination practices

Table 2 provides a high-level summary of types of interventions that can be considered when addressing stigma in the health system, using examples rooted in evidence. The following section takes a deeper look into how these interventions have been applied in practice and how they might be expected to address stigma in and across different levels. It is noteworthy that considerable research on stigma comes from the field of mental health. This is in part due to a worldwide focus on mental health as well as leadership in Canada.

Also included in this section are examples of interventions (in text boxes) identified as promising by participants in CPHO discussion groups.

Individual- and Interpersonal-level Interventions

Strengthening Resilience

The Stigma Model emphasizes the importance of addressing stigma drivers and intervening to prevent stigma and discrimination. However, it is also necessary to support those who have experienced stigma. Reducing the impact of stigma on well-being is often the target of individual-level psychoeducation programs.[193–195] These interventions are frequently in a group format with cognitive and behavioural elements, such as cognitive-behavioural therapy or acceptance and commitment therapy, and are intended to change internalized stigmatizing beliefs, improve coping skills, support empowerment, and/or build social supports.[193–197] Promising results have been highlighted in systematic reviews of these approaches as a support for people living with HIV, people who use substances, and people living with mental illness, though the evidence is mixed.[193–198] The potential for coping and community-support interventions to mitigate the impact of stigma have also been identified for LGBT communities.[106, 199]

INTERVIEW QUOTE

"I think that kind of dialogue is starting to occur, I would say and it is largely led by Indigenous communities and who are saying that is not appropriate to just focus on deficiencies. We need to focus on strength-based models, look at groups that are thriving and look at that as models for other groups to follow, and understand self-determination and other factors that remove stigma."

Building Awareness, Changing Attitudes

Most of the stigma intervention research has focused on challenging stereotypes and prejudice held by individuals, with the goal of reducing stigma practices at an interpersonal level. This research base has generally focused on education and contact interventions to reduce stigma associated with stigmatized health conditions, but there is little research on long-term impact. Some systematic reviews suggest contact interventions are particularly effective in reducing stigma, while others suggest that education and contact interventions offer similar impacts.[198, 200, 201]

Education interventions use facts to target stereotypes and challenge prejudice. In contact interventions, people from groups that experience stigma share their personal stories. These connections are intended to challenge negative attitudes and behaviours, break down "us" vs. "them" categories, and highlight all the other aspects of someone's identity (e.g., mom, baseball lover, teacher). Education and contact interventions have both been associated with small-to-medium immediate effects upon self-reported stigma knowledge and/or attitudes in systematic reviews related to mental illness or HIV.[198, 201–204] These interventions have also shown promise in reducing self-reported stigma related to substance use.[190, 197]

DISCUSSION GROUP QUOTE

"We [the broader health system] tend to be more and more involving, the people who are bearing the greatest burden of that form of stigma, of a particular form of stigma, we are tending to involve people in creating the solutions."

Discussion Group Reflections on Addressing Stigma

Participants highlighted the CHAMPS study (Community Champions HIV/AIDS Advocates Mobilization Project) as an example of a stigma reduction intervention that brought together community leaders and people living with HIV. CHAMPS enlisted people living with HIV and HIV-negative community leaders, including those from the faith, social justice, and media sectors to participate in a training workshop. As part of the workshops, participants engaged in reflection and experiential learning activities to become more aware of their own biases and responses to stigma and to develop strategies to address stigma. Results indicated that the training changed attitudes as well as behaviours over the course of several months in both people living with HIV and community leaders.[205]

Institutional-level Interventions

Stigma drivers and practices also exist at institutional and population levels, where stigma is embedded and sustained. The organization as a whole is an important target of change.[108, 206–210] This includes organizational-level interventions, such as creating inclusive physical environments, building workforce diversity, and policy and practice changes. This shifts the focus and responsibility for healthcare interactions from individuals to include the broader factors that shape these interactions.[22, 208, 210] Relatedly, multi-level interventions are also included in this section, to highlight important advances in the health field regarding anti-stigma and equity-oriented initiatives.

While institutions are at the core of this section, other interventions are included that target health providers at individual or interpersonal levels. These interventions are designed and delivered in the context of the participants' roles in health systems, and best implemented alongside other efforts across healthcare institutions. A whole-organization approach also emphasizes the bidirectional influence between individuals and institutions.

Addressing Bias in Health Practice

To improve practice and more adequately meet the needs of all patients, it is important to understand and address both implicit and conscious stigma beliefs and practices. There is a growing awareness of the nature and potential impact of implicit bias on health inequalities.[211–213] Common approaches targeting implicit bias among health providers include efforts to reduce implicit associations or to control how they influence judgement and behaviour.[213] This kind of self-reflection can include perspective-taking (consciously assessing an interaction from a patient's perspective) and individuation (consciously focusing on specific information about an individual rather than assumptions based on social identity).[211–213] Though the field is still emerging, there are some promising findings.[212, 213] Addressing implicit bias has also been identified as being important to reduce stigma and discrimination for Indigenous peoples in Canada, people experiencing mental illness, LGBTQ2+ populations, and people who use substances.[22, 197, 214, 215]

DISCUSSION GROUP QUOTE

"So many systems think our families are broken and they don't know what we need. People know what they need but we just don't listen to them."

Education, contact and skill-building interventions for healthcare providers are the most common approaches targeting conscious stigma in health facilities related to HIV, mental illness, and/or substance use.[113] Many interventions include multiple approaches; contact and knowledge-building are the most common. In a recent systematic review, several anti-stigma initiatives were identified as having promising results, but methodological variations made it difficult to compare across fields or draw firm conclusions about effectiveness.[113]

Narrative reviews focused on mental health, and extending farther back than five years, suggested more success. Though the research base is small, contact and education interventions showed promise in reducing self-reported stigma among health providers, specifically short-term improvements in knowledge and behaviour.[198, 204]

Mental Health Commission of Canada's Opening Minds Initiative (MHCC)

The "Understanding Stigma" workshop was developed to address mental illness stigma among healthcare professionals using social contact alongside educational and action-oriented components.[216] A meta-analysis of six replications of the program had encouraging results. The workshop was associated with self-reported changes in attitudes and intended behaviour.[216]

MHCC also supported the evaluation of a number of anti-stigma interventions across the country. This research identified a number of key program elements to address mental health stigma for health-care providers (see below), with multiple forms of social contact and an emphasis on recovery identified as most important for effective programs.[217]

Key program elements of "Opening Minds"

1. Social contact in the form of a personal testimony from a trained speaker who has experienced mental illness
2. Multiple forms or points of social contact, where people with lived experience can be seen as educators rather than patients
3. Focus on behaviour change by teaching skills that help healthcare providers know what to say and do
4. Engage in myth-busting
5. Enthusiastic facilitator or instructor who models a person-centred approach
6. Emphasize and demonstrate recovery as a key part of messaging, including the important role of health providers in this process

INTERVIEW QUOTE

"What we have found is that education programs that share stories… We call it contact-based education or social contact. People hearing from individuals with lived experiences of mental health problems and mental illness who talk about their stories share what it was like when they had a mental illness, but talk about the importance of getting treatment and how their lives have changed dramatically once they got that help that was needed."

Educational curricula and training also have potential to build knowledge and change attitudes among health providers related to LGBT populations and their health.[218] While the stigma experienced by patients who are transgender has had limited focus in research, contact interventions have been identified as an approach that may address provider bias.[106]

As previously noted, addressing stigma in health systems requires concurrent efforts across health institutions. Research has identified emerging practices but there are no conclusions about effectiveness. Approaches to changing policy and practice include: targeting all levels of clinical, non-clinical and management staff including trainees; changing physical aspects of the environment; tailoring approach to organizational context and culture; and targeting multiple levels concurrently.[108, 113, 219, 220] For organizations providing services to people who experience stigma related to their health conditions, this can also involve changing what "success" looks like. For example, research in Canada explored varying ideas about success among health and social service providers who work with women who are pregnant and using substances; service providers suggested that success for clients could include having their self-defined needs met, experiencing stability and self-respect, recognizing strength and resilience, and healing in their own time.[221]

Cultural Competence to Cultural Safety

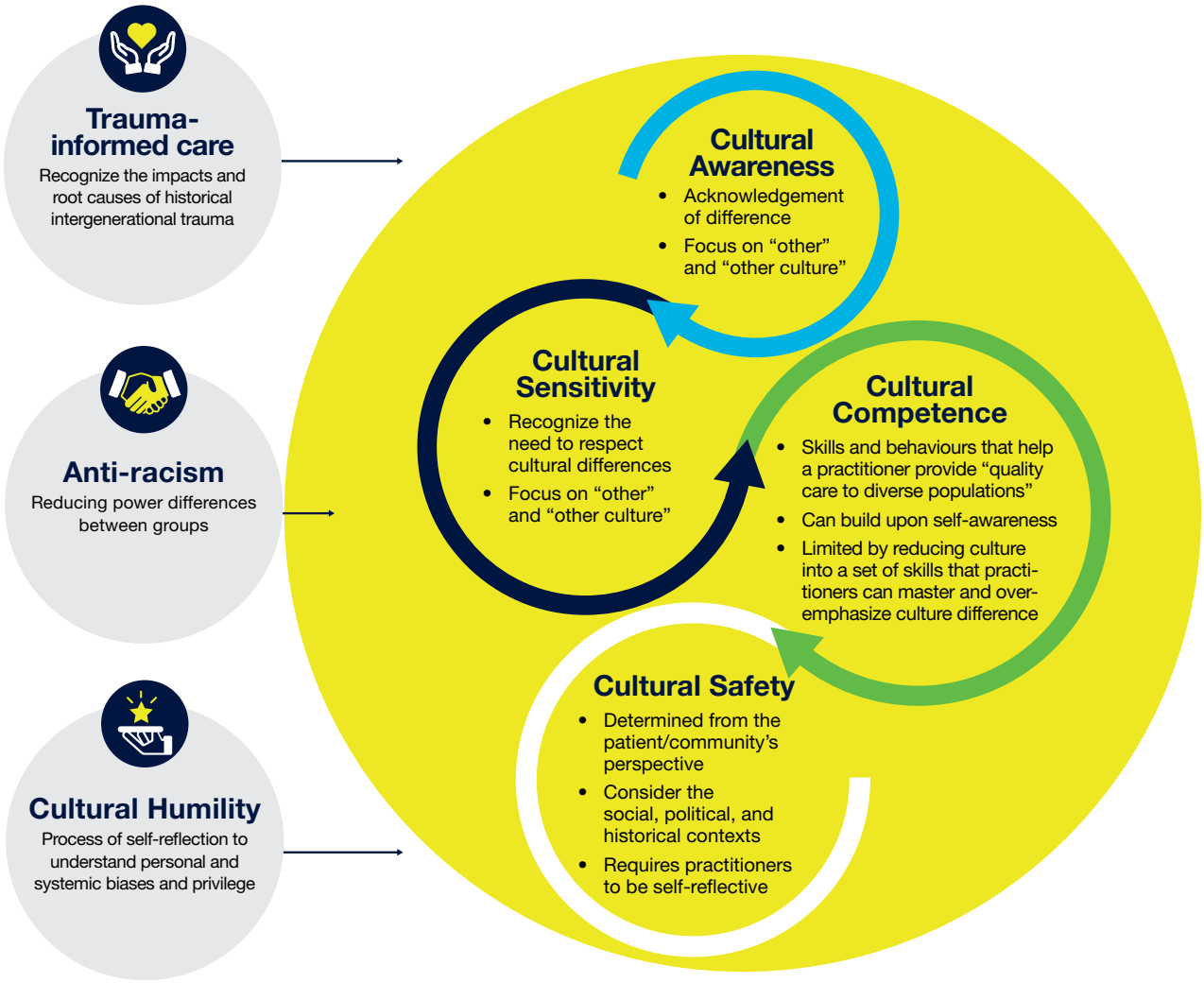
The field of cultural competency offers another approach to address stigma in healthcare institutions. Broadly, cultural competency interventions involve developing awareness, knowledge and attitudes among health providers to help them work more effectively in cross-cultural situations.[222] This has generally been a focus for stigma and discrimination related to social identities, such as racialized and Indigenous populations, but the language and overall lens has broadened to include other groups such as LGBT populations.[106, 210, 218]

This is an evolving field. Previous approaches focused on teaching healthcare providers about the needs and experiences of particular racial or cultural groups, and these were criticized for oversimplifying and stereotyping "culture" and ignoring diversity within.[222] While training for healthcare providers remains the most common approach to building cultural competence in health systems for Indigenous peoples and racialized populations the scope has expanded to include a focus on institutional change.[206, 207, 210, 222] This includes culturally specific programs for patients, patient navigators, and workforce diversity.[206, 207, 219] In systematic reviews, some initiatives were associated with improvements in self-reported provider knowledge or attitudes as well as patient-reported health care access, and/or patient satisfaction.[206, 207, 222] However, results were mixed and the quality of research was low.[210, 222] There was no or weak evidence for impact on patient outcomes.[210, 222]

DISCUSSION GROUP QUOTE

"Health systems should look like the people who come to visit them."

FIGURE 9: **Continuum of Cultural Safety***



* Adapted from NCCIH and BC First Nations Health Authority by the CPHO Health Professional Forum.

In response to critiques and alongside a growing focus on addressing racial health inequalities, factors such as trust/mistrust, bias, power, privilege, discrimination, and critical reflection have become a focus within "cultural competence". [222] Many different individual-, interpersonal- and institutional-level initiatives are now considered "cultural competence" interventions, though there is considerable variation in approach and level of intervention.

Approaches focused on "cultural safety" have emerged in response to the limitations of previous practices. Cultural safety moves away from a focus on differences in culture to a view of the health system environment as a site for change (Figure 9).[208] As a model of health care created by Indigenous nurse educators in New Zealand, cultural safety was designed in response to the health implications of colonialism, and looks at power dynamics in health systems.[22, 223] It is intended to create spaces where everyone feels respected and physically, emotionally, socially, and spiritually safe.

While evidence is still emerging, research in Canada has identified a number of key components in cultural safety interventions. This includes provider self-reflection, addressing bias and discrimination, building relationships with patients, sharing power, validating a patient's way of knowing, and meaningful training for healthcare providers.[22, 208, 223, 224] Aspects of this are embedded in "cultural humility" which is an important related concept to be used by healthcare providers to enable cultural safety.[225] It is a process of self-reflection, to understand bias and build respectful approaches and relationships rooted in mutual trust.[225] Cultural humility involves an awareness of oneself as a learner in relation to understanding someone else's experiences.[225]

Institutional-level cultural safety interventions include building partnerships with communities, creating safe and welcoming physical spaces reflective of the populations they serve (e.g., signage in Indigenous languages, sacred spaces in hospitals), institutional commitments to cultural safety, and hiring and supporting Indigenous healthcare providers.[22, 208, 223, 224] Healthcare organizations can also change internal policies to support cultural safety, such as creating flexibility in appointment scheduling to increase responsiveness, while building trusting relationships.[208]

In addition to Indigenous peoples, cultural safety has the potential to support other groups facing discrimination. In particular, cultural safety has been identified as relevant for transgender populations and racialized populations.[109, 174, 227]

DISCUSSIONS GROUP QUOTES

"…Holistic care is crucial, it is not a tick box, and you need to understand the whole person and the lived experience."

"What we do at the [interpersonal level] helps alleviate the individual stigma, but only if the structural [systemic] stigma is positively changed."

Discussion Group Reflections on Addressing Stigma

In response to British Columbia's Transformative Change Accord First Nations Health Plan, devolving First Nations health services in the province of British Columbia back to First Nations, the San'yas Indigenous Cultural Safety Training Program was created and delivered across all British Columbia Health Authorities.[226]

Cultural Safety Declarations

On April 23, 2019, the Public Health Agency of Canada, along with Health Canada and Indigenous Services Canada, signed the *Declaration of Commitment to Advance Cultural Safety and Humility in Health and Wellness Services and Organizations* with the British Columbia First Nations Health Authority. The declaration reflects a shared commitment to creating an environment where Indigenous peoples feel safe in accessing the Canadian health system. The overarching goal is to identify opportunities to reduce the systemic barriers and harms that Indigenous peoples experience, raise awareness about existing systemic discrimination, and address inequities in outcomes for Indigenous peoples. Cultural humility requires self-reflection to understand biases, address power imbalances and develop respectful processes where people feel safe to access health systems. The Declaration addresses the Calls to Action numbers 23 and 57 put forth by the Truth and Reconciliation Commission of Canada that calls upon all levels of government to ensure that healthcare professionals and public servants are educated on the history of Indigenous peoples.

DISCUSSION GROUP QUOTE

"We need to bring humanness into this. More faces to narratives. There needs to be champions at the moment and leaders, but we do not want to tokenize either. We need to all want it."

Trauma- and Violence-informed Care

Stigma practices can include and are exacerbated by interpersonal and structural violence. Trauma- and violence-informed care has emerged in recognition of the many forms of trauma and the potential for sustained impacts of trauma.[230] This approach shifts thinking from "What is wrong with you?" to considering "What happened to you?". This supports an exploration of how trauma influences well-being and its potential impact on behaviour.[231] This approach is not intended to provide specialized therapeutic support to address trauma but rather to reduce the potential for harm and retraumatization. This includes attention to a variety of potentially traumatizing experiences in health care, including being in a physically vulnerable position during an exam, or loud waiting rooms. It also includes a recognition of the emotional intensity of disclosing trauma and the importance of asking about trauma in a sensitive, respectful, and appropriate manner.[231]

The four principles of trauma- and violence-informed care are:[232]

1. building awareness among health providers about trauma, violence and its impacts on people's lives and behaviour,
2. creating emotionally and physically safe and welcoming environments for everyone, including using non-stigmatizing language,
3. fostering opportunities for choice, collaboration and connection, and
4. using a strengths-based and capacity-building approach to support people.

Institutional Accountability

The broader policy environment can influence the success of institutional initiatives. For example, there is little focus within current accountability frameworks related to stigma reduction, which makes it hard to track existing activity or impacts, and means there is little structure or incentive to support new or ongoing efforts.[235] The potential of this approach has been identified in systematic reviews of organizational cultural competency initiatives.[219] While research is too limited and varied to support firm conclusions, audit and quality improvement activities have been found to provide a structure to identify and drive action on aspects of culturally competent healthcare for Indigenous peoples.[219]

Accountability frameworks that focus on stigma reduction could be supported by monitoring the accessibility, quality and/or relevance of health services. This could include breaking down quality improvement data to explore the different experiences of groups most likely to experience stigma, which would require meaningful and respectful collection of patient demographic data.[236–238]

Discussion Group Reflections on Addressing Stigma

The Truth and Reconciliation Commission's (TRC) Calls to Action offer a path forward, to address racism experienced by Indigenous peoples in the health system and beyond. Discussion Group participants shared examples of a local and provincial initiative aiming to respond to the 94 Calls to Action:

Following the release of the TRC's Calls to Action, Saskatoon Health Region (now part of the Saskatchewan Health Authority) developed a framework for action and accountability across the health system. This framework refers to the Calls to Action numbers 18–24 surrounding health. For instance, Call to Action number 23 asks all levels of government to increase the number of First Nations, Inuit, and Métis professionals working in the healthcare field, ensure the retention of First Nations, Inuit, and Métis healthcare providers in Indigenous communities, and provide cultural competency training for all healthcare professionals. The TRC Engagement Framework outlines action at multiple levels where staff can respond to the Calls to Action in ways that "draw connections between everyday work as practitioners and systemic change in our community and beyond."[228] This framework offers opportunities and examples on actions that empower staff to respond to the Calls to Action within the health system at the partnership, organizational, departmental and practitioner levels.

To respond to Call to Action number 22, regarding inclusion of Elders as a strategy to improve care of Indigenous patients, a primary care clinic in Vancouver's downtown east side engaged Indigenous Elders to provide cultural mentorship to patients through one-on-one sessions, group cultural teaching circles, and land-based ceremony. Of the 37 patients who participated in a follow-up interview, all but one participant described a benefit from their work with Elders.[229]

DISCUSSION GROUP QUOTE

"People just love the Elders being involved in health care with them. Then we also involved the Elders in the community, in advisory committees, in all our meetings. We would bring together quarterly meetings and have everybody's input, about the direction we're going in, so people really felt welcomed, wanted, felt heard, had their voices heard."

EQUIP: A Canadian Health Equity Intervention

One promising Canadian example of a theoretically-informed and empirically-tested health equity intervention that addresses stigma drivers and practices is EQUIP Health Care. EQUIP is a multi-level intervention that combines a focus on cultural safety, trauma- and violence-informed care, and harm reduction as key dimensions of Equity-Oriented Health Care (EOHC) that must be contextually tailored to the setting, community and diverse populations served. EQUIP involves staff education and focuses on changing practice, as well as the development and implementation of an organization-wide action plan for change.

In four Canadian primary health clinics, the EQUIP model was associated with an increase in self-reported awareness and confidence related to equity-oriented health care among staff.[209] It was also associated with organizational strategies to address racism at multiple levels, improving the physical space of waiting rooms, and organizational policy and practice changes to support harm reduction.[209] Longitudinal research completed with EQUIP clinic patients suggests that when patients received EOHC, they felt greater comfort and confidence in the care they received and, subsequently, greater confidence in their ability to manage and prevent health problems.[234] This increase in confidence predicted patient-reported improvements in depressive symptoms, PTSD symptoms, chronic pain, and quality of life.[234]

EQUIP is now being tested in three diverse emergency departments and is integrating the concept of Front-line Ownership, in which direct service providers identify priorities and lead changes towards destigmatizing practices and EOHC.

Population-level Interventions

At the population level, interventions address stigma drivers and practices by targeting social norms as well as public policy. Interventions at this level cut across multiple systems, and can powerfully influence stigma within and beyond the health system.

Changing Social Norms

Population-level campaigns challenge stereotypes and prejudice using education and contact models similar to individual- and interpersonal-level interventions. Evaluation activities have generally focused on mass media campaigns targeting mental health stigma, including *Time to Change* (England) and *Beyond Blue* (Australia). There is evidence for small to moderate short-term positive impacts of population-level mass media campaigns to influence stigma, with all research from narrative reviews in the field of mental health.[189, 198] Alongside local initiatives, *Time to Change* targeted the general population through national mass media and social marketing activity, with a focus on education, reducing prejudice and changing behaviour.[189] There was an improvement in self-reported knowledge, attitudes, and intended behaviour at the population-level, as well as a reduction in discrimination reported by mental health service users.[189, 198, 239] Australia's *Beyond Blue* used population-level mass media activities, among others, to target public knowledge, beliefs, and skills related to mental health.[198] The campaign was associated with positive changes in self-reported public attitudes.[198]

Stigma is also impacted by media representations, which can influence stigma drivers like fear and prejudicial attitudes.[240] In mental health, media-based anti-stigma interventions include media coverage monitoring after national or local anti-stigma initiatives or the release of mental health reporting guidelines, as well as education for journalists or journalism students. There is little research on the effectiveness of these interventions, and findings are mixed, but the most promising approaches include contact-based educational interventions and guidelines developed and shared by authoritative institutions.[240]

Discussion Group Reflections on Addressing Stigma

Participants discussed interventions that promoted empowerment through the arts. For example, documentaries such as "Take Me to the Prom" detail experiences of LGBTQ2+ people going to their high school proms decades after leaving high school.[241] Arts-based interventions can improve representation in the media and have the potential to change social norms.

Rights and Protections for All Canadians

Laws and policies can prevent and provide protections against discriminatory behaviour, while also signalling that stigma and prejudice are unacceptable.[183, 242] In Canada, this includes the *Canada Human Rights Act* and the *Canadian Charter of Rights and Freedoms*. Population-level policy interventions targeting stigma drivers and practices have the greatest potential for widespread impact.[106, 191, 242] This is evident in research exploring the relationship between policies and health inequalities.

An important example in Canada is the extensive research identifying associations between residential school attendance among Indigenous peoples and a wide variety of mental and physical health inequalities for former residential school attendees as well as subsequent generations.[243] Residential schools attempted to erase the language, cultural practices and beliefs of Indigenous children, and many children also experienced physical, sexual, and/or emotional abuse.[243] Residential schooling has been linked to poorer physical health, including increased rates of chronic and infectious diseases, as well as mental distress, depression, substance use, stress, and suicidal behaviour.[243]

Much of the other population-level research on the link between stigmatizing policies and population health outcomes comes from the United States. Jim Crow laws—state and local laws that, until 1964, had legalized racial segregation—have been associated with health inequalities in breast cancer, infant death and premature mortality among Black Americans.[244–246] In another example, passing state-level laws permitting denial of services to same-sex couples was associated with an increase in the proportion of sexual minority adults reporting mental distress.[247] Conversely, laws that extend equal rights are linked to increased well-being. In a longitudinal study of bisexual and lesbian women in Chicago, civil union legislation was associated with lower levels of stigma consciousness, perceived discrimination, and depressive symptoms.[248]

DISCUSSION GROUP QUOTE

« Il faut aller au-delà des systèmes existants. [On a] besoin d'une sensibilisation et … [un] message fort de société...Les autres personnes non-minorité doivent être influencé par la réalité – le prochain combat, c'est celui-là qui faut absolument traiter. »

"It is necessary to go beyond existing systems. [We] need awareness and... [a] strong social message... Other non-minority people must be influenced by reality—the next battle is the one that must be dealt with."

There is limited research evaluating the impact of population-level policy initiatives related to stigma on health inequalities in the Canadian context. However, existing laws, such as the criminalization of HIV non-disclosure and personal drug use, have been identified for their role in furthering stigma.[249–253] Discrimination has also been codified into legislation such as the *Indian Act*. Passed nearly 150 years ago, this law continues to govern and restrict key spheres of life, such as land, identity, self-governance, and economic activity for First Nations.[22, 254–256] This occurs alongside inadequate resources for Indigenous education, housing and health and social services.[22, 116]

There is a recent example of how evidence has informed new policies to reduce stigma. In December 2018, Canada was the first country to sign on to the global U=U (Undectable is Untransmittable) Campaign. This campaign is based on evidence demonstrating that, when an individual is being effectively treated for HIV and maintains a suppressed viral load, there is effectively no risk of sexual transmission. Stigma remains one of the greatest barriers for Canadians in accessing HIV prevention, testing, treatment and support, and this shift has important implications for reducing HIV stigma. In response, Justice Canada announced it would issue a new directive related to the prosecution of HIV non-disclosure, based on the scientific evidence reviewed by the Public Health Agency of Canada.[257]

Principles to Guide Anti-stigma Interventions

Despite an increase in anti-stigma intervention research, it is still difficult to know "what works", in what context, to address stigma and discrimination. This is a common challenge in intervention research. Time and/or resources are often inadequate to rigorously design, implement, and evaluate interventions (see text box). This process is even more complicated for population-level interventions. This has led to an uneven distribution of research across levels and a mismatch between the focus of most intervention research (individual or interpersonal levels) and the levels where the greatest impact is possible (institutional or population levels).

A better understanding of what works also requires the greater inclusion of diverse voices and ways of knowing. While the responsibility for change rests in the hands of decision-makers and system leaders, it is communities themselves who have a long history of strength and leadership in the face of stigma and discrimination. The foundation of our efforts to address stigma and discrimination comes from the community, including people with lived experience and community-based organizations. Communities experiencing stigma have supported each other to build solidarity and challenge stigma drivers and practices, in order to mitigate the impacts of stigma experiences among individuals, families and communities.[22, 258, 259]

Expanding Our View of Evidence

Colonialism and racism have influenced which knowledge systems are valued and which are not. This has resulted in the dominance of western biomedical knowledge, and devaluation of Indigenous knowledge systems or "ways of knowing".[22] It is important that our collective efforts are informed by Indigenous ways of knowing, as well as the experiential knowledge of people with lived experience of stigma. For this report, this knowledge comes from Indigenous and racialized scholars, as well as our discussion groups.

The Action Framework is a starting point that identifies promising interventions based on our knowledge to date. Our efforts to develop, adapt, implement, and evaluate anti-stigma interventions can create meaningful change now while also advancing this field into the future. Several principles were identified through the evidence review that, alongside key tenets in public health, can provide useful guidance for our next steps.

Core Principles for Developing Anti-stigma Interventions

1. Driven by collaboration between health system leaders and people with lived experience of stigma
2. Designed based on research evidence, diverse ways of knowing, and experiential knowledge
3. Multi-level, with particular attention to multi-level initiatives that prioritize institutional- and/or population-level interventions to address systemic stigma and discrimination in health systems
4. Guided by approaches such as cultural safety and trauma- and violence-informed practice
5. Attends to intersectionality, including the strengths, resources, and solidarity within communities who experience stigma
6. Grounded in principles of intervention research and implementation science, to advance knowledge in the field

FIGURE 10: What Does a Stigma-free Health System Look Like?[xv]

xv These ideas came from two discussion groups. Participants were asked what a stigma-free health system would look like to them.

Way Forward

While stigma is shaped and kept in place by larger social and economic forces, including historical policies and practices, the health system can be a powerful leading sector to support change in Canada. If we use our full capacity at all levels across the health sector, we can influence change on a broader scale.

Those who work in health set out to help others live a healthy life and get quality care if they are sick, so critiquing our health system and examining our personal biases is difficult at both emotional and cognitive levels. However, for us to move forward, we have to acknowledge unacceptable policies and practices that perpetuate power dynamics and withhold resources from those who may need them the most.

To create a more inclusive health system, it takes brave leadership and sustained commitment to change the status quo through multiple actions, at multiple levels. It requires a more proactive approach to address common and distinctive barriers experienced by stigmatized individuals as they try to access health resources.

We each have a role in this.

As **HEALTH SYSTEM LEADERS**, we need to ensure that health policies protect and support people who face stigma, and dismantle policies that discriminate and exclude them from receiving health services.

We can deliver high-quality services to all of our patients and clients in safe, respectful, and welcoming environments. This requires implementation of a range of complimentary actions including:

- cultural safety policies and practices that equip staff to provide sensitive and appropriate programs and services;
- trauma- and violence-informed approaches that ensure health professionals use non-stigmatizing language and understand trauma as a risk to achieving optimal health; and
- support and fund the collaboration and meaningful engagement with people who have living experience of stigma in developing health policies and programs.

Health education institutions and professional associations must work with partners, including stigmatized persons, to guide the transformation of practices, curricula, and professional competencies of health providers to ensure that stigma in our health system is no longer perpetuated.

It is crucial that we **measure and monitor the progress of our actions**. This is a key component of institutional change and necessary if we are going to make a difference. We can systematically stratify our data by groups that are most likely to be stigmatized and critically reflect on the results. Regular monitoring and setting goals and targets for the institution, staff, and patient improvement can lead to lasting, improved health outcomes and quality of care.

As **RESEARCHERS**, understanding health inequities is an important goal of our work. To do this, we must address the fundamental and unacceptable gaps in our national data—we do not have good disaggregated data on the health status of diverse populations or their experiences of stigma. For example, we are not able to consistently report on life expectancy for people who identify as LGBTQ2+, those who are marginally housed, people who use substances, and other diverse populations. We must also facilitate collaborative research across health, social, and behavioural sciences that helps us look at the impact of multiple stigmas. Priority must be placed on strengthening intervention and implementation research so that we can determine what works for those experiencing stigma related to health conditions and social identities.

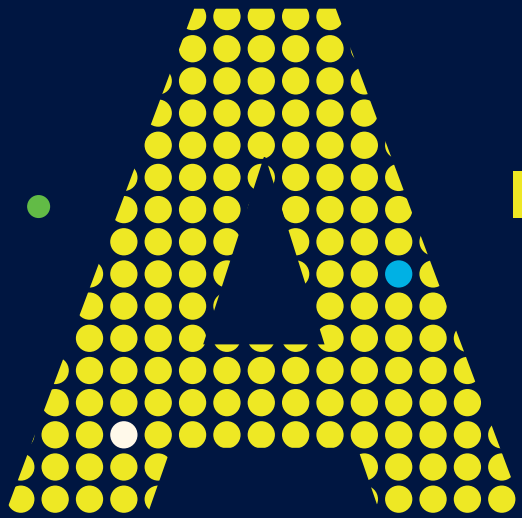
As **INDIVIDUALS**, we bring our worldviews and personal histories to our work. We have biases and we are vulnerable to the use of stigmatizing language.

What can you do about yours?

1. **Work on your thought processes and challenge your filters.** Stop using dehumanizing language. Biases can be unlearned. Identify and challenge negative stereotypes or myths in the media, and self-monitor your own thoughts.
2. **Bring this awareness to your organization.** Critically examine your organizational culture and make changes to any discriminatory policies or exclusionary practices. Implement the Action Framework described in this report within your organization.
3. **Commit to ongoing learning.** Acknowledging, understanding, and challenging your own biases and systemic stigma is a life-long commitment. Continue to challenge yourself and your organization, and look for ways to improve.

In Canada, we have deep and well-rooted values of respect, diversity, and inclusivity. This positions us to continue strengthening these foundations and promote optimal health for all.

Ending stigma and building an inclusive health system is an important legacy we can leave our future generations.



APPENDIX A

Chief Public Health Officer's Health Status Dashboard

Dashboard Overview

The dashboard uses a diverse set of health indicators to provide a snapshot of the overall health of Canadians. Indicators are grouped in three broad categories: general health status (Table A), factors influencing health (Table B) and health outcomes (Table C). The dashboard is reviewed annually to ensure that most recent indicator results are included. Previous dashboard version results are used in cases where no updates are available.[260] Indicator results per sex are provided, as available. High-level trend analysis results report positive ("better"), negative ("worse") or neutral ("similar") data trends over time. In a few cases, a trend conclusion may not be available ("N/A") due to data or methodological limitations. International benchmarking results compare Canada relative to similar high-income countries, such as the Organisation for Economic Cooperation and Development (OECD) member average. Possible results are "better" or "worse" than benchmark and "N/A" in the event that no comparable international indicator was identified.

TABLE A: General Health Status

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Life expectancy at birth	Overall life expectancy in years	82	F 84	M 80	2015–2017	Vital Statistics	Better	Similar[i]
Health adjusted life expectancy (HALE) at birth	Overall HALE in years	70	F 71	M 69	2010–2012	Multiple sources[ii]	Better	Better[iii]
Perceived health	% of population aged 12 years and older reporting "very good" or "excellent" health	61	F 60	M 61	2018	Canadian Community Health Survey	Similar	Better[iv,v]
Perceived mental health	% of population aged 12 years and older reporting "very good" or "excellent" mental health	69	F 66	M 71	2018	Canadian Community Health Survey	Worse	N/A

i Organization for Economic Cooperation and Development, Health at a Glance 2017.

ii Statistics Canada, Canadian Vital Statistics, Birth and death databases and population estimates; Canadian Community Health Survey; National Population Health Survey, Health institutions component; Residential Care Facilities Survey; Canadian Health Measures Survey; Census of population.

iii World Health Organization, World Health Statistics 2018.

iv Organization for Economic Cooperation and Development, Society at a Glance 2016.

v Compared to most other countries, Canada had a different set of survey question response categories, creating a positive bias for this estimate.

TABLE B: Factors Influencing Health

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Social factors								
Community belonging	% of population aged 12 years and older reporting a "somewhat strong" or "very strong" sense of belonging to local community	68	F 70	M 67	2018	Canadian Community Health Survey	Similar	N/A
Poverty (Canada's Official Poverty Line)	% of population living below Canada's official poverty line, based on the Market Basket Measure	10	F 10	M 9	2017	Canadian Income Survey	Better	N/A
Childhood poverty (Canada's Official Poverty Line)	% of children living below Canada's official poverty line, based on the Market Basket Measure	9	F 9	M 9	2017	Canadian Income Survey	Better	N/A
Education	% of population aged 25 years and older without a certificate, diploma or degree	13	F 13	M 14	2018	Labour Force Survey	Better	Better[vi]
Core housing need	% of households in core housing need[vii]	13	N/A		2016	Census	Similar	N/A
Food insecurity	% of households that are food insecure (moderate or severe)[viii]	8	F 10	M 7	2018	Canadian Community Health Survey	Similar	N/A

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vi Organization for Economic Cooperation and Development, Education at a Glance 2018.

vii A household in core housing need is one whose dwelling is considered unsuitable, inadequate or unaffordable and whose income levels are such that they could not afford alternative suitable and adequate housing in their community.

viii Moderately food insecure: indication of compromise in quality and/or quantity of food consumed; severely food insecure: indication of reduced food intake and disrupted eating patterns.

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Substance Use								
Smoking	% of population aged 15 years and older who report being a current daily or occasional smoker (cigarettes only)	15	F 13	M 17	2017	Canadian Tobacco, Alcohol and Drugs Survey	Similar	Better[i]
Cannabis	% of population aged 15 years and older who report daily or almost daily cannabis use in past 3 months	3	F 3	M 4	2017	Canadian Tobacco, Alcohol and Drugs Survey	Similar[ix]	Worse[x]
Alcohol	% of population aged 12 years and older who report heavy drinking[xi]	19	F 15	M 24	2018	Canadian Community Health Survey	Similar	Similar[i]
Opioids	Rate of apparent opioid-related deaths per 100,000	12	N/A		2018	Opioid surveillance	Worse	N/A
	Rate of hospitalizations due to opioid poisonings per 100,000	17	F 15	M 18	2017	Hospital Morbidity Database	Worse	N/A

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ix Limited number of available data points—interpret with caution.

x World Health Organization, Cannabis use lifetime.

xi Heavy drinking: males having five or more drinks, or women having four or more drinks, on one occasion, at least once a month in the past year.

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Childhood risk and behavioural factors								
Bullying	% of grade 6–10 students who were victims of bullying more than once or twice in the past two months	28	F 29	M 27	2018	Health Behaviour in School-aged Children	Similar	Similar[xii]
Physical activity	% of children and youth (aged 5 to 17 years) that accumulate an average of at least 60 minutes of moderate-to-vigorous physical activity per day	39	F 26	M 52	2016–2017	Canadian Health Measures Survey	Similar	N/A
Sedentary behaviour	% of children and youth (aged 5 to 17 years) who report meeting sedentary behaviour recommendations[xiii]	54	N/A		2016–2017	Canadian Health Measures Survey	N/A	N/A
Overweight and obesity	% of population aged 5 to 17 years classified as overweight by WHO definition	18	F 21	M 16	2016–2017	Canadian Health Measures Survey	Similar	Similar[i,xiv]
	% of population aged 5 to 17 years classified as obese by WHO definition	11	F 9	M 12	2016–2017	Canadian Health Measures Survey	Similar	Similar[i, xiv]
Child abuse	% of population aged 15 years and over who experienced any of three types of child abuse[xv] before age 15	34	F 32	M 37	2014	General Social Survey	N/A	N/A

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xii Organization for Economic Cooperation and Development, PISA 2015 Results (Volume III).

xiii Sedentary behaviour recommendations: spending two hours or less per day watching television or using a computer during leisure time.

xiv The indicator used combined children who are overweight and obese.

xv Types of child abuse considered are physical abuse, sexual abuse and/or witnessing violence by a parent or guardian against another adult.

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Early childhood protective factors								
Early development index	% of children vulnerable in one of five areas of development[xvi] prior to entering grade 1	26	F 20	M 34	Pool of various years	Offord Centre for Child Studies, McMaster University	N/A	N/A
Immunization	% of 2-year-old population that has received one dose of measles vaccine	90	F 92	M 89	2017	Childhood National Immunization Coverage Survey	Similar	Worse[xvii]
	% of 2-year-old population that has received the recommended 4 doses for diphtheria, pertussis and tetanus	76	F 78	M 74	2017	Childhood National Immunization Coverage Survey	Similar	Worse[xvii]
	% of 2-year-old population that has received three doses of polio vaccine	91	F 91	M 90	2017	Childhood National Immunization Coverage Survey	Similar	N/A
	% of 2-year-old population that has received one dose of varicella (chickenpox) vaccine	83	F 84	M 82	2017	Childhood National Immunization Coverage Survey	Similar[xviii]	N/A

Continued on next page

xvi The five areas of development are Physical Health and Well-Being; Social Competence; Emotional Maturity; Language and Cognitive Development; and, Communication Skills and General Knowledge.

xvii Organization for Economic Cooperation and Development, OECD Family Database.

xviii Interpret with caution due to data quality concern.

Topic	Indicator	Result	Result by sex	Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Maternal and infant health factors							
Low birthweight	Birth-weight less than 2,500 grams (% of live births)	7	F 7 M 6	2017	Vital Statistics	Similar	Similar[i]
Breastfeeding	% of female population aged 15 to 55 years who had a baby in last 5 years that report exclusively breastfeeding for at least 6 months, without additional liquid/water or solid food	37	N/A	2018	Canadian Community Health Survey	Similar	Similar[i]

TABLE C: Health Outcomes

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Chronic diseases and injuries								
Cancer	Incidence rate of all newly diagnosed cancers, per 100,000 (all ages)	516	F 496	M 548	2017	Canadian Cancer Registry	N/A	Similar[i]
	Incidence rate of all newly diagnosed colo-rectal cancers, per 100,000 (all ages)	66	F 55	M 80	2017	Canadian Cancer Registry	Similar	N/A
Cardiovascular disease	Incidence rate of all newly diagnosed cases of ischemic heart disease, per 100,000 (age 20 years and older)	599	F 489	M 716	2016	Canadian Chronic Disease Indicators	Better	Better[i]
Diabetes	Incidence rate of all newly diagnosed cases of diabetes, per 100,000 (age 1 year and older)	604	F 541	M 668	2016	Canadian Chronic Disease Indicators	Better	Similar[i]
Mood disorders	% of population aged 12 and over who reported that they have been diagnosed by a health professional as having a mood disorder[xix]	9	F 11	M 7	2018	Canadian Community Health Survey	Worse	N/A

Continued on next page

xix Mood disorder includes depression, bipolar disorder, mania or dysthymia.

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Chronic diseases and injuries								
Dementia (including Alzheimer's disease)	Rate of newly diagnosed dementia cases, including Alzheimer's disease, per 100,000 (age 65 years and older)	1351	F 1489	M 1193	2016	Canadian Chronic Disease Indicators	Better	Similar[i]
Suicide	Suicide mortality rate per 100,000	11	F 6	M 17	2017	Mortality Database	Similar	Similar[i]
Unintentional injuries	Rate of hospitalizations due to unintentional injuries per 100,000 (age-standardized)	599	F 550	M 636	2017–2018	Canadian Institute for Health Information Health Indicators	Better	N/A
Communicable diseases								
Tuberculosis	Incidence rate of active tuberculosis disease cases per 100,000	5	F 4	M 6	2017	Canadian Tuberculosis Reporting System	Similar	Better[xx]
Hepatitis C	Rate of reported Hepatitis C disease cases per 100,000	32	F 24	M 39	2017	Notifiable Diseases Surveillance	Similar	Better[xxi]
HIV	Incidence rate of HIV diagnosis per 100,000	7	F 3	M 10	2017	Notifiable Diseases Surveillance	Similar	N/A

xx World Health Organization. (2018). Global Tuberculosis Report.
xxi World Health Organization. (2017). Global Hepatitis Report.

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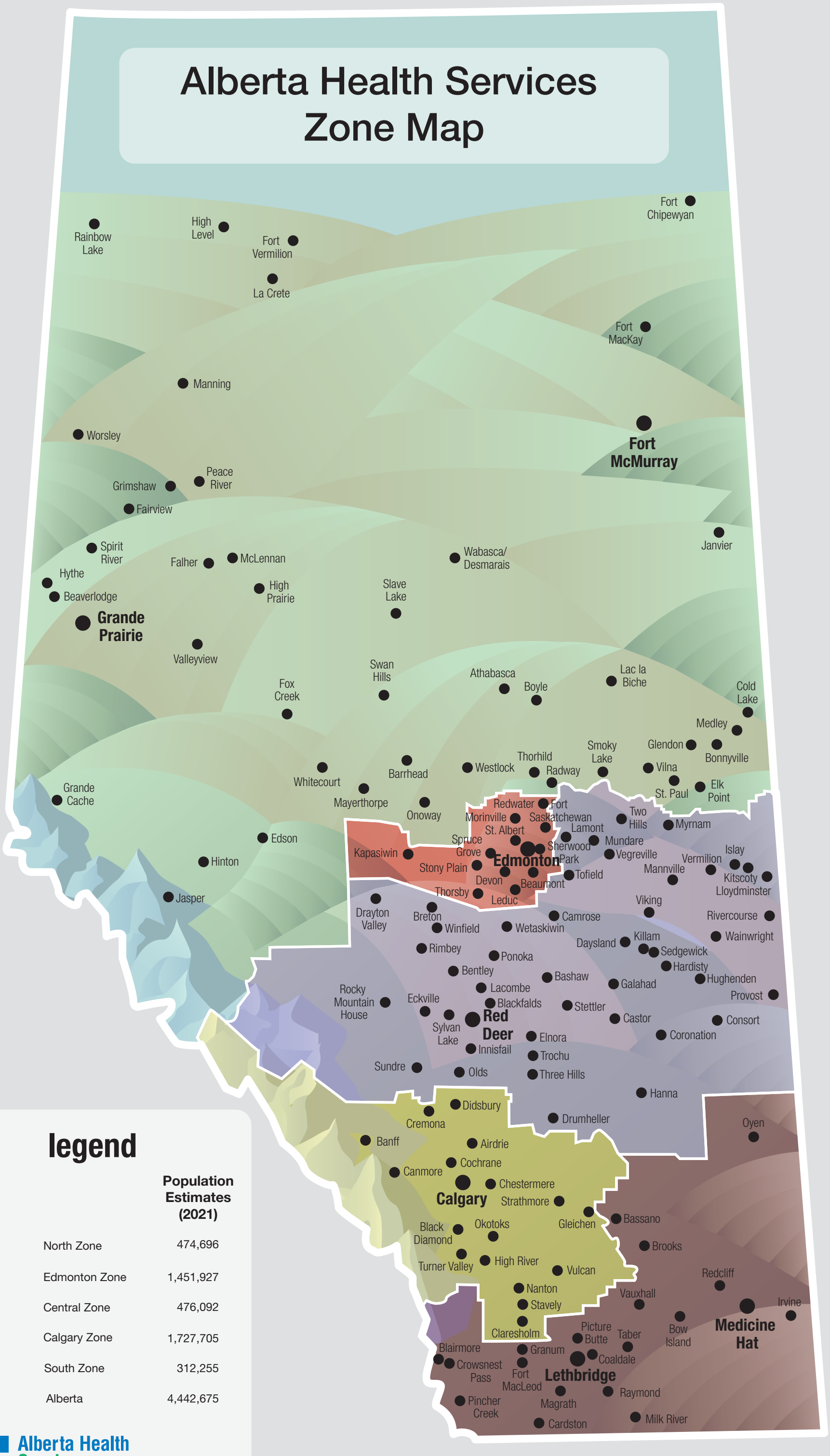
Alberta Health Services Zone Map



legend

	Population Estimates (2021)
North Zone	474,696
Edmonton Zone	1,451,927
Central Zone	476,092
Calgary Zone	1,727,705
South Zone	312,255
Alberta	4,442,675

Alberta Health Services

COVID-19 Info: For Albertans | For Health Professionals | Vaccine | Assessment & Testing | Results | Visitation

A CMOH order remains in effect that requires continuous masking at all AHS, APL and Covenant facilities provincewide.

EMS in the Central Zone

Your source for current, accurate information on the progress being made to improve Emergency Medical Services (EMS) care for all Albertans

EMS: Saving Lives, Improving Care

EMS activity in the Central Zone:

- Wainwright EMS has transitioned to an ALS/BLS service with two paramedic positions and six EMT positions. BLS ambulances provide essential medical care, but ALS ambulances are able to respond to more complex medical situations, with at least one paramedic and more life saving equipment on board.
- Borderless' dispatch allows EMS resources to be called in from neighbouring communities when required and also ensures the closest ambulance is sent to emergency calls. Previously, ambulances were restricted as to where they could respond based on municipal borders.
- The Community Health and Pre-Hospital Support Program (CHAPS) has been rolled out across the province. Paramedics are able to refer patients to Home Care and other community services that help these patients remain safe in their home and reduce their need for EMS transport to emergency departments.
- Medical protocols have been established to ensure all patients, wherever they are in the province, receive the same level of care.

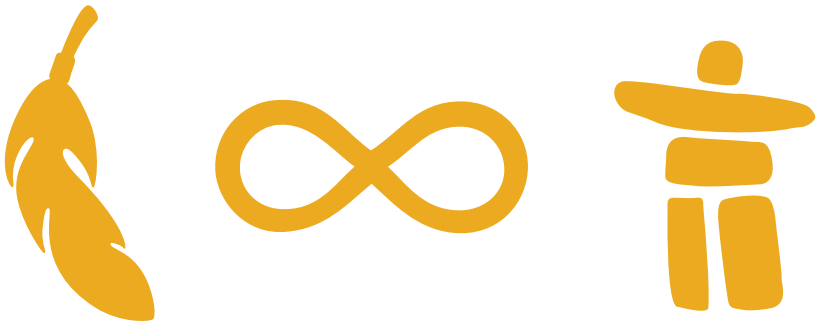
EMS Wait Time Reporting

- Camrose
- Lacombe (Quarterly)
- Olds (Quarterly)
- Red Deer
- Rocky Mountain House (Quarterly)
- Sylvan Lake (Quarterly)

Related Information

- Community Paramedics
- How to read the charts
- EMS FAQs
- EMS Data FAQs

Share your wisdom



Have a voice in Indigenous health services

Alberta Health Service is looking for people to advise us on how to better serve Indigenous peoples.

Through our Wisdom Council, we will explore ways to improve health services and rebuild trust.

If you're interested in joining our council, contact us by March 31, 2022, at:

WisdomCouncil@ahs.ca

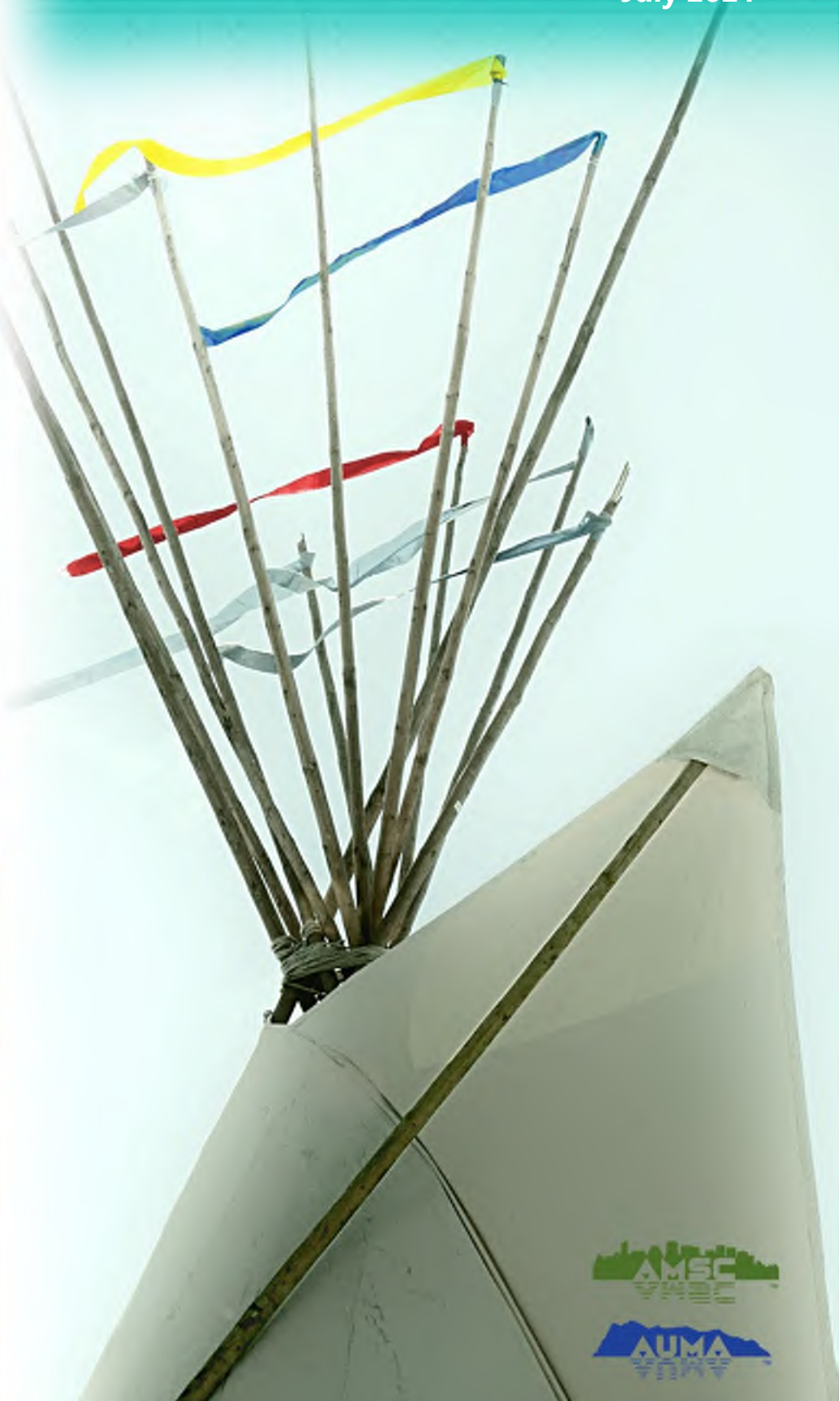
Learn more about our Wisdom Council at:

Healthy Albertans.
Healthy Communities.
Together.

Alberta Health Services

A Municipal Guide to the Truth and Reconciliation Commission's Calls to Action

July 2021



Land Acknowledgement

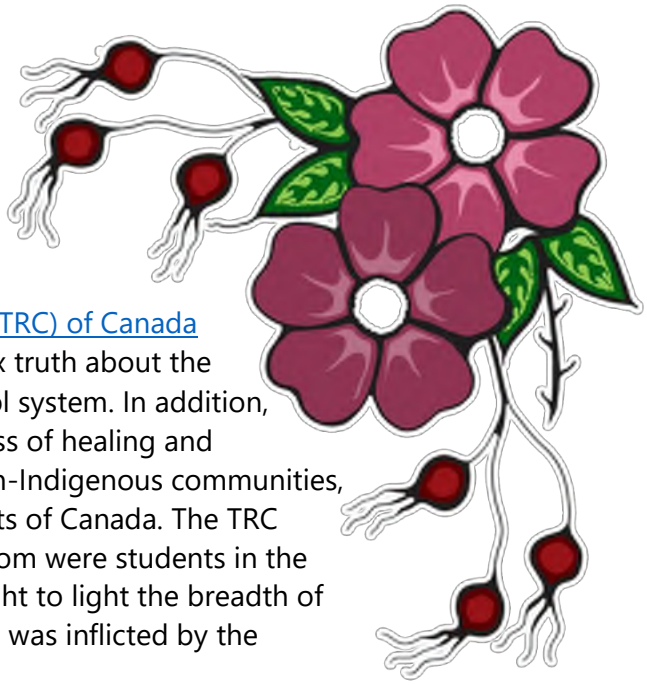
The Alberta Urban Municipalities Association (AUMA) acknowledges the traditional land on which we are headquartered is in Treaty Six Territory. We honour and respect the history, languages, and culture of the diverse status and non-status Indigenous peoples who call this territory home such as the nêhiyaw (Cree), Dené, Anishinaabe (Saulteaux), Nakota Isga (Nakota Sioux), and Niitsitapi (Blackfoot) peoples. We also acknowledge this land as the Métis' homeland and the home of many Inuit.

As the voice for urban municipal governments situated across the province of Alberta, we encourage all municipal governments to be informed about the traditional lands, Treaties, and history and cultures of Indigenous peoples local to their region.

Learn more through resources such as:

- Government of Alberta's map of the Treaty territories, First Nations reserves, and Métis Settlements.
- Visit www.native-land.ca for an interactive map of territories, languages, and Treaties.
- Download the Whose Land app for mobile use.

Imagery by Cree-ative Vision



Background

For over 100 years, Indigenous children in Canada were removed from their families and sent to institutions known as residential schools. In 2008, the Truth and Reconciliation Commission (TRC) of Canada was established to reveal to Canadians the complex truth about the history and ongoing legacy of the residential school system. In addition, the TRC was intended to guide and inspire a process of healing and reconciliation between Indigenous families and non-Indigenous communities, churches, governments, private sector, and residents of Canada. The TRC heard from more than 6,500 witnesses, most of whom were students in the residential school system. Witness testimony brought to light the breadth of physical, sexual, spiritual, and emotional abuse that was inflicted by the residential school system.

In 2015, the TRC released a six-volume report that documents the experiences of the survivors and the legacy left by residential schools. One of the reports outlines 94 Calls to Action on how governments of all levels, institutions, and residents of Canada can support the process of reconciliation.

Purpose of this Guide

Since the release of the TRC reports, AUMA members have increasingly sought guidance on how to support reconciliation. The purpose of this guide is to assist municipal leaders to understand the calls to action that are most relevant to Alberta municipal governments in terms of scope of responsibility and applicability to municipal service delivery. While we encourage readers to review all 94 Calls to Action made by the TRC, this guide narrows the list down to 12 calls to action that can serve as a starting point for your municipal government.

It is important to note that each municipal government will be at a different point in its journey to support reconciliation and that this document should not be considered a source of definitive guidance, but a resource of suggestions for municipalities that are starting out. As you move forward, ensure that you work closely with local Indigenous leaders throughout the process and for additional resources, visit AUMA's Welcoming and Inclusive Communities initiative.

What does reconciliation mean?

The term 'reconciliation' often has different interpretations, but for the purposes of this guide, the Truth and Reconciliation Commission of Canada refers to reconciliation as:

> *An ongoing process of establishing and maintaining respectful relationships. A critical part of this process involves repairing damaged trust by making apologies, providing individual and collective reparations, and following through with concrete actions that demonstrate real societal change.*

In its simplest form, reconciliation is about Indigenous and non-Indigenous peoples coming to terms with the events of the past in a manner that rebuilds trust and respectful relationships. This will enable people to work out historical differences and build healthy relationships with a focus on bettering future generations in Canada.

Recommendation of Calls to Action for municipalities

#	Call to Action	Rationale
3	Fully implement Jordan's Principle to ensure First Nations children are not denied or delayed in accessing essential public services.	Municipalities can review all municipal services to children to ensure access is equitable and without discrimination. Where possible, municipalities can also support local healthcare, social, and educational professionals to remedy systemic and institutional practices so that Indigenous youth can access the services and supports they need, when they need them.
17	Enable residential school survivors and their families to reclaim names changed by the residential school system by waiving any administrative costs.	Municipalities that charge a fee for any name changes are encouraged to waive this fee if it is for the purpose of reclaiming a family name.
40	In collaboration with Indigenous people, create Indigenous-specific victim programs and services with appropriate evaluation mechanisms.	There are opportunities for municipal governments to advocate, create, and expand victim services programs in partnership with the Government of Alberta and local organizations.
45.iii	Renew or establish Treaty relationships based on principles of mutual recognition, mutual respect, and shared responsibility for maintaining those relationships into the future.	Municipal government leaders can build relationships with local and regional Indigenous organizations and leaders to open space for conversation on issues of mutual interest.
57	Educate public servants on the history of Indigenous peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Indigenous rights, Indigenous law, and Indigenous–Crown relations.	Possibly one of the most impactful ways that municipal governments can support reconciliation is to update internal training programs to regularly educate staff about the history of Indigenous peoples in Canada, including the residential school system, and how that impacts relations between Indigenous and non-Indigenous people today. This training may include a focus on intercultural competency, conflict resolution, human rights, and anti-racism.
66	Establish funding for community-based youth organizations to deliver programs on reconciliation.	While this call to action is directed to the federal government, municipalities can also partner with local organizations to raise awareness and encourage conversations with youth about reconciliation.

#	Call to Action	Rationale
69.iii	Encourage libraries to commit more resources to public education on residential schools.	Municipalities can partner with libraries to host speaker events and sharing circles and promote literature that will increase awareness about the history and legacy of residential schools.
77	Work with the National Centre for Truth and Reconciliation to identify and collect copies of all records relevant to the history and legacy of the residential school system.	Municipalities can explore historical corporate and cemetery records to identify and deliver any relevant documentation to the National Centre for Truth and Reconciliation. This may include partnering with the local museum(s).
93	Create/revise information kits for newcomers to reflect the history of Indigenous peoples, including information about the Treaties and the history of residential schools.	Municipalities can develop a handout about the history and culture of Indigenous peoples in the region and share it with immigrant serving agencies as well as make it publicly available online. Consider developing the handout in multiple languages to better support newcomers to understand the cultural context.
The following calls to action are most relevant to municipal governments that are located near a formal residential school site.		
75	Implement strategies for the ongoing identification, documentation, maintenance, commemoration, and protection of residential school cemeteries or other sites at which residential school children were buried.	This call to action is directed at the federal government, however, due to the municipal role in oversight of land use planning and cemetery management, municipal governments can take active steps to meet this call to action.
79.iii	Implement plans to commemorate residential school sites, the history of residential schools and contributions of Indigenous peoples to Canada's history.	This call to action is directed at the federal government, but municipal governments can also implement plans to commemorate the history to build awareness and support reconciliation.
82	In collaboration with survivors and stakeholder organizations, install publicly accessible and visible monuments to honour survivors and all the children who were lost to their families and communities.	This call to action is directed at provincial and territorial governments, but municipal governments can also support reconciliation through local installments.

A full list of the 94 Calls to Action is available at the National Centre for Truth and Reconciliation.

Examples of municipal actions in Alberta

City of Calgary
In 2016, the City of Calgary's Calgary Aboriginal Urban Affairs Committee developed the White Goose Flying Report, which outlines eighteen calls to action that the City of Calgary has taken ownership to implement. It also summarizes twelve calls to action that the City will support arms-length organizations to implement and an additional thirteen calls to action where the City will call for other partners and stakeholders to take leadership of.

City of Edmonton
Co-created with the local Indigenous community, the City of Edmonton's Indigenous Framework was broadly informed by the United Nations Declaration on the Rights of Indigenous Peoples, the Missing and Murdered Indigenous Women and Girls Calls for Justice, and the Truth and Reconciliation Calls to Action. The Indigenous Framework makes seven commitments and outlines four roles for City employees to embody the principles of the Framework. Prior to the release of the TRC's Calls to Action, the City of Edmonton had already implemented a human resource training program to educate employees about the history of the residential school system. To this day, thousands of City staff have participated in the training.

City of Lethbridge
In 2017, the City of Lethbridge and the Lethbridge Indigenous Sharing Network released a ten-year Reconciliation Implementation Plan. The Plan outlines five calls to action that the City will take ownership of and thirteen calls to action that will be led by the broader community. Every September, the City hosts a week of events to promote reconciliation and, in 2019, the City adopted 'Oki', the Blackfoot word for "greetings", as the City's official greeting.

Town of Canmore
In 2017, the Town of Canmore made a commitment to advance fifteen calls to action. Examples to-date have included incorporating Indigenous books, art, and imagery into public spaces and social programs, installing signage highlighting the history of Indigenous peoples in the Bow Valley, and hosting blanket exercises for council, staff, and summer programs.

Federation of Canadian Municipalities
In 2016, the Federation of Canadian Municipalities (FCM) published Pathways to Reconciliation, which summarizes the actions of Canada's largest cities to respond to the calls to action.

How AUMA is responding to the calls to action

Like any organization, AUMA is on its own journey to support reconciliation. In 2019, AUMA made a commitment to implement action 45.iii and action 57. That work has started with annual training for AUMA's Board and staff on the history of Indigenous peoples in Canada including the legacy of the residential school system. This work will continue while we use our events and capacity to raise more awareness about Canada's history and how municipal leaders can be influential voices in the journey of reconciliation. For more examples and guidance, contact us at wic@auma.ca.

WORKSHOPS ON CANADA’S HISTORY AND THE MUNICIPAL ROLE IN RECONCILIATION

← News

Jul 6
2021

Do you want to expand your understanding of the history of Indigenous peoples in Canada? Are you looking for guidance on how your municipality can support reconciliation?

Either way, you are in luck!

The AUMA and the Rural Municipalities of Alberta (RMA) are co-hosting two virtual workshops that will explore how past government policies have defined today’s relationship between Indigenous and non-Indigenous peoples. These workshops will provide municipal leaders with a deeper understanding of:

- Canada’s history of government policies and their effects on First Nations, Inuit, and Métis people.
- The learnings from the Truth and Reconciliation Commission of Canada and the 94 Calls to Action.
- Indigenous intersectionality and guidance on terminology.
- Common myths and how unconscious bias continues to contribute to misconceptions, prejudices and stereotyping of Indigenous peoples.

- Practical steps for municipal governments to advance reconciliation and create inclusive workspaces.

Who should attend?

This session is designed for municipal elected officials and senior municipal administrators who want to understand how government policies have affected Indigenous peoples and how to support reconciliation in their communities.

About the facilitator

Roy Pogorzelski is Métis from Saskatchewan, and his family comes from the communities of Green Lake, Meadow Lake and Batoche in the north. Roy is a former inclusion consultant for the City of Lethbridge and was the co-chair of the community-led reconciliation sub-committee that developed the City of Lethbridge’s 10-year Reconciliation Implementation Plan. As the President of RWP Consulting, Roy delivers training to organizations across Canada on issues of equity, diversity, and inclusion. He has served on boards such as the Canadian Race Relations Foundation and Alberta’s Anti-Racism Advisory Council, and he is a sessional instructor of Indigenous Studies at the University of Lethbridge.

Dates

Registrants can choose from one of two dates:

- July 23, 2021 – 1:30-4 p.m.
- July 26, 2021 – 1:30-4 p.m.

Cost

$25 plus GST

How to Register

Registration is limited to 25 people per session, so **register today**. If you have questions about this session, please email **advocacy@auma.ca**.

DISCOVER

MORE NEWS

More Business Service News

APR 12, 2022

Update from the Legislature – April 13, 2022

APR 12, 2022

Priority Update Webinar: Alberta Environment and Parks (April 25)

APR 12, 2022

EPR Municipal Transition Webinar on April 20

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We keep you informed. Subscribe to one of our regular newsletters.

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WELCOMING & INCLUSIVE COMMUNITIES INITIATIVE

The Welcoming and Inclusive Communities (WIC) initiative is a partnership between Alberta Municipalities and the Government of Alberta. It works to support municipalities as they implement policies and practices that help overcome issues of racism and discrimination.

The WIC initiative

The WIC initiative works to create communities where all residents and visitors enjoy a sense of where diversity adds to the social and economic vibrancy of the community, improving the quality residents.

We invite you to delve deeper and find the ideas, information, and resources that will support mu seeking to be more inclusive. Whether your municipality is just starting out, wants to evaluate its initiatives, or is considering whether or not to join the **Canadian Coalition of Inclusive Municipali** webpages are for you.

Contact us if you have examples, updates, or resources that would add value for others.

MORE ABOUT WIC

PROMOTE INCLUSION

Tools to help you pursue social inclusion

Opportunities abound to promote equity and inclusion and reduce racism and discrimination. To help you either get started or continue to advance the work you are already doing, we have developed and consolidated a number of tools and resources for you to download. Click on any of the categories below to learn more.

All forms of diversity

-→

Ability

-→

Age

-→

LGBTQ+

-→

Indigenous peoples

-→

Newcomers

-→

Funding

-→

STAY UP TO DATE!

We keep you informed. Subscribe to one of our regular newsletters.

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Alberta Municipalities
Strength In Members

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COVID-19 : Info update (https://canadacouncil.ca/covid-19-information)

Coalition of Inclusive Municipalities

Building open and inclusive communities

JOIN THE NETWORK (HTTPS://EN.CCUNESCO.CA/NETWORKS/COALITION-OF-INCLUSIVE-MUNICIPALITIES/JOIN-THE-COALITION)

VIEW MEMBERS (HTTPS://EN.CCUNESCO.CA/ABOUT-CCUNESCO/OUR-MEMBERS#CCMARD)

MosaïCanada 150, Gatineau, Quebec.
Michel Rathwell, 2017

This network brings together municipalities that want to improve their policies against racism, discrimination, exclusion and intolerance. Its strength lies in the shared experiences of its members. Together, the municipalities undertake initiatives to eliminate all forms of discrimination with a view to building open and inclusive societies.

The Network in Canada

In Canada, 96 cities are members of the Coalition of Inclusive Municipalities. They advance initiatives to:

- improve their practices to promote social inclusion
- establish policies to eradicate all forms of racism and discrimination
- promote human rights and diversity

The cities follow through on the Coalition's commitments for respecting, protecting and promoting human rights and diversity.

Coalition of Inclusive Municipalities

Because it values and respects all its members, an inclusive municipality builds a society without fences, where everyone has an equal chance at participating in its economic, political, social, cultural and recreational life, and to thrive there.

Stay tuned: follow our blog and check out our resources

PUBLICATION

Small and rural municipalities (/-/media/Files/Unesco/Resources/2021/08/SmallAndRuralMunicipalities.pdf)

27 August 2021

This toolkit provides practical information and resources for small and rural municipalities in order to support and strengthen their work in fighting racism and discrimination in all its forms, while also emphasizing the importance and benefits of embracing inclusionary practices.

BLOG POST

A call to mobilize against racism and discrimination (https://en.ccunesco.ca/blog/2020/6/call-to-mobilize-against-racism-discrimination)

24 June 2020

During the current pandemic, we see the disproportionate impact of the crisis on racialized people, Indigenous people, immigrants and families with lower incomes. This is why the struggle against racial discrimination remains a central element in the Canadian Commission for UNESCO's work.

PUBLICATION

The Coalition of Inclusive Municipalities: A Guide for New and Established Members (/-/media/Files/Unesco/Resources/2020/04/ToolkitCoalitionInclusiveMunicipalities.pdf)

08 April 2020

This updated toolkit provides practical information and resources for municipalities in order to support and strengthen their work in fighting racism and discrimination in all its forms, while also emphasizing the importance and benefits of embracing inclusionary practices.

CHECK OUT OUR RESOURCES (HTTPS://EN.CCUNESCO.CA/RESOURCES#F:NETWORK=[CANADIAN COALITION OF MUNICIPALITIES AGAINST RACISM AND DESCRIMINATION])

READ OUR BLOG (HTTPS://EN.CCUNESCO.CA/BLOG)

Read about the International Coalition of Inclusive and Sustainable Cities - ICCAR, launched by UNESCO in 2004.

FIND OUT MORE ABOUT THE GLOBAL NETWORK (HTTP://WWW.UNESCO.ORG/NEW/EN/SOCIAL-AND-HUMAN-SCIENCES/THEMES/FIGHT-AGAINST-DISCRIMINATION/COALITION-OF-CITIES/)

CCUNESCO operates within the Canada Council for the Arts (https://en.ccunesco.ca/about-ccunesco)

Stay up-to-date with our activities and initiatives

SUBSCRIBE TO OUR MAILING LIST (HTTPS://EN.CCUNESCO.CA/SUBSCRIBE)

Join the conversation:

(https://twitter.com/CCUNESCO)

(https://www.facebook.com/ccunesco)

(https://www.youtube.com/channel/UCnMpROH8pfbh6HWK9NxvKLQ)

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Privacy (http://canadacouncil.ca/about/public-accountability/privacy-notice)

Copyright (http://canadacouncil.ca/about/public-accountability/copyright)

The Canadian Commission for UNESCO's offices, located in Ottawa, are on the unceded, unsurrendered Territory of the Anishinabe Algonquin Nation whose presence here reaches back to time immemorial. Read the full statement (https://canadacouncil.ca/commitments/indigenous/land-acknowledgement).

English (https://en.unesco.org/indigenous-peoples) Français (https://fr.unesco.org/indigenous-peoples) Español (https://es.unesco.org/indigenous-peoples)

Русский (http://en.unesco.org/indigenous-peoples) العربية (http://en.unesco.org/indigenous-peoples) 中文 (http://en.unesco.org/indigenous-peoples)

Member States (http://www.unesco.org/en/member-states/) Staff (https://en.unesco.org/staff) Intranet (http://intranet.unesco.org)

"Building peace in the minds of men and women"

UNESCO (https://en.unesco.org/)

(https://en.unesco.org/)

Indigenous Peoples

Indigenous peoples live in all regions of the world and own, occupy or use some 22% of global land area. Numbering at least 370-500 million, indigenous peoples represent the greater part of the world's cultural diversity, and have created and speak the major share of the world's almost 7000 languages. Many indigenous peoples continue to be confronted with marginalization, extreme poverty and other human rights violations. Through partnerships with indigenous peoples, UNESCO seeks to support them in addressing the multiple challenges they face, while acknowledging their significant role in sustaining the diversity of the world's cultural and biological landscape.

UNESCO places the needs of indigenous peoples amongst its priority areas for response. For more information on indigenous peoples, please email indigenouspeoples@unesco.org (mailto:indigenouspeoples@unesco.org)

- UNESCO Policy on engaging with indigenous peoples (https://en.unesco.org/indigenous-peoples/policy)
- International Day of the World's indigenous peoples
- International Decade of Indigenous Languages (IDIL 2022-2032) (https://en.unesco.org/idil2022-2032)
- 2019 International year of Indigenous Languages (https://en.unesco.org/IY2019)
- International Mother Language Day
- UNESCO and the Sessions of the UN Permanent Forum on Indigenous Issues

Home (https://en.unesco.org/indigenous-peoples)

Education and intergenerational transmission (https://en.unesco.org/indigenous-peoples/education)

Sustainable development and environmental change (https://en.unesco.org/indigenous-peoples/sustainable-development)

Social inclusion and social change (https://en.unesco.org/indigenous-peoples/social)

Cultural and linguistic diversity (https://en.unesco.org/indigenous-peoples/culture)

Knowledge societies and ICTs (https://en.unesco.org/indigenous-peoples/icts)

UNESCO policy on engaging with indigenous peoples (https://en.unesco.org/indigenous-peoples/policy)

Who's who (https://en.unesco.org/indigenous-peoples/contact)

NEWS

next › (https://en.unesco.org/indigenous-peoples?page=1)

(https://en.unesco.org/news/unesco-calls-recognizing-african-indigenous-knowledge-disaster-management)

02 December 2021

UNESCO calls for recognizing African Indigenous knowledge in disaster management (https://en.unesco.org/news/unesco-calls-recognizing-african-indigenous-knowledge-disaster-management)

(https://en.unesco.org/news/united-nations-and-indigenous-peoples-work-together-our-planet)

10 September 2021

United Nations and indigenous peoples work together for our planet (https://en.unesco.org/news/united-nations-and-indigenous-peoples-work-together-our-planet)

(https://en.unesco.org/news/building-capacity-indigenous-youth-and-creating-indigenous-audiovisual-archives-through-wiki)

06 September 2021

Anti-Racism

Race

Racialization

Whiteness

White Privilege

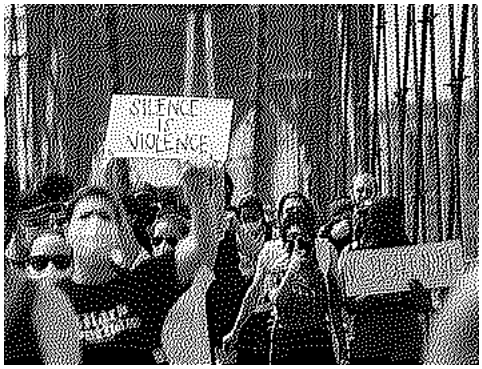
Racism

Forms of Racism

Strategies of Liberal Racism

Forms of Racism

Individual vs. Systemic



"It was just a personal opinion."

"I was just doing my job and following procedure."

"Anyone can apply for that job."

"Anyone can play hockey or take music lessons in this city."

Racism occurs between individuals, on an interpersonal level, and is embedded in organizations and institutions through their policies, procedures and practices. In general, it may seem easier to recognize individual or interpersonal acts of racism: a slur made, a person ignored in a social or work setting, an act of violence. However, "individual" racism is not created in a vacuum

cannot be anti-racist within, and despite, systems and institutions that are systemically racist.

WHAT IS INDIVIDUAL RACISM?

Individual racism refers to an individual's racist assumptions, beliefs or behaviours and is "a form of racial discrimination that stems from conscious and unconscious, personal prejudice" (Henry & Tator, 2006, p. 329). Individual racism is connected to/learned from broader socio-economic histories and processes and is supported and reinforced by systemic racism.

Because Canadian culture tends to privilege individualism and freedom of speech, some people argue that their statements/ideas are not racist because they are just "personal opinion." Here, it is important to point out how individualism functions to erase hierarchies of power, and to connect unrecognized personal ideologies to larger racial or systemic ones. Individualism can be used as a defensive reaction which why it is crucial to understand systemic racism and how it operates.

It should also be noted that people of colour and Indigenous people may oftentimes internalize racism, knowingly or unknowingly, usually as a survival mechanism. Internalized racism can be defined as “the individual inculcation of the racist stereotypes, values, images, and ideologies perpetuated by the

of ways, ranging from skin bleaching to policing one's own behaviour in order to defy a stereotype, "fit in," or not appear as "too much" of something that is not the "norm."

↳ See Maisha Z. Johnson's 5 Signs That I'm Struggling with Internalized Racism

WHAT IS SYSTEMIC RACISM?

Systemic racism includes the policies and practices entrenched in established institutions, which result in the exclusion or promotion of designated groups. It differs from overt discrimination in that no individual intent is necessary (City of Toronto).

It manifests itself in two ways:

1. Institutional Racism: Racial discrimination that derives from individuals carrying out the dictates of others who are prejudiced or of a prejudiced society
2. Structural Racism: Inequalities rooted in the system-wide operation of a society that excludes substantial numbers of members of particular groups from significant participation in major social institutions (Henry & Tator, 2006, p. 352).

Some forms of systemic racism may be more explicit or easier (for some) to identify than others:

- The 1923 Exclusion Act (Canada)
- Jim Crow Laws (US)
- American Indian Boarding Schools (US)
- The exclusion of African-American golfers from elite, private golf courses in the (US)
- "Universal suffrage" not including Indigenous North American women (nor did Indigenous men receive the vote until 1960, unless they gave up their status/identity as Indigenous).

Other forms or manifestations of systemic racism may not be as readily obvious to some, usually to those privileged by the system. We've included a few more examples of systemic racism as follows:

Education:

School curricula claims to be "inclusive" and "representative," and there have been some significant improvements in curricula development and delivery in recent decades. However, these shifts towards "inclusiveness" are often problematic, resulting in a lack of engagement/participation of Indigenous students and students of colour because:

now, with Indigenous people and people of colour "added in." The voices/perspectives of marginalized communities — their own experiences of this place —are typically not heard directly because the story is still told by predominantly white curriculum developers speaking "for" these communities. This applies most obviously to Social Studies and History but also to Math and Science, which are Western/European based. The curriculum/teachers do not recognize that every culture in the world has its own history and approach to mathematics and science, even if it is not articulated in Western terms.

- Teacher education does not tend to involve anti-racism education in any way that is meaningful for the students and teachers who experience racism daily, or for white students and teachers who want to participate in anti-racism/social justice. What work is done is at the surface level, and ignores historical and current power imbalances — including, in the classroom.

Hiring and Advancement Practices:

While many businesses and corporations have "diversity" policies, and many individuals in these workplaces do want a more representative work force, many businesses and corporations are still predominantly white. One need only to look at the photos in any Business Section of a city newspaper to see this. Why is this the case? White individuals tend to feel more

many companies are using the concept of "fit" in hiring practices. "Fit" refers to how a person is perceived as “fitting in to” and “contributing to” an existing workplace. It is discouraging, but perhaps not surprising, then, that white employers will, generally, see white applicants (with white, middle-class perspectives) as a better fit than a person of colour whose first language is not English.

Access to Sports/Recreation:

Organized hockey, from Minor Hockey to the NHL, is predominantly white (and still male). There is no explicit policy that excludes people of colour and Indigenous people from participating in organized hockey, yet there are few players of colour/Indigenous players. What is it that keeps organized hockey “white”? Playing hockey is expensive (fees and gear), time consuming for families, requires transportation and an accommodating work schedule, and in Alberta, is conducted in English. While there is no “intent” to exclude non-English speaking, lower-income, shift-working, single-parent families from playing organized hockey, the system is designed by and for middle-class, professional white families.

- City of Toronto. (1991). *Race Relations: Myths and Facts*. Toronto Mayor's Committee on Community and Race Relations.
- Henry, F., & Tator, C. (2006). The Colour of Democracy: Racism in Canadian Society. 3rd Ed. Toronto, ON: Nelson.

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INDIGENOUS CORPORATE TRAINING INC.

What Reconciliation Is And What It Is Not

August 16, 2018

For a very long time, mainstream Canadians were unaware of the hor and conditions that 150,000 Indigenous children endured in **schools** over a period of more than 100 years. For many inkling of the atrocities the children suffered was when t Stephen Harper delivered the **Statement of Apology** on behalf of Canadians for the Indian residential school system in 2008.

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The grassroots Idle No More movement raised awareness of Indigenous **issues** in 2012 with round dances, rallies, teach-ins, and social media. The movement gained significant media attention which brought it onto the radar of mainstream Canada.

The next hit of awareness was in 2015 with the publication of the Truth and Reconciliation Commission (TRC) report and **94 calls to action**. The calls to action, in particular, awoke in many individuals, organizations, and governments a realization that they had not just a role to play but a moral responsibility to make amends for the past.

It's now five years since the TRC report and **reconciliation** is a familiar term to most of us. But, there's still confusion over what it means and who is responsible, which could lead to reconciliation become nothing more than a platitude.

> The TRC definition of reconciliation:
>
> ". . . Reconciliation is about establishing and mai
> mutually respectful relationship between Aborig
> Aboriginal peoples in this country. In order for th
> there has to be awareness of the past, an acknowledgement of the harm that has been inflicted, atonement for the causes, and action to change behaviour." [1]

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To flesh out what reconciliation is and is not, here's a list of considerations that may contribute to understanding reconciliation.

Reconciliation is:

- Critical
- Complex
- Multifaceted
- Continuous
- A process
- About working towards solidarity as a society and country
- The responsibility of every Canadian
- Honouring **treaties**
- Acknowledging and respecting Indigenous **rights and title**
- Acknowledging and letting go of negative **perceptions** and **stereotypes**
- Acknowledging the past and ensuring that history never repeats
- Learning about Indigenous history
    - Recognizing the inter-generational impacts of colonization, attempts at assimilation, and cultural genocide
    - Recognizing the critical roles, Indigenous People
      creation of Canada, their contributions to **world**
- Taking responsibility as a person, a parent, an employee, an employer to:
    - Never utter, accept, or ignore a racist comment

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    - Never utter, accept, or ignore a statement that includes a stereotype about Indigenous Peoples

- Respect for:
    - Indigenous individuals
    - Indigenous **beliefs**, **cultures**, traditions, **worldviews**, challenges, and goals
- Recognition and support of the deep connections Indigenous Peoples have to the land.
- Supporting the reclamation of **identity**, **language**, culture, and nationhood
- Healing for all Canadians
- Good people doing good things
- Building **relationships**
- Never giving up despite setbacks
- Humility
- An opportunity to move forward
- A commitment to taking a role and assuming responsibility in working towards a better future for every Canadian

Reconciliation is not:

- A trend
- A single gesture, action, or statement
- A box to be ticked
- About blame
- About guilt

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- About the loss of rights for non-Indigenous Canadians
- Someone else's responsibility

Listen to the children in this short video after they learn about Indian residential schools. There is sadness, shock, pain, and awareness but ultimately there is hope and a desire for change.

- **Journey of Reconciliation** Educating our youth - Truth and Reconciliation Commission of Canada

I believe Canada has moved to a point at which we no longer ask "whether reconciliation is possible" but "how is reconciliation possible." And from that position, increasingly non-Indigenous Canadians are asking "what can I do?"

This blog post is also posted on **Ontario Nature Blog**

Here's a related article that delves into the controversy around statues of historical figures: **Let's not make reconciliation a political football**

And here's an interesting reconciliation action in Australia:

- **Australians Are Now Encouraged to Include Traditional Indigenous Place Names When Addressing Mail**

Check out this CBC article

- **Ojibway artist from Red Lake Ontario, Collaborates with NHL's Chicago Black Hawks on Land Acknowledgeme**

And here's a Personal Pledge of Reconciliation* with In
you started with your commitment to reconciliation. Click the image to grab your
form.

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[1] Honouring the Truth, Reconciling for the Future Summary of the Final Report of the Truth and Reconciliation Commission of Canada, The Truth and Reconciliation Commission of Canada, 2015, p. 6

* An excerpt from **21 Things You May Not Know About The Indian Act** by Bob Joseph

Topics: **Reconciliation**

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- **Become a Mentor to Indigenous Youth as a Part of Your Reconciliation Journey**
- **How Can You Politely Correct Someone Without Causing Guilt or Reaction?**
- **How Family Day and Indigenous Reconciliation Go Together**
- **Indigenous Corporate Training Inc. donates $10,000 to Covenant House**
- **Scientific and Indigenous Perspectives**

Posts by Topic

- **Reconciliation** (55)
- **Indigenous Awareness** (54)
- **Aboriginal Awareness** (48)
- **Indigenous relations** (45)
- **Aboriginal Consultation and Engagement** (44)

see all

***Indigenous Corporate Training Inc.**, provides information on this blog for free as a resource for those seeking information about Indigenous Peoples in Canada. Readers looking for more detailed information, or who have questions, can sign up for our fee-for-service training. Also, ICT encourages everyone who reads this information to use their best judgment given their own circumstances, vulnerabilities, and needs, and to contact a consulting or legal professional if you have more specific questions. Join the conversation over on our **Linkedin** page.*

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What are your key challenges?

Indigenous Awareness

- ✔ Understanding how history impacts Indigenous Peoples
- ✔ Understanding how current Indigenous issues impact Indigenous communities

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- Understanding Indigenous self-government
- Understanding the constitutional, political and legal context of Indigenous issues
- Understanding how Indigenous and western world views impact decision-making

Indigenous Relations

- Understanding how to cultivate Indigenous relationships
- Understanding business reasons for work with Indigenous Peoples
- How to begin to consult with Indigenous Peoples
- Fear of saying or doing the wrong thing
- How to manage risk when cultivating Indigenous relationships

Who should take this course?

- Those new to & those experienced in Indigenous relations
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- Resource, construction sectors
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This training was exactly what I was looking for. It addressed my training needs from a human and workplace perspective. I am now equipped with many tools to ensure that I have effective, respectful and worthwhile interactions with Indigenous communities in the future.

L. S. • Agriculture and Agri-Food Canada

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"Very eye opening. Very interested particularly in the treaty history and current processes, well covered. I liked the fact that audience questions and possible prejudices were dealt with on a professional, understanding level."

S. B. • Royal Roads University

"An excellent introduction to Indigenous Peoples in Canada, their history, culture, and the communications styles. Time well spent." (eLearning)

B.F. • CCEM

Your Commitment **+** Our Training **=** Informed Indigenous Relations

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Local Employment Planning Council

Conseil local de planification en matière de l'emploi

GUIDE TO DEVELOPING INDIGENOUS INCLUSION POLICIES

September 2018

IN PARTNERSHIP WITH:

IndigenousWorks

Local Employment
Planning Council

ABOUT THE LOCAL EMPLOYMENT PLANNING COUNCIL (LEPC)

The North Superior Workforce Planning Board is one of eight Local Employment Planning Councils in the Province of Ontario. The LEPC for the Thunder Bay District brings together key stakeholders in Northwestern Ontario. It connects employers, industry associations, sector groups and other employer groups with appropriate employment and training services to address workforce needs.

This report was made possible in part through the support of the Government of Canada and the Government of Ontario. We greatly appreciate their generous support but emphasize the following: the views expressed in this report are those of the authors and do not necessarily reflect the opinions of the Local Employment Planning Council (LEPC), the North Superior Workforce Planning Board, our Directors, supporters, donors, partners, the Government of Canada or the Government of Ontario. Quotation with appropriate credit is permissible.

The information presented in this report is current at the time of printing.

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TABLE OF CONTENTS

Acknowledgements	A
Advisory Committee	A
Employer Test Group	1
Introduction	2
What is Indigenous Inclusion?	3
Features of an Inclusive Workplace	3
A Seven Stage Model to Inclusion	4
What is a Policy?	5
What Do Policies Do?	5
Types of Indigenous Inclusion Policies	6
How to Develop an Indigenous Inclusion Policy	7
How an Inclusion Policy Can Add Value to Your Business	8
Tips for Companies for Their Indigenous Inclusion Policy Development	9
What Makes a Good Indigenous Inclusion Policy?	10
Sample Templates of Indigenous Inclusion Policies	11
Template # 1 – Comprehensive Indigenous nclusion Policy	12
Template # 2 – Indigenous Cultural Safety	15
Template # 3 – Indigenous Procurement Policy	17
Template # 4 – Workplace Diversity and Inclusion Policy	18
Template # 5 – Indigenous Peoples Policy	19
Your Indigenous Inclusion Policy Will Distinguish Your Company	20

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EMPLOYER TEST GROUP

We would like to extend our sincere appreciation to all local employers that took part in our Employer Test Group noted below. It is with your input and ongoing contributions to organizational inclusion that we are able to move forward to address the needs of the Thunder Bay District workforce. The Employer Test Group offered discussion about the roles of inclusion policies in their various workplaces. They also provided valuable insights into many issues pertaining to Indigenous inclusion policy formation. Insights were provided on the business case and need for inclusion policies, how such policies should be designed and introduced, as well as the issue of policy fit and measurement, to name just a few examples. Employers who voluntarily participated in the Employer Test Group are listed using the North American Industry Classification System (NAICS) code to identify the business sector which they represent. We would like to thank the members of the LEPC for their support and guidance on this and all other projects.

	Industry	NAICS Code
Employer 1	Professional, Scientific and Technical services	54
Employer 2	Retail Trade	44-45
Employer 3	Public Administration	91
Employer 4	Public Administration	91
Employer 5	Utilities	22
Employer 6	Health Care and Social Assistance	62
Employer 7	Information and Cultural Industries	51
Employer 8	Health Care and Social Assistance	62

INTRODUCTION

This Guide is about workplace policy development to encourage Indigenous inclusion. It has been developed through the course of a 7-month project ending in September of 2018.

THE PROJECT HAS THREE GOALS:

1. Increase Indigenous employment in the Thunder Bay District;
2. Raise awareness among employers about the workforce potential of Indigenous people in the Thunder Bay District; and
3. Develop and distribute policy examples and policy templates for business which can be used to guide their efforts on Indigenous recruitment, advancement and retention as well as workplace inclusion.

This project was divided into phases during which information and research was gathered, analyzed and used to develop policy examples and policy templates pertaining to Indigenous inclusion. An Advisory Committee consisting of 14 representatives from Indigenous organizations and local businesses provided advice throughout the life of the project.

Indigenous Works was hired to do research and develop documentation for the project. They are an ISO-Certified National Organization with 20 years' experience working with companies and Indigenous organizations for inclusion and employment strategies.

This Guide is intended to assist companies and organizations to develop an Indigenous Inclusion Policy. The Guide explains some of the differences in policy approaches and some of the thinking and contexts underlying them. There are templates provided which illustrate different approaches to be taken to Indigenous inclusion policy development.

The adoption of an Indigenous Inclusion Policy sends an important message both to your management and staff as well as to external audiences that your company has made a serious commitment to working with Indigenous people, businesses and communities and that you are committed to inclusion.

WHAT IS INDIGENOUS INCLUSION?

Indigenous Works defines inclusion as an organizational state that is embraced as a cultural norm, with enterprise-wide workplace strategies as well as a culture which invites the full participation of Indigenous people into all aspects of business operations. It is where leadership and employees are welcoming of Indigenous people, their experience and outlooks, where diversity is valued, the spirit of reconciliation has been embraced and calls to action have been acted on in meaningful ways.

FEATURES OF AN INCLUSIVE WORKPLACE

1. Inclusion has been embraced as a core competency and embedded into the organizational culture;
2. Companies share their organization's experience and achievements with inclusion and explain how it has helped their performance;
3. Human rights and responsibilities are promoted and respected. Employees are free of concerns related to basic equity issues;
4. Comprehensive Indigenous procurement, recruitment and corporate social responsibility strategies have been developed as part of an enterprise-wide coordinated approach;
5. Indigenous people are employed and retained in all areas of the organization including the senior leadership and executive positions;
6. There are significant revenues and jobs gained by Indigenous people and businesses through the organization's supply chain;
7. Indigenous community sustainable gains have been realized as a result of the relationships built between the company and the community;
8. High levels of Indigenous employee engagement are seen and experienced in the organization;
9. Leadership has put into place the resources needed to sustain its Indigenous inclusion strategy and it may have introduced an inclusion policy framework or statement;
10. Indigenous inclusion is integral to the mission and vision of the organization;

WHAT INCLUSION LOOKS LIKE TO ME

"To me, inclusion means taking to heart the Truth and Reconciliation Commission's Calls to Action as they relate to our business, including relationship building, access to training and economic opportunities and educating our employees on the history of Indigenous Peoples."

WHAT INCLUSION LOOKS LIKE TO ME

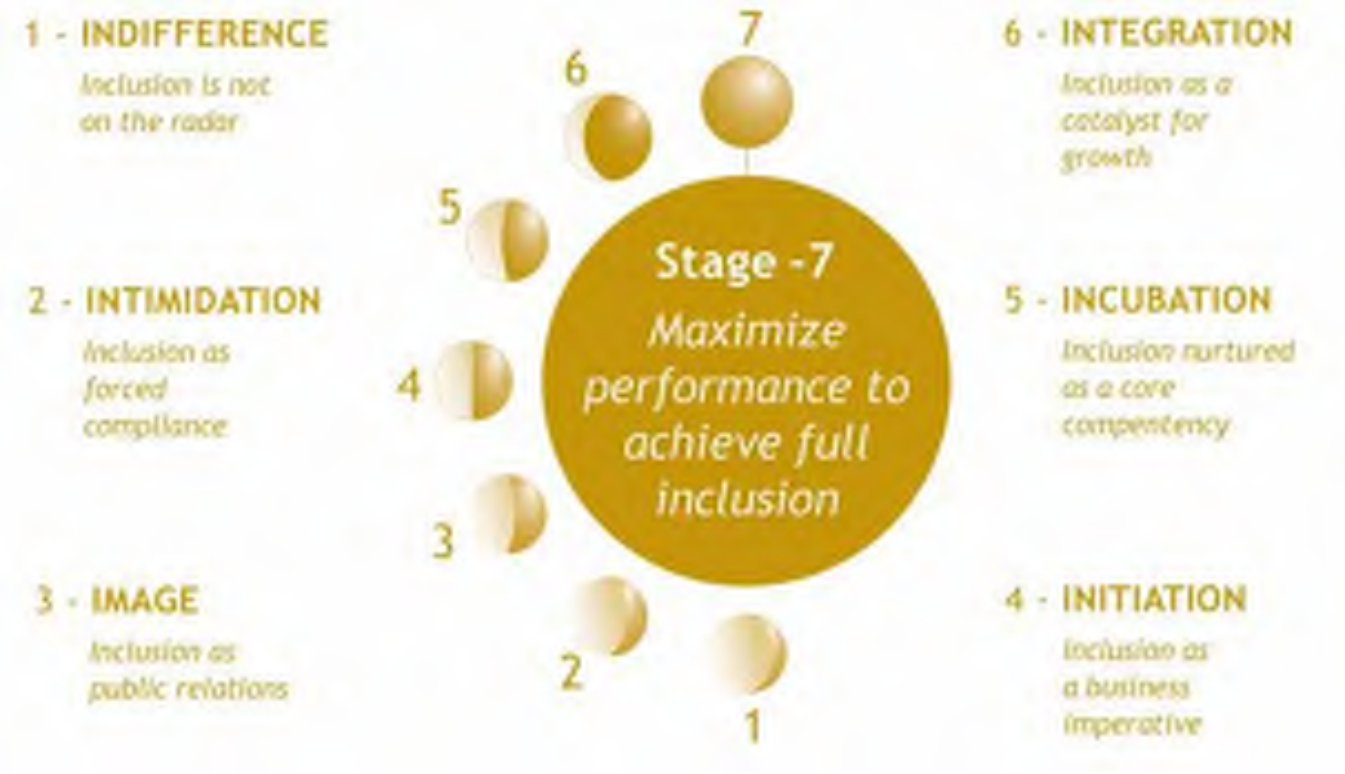
"Inclusion to me means to be an equal participant of something, the workplace, society, a partnership or the economy. It infers respect for each other and being transparent. It also means taking the time to understand or try to understand different worldviews."

11. Inclusion 'matters' to the company's clients, shareholders and stakeholders;
12. The organization's executive team is held accountable for achieving all or some of the organization's Indigenous inclusion goals;
13. Indigenous employees would tend to agree that they are 'very engaged' in the company's mission;
14. Indigenous employees agree that the organization is a Workplace of Choice;
15. The organization's inclusion workplace strategy has been in effect for a period of time;
16. The organization has done a studied review of the Truth and Reconciliation Commission's Calls to Action and have developed meaningful responses;
17. Indigenous communities or businesses cite the organization as one which has been especially successful in developing good engagements, relationships and socio-economic outcomes with Indigenous people, communities and businesses;
18. The organization reports on its inclusion strategies and can measure its progress on its workplace inclusion 'position' from year to year. (This is explained further in the next section). It produces a report and shares the results with stakeholders, clients and shareholders; and
19. A learning model has been introduced into the organization which provides the means for knowledge building and transfer about its inclusion strategy.

A SEVEN STAGE MODEL TO INCLUSION

Indigenous Works has developed a 7-stage workplace model of Indigenous inclusion which is called the Inclusion Continuum. The model depicts the roadmap that organizations follow to become more inclusive, gradually enabling more effective workplace and employment strategies to be developed. The Continuum describes the organizational features and competencies needed at each stage to achieve elevated levels of performance in Indigenous employment, business development, community relations, etc. Movement along the continuum depends on companies developing their cultural competencies, improving their understanding of Indigenous people, their history and culture. Companies' position on the Inclusion Continuum can be measured from year to year to track and assess progress.

INCLUSION CONTINUUM



1 The tool is available through Indigenous Works, visit www.Indigenousworks.ca

WHAT IS A POLICY?

A policy is a deliberate system of principles to guide decisions and achieve rational outcomes: a statement of intent implemented as a procedure or protocol.

Policies are typically the responsibility of Executive members or the Board of Directors for a company or organization. Policy development may be undertaken by a committee formed from board membership or some other executive body. Policy development may also be delegated to senior level management who bring forward recommended policy to the Board or Executive for their approval. Policies serve as a guideline for operational decision-making. Policies are helpful in highlighting the rules, values and beliefs of the organization. In addition, policies act as a basis for guiding the organization's actions.

WHAT DO POLICIES DO?

Policies provide critical direction for an organization in a variety of ways:

1. They guide organizational behaviours;
2. Define the resources with which organizational goals can be achieved;
3. Define roles and responsibilities in areas of business;
4. Help identify significant issues affecting organizational success; and
5. Define the scope or spheres within which decisions can be taken by subordinates in an organization.

TYPES OF INDIGENOUS INCLUSION POLICIES

There are quite a range of Indigenous inclusion policies in use by companies and organizations throughout Ontario and Canada. The diagram below illustrates how some of those policies align with workplace needs. Some inclusion policies have a targeted application to specific areas of the workplace such as employment, Indigenous community relations, Indigenous business development or procurement. Other inclusion policies strike across the organization, providing an 'enterprise-wide' approach to inclusion.

HOW TO DEVELOP AN INDIGENOUS INCLUSION POLICY

There are steps to developing Indigenous inclusion policies. The questions here will assist you and prompt you to start the process.

POLICY FORMATION

Questions to Guide the Policy Formation Process

- What are the top 3-4 issues that are driving the need for the policy?
- Is there uniform agreement on these issues throughout the company?
- Is there an area within the organization that these issues have surfaced?
- What are the top 3-5 principles that will guide the policy?
- What values does the organization hold as important?
- In what ways do these values inform the development of the new policy?
- What would the policy likely be called (e.g. "A Policy to…")?

Purpose of the Proposed Policy

- What is the internal business case for the policy and its adoption from the company's perspective? How important is this policy to the organization's corporate objectives and its bottom line?
- What is the purpose of the policy within the organization and externally?
- Who will use the policy? Who would be impacted and in what ways?
- What are the consequences of the company not developing and/or adopting the policy?

Policy Design

- What role will users have in shaping the policy?
- What are the implications of such a policy from the perspective of the stakeholders (e.g. employees, members, clients/customers)?
- What does it look like or how would I apply it at the board of directors' level, at the accounting level at the governance level and at the ground level?
- Is the policy to be directed to internal users, external users or both?
- Will the policy be enforceable or advisory in nature and what are the consequences of not following or deviating from the policy?
- What is your company or organization trying to change through the introduction of this new policy (e.g. exemplary practices, rebranding, attract a new target market, diversify employee demographics)?
- Will the policy be construed as the comprehensive statement of your organization's position or "stance" on Indigenous development issues?
- How will the policy be interpreted and implemented by employees, the Board, sub-contractors, etc.?
- Who will be responsible for implementing and reporting on the impacts of the policy?
- How accessible will the policy be? How visible will it be? Who will be able to change the policy?
- How will the policy be ratified? Who will do this?
- Would there be any parts of the company or organization to whom the policy would not apply (i.e. immunity vs. relevance)?
- What procedures, rules and controls will be needed to implement and support the policy?
- It is important to consult relevant business units within the organization about the development of the policy. In advance of its ratification, business units will need to consider the operational impacts that the policy may have. They may need to develop procedures to align with the policy needs. Consideration should be given to how this internal consultation should be undertaken.

Scope of the Policy

What kinds of subject matters would we expect to see in the policy?

- Indigenous employment within the company;
- Contracting and procurement practices;
- Commitment to Indigenous (community) development (sustainable development);
- Practices/approaches when dealing with Indigenous people (protocols that should/will be followed);
- Code of ethics/behaviours;
- Business development (encouraging and creating opportunities);
- Partnership opportunities; and
- There may be positions on specific issues that need to be highlighted or clarified in the policy. For example, a company may want to articulate its position on the opportunities for Indigenous people to build equity in development projects.

Implementation Mechanisms

- Sometimes policies will also include procedures (e.g. a manual, set of procedures, etc.);
- The document should state whether the policy is mandatory or not;
- It should refer to the organization's Code of Conduct or other such protocols/policies already adopted; and
- Will there be incremental resources needed to support the implementation of the policy?

Timing

- How soon does the policy need to be in effect?

Leadership

- Who within the organization takes the lead with the formation of the new policy? Who will be involved in its formation? Who will have input and how much input will they be afforded?
- What communications, if any, will be undertaken to inform groups that this policy is under consideration (e.g. client, shareholders, employees/sub-contractors)?

HOW AN INCLUSION POLICY CAN ADD VALUE TO YOUR BUSINESS

Companies tend to be somewhat advanced in their Indigenous inclusion strategies before they will adopt an Indigenous inclusion policy.

Once companies gain momentum they may adopt an inclusion policy as a way to solidify or consolidate their Indigenous engagement and inclusion planning and processes. A policy helps define your company as an employer of choice and gives you better opportunities to attract Indigenous people to your workplace. If the policy has even broader scope it can also define you as a company of choice with whom Indigenous businesses and organizations will want to do business and build broader and longer-term relationships.

The adoption of an Indigenous inclusion policy offers an important way for your company to convey that it has reached a level of maturity in its Indigenous engagements or relations. Ideally, the policy should signify that you have successfully integrated Indigenous inclusion principles into your core mission and business plan. This gives you credibility and reputational value. At the same time, it also defines some important commitments and accountabilities. A further benefit, the adoption of a policy is also a way for your company to achieve the internal coordination needed (e.g. people, resource allocation) to achieve your inclusion goals.

TIPS FOR COMPANIES FOR THEIR INDIGENOUS INCLUSION POLICY DEVELOPMENT

Before you begin, make sure that you have a plan in place to address some of the issues which tend to act as barriers to policies being adopted.

- Make sure your executive or senior leadership is on-board and have mandated the policy;
- Define your business case for Indigenous engagement and inclusion. How will a new policy add value to your business?
- Find a place in the organization from which to launch the policy. Will it be within human resources, business or within the executive itself? Which division or unit will 'own' or host the policy, drive it and ensure that the accountability needs are fulfilled?
- Be able to explain how this new policy fits with other policies which your company currently has in place;
- Is your company's policy development and approval process clear? Are there issues with the process itself that first need to be addressed?
- Is your company going to be able to live up to its policy commitments? How will it be able to evidence that success?
- Systems challenges may need to be addressed. For example, you may need to introduce changes to your employment systems so that your organization is able to effectively measure and track how many Indigenous people you currently employ. This may necessitate work with your technology staff or contractors to make these systems changes;
- Is the timing right for your company to adopt an inclusion policy or are there many other priorities and issues which are taking precedence or priority? Is now the right time to introduce an Indigenous inclusion policy?
- Have you defined the right Indigenous inclusion policy for your company's needs? Do you want an employment policy or something that cuts across several functional areas of your organization (i.e. enterprise-wide)?
- Is the language and purpose of the policy clear? Is there good understanding of management's and employees' roles in the policy and what tracking and reporting is needed?

A new Engagement Index developed by Indigenous Works scored Ontario's corporate/Indigenous engagements at only 8 out of 100. Moreover, most companies have no meaningful plans in place to work with Indigenous people, businesses or communities. The adoption of an Indigenous inclusion policy generally means that an inclusion strategy (or strategies) have already been adopted or developed.

Companies with higher scores on their Engagement Index tend to have more intentional and more sophisticated Indigenous strategies. Ask yourself these questions. "Is my company ready to engage with Indigenous people? Among other preparations, have we developed the right cultural competencies and educated ourselves about Indigenous people, their histories and outlooks?"

WHAT MAKES A GOOD INDIGENOUS INCLUSION POLICY?

The Advisory Committee for the Local Employment Planning Council's Indigenous Inclusion Policy Development Project were asked to provide their input on what makes a good Indigenous inclusion policy. The following are their recommendations:

1. Leadership needs to uphold the Indigenous inclusion policy. If someone within the business or organization transgresses the policy, there should be consequences. Otherwise, if the negative action or behaviour is condoned, then this serves to undermine the policy;
2. Policies should have the effect of creating standards in a business or organization. For example, a policy on Indigenous workplace inclusion or a respectful workplace policy should inform on what are acceptable behaviours, decorum and interactions between and among employees and management;
3. A company that adopts strong Indigenous inclusion policies should be celebrated. Its leadership and organization should be promoted as an example to other members of the business community. Government also needs to play a leadership role by adopting and enforcing strong Indigenous policies;
4. The best policies are those that act as a guide to measurable organizational behaviours or actions. Companies and organizations that adopt Indigenous inclusion policies do so for a variety of reasons. Is there a business case underlying the adoption of the policy? How does the policy support the businesses' or organization's goals?
5. There is a need for appropriate metrics to measure the effectiveness of the policy. Policies need an accountability framework. There needs to be clarity about whom within the organization is responsible for the effective implementation of the policy. What structures are put into place to ensure that adequate reporting and metrics are compiled? To whom is the company accountable in terms of effective implementation and measurable results? How often is reporting done on the policy and to whom?
6. What is the 'policy culture' in a business or organization? For some, policy plays a very important role in day-to-day operations. What measures are taken to ensure that adopted policies continue to be animated? What needs to happen at an organizational level to ensure that policies are 'active' and top of mind? Accountability is important throughout the organization;
7. It is important to communicate policies, both internally and externally. Policies can play a key role as a way for companies to position themselves with Indigenous communities. Companies that have strong Indigenous policies signal that they want to develop good Indigenous relationships. But these policies must be followed and enforced;
8. There may be different policies adopted to combat racism. Indigenous people can face racism on a daily basis. Some companies and organizations have adopted Anti-Racism Policies or Racism-Free Policies, Zero Tolerance Policies, or Respectful Workplace Policies. These are all examples of Inclusion policies.

SAMPLE TEMPLATES OF INDIGENOUS INCLUSION POLICIES

Here are five sample templates to give you an idea of what different Indigenous inclusion policies can look like. Each example provided addresses inclusion in different ways with varied emphasis on Indigenous employment, business or other intended outcomes. One is specific to a sector. Two are specific to workplace inclusion and promoting effective working arrangements for Indigenous people and in respect to teamwork and performance.

Note that while the objectives of these policies are different they share many of the same features in their composition.

- Goal or Position Statement (in one or two sentences what outcomes does the policy seek to achieve?);
- Principles (foundational principles on which the policy is founded);
- Scope (to whom in the organization does the policy apply?);
- Definitions (defining important terms used in the document);
- Authority and Accountability (who is responsible for the policy, areas of responsibility and accountability to ensure it is carried out successfully?);
- Relationship between this policy and others? (e.g. founding legislation);
- Policy Review (when will the policy be reviewed again?); and
- Reporting (what are the internal and external reporting requirements for the policy outcomes?).

Some policies are nothing more than aspirational goals or principles for an organization. Other policies provide the means of implementation to determine whether and how the outcomes intended by the policy are being achieved. Sometimes policies are accompanied by administrative procedures which speak to the details of its implementation within the organization.

TEMPLATE #1 – COMPREHENSIVE INDIGENOUS INCLUSION POLICY

TEMPLATE #2 – INDIGENOUS CULTURAL SAFETY – HEALTH SECTOR

TEMPLATE #3 – INDIGENOUS PROCUREMENT POLICY

TEMPLATE #4 – WORKPLACE DIVERSITY AND INCLUSION POLICY

TEMPLATE #5 – INDIGENOUS PEOPLES POLICY

TEMPLATE 1 COMPREHENSIVE INDIGENOUS INCLUSION POLICY

STATEMENT OF PURPOSES

Company A is dedicated to growing and promoting exemplary relationships with Indigenous people, businesses and communities throughout Canada.

The Company wants to employ Indigenous people as well as conduct business with Indigenous entrepreneurs and Indigenous development corporations. Company A wants to enter into mutually beneficial joint ventures and partnerships as well as other agreements and understandings which bring value to the Company as well as to Indigenous people, businesses and communities.

Company A aspires to be an "Employer of Choice" with Indigenous people. The Company is dedicated to creating a workplace which is inclusive and honouring of Indigenous Peoples' history, culture and heritage.

PRINCIPLES

Company A will adhere to the following principles in the implementation of its Indigenous Policy:

1. Respect and transparency are important in Company A's discussions and transactions with Indigenous people, businesses and communities;
2. Trust is built and earned and stands as the foundation of any good relationship;
3. Business relationships and transactions must be fair and equitable for parties;
4. Company A will act with good will and intent in all of its Indigenous initiatives;
5. The Company will seek to be a model for exemplary Indigenous relations;
6. Indigenous employment practices will be characterized by fairness, reasonableness, and an absence of bias and harassment; and
7. The Company embraces diversity and inclusion as vital components of a successful, engaging and productive workplace.

SCOPE

This policy applies to all employees, divisions and business units within Company A in Canada as well as to Indigenous people, businesses and communities seeking to work with or grow relationships with the Company.

DEFINITIONS

Indigenous - In this policy 'Indigenous' refers to First Nations, Métis and Inuit Peoples.

Indigenous Business - means

- A business that is at least 51% Indigenous owned and controlled; or
- A business that has 6 or more full-time Indigenous staff members and at least one-third of employees are Indigenous;

Company – refers to Company A and its operations in Canada.

Division Indigenous Strategy – means a set of procedures that will be established by the appropriate business divisions or business units within the Company to achieve the purpose, planning and implementation of this policy. The procedures will describe the set of objectives, actions and operations that must be achieved and performed within a division or business unit. It describes the accountabilities, who is responsible for doing and reporting on those actions as well as when they occur. The procedures may include descriptions and other narratives which describe the systems needed to achieve the policy purposes within that business unit or division. These procedures become the standard.

Joint Venture: A joint venture can consist of two or more Indigenous businesses, or an Indigenous business and one or more non-Indigenous businesses, provided that in all cases the Indigenous business[es] own and control at least 51% of the joint venture.

TEMPLATE 1 COMPREHENSIVE INDIGENOUS INCLUSION POLICY

PROVISIONS

1. Authority and Accountability

- Company A's Executive approves the Indigenous inclusion policy for the Company and delegates additional authorities as needed;
- Company A's Executive approves any financial resources needed to support this policy;
- Senior VP's of the Company's business units are responsible for implementing strategies (Division Indigenous Strategies) that assist in meeting the purposes, planning and implementation of this policy;
- The Vice President of Indigenous Relations is responsible for:
  - Creating and maintaining the Guidelines for different business Lines or Divisions within the company and their respective Indigenous Strategies. The Guidelines include the format, standards and criteria to be used;
  - Completing an Annual Public Roll-up Report of all Indigenous transactions and initiatives in Canada completed under the intent of this policy;
  - Working with senior managers to ensure that their respective Unit's or Division's Indigenous Strategies conform to the approved Guidelines.

2. Planning and Implementation

i) This policy will guide the activities of different divisions and business units within the Company in helping to achieve the purposes of the Indigenous policy.

- Schedule 1 - Indigenous Business Development
- Schedule 2 - Indigenous Employment

(See description below)

ii) [a] Communications and promotional activities will be undertaken in order to build understanding of this policy and its purposes:

- Internally
- Externally (general public)
- Stakeholders (e.g. Company subcontractors)

[b] Company A will produce a Public Annual Report which details the work undertaken by the Company in the previous year to support this policy and its purposes.

[c] The Company may periodically make gifts or donations to Indigenous people, businesses or communities, in alignment with its corporate social responsibility guidelines.

TEMPLATE 1 COMPREHENSIVE INDIGENOUS INCLUSION POLICY

SCHEDULES

Schedule 1 - Indigenous Business Development

The Company will undertake the following:

- Encourage Indigenous business participation in its supply chain;
- Encourage opportunities for qualified Indigenous businesses to supply goods and services to the Company;
- Implement an Indigenous Supplier Development Program;
- Track and monitor purchases from Indigenous businesses;
- Enter into partnerships with Indigenous groups and organizations with the express purpose of forming an Indigenous joint venture;
- Establish Guidelines to encourage and support the Company's non-Indigenous subcontractors to increase their Indigenous employment and purchases;
- Enter into agreements with Indigenous groups, organizations and businesses for the purpose of achieving specific business objectives.

Schedule 2 - Indigenous Employment

Company A will undertake the following:

- Actively recruit Indigenous people to the Company;
- Encourage a workplace culture of teamwork and cooperation by providing Indigenous Awareness Training, diversity training, or similar kinds of training;
- Encourage and foster an inclusive workplace which recognizes Indigenous culture, history and heritage;
- Implement training programs for the purpose of advancing Indigenous employees in accordance with their experience, interests and qualifications and as business conditions for the Company allow;
- Track and monitor Indigenous employment numbers.

TEMPLATE 2 INDIGENOUS CULTURAL SAFETY

OVERVIEW

Company B recognizes that Indigenous people are underrepresented in its workforce. Company B equally recognizes the importance of diverse ethnic groups and their role/importance in a representative workforce. However, Indigenous people are significantly underrepresented. Focused strategies are needed to build a culturally safe environment and representative workforce including cultural competencies, recruitment, retention, education, partnerships and communication. These strategies focus on, but are not limited to Indigenous people.

DEFINITIONS

In this policy, **Indigenous** refers to First Nations, Métis and Inuit peoples.

All staff means Company B's employees, practitioners, professional staff, contractors, vendors, students and volunteers.

Cultural competency means a set of congruent behaviors, attitudes and policies that come together in a system, agency or profession that enables that system, agency or profession to achieve cultural diversity and to work effectively in cross-cultural situations.

Cultural safety exists when an environment is created and respected and where people, customers and workers feel safe, understood and respected to optimize the customer experience.

First Nation includes any of the Indigenous peoples or Indian communities of Canada, especially one formally recognized by the Canadian Government.

First Nations include:

- Status (registered) treaty Indians;
- Non-status (unregistered) Indians.

Inuit are Indigenous people of the Canadian arctic. The arctic is divided into territories: Nunavut, Yukon and Northwest Territories along with Northern Quebec and Northern Labrador.

Métis are descendants of First Nation and European heritage. Métis people are defined under the Métis National Council as a person who self-identifies, who is of historic Métis ancestry and/or belong to a Métis local or is accepted as Métis by the Métis Nation.

Persons with Disabilities is an individual who has a long term or reoccurring physical, mental, sensory, psychiatric or learning impairment and;

- Considers themselves to be disadvantaged in employment by reason of that impairment;
- Believes that an employer or potential employer is likely to consider them to be disadvantaged in employment by reason of that impairment; and
- Includes persons whose functional limitations owing to their impairment have been accommodated in their current job or workplace.

Partnerships refer to a relationship involving the sharing of power, work, support, resources and/or information of others for the achievement of joint goals and/or mutual benefits.

Representative workforce means a workforce where all levels of the organization reflect the diversity of the community served and where individuals who are underrepresented in the workforce have equitable access to employment.

Self-identified staff are those who have voluntarily declared that they consider themselves to be in a designated Equity Group as defined by the Ontario Human Rights Commission these equity groups are Indigenous, Visible Minority, Women and Persons with disabilities.

Visible Minorities are persons other than Indigenous peoples, who are non-white in color/race regardless of their place of birth.

PURPOSE

The purpose of this policy is to establish Company B's' position regarding representative workforce, cultural competency and cultural safety within Company B.

TEMPLATE 2 INDIGENOUS CULTURAL SAFETY

PRINCIPLES

- A representative workforce must be at the level of representation of the diversity of the community/population served;
- Cultural competency must be embedded in workplace culture, practices and beliefs in order to serve staff, patients, customers, clients, residents and families of Company B;
- Company B recognizes the interconnectedness between a representative workforce and cultural competency regarding the provision of culturally safe, quality healthcare service to a diverse client base; and
- Company B recognizes the importance of partnerships with organizations committed to establishing a workforce that is representative of the community served.

POLICY

- Company B is committed to building a workforce that is representative of the community served in order to provide quality, client-centred experiences to patients, customers, clients, residents and families.
- Company B's representative workforce strategies focus on, but are not limited to Indigenous peoples.
- Company B shall ensure an organizational strategy is implemented to build a representative workforce that will:
  - Enhance organizational cultural competency;
  - Increase self-identified staff;
  - Decrease self-identified staff turnover by increasing Indigenous retention rate;
  - Enhance internal and external positive cross-cultural relations.

ROLES AND RESPONSIBILITIES

All Staff

- Promoting, creating and maintaining a culture of inclusiveness and respect for diversity.

Managers/Supervisors

- Foster and promote a workplace environment that is sensitive and supportive of representative workforce activities and initiatives.

Policy Management

- The management of this policy including policy education, monitoring, implementation and amendment is the responsibility of the Director, Representative Workforce and Indigenous Health.

Non-Compliance/Breach

- Non-compliance with this policy will result in an investigation. Repeated non-compliance may result in disciplinary action, up to and including termination of employment and/or privileges with Company B.

TEMPLATE 3 INDIGENOUS PROCUREMENT POLICY

PURPOSE

Company C will work with Indigenous communities to promote economic development through the identification of opportunities that offer Indigenous communities and businesses the ability to participate in the procurement of goods and services in support of Company C's operational and project requirements.

PRINCIPLES

Company C promotes open and transparent consultation and communication and strives to build lasting relationships with Indigenous communities and businesses. Company C is committed to ensuring these relationships are based on trust, mutual respect and the achievement of common goals.

Company C has dedicated personnel who connect Indigenous companies with Company C's procurement opportunities and provide advice, information and materials to help Indigenous businesses in the following ways:

- Assist in identifying procurement and economic development opportunities;
- Assist in identifying the processes used to procure goods; and
- Build procurement bidding expertise to assist with the Company C's bid process.

INDIGENOUS BUSINESSES

Increasing Indigenous participation in the procurement of goods and services is a key goal of Company C. Procurement through direct awards, select tenders and specified Indigenous content in bid documents where appropriate will enable us to realize this goal. To ensure that procurement practices are consistent with our goals, the following criterion is utilized to qualify Indigenous businesses:

- Sole proprietorships - business must be wholly owned by an Indigenous person;
- Limited company - business must have at least 51 percent of the equity (including any common or voting shares) owned by one or more Indigenous Businesses or Indigenous People;
- Partnership or joint ventures - business must have at least 51 percent ownership rights (including any voting rights) directly held by one or more Indigenous Businesses or Indigenous People; and
- As determined by Company C in its sole discretion from time to time, any other businesses with a substantial amount of ownership rights held by one or more Indigenous businesses or Indigenous people.

PROCUREMENT PRACTICES

To ensure opportunities are extended to Indigenous communities and businesses, the following procurement practices may be utilized, as applicable:

- **Direct awards –** a contract for goods or services that is awarded on an open book basis or without a request for proposal or special requirements for tender basis;
- **Limited competitive bidding –** a bid where there is an acknowledged number and/or capacity of Indigenous businesses in a particular commodity or service area, and where fair market value is achieved, Company C may establish a competitive Indigenous procurement process where only qualifying Indigenous businesses will be requested to bid on the procurement. This can include limiting the number of invitations with a minimum of at least three invitations; and
- **Inclusion of Indigenous** content as a component of the bid evaluation criteria-select Company C procurement opportunities may be required to include an Indigenous Opportunities Requirement (IOR). The IOR requires that bidders include, in their bid documents, a plan to ensure that an awarded contract must include specified Indigenous participation and benefits as measured in direct or indirect Indigenous content value.

This flexible tool allows non-Indigenous companies to provide benefits to Indigenous peoples and communities, assisting Company C to meet its Indigenous participation objectives, through a range of options including training, employment, procurement, contributions to Indigenous youth and other programs as specified by the company. Regardless of the practice used for procurement, Company C will always seek competitive market-based costs and will not compromise safety, the environment, quality or schedule.

TEMPLATE 4 WORKPLACE DIVERSITY AND INCLUSION POLICY

STATEMENT OF PURPOSE

Company D is committed to providing a workplace which promotes innovation and creativity through our diverse and inclusive talent pool. Company D aims to ensure that all those participating in our workplace are treated with respect, dignity and fairness with an aim of creating an environment which promotes positive working relationships. This policy is designed to ensure that all employees understand Company D's commitment to recognizing the value of diversity in our workplace as supported through equal employment opportunities and ensuring work practices promote equality and are non-discriminatory.

SCOPE

This policy applies to employees as well as contractors acting on behalf of Company D.

DIVERSITY AND INCLUSION

Company D recognizes that all people bring different qualities, abilities, skills, knowledge, experiences, perspectives and attitudes to work. Valuing and making the most of these differences can improve the workplace for individuals and enhance Company D's overall performance.

We understand diversity as the presence of a wide range of human qualities and attributes within a group organization or society. The dimensions of diversity include but are not limited to ancestry, culture, ethnicity, gender, gender identity, language, physical and intellectual ability, race, religion, sex, sexual orientation and socio-economic status.

RECRUITMENT AND SELECTION

Company D recognizes the value of diversity in our workplace and strives to promote fairness and equal employment opportunities. The decision to employ or engage an individual is based on merit, the potential and the ability to carry out the role. Company D seeks to address conscious and unconscious bias in recruitment through a panel interview, with the involvement of the Human Resources Manager in the process.

CAREER DEVELOPMENT AND SUCCESSION PLANNING

Company D is committed to identifying and implementing programs that will assist in the development of a broader and more diverse pool of skilled and experienced employees. Company D seeks to develop its officers, employees and contractors to prepare themselves for higher levels of responsibility by offering equal opportunities for career development based on knowledge, skills and leadership prospects for future success. Internal promotions and our employee recognition program are widely encouraged as a development as well as a retention strategy.

EXPECTED BEHAVIOUR AND CODE OF CONDUCT

Company D values a workplace culture that is respectful of inclusion and diversity. There is zero tolerance for bullying, discriminating, harassing victimizing or vilifying behaviours. This is achieved through continuously educating our employees and contractors on the standards Company D expects of its employees.

FLEXIBLE WORKING ARRANGEMENTS

Company D acknowledges that the needs of employees change during different stages of life with different family support and care requirements. As such, Company D offers the opportunity to work part-time or with flexible start and finish times (in agreement with the manager) and the adoption of other supportive practices that enables employees to achieve work-life balance. Employees returning from parental leave have the right to request flexible working arrangements and Company D will give careful consideration to come to an arrangement that balances both the needs of the employee and the business.

TEMPLATE 4 WORKPLACE DIVERSITY AND INCLUSION POLICY

BREACH OF POLICY

All individuals covered by this policy are expected to adhere to the standards of behaviour contained herein, at all times. Any employee or contractor, who is found to have breached this policy will be disciplined accordingly, which may lead to, and include termination of employment or engagement.

MEASURABLE OBJECTIVES

Each year a Policy Committee will establish or review measurable objectives for achieving the goals of this policy.

REPORTING

Each year a Policy Committee will develop a report about the outcomes achieved under this policy.

TEMPLATE 5 INDIGENOUS PEOPLES POLICY

Company E is committed to engaging with Indigenous communities where we have activities. Meaningful engagement and consultation begin with respecting the rights of Indigenous peoples, whose legally recognized lands and traditional territories are within or in close proximity to the areas where we operate.

We engage early and often with communities to build solid relationships based on mutual trust and respect of customs and culture, a shared understanding of issues, transparency, inclusiveness, two-way dialogue, and collaborative problem-solving to achieve mutually satisfactory outcomes.

The intent of our Indigenous Peoples Policy is to guide development of these relationships over the lifecycle of our projects. It reinforces Company E's commitment to foster opportunities for Indigenous people to participate in the economic, environmental and social benefits of Company E's community developments, ensuring these benefits reflect community interests and our commitment to responsible development.

The policy also focuses our work with Indigenous communities in four key areas:

- Engagement and consultation;
- Business development and capacity building;
- Indigenous employment; and
- Community investment.

It also contributes to our efforts to ensure consistent practices and high standards in engaging Indigenous peoples across our operations.

GUIDING PRINCIPLES

- The traditional cultures, land uses, customs, knowledge and integrity of Indigenous people;
- Open and transparent two-way dialogue with Indigenous people; and
- Building and sustaining long-term relationships with Indigenous people that span the project lifecycle;

WE RESPECT

- The rights and traditional decision-making of Indigenous people;
- The need for honest and fair dialogue with Indigenous peoples regarding both the impacts of Company E's operations and our ability to respond to their interests and aspirations; and
- The need to build our social license to operate with Indigenous people.

WE ARE INCLUSIVE

- In consultation and engagement activities to ensure the voices of the leadership, elders, youth and community members are heard; and
- In promoting education, employment, community investment and economic development opportunities for Indigenous people.

WE ACT WITH INTEGRITY

- Company E does what we say we will do.

YOUR INDIGENOUS INCLUSION POLICY WILL DISTINGUISH YOUR COMPANY

Few companies have adopted an Indigenous inclusion policy. This is partly because there are few resources available to help companies get started on one. This Guide was intended to point companies in the right direction by providing some of the rudiments of policy formation as well as examples of inclusion policies. As you think about whether an Indigenous inclusion policy is right for your company, you will need to consider whether and how it will support your inclusion strategy or strategies. There are a variety of considerations to think about. Your policy journey is important to your company, just as it is to Indigenous people. Be assured that if you are successful in adopting a meaningful Indigenous inclusion policy, it will distinguish your company for its leadership role in seeking to define its relationship with Indigenous people, businesses and communities.

Local Employment Planning Council
Conseil local de planification en matière de l'emploi

For more information about this project contact your Local Employment Planning Council or visit our website at www.nswpb.ca/lepc

Indigenous Works was the consultant hired to work in partnership with the Local Employment Planning Council to complete this project. For more information about Indigenous Works go to www.indigenousworks.ca

Indigenous Works

Creating an Inclusive Society:
Practical Strategies to Promote Social Integration

DRAFT

DESA 2009

TABLE OF CONTENTS

Definition of key terminology **3**

CHAPTER ONE: A VISION FOR AN INCLUSIVE SOCIETY **4**

I. Introduction **4**

II. Creating an Inclusive Society **8**
What is meant by an inclusive society? 8
Elements necessary for creating an inclusive society 8
Understanding social inclusion 11

III MAPPING THE LANDSCAPE OF INCLUSION AND EXCLUSION **17**
Key areas for social inclusion and exclusion 17
Key Groups to be included: Who is marginalized? 21

IV. APPROACHES TO PROMOTING SOCIAL INCLUSION **29**
Removing the obstacles to social inclusion 30
Inclusive policy fraework 33
Costs and benefits of social inclusion 37

V. CONCLUSION **38**

CHAPTER TWO: ROLE OF LOCAL GOVERNMENTS IN PROMOTING SOCIAL INCLUSION AND PARTICIPATION **42**

I. Introduction **42**

II. Challenges and opportunities for local governments in promoting social inclusion and combating social exclusion **44**
Challenges facing local governments 44

III. Promoting Social Inclusion at the local level **47**

IV. Good initiatives which promote social inclusion at the local level **52**

V. Conclusion **60**

Annex I: Compilation of existing approaches to capture, analyze and measure the multiple dimensions of social inclusion and other related concepts **62**

References and resources: **63**
Bibliography 63

DRAFT

Definition of key terminology

While there is no single agreed understanding of the key terminology, social integration, social inclusion, social cohesion and social participation, the following definitions are used in this publication.

Social Integration

Social integration is understood as a dynamic and principled process of promoting the values, relations and institutions that enable all people to participate in social, economic, cultural and political life on the basis of equality of rights, equity and dignity. It is the process in which societies engage in order to foster societies that are stable, safe and just – societies that are based on the promotion and protection of all human rights, as well as respect for and value of dignity of each individual, diversity, pluralism, tolerance, non-discrimination, non-violence, equality of opportunity, solidarity, security, and participation of all people, including disadvantaged and vulnerable groups and persons.

Social Inclusion

For Part I of the publication, social inclusion is understood as a process by which efforts are made to ensure equal opportunities for all, regardless of their background, so that they can achieve their full potential in life. It is a multi-dimensional process aimed at creating conditions which enable full and active participation of every member of the society in all aspects of life, including civic, social, economic, and political activities, as well as participation in decision-making processes. In Part II of the publication, social inclusion is understood as the process by which societies combat poverty and social exclusion

Social Exclusion

Social exclusion is understood as the condition (barriers and process) that impede social inclusion. Social exclusion is a process through which individuals or groups are wholly or partially excluded from fully participating in all aspects of life of the society, in which they live, on the grounds of their social identities, such as age, gender, race, ethnicity, culture or language, and/or physical, economic, social disadvantages. Social exclusion may mean the lack of voice, lack of recognition, or lack of capacity for active participation. It may also mean exclusion from decent work, assets, land, opportunities, access to social services and/or political representation.

Social Cohesion

Social cohesion refers to the elements that bring and hold people together in society. In a socially cohesive society all individuals and groups have a sense of belonging, participation, inclusion, recognition and legitimacy. Social cohesive societies are not necessarily demographically homogenous. Rather, by respecting diversity, they harness the potential residing in their societal diversity (in terms of ideas, opinions, skills, etc.). Therefore, they are less prone to slip into destructive patterns of tension and conflict when different interests collide.

Social Participation

Social participation is understood as the act of engaging in society's activities. It refers to the possibility to influence decisions and have access to decision-making processes. Social participation creates mutual trust among individuals, which forms the basis for shared responsibilities towards the community and society.

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Chapter One: A Vision for an Inclusive Society

I. Introduction

The World Summit for Social Development, held in March 1995, established the concept of social integration to create an inclusive society, "a society for all", as one of the key goals of social development. The Copenhagen Declaration and Programme of Action, a key outcome of the Summit, pledged to make the eradication of poverty, full employment and social integration overriding objectives of development. Member states made a commitment[1] to promote social integration through fostering inclusive societies that are stable, safe, just and tolerant, and respect diversity, equality of opportunity and participation of all people, including disadvantaged and vulnerable groups and persons (See table 1).

Following the Copenhagen Declaration, significant policy commitments were made in the Millennium Declaration (2000), adopted at the Millennium Summit in September 2000. The Millennium Declaration subsumes social integration in its synthesis of peace, security, development and human rights,[2] and further embodies social inclusion principles as well as the objectives and goals set out in the Copenhagen Declaration. The Millennium Development Goals (MDGs), which is considered to be the most ambitious framework for development with specific targets and indicators to monitor the progress, were derived from the agreements adopted at the World Summits and Conferences organized by the United Nations in the previous decade, including the World Summit for Social Development. Specifically, MDGs contains one of the objectives of the Social Summit, "poverty eradication" which was designated as the MDG Goal 1 - Eradicate extreme poverty and hunger (see Annex XX). The process of social integration also serves an important part in achieving the goal of sustainable development, particularly in view of the direct and indirect impacts to be brought by ongoing climate change and food insecurity on the most vulnerable populations.

In the realization that a broad development vision and commonly agreed objectives arising from the United Nations conferences and summits were not comprehensively addressed in the MDGs, the 2005 World Summit crystallized these internationally agreed development goals, including the MDGs, into a broad and compelling United Nations development agenda[3]. Achieving full and productive employment and decent work for all, including women and young people - the second goal of the Social Summit, was recognized as a central objective of relevant national and international polices and development strategies designed to achieve the MDGs[4], and has subsequently been added as a new target 1.B under the MDG Goal 1[5] (See the table XX, see SG's Report on the Work of the Organization, 2006).

However, the remaining goal of the Social Summit, "promoting social integration", has not been effectively integrated into the MDGs so far, despite the fact that these three goals are inter-related and mutually reinforcing. The Social Summit recognized that "social integration was an important determinant of, and significantly affected by, poverty and unemployment and that

[1] Delegates from 186 countries and representatives from 811 non-governmental organizations are among those who participated.
[2] A/60/1, para 103
[3] World Summit 2005, Resolution adopted by the General Assembly - A/RES/60/1
[4] World Summit 2005, Resolution adopted by the General Assembly - A/RES/60/1, 47)
[5] SG's report on the work of the Organization (2006)

combating those ills was essential". It further viewed that the failures of social integration will lead to "social fragmentation; widening disparities and inequalities; and strains on individuals, families, communities and institutions as a result of the rapid pace of social change, economic transformation, migration and major dislocations of population, particularly in areas of armed conflict".[6]

The issue of social inclusion/exclusion is not only imperative in the attainment of MDG Goal 1 "Eradicating extreme poverty", but also other Goals, such as achieving universal education, promoting gender equality, reducing child mortality, and improving maternal health. Unless we pay closer attention to the issue of social inclusion/exclusion, some segments of the population will continue to be excluded from the progress made so far. In fact, it has now become a commonly shared view that the overall progress in achieving MDGs across regions will not be possible, if we continue to do our "business-as-usual". The remaining goal of the Social Summit, "promoting social integration", can play an effective role in accelerating the progress in achieving MDGs.

An encouraging recent development is the adoption of a Declaration on Social Justice for a Fair Globalization at the International Labor Conference (2008, 97th session). The Declaration which, while acknowledging the benefits of globalization, calls for a new strategy to effectively respond to growing challenges posed by globalization, such as income inequality, continuing high levels of unemployment and poverty, vulnerability of economies to external shocks, and the growth of both unprotected work and the informal economy. These actions were based on the conviction that "investing in full and decent work opportunities constitutes a commitment to fairness and justice and to more effective public policy and better governance"[7], so that the poorest and the disadvantaged could also be included in benefiting from the economic growth. Also, in a recent Secretary-General's report on the second UN Decade For the Eradication of Poverty (2008-1017)[8], the need for "better understanding of the deep-rooted obstacles" as well as broader and more inclusive national poverty reduction strategies was underscored to address multifaceted dimensions of poverty, including empowerment and participation of disadvantaged groups, in the development process.

The question now is how to make the concept of social inclusion operational, even in the face of resistance to change. Indeed, in some cases, social exclusion is willfully pursued as it serves vested interests. The challenge for policy makers and social scientists is, therefore, to find ways to dissociate the concept of social inclusion from the utopian realm of a "perfectly inclusive" world vision to redefining it as a practical tool used to promote an inspirational yet realistic set of policy measures geared towards a "society for all." This requires a paradigm shift so as to recognize the dignity, value and importance of each person, not only as an ethical norm and moral imperative, but also as a legal principle, a societal goal, and ultimately, practice. "No human being should be condemned to endure a brief or miserable life as a result of his or her class, country, religious affiliation, ethnic background or gender"[9]. To this end, social inclusion, as an overarching goal as well as a multi-dimensional process can play a critical role in promoting sustainable human development.

[6] Review of further implementation of the World Summit for Social Development and the outcome of the twenty-fourth special session of the General Assembly – E/CN.5/2005/6, para 165
[7] Implementation of the outcome of the World Summit for Social Development and of the twenty-fourth special session of the General Assembly (A/63/133, para 8)
[8] A/63/190, para 7
[9] Ibid, paragraph 8

World Summit for Social Development, Copenhagen Declaration on Social Development*-1995 (Table 1)*

1. *Commitment to creating an economic, political, social, cultural and legal environment that will enable people to achieve social development.*
2. *Commitment to the goal of eradicating poverty in the world, through decisive national actions and international cooperation, as an ethical, social, political and economic imperative of humankind.*
3. *Commitment to promoting the goal of full employment as a basic priority of our economic and social policies, and to enabling all men and women to attain secure and sustainable livelihoods through freely chosen productive employment and work.*
4. *Commitment to promoting social integration by fostering societies that are stable, safe and just and that are based on the promotion and protection of all human rights, as well as on non-discrimination, tolerance, respect for diversity, equality of opportunity, solidarity, security, and participation of all people, including disadvantaged and vulnerable groups and persons.*
5. *Commitment to promoting full respect for human dignity and to achieving equality and equity between women and men, and to recognizing and enhancing the participation and leadership roles of women in political, civil, economic, social and cultural life and in development.*
6. *Commitment to promoting and attaining the goals of universal and equitable access to quality education, the highest attainable standard of physical and mental health, and the access of all to primary health care, making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age or disability; respecting and promoting our common and particular cultures; striving to strengthen the role of culture in development; preserving the essential bases of people-centred sustainable development; and contributing to the full development of human resources and to social development. The purpose of these activities is to eradicate poverty, promote full and productive employment and foster social integration.*
7. *Commitment to accelerating the economic, social and human resource development of Africa and the least developed countries.*
8. *Commitment to ensuring that when structural adjustment programmes are agreed to they include social development goals, in particular eradicating poverty, promoting full and productive employment, and enhancing social integration.*
9. *Commitment to increasing significantly and/or utilizing more efficiently the resources allocated to social development in order to achieve the goals of the Summit through national action and regional and international cooperation.*
10. *Commitment to an improved and strengthened framework for international, regional and sub-regional cooperation for social development, in a spirit of partnership, through the United Nations and other multilateral institutions*

Source: UNDESA

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United Nations Millennium Declaration (Table 2)

I. Values and principles

1. We, heads of State and Government, have gathered at United Nations Headquarters in New York from 6 to 8 September 2000, at the dawn of a new millennium, to reaffirm our faith in the Organization and its Charter as indispensable foundations of a more peaceful, prosperous and just world.

2. We recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs.

3. We reaffirm our commitment to the purposes and principles of the Charter of the United Nations, which have proved timeless and universal. Indeed, their relevance and capacity to inspire have increased, as nations and peoples have become increasingly interconnected and interdependent.

4. We are determined to establish a just and lasting peace all over the world in accordance with the purposes and principles of the Charter. We rededicate ourselves to support all efforts to uphold the sovereign equality of all States, respect for their territorial integrity and political independence, resolution of disputes by peaceful means and in conformity with the principles of justice and international law, the right to self-determination of peoples which remain under colonial domination and foreign occupation, non-interference in the internal affairs of States, respect for human rights and fundamental freedoms, respect for the equal rights of all without distinction as to race, sex, language or religion and international cooperation in solving international problems of an economic, social, cultural or humanitarian character.

5. We believe that the central challenge we face today is to ensure that globalization becomes a positive force for all the world's people. For while globalization offers great opportunities, at present its benefits are very unevenly shared, while its costs are unevenly distributed. We recognize that developing countries and countries with economies in transition face special difficulties in responding to this central challenge. Thus, only through broad and sustained efforts to create a shared future, based upon our common humanity in all its diversity, can globalization be made fully inclusive and equitable. These efforts must include policies and measures, at the global level, which correspond to the needs of developing countries and economies in transition and are formulated and implemented with their effective participation.

6. We consider certain fundamental values to be essential to international relations in the twenty-first century. These include:
• **Freedom.** Men and women have the right to live their lives and raise their children in dignity, free from hunger and from the fear of violence, oppression or injustice. Democratic and participatory governance based on the will of the people best assures these rights.

•. **Equality.** No individual and no nation must be denied the opportunity to benefit from development. The equal rights and opportunities of women and men must be assured.

• **Solidarity.** Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with basic principles of equity and social justice. Those who suffer or who benefit least deserve help from those who benefit most.

• **Tolerance.** Human beings must respect one other, in all their diversity of belief, culture and language. Differences within and between societies should be neither feared nor repressed, but cherished as a precious asset of humanity. A culture of peace and dialogue among all civilizations should be actively promoted.

• **Respect for nature.** Prudence must be shown in the management of all living species and natural resources, in accordance with the precepts of sustainable development. Only in this way can the immeasurable riches provided to us by nature be preserved and passed on to our descendants. The current unsustainable patterns of production and consumption must be changed in the interest of our future welfare and that of our descendants.

• **Shared responsibility.** Responsibility for managing worldwide economic and social development, as well as threats to international peace and security, must be shared among the nations of the world and should be exercised multilaterally. As the most universal and most representative organization in the world, the United Nations must play the central role.

II. Creating an Inclusive Society

WHAT IS MEANT BY AN INCLUSIVE SOCIETY?

> *An inclusive society is a society that over-rides differences of race, gender, class, generation, and geography, and ensures inclusion, equality of opportunity as well as capability of all members of the society to determine an agreed set of social institutions that govern social interaction. (Expert Group Meeting on Promoting Social Integration, Helsinki, July 2008)*

The World Summit for Social Development (Copenhagen 1995) defines an inclusive society as a "society for all in which every individual, each with rights and responsibilities, has an active role to play". Such an inclusive society must be based on respect for all human rights and fundamental freedoms, cultural and religious diversity, social justice[10] and the special needs of vulnerable and disadvantaged groups, democratic participation and the rule of law. It is promoted by social policies that seek to reduce inequality and create flexible and tolerant societies that embrace all people.

There are different views in terms of how a socially inclusive society functions. "Integration in all its forms may simply imply the existence of a stable community in which people can find a niche." (Taylor, 2007:3). This simple expression touches the heart of the definition of social integration and social inclusion, which is: difference among members of society is acceptable. Social integration or social inclusion does not mean a uniformity of people but a society which has room for diversity and still fosters engagement. To achieve social integration and social inclusion, voices of people and their needs and concerns, need to be heard. Not only some but all members of society with different backgrounds must have a say and a stake in *their shared* society. This inclusiveness of society creates and maintains stability as well as a readiness to embrace change when necessary.

In order to further our understanding of the concept of social integration and social inclusion, we will begin by taking a closer look at what determines or represents an inclusive society, and why it is important to build such a society. In very basic terms, "International human rights law requires governments to respect individuals' civil and political rights – such as their rights to free speech, fair trial, and political participation – and to promote their economic, social and cultural rights – such as their rights to health care and education."[11] In an inclusive society, members not only have the right to education or the right to political participation but actually take part in the process, using the right to education and having a vote that actually counts in a political process. What is most significant in creating an inclusive society is the engagement of the individual in the process by which society is managed, ordered and represented.

ELEMENTS NECESSARY FOR CREATING AN INCLUSIVE SOCIETY

[10] Social justice refers to the principles, values and belief that every individual and group is entitled to fair and equal treatment, which is necessary for the achievement of a society in which all people have equal access to rights, not only under law, but in all aspects of life, and all people get an impartial share of the benefits as well as carry a fair share of the responsibilities of society.

[11] Check with Aki, where this quotation comes from.

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The Social Summit defined that the aim of social integration is to create an inclusive society, in which every individual, each with rights and responsibilities, has an active role to play.[12] But what makes some societies more inclusive than others? What are the critical elements for creating and maintaining an inclusive society in practical terms? An inclusive society is based on the fundamental human rights value, that is, "all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood[13]" It is a society in which all members, regardless of their backgrounds, are able and motivated to participate in civic, social, economic and political activities. For this to happen, legal, regulatory and policy frameworks must be inclusive, and uphold and promote just and inclusive processes in all areas of implementation, so that equal access to basic education, public space, facilities and information are ensured, and diversity and cultural pluralism are respected and accommodated.

As a pre-requisite, *respect for all human rights, freedoms, and the rule of law*, both at national and international levels, are fundamental. Every member of society, no matter what his or her economic resources, political status, or social standing, must be treated equally under the law. Legal instruments ensure the guiding principles that will guarantee equity[14], justice and equal opportunities for all citizens. Violators of human rights should be brought to justice. The judiciary which serves to protect just societies must be impartial, accountable and inclusive to giving weight to the opinions of those who defend the inclusiveness of the society at the local, regional and national levels. *Maintaining the security* of all individuals and their living environment is paramount in creating a feeling of inclusion and an atmosphere of participation in society.[15]

To create and sustain inclusive societies, it is critical that all members of society are able and motivated to *participate in civic, social, economic and political activities*, both at the local and national levels. A society where most members, if not all, feel that they are playing a part, have access to their basic needs/livelihoods, and are provided with the opportunity to participate in decision-making processes that affect their lives, is a society that will best foster principles of inclusiveness.[16]

The existence of a strong civil society is fundamental for active participation and making public policies and institutions accountable. It fosters a respect for the rights, dignity and privileges of all people, while assuming that they fulfill their responsibilities within their society. There must be freedom for people to express diverse views and develop unconventional unique ideas. Members of society must have the confidence to engage and interact with each other, and build mutual trust while acknowledging their differences.[17]

In order to encourage all-inclusive participation, there must be *universal access to public infrastructure and facilities* (such as community centers, recreational facilities, public libraries, resource centers with internet facilities, well maintained public schools, clinics, water supplies and sanitations). These are the basic services which will create, when partly or fully put into

[12] The Copenhagen Declaration and Programme of Action, Chapter 4, page 95
[13] Fact Sheet No.2 (Rev.1), The International Bill of Human Rights
[14] Equity refers to a condition in which society is characterized by justice, equality, impartiality and fairness, including fair and equal distribution of power, economic resources, opportunities, goods and services across the social spectrum. In an equitable society people are not excluded from the activities of society, such as education, employment, or health care and there is no bias or favoritism.
[15] Summary of E-dialogue on "Creating an Inclusive Society: Practical strategies to promote social inclusion", organized by DPSD/UNDESA, 23 May - 17 June, 2007.
[16] Ibid
[17] Ibid

DRAFT

place, conditions for people to have a sense of belonging by not suffering the painful consequence of being unable to afford them. As long as both the advantaged and disadvantaged have equal access to or benefit from these public facilities and services, they will all feel less burdened by their differences in socio-economic status, thus alleviating a possible sense of exclusion or frustration.[18] It is important to note though, that access alone does not necessarily ensure use of public facilities, as unequal relations within communities and households may inhibit the use of facilities by vulnerable groups. Addressing the unequal power relations is therefore a necessary step to increase participation.

Similarly, *equal access to public information* plays an important role in creating an inclusive society, as it will make popular participation possible with well-informed members of society. Information that pertains to the society, such as what a community owns, generates, or benefits from, should be made available to all. Collective participation, through accepted representations of all classes and backgrounds, in the planning, implementation and evaluation of community activities should be sought after. Publication/information sharing and increasing the accessibility of the community's activities will eliminate doubts and suspicions which could otherwise create a sense of exclusion. The mass media can be used as an effective tool to educate and enlighten members of society.[19]

Equity in the distribution of wealth and resources is another critical element of inclusive societies. How the resources are allocated and utilized will significantly affect the orientation of a society, either towards a more integrated, inclusive society, or an exclusive, polarized, and disintegrated one. Therefore, socio-economic policies should be geared towards managing equitable distribution and equal opportunities. Inclusive policies, instructions and programs that are sensitive to and cater to the less advantaged and vulnerable need to be put in place in all areas/sectors, including public health, and effectively implemented. There is a need for a strong monitoring and evaluation tools to demonstrate whether inclusiveness was actually achieved, as well as highlight areas for improvement.[20]

Another dimension of inclusive societies is tolerance for and appreciation of *cultural diversity.* This includes societies that celebrate multiple and diverse expressions of identities. By celebrating diversity, there is a recognition and affirmation of the differences between and among members of society, which enables societies to move away from labeling, categorizing, and classifying people, towards more inclusive policies. Also, enabling a diversity of opinions provides the checks and balances crucial for the development of society, while allowing for the greatest amount of diverse opinions to enter every discourse.[21]

Education plays a critical role in this area, as it will provide opportunities to learn the history and culture of one's own and other societies, which will cultivate the understanding and appreciation of other societies, cultures and religions. Particularly for young people, education provides the opportunity to instill values of respect and appreciation of diversity. At the same time, education can empower those who are marginalized or excluded from participating in discussions and decision-making. Learning about the historical processes and changes allows people to understand the way in which they and others have been affected by socially inclusive or exclusive policies, which ultimately influences the values, choices and judgments of individuals, in particular, those who are in decision-making positions.[22]

[18] Ibid
[19] Ibid
[20] Ibid
[21] Ibid
[22] Ibid

DRAFT

Effective leadership is crucial to the development of an inclusive society. Where leadership is not representative of the society, a disconnection between the people and their leaders may eventually result. The most common way of addressing this critical element at the local level is by engaging in open consultations with members of society about municipal issues such as the budget, and enhancing the free and timely flow of information to citizens and other stakeholders. Popular participation in decision-making and policy formulation processes could be sought for at all levels of governance. At the same time, there must be an effort made to achieve transparency and accountability by all decision-makers and stakeholders.[23]

Finally, there is a need to create *positive narratives of an inclusive society of the future*, and enable each member of society to share, understand and contribute to those narratives. Potent narratives on the future can act like a magnet drawing society towards its envisioned future. A society with no vision for the future indicates a society in decline. Societies that maintain a unity of purpose, or a shared vision embraced by the community, and encourage broad-based stakeholder participation in the formulation of that goal, will be more inclusive as every member will be working synergistically towards a unified objective.[24]

UNDERSTANDING SOCIAL INCLUSION

The concepts of social integration and social inclusion are similar ones, and in fact overlap each other in many ways. However, some differences exist which are useful to be examined in order to avoid confusion. It is worth mentioning that any attempts to differentiate these two concepts will inevitably face a challenge, as there is no single agreed definition for either. The concept of social integration was created through political consensus among member states at the World Summit for Social Development. Social inclusion or social cohesion were preferred terms for some, however, it was a consensus agreement that the concept of social integration allows broader interpretation. The Social Summit approached social integration in terms of goals, principles and process. It is important to understand that social integration is not an end-state that societies can achieve, but a dynamic process in which societies engage in order to further human development.[25]

The concept of social inclusion is similar to that of social integration. However, social inclusion, focusing on creating conditions for equal opportunities and equal access for all, is considered to be useful when describing the actual process involved in promoting social integration. Social inclusion is also often more easily accepted as a policy goal, as it clearly eliminates a connotation of assimilation that some associate with the term "integration" - not all individuals and/or groups in societies are eager to be "integrated" into mainstream society, but all strive to be included.

> *Inclusion is community. No one becomes included by receiving handouts, even if these handouts are given by public bodies and with public resources. No one becomes included by being treated by a program in which they are no more than a number or a statistic. Inclusion is connection to the network of community development, it is to become more than a speck of dust, to have a forename and surname, with one's own distinctive features, skills*

[23] Ibid
[24] Ibid
[25] Participatory Dialogue: Towards a stable, safe and just society for all", UN, 2007

DRAFT

and abilities, able to receive and give stimulus, to imitate and be imitated, to participate in a process of changing one's own life and collective life. (Busatto, 2007: 4)

The above quotation places emphasis on the recognition of the individual and the relationship between community and the individual. This suggests that inclusion is a mutually beneficial state for both the community and the individual. When people rely upon each other and the success of their interactions, that responsibility and interdependence creates a commitment to the social processes in a community. The depiction of social inclusion at the local level is useful as it addresses inclusion at a manageable and feasible level. In a smaller geographic region than the nation, there is much greater opportunity to develop inclusive systems, economically and socially as well as politically. Cities can thus be seen to provide the space for testing and expanding notions of social inclusion. The role of local government in promoting social inclusion and participation is further discussed in chapter 3.

As mentioned earlier, there are numerous definitions and concepts of social inclusion,[26] and despite a multitude of discussion, it is still difficult to obtain agreement on the term. Lombe notes that: "Inclusion is the realization that everyone has essential dignity and everyone has something to contribute." (Lombe, 2007:3) Social inclusion can be described as a "multi-dimensional process aimed at lowering economic, social and cultural boundaries between those who are included and excluded, and making these boundaries more permeable" (Therborn, 2007.2). It is a dynamic phenomenon, as its boundaries are changing over time, space, and in quality. Sen described social inclusion as "being characterized by societal elements that would include the active participation by citizens, equality of opportunities, and basic levels of well-being."[27]

At the core of most definitions of social inclusion lies the concept of ***full participation in all aspects of life***, while exclusion refers to the conditions (barriers and processes) that impede inclusion. Participation is most significant as it denotes an active involvement in the process, not merely having access to society's activities, but engaging in them, and building and maintaining a social network. Participation also creates a sense of responsibility towards others, a community or an institution, and influences decisions or enables individuals to have access to the decision-making processes[28].

In this publication, social inclusion refers to a process by which efforts are made to ensure equal opportunities for all, regardless of their background, in order to enable full and active participation in all aspects of life, including civic, social, economic, and political activities, as well as participation in decision-making processes. Social inclusion can be approached as a goal, an objective, and a process. Its process affects almost all societal activities, and should therefore be approached from various dimensions. (EGM Paris)

Exclusion conversely is a process and a state resulting in lack of access to full participation in mainstream society. The manifestations of social exclusion are often understood differently

[26] Note: Beall originates the terms in French public policy and Rene Lenoir for popularizing the term in France, as well as highlighting the historical disregard of les exclus or 'the others' by the social contract of the French republic. (Viswanathan, L. et al, 2003:5).
[27] Viswanathan, L. et al, 2003:5
[28] "Social Participation and Social Capital", Raymond Breton, University of Toronto http://canada.metropolis.net/events/civic/rbreton_e.html

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according to the perceived needs of the society. For example, in some societies, women may be the main excluded group, in other societies, immigrants or racial, ethnic and religious minorities are excluded.

Dimensions of Social Inclusion and Exclusion

The focus of this section is predominantly on social inclusion, which inherently includes the factors of social exclusion. In order to promote social inclusion, it is important to understand the processes through which individuals or groups are excluded, as promotion of inclusion can only be possible by tackling exclusion. Social inclusion needs to occur on various dimensions and multiple levels. It is a process through which the dignity of each individual is recognized, needs and concerns of all people are reflected, rights of all people are not only guaranteed in legislation, but also respected, and people are able to participate actively in life activities. The process of social inclusion needs to take place simultaneously at multiple levels, from the individual, community and local levels, to the regional and national levels, as social inclusion is a subject which concerns all stakeholders in society. While social inclusion involves formal (societal) level engagements, ensuring that institutions in society reflect, uphold, respect, and activate the inclusive processes within society, it at the same time, addresses the informal (individual) level of engagements, and as such, perceptions and experiences of individuals, how they think and feel, also need to be taken into account. Social inclusion reflects, on the one hand, an individual's experience of and possibilities for self-actualization, and on the other hand, societal capacities to eliminate causes of exclusion and ensure equal opportunities for all[29]. Figure 1 illustrates the multiple levels involved in a social inclusion process.

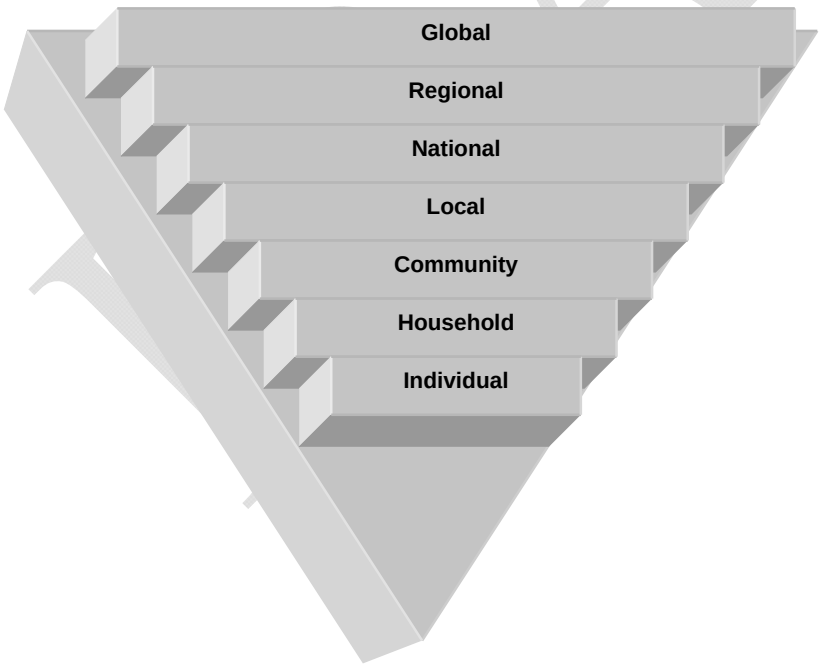

Figure 1: *Levels involved in a social inclusion process*

[29] Final Report of the Expert Group Meeting on "Creating an Inclusive Society: Practical strategies to promote social inclusion", May 2008, unpublished.

***S**teps to promoting social inclusion*

In order to understand the actual process of social inclusion, Goran Therborn (2007, 2) suggests that the following five categories of inclusion could be considered as incremental steps to promote social inclusion. These steps are hierarchical with visibility as the first step. Without the possibility to fulfill the lower steps the person is deterred and limited from climbing to the next step. Each of the five steps can be approached and understood in terms of both "process" and "contents" (see figure 2).

Figure 2: *Steps to promoting Social Inclusion*

The five steps are as follows:

1) ***Visibility***:
First and foremost, people need to be noticed, recognized, and have their own voices. There is no possibility of having a voice if an individual or group is not accounted for and represented in the processes that make up formal society. One of the greatest difficulties even at a local level is the actual census of population. People remain uncounted and therefore invisible.

2) Consideration:
The concerns and needs of individuals and groups are taken into account by policy-makers. Often policy-makers do not consider the poor and other marginalized groups as important stakeholders, and therefore, do not incorporate their needs and concerns.

3) Access to Social Interactions
People must be able to engage in society's activities and social networks in their daily life, including economic, social, cultural, religious, and political activities.

4) Rights:
People must have rights to act and claim, rights to be different, legal rights, rights to access social services, such as housing, education, transportation, and health care. They must have

DRAFT

the right to work and the right to participate in social, cultural and political life. The right to claim will regress if one is discriminated.

5) Resources to fully participate in society

Those who do not have access to rights are not able to participate fully in society. However, even if people have rights to access, they cannot participate fully without adequate resources. Therefore, resources to fully participate in all aspects of societal activities are the ultimate step for successful social inclusion. It is not only because of lack of financial resources that people are unable to participate, or stop participating, but also because of conditions, such as insufficient time or energy, spatial distance, lack of recognition, lack of respect, physical conditions or constraints. These elements all need to be taken into consideration.

Dimensions and elements of Social Inclusion and Exclusion

Figure 3 below illustrates the multidimensionality of social inclusion. Social inclusion touches almost all dimensions of life, both individual and societal. These dimensions can be categorized in many different ways. In fact, there are various attempts to categorize the dimensions of social exclusion and inclusion. As each context or purpose of social inclusion varies significantly, it would be best if each society or community identify the most appropriate dimensions in consultation with wide range of stakeholders. Also, social inclusion can be promoted at many different levels, which has different objectives and target beneficiaries. For example a national government may be interested in identifying dimensions that have a linkage with their sectoral policies, such as education, health, employment, access to basic services, etc. A local government may be more geared towards creating innovative categories, for example, social capitals, social mobility, etc.

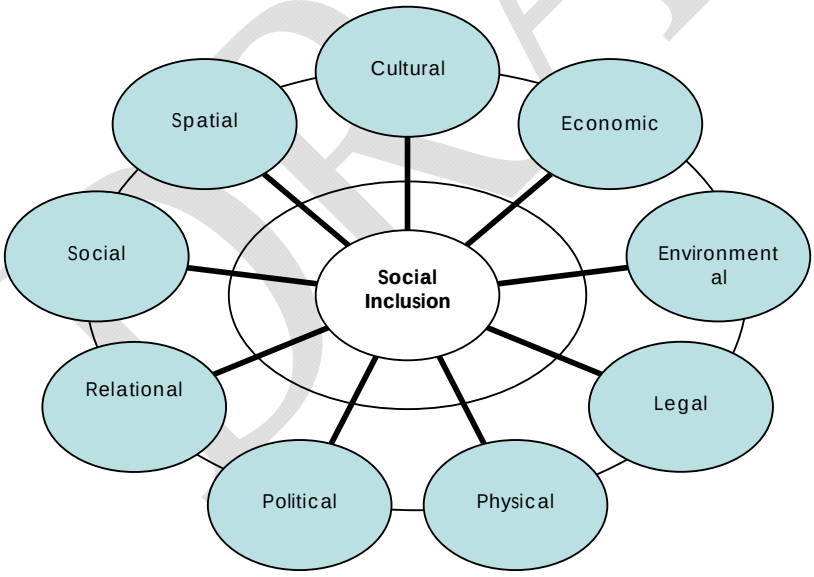

Figure 3: *Dimensions of Social Inclusion*

The table below is inspired by the Laidlaw Foundation Social Inclusion Framework (2002) and Shookner's Dimensions of Social Exclusion and Inclusion (2002). It contains a list of dimensions of social inclusion and exclusion, and elements, which relate to these dimensions. This list is one example of various attempts to categorize the dimensions and elements of social exclusion and inclusion. The elements are listed randomly and not in order of priority. For each dimension, further elements of social inclusion and exclusion may be identified.

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Table 1: *Dimensions and elements of Social Exclusion and Inclusion*

Elements of Exclusion		***Elements of Inclusion***
- Exclusive policies and legislation - Lack of respect for human rights - Discrimination, intolerance, stigma, stereo-typing, sexism, racism and homophobia - Fear and psychological insecurity - Lack of access to basic services, including education, health care, clean water and sanitation - Lack of access to decent work and employment - Lack of resources to sustain livelihood - Lack of access to land - Lack of access to credit - Lack of transparency in decision-making - Lack of access to political processes - Lack of access to information and communications - Lack of transportation - Lack of access to public spaces - Physical Insecurity - Segregation - Violence and abuse	Cultural Economic Social Environmental Legal Physical Political Relational Spatial	- Inclusive policies and legislation - Access to clean and safe places for living, work and recreation - Access to information and communication - Access to public spaces - Access to resources - Access to basic services, including education, health care, clean water and sanitation - Access to transportation - Transparent and accountable decision-making processes - Adequate income and employment opportunities - Affirmation of human rights - Opportunity for personal development - Respect for diversity - Freedom (of choice, religion, etc.) - Participation in decision-making - Social protection - Solidarity

It is worth noting that elements of exclusion and inclusion cannot be limited to only one dimension, but need to be dealt with from various angles. Discrimination for example, can be addressed not only through the social dimension, but also through legal, cultural, and political dimensions. Another example, poverty eradication strategies, one of the key areas in which social inclusion objectives needs to be mainstreamed, requires interventions in a wide range of areas, from macro-economic, to employment, social protection, housing, education, health, information and communications, mobility, security and justice, leisure and culture. It is necessary, therefore, to mainstream the objective of social inclusion into all relevant policies in multiple dimensions. When we address the issue of social mobility, it is necessary to examine if there is a public transportation system in a particular neighborhood, to assess the degree of access for marginalized communities to social, political, cultural, and economic life. If we look into education, we need to examine if there is equal access to formal and informal education for all, and if certain groups of children (differing in for example ethnicity, gender, or religion) may be excluded. Regarding the health sector, we need to examine if specific needs of vulnerable groups are addressed, or if there is any discrepancies between mortality rates or life expectancy between excluded groups and mainstream groups.

For successful social inclusion to take place, it is useful to examine the areas in which inclusion is weak and where exclusion is most prevalent; where engagement is least successful and participation is faltering. How and why are people being left out of the processes that make up society? Who does it affect and what are the economic, social and political environments in which the problem is most apparent? Structures, processes and relations of power that exist within societies, which result in the inclusion of some and exclusion of others, need to be

examined. As a starting point, the next section examines some key areas where social inclusion perspectives need to be incorporated, as well as which groups of people are typically excluded.

III MAPPING THE LANDSCAPE OF INCLUSION AND EXCLUSION

KEY AREAS FOR SOCIAL INCLUSION AND EXCLUSION

There are several key areas in which social inclusion objectives need to be integrated; poverty, employment and sustainable development. These three areas are highlighted as they are part of the major UN agenda. Poverty eradication and employment creation, two goals of the Social Summit, are considered to be key areas to achieve the goal of creating an inclusive society. Likewise, promotion of social inclusion is considered to be an important determinant of the attainment of poverty eradication and employment creation. The major socio-economic and political challenges of climate change has emerged as an additional incentive for promoting inclusive policies in the context of mitigation and locally driven adaptation and supporting fragile ecosystems, particularly in the developing world. Incorporating social inclusion perspectives in these areas will provide substantial possibilities for promoting social inclusion. Examples of initiatives which contribute to promoting social inclusion at the local level within these areas and others are presented in chapter 3.

Poverty

Poverty interacts with social exclusion in important ways and it has been recognized as the key challenge of our time. Despite various efforts through the adoption of the Millennium Development Goals, poverty, inequality and social exclusion remain rampant in many countries, and are closely connected. UNDP National Human Development Report (2007) for Ghana indicated that there is a high correlation between poverty and social exclusion[30], but that not all poor are socially excluded, nor that all the vulnerable socially excluded people are poor. It also indicated that an increase in poverty induces an increase in social exclusion.

The notion of social exclusion can contribute to the understanding of the nature of poverty, as well as help identifying causes of poverty that may otherwise be neglected.[31] Almost by definition, poverty limits the access of people to the most basic levels of social inclusion. Not only directly, in the form of material deprivation, such as the inability to afford shelter and buy food, but also in regards to agency; the poor are often without the willingness and capacity to act, and psychologically disempowered, as they feel excluded from the greater society, discouraged of becoming visible, participating and contributing.[32] If the poor are systematically excluded from mainstream society, their exclusion can impede social progress and endanger social and political stability. The degree of inequality in a society is considered to be more closely

[30] Ghana UNDP Human Development Report: Towards more inclusive society, 2007, page 3 and 53
Note: Based on a survey conducted by ClayDord Consult (2004), poverty contributes extensively to the exclusion and accounts for approximately 60.63 percent of social exclusion in Ghana.
[31] Sen, 2000
[32] UNDP, 2007, Ghana report; UNDP, Human Development Report, 2007

DRAFT

correlated with crime levels than poverty.[33] Even though there is no direct causal relationship between poverty and violent conflict, the poverty associated with high degree of inequality and exclusion/marginalization can be a major contributing factor to higher crime rates and higher risks of social tensions, social disintegration, and ultimately violent conflict.[34] Poverty reduction strategies and efforts are therefore some of the most important fronts in promoting social inclusion.

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It is evident that we will not be able to eradicate poverty if we continue to exclude those who are vulnerable and disadvantaged. As long as we fail to address the root causes of poverty and exclusion, some segments of the population will continue to be left out of the benefits gained by society as a whole. The World Social Summit identified poverty eradication as an ethical, social, political and economic imperative of mankind and called on governments to address the root causes of poverty, provide for basic needs for all and ensure that the poor have access to productive resources, including credit, education and training. In order to achieve the MDG goal of eradicating extreme poverty and hunger, with the specific target of halving the proportion of people whose income is less than 1$ a day, social inclusion must play a key role, as it addresses root causes of poverty in all its dimensions. Social inclusion entails promoting a people-centered approach to poverty eradication, advocating the empowerment of people living in poverty through their full participation in all aspects of political, economic and social life, especially in the design and implementation of policies that affect the poorest and most vulnerable groups of society. An integrated strategy towards poverty eradication necessitates implementing policies geared to more equitable distribution of wealth and income, and social protection coverage. (http://www.un.org/esa/socdev/social/poverty/)

Employment

Full employment, self-employment or adequately remunerated work is an effective method of combating poverty and promoting social integration and social inclusion. When members of society have work, they automatically become stakeholders in the economic realm. Engagement in and access to the labor market is therefore the first and most important step in participation in the economic processes of society, and employment and self-employment are the most salient aspects of economic inclusion. Employment also acts as a source of identity and gives access to a social network.

Exclusion of the weakest groups from the labor market and lack of gainful employment represents another threat to social inclusion and cohesion. For the poor, labor is often the only asset they can use to improve their quality of life, therefore, unemployment can have extremely damaging effects on the livelihoods as well as well-being of individuals, households and the entire community. Global unemployment is at a historical high at nearly 200 million in 2006,[35] with a more than 20 percent increase in official unemployment over the decade. The quality of employment has deteriorated so that half of the labor force does not make enough money to escape poverty.[36] Women and young people are particularly affected. Where job growth has taken place, it has been concentrated in insecure, informal employment with low wages and few benefits. Typically, vulnerable and disadvantaged groups have less opportunities to participate

[33] Crime and Development in Latin America: Caught in the cross-fire, UNODC, May 2007
[34] Participatory Dialogue: Towards a stable, safe and just society for all, page 55
[35] Global Employment Trends, ILO, January 2007
[36] Full and Productive Employment and Decent Work: Dialogues at the Economic and Social Council, United Nations, DESA 2006, page 3 and 31

DRAFT

in the formal sector, due to existing obstacles such as lower levels of education, lack of skills, lack of vocational training, lack of information, lack of social network, or de jure or de facto discrimination, both in hiring and in starting businesses. As a result, those who are vulnerable and disadvantaged engage in economic activities predominantly in the informal sector, often as 'working poor' – employed, yet unable to lift themselves out of poverty. Even though the "informal economy" is recognized as vital to sustain livelihood for the most vulnerable groups, particularly in developing and transition countries, participation in informal economy, by definition, indicates a lack of social protection, a lack of protection by labor laws, absence of rights at work, low job security, and the lack of representation and voice. [37]

It is important to reduce existing barriers to labor markets, not only by instilling 'social responsibility' practices, but also by creating incentives for creating diverse workforces in the private sector. This includes public policies promoting equal opportunities, providing social and economic incentives to enterprises and organizations that promote inclusive values and practices, creating a new vision for inclusive organizational culture based on the basic premise that every individual is entitled to equal opportunities and self-realization, regardless of his/her gender, age, race or religion[38]. The size and diversity of the active labor force should be expanded through progressive labor market policies, while ensuring a better linkage between social protection, life-long learning, and labor market reforms, so that they are mutually reinforcing. There should be a focus on creating better and more productive jobs, particularly those that can absorb the high concentrations of working poor. Among the necessary elements for creating such jobs are investing in labor-intensive industries, especially agriculture, encouraging a shift in the structure of employment to higher productivity occupations and sectors, and upgrading job quality in the informal economy.

Social economy enterprises, such as cooperatives, offer an important source of productive self-employment, as they create income-generating opportunities for poor communities, as well as vulnerable groups such as women, youth, indigenous peoples, persons with disabilities and other marginalized groups. In particular, agricultural cooperatives create employment in areas such as food production, marketing, credit, insurance and transportation. Cooperatives, especially agricultural cooperatives, enhance food security as well as job security for the members and their families, through providing competitive wages, promoting additional income through profit-sharing, distribution of dividends and other benefits, and supporting community facilities such as health clinics and schools that do private sector businesses[39]. In addition, there should also be a focus on providing poor people with the necessary skills and assets that will enable them to take full advantage of any expansion in employment potential.[40] Job-creation should be situated at the center of national social inclusion strategies.

Geographic Disadvantage

The geographic characteristics of communities can have a significant effect on the level of inclusion in a society. The world is often described as comprising the 'North' and the 'South', with the North conventionally being viewed as being more economically powerful and wealthy. However, poverty and social exclusion exists across regions, even in the richest countries. When

[37] Decent work and the informal economy, Report IV, International Labor Conference, ILO, Geneva, 2002
[38] Cooperation at Work: A study in a Bi-National Factory, Dr. Zeev Degani, Marzuq Halabi, Tamar Gross, unpublished, 2007. http://www.un.org/esa/socdev/sib/egm'07/documents/Delta%20final%20version-RT.pdf
[39] http://www.un.org/esa/socdev/social/poverty/
[40] http://www.un.org/esa/socdev/social/poverty/poverty_and_employment.html

looking at the national or regional levels, disparities become clearer and the definitions around them take on a more contextual character. There are many regions which suffer from spatial disadvantage in that they are far from natural resources or public transportation, or without access to capital, credit and information, which could provide economic benefits and the possibility to engage in markets and the use of their labor force.

People living in poverty and living in certain geographic locations, particularly in the least developed countries, and small island states, arid and high mountain zones, in densely populated coastal areas, or dry lands, are considered to be the most vulnerable for the effect of climate change. *Human Development Report 2007/2008 (Fighting climate change: Human Solidarity in a divided world, UNDP) vividly illustrates how the livelihoods of these vulnerable populations will be affected by droughts, floods, extreme weather, tropical storms, sea level rises, c*hanges in run-off patterns of rivers, glacial melt, and the *spread of diseases, etc. A*s such, the current threat of climate change has significant implications for any efforts to promote social integration and inclusion.

The negative ramifications of climate change often interact with existing social and economic constraints. The impacts of climate change and the possibility for social exclusion are likely to vary considerably depending on factors such as socio-economic status and geographical location. The poorest and most vulnerable communities are the first ones to be affected by "climate shocks", not only during the post disaster period, but also for much longer periods, as they are exposed to a wide range of incremental risks, from food insecurity, malnutrition, loss of jobs and/or income, land degradation, reduction in arable land and agricultural production. Also, they do not possess adequate resources to cope with the challenges[41]. With regard to health and nutrition, the most vulnerable groups are children and older people.[42] Social inclusion efforts may be able to enhance their coping mechanisms. One area which is gaining interest is social protection programmes in the form of safety net programmes or cash transfers that can help people cope, while expanding opportunities for employment, nutrition and education[43].

Migration is an option people often resort to as a coping mechanism where their opportunities are limited. Migration depletes the human capital of societies which may already be capital deficient. The rural-urban migration which forms part of these changes has fundamentally altered the composition of both areas, and redefines 21st century cities throughout the world. Rather than converging with economically more developed urban regions, rural areas are falling further behind. Migration provoked by climate change, places migrants at increased risk of poverty and settlement in marginal areas that are at high risk of environmental disaster.

Although geographic disadvantage may present great difficulties for policy makers, it must be taken into account and looked at contextually when developing policy and strategies to promote inclusion. It is necessary to integrate social inclusion objectives into an overall sustainable development agenda, in particular strategies, plans and programmes to tackle the challenges posed by climate change, and other measures at mitigation so that the irreversible changes already underway are not further amplified over the next few decades. [44]

[41] Human development report 2007/2008, Fighting Climate Change, UNDP
[42] Climate change and human health - risks and responses. published by WHO in collaboration with UNEP and WMO. 2003 http://www.who.int/globalchange/publications/cchhsummary/en/
Summary report from the Joint UNEP-UNAIDS meeting to review a position paper on HIV and AIDS and Climate Change, July, 2008
http://data.unaids.org/pub/BaseDocument/2008/UNAIDS_UNEP_joint_statement_climate_change_en.pdf
[43] Human Development Report: 2007/2008: Fighting climate change: Human Solidarity in a divided world
[44] United Nations. 1987."Report of the World Commission on Environment and Development." General Assembly Resolution 42/187, 11 December 1987. Retrieved: 2007-04-12)

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KEY GROUPS TO BE INCLUDED: WHO IS MARGINALIZED?

Examining the concept of social inclusion with a specific group of marginalized people in mind is an important approach to locating exclusion in the societal framework. Lack of engagement in the processes, which constitute civil life, begins a cycle which is difficult to escape. It is the role and responsibility of policy-makers, social institutions, civil society, and the private sector to address these issues and to seek out, identify and make visible the marginalized.

There is a substantial variation from country to country regarding which groups are subject to exclusion. Women, people living in poverty, persons with disabilities, children, youth and older persons are particularly vulnerable. In many countries, social cohesion is threatened by social tensions or institutional biases that exclude people with different ethnic, religious or cultural backgrounds. Recent migrants are also often excluded by local communities or society at large.

Social groups with particular disadvantages and vulnerabilities and groups that are discriminated against and/or marginalized are the natural, though not sole, beneficiaries of inclusive policies. In a certain sense, every individual and member of society gains from a more inclusive society that encourages and promotes individual development and supports empowerment. Inclusive participation is quintessentially a bottom-up process where action is undertaken by ordinary people. It enhances the quality, credibility and most importantly, ownership of the decisions taken. That is why the inclusive society or "society for all" is not only an abstract notion but also a very practical policy goal.

Social Identity and Social Categorization

Society can be described as being composed of social groups. People perceive themselves partially as individuals with unique characteristics, perceptions, thoughts, dreams, hopes, and so on. This constitutes their individual identities. People also perceive themselves as members of social groups and others perceive them as such. This constitutes their social identities.[45] Social identity is understood as the individual's self-concept derived from perceived membership of social groups[46]People have multiple social identities corresponding to widening circles of group memberships, such as gender, age, education, economic status, ethnicity, religion, language, nationality, etc. Social identity can be made evident through the use of markers such as language, belief, clothes, and behavior, and the effect of the markers depends on their recognition by others. The individual can discuss the meaning of the markers with others in a negotiation of their social identity[47].

Social identity can be a source, as well as an outcome of processes of social exclusion. In general, people desire a positive social identity and to belong to a group that is valued, respected and resourceful, rather than a low social status group that threaten a positive social identity and reduce self-esteem. Often, individuals and groups achieve positive social identity through discriminating and/or excluding other groups that they perceive as lower status than themselves.

[45] Untied Nations, DESA, Participatory Dialogue: Towards a stable, safe and just society for all, 2007

[46] Tajfel, H. & Turner, J. C. (1986). The social identity theory of inter-group behavior. In S. Worchel and L. W. Austin (eds.), *Psychology of Intergroup Relations*. Chigago: Nelson-Hall

[47] Mead, G. (1934) *Mind, Self, and Society*. University of Chicago Press.
Stryker, Sheldon (1968). "Identity Salience and Role Performance". *Journal of Marriage and the Family* 4: 558–64

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It is paradoxical, but groups that experience exclusion and discrimination are even more likely to discriminate against other groups of higher or lower status, so that they can raise their self-esteem.[48]

The power imbalances between groups with different social identities can lead to the use of labels to categorize others, often with the use of stereotypes, and based on characteristics such as appearance, age, physical status, gender, sexual orientation, ethnicity, and religious, political and cultural affiliations. Often these characteristics have been given meanings and values by those in power which result in discrimination, lack of access to socio-economic resources, and social exclusion. Examples of labels and categories could be *young Catholic woman in a wheelchair*, *Aboriginal older man*, *conservative female African-American from rural area,* and *young man from Asia living with HIV,* etc. The young Catholic woman may have difficulties being gainfully employed, not because of her condition but because there are physical barriers such as inaccessible buses or staircases in the workplace which obstruct her access. The young man from Asia may meet obstacles in his attempts to study abroad, as some countries do not permit access to people living with HIV. The process of labeling and categorization can lead to people concealing a social identity, in anticipation that they may experience discrimination or not be accepted in their society.

The meaning and values of these labels and categories may appear to reflect essential and inherent qualities, but in reality their meaning is a product of interaction and a social construction of a particular culture or society. They should be viewed as the result of the interaction between a person and his or her environment and not something that resides in the individual. So whether or not a specific characteristic leads to inclusion or exclusion of the individual depends on the society's values and culture, as well as the particular circumstances. Belonging to the category of women, for example, does not necessarily create a condition for exclusion. Furthermore, an individual can be included in one area, but excluded in another, and people who are marked by several disadvantageous characteristics are vulnerable to experiencing social exclusion in more spheres of life.

In order to achieve social inclusion it is necessary to change the meanings and values which are associated with unfavorable characteristics and the culture which they are embedded within, including unequal power relations. This is a comprehensive task which must take place at all levels of society. In this process it is important that the implicated individuals are involved and in a position to participate in defining the meaning and values of their own characteristics, markers and social identities. Some groups may wish to maintain their distinct group identities, languages, traditional beliefs, worldviews and ways of life,[49] without integrating into mainstream society. This should be possible in an inclusive society, as social inclusion implies that the rules of society apply to all identity groups, without necessarily integrating the identities of individuals or groups.[50] Social inclusion processes aims at ensuring that society is accepting of all people, and those who are different from others are not only included, but given the possibility to participate in decision-making processes that affect their lives. The effect of everyone having the possibility to participate in defining the meaning of their own social identities will be a society which is inclusive and participatory, which embraces diversity and instills a sense of belonging.

The following section contains a discussion of some of the important social groups where the issue of social inclusion is most relevant. These groups include women, youth, and older

[48] Untied Nations, DESA, Participatory Dialogue: Towards a stable, safe and just society for all, 2007
[49] Resource Kit on Indigenous Peoples' issues, United Nations, DESA, 2008, page, 7
[50] Participatory Dialogue: towards a stable, safe and just society for all, United Nations, DESA, 2007

DRAFT

persons, persons with disabilities, indigenous peoples, migrants, ethnic and religious minorities, and people living with HIV/AIDS.

Women

> *"It is impossible to realize our goals while discriminating against half the human race" Kofi Annan 2006*[51]

Around the world, traditional gender roles and deeper structural inequalities related to power imbalances rooted in patriarchal societies continue to place women at a disadvantage relative to men in all spheres of life. Many of these power-imbalances are acted out in the space of the household. Women are subject to social exclusion caused by issues such as poverty, power imbalances, gender-based violence, conflict, restrictions in access to resources and exclusion from decision-making. Women continue to bear a disproportionate burden of poverty and constitute the majority among 1 billion people living in extreme poverty[52]. Their persistent limited access to credit, land and training in new technologies and fewer educational and employment opportunities, inhibit efforts to extricate them from poverty. Women's labor is more likely than men's to be underpaid or unpaid. Women constitute over 60 per cent of unpaid family workers, meaning that women of all ages continue to lack access to job security and social protection.[53] Violence against women is a pervasive violation of women's human rights and a major impediment to achieving gender equality and social inclusion of women. Women's access to formal peacemaking and peace building processes remains limited - they are hardly present during negotiations for peace agreements.[54] Furthermore, women's political participation is weak - globally, as of January 2007, women represented only 17 per cent of single and lower houses of parliament.[55] It is important to note that being a woman does not necessarily create a condition for exclusion as women are not a homogenous group.

Youth[56]

> *"There is an urgent need for policy-makers to develop clear strategies and policies aimed at promoting the participation of young people as important stakeholders, actors and partners. Such strategies include: setting youth issues as a national priority; identifying existing youth networks and youth leaders and involving them in policy-making processes; exploring policy options; providing opportunities for policy dialogue with youth, and building institutional capacity." (Expert Group Meeting on "Youth in Africa: Participation of youth as partners in peace and development in post-conflict countries", Namibia, 2006)*

DRAFT

[51] Quoted in DFID 2007. Gender Equality Action Plan 2007-2009: making faster progress to gender equality
[52] Progress report and collection of resources on Women and Poverty by the UN International Research and Training Institute for the Advancement of Women. INSTRAW, 2006
53 United Nations 2007. The Millennium Development Goals Report 2007
[54] General Assembly Sixty-second session, Introductory Statement by Ms. Rachel Mayanja, Assistant Secretary-General Special Adviser on Gender Issues and Advancement of Women, 15 October 2007
[55] The Millennium Development Goals Report 2007, United Nations, New York, 2007
[56] The United Nations defines 'youth', as those persons falling between the ages of 15 and 24 years inclusive. It is, however, the operational definition and nuances of the term 'youth' often vary from country to country, depending on the specific socio-cultural, institutional, economic and political factors. Within the category of "youth", it is also important to distinguish between teenagers (13-19) and young adults (20-24).

Young people between the ages 15 and 24 years, constituted 18 per cent (1.2 billion) of the world's population in 2007, and are considered to be best educated youth generation in history[57]. They are also better equipped to explore abundant and diverse information and knowledge worldwide through information and communication technology. However, these advantages do not necessarily bring benefits to many young people, especially those living in developing countries. They are facing exclusion in economic social and political participation. Unemployment and underemployment is significantly higher among youth in many countries in the world.

The difficulty of finding decent work and productive employment is compounded by a host of other problems confronting young people, including illiteracy and insufficient training. The crisis of youth unemployment deprives young people of the opportunity to secure independent housing or the accommodations necessary for the establishment of families and participation in society. Unemployment creates a wide range of social ills and young people are particularly susceptible to its damaging effects: the lack of skills, low self-esteem, marginalization, impoverishment and social exclusion.[58] Furthermore youth unemployment can lead to increased vulnerability among young people to drugs and crime, which leads to further social exclusion. There is evidence that unemployment can expose youth to greater risks of lower future wages, repeated periods of unemployment, longer unemployment spells as adults, and income poverty, and thereby lead to the risk of life-long social exclusion.[59]

Many adults believe that the benefits of youth participation accrue mainly to the young people themselves, rather than to society as a whole. For example, youth are often invited to participate in adult-organized or political activities in ways that are tokenistic or symbolic. In addition, approaches to youth participation are frequently shaped by the expectations of adults on what youth will do or say, thereby limiting the involvement and input of young people.[60] Often the limitations which adults set on youth are the product of negative stereotyping in which youth are generalized as being immature, radical or rebellious.

Girls and young woman face certain risks, which may lead them to social exclusion. Measures are still inadequate to protect girls and young women from various forms of gender-based violence, including harmful traditional practices, such as female genital mutilation, forced early marriages, trafficking and sexual abuse. Early pregnancies and unsafe abortions are a major health risk for girls and young women around the world[61]. In addition to the stigma involved the unavailability of childcare services forces young mothers to drop out of school, which reduces their employability and increases the possibility of social exclusion in the future.

Older Persons

[57] World Youth Report 2007, UN, 2007
[58] The World Programme of Action for Youth on Employment, 1995 (A/RES/50/81)
[59] Conference room paper Commission for Social Development, Forty-fifth session, 7-16 February 2007, Item 3 (c) of the provisional agenda, Follow-up to the World Summit for Social Development and the twenty- fourth special session of the General Assembly: Emerging Issues - Youth Employment: Impact, Challenges and Opportunities for Social Development
[60] Sunaina Maira (2007). Youth and Participation in Decision-Making. Paper presented at the Expert Group Meeting for the World Programme of Action for Youth: "Youth in Civil society" and "Youth and their Well-being" (19-21 May 2008) United Nations Headquarters, New York.
[61] United Nations 2007. World Youth Report 2007. Young People's Transition to Adulthood: Progress and Challenges. (Sales No. E.07.IV.1)

DRAFT

Older persons are a growing segment of the population, particularly in developed countries. One out of every ten persons is now 60 years or above, and it is predicted that by 2050, one out of five will be 60 years or older; and by 2150, one out of three persons will be 60 years or older[62]. In some developed countries today, the proportion of older persons is already one in four. During the first half of the 21st century that proportion will be close to one in two in some countries.[63] Exclusion of older persons is extremely common. In some ageing societies, a negative view around ageing has developed among young people, and some media use the term, "age wars", citing age-based competition over resources (particularly for health care and income security). The consequence of age-prejudice is the perpetuation of a mental "age ghetto" that is detrimental to society and, evidently, to the youth themselves as they grow old.[64]

While still in the workforce older workers face barriers in promotions and hiring. In many countries, companies more or less openly refuse to hire people above a certain age despite the increasing lifespan and average age of the population. Employers may also encourage early retirement or lay off disproportionately older/more experienced workers. For those who are no longer working, the loss of the sense of belonging and meaningfulness associated with work, and the engagement in a working population at large with a common goal, can be difficult.[65]

Despite prevalence in many places of narrow stereotypical images of older persons, the reality is that human diversity increases with age and the accumulation of life time experience enriches the different ways in which older people can negotiate their identity. The trends mentioned above, call for measures that will restore the possibility for easy interactions and collaborations of the generations. Also, the developmental potential and diversity of late life need to be explored and supported, while also addressing the health care and income security needs of this stage of life.

Persons with Disabilities

Persons with disabilities constitute a group at risk of exclusion. They are often denied the opportunities of full participation in the activities of the socio-economic and cultural system which they are part of. This deprivation comes about through physical and social barriers that have evolved from ignorance, indifference and fear. In most parts of the world there are deep and persistent negative stereotypes and prejudices against persons with disabilities, which lead to social exclusion. There are an estimated 650 million persons with disabilities worldwide, or 10 per cent of the global population. Approximately two thirds live in developing countries. In certain developing countries nearly 20 per cent of the general population in some way has a disability.[66]

Many persons with disabilities are excluded from active participation in society because of barriers for their physical access to public space, such as: doorways that are too narrow for wheelchairs; steps that cannot be mounted leading to buildings, buses, trains and aircraft; telephones and light switches that cannot be reached; sanitary facilities that cannot be used. Similarly they can be excluded by other types of barriers, for example oral communication which ignores the needs of the hearing impaired and written information which ignores the needs of the visually impaired. Such barriers are the result of ignorance and lack of concern;

[62] The Population Division, DESA United Nations
[63] http://www.un.org/esa/socdev/ageing/popageing.html
[64] http://www.un.org/esa/socdev/ageing/society_steps_fostering.html
[65] http://www.un.org/esa/socdev/ageing/index.html
[66] Demographic yearbook ask Vanessa for exact reference

DRAFT

they exist despite the fact that most of them could be avoided at no great cost by careful planning.[67] People tend to avoid contact and personal relationships with those who are disabled. The pervasiveness of the prejudice and discrimination affecting persons with disabilities and the degree to which they are excluded from participating in social interaction, produce psychological and social problems for many of them. The language used to refer to persons with disabilities has also played a significant role in the social exclusion of persons with disabilities. Terms such as "crippled" or "mentally retarded" are clearly derogative.[68]

Indigenous Peoples

Indigenous peoples have historically faced social exclusion and marginalization. They are disproportionately represented among the poor and extremely poor and their levels of access to adequate health and education services are well below national averages. Indigenous peoples number about 300 to 370 million globally. While they constitute approximately 5% of the world's population, indigenous peoples make up 15% of the worlds poor. Furthermore, indigenous peoples make up about one third of the world's 900 million extremely poor rural people.[69] Indigenous peoples face huge disparities in terms of access to and quality of education and health. In Guatemala, for example, 53.5% of indigenous young people aged 15-19 have not completed primary education, as compared to 32.2% of non-indigenous youth.[70] In Bolivia, the infant mortality rate among the indigenous population is close to 75/1000, as compared to 50/1000 for the non-indigenous population.[71] Indigenous peoples around the world have sought recognition of their identities, their ways of life and their right to traditional lands, territories and natural resources; yet throughout history, their rights have been violated.

Indigenous women suffer from multiple discriminations, both as women and as indigenous individuals. They are subjected to extreme poverty, trafficking, illiteracy, lack of access to ancestral lands, non-existent or poor health care and to violence in the private and the public sphere. This violence is exacerbated when indigenous communities find themselves in the midst of conflict and women become the target of violence with political motives, when going about their daily work, fetching wood or water for the family. Indigenous children and youth also face extreme problems and social exclusion caused for example lack of health care service, incarceration and lack of legal protection, forced relocation and loss of land, lack of culturally appropriated education, illiteracy and drop-out rates, trafficking and sexual exploitation. [72]

Migrants

One in every fifty human beings – more than 190 million persons – lives outside of their countries of origin as migrants. [73] Migrants differ in terms of ethnicity, religion, beliefs, languages and traditions from those in the communities to which they move. As a result, they

[67] World Programme of Action Concerning Disabled Persons, adopted by the General Assembly on 3 December 1982, by its resolution 37/52
[68] http://www.un.org/disabilities/
[69] IFAD (2007), *Statistics and key facts about indigenous peoples*
[70] UNESCO (2004), *La conclusión universal de la educación primaria en América Latina: ¿estamos realmente tan cerca? Informe Regional sobre los objetivos de desarrollo del Milenio vinculados a la educación*
[71] ECLAC (2005), *Millennium Development Goals: A Latin American and Caribbean Perspective*
[72] http://www.un.org/esa/socdev/unpfii/index.html
[73] *Trends in total migrants stock: the 2005 revision*, United Nations, Department of Economic and Social Affairs, Population Division, February 2006

are often victims of discrimination, racism, xenophobia and social exclusion, having little or no participation, influence or communication with the processes in society. The fact that an increasing proportion of international migration today is irregular and unauthorized facilitates abuse and exploitation. But, even when their movements are legal and authorized, non-citizens face high levels of discrimination.[74]

Quite often migrants are geographically marginalized, grouped together in areas of disadvantage with little or no access to the mainstream labor market and economic and social opportunities. Cheaper and more available housing outside of cities can become the area where migrant's communities convene or conversely over-populated and disadvantaged urban areas. Access to services and transport may be hindered by location essentially excluding and marginalizing migrant communities.

The inclusion of migrants into the mainstream society can be hindered by a variety of forces: exclusionary social policies which unfairly exclude migrants from access to health, education and social security systems, or exclusionary elements within labor markets, which discriminate against migrants by non-recognition of qualifications and exclusion from some jobs on the basis of background rather than qualifications or proven ability and experience; citizenship and residency qualification guidelines that restrict access of immigrants and their children (and subsequent generations) and immigrant groups' cultural and linguistic rights not being recognized in all host societies.[75]

Ethnic and Religious Minorities

Every large society contains ethnic, religious or linguistic minorities (Note[76]). Ethnic minorities may be migrant, indigenous or landless nomadic communities. Ethnic identity is marked by the recognition from others of a group's distinctiveness and by common cultural, linguistic, religious, behavioral or biological traits. Persons belonging to religious minorities have a faith which is different to that held by the majority.

Ethnic and religious minorities are often victims of discrimination, racism, xenophobia and social exclusion. In some countries, people may be prosecuted for their religious faith and practices. Xenophobia towards ethnic and religious minorities can in some cases be directed against a group which has been present for centuries. This form of xenophobia can elicit or facilitate hostile and violent reactions, such as mass expulsion of immigrants, or in the worst case, genocide. It is worth noting that some ethnic or religious minorities choose to maintain their cultural or religious identities, and intentionally resist any attempts to assimilate themselves into mainstream society. These groups should however also be included and given an opportunity to actively participate in political, economic, social and cultural activities in their societies.

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[74] *International Migration, Racism, Discrimination and Xenophobia*, A publication jointly produced by: International Labour Office (ILO), International Organization for Migration (IOM) and Office of the United Nations High Commissioner for Human Rights (OHCHR) In consultation with Office of the United Nations High Commissioner for Refugees (UNHCR). August 2001

[75] Aki has forgotten to put the complete reference in the reference list !!! Hugo, 2005: 30-31…

[76] Note: Minority is understood as a sociological group that is disadvantaged to a dominant group, in various areas, such as, social status, education, employment, wealth or political power. Minority does not mean population minority group.

Ethnic and religious minorities are not necessarily small groups; they may consist of one third or even a half of a country's population. Nevertheless, members of minority groups may be treated differently in their society, which often creates tension between majority and minority groups. Countries where "power and wealth are very unfairly distributed between ethnic or religious groups" are more prone to conflicts, and therefore there is a need to "promote political arrangements in which all groups are fairly represented, combined with human rights, minority rights and broad-based economic development.[77]" The diversity that minorities bring to the nations should be understood as important contributions to the society.

People living with HIV/AIDS

> "*Since the beginning of the epidemic, stigma, discrimination, and gender inequality have been identified…as major obstacles to effective responses to HIV. Yet there has never been serious political and programmatic commitment to doing anything about them."* [78]
> *Peter Piot, Executive Director, Joint United Nations Programme on HIV/AIDS*

People with diseases are often subject to social exclusion, and people living with HIV and AIDS are particularly often subject to discrimination, human rights abuses and social exclusion. Stigma and discrimination operate at multiple levels throughout society: within individuals, families, communities, institutions and media, and in government policies and practices.[79] In many countries and communities, the stigma associated with HIV/AIDS and the resulting discrimination can be as devastating as the illness itself: abandonment by spouse and/or family, social ostracism, job and property loss, school expulsion, denial of medical services, lack of care and support, and violence.[80] Civil society reports from over 30 countries indicate that stigma and discrimination against people living with HIV/AIDS remains pervasive. 40% of countries, including half of the countries in sub-Saharan Africa, have yet to adopt anti-discrimination laws to protect people living with HIV/AIDS.[81]

Furthermore, stigma and discrimination constitute one of the greatest barriers to dealing effectively with the epidemic. Stigma and discrimination discourage governments from acknowledging or taking timely action against HIV/AIDS. They deter individuals from finding out about their HIV status. And they inhibit those who know they are infected from sharing their diagnosis and taking action to protect others and from seeking treatment and care for themselves.[82]

Women living with HIV in general experience greater stigma and discrimination than men and are more likely to experience its harshest and most damaging forms, and have fewer resources

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[77] Kofi Annan, Secretary-General of the Untied Nations in his statement on presenting his Millennium Report, 3 April 2000.

[78] Piot, P., *How to reduce the stigma of AIDS,* Keynote address. August 12, 2006: Symposium at the XVI International AIDS Conference, Toronto.

[79]Heijnders, M. and Van der Meij, S.. The fight against stigma: An overview of stigma-reduction strategies and interventions. *Psychology, Health and Medicine*, 2006. 11(3): p. 353-363.; Ogden, J. and L. Nyblade, Common at Its Core: HIV-Related Stigma Across Contexts. 2005, International Center for Research on Women: Washington, DC.

[80] UNAIDS, 2007. Report: Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes- A resource for national stakeholders in the HIV response

[81] Combating stigma and discrimination is vital to improving access to HIV/AIDS care, say UNAIDS and WHO, Press release Kampala, Uganda, 26 October 2003, http://data.unaids.org/Media/Press-Releases01/kampala_pr_26oct03_en.pdf

[82] http://www.unaids.org/en/PolicyAndPractice/StigmaDiscrim/default.asp

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for coping with it. Violence is a severe consequence of stigma faced principally by women. Both women and girls report increased violence at the hands of their partners for requesting condom use, accessing voluntary testing and counseling, refusing sex within or outside marriage or for testing HIV-positive. [83]

IV. APPROACHES TO PROMOTING SOCIAL INCLUSION

> *Promoting respect for democracy, the rule of law, diversity and solidarity and removing institutionalized inequalities are critical to successful social integration. To that end, national Governments and their development partners have utilized the educational systems and the various media to advance an understanding of the multiple facets of social integration and to promote tolerance in their societies. Participation by all, including civil society organizations, in policy formulation, implementation and monitoring requires responsive and accessible Government as well as capacity of and opportunity for all, especially the vulnerable and groups with special needs. Equity, social justice and equality of access and opportunity, for both basic services and work, are important concepts to promote social integration.*
>
> *The Copenhagen Declaration and Programme of Action[84], which was further underscored in the five year review of implementation of the Summit.*

Social inclusion, as a multi-dimensional process to create conditions, which enable full and active participation in all aspects of life, is a concept with universal appeal. It is evident that social inclusion must be and has become a priority in international policy discourse. However, the challenge lies at the core: how to apply the concept in real life situations, and how to operationalize it through mobilizing all actors in society, at the local, regional, national, and international levels.

There are numerous ways to promote social inclusion and remove impeding obstacles. Important are protection and empowerment of the vulnerable and marginalized, proclaiming the right to differ, and eliminating discrimination based on attributes, such as gender, age and ethnicity. Social inclusion can also be approached as an overarching cross-sectoral concept, which will then be incorporated, as an objective and a process, into sectoral policies, strategies, programmes, and other initiatives. Each policy or strategy must be reviewed as to whether it is inclusive, and if participatory measures are installed in the policy formulation, implementation and monitoring processes. This approach is particularly useful when tackling the structural aspects of social inclusion/exclusion, in areas such as poverty eradication, employment and education. Institutional structures need to be transformed and institutional capacities need to be strengthened to promote social inclusion. Strategies need to be devised for enhancing visibility, taking into consideration the individual's needs and concerns, facilitating dialogue, and promoting community participation. The following sections discuss some of the existing frameworks and approaches and provide an overview of conceptual framework considered to be most relevant in promoting social inclusion.

[83] UNAIDS, 2007. Report: Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes- A resource for national stakeholders in the HIV response

[84] This was further underscored in the five year review of implementation of the Summit (E/CN.5/2005/6, para 166)

REMOVING THE OBSTACLES TO SOCIAL INCLUSION

Eliminating/Amending Discriminatory Laws and Practices

Many exclusions stems from discrimination of individuals or groups on the grounds of their attributes, or social, economic or physical disadvantages. The act of discrimination is a violation of international human rights, as human rights ensure that every single human being is entitled to enjoy his or her rights without unreasonable distinction as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status. Human rights are founded on respect for the inherent dignity and worth of each person, and are applied equally and without discrimination to all people. Eliminating or amending customary laws or practices that are discriminatory will be the fundamental first step to lay the foundations for an inclusive society.

There are core legally binding international human rights treaties within the United Nations human rights system, which can be effectively applied to promote inclusion of vulnerable groups. These are: Convention on Civil and Political Rights (ICCPR), Convention on Economic, Social and Cultural Rights (ICESCR), Convention on the Elimination of All Forms of Racial Discrimination[85] (CERD), Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), Convention on the Rights of Persons with Disabilities (CPRD), and Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICPMW)[86].

In addition, there are many other universal instruments relating to human rights, including the Universal Declaration of Human Rights. Among those, the following are useful to address the issue of those who belong to vulnerable groups. For the rights of indigenous peoples and minorities, Declaration on the Rights of Indigenous Peoples[87], Indigenous and Tribal Peoples Convention (1989), Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities[88], Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief[89] and United Nations Principles for Older Persons[90].

Special Rapporteurs are appointed to monitor the effective implementation of these Conventions and Declarations. For example, the mandate of the Special Rapporteur on freedom of religion or belief[91], is to examine "incidents and governmental actions in all parts of the world which are inconsistent with the provisions of the Declaration on the include Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief" as well as "to recommend

[85] Here, "racial discrimination" is defined as "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life

[86] http://www2.ohchr.org/english/law/index.htm#core

[87] Adopted by the General Assembly Resolution 61/295 of 13 September 2007

[88] Adopted by General Assembly Resolution 47/135 of 18 December 1992

[89] Adopted by General Assembly Resolution 36/55 of 25 November 1981

[90] Adopted by General Assembly Resolution 46/91 of 16 December 1991

[91] Created by the Commission on Human Rights in 1986, in its resolution 1986/20 (check)

remedial measures"[92]. In order to monitor the way which States Parties are fulfilling their human rights obligation under the respective treaty, mechanisms have been developed for each Convention[93], including monitoring Committees and Optional Protocols, which allow any individuals or groups to submit their complaints directly to the Committee. For example, the Committee on the Elimination of Racial Discrimination is monitoring discrimination against minorities through examining the periodic reports. In addition, since 1993, the Committee developed early warning measures to prevent serious violations of the Convention, with the aim to prevent existing problems from escalating into conflicts.[94] However, as further addressed in the following section, these Conventions and International Treaties, national laws to eliminate inequality and/or discriminations have limited effects, due to lack of enabling environments, such as easy access to information, appropriate mechanisms and funds for enforcement, empowerment of those who are marginalized or disadvantaged to enable their participation.

Special Measures

Some Conventions allow State Parties to take special measures to eliminate discrimination and stereotyping or protect the rights of certain specific groups in order to meet their particular needs. For example, ILO Convention No. 111 specifically refers to special measures to address the situation of indigenous and tribal peoples.[95] Another example is the article 5 of CEDAW, which requires to take "all appropriate measures to modify the social and cultural patterns of conduct of men and women", in order to "eliminate prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women".

Quota systems are another effective way of ensuring inclusion of excluded groups into employment opportunities and political institutions. For example, in the case of determining women's political representation, the most decisive factor remains gender quota systems. In 2006, countries with quotas nearly doubled the number of women elected, compared to countries without any form of gender quota system.[96]

International Policy Frameworks pertinent to social groups

Achieving social inclusion requires long-term strategic response on the part of all institutions and organizations, also at an international level. There are mechanisms in place through a variety of international bodies and groups to support empowerment and capacity building of vulnerable and disadvantaged groups, including women, youth, older persons, persons with disabilities, and indigenous peoples. In this area, comprehensive frameworks have already been developed with their implementation action plans or programmes adopted at the United Nations summits and conferences. Among others, the following are important: The Beijing Platform for Action; The World Programme of Action for Youth; The Madrid International Plan of Action on

[92] Since 1994, the Special Rapporteur has on a yearly basis been requested to report to the General Assembly, as reiterated most recently in General Assembly resolution 61/161.
[93] Pamphlet No. 4 of the UN Guide for Minorities
http://www.ohchr.org/Documents/Publications/GuideMinorities4en.pdf and also see:
http://www2.ohchr.org/english/law/minorities.htm
[94] Pamphlet No.4 of the UN Guide for Minorities
[95] Eliminating discrimination against indigenous and tribal peoples in employment and occupation, A Guide to ILO Convention No. 111 (2007)
[96] Statement by Ms. Rachel Mayanja, Special Adviser of the Secretary-General on Gender Issues and Advancement of Women at the 10th session of the Regional Conference on Women in Latin America and the Caribbean, Quito, Ecuador, 6 August 2007

Ageing; World Programme of Action Concerning Disabled Persons. These commitments are expected to be implemented nationally and sub-nationally. Further efforts should, therefore be centered around effective implementation of these frameworks and programmes of action concerning the vulnerable groups and individuals at national, regional and local levels, in order to promote social inclusion.

The issues pertinent to these social groups are discussed at the following inter-governmental forum, the Commission for Social Development and the Commission on the Status of Women. These functional commissions of the Economic and Social Council (ECOSOC) meet annually to monitor the progress of the implementation of these international agreements, [97] submit recommendations to ECOSOC, which will subsequently be adopted at the General Assembly. In addition, the UN Permanent Forum on Indigenous Issues serves as an advisory body to the ECOSOC, providing expert advice and recommendations on indigenous issues. A Forum on Minority Issues[98] has also been established in 2007, which provides a platform for promoting dialogue and cooperation on issues related to national or ethnic, religious and linguistic minorities. This Forum will provide thematic contributions and expertise to the work of the independent expert on minority issues, as well as identify and analyze best practices, challenges, opportunities and initiatives for the further implementation of the Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities.

Transforming the Mindset of People

While changes in legislation and policies supportive of vulnerable and marginalized groups, improvements in their access to resources and participation are fundamental steps to take, they do not by themselves, change relations of power, as their implementation is frequently obstructed by entrenched structures and values, and undesirable discourses, with culture and religion continuing to be used by a privileged few to legitimize unequal power structures. Unequal power relations must therefore also be challenged and transformed at the meso- and micro-level if social inclusion is to be enhanced. Social inclusion of the excluded groups can only happen if everyone becomes "part of the group" that defines the culture, values and standards of the society in which they live. Actions which can be used towards this purpose include education, dialogue and public awareness campaigns. [99]

It is vital that the entire educational system is geared towards addressing the patterns of exclusion, and promoting pluralism, and respect for diversity and dialogue, as exclusionary behavior is often perpetuated through educational curricula. School curricula promoting social inclusion should be established, for example, a curriculum offering theoretical understanding of how we fit into a larger global. Faith-based organizations and media can also play a major role in transforming people's mindset, and therefore should be included as important stakeholders in the endeavor in promoting social inclusion. Both faith-based organizations and media can be very effective in increasing socially inclusive discourse and reduction of use of language, which causes categorization and discrimination.

The process of social inclusion should not merely be reversing the social order from one group to another, but should be transforming a society into a new, more inclusive one. It is a process to

[97] See: http://www.un.org/esa/socdev/
[98] Human Rights Council resolution 6/15 of 28 September 2007
[99] Quoted from message from forum: "*Where's the Power in Women's Empowerment?"* organized by the UN Economic and Social Commission for Asia and the Pacific (ESCAP). organized by Ms. Noeleen Hayzer, Under-Secretary-General and ESCAP's Executive Secretary

"level the playing field" for both the disadvantaged and advantaged, which is required for social transformation. Transforming the mindset of people is about creating solidarity and about the realization that though there are differences we are all human beings; it is about encouraging the acceptance of others and interrelations among groups who may not share affinity, common values, or have empathy towards one another. So far, efforts tend to focus on empowering those who are marginalized through cultivating confidence and capacity, but not so much on strengthening the capacity of the dominating majority. It is critical, however, to engage the people in mainstream society, so that they feel more comfortable in embracing those who are excluded, feel less insecure for their participation, and are ensured that the inclusion of individuals and groups with different cultures, beliefs or values does not pose a threat to them.

Participatory dialogue can be an effective tool to create a safe space for people with different backgrounds to create positive relationships and common understandings. Unlike negotiation or mediation, dialogue focuses on building relations and trust among individuals or groups that hold fundamentally different positions, which are grounded in different values, culture, identities or world views. These issues, involving values, belief or identity, are so deep-rooted that there is very little space for compromise. And in such circumstances, "the traditional method of conflict resolution does not produce the expected results, as parties involved feel threatened, and there is upsurge in stereotyping, misrepresentation, and marginalization".[100] Dialogue can facilitate lowering boundaries between those who are excluded and included, through providing opportunities for learning each other's points of view as well as feelings, which will create human connection and mutual understanding, and eventually mutual trust. When people do not have to "give up" something of value, they are more likely to behave in a less self-defensive manner, and engage in the process to create a common future for society.

INCLUSIVE POLICY FRAEWORK

Once policies have determined and prescribed an outline of action to be taken, the institutional mechanisms at the national level must take on the responsibility of implementation. To promote social inclusion, the legal systems and security forces must be impartial and uphold the most basic rights for all members of society. Schools, universities and governments must assure the access and accessibility to education for every individual. Social institutions must develop and create housing and welfare systems, training programmes and promote knowledge, information and community responsibility.

Governance and policy-making processes need to become more transparent and inclusive in their functioning and also uphold social inclusion principles. Policy must be tailored and rewritten to reflect the needs, concerns, languages and cultures of diverse population. If the aim is to have an inclusive society, where everyone participates and engages with societal and governmental processes, then it is necessary to encourage or create a system where socially excluded groups become stakeholders in the social, political and economic process and the success of a society. Simply writing a policy which includes them will not create this. If people feel that they have a voice then they will be encouraged to include themselves. The chance to use this voice must be offered and members of society must be engaged.

Finally, it is important to understand that inclusive policies apply to everyone, and should not be understood as a special treatment for certain groups, which often exacerbate the existing division rather than create unity in society. The core idea of social inclusion is ensuring equal

[100] Participatory Dialogue: Towards a stable, safe and just society for all", UN 2007, page 56 – 57.

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treatment of all regardless of their background, so that everyone has equal opportunities and access, equal rights and responsibilities, and is able to participate in all aspects of their life activities. Social inclusion is an overarching concept that aims at transforming our thinking, process, policies, strategies, and programmes. While there is a need to target our efforts to empower those who are excluded, it is also important to make the mainstreaming society more inclusive. And this will require the efforts of not only government, but also every individual, community, local authorities, civil society organizations, faith-based organizations, the private sector, as well as the very people and groups who are disadvantaged and marginalized. Everyone has a stake and responsibility in achieving an inclusive society.

Setting Social Inclusion Objectives

Based on the overall framework established at the international level, national governments need to identify their own social inclusion goals and objectives, incorporating their specific needs and context. The broad social inclusion goals or objectives need to be connected to the particular vision people have for their society – a positive image of an inclusive society of the future. This vision needs to be framed as concretely as possible, which allows effective monitoring and analysis, possibly using a set of indicators. These goals and objectives then trickle down to local and community levels, so that there is coherence between goals set at the national and local levels. The objectives set by each community may differ, but the broad overall goals or principles should be commonly shared across communities.

In addition to objectives, it is useful to set a couple of principles to make social inclusion goals more explicit. Such principles may be: shared future, rights and civic responsibilities, mutual respect, respect for diversity, social cohesion, equality, equity, social justice, social contract, trust in the institutions as well as in neighbors, sense of belonging, inter-connectedness, etc.

A good example of social inclusion objectives and principles has been formulated by the UK Social Unit's Commission on Integration and Cohesion[101]. The primary concern of the Commission is social cohesion that encompasses racial, ethnic and religious differences, primarily arising out of the community conflicts which emerged recently. (See Text Box XX) A second example is a set of objectives from the "Good Relations" work of Northern Ireland, which was recently a conflict-ridden divided society. (See Text Box XX).

[101] Report of the Commission on Integration and Cohesion, "Our Shared Future" (2007) http://www.integrationandcohesion.org.uk/Our_final_report.aspx

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Setting Objectives

The Commission on Integration and Cohesion of UK was established in 2006 to promote social cohesion that encompasses racial, ethnic and religious differences. Their objectives are expressed in the following terms:

- *There is a clearly defined and widely shared sense of the contribution of different individuals and different communities to a future vision for a neighbourhood, city, region or country*
- *There is a strong sense of an individual's rights and responsibilities when living in a particular place people know what everyone expects of them, and what they can expect in turn.*
- *Those from different backgrounds have similar life opportunities, access to services and treatment.*
- *There is a strong sense of trust in institutions locally to act fairly in arbitrating between different interests and for their role and justifications to be subject to public scrutiny.*
- *There is a strong recognition of the contribution of both those who have newly arrived and those who already have deep attachments to a particular place, with a focus on what they have in common.*
- *There are strong and positive relationships between people from different backgrounds in the workplace, in schools and other institutions within neighbourhoods.*

(Fitzduff, 2007:4)

Table XX

In Northern Ireland, improving relationships between and within communities is a long term goal. The "Good Relations Indicators Working Group" was established to identify and develop a set of high level, outcome focused indicators to monitor the impact of the policy and strategic framework of good relations over time. The priority outcomes were identified as follows.

1. *Northern Ireland society is free from racism, sectarianism and prejudice.*
2. *All places are shared, safe, inclusive and welcoming for everyone.*
3. *Positive and harmonious relationships exist between communities at interface areas.*
4. *Increased sharing in education*
5. *Northern Ireland is a community where people of all backgrounds work, live, learn and play together.*
6. *All work places are safe and shared.*
7. *Minority ethnic people participate in public, political and economic life.*
8. *Minority ethnic people benefit from equality in health and welfare.*
9. *Northern Ireland is a place where cultural diversity is embraced, respected, valued.*
10. *Victims/survivors have a voice.*
11. *Public service delivery in Northern Ireland provides value for money on a shared, inclusive and equal basis.*

Source: Good Relations Indicators Baseline Report (2007) http://www.ofmdfmni.gov.uk/good-relations-report.pdf

Table XX

Mainstreaming Social Inclusion Objectives

Once social inclusion goals and principles are set, the next step is mainstreaming social inclusion goals and objectives in various legislations, sectoral policies, strategies, programmes and projects, for example mainstreaming social inclusion goals and objectives into education policies, employment policies, or poverty reduction policies, or public information policies. Other examples are: mainstreaming of the rights of persons with disabilities into the wider development agenda[102] and mainstreaming of gender perspectives across legislation and policies.

Social inclusion may be perceived as a big step or as involving a dramatic change. This notion should be dispelled, as the mainstreaming of the concept of social inclusion is very achievable and would constitute in many areas only slight changes but with very significant effect. The concept should be approached as a positive development tool, one committed to creating a sustainable and increasingly successful society for all. Respecting and accommodating diversity, while sustaining or even enhancing economic growth and cultural and community benefits, as well as personal and collective satisfaction - such a vision of inclusiveness should be endorsed by every member of society.

There are many areas in which the ideals of social inclusion can be implemented. It is necessary to identify the main themes and situations where positive, measurable and effective change can be brought about. It seems as though the fostering of a stake-holders attitude in all members of society so that an investment in the economic, political and social processes is seen as productive, useful and effective, is the most explicit goal in achieving the objectives of social inclusion.

The EU objectives for Social Protection and Social Inclusion exemplify how social inclusion can be comprehensively addressed as a common priority area (see table XX). The European Union is presently in an optimal position to tackle social inclusion and exclusion issues with an overarching justice system and many common policies, goals and a joint commission. Coming out of the Lisbon Agenda (2000), social inclusion has become one of the priority areas of EU development policy. The objectives highlight the cross-disciplinary and multidimensional character of inclusion linked to sectoral policies and statistical data (indicators) for all EU member states.

EU Objectives for Social Protection and Social Inclusion

EU Social Protection and Social Inclusion Process currently covers three strands: Social Inclusion; Pensions; and Healthcare and Long-term Care

Three objectives of Social Inclusion strand are:

In order to make "a decisive impact on the eradication of poverty and social exclusion", three objectives were set under the social inclusion strand, that are:

- "access for all to the resources, rights and services needed for participation in society, preventing and addressing exclusion, and fighting all forms of discrimination leading to exclusion";

[102] Report of the Secretary General on the Implementation of the World Programme of Action concerning Disabled Persons [A/62/157], 2007

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- ”the active social inclusion of all, both by promoting participation in the labour market and by fighting poverty and exclusion”;
- ”that social inclusion policies are well-coordinated and involve all levels of government and relevant actors, including people experiencing poverty, that they are efficient and effective and mainstreamed into relevant public policies, including economic, budgetary, education and training policies and structural fund programmes”.

Key Priorities of the EU

- increase labour market participation by expanding active policies and ensuring a better linkage between social protection, education and lifelong learning;
- Modernize social protection systems to ensure they are sustainable, adequate and accessible to all;
- Tackle disadvantages in education and training by investing more in human capital at all ages and focusing particularly on the most disadvantaged groups;
- Eliminate child poverty by guaranteeing their education, increasing the assistance given to their families and ensuring that their rights are protected;
- Ensure decent accommodation for vulnerable groups and develop integrated approaches to tackling homelessness;
- Improve access to quality services in the fields of health, social services, transport and the new information and communication technologies;
- Eliminate gender-based discrimination and increase the social integration of people with disabilities, ethnic minorities and immigrants.

Source: Joint Report on Social Protection and Social Inclusion 2005

Table XX

COSTS AND BENEFITS OF SOCIAL INCLUSION

Some question whether the costs of promoting social inclusion and participation are worth the benefits. Contrary to a widely shared view, economic constraints to redress in equality and exclusion are not very robust. In fact, many countries that achieve relatively equal societies demonstrate stronger economic competitiveness. (Therborn: 2007) Moreover, the cost of inclusion should not be approached through only economic terms, as it also includes social costs, which need to be carefully examined. The consequences for not including a part of the society will be significant in the long run: increase in insecurity, high crime rates, brain drain, emigration, social conflict, expansion of slums, instability, urban violence, divided societies, and violent conflict, etc.

Social inclusion could also be viewed as an opportunity cost. There is, not only social costs of excluding some, but also lost opportunity by not including them. For example, in a globalized world, understanding people with different backgrounds, their culture, their customs and values, has added-value. Those individuals, employers, or institutions who understand diverse views appeal to a wide range of population, and are therefore, more likely to succeed. For example, in a global marketplace, a company that employs a diverse workforce is more creative, innovative, and better able to understand the demographics of the marketplace it serves and is thus better equipped to thrive in that marketplace than a company that has a more limited range of employee demographics.[103]

[103] Bassett-Jones, N. and Lloyd, G. (2005) 'The paradox of diversity management', *Journal of Creativity and Innovation Management*, vol. 14, no. 2, pp. 169-175, June

The cost of social inclusion is ultimately a matter of political will, as those who are advantaged are skeptical to change as they have vested interest in maintaining status quo. Building awareness around costs of exclusionary policies and practice, from multiple perspectives, is crucial. If we carefully analyze the costs and benefits of inequality/equality and exclusion/ inclusion for each individual, each community, as well as for the society as a whole, the benefit that social inclusion could bring about is evident. Social inclusion is a necessary key process for sustainable development. Therefore, the cost for social inclusion should be seen as a long-term investment for sustainable development.

V. CONCLUSION

Social inclusion is a multi-dimensional and cross-sectional concept, which needs to be mainstreamed into various areas, at national, regional and local levels. It lies, not only within one tier or section of society, nor does it rely on only one area of policy to exact changes. There is a larger and infinitely more comprehensive aim to social inclusion that encompasses many areas of society and humanity.

If a vision can be created which is communicable to the masses and stems from a collective agreement that promotes diversity, tolerance, empowerment, inclusion, participation and community-minded action, then important steps can be made. Fostering a common purpose in all members of society which has input from all sectors is crucial.

Understanding how the dimensions of inclusion are structured and realizing its diverse nature is necessary for this. As inequality and exclusion are produced systematically, they can be tackled. It is necessary to distinguish inequality from being different. While we can be different, we all need to be provided with equal opportunities and access. Accommodating people with different backgrounds and working together to build a common future is a core value of an inclusive society. Developing a concept of inclusion in which people get together, are interconnected, and share sense of belonging as well as sense of responsibility, is necessary.

If this concept of social inclusion is promoted, cycles of exclusion and traditional blockades, structural and perceived, will begin to dismantle. This would constitute an important step towards an inclusive society. Equally, while the actual fiscal responsibilities involved in creating inclusive societies may initially present a challenge, the viewpoint should be promoted that the investment in motivating participation in all sectors of society is an investment in a successful and sustainable future and a more balanced society, meeting the needs of all it's members, where investment in inclusion and the resulting change in society are actually beneficial to all.

Finally, there is a need for specific tools to map out the areas for improvement and measure progress in order to formulate or amend existing policies and interventions to make them more inclusive. Chapter Two of this report will discuss at length the necessary conditions, requirements and possible approaches to capture, analyze and measure the multiple dimensions of social inclusion, the reasoning behind the need and roles for social indicators and the process of developing indicators that fit for specific contexts of each society.

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Recommendations of EGM (2007)

II-1. Actions to be taken to reduce obstacles for social inclusion

In order to reduce obstacles for social inclusion and promote respect for human dignity, the following actions were proposed:

- Set clear and targeted social inclusion, cohesion and well-being goals, with the appropriate strategies to achieve these goals, including the implementation of policies that will further social inclusion. Suggested policy goals include:
    - Promote social inclusion, social cohesion;
    - Promote gender equality;
    - Ensure equal opportunity for all, including on the labor market;
    - Promote equal access to basic quality social services (education, health, transport, shelter, etc.);
    - Ensure access for all to the resources (including land), rights and services, that are necessary for a true participation in society;
    - Prevent and address social exclusion, and eliminate all forms of discrimination;
    - Recognize the dignity and respect for each and every individual regardless of their background, as a moral and legal principle/instrument;
    - Overcome spatial components of exclusion (e.g. land policy);
    - Create safety and sense of security; and
    - Establish well-being of people as a policy objective.

  In order to achieve the above policy goals, there is a need to strengthen capacities and develop tools in the following areas:

    - Formulate social inclusion policies that are adequate, accessible, financially sustainable, adaptable and efficient;
    - Provide support to and strengthen capacities of institutions that are working on justice and social inclusion;
    - Enhance access to knowledge and information (including ICTs);
    - Empower people to participate in the design, implementation and monitoring of policies, as well as in the planning, budgeting, and resource mobilization (including civil society, the private sector, academia, various social groups);
    - Invest in social capital - building trust amongst people and between institutions;
    - Invest in and enhance capacities of key social welfare institutions that can create effective linkages between existing sectoral indicators and expertise with inclusive goals (For example, public health and public mental health infrastructures and their use of, and responses to, measures implicated in inclusion/exclusion such as well-being and social trust through population-level interventions);
    - Build effective partnerships, recognizing the complementary responsibilities of different sectors within society, within and between (sub-)national governments, as well as the need for an increased cooperation between United Nations entities and other international institutions;
    - Create an open space for dialogue to explore policy options, common values and identity, bringing communities together, and ensuring that the excluded and marginalized are heard;
    - Build capacity in good governance, accountability and transparency at national and sub-national levels;
    - Strengthen statistical capacity for data collection and better analysis and better use of data at national and sub-national levels; and
    - Mobilization and mobility.

II-2. Mechanisms or processes most productive in creating and sustaining an inclusive society

- Articulate the concept of social inclusion as a foundation for inclusive policies, which affect all citizens' lives, in particular those of the minority and vulnerable groups.

    - Clearly state the right/opportunity to be different while also being included and actively participate in processes, spaces, and institutions.
    - Differentiate the concept of "social inclusion" from merely "reducing disparity among people", which were common indicators in the past. Social inclusion is a much wider concept, incorporating distinctive and relevant dimensions such as: alienation; social mobility; access to space; sense of ownership; trust among people and institutions, being part of society; and well-being of individuals. Social inclusion indicators should go beyond traditional disparity indicators, and should not rely on a single indicator alone.
    - As such, the following components should be further explored and considered to be an integral part of social inclusion:
        - Social capital: linking the relationship between the state, government and public services, and citizens, focusing on the interface
        - Overcome spatial components of exclusion (e.g. land policy)
        - Social mobility: effective public transportation system, walk-ways to increase access for marginalized communities to social and economic life, including labor market
        - Mobilization:
        - Well-being: capture how people experience their lives (how people think and feel about their lives). Try to integrate a subjective and cognitive/affective component into the concept of social inclusion, which is currently absent. This will include the use of measures already developed in this area that can link with existing capacities such as community mental health networks.
        - Open Space for everyone to engage in dialogues and exchanges (i.e., Porto Alegre, Observatory in the City Hall)

- Mainstream the objectives of social inclusion into existing polices and programmes in all areas, including regulatory framework, governance, economic planning, education, health, housing, employment, and urban planning, etc.

    - Demonstrate commitment to "inclusion-driven" policy-making measures, through prioritizing social inclusion dimension, better described as "Convivencia/ Interconnectedness/Ubuntu", or "sense and feeling of belonging", in rectifying existing economic and social disparities and policy priorities. This "Convivencia/ Interconnectedness/ Ubuntu" dimension is to be considered as an overarching goal for people's aspiration and, at the same time, it needs to be incorporated into all polices and programmes in other key areas. Specific actions to be taken include:
        - Formulate policies that promote a sense of belonging
        - Redefine collective pride and identity in an inclusive and participatory manner
        - Define a shared future with accommodating diversity
        - Create a mechanism for envisioning processes at local, regional and national levels.
        - Develop resilient and accessible dispute resolution mechanisms such as, facilitation, consultation, participatory dialogue, public hearing to enable reasonable accommodations of different views, values and cultures, etc.
        - Invest in measuring strategies that capture this dimension

Such strategies should have actionable responses that prioritize the connections between the "Convivencia/Interconnectedness/Ubuntu" dimension and other disparities and policy priorities

- Identify indicators on inclusiveness of a society, and monitor the effectiveness of the inclusive policies and strategies. It is important to use a multi-method approach that uses qualitative approaches in addition to quantitative ones, to provide explanation for the findings.

- Advocate through effective use of the media, and effective partnerships with policy makers, civil societies, and the private sector to put into force the social inclusion agenda. Also support corporate bodies to meet their social responsibility goals.

Note:

1. Seven essential securities which are often denied: labor market security (adequate employment opportunities through high levels of employment ensured by macroeconomic policies); employment security (protection against arbitrary dismissal, regulation on hiring and firing, employment stability compatible with economic dynamism); job security (a niche designated as an occupation or "career", the opportunity to develop a sense of occupation through enhancing competences); work security (protection against accidents and illness at work, through safety and health regulations, limits on working time and so on); skill reproduction security (widespread opportunities to gain and retain skills, through innovative means competences); work security (protection against accidents and illness at work, through safety and health regulations, limits on working time and so on); skill reproduction security (widespread opportunities to gain and retain skills, through innovative means as well as apprenticeships and employment training); income security (provision of adequate incomes); and representation security (protection of collective voice in the labour market through independent trade unions and employers' organizations and social dialogue institutions).

For the ILO however, the most meaningful way of looking at the situation of those in the informal economy is in terms of decent work deficits. Poor-quality, unproductive and unremunerative jobs that are not recognized or protected by law, the absence of rights at work, inadequate social protection, and the lack of representation and voice are most pronounced in the informal economy, especially at the bottom end among women and young workers.

2. Out of 59 countries observed by the World Bank, 10 countries (17%) demonstrated positive income growth with decreasing inequality, 26 countries (44%) positive income growth but increasing inequality, 20 countries (34%) negative income growth with increasing inequality, and
3 countries (5%) negative income growth with decreasing inequality.

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Chapter two: Role of Local Governments in Promoting Social Inclusion and Participation

Stavros Stavrou & Liam Coakley

I. Introduction

New challenges posed by globalization affect not only national governments, planners and policy-makers, but also regional, provincial and local governments who need to cope with new dynamics operational at a level beyond their direct control. How people set and meet their goals and aspirations depends to a large extent, on their immediate economic and social environment. Successful policies to respond to globalization need to start with local communities[104]. Indeed, it could be argued that it is at the local level where contemporary social and economic transitions have the most fundamental impact.

In a globalized world, not only information and goods, but also people are on the move across cities, provinces, and national borders. An urban life characterized by living together with people with different backgrounds has become an increasingly complex reality of daily life for many ordinary people. How to manage diversity in a transformative manner has thus become a critical issue for local governments that aim to build a peaceful and prosperous society. While an ongoing degree of social transformation is inevitable and indeed ordinarily to be welcomed as part of a developing society, the sometimes rapid onset of such transformations in recent years has led to the experience of tension in many places. Confrontations stemming from cultural, ethnic, religious and other differences sometimes give rise to irrational fears, prejudices, and can encourage the development of racism and practices of discrimination.

Within the next few years, more than half of the world's population will be living in and around cities[105]. The city is home of the socially excluded as well as the included and it is the place where the difference between the included and the excluded is painfully visible. Mayors and city councils take most of the decisions that have a practical bearing on people's lives. In a modern metropolis, what the city governors do and don't do, what they strive for and neglect, determines the level of social inclusion in their areas of responsibility. A metropolitan city is "a universe in itself, as complicated as a national scene, but more intense, since the subjects of your governing are only miles away and when there is roar of disgruntlement the sound cannot be ignored" (Martin Angeby, 2007).

Negative social conditions at the local level creates fertile ground for the exclusion of those who are different from the majority of people living in the society based on their social, cultural, religious, ethnic or behavioral characteristics. The sense of impermanence created by exclusion discourages the excluded from investing themselves in the locales in which they live. Lack of attachment to the place of residence can have a negative effect, especially when experienced

[104] A Fair globalization: Creating opportunities for all, ILO, 2004

[105] According to the third World Urban Forum (Vancouver, June 2006), most of the population growth is happening in cities, and the majority of them are in the poorest countries. It is projected that the number of people living in urban areas will, for the first time in history, outnumber those living in rural areas. In 1976, one-third of the world's inhabitants lived in cities. Thirty years later in 2006, cities are home to half the world's population, and data suggests this proportion will continue to grow to two-thirds of the world's population - or six billion people - by 2050. http://www.unhabitat.org/categories.asp?catid=41

DRAFT

horizontally across a sub-set of the population. Excluded people with shared characteristics can react violently as a group against the experience of 'horizontal' inequality and disadvantage in society.

The increasing complexities of the demography of residents and in particular, the increasing and unprecedented levels of immigrants with different backgrounds, pose a significant challenge to local governments. Many local governments are coping with the new reality through developing new strategies, which generally have two fronts. While there is a need to integrate new residents into mainstream society, local governments need to transform the existing policies, institutions, processes, infrastructures, spaces, programmes and practices to be more inclusive, and furthermore they need to transform the mindset of people to accommodate diversity. Formulating wide-ranging inclusion goals in coordination with national government and the civil society is vital, and with the emergence of social inclusion units in local governments, the opportunity arises to expand the responsibility, range and types of activities that local governments can take on in tackling exclusion. "The activities of the local authority have an important economic and social impact. Increasingly, the authority is being asked to respond in a more coordinated manner to social and cultural issues. It is working closer with communities in addressing social exclusion, developing participatory planning models and in developing social capital" (Galway City Council, 2006).

While, it would be overly-simplistic to hold that the city, as an administrative unit, has the possibility to promote inclusion rather than exclusion in isolation from all other administrative units existing within a country, local governments (or local areas) do occupy a potentially pivotal position when it comes to the promotion of economic, social and cultural inclusion, especially if their actions are: 1) coordinated with other administrative structures operating in the area, and 2) validated by national policies that acknowledge the key role local governments play in the promotion of inclusion. Managing this process will inevitably pivot on the formulation of new responses to and a rethinking of urban governance, urban strategy, urban policy and urban practice in order to meet the challenges and capitalize on the opportunities that will arise.

The following sections explore some of the common challenges local governments are facing in their localities, and highlights possible approaches which are considered to be useful in promoting social inclusion and combating social exclusion. Finally, this Chapter presents examples of innovative initiatives that local governments have carried out in recent years, which have been successful in promoting social inclusion in its various dimensions. These examples are meant to provide inspiration for local practitioners and can be used as examples of good practices. At the same time, it is hoped that national governments and international actors may find useful lessons from these local initiatives, which can be reflected in their efforts in creating an inclusive society.

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II. Challenges and opportunities for local governments in promoting social inclusion and combating social exclusion

CHALLENGES FACING LOCAL GOVERNMENTS

An increasingly diverse and growing local population

In recent years, the challenge of including all people in society has been complicated by various factors, including, growing inequality, widening income disparity, and jobless growth, which has lead to increased incidents of unemployment and underemployment, particularly among youth. Also the growing population movement - rural to rural, rural to urban, and cross-border migration, while creating new opportunities for local communities as resources are mobilized through remittances form migrant workers, have also caused uncontrolled urbanization and expansion of urban slums and deteriorating security, which poses serious challenges for local governments. Unskilled migrant workers for example, tend to be concentrated in the margins of the labor market, occupying the lowest socio-occupational categories of their host societies which are off the wage scale and subject to the harshest working conditions (UNDESA, 2004). Institutional discrimination between the highly-paid skilled and officially well-accepted, and the unskilled majority reinforces patterns of marginalization and segregation, further undermining processes of social cohesion (Marconi). Furthermore, even where migration involves economic betterment for the individual concerned - the migrant may be subject to gender, ethnic and racial discrimination in the host society, which may lead to criminalization. Unfortunately many local governments have remained stultified in the face of growing social complexity and challenge, neither reflecting nor comprehending the changes and tensions that are building in local areas today.

Exclusion can be a spatial experience and therefore access to the public spaces of the city, the space beyond private control, are important as they allow for a person to claim their place in society. To be denied access to such locations will inevitably foster feelings of invisibility and encourage a sense of marginalization from the mainstream society. Poor and marginalized populations often concentrate in and depend on informal settlements, which give them a feeling of security; as such settlements of migrants protect them from daily experiences of discrimination and stigmatization (Achermann and Chimienti, 2005). Often, these settlements are located in peripheral urban locations, and constitute a spatial expression of social exclusion in urban contexts as the populations are inevitably marginalized by virtue of their residential situation and denied access to the full range of city spaces placed at the disposal of others. The location of these informal settlements, often found just outside the control of municipal authority, further hampers effective interventions, as local governments are unable to address or improve the conditions of these informal settlers who reside outside of their authoritative mandates. More integrated regional approaches, which have been already taken by some metropolitan areas, may be a solution.

Local governments must recognize the diverse nature of the challenge of having to deal with an increasingly diverse and growing population in order to foster social inclusion in the city and also recognize the axes of connection that exist across all experiences of exclusion. While the manifestly diverse nature of exclusion necessitates the institution of a variety of targeted interventions, the various challenges of exclusion cannot be addressed in isolation. Local

DRAFT

governments must institute a coordinated, flexible and multi-faceted response to the challenges presented, across all relevant sectors.

Capacity of local government

The capacity of local governments to accommodate different needs of diverse groups is critical, if civic participation and civic engagement are to occur. Traditionally, local government dealt mainly with roads, public transportation and land use. However, recently new areas, such as the economic and social dimensions of local development, have been included as responsibilities of local governments. For example, at the request of stakeholders in the region, the policy makers in the Stockholm metropolitan areas decided to include a social dimension in its regional development plan, capitalizing a person's ability to connect with his/her coevals, in their drive to foster a city that truly embraces all its residents. Through a series of stakeholder meetings they have engaged with creating a vision of inclusion, by focusing on strengthening social capital, in particular "bridging capital", a type of social capital[106] focusing on social networks of people of different backgrounds. (Martin Angeby).

Such Multi-stakeholder Processes (MSP), however, may not always work, especially where the institutional capacity of local government is weak, due to brain drain of local human resources, lack of clarity on the role of local governance, lack of financial resources, lack of coordination with central government, or lack of political skills. In this case, the capacity building of local government must also be addressed as a priority. The gap in capacity is not necessarily limited to local government, but also to that of stakeholders, in particular, those who have been excluded so far, such as women, youth, the poor, older persons, indigenous peoples, peoples with disabilities, ethnic and religious minorities. Local governments are also affected by the political attitude of the central state, which may be committed or opposed to local control of public functions and resources. The central position can vary across regions or other parameters, and can shift quickly depending on dominant political groups. Local governments in wealthier areas may have more strength in negotiating with central counterparts. Depending on the degree of decentralization, the local government may be unable to implement commonly agreed objectives due to insufficient financial resources and administrative authorities, which may create dissatisfaction among local communities. Local governments need to reconcile the expectations of the residents and the actual delivery of the tangible results.

While coming up with strategies and policies are important roles of governments locally, local governments must be able to see beyond a short time period and invest in and facilitate sustainable and long-term projects and initiatives that aim to enhance the quality of life in their area. As UNDESA (2008: 9) states, "the institutions and processes of public governance should aim systematically at enhancing public welfare fully and equitably". A sustainable pattern of civic engagement in public governance is of paramount importance here as such participation can enhance the very nature of governance itself, through the higher levels of transparency it encourages.

In this light, one of the most important roles of local government is accessibility to the government itself and its processes. This means accessibility to the buildings and services that government runs, accessibility to all documentation and information, and accessibility to its members. Some local authorities have begun to engage with electronic media to ensure that they

[106] Michael Woolcock, The place of social capital in understanding social and economic outcomes, *www.oecd.org/dataoecd/5/13/1824913.pdf*

engage with their populations. Local governments use this e-format to make announcements and to administer forums where issues affecting local communities can be discussed. While mixed results can be experienced, a host of less formalized inputs and arrangements are possible as well as, for example, patterns of Network Governance, Deliberative Democracy and Direct Democracy (UN E-Government Survey 2008: From E-Government to Connected Governance. UNDESA, 2008: 69-71).

There are also other challenges; how the bottom-up decisions are coordinated with national policies and/or strategies; how to reconcile with existing legislative framework; how to ensure that the capacity of those excluded are built; how to address the existing power imbalances; and how to make local governance truly inclusive. Another area which needs more attention is the capacity of local government in data collection for planning, policy analysis, and monitoring. In particular, data disaggregated by gender, age, or other social attributes are important for mapping out where exclusion exists, and insufficient data is a challenge.

Local Governance: Local representation and civic participation

Effective local governance[107] is key to promoting social inclusion and combating social exclusion, as it improves access to basic services, mobilizes human and financial resources, and strengthens social and human capital. Likewise, broad-based participation, contributes to good local governance, to fostering transparency, accountability, legitimacy and to making quality decisions with higher levels of implementation and compliance.[108] As the political environment at national and local levels significantly affect the way in which decisions are made, the legitimacy of participatory processes, however, need to be carefully examined. Some understand governance as "the manner in which power is exercised, who exercises it, for what purpose and how this power is shared[109]", the existing governance structures have significant implications for social inclusion processes. There is a delicate balance, and sometimes a conflicting interest, between local representation and direct broad-based participation, depending on the way in which representatives are selected. While local governments are capable of reaching out to various segments of population and mobilizing communities, it is difficult to assess how representative those selected are of the members of society. There may be a case in which individuals with stronger power or incentives may be selected unfairly, which can result in a significant barrier to inclusion of the excluded. Equally, "community groups themselves can become the barrier to inclusion because they are so issue focused and do not see or want to see the bigger picture and how it affects a larger group or the whole community" (FCC, 2008). It is often the case that excluded people or groups are neither participating nor represented in decision-making processes.

Even where there is a political will to reach out to those who are excluded, gaining access to and identifying the needs and concerns of all members of society remains a challenge. In many cases, the excluded are 'invisible', as they are often not included in the official statistical data and are

107 Although there is no single agreed definition, local governance is generally understood as "a broad spectrum of issues and actors that influence local political, economic and overall human development planning and decision-making. Some of the elements shaping local governance include political patterns, institutional arrangements, accountability mechanisms, the degree of civil society empowerment and capacities for generating local resources107" The World Bank defines governance as the processes and institutions by which authority in a country or a local municipality is exercised for the common good, and this exercise of authority includes: 1) the process by which those in authority are selected, monitored, and replaced; 2) the capacity of the local government to manage its resources effectively, and to implement sound policies; and 3) the respect of citizens and the local government for the institutions that govern economic and social interactions between them.

108 OECD, 2001 a, p.6, cited in Citizen participation and pro-poor budgeting, DESA, 2005

109 Citizen participation and pro-poor budgeting, DESA, 2005

often absent in societal institutions and processes. Getting people to engage with government, not only casting a vote in selecting their representatives, but also being involved in contributing to decision-making processes that affect their lives can be even more difficult. Language barriers, fear, lack of confidence and trust in the system, cycles of violence and poverty can all contribute to hesitation and distrust of authorities including governments. This can translate into an unwillingness to participate. Common groups who tend to be excluded from participation include: women, youth, older persons, persons with disabilities, indigenous peoples, migrants, ethnic and religious minorities, people living with HIV/AIDS, ex-combatants, refugees, and the poor. The challenge for local government is to create an environment where these groups are motivated and enabled to engage in discussion of matters affecting their lives.

Citizenship

In a diversified local environment, it is easier for many residents to identify with the city where they live, work and interact, rather than the national state. In policy discourse related to social inclusion, citizenship is frequently invoked. Yet, citizenship, as a legal status with a bundle of legal rights and duties attached, inevitably marks a distinction between members and outsiders based on their different relations to particular states (Baubcock et al, 2006: 5). Citizenship, by definition, is membership of a political community and includes rights to political participation[110]. In many countries, this definition excludes some segments of city residents from being citizens, including asylum seekers, refugees, migrant workers, and temporary residents. There is therefore a need for finding a way to allow inclusion of all residents in a particular location so that some of them are not be excluded or marginalized.

If a local government is to be all-inclusive, then all of the people within its sphere of influence must be taken into account, regardless of their social/ethnic/political /behavioural specificities. A new construct of "membership" may be considered as a viable solution. As cities are seen to bear the greatest responsibility for managing and ministering migrant populations, and because they suffer from the ambiguities and inflexibilities of national policy, both Sandercock (2004) and Baubock (2003) find that cities should be given far more autonomy and be granted powers to bestow "membership" on those who fulfil certain criteria, which ideally be accompanied by a set of social policies to respond to the needs of new settlers, such as language policies and culturally sensitive social services provision. The concept of "membership" should be part of an urban policy response to accommodate a diverse population in global cities. This new way of thinking is increasingly being discussed in trans-national municipal networks, in order to permit participation and governance by all those living in a territory in whatever manner (joint statement issued by the Congress of Local and Regional Authorities of Europe and the Council of Europe COE/CLRAE 2006).

III. Promoting Social Inclusion at the local level

As the issue of social integration and social inclusion has become a reality of local governments, they must recognize the diverse nature of the challenge, and that initiatives to promote social inclusion need to take place in various fronts at multiple levels. A social inclusion strategy should be the starting point for identifying a series of practical objectives and actions that can positively impact processes to decrease the levels of social exclusion, and poverty, and improve the quality of life of every member of society. Local government should formulate an effective local solution involving all residents within a participatory framework devising, promoting and

[110] Wikipedia. The Definition varies, depending on countries.

DRAFT

monitoring initiatives that will achieve measurable positive change. There are a range of modalities and strategies of inclusion available to local governments attempting to counter marginalisation and promote social inclusion. In Chapter 1 a number of recommendable actions to promote social inclusion are presented, and these can also be applied to local governments, they include: eliminating discriminatory laws and practices; transforming the mindset of people; producing inclusive policy framework; setting social inclusion objectives and mainstreaming social inclusion objectives. Furthermore, if local governments adopt social inclusion as a goal, it is recommendable to undertake and increase multi-stakeholder dialogue and processes; civic engagement; social inclusion units; and social protection. These topics will be discussed and presented in the following sections.

Multi-stakeholder processes to promote coordination

Multi-stakeholder processes (MSP), which foster dialogue across stakeholders to build common understanding on certain issues, and set common goals, allow people to engage with an idea in a safe and supportive environment. In any given situation, stakeholders will represent a wide range of people. In terms of inclusion, often it is the excluded themselves, the greatest stakeholders in their own lives, who are left out of policy design and its resulting implementation. It is the place of their local governments to find and make heard their voices and create leaders and representatives from distinct community groups and furthermore to facilitate relevant interaction with other stakeholders, government, the private sector, various social groups, and other members of society.

For this to happen, local government facilitators must be conceptually 'multi-lingual'. They must be able to use the often different vocabularies that resonate with different groups and discuss issues relevant for everyone. However, when safe spaces for dialogue are created, people who participate will be engaged and their societies will evolve from within. In order to create such a dialogue space, local government and its processes must present an inviting, safe, open and participatory environment which encourages interaction and input from its community.

It is recommendable to institute a coordinated, flexible and multi-faceted response to the challenges presented, across all relevant sectors. Programmes to promote single elements of economic, social, cultural, political and demographic inclusion (etc.) all have a place in a broad-based approach, but inclusion may best be operationalized through the institution of a variety of perspectives, working together in a coordinated manner in an effort to support the necessity to perform well economically, while ensuring social cohesion and sustainability.

An example of how local authorities can support multi-sector collaboration can be found in Flanders, Belgium, where a regional government decree in 2004 institutionalized the direct participation of local stakeholders and citizens in multi-sectoral collaboration on social rights. In one of the cities, Ghent, 450 local actors of the health and welfare sector have been clustered in 11 thematic forums: legal help; support and security of minors; services for young people and adolescents; child care; ethnic cultural minorities; people with a disability; the elderly; housing; work and employment; people living on a "critical income"; and health. The local authorities facilitate and support the collaboration of the various organizations and sectors through the collection and monitoring of data, information and communication, access to services, and efforts to make services more pro-active. They are also responsible for networking between all the sectors with a view to improving coordination. They pick up the proposals and plans, and are responsible for channelling them to the province, region, federal state or the European Union for translation into relevant political decisions and legislation. (WHO Report, 2008)

DRAFT

Given the different capacities to effect change present in different governmental structures, inclusive policies should ideally be able to integrate local, regional and national abilities and resources vertically, and encourage dialogue horizontally between different administrative units operational at the same scale, to ensure a holistic and a multi-dimensional response to local need. The knowledge and ability to combat exclusion as well as develop more responsive and accountable services ideally exists, or to be created, at the national level, which then needs to be transferred and translated into local government capacities as it is they who often play pivotal roles. In Ireland, for example, inclusion is fostered through a series of mechanisms operational from the national – such as social partnership agreements, to the local – via public consultation workshops (Mangan, 2008: 9-10).

Furthermore, a highly significant role of local government is to facilitate partnership between members of society, interest groups and stakeholders in the community. If local governments can successfully portray, to these stakeholders, the importance and benefit of open dialogue, participation and co-operation, through facilitating networks, and sharing information and resources, a significant amount of inclusion can result. As Busatto (2007) states, "the role of local government is sharing responsibility with all members of society, fostering a strong sense of co-responsibility in each citizen and institution, stimulating transversely of knowledge within government agencies…The result will certainly be a systemic approach to problems and solutions, a huge collective intelligence to the service of all city dwellers".

A key factor of socially inclusive and sustainable development is that communities take ownership of program components. Communities are represented by civil society but also include private sector interests. From the outset communities would have to be involved with the process in the planning, intentional design, and establish consensus on the kind of change that local governments would like to implement. It is therefore imperative that the mapping of stakeholders is undertaken before any strategy is devised or plans put into operation.

The challenge that local governments have is ensuring that they have an exhaustive list of all Civil Society Organizations (CSOs), which are representative of all communities, and that in working with communities, the CSOs identified are indeed their legitimate representatives. This might entail sponsoring forums to enable communities to elect representatives or form community based organisations (CBO's) that would be representative of their interests. The next challenge is creating forums whereby all community representatives can participate in dialogue. This might involve setting up local community forums which in turn elect one or more representatives to speak on their behalf at larger local government level forums. Such a process is very time consuming, so sufficient lead-in periods will have to be planned and accommodated for. Once all stakeholders are mapped and communities have bought into the process, an agreed format of how communities respond to challenges, how the participatory dialogue process meets, identifies, implements, monitors and evaluates projects and how the funding mechanisms work, will have to be agreed upon by the stakeholder forum. The next task would be to agree to a terms of reference for a social inclusion strategy.

Creating knowledge base on good practice: experience sharing of social inclusion practices

Many cities have developed, or are developing, integrated policies and practices that seek to enhance social inclusion and harness the strengths inherent in their diverse populations. In this regard, local governments can do much to promote a vision of inclusion and equality by their own functioning. It is necessary for local governments to examine positive and successful social inclusion practices, find new ways to incorporate these practices into their own policy and action

DRAFT

plans, and share their experiences horizontally with other local governments, as gaining insights from lessons learned of others as well as adopting good practices will enhance any effort at local level. Creating a knowledge-base at the provincial and national levels is one way of doing this, but also a more innovative approach, using an E-format, to create a "Community of Practice" on the existing local government network, may be another way. International organizations have also started compiling good practices and lessons learned, and may be a good source of facilitating such experience-sharing networks and workshops at the global level.

An example of a successful horizontal experience sharing network can be seen in the network "The Alliance of Mayors Initiative for Community Action on AIDS at local level" (AMICAALL). AMICAALL is a growing network of local government authorities, mayors and municipal leaders committed to supporting sustainable responses to the HIV/AIDS epidemic at the local urban level. The network has national chapters in 13 African countries. The objectives of the alliance are to enhance advocacy and urban local leadership for HIV/AIDS response in urban local governments, enhance institutional capacity development for effective HIV/AIDS response in urban local governments, strengthen coordination of the multi-sectoral response to HIV/AIDS in urban local governments, facilitate the development of partnerships and networks for HIV/AIDS response at local and international levels, and mobilize resources to support HIV/AIDS initiatives in urban local governments. (Emilio Ovuga, Ted Boardman, Danuta Wasserman, .Integrating mental health into primary health care: local initiatives from Uganda, World Psychiatry, February 2007, 6(1)60-61.)

Civic Engagement

A potential path forward in the promotion of social inclusion by local governments may lie in the area of civic participation, as all moves towards inclusion depend on active participation by members of society themselves. To feel part of a whole, a person must be able to participate in the decision-making structures that impact on his/her life. The exclusion of even one group inherently destabilises efforts in the area. The most basic manifestation of this issue is that local governments need to be able to hear from the members of society and talk with them, as without knowledge of their interests, local governments will be powerless to include the needs of the diverse members of society in the decision-making processes. This is especially important as "experience has shown that inclusion of the full range of stakeholders is not only an essential pre-condition for successful participatory decision-making but also vital for promoting equity and social justice in urban governance." (UNHCS, 2001:19) The benefits of such participation include: stakeholders' increased self-awareness; the construction of positive social relations between otherwise separated groups; broad ownership of any outcomes; and wider dissemination of the outcomes of the dialogue.

It is clear, when changes occur, that resultant policy shifts tend to suffer from long and complex chains of command at local level and can therefore be ineffective on the ground. However, an engagement with civil society, when nurtured by actors influential at local level, as for example local government, can affect change by fostering a freedom to express, freedom to disagree, and freedom to be different. Such patterns can then encourage the creation of horizontal connections between different groups and those charged with governance at local level, not simply between local government and the people, vertically. While such a pattern will require a bottom-up willingness to participate in the very processes that may be implicated in a person's feelings of exclusion, participation in such patterns may encourage a significant rapprochement between the excluded and the society at large.

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Introduced in 2007, The Citizenship Fund Initiative in The Hague, Holland is an example of a creative initiative increasing local participation and representation. The Citizenship Fund makes €1 million available every year for projects from residents to improve the social quality in their neighbourhood and/or to build bridges between population groups. The rules for selection include that the plan must be supported by at least 10 residents, who must be willing to carry out the plan themselves (if necessary with professional support). Encounter, dialogue and active co-operation between different population groups should be a crucial aspect of the plan. For every ambitious and sustainable plan there is a maximum grant available of €25,000. Each year, an independent committee makes a selection of the best projects that have been sent in for a contribution from the citizenship fund. The people of The Hague decide by voting which of the nominated projects will be given the citizenship award. (www.thehagueprocess.org)

Social Inclusion Units

Supporting local governments in strengthening their capacity is important, especially in the areas of social inclusion and poverty reduction. In order to formulate potential inclusion programs, local government, in collaboration with various stakeholders, could consider establishing "Pilot Social Inclusion Units" in selected sub-local authorities to span social inclusion strategy for a minimum period of three-year, mainly for learning, but also for enhancing awareness of social inclusion within individual local authorities. This will also ensure that the issue of social inclusion and exclusion is tackled across the full range of local activities in a cohesive and coordinated manner. As a pre-requisite for operationalizing social inclusion units, local governments need to map out all stakeholders and work with them in developing commonly agreed processes for implementation, as well as financial arrangements for both activities.

An example of similar initiative in this area is the "Social Inclusion Initiative" in Australia, which was established in 2002. The focus of the initiative is to provide the South Australian Government with advice on innovative ways to address some of the most difficult social problems. The Initiative has a strong emphasis on providing opportunities for the most vulnerable members of society to participate in the social and economic life of the community, including the unemployed, homeless, mentally ill and those that are disadvantaged as a result of a physical or intellectual disability. (http://www.socialinclusion.sa.gov.au/)

Social Protection

Social protection lies at the core of social inclusion policies and is a central measure to promote inclusion. It is vital that local governments create 'modern' systems of social protection which include protection transfers to households such as pensions, child benefits, and welfare, as well as access to social assistance, such as health care, education, housing, and recreation, all of which play an important role in an inclusive society. Social protection has both protective and developmental functions; it can address vulnerability in the form of reactive actions to redress the impacts of exclusion and prevent the worst effects of livelihood shocks, as well as offer "transformative" support to enable socially excluded and vulnerable individuals and groups to move into situations of inclusion. Social protection can generate outcomes which contribute to economic objectives (livelihoods) and human development objectives (capabilities). We should aim at developmental forms of social protection that can bring about economic and social benefits and identify and promote positive externalities and empowerment, rather that reinforce dependencies. With this approach social protection can be viewed as an investment, and not an expense.

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The design of social protection schemes is very important and should avoid stigmatizing people; targeting may stigmatize people and unwillingly contribute to social disintegration – on the other hand, special needs of specific groups should not be neglected. Social protection mainly addresses those who are vulnerable, but the vulnerable are not only the poor, we may all be vulnerable in certain times of life. In the designing of social protection programs particular attention should be paid to the vulnerability of children, so as to break the cycle of intergenerational poverty. It is also important to be aware of the urban bias of social protection provision and ensure that social protection reaches people living in rural areas. Furthermore social protection policies need to meet certain criteria, such as sustainability; feasibility; right-based aspect; judicious management, and community support.

IV. Good initiatives which promote social inclusion at the local level

In the following sections good initiatives which promote social inclusion at the local level are presented as examples of good practices for local practitioners. Bear in mind that each case is context specific, and merely applying the same approach will not necessarily produce the same results. Each section relates to a specific dimension of social inclusion and the examples presented relate to these dimensions. The examples are presented under a key dimension, but can relate to several dimensions at once. More examples of good initiatives promoting social inclusion at local, national and global level can be found in annex XX

Initiatives promoting the cultural dimension of social inclusion

Societies are increasingly made up of different subcultures; groups of people with distinct sets of behavior and beliefs that differentiate them from a larger culture of which they are a part, including people of different religions, different languages, different ideologies, and different ethnicity. This diversity poses a challenge to local governments when trying to create a common vision for the future. However, when a sense of individual and collective belonging is mediated by the built environment and its socio-spatial relations, everyday practices of life in the city can take place within a social bond of belonging to and participating in the local community or city, and basic rights can be guaranteed for everyone.

There is an urgent need for the emergence of new policies which allow for all members of society to have opportunities to enjoy all aspects of their lives in a particular location without being excluded or marginalised due to their backgrounds or status. Diversity should be recognised and respected as a source of strength in contemporary society. Cultural participation is one of the aspects which need to be addressed when accommodating diversity. Access to diverse cultural events substantially improves the quality of life, the communication and dialogue among different groups and contributes to a harmonious existence in the society. In this perspective, local governments can implement and support measures addressing vulnerable people with special cultural characteristics and invite them to participate in current cultural events and to express themselves. Initiatives to gain insight and get familiar with immigrants' and other cultural groups' cultural heritage, such as promotion of artistic work, lectures on subcultures, and sports programs for vulnerable groups, would enhance the process of social inclusion.

An example of a local government which has made efforts to accommodate a diverse population in various ways is Frankfurt, which from 1989-1995 embarked on an ambitious social experiment to create a multicultural city in an anti-immigrant minded society, establishing AMKA (the Municipal Department of Multicultural Affairs), in the Lord Mayor's office. AMKA's tasks were to work in

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collaboration with all the agencies of the state to promote the social integration of the city's 30% non-German population, and to work directly in the public sphere, to involve itself in a process of '*zusammenwachsen*' or 'growing together' of all ethnic groups into a peaceful multicultural society, respectful of difference (Friedmann and Lehrer, 1997). AMKA's political objectives have included: Reducing the ethnic German population's fear of people with different ethnic backgrounds, and the number of violent acts against people with different ethnic backgrounds; encouraging public discussion of migration and the limits of social tolerance; working towards the active participation of newcomers in the public affairs of the city; encouraging the cultural activities of residents with diverse ethnic backgrounds; and offering in-service training for members of the municipal bureaucracy in intercultural communication.

AMKA worked towards these objectives through three main fronts: public hearings; the creation of a Municipal Advisory Council of Foreign residents; and through strengthening the many voices of civil society among foreign residents. Over three years there were two hearings and a public forum. The second sphere of AMKA's work involved the creation of a Foreign Residents' Advisory Board, whose members were chosen by election, and had the right to attend city council meetings, and the opportunity to review and comment on the municipal budget proposal. The third sphere, strengthening civil society, involved a number of activities, including preparing a register of all organizations run by migrants, supporting multicultural events with financial and technical assistance, working with sports clubs, and providing allotment gardens for immigrants. (Friedmann & Lehrer, 1997)

Another example of a local government initiating a strategic plan to increase social and intercultural coexistence is the local government of Madrid, Spain. In March 2005 Madrid city council launched a plan which constitutes the practical outcome of a debate on migration matters between governmental and non-governmental participants convened within a social forum. The objectives of the initiatives have been defined as: fostering the institutional progress of immigrant reception at the municipal level; to provide better access to civil rights and resources for immigrants; and to improve coexistence between Spaniards and foreigners in order to create dynamic and harmonious neighbourhoods.

The 'Plan Madrid' contains a clear set of working areas and instruments to attain the objectives. Since the 'Plan Madrid' was adopted, the city has established the first of three information centres for the integration of immigrants, and it has founded a centre to facilitate immigrants' access to the local housing market. Regarding active participation in civil society, various institutions have been established on the basis of Madrid's plan for peaceful co-existence, including institutions aimed at initiating an effective intercultural dialogue. In round tables for intercultural dialogues in the districts topics of everyday intercultural understanding are discussed; representatives of these round tables are requested to meet in the Madrid forum for a dialogue of neighbours, which functions as a communication and advisory body on relevant issues. Other initiatives include a yearly social forum, an association to promote the creation and establishment of immigrant organisations, and an intercultural programme to support initiatives of Madrid civil society for the advancement of intercultural coexistence in the city.

In the wake of the Plan Madrid a scientific institute, the Monitoring centre for migration and intercultural coexistence of the city of Madrid has been created. Since 2005 the centre has exercised analytical as well as practical functions: besides investigating different aspects of the migration phenomenon in the city, it coordinates the exchange of relevant information within competent municipal structures. (Brokert, 2007)

Initiatives promoting the political dimension of social Inclusion

Political inclusion of all members of society, in the form of popular participation in decision-making processes and policy formulation, is a central aspect of social inclusion and should be sought for in all aspects of local governance.(Kliksberg on Participation) Research shows that as societies modernize, people increasingly want to have a say in the decisions which affect their lives. (Halman, 2008; Inglehart and Welzel, 2005) This includes issues such as resource

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allocation or organization and regulation of care. Political inclusion entails that each individual has a say in decisions that affect his/her life. The opportunity for everyone to participate and engage in decision-making processes is vital to promoting social inclusion. Another aspect of political inclusion is access to information so that each individual can make an informed-decision. An effort must be made to achieve equal access to transparent and accountable public information.

Local governments can do a lot to promote a vision of political inclusion through their own functioning. For example, having representatives in government from all segments of the population may provide one way of creating a diverse and representative government. Other conduits for increased political participation may include: diverse members of society's access to and participation in policy formation and budgeting. An example of politically inclusive democracy processes can be seen in the municipality of Cuqu'o Jalisco, Mexico, where deliberative democracy processes have been instituted to valorise the creation of a dialogic pattern of negotiation around policy matters. Innovative forms of dialogue have been fostered around public investments in the area through the creation of the Democratic Municipal Council of Cuqu'o (CODEMUC). Participating communities were able to elect representatives who were empowered to make decisions on the use of public monies on their behalf. A web of interactions arose, in which ordinary people were empowered to voice their opinions and hold their elected representatives accountable. (www.deliberative-democracy.net/resources/contrib/selee_20030801.shtml).

Another example of successful political inclusion is The Participatory Budgeting (PB), practiced in Brazil. It allows each sub national area in Brazil to have a voice in the annual allocation of capital investments. It entails a delegation of statutory powers of the executive branch of local governments. PB is an instrument of empowerment and social inclusion as communities are recognised as having urban collective rights that legitimate both their claims and demands and their participation in the decisions taken to meet them. The PB ensures direct popular participation through voting at the plenaries to select priorities for investments and elect representatives on the forum and the PB council. It is structured to ensure transparency and objectivity through an open voting system and the use of quantitative criteria at every step leading to the budget allocation.

The central features of the programme are the district and thematic plenary assemblies that gather in different areas of the city to participate in the budget-writing process. Each year, citizens, area representatives and delegates from local community-based organizations and NGOs meet with public officials to determine investment priorities. The opportunity to participate in decisions regarding the allocation of public funds for projects has fostered a shift in the local political culture from dishonest political bargaining to constructive debate and civic engagement in governance. Since its emergence in Porto Alegre, participatory budgeting has spread to hundreds of Latin American cities, and dozens of cities in Europe, Asia, Africa, and North America. More than 200 municipalities are estimated to have initiated participatory budgeting programmes. (Serageldin & Driscoll, et al., 2004; Souza, 2001)

Another initiative that was recently implemented in Porto Alegre, partly as an outcome of the successful participatory budgeting, is that of Local Solidarity Governance (LSG). Local Solidarity Governance is a proposal for the reformulation of Porto Alegre's management model and the relationship between state and society. The program is based on three principles: plurality, dialogue and consensus and aims at acknowledging the differences in society to foster mutual respect and dialogue, promoting the formation of a community with social co-responsibility projects and agreements in favour of development (Busatto, 2007). The purpose

DRAFT

of the LSG is to transform Porto Alegre into a multi-connected, *Network-City* that provides citizens and communities with the opportunity to exercise their full rights and responsibilities within an environment of participative democracy. One of the outcomes of LSG is the "City Observatory", which is a portal for information distribution for neighbourhoods and regions. Through democratizing the access to information, offering an easy understanding of information and extending the knowledge, the project aims at empowering local communities and qualifying social networks and instances of participatory democracy. (http://www2.portoalegre.rs.gov.br/observatorio/)

An example of how political inclusion can be increased through decentralization can be observed in Bolivia. The Popular Participation Law (PPL) was passed in 1994, with the aim of ensuring that the decentralization system included the participation of local level civil society and grassroots organizations in municipal planning. The PPL came into being largely as a result of the effort and struggle of civil society organizations to be heard and have a voice in politics (Calderon, 2003). The Popular Participation Law re-divided the entire territory of Bolivia into various municipalities based on two criteria: population and land area. Presently, the country has 311 municipalities. This marked a dramatic change for the organization of the Bolivian state: the Law transferred 20 percent of the national budget to the country's 311 municipalities and mandated grassroots participation in local planning and budgetary oversight. Rural areas, where the presence of the state was practically non-existent before 1994, were particularly benefited from this policy. The law produced a more equal distribution of government revenue and extended democratic political processes to rural, indigenous and peasant groups who were previously excluded from formal political participation. (Calderon & Pinc, 2003)

Initiatives promoting the economic dimension of social inclusion

Economic assets are essential if the marginalised are to move beyond exclusion. The presence of an equitable political economy is of primary importance here and it is consequently unsurprising that access to economic development is a central focus of many social inclusion programmes and initiatives, such as UNDP and UN-HABITAT's Urban Management Programme (UMP) which recognises that access to finance represents a key conduit of social inclusion for economically marginalised urban inhabitants. Activities favoured in these programmes can include efforts to improve the capacity of local governments to organise community savings schemes and developing their ability to administer schemes that may lead to increased income generation. (http://ww2.unhabitat.org/programmes/ump/)

Furthermore, local governments need to create greater means whereby the socially excluded can access the labor market, as employment automatically gives individuals the possibility to participate in the economic processes of society. Incentives should be created for employing a diverse workforce, including the encouragement of corporate social responsibility practices, and tools and support need to be developed and disseminated to help employers who wish to open their doors to socially disadvantaged people.

An example of an initiative which increases employment possibilities for persons with disabilities can be found in British Columbia, where the Minister's Council on Employment for Persons with Disabilities in 2006, in partnership with 2010 Legacies Now launched the 10 by 10 Challenge, a province-wide challenge to all communities and employers to raise the number of employed persons with disabilities by 10 percent by 2010, equated to 13,000 new jobs for persons with disabilities. This challenge has been beneficial for communities participating as there are labor shortages in many parts of the province, while persons with disabilities continue

DRAFT

to face an employment rate 20 percent lower than the non-disabled of the population. To launch the Challenge, every community in British Columbia, Chamber of Commerce and over 50 business sectors received information on customized target numbers. 10 by 10 Toolkits were also provided which contain materials that make the business case for, and describe the benefits of, hiring persons with disabilities. The tools provide practical information to help communities and industry sectors achieve their specific 10 by 10 goal.
(http://www.fas.ie/en/PubDocs/AnnualReports/ANNUAL_REPORT05/services_social_inclusion.htm)

A similar initiative is Michigan's Medicaid Infrastructure Grant (MIG) Project, USA. In June 2005, Centers for Medicare & Medicaid Services (CMS**)** awarded the Michigan Department of Community Health, Office of Long-Term Care Supports and Services grant funds to increase competitive employment outcomes for people with disabilities. Key efforts and initiatives include: Developing collaborative partnerships between individuals with disabilities, state-wide advocacy organizations, the Michigan Rehabilitation Services, the Michigan Department of Human Services, the Social Security Administration and the Michigan Business Leadership Network; Researching, evaluating, developing, and implementing strategies and policies to remove barriers to competitive employment; Protecting and enhancing workers healthcare, other benefits, and employment; and collaborating with the Michigan Business Leadership Network to increase employer benefits for employing a diverse workforce.

Khushal Pakistan Programme (KPP) is a different type of example of a promising intervention, which is aimed at generating economic activity through public work and temporary employment, and thus creating jobs and providing crucial infrastructure in rural and low-income areas. The programme is a poverty elimination effort, targeting and promoting the inclusion of rural poor. It has resulted in farm-to-market roads, rehabilitation of water supply schemes, small rural roads, streets, drains, and storm channels in villages and by December 2003, the programme has provided job opportunities for around 2 million people.
(www.pakistan.gov.pk/divisions/ContentInfo.jsp?DivID=45&cPath=618_621&ContentID=3270) It is important to recognize, that when tackling poverty, it involves not only economic measures and improvement in infrastructure and services, but also requires building social capital: the networks, norms and trust that facilitate co-ordination and co-operation for mutual benefit.

Initiatives promoting inclusion into social services

Increasing access to social services, such as universal access to quality basic education and universal health care, is an important aspect of social inclusion as these services enable people to function in and contribute to society. In the Residential Care Centres for Migrant Families' Children, Orissa, India, the focus of the social service provided is care and education of children of rural migrant workers who migrate under conditions of distress. Seasonal migration of agricultural labour is a common problem in certain parts of Orissa. The main reasons for such migration are high proportions of landless labourers in a few districts because of skewed land ownership patterns (in some pockets, 2% of the population owns 90% of the land), the underdevelopment and poor socioeconomic conditions that result, long-term indebtedness and lack of job opportunities. The objectives of the programme is to allow children to continue their education without disruptions caused by migration and ensure that children are still within the reach of the community to provide them care and support. A major achievement of the RCCs is to place emphasis on the rights and needs of migrant children in a context where large-scale migration under distress conditions is not recognized in state policy measures. By offering

DRAFT

parents options to educate their children, both at source and destination of migration, the intervention provides parents with some degree of choice, ensuring that these choices do not harm children's access to education. Furthermore, by providing the children of migrants with the opportunity to receive an education, an attempt is made to break the cycle of intergenerational poverty. (www.sristi.org/rjmc/shiksha/index1.htm)

Another example of a local initiative which illustrates how social inclusion can be enhanced by increasing social services in the form of home based health care can be found in the Enlarged Community Rehabilitation Project (ECR), Istanbul, Turkey. ECR is a Health Affairs Department initiative that provides Home based health care to patients who are not covered by any health insurance system or who are in great need of help. The process starts with a visit in the townships to assess the health situation of the people in need: sick, persons with disabilities, pregnant, older persons or deprived people. This step is followed by the visit of a physician and a nurse to the houses to examine the patients and make treatment plans. According to the patient's state of health, further investigations and examinations by specialist physicians are carried out. Surgical operations are also performed if required. For severely socially deprived families, fuel for heating and food aid is provided. So far the project has covered 29 townships in Istanbul and 1,303,801 houses have been visited. The ECR Project has achieved many social and economic benefits for the city by helping many people with treatment and assistance in dealing with social problems enabling them to become active and well functioning participants in society. (http://www.bestpractices.org/bpbriefs/social_services.html)

The Hygiene Promotion, Sanitation, and Water Supply (HYSAWA) project is a quite different example and is local initiative which has increased social inclusion of an indigenous group, the Jumma people of the Chittagong Hill Tracts (CHT) in Bangladesh, by increasing their awareness of proper hygiene and providing them access to water and sanitation facilities. The implementation of the HYSAWA project has showcased successes in addressing rural water supply, sanitation, and hygiene programs, in a fruitful cooperation among NGOs, local governments, and communities.(http://www.adb.org/Water/Topics/Rural-WSS/default.asp; http://www.hysawa.org/)

Initiatives promoting the physical dimension of social Inclusion

Having rights and possibilities to access the physical space of the city is a recurring theme among projects aimed at addressing marginalisation. For example in the case of persons with disabilities, older persons and parents with prams, optimizing the physical aspects of the built environment are important to achieve inclusion. The provision of ramps, sufficiently large and unblocked corridors and doors, the placement of door handles, and the availability of assistance and support can ensure that everyone has access to a workplace, a place of entertainment, a voting booth, transport, a court of law, etc. (http://www.un.org/disabilities/default.asp?id=224)

An example of a local initiative aiming to improve the physical environment to allow access to more people can be seen in The *Disability Standards for Accessible Public Transport 2002,* Western Australia. Western Australia is a strong supporter and champion for ensuring that public transport is accessible to all. The Public Transport Authority has a *best practice* bus replacement program, developed as an action plan endorsed by the Human Rights and Equal Opportunities Commission. The program involves buying approximately 65 new buses each year which must meet the Transport Standards. Of the 1050 buses in the fleet, 510 are now fully accessible. Because of this fleet replacement program, existing buses are not being retrofitted. The bus replacement program is a key strategy for meeting requirements that involve structural changes to the bus fleet, such as priority seating. Items such as symbols, signs, alarms and

DRAFT

information are being installed. A *Best Practice* program is in place to audit, refurbish and redesign older bus stations and bus-train interchanges to meet the Transport Standards. (Department of Planning and Infrastructure, 2006. www.ag.gov.au/dsfapt/welcome.html)

Initiatives promoting the spatial dimension of social inclusion

Access to housing is a spatial aspect which contributes to social inclusion. A place to call home is of pivotal importance in society in general. Not only does it provide shelter but it also anchors the person in society by acting as a conduit for sense of place. At its most basic sense, 'home' grounds a person and allows that individual to buy into many wider associations with locality, community, city and region. In this regard, to be without adequate housing is perhaps one of the most marginalising of contemporary experiences.

'The Partners in Development Programme', Naga City, Philippines, is an example of a social amelioration program which has had the effect of reducing social exclusion and bringing participants in the programme closer to mainstream society. It is primarily designed to empower squatters and slum dwellers which comprise 25 percent of the city population residing in 21 urban districts of Naga City. The program recognizes the role that the urban poor play in the city's economy and it addresses the absence of security of land tenure among the most socially excluded people resident in the city as well as the lack of basic infrastructure in their communities. The program has two main components: 1) land acquisition and 2) urban development to increase the socially sustainable nature of their areas in question. The program has been successful in resettling 2,017 families to relocation sites with a combined area of 33 hectares; secured home lots for 789 squatter families; and upgraded 27 urban poor communities which host around 2,700 families. Six years after the program was launched, Naga's urban poor are more empowered and involved in society through a credible and effective tripartite mechanism for solving land tenurial issues that the Program has institutionalized. This programme is generally regarded as a revolutionary experiment in local governance with civil society being empowered to work closely with local government to design, implement and evaluate the City's strategic management. "Partners in Development" is acknowledged as a model urban poor program among Philippine local governments today. (http://www.unesco.org/most/asia8.htm)

Another aspect of the spatial dimension of social inclusion is that local governments can engage in furthering social inclusion by the way they design, develop and maintain the built environment in cities. The careful development of public spaces is a case in point: these can be designed in ways that allow people to feel safe in them, to easily find their way around in them, and to use them for gathering (leisure and work), recreation and other purposes. Examples of programmes which seek to give potentially excluded people more access to the city but with a different emphasis are supported in Dublin, Ireland and Curitiba, Brazil.

The Dublin City Council initiative is focused on the provision of secure access to communal public space in the city. It does so on the premise that "the provision of community facilities, such as education and library services, health services, community centres, meeting places and places of public worship, all contribute positively to the support and development of communities…" (Dublin City Council, 2007: 20) This initiative is based around the maximisation of facility use, partnering with schools and churches and public buildings to make the best possible use of existing infrastructure, improving and sharing facilities and promoting a partnership between groups and users of facilities. This is a useful practice, as not only does it provide a location in which to pursue the activities in question and also save money, but by

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promoting a shared use, vision and partnership it inherently increases inclusion and creates a community and sense of place and common purpose amongst the people that use it (Fingal County Council, 2008).

In Curitiba, Brazil, the Sustainable Transport Planning programme seeks to secure free access to the space of the city by encouraging the use of a sustainable transit orientated pattern of city development. Curitiba effectively encourages greater inclusion of its marginalised people by allowing for greater access to and use of the city. Innovative measures in this programme include the introduction of an inexpensive "social fare" on public transport services. This fare inevitably benefits the marginalised in the city, most often those whose residential locations are to be found in peripheral urban locations. Other measures include the dedication of a series of 'green park areas' to potentially excluded groups such as immigrants and ethnic minorities. (Rabinovitch, J. Curitiba: towards sustainable urban development. Environment and Urbanization, Vol.4, No.2 October, 1992)

Spatial inclusion has also been approached by UNESCO and UN-HABITAT in the joint initiative of the Right to the City (RTTC). The main objective of RTTC is to promote "inclusive cities" and to primarily address Mayors, municipalities, city professionals and international NGOs that group together associations of cities and city dwellers. It encourages the residents to engage in their right to occupy public space and to participate as an equal in public affairs and urban democratic processes. Its emphasis is less on legal rules and more on norms, practices, meanings and identities, which all have political implications and urban policy consequences. A number of initiatives are being carried out at various levels towards promoting a rights-based approach and ensuring the 'Right to the City' for all urban dwellers. In this initiative the city is viewed as being responsible for guaranteeing equitable access to all to the opportunities it has to offer, and thereby fulfilling a social function.
(http://www.unhabitat.org/cdrom/networking/urban_policies_and_the_right.html; http://portal.unesco.org/shs/en/ev.php ; UNESCO/UN-HABITAT, International Public Debates on "Urban Policies and the Right to the City". Third Meeting of the Working Group. December 2006, UNESCO Paris)

Initiatives promoting the relational dimension of social Inclusion

To feel included in society at the local level people have to feel a sense of belonging that extends beyond the inclusion operationalized through access to the material needs of life. This is a subtle experience but one which is vitally important if truly socially inclusive environments are to be created and supported. The experience of social support and contact is vital to experience being socially included. An aspect of relational inclusion is creating solidarity and encouraging the acceptance of others and interrelations among groups who may not share affinity, common values, or have empathy towards one another. Participatory dialogue, presented in Chapter 1, is one approach which is recommendable to use in these situations. Initiatives which support contact between people, including marginalized groups, solidarity and the formation of new relationships should be encouraged by local governments.

An example of a residential community that supports development of relationships between generations is Hope Meadows, Illinois, USA. Hope Meadows provides low-cost housing to foster care families, and low income older persons who contribute to the community by volunteering a minimum of six hours per week. Older persons' volunteer tasks can include tutoring, playground supervision, and guarding school crossings. In Hope Meadows neglected and abused children who have been removed from their biological parents for their safety, find a

DRAFT

permanent and caring home with adoptive parents, as well as surrogate grandparents. The older persons are integral to the healing of the children and the children provide a sense of purpose in the daily lives of the older persons. (Eheart and Hopping, 2001) (http://www.generationsofhope.org/hm_main.html).

The campaign VI KBH'R' (We Copenhageners), by the city of Copenhagen Council in Denmark, is an example of a local government initiative which aims to increase cross-cultural relations and dialogue between members of society and make more Copenhageners feel accepted as equal citizens, part of a unity and as Copenhageners. Inclusion is understood by the Copenhagen Council as equal participation in the city's activities; trusting relations between the city's citizens and the city's institutions and the experience of unity and togetherness through dialog and communities across different backgrounds culturally and attitudinal. The 3 year campaign celebrates and acknowledges diverse religious, national and cultural holidays and a pool of 1 mill kr. annually goes to support initiatives that strengthen diversity and inclusion in Copenhagen, such as debates, concerts, public dinners, and dialog events. The campaign is closely connected to a string of Copenhagen Council's other focus areas, including the prevention of and fight against radicalization amongst the cities people and efforts against discrimination.
(http://www.oplevforskellighed.dk/)

V. Conclusion

Planners and policy-makers of local governments have the clear responsibility to foster unity among diverse populations and create a vision for a common future that pivots on the acceptance of difference and animation of societies with a view to harnessing the strengths that are inherent in diverse societies. A key challenge will inevitably rest with the need to ensure that all people are able to engage with society and benefit from the possibilities inherent in contemporary life and therefore that all people are included, irrespective of their social attributes. In this process 'the local matters'. Local governments have a critical role in promoting social inclusion, and programmes and policies need to be tailored to address specific local needs.

Participation of all members of society is essential. While, on the one hand, underlining the importance of equity and equal access for all and participation of all residents in decisions that impact on them, there must, on the other hand, be a processes that seeks to promote diversity and the participation of 'groups of difference' in the process of governance. Responding to the needs of vulnerable groups, such as the poor and marginalised, the disenfranchised migrants, youth and the elderly should be a central feature of inclusive governance. In fact this represents a litmus test of good local governance as a whole. If local governments are to respond to the challenge of social inclusion, they will have to reinvigorate, refocus, redefine paradigms and reclaim the participatory process that first brought them into being rather than trying to identify or uncover some new direction.

The need to engage successfully with all potential stakeholders is clear. Everyone must be encouraged to participate and partnership must be facilitated. The real challenge for local government lies, not simply identifying and including all relevant actors, but in the need to encourage a real level of engagement in the process among potentially reluctant parties.

This chapter has endeavored to outline what the challenges are for local governments in promoting social inclusion and why it is important that a new form of coordination and

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engagement is instituted if local governance models are to be truly socially inclusive. Approaches to promote social inclusion and examples of good practice that highlight how meaningful social inclusion can occur are presented as inspiration and to gain a better understanding of practical actions that can promote social inclusion.

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Annex I: Compilation of existing approaches to capture, analyze and measure the multiple dimensions of social inclusion and other related concepts

Available in a separate document

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INDIGENOUS CORPORATE TRAINING INC.

Building Indigenous community capacity and the duty to consult

February 10, 2017

While the duty to consult is a hard fought for, constituti
component of resource project development, in reality i
burden for an Indigenous community. In '**Duty to Consult' a Cruel Joke If First Nations Can't Handle the Load**, Alex Power, a Regulatory and Research Specialist with the Yellowknives Dene First Nation, defines the impact the duty to

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consult places on an Indigenous community in terms of processing the associated tsunami of paperwork. Here's his description of what's involved in terms of an Environmental Assessment (EA) for a major project:

"Throughout an EA, First Nations (and other proponents) have an opportunity to review and critique the reports submitted by the developer. Proponents make information requests, review evidence, and make written submissions culminating in a multi-day public hearing. The process is rigorous.

The problem is, Indigenous groups don't have the resources to properly review much of this material. Again, this process generates thousands of pages of reports spanning multiple disciplines in science, engineering, and socio-economics. If they're lucky, a community might have one staff member (like myself) charged with reviewing and responding to all environmental assessments, water licenses, land-use permits, wildlife regulations, and conservation plans.

In short, there's no possible way for an Indigenous g
thorough responses to even a small proportion of a
[1]

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Many communities simply don't have staffing resources to work through the number of reports delivered to them - let alone have staff with EA review experience. Also, there are other, more dire, pressing demands on chiefs, council and office staff. The responsibilities of chief and council are the equivalent of all three levels of government - federal, provincial and municipal - and they will put the needs of the community above the needs of a project proponent.

I think the article hit the nail on the head so I shared it on my social media platforms to see what others would have to say. This response drills down on the situation:

> In BC, the provincial government sends out about 200,000 referrals to First Nations annually. (Just BC and not counting those of the federal government or industry.) Using round numbers of, say, 200 First Nations in BC that means on average each Nation gets about 1,000 referrals a year. There are about 250 working days a year (50 weeks x 5 days a week) meaning that the average First Nation would have to completely review 4 referrals every day. And bear in mind that a referral can be anything from a routine cutting permit application to a proposal for a new mine, pipeline or hydro power project. In addition to funding for staff to properly understand and assess these referrals think of the intellectual, physical and political capital required of First Nation leaders to themselves understand and take rational decisions.
>
> Even if a Nation has 50 staff dedicated only to referr
>
> reasonably expect the community to take responsib
>
> exceedingly complex matters every day while also d
>
> elders and water and roads and language and ... and ...and..?

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There simply has to be a better way. The solution lies in how innovative a company wants to be.

Let's take a look at this from the perspective of a forestry company. Most forestry operations are on traditional or treaty lands which means the **duty to consult** will be invoked by government, who then normally delegates the administrative or procedural aspects of the consultation. Most forestry companies are "process" driven. So, if you're a process driven company waiting to start work on a new cutblock but one part of the process, say the EA review, is preventing you then you need to find a way to facilitate the EA review process.

So what's a company supposed to do?

One option would be to wait for the provincial government to solve the problem which they have tried to do with different kinds of arrangements such as Forest Consultation and Revenue Sharing Agreements. These agreements have had an impact but there are still backlogs and challenges.

Another option would be for the company to look inward to solve this problem. I suggest a cost efficient solution such as providing funding to the community so that the community can hire people to review referrals on their behalf. This way, there is a degree of certainty of when the EA will be completed which means a company can at least tentatively schedule the work into budgets.

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- **Corby Lamb - First Nations Forestry**

For the record, I have presented this alternative to many different companies and have heard a range of "we won't do this" replies such as: that it would set a precedent.....or that it's against the company's philosophy to provide capacity funding for a community.....or why would we do this for them when we don't do it for anyone else. When I hear these kinds of answers I tend to think "Hmm, so it's an attitudinal problem, not a financial problem."

If we made it a financial problem, the company could provide funding for the community to hire people to do the review for the community and the process would proceed in a timely manner. Or, they can wait, sometimes indefinitely for the community to find the resources (human, time and financial) to deal with the process - for a process driven forestry company, this would likely be frustrating.

There you have it. Why wouldn't a company provide capacity funding to an Indigenous community if it meant that the duty to consult was dealt within a finite period of time. A company that looks for ways to mitigate the added demands their needs place on the community's resources shows they understand the challenges many communities face in terms of capacity to take on extra work.

This is an interesting article on capacity funding:

- **Dvisional Court Finds Duty to Consult Required C**
  Promised Capacity Funding

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We hope you found this article on Indigenous community capacity interesting. This free ebook provides summaries of the foundational Supreme Court of Canada rulings. Just click the image to grab your copy.

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INDIGENOUS CORPORATE TRAINING INC.

Reconciliation with Indigenous Peoples: A Holistic Approach

Toolkit for Inclusive Municipalities in Canada and Beyond

Canadian Commission for UNESCO

COALITION OF INCLUSIVE MUNICIPALITIES

advancing reconciliation

United Nations Educational, Scientific and Cultural Organization

CANADIAN COMMISSION FOR UNESCO

With the support of the

International Coalition of Inclusive and Sustainable Cities – ICCAR

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The Canadian Commission for UNESCO helps Canadians share knowledge locally and globally in order to create better societies and build peace in the minds of everyone. To do so, the Commission facilitates cooperation in the fields of education, science, culture, communication and information to address some of the most complex challenges facing the world today. With its initiatives and networks, CCUNESCO supports the United Nations 2030 Agenda for Sustainable Development and other UNESCO priorities. The Commission operates under the authority of the Canada Council for the Arts.

Table of Contents

02 Introduction

04 Background
05 Historical Events
08 Demographics
10 Rights and Calls to Action

11 What Municipalities Can Do
12 Engage with Indigenous communities and individuals in various areas of municipal work
13 Learning and growth: a model

14 Successful Strategies

17 Reconciliation in Practice – A Holistic View
18 Knowledge Systems
19 Action Processes
22 Spiritual Beliefs
23 Values and Protocols

25 Do's and Don'ts
26 Tools and resources

27 Featured Municipalities
27 Winnipeg, Manitoba
28 Whitehorse, Yukon
28 Montréal, Québec
30 Val-d'Or, Québec

31 Conclusion

32 Endnotes

Introduction

Advancing reconciliation is part of the broad mandate of the Coalition of Inclusive Municipalities (formerly the Canadian Coalition of Municipalities against Racism and Discrimination – CCMARD). Signatory municipalities of the Coalition are committed to strengthening their policies and programs in a number of areas of municipal responsibility including service delivery, employment, housing and cultural activities. The implementation of these objectives can directly contribute to advancing reconciliation.

In Canada, as of May 2019, nearly 80 municipalities have joined the Coalition. The Coalition itself is part of the International Coalition of Inclusive and Sustainable Cities – ICCAR, an initiative launched by the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 2004 to promote efforts by cities around the world to address racism, xenophobia, discrimination and exclusion.

Members of the Coalition of Inclusive Municipalities advance initiatives to:

- establish policies to eradicate all forms of racism and discrimination
- improve their practices to promote social inclusion
- promote human rights and diversity

A survey of Canadian municipalities conducted by the Canadian Commission for UNESCO (CCUNESCO) in 2017 identified a need for additional information to help municipalities learn about and respect the rights of the Indigenous population, both collectively (peoples) and individually (people), including those who live in municipalities.

This publication is in part a practical tool and resource to respond to this need. It includes a brief overview of Canadian-Indigenous relations and the call for reconciliation in this context. It provides definitions of common terms, and identifies additional reading and resources. It is also partly inspirational. Municipalities have generously shared their stories, practical advice and promising practices in order to encourage others to take action. A holistic approach to Indigenous-municipal relations is presented to support cross-cultural understanding.

We hope that this publication encourages dialogue, learning, consensus-building and collaborative action in pursuit of inclusion, justice and, ultimately, reconciliation.

Sébastien Goupil
Secretary-General
Canadian Commission for UNESCO

"Reconciliation is about establishing and maintaining a mutually respectful relationship between Aboriginal and non-Aboriginal peoples in this country."
– Truth and Reconciliation Commission of Canada[1]

UNESCO's Policy on Engaging with Indigenous Peoples reaffirms its commitment to implementing the *United Nations Declaration on the Rights of Indigenous Peoples* in its mandated areas.

The Canadian Commission for UNESCO's Let's Talk About Reconciliation, initiative for public libraries aims to encourage participation by Canadians who are not directly involved in the reconciliation process or who are not exposed to Indigenous history and cultures. These cross-country dialogues aim to strengthen relations between the Indigenous and non-Indigenous communities by creating a space where the two communities can interact with each other in a spirit of openness and mutual discovery.

Background

The destructive history of Canadian policies on Indigenous peoples has been described in major national studies over the past several decades. Most recently, the Truth and Reconciliation Commission (TRC) concluded in its 2015 report that since Confederation, Canada's Indigenous policies had the effect of eliminating Indigenous governments; ignoring Indigenous rights; terminating treaties; and causing Indigenous peoples to cease to exist as distinct legal, social, cultural, religious and racial entities in Canada.[2]

Ongoing disparities are "reflected in the intense racism some people harbour against Aboriginal peoples and in the systemic and other forms of discrimination Aboriginal people regularly experience in this country."[3] These consequences have been compounded by a lack of respect by non-Indigenous peoples for Indigenous peoples and a loss of self-respect and pride in themselves by Indigenous peoples.[4] The timeline below highlights some important historical events that have contributed to our need for reconciliation.

Did you know

The terms 'Aboriginal' or 'Indigenous' refer to First Nations, Inuit and Métis peoples collectively. 'Indigenous' is the more commonly used term following the adoption of the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).* The term 'Indigenous peoples' is used when referring to nations, and the term 'Indigenous people' is used when referring to Indigenous individuals.

First Nations is a collective term referring to Haida, Blackfoot, Cree, Maliseet, and others. Individual communities are referred to as a First Nation. It is respectful and recommended to refer to the specific nation by the name the nation or community uses to describe themselves (i.e. traditional names).

The term Inuit, an Inuktitut word meaning "the people", is the collective term for those individuals and their future generations who are party to one of the Inuit Comprehensive Agreements. An individual member of this community is an Inuk.

The term Métis does not include everyone of mixed European and Indigenous ancestry. The Supreme Court (R. v. Powley, 2003 SCC 43) determined that Métis are those who self-identify as Métis, have an ancestral connection to a historic Métis community, and are accepted by that modern community.

Other terms have come and gone out of favour over the years. These include 'Indian', 'Eskimo', 'Half-breed', 'Native', etc. However, some of these terms are used in legislation, like the *Indian Act*, or even the *Constitution of Canada* – for example, section 35(2), which defines "aboriginal peoples of Canada" to include "the Indian, Inuit and Métis peoples of Canada". These terms remain in use, therefore, but should only be used when citing a quote or when referencing the specific legislation.

Historical Events

This is a timeline of some key historical events and/or interactions between Indigenous and non-Indigenous peoples in Canada. Developing a joint history timeline is a great way to learn about each other.

Municipalities and Indigenous partners may wish to work together to develop a local history timeline. It is a great way to start a conversation and get to know each other a little better.

Indigenous histories are recounted from time immemorial – that is, from the time of ancestral histories beyond memory. Oral traditions recount stories of origins and other important cultural knowledge (For example: Sky Woman falls, Wîsahkêcâhk and the flood, Sedna, Glooscap frees the water). These stories also remind us that First Nations and Inuit were self-governing and exercised exclusive control of all territory now called Canada.

1000 Norse establish settlement at L'Anse aux Meadows

1400s Europeans explore the Americas

1455 and 1493 Papal bulls authorize European nations to seize Indigenous lands in the Americas and enslave the peoples they find there

1500s Further travels by Europeans and encounters with new Indigenous nations result in foreign diseases infecting Indigenous peoples

1534 France claims ownership of New France

1537 Papal bull acknowledges Indigenous peoples are human and forbids their enslavement

1574-1778 Frobisher's search for the Northwest Passage to Asia constitutes first known contact with Inuit

1600s Commercial fur trade attracts more Europeans to Canada

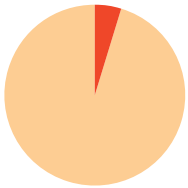
Continued on next page

1700s	Métis emerge as a distinct culture
1763	British Royal Proclamation requires treaty with Indigenous nations prior to settling in their territory – this remains the law in Canada
1771	First Moravian Mission established among Inuit at Nain, Labrador
1812	War with the United States; Six Nations Confederacy and British jointly repel attacks
1867	Confederation
1869	10,000 Métis in Red River (now Winnipeg) form a Provisional Government
1870	First Residential Schools open
1871-1921	Canada negotiates the numbered Treaties
1874 and early 1900s	Métis are issued scrip for money or land
1876	First Nations peoples restricted to reserves (*Indian Act*)
1884-1951	Potlatch and other traditional gatherings and customs are banned
1885-1951	First Nations peoples required to obtain a pass from the Indian Agent to leave the reserve
1885	Métis and First Nations men executed, including Louis Riel (Battle at Batoche)
1903	First RCMP posts established in the Arctic
1927-1951	First Nations banned from hiring lawyers to pursue claims against the government
1941	Canada issues Inuit with numbered identification discs to use in place of their names

1953-1955	Inuit forcibly moved to High Arctic to reinforce Canadian sovereignty – many die
1969	White Paper issued by federal government recommends repealing the *Indian Act* and assimilating all Indigenous people – sparks Indigenous political activism and creation of national Indigenous organizations
1982	Constitutional amendments include recognition of Aboriginal and treaty rights
1996	Royal Commission on Aboriginal Peoples Report lays out strategy for redressing Indigenous rights but the advice is not acted on by Canada
1996	Last Residential School in Canada closes at Gordon First Nation in Saskatchewan
1999	The new territory of Nunavut is created
2007	Canada apologizes for Residential Schools
2015	Truth and Reconciliation Commission Report concludes that Residential Schools attempted cultural genocide and issues 94 Calls to Action
2016	Canada endorses UNDRIP without qualification and establishes the National Inquiry into Missing and Murdered Indigenous Women
2019	*Indigenous Languages Act* tabled in Canadian Parliament Simultaneous translation of Indigenous languages offered in House of Commons for first time

The social and economic costs within Canadian society of these policies and events have been enormous. High rates of suicide, homelessness, unemployment and death within the Indigenous communities are the tragic human measure of colonial and assimilationist policies. Many Canadians are shocked when they learn about the destructive effect of colonialism on Indigenous communities over the years. It challenges cherished ideals about Canada as a nation. Changing the status quo means giving up old ideas, replacing control with collaboration, and learning new ways of looking at the world.

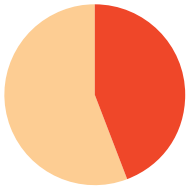
Demographics



Indigenous peoples comprise approximately **4.9%** of the Canadian population.

Over **977,000** First Nations, 587,000 Métis, and 65,000 Inuit.

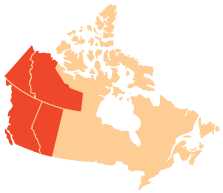
There are more than **70** Indigenous languages, 30 of which are spoken by more than 500 speakers.[5]



44.2% of status First Nations peoples live on reserves.

62.6% of Métis live in urban settings.

72.8% of Inuit live in Inuit Nunangat.



More than **50%** of the total population of First Nations peoples live in the four western provinces.

24.2% of First Nations peoples live in Ontario. Ontario also reports the largest population of Métis people.

Winnipeg, **Edmonton**, **Vancouver** and **Toronto** have the largest number of Indigenous residents.

Average age in 2016 was **32.1 years old**

Debunking myths, misconceptions and stereotypes
There are many myths, misconceptions, and stereotypes circulating about Indigenous peoples. A common impression of the 'typical Indigenous person' is of someone who does not pay taxes, gets free education, lives on a reserve, and is unemployed. These stereotypes damage Indigenous peoples and relationships with non-Indigenous people.

1 Truth

Most Indigenous peoples pay the same taxes as other Canadians, except for certain exceptions for status First Nations peoples who live or work on reserves, less than 1% of the total Canadian population.[6]

2 Truth

Only status First Nations children living on reserves get some funding from the federal government to attend local schools. Inuit, Métis and status First Nations peoples living off-reserve receive no such funding. Some Indigenous students also receive federal funding to attend post-secondary school, but not all students who wish to attend receive funding.

3 Truth

More than half of status First Nations peoples live off-reserve and most of them live in urban centres.[7] Inuit and Métis do not have reserves.

4 Truth

There are more than 43,000 Inuit, Métis and First Nations business owners in Canada and Indigenous businesses contributed $12 billion to Canada's economy in 2016.[8]

Rights and Calls to Action

The legal framework for the protection of Indigenous rights includes Section 35 of the *Constitution Act, 1982*. It also includes binding legal commitments, like the *Royal Proclamation of 1763*, and Treaties signed over the centuries. Supreme Court of Canada decisions have clarified these rights and interpreted the Treaties.[9] In 2016, Canada joined the global community in adopting the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*. The Declaration describes the agreed-upon minimum standard of rights of Indigenous peoples around the world. A review of these documents is necessary to understand the legal context in Canada.

The Truth and Reconciliation Commission of Canada (TRC) challenged Canadians to adopt a new relationship between Indigenous and non-Indigenous peoples. They recommended a nation-to-nation approach. The TRC urged giving up colonial policies and taking a new approach based on 10 Principles of Reconciliation and 94 Calls to Action. Reconciliation addresses the deep structural problems in terms of the way land, resources, money, education, housing and health care are distributed in this country, which undermine our collective wellbeing. The overall task is to build a new relationship with Indigenous peoples. It will take the effort of all Canadians to contribute to holistic changes in the way we live, work and govern ourselves.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)
It describes both individual and collective rights of Indigenous peoples around the world. The document sets out principles and commitments that UN Member States agreed to support, including Indigenous rights regarding:

- sovereignty
- culture
- identity
- religion
- language
- health
- education
- environment
- territory

UNDRIP is the most advanced and comprehensive declaration on Indigenous peoples' rights: its 46 articles describe specific rights and actions that governments commit to in order to protect these rights. The "right to be free of discrimination" is one of the four main themes of the Declaration.

Reconciliation

"[T]he term "reconciliation" implies that the parties were once whole, experienced a rift, and now must be made whole again. But in colonial settings, this is not the case. The relationship between Indigenous and settler peoples in Canada was one of nations encountering nations, where one gradually oppressed and marginalized the other. Indigenous peoples never agreed to the denial of their sovereignty, cultures or identities. Thus, in the Canadian context, reconciliation must refer to "transformative" as opposed to "restorative" reconciliation."[10]

What Municipalities Can Do

Municipal governments (defined here to include all forms of local government including townships, counties and regional governments) are taking up this challenge. They are adopting new policies and ways of working, learning about Indigenous peoples across Canada, developing mutually beneficial agreements with local Indigenous communities, and sharing services developed through collaborative initiatives.

Municipalities are encouraged to reflect upon all 94 Calls to Action and consider how they can advance implementation. Of the 94 Calls, five specifically refer to municipal governments, and another four call on "all levels of government" to take particular action. As a starting point, these nine Calls to Action can provide a focus for municipal action, although there are many more areas where municipalities can support action.

With their capacity to bring the national reconciliation effort home to the local level, municipalities are not only critical partners. They have the capacities to be leaders in reconciliation through an authentic and inclusive dialogue with Indigenous peoples and governments.

"The TRC was a six-year undertaking, engaging thousands of Indigenous Peoples and non-Indigenous Canadians. Through this multi-year process, the TRC laid out what must be done. The second stage of the journey to reconciliation begins by determining how to implement the Calls to Action. Since the TRC process began in 2009, municipalities have seen significant changes in how we understand the issues and relationships with First Nations, Inuit and Métis peoples that live in our cities, resulting in new and revitalized relationships with local Indigenous leaders and organizations."[11]

Calls to Action Related to Municipalities

- Nº 40 – Establish Indigenous-specific victim programs and services
- Nº 43 – Adopt and implement UNDRIP
- Nº 47 – Reject concepts used to justify European sovereignty over Indigenous peoples and land
- Nº 57 – Educate municipal public servants and develop skills in intercultural competency, conflict resolution, human rights and anti-racism efforts
- Nº 64 – Require denominational schools to provide comparative religious studies including on Indigenous spiritual beliefs and practices
- Nº 75 – Protect Residential School cemeteries
- Nº 77 – Provide records of Residential Schools to the National Centre for Truth and Reconciliation
- Nº 87 – Provide public education on the history of Indigenous athletes in Canada
- Nº 88 – Take action to support the development of Indigenous athletes

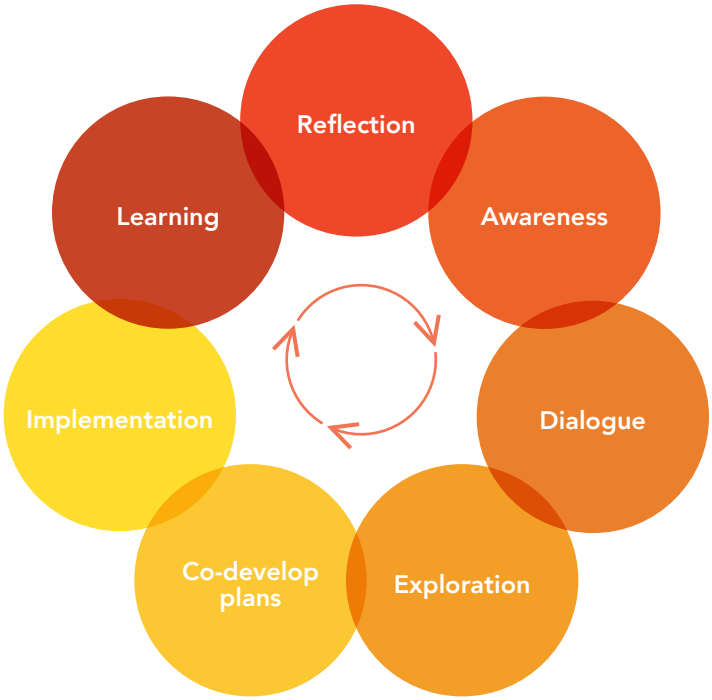
Engage with Indigenous communities and individuals in various areas of municipal work

Consider the host of local issues for which municipalities are responsible – land-use planning, economic development, affordable housing, clean drinking water, policing and justice, fire and emergency response – and how these touch on the rights and interests of neighbouring Indigenous governments and Indigenous people living in towns and cities. Municipalities are encouraged to engage with Indigenous people living within the municipality, to ensure that the municipality is inclusive of all residents and serving their needs. In addition, municipalities should strengthen relations with neighbouring Indigenous communities and governments in whose traditional territories the municipality is located.

Municipalities can be good neighbours by sharing their plans and priorities, discussing possible new infrastructures, and offering to share services with Indigenous communities or purchase services from them. Working together may prove challenging, but imagine the new opportunities for cost savings, jobs and economic development, improved levels of service, and better land management and environmental protection, among others![12]

The Power of the Arts and Culture
CULTURAT is an ambitious and innovative social project that mobilizes the general public, socioeconomic groups, the media and Indigenous communities of Abitibi-Témiscamingue, QC, towards the beautification of the territory through the arts and the creation of attractive and welcoming public spaces. It also encourages the knowledge, consumption and appreciation of local and regional cultural and artistic richness. Coordinated by Tourisme Abitibi-Témiscamingue, the initiative celebrates the heritage of local First Nations and promotes relationships between Indigenous and non-Indigenous peoples. As of May 2019, 62 municipalities, 7 band councils and 17 organizations have signed the CULTURAT charter. Many school boards, businesses and citizens in the region are also showing their support for the initiative.

Learning and growth: a model



Successful collaboration can be built through a process of ongoing learning and sharing. Municipalities can start the process by learning everything they can about Indigenous peoples and their rights. Educate yourself, your staff and elected officials, and your community about historical facts, different Indigenous cultures, and legal rights. Reflect on and understand how your municipality can improve its own policies, practices, procedures and institutional values to achieve fully respectful relationships. Once you understand the basics, reach out to your Indigenous neighbours and start to build a respectful relationship based on a true appreciation for each other that will evolve over time. With a respectful dialogue underway, communities can explore a host of issues on which they might collaborate. Finally, communities can co-develop plans to address these issues and work together on their implementation. Knowledge, awareness, respect, and appreciation will build over time as we take on new ideas, processes, and relationships. This is a cyclical and evolving process. Bring an open mind and an open heart, and be ready to challenge yourself and your preconceptions.

June 21 - National Indigenous Peoples Day
The day is marked by festivals, traditional dances, singing, pow-wows, storytelling, and more. As a municipality, you can host and take part in the celebrations. Need some ideas? The Indigenous Tourism Association of Canada and Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC) websites offer plenty of ideas of interest for municipalities and their partners. The website also offers tips to promote your June 21 event. The Celebrate Canada program also provides funding opportunities for community celebratory events for which municipal governments are eligible.

The Media and Reconciliation

Your local media have a role to play in the reconciliation process. Reporting in Indigenous Communities (RIIC) offers a guide and checklist. The information is organized into three areas of reporting where journalists face challenges when producing news stories about Indigenous peoples: (i) At the Desk – how to research and pitch stories; (ii) In the Field – how to gather information for these stories; and (iii) On the Air – how to present stories about Indigenous peoples.[13]

Successful Strategies

Reconciliation is a complex issue and will take time. Identifying tangible opportunities for success along the way will help keep motivation high as you move through the stages of understanding, collaborating, and advancing meaningful knowledge and practices around reconciliation.

Here are some ideas for easy wins.

1 Understanding

- ✓ Learn at work – Workshops, online training and guest speakers, including Indigenous speakers, can help introduce the topics and get people talking. Topics might include:
  - Indigenous peoples and Canada
  - Human rights and Indigenous rights
  - Truth and Reconciliation Commission of Canada and Calls to Action
  - Protocols of place
- ✓ Provide training to senior leadership and management, service providers and frontline workers.
- ✓ Learn the culture and history of the Indigenous peoples in your area, such as by attending events and listening. Indigenous peoples in Canada have diverse worldviews that are reflected in the cultures, languages and ancestral knowledge of their communities. The Inuit are different from the First Nations and Métis and there are many variations among First Nations. For example, the Mi'kmaq from the East Coast are quite different from the Blackfoot of the Prairies.

Katzie First Nation provides a Katzie 101 training to the council and staff of the City of Pitt Meadows, B.C. to better inform them about Katzie history, culture and current realities. Have you considered inviting local Indigenous communities, Elders or organizations to speak with your municipal officials?

2 Collaborating

- Organize discussions and meetings with local Indigenous community representatives; this can help with forward momentum and build the foundation of new relationships and potential partnerships.
- Invite Indigenous women, youth and Elders to your meetings to ensure you address everyone's perspectives, issues and concerns.
- Consider hiring a facilitator who is experienced in working with Indigenous communities to help ensure protocols are met for all participants, common goals are established, and difficult moments or conflicts are mitigated.
- Establish a group of representatives, including Indigenous representatives, who are able to meet regularly, set and work on achievable goals, and keep the collaboration moving forward.
- Join the Coalition of Inclusive Municipalities of the Canadian Commission for UNESCO.
- Support dialogue between municipal departments and branches such as local police authorities and Indigenous peoples to identify opportunities for training and improved relations.
- Consider reaching out to research centres or networks to inquire about data or statistics that the municipality alone cannot generate.
- Inquire if your provincial or territorial municipal association provides support to municipalities for implementing UNDRIP, the TRC's Calls to Action, or training for municipal officials. Is reconciliation a topic at their next annual meeting?
- Work with local chambers of commerce, training organizations or schools, universities, and colleges to develop programs that could contribute to train Indigenous peoples – especially youth – to fill local job vacancies.
- Work with service-providers and local organizations to ensure access to housing for Indigenous peoples within the municipality and to help address poverty reduction.

The Town of Hearst and the Constance Lake First Nation in Ontario have been working together on various projects. In 2016, they worked together to develop a joint mining-readiness strategy to prepare themselves to benefit from a new graphite mine. In 2018, they signed an agreement to share solid-waste management services.

3 Advancing

- ✔ With partnerships established, identify short, medium- and long-term collaborative projects.
- ✔ Prioritize reconciliation within municipal planning. This can assist in generating activities and successes. Indigenous communities and municipalities struggle with limited resources, including financial, human and technical supports. These topics should not be avoided or minimized but may constitute important discussion and action points that require solutions.
- ✔ Continue to build on your knowledge and capacity to engage effectively with Indigenous peoples.

The Municipality of the County of Antigonish, NS, the Eastern-Straight Regional Enterprise Network and Paqtnkek Mi'kmaw Nation have been working together since 2016 to strengthen collaboration and build a more resilient local economy. As a result of discussions, Paqtnkeke and the Municipality have signed a historic friendship agreement; are making joint applications for renewable-energy projects; are sharing services and land-use planning; held a joint green-energy workshop; and are planning a regional economic development forum between First Nations and local governments.

Did you know

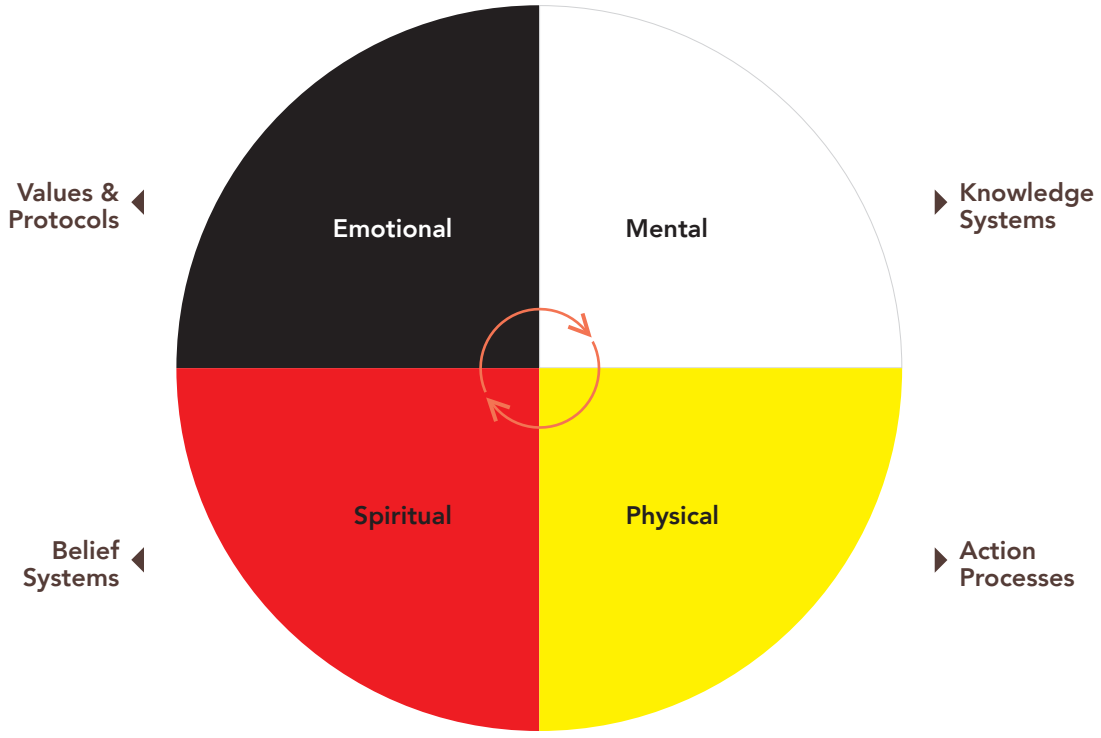
Did you know some First Nations, Inuit and Métis are responsible for local governance, including the operation of municipalities? In the Northwest Territories there are only two Indian Act Reserves, and other local settlements are operated through self-government agreements or designated authority of various First Nations. In Alberta, the Métis Settlements General Council manages eight settlements established by Alberta under the Métis Settlements Act. Inuit, as the dominant population in Nunavut, as well as parts of Northern Québec and Labrador, also govern their own municipalities or settlements.

Newcomers and Reconciliation

Identify opportunities to create and continue dialogue to build stronger relationships between new Canadians and First Nations, Métis and Inuit peoples in your community. You could for example host a dialogue circle involving newcomers and Indigenous peoples and feature discussions and topics significant to the contributions and history of Indigenous Peoples, the history and legacy of Residential Schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, and treaties and the treaty relationship.[14]

Reconciliation in Practice – A Holistic View

A holistic view of reconciliation honours many Indigenous worldviews and can provide a useful framework for systemic change. A holistic approach considers four interconnected areas – mental, physical, emotional and spiritual. This section offers some examples of how municipal initiatives designed to lead to reconciliation are progressing in each of these four areas. If we address each area in our reconciliation journey, we can begin to generate the systemic changes we aim to achieve. The graphic below shows one example of how municipalities can think about the four interconnected areas. In this graphic, Knowledge Systems are linked to the Mental Domain; Action Processes are linked to the Physical Domain; Belief Systems are linked to the Spiritual Domain; and Values and Protocols are linked to the Emotional Domain.



Knowledge Systems

Many municipalities are exploring the TRC Calls to Action and UNDRIP to consider how these might be implemented locally. Some municipalities have prepared for reconciliation by creating new policy, establishing new government departments, and creating new staff positions. An important part of the process is for municipalities to work jointly with appropriate First Nations, Métis and Inuit governments, communities, organizations and individuals to develop plans and strategies supporting reconciliation.

- The City of Calgary, AB, is supported by the Calgary Aboriginal Urban Affairs Committee, which serves as an advisory committee to City Council. The Committee operates with a 10-Year Strategic Plan and reports annually to City Council on its achievements. Their work has resulted in three significant documents to advance reconciliation in partnership with the Kainai Nation, Siksika Nation, Wesley Nation, Chiniki Nation, Bearspaw Nation, Tsuut'ina Nation, and Piikani Nation. The White Goose Flying Report is the City's response to the TRC Calls to Action. The Indigenous Policy Framework and the Indigenous Policy documents describe the local First Nations' history and landscape prior to treaty and the importance of these in the City's planning and decision-making processes.

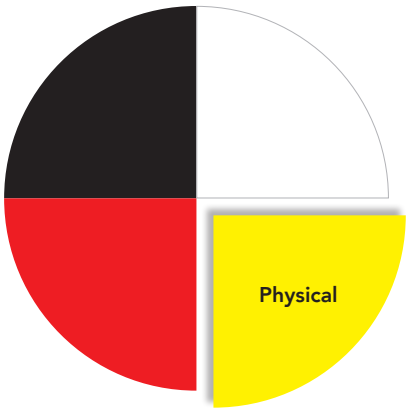
- The City of Lethbridge, AB, and the Lethbridge Indigenous Sharing Network have created a Reconciliation Implementation Plan (2017-27) that was unanimously adopted by City Council. The plan was developed in partnership with the Kainai Nation and the Piikani Nation.

- The City Council in Vancouver, BC, designated Vancouver as a City of Reconciliation and began initiatives to begin healing and forging new relationships. A Framework for City of Reconciliation was adopted, focusing on cultural competency, strengthening relations, and effective decision-making at the corporate level (within the overall service provision). Council also adopted the City's response to 27 TRC Calls to Action, identifying 41 City initiatives under three themes: Healthy Communities and Wellness; Achieving Indigenous Human Rights and Recognition; and Advancing Awareness, Knowledge and Capacity.

- The City of Prince George, BC, has adopted a Reconciliation Framework which contains corporate strategies based on the UNDRIP, recommendations from the TRC, and the City's Commitment to the Coalition of Inclusive Municipalities.

- The City of Toronto, ON, with support from the Aboriginal Affairs Committee (soon to be Indigenous Affairs Committee) and a recommendation from the Urban Indigenous Community of Toronto, established the Indigenous Affairs Office in 2017. The IAO strives to strengthen the City's relationship with Indigenous communities and advance reconciliation. While the City remains committed to embedding the responsibility for Indigenous priorities across City divisions, the IAO will provide more focused and coordinated leadership on Indigenous affairs. This office builds on Commitments to Indigenous Peoples as well as existing work.
- In 2018, the City of Montréal, QC, created a new position, Commissioner of Indigenous Affairs, to lead the development of Montréal's reconciliation strategy, help implement the principles of UNDRIP, provide training to elected officials and staff, and advise the Mayor and Council about reconciliation.

Action Processes



Reconciliation involves multiple partners working in a positive relationship, with a willingness to collaborate. Successful partnerships often lead to policy development, tangible actions and greater understanding of diverse values and protocols.

- The City of Saskatoon, SK, has identified Reconciliation, Inclusion and Diversity as one of its key areas of focus and released a strategic Response to the TRC. The City of Saskatoon, Office of the Treaty Commissioner, Saskatoon Tribal Council and Central Urban Métis Federation Inc., along with 54 supporting organizations, launched an initiative known as Reconciliation Saskatoon. These organizations joined together to further a citywide conversation about the process of reconciliation, provide opportunities for transformative experiences at events, and inspire citizens to engage in calls to action.
- The Burnaby Village Museum in Burnaby, BC, has worked with local First Nations to launch a series of cultural presentations in which local Coast Salish community members share knowledge about various aspects of their culture and history. Coast Salish content is also included in programs that the Museum and School District host for K-12 students.
- The mayor of Sept-Îles, QC, invited the Chief, an Elder and community members from the Innu Takuaikan Uashat mak Mani-Utenam to his swearing-in ceremony. They have held council-to-council meetings and established two joint working committees – one on reconciliation and one on infrastructure and other files.
- The City of Victoria, BC, has a Witness Reconciliation Program with the Songhees and Esquimalt Nations that reflect traditional Indigenous witness journeys as a means of identifying and advancing reconciliation activities

and processes. This program also began a City Family that includes City Council members, Indigenous advisors and City staff; all meet regularly to imagine ways of creating everyday awareness of the history, present and future of the Songhees and Esquimalt Nations within the city.

- The City of Red Deer, AB, City Council passed a motion in 2015 to address five TRC Calls to Action and, in 2017, signed a Protocol Agreement with the Urban Aboriginal Voices Society. The Protocol represents the shared commitment between the voices of the Aboriginal community in Red Deer and the City of Red Deer to share in the vision to create a strong, engaged community that embraces its diversity, improves well-being, and maintains a good quality of life. It is guided by the principles of equity, leadership, collaborative action, and participation and diversity when making decisions, developing plans and implementing actions on issues of common concern.

- The Val-d'Or First Nations Community Mixed Police Station - PPCMA (Quebec) encourages a community approach to maintaining peace, order and public safety by intervening as second-line responders. The PPCMA offers support and assistance to patrol officers of the Sûreté du Québec de la MRC de La Vallée-de-l'Or through teams composed of police officers and social workers who can, for example, direct vulnerable, intoxicated or homeless persons to appropriate services.

- Some municipalities and Indigenous governments have adopted formal collaborative governance structures that support their capacity to share and work together. Examples include the Eeyou Istchee James Bay Regional Government, QC, and the Alberni-Clayoquot Regional Government, BC. The latter consists of a federation of municipalities and four treaty First Nations. Another example is Pitu'paq, a volunteer collaboration between five First Nations and five municipalities established in 2001; the group meets monthly to address the environment of Bras d'Or Lakes, Cape Breton, NS.

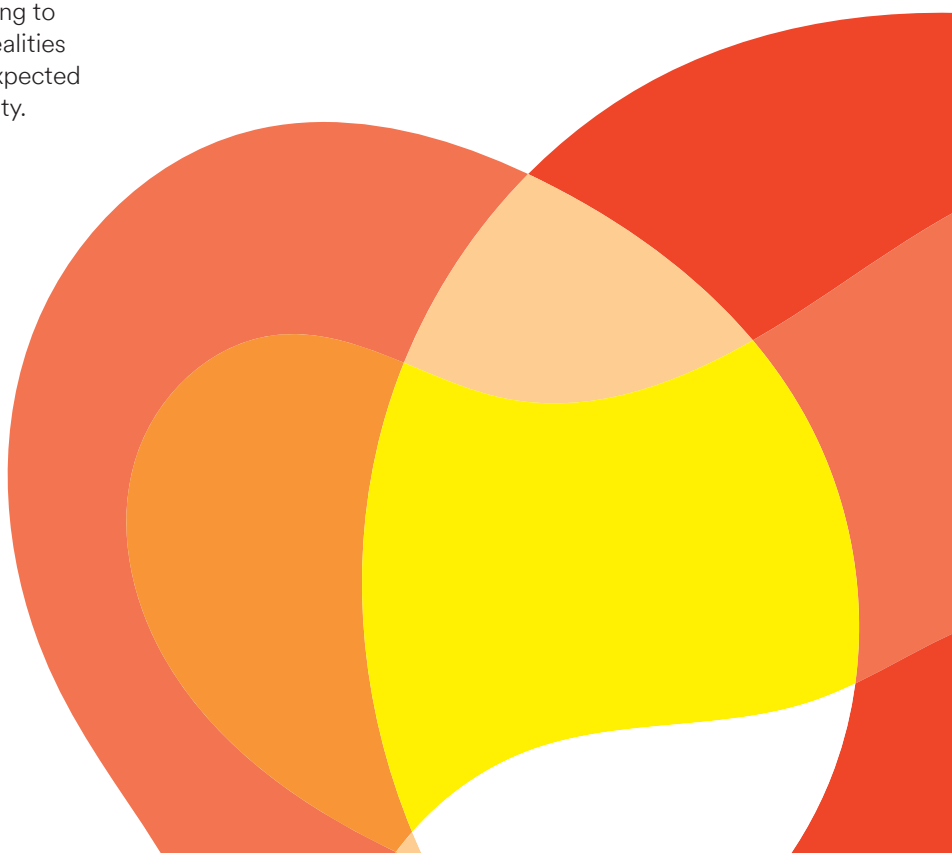
- Collaborations often lead to formalized agreements that form the basis of subsequent specific projects. The Town of Temiscaming, Municipality of Kipawa, QC, and Eagle Village First Nation signed a Friendship Accord. Pitt Meadows, BC, and Katzie First Nation signed water, sewer and fire agreements as well as a Friendship Agreement. The Town of Hearst, ON, and Constance Lake First Nation signed a Sustainable Development Agreement to cooperate on solid-waste management while improving the environment, reducing costs, and establishing a base for future relations. Edmundston, NB and Madawaska Maliseet First Nation have signed a Joint Friendship Accord.

- Economic initiatives are taking shape among municipalities and Indigenous communities. The Town of The Pas, MB, Regional Municipality of Kelsey, MB, and Opaskwayak Cree Nation signed a Friendship Accord and jointly pursue economic development initiatives. Together, they also published an investor-attraction brochure and launched an investor-attraction website. The City of Edmonton, AB, and Enoch Cree Nation signed a Memorandum of Understanding based on government-to-government relations and are working together to explore community economic development, housing, transit, green energy and co-management of a provincial park. Halifax, NS, is working with the Mi'kmaq Sport Council of Nova Scotia to host the 2020 North American Indigenous Games; thousands of people are expected to attend events across the Halifax Regional Municipality and at Millbrook First Nation.

- The City of Pitt Meadows, BC, included Katzie names for their public meeting spaces at City Hall. Powell River, BC, in collaboration with Tla'amin Nation, has developed a waterfront recreation space that includes Coast Salish language on all signage. Municipalities such as Sept-Îles, QC, Fort Smith, NWT, and Whitehorse, YT, have added Indigenous local languages to certain stop signs. The City of Toronto, ON, has changed the official signs for several of its major streets, to Anishinaabemowin and Mohawk language names. The City of Winnipeg, MB, developed a poster with "welcome" in many local Indigenous languages that businesses are invited to display in their premises.

- Nine Quebec municipalities and the *Regroupement des Centres d'amitié autochtones du Québec* (Native Friendship Centres) joined forces to address Indigenous urban issues. Three meetings were organized between the Mayors from these nine municipalities and representatives from local Native Friendship Centres. The outcomes include the signing of a *Mutual Commitment to Improve the Living Conditions of Aboriginal People* (2017) and the adoption of a joint Action plan (2018) to bring people together and secure services for Indigenous peoples in urban settings. In 2016, as part of this process and to continue the dialogue, the Union des municipalités du Québec established a Joint Committee on Urban Aboriginal Issues. Participating municipalities are Chibougamau, Joliette, La Tuque, Maniwaki, Montréal, Roberval, Senneterre, Sept-Îles, and Val-d'Or.
- In 2018, the City of Montréal hosted the First Summit of First Nations and Municipalities on Reconciliation, organized in collaboration with the Union des municipalités du Québec, the Fédération québécoise des municipalités and the Assembly of First Nations Québec-Labrador. More than 50 mayors from Quebec municipalities and half of the Chiefs of First Nations in Quebec attended. Among the commitments taken by parties were promotion of collaborative good practices between municipalities and First Nations, and collaboration to offer training to elected officials about the history and realities of Indigenous Peoples. The Summit is expected to be held yearly in a Quebec municipality.

2019 is the International Year of Indigenous Languages. Supporting Indigenous-language speakers, educators and champions in the revitalization and maintenance of Indigenous languages is one way that we can all work towards reconciliation. Check out the Indigenous Languages in Canada Reference Sheet published by the Canadian Commission for UNESCO to learn more about what your municipality can do to support Indigenous languages.



Spiritual Beliefs

Indigenous and non-Indigenous communities enjoy social gatherings. Sharing food, storytelling, dance, art, music and traditional knowledge are an important way to learn about Indigenous cultures. Opening up opportunities for Indigenous peoples to share their worldviews and perspectives within the municipal landscape can help break down barriers and increase learning experiences.

- The event KWE! Meet with Indigenous Peoples aims to present the 11 Indigenous Nations in Quebec to the public. The event's program includes shows by Indigenous artists, discussions on the issues faced by Indigenous communities, short films, workshops on traditional knowledge, demonstrations of arts and crafts as well as meeting people. The event is organized by the Huron-Wendat Nation, the host Nation, and the Assembly of First Nations Quebec-Labrador in collaboration with different partners including the City of Québec.
- The City of Medicine Hat, AB, is planning a reconciliation-awareness event as part of Raising the Curtain: A Celebration of Diversity and Inclusion. In addition, the City's Arts and Heritage Advisory Board has set a goal to facilitate reconciliation through arts, heritage and cultural activities.
- Oakville, ON, has developed a trail and information system featuring a series of 13 plaques containing stories and information relating to land, water and sky, developed in partnership with the Mississaugas of the New Credit First Nation and other Indigenous community members.
- In Ottawa, ON, Pimisi Station along Ottawa's new light rail transitway has been designed to incorporate an Algonquin cultural theme, reflecting both the historical and contemporary cultural significance of the Algonquin people.
- Cochrane, AB, hosts the Cochrane Community Awards, including an Equity & Inclusion Champion Community Award. It has garnered a lot of attention, with all nominees acknowledged at a sold-out awards ceremony. Having community faces and people who can tell a story about the positive impacts they are having in a community often brings a new humanity to situations or issues that can help to dispel myths, assumptions and stereotypes.
- The City of Winnipeg, MB, developed a Smudging Standard which allows traditional ceremonies such as smudging in City facilities. Indigenous and non-Indigenous staff can thus embed traditional cultural practices in events and meetings, as well as for personal self-care.

Values and Protocols

An important consideration in every municipality is the recognition of the traditional territory of Indigenous peoples. Acknowledging Indigenous peoples and territories reaffirms the foundation of reconciliation relationships. Inclusion committees, campaigns and education initiatives can also be an important part of reconciliation efforts by integrating Indigenous values and protocols.

- The City of Vancouver, BC, uses appropriate protocols that respect the traditions of welcoming, blessings and acknowledgement of the unceded territory of the Musqueam, Squamish, and Tsleil-Waututh.
- The City of Winnipeg, MB, Citizen Equity Committee published a card acknowledging "Treaty 1 Territory, and the traditional lands of the Anishinaabe, Cree and Dakota as well as the Birthplace of the Métis Nation and the Heart of the Métis Homeland."
- The City of Sept-Îles, QC, has participated in sport and cultural events at the invitation of Innu Takuaikan Uashat mak Mani-Utenam. They are also working together to address environmental concerns of both communities.
- Inclusion committees and campaigns form an important part of reconciliation efforts and can integrate Indigenous values and protocols. The social policy of the Town of Cochrane, AB, established the municipal responsibility of upholding the TRC Calls to Action; it acknowledges the need to redress the legacy of Residential Schools and advance reconciliation, with the *United Nations Declaration on the Rights of Indigenous Peoples* as a framework. The entire Town of Cochrane Management team is participating in a year-long Indigenous training curriculum to support the Call to Action.
- The City of Ottawa, ON, has a Reconciliation Action Plan and an Aboriginal Working Committee (AWC) that strengthen relationships between the City and the Indigenous community. The AWC is a partnership between the Ottawa Aboriginal Coalition, representing Indigenous service providers, the City of Ottawa and other community partners. The AWC has adopted a culturally-centred working model that reflects urban service priorities of the Indigenous community including culture, health, housing, education and employment.
- In St. Albert, AB, the Community & Social Development Department initiated the It Starts With Me campaign for creating Welcoming & Inclusive Communities. The campaign helped City staff and residents reduce misinformation and dispel myths and stereotypes. Other projects of the municipality include the creation of a Healing Garden, educational programs for schools and the community, museum exhibits, street signs in English and Cree, and interpretive signage in Cree, English and French. Numerous KAIROS Blanket Exercise events have been held for residents, teachers and youth.

- There are a number of education initiatives supporting reconciliation by municipalities and other organizations. The Regional Municipality of Wood Buffalo, AB, has identified 23 TRC Calls to Action for consideration, engaged with Indigenous partners, and hosted TRC engagements with municipal employees and the public. The Municipality offers Aboriginal Awareness and TRC training, which provide information to learn about Indigenous history, colonialism, residential schools and the TRC. The training increases employee knowledge about Indigenous history, intergenerational trauma, continued challenges Indigenous people face, and strategies to move forward in building trust and positive collaborations with local Indigenous communities and governments.
- In Saskatoon, SK, the Building New Relationships program assists those working with newcomers to become more informed about First Nations peoples and the treaties that form the foundation of the Canadian Constitution. The Office of the Treaty Commissioner (OTC) developed a two-day 'train the trainer' program to help build relationships with First Nations' peoples and learn about their history and traditional culture. The City's *I am the Bridge anti-racism public education campaign* had citizens share their experiences with racism and ways to eliminate it. This video is showcased on the city website, social media and YouTube – in keeping with the City's commitment to respond to the TRC Calls to Action, as well as the Strategic Plan (2013-23) goal to enhance relations with Indigenous organizations through the development of educational opportunities. The City also collaborated with the Saskatchewan Indigenous Cultural Centre (SICC) and the Office of the Treaty Commissioner (OTC) to develop the First Edition of *ayisīnowak: A Communications Guide*. The Guide is intended to assist City employees build successful partnerships with First Nations, Métis and other Indigenous organizations by providing a basic outline of Indigenous understandings and governance systems.
- The City of Vancouver, BC, has implemented Cultural Competency workshops and online training modules for all levels of staff in service areas. The training has raised understanding and appreciation of Indigenous history and culture, including the impacts of the Residential School systems and related issues for staff that work and interact with Indigenous clients, co-workers, communities and suppliers. In addition, Vancouver has issued *First Peoples: A Guide for Newcomers* to offer information about Indigenous peoples in the region.

Do's and Don'ts

Do construct reconciliation initiatives together with Indigenous communities!

Knowledge Systems

- ✓ Do educate municipal personnel about the local Indigenous cultures, read the applicable treaties, and watch and read Indigenous news
- ✓ Do discuss similarities and differences together among municipal and Indigenous governance systems
- ✓ Do find points of agreement and build consensus
- ✓ Do take time to read the Truth and Reconciliation Report and its Calls to Action
- ✓ Do consider taking an online course on Indigenous peoples, cultures, history, etc.
- ✗ *Don't assume the treaties are ancient history and have no legal authority*

Action Processes

- ✓ Do attend public events hosted by Indigenous communities and organizations and invite Indigenous peoples to municipal events
- ✓ Do hold regular Council-to-Council and staff-to-staff meetings to set and work on achievable goals, and keep the collaboration moving forward
- ✓ Do share and discuss plans for the future with Indigenous governments and organizations
- ✗ *Don't make plans that affect Indigenous communities without involving them from the outset*

Belief Systems

- ✓ Do understand that spiritual practices are part of Indigenous culture and business relationships
- ✓ Do develop partnerships that will be long-term
- ✓ Do imagine possibilities for positive outcomes and keep an open mind
- ✓ Do respect Indigenous spiritual and historical sites
- ✗ *Don't assume all Indigenous peoples or nations are the same*

Values and Protocols

- ✓ Do be respectful in thought and behaviour
- ✓ Do ask Indigenous representatives about appropriate local protocols
- ✓ Do communicate honestly and openly
- ✓ Do be patient and understanding about punctuality – Indigenous leaders and communities may take longer to reach decisions or may not be able to attend pre-scheduled meetings owing to other obligations

Don't give up after the first try – building trusting, respectful relationships takes time.

Tools and resources

Contact the Federation of Canadian Municipalities for helpful tools, including:

- *Pathways to Reconciliation*
- First Nations – Municipal Collaboration Programs
- *Stronger Together: A Toolkit for First Nations-Municipal Community Economic Development Partnerships*
- *Service Agreement Toolkit*
- *Solid Waste Management Toolkit*
- First Nation-Municipal Land Use Planning Tool
- Templates for and examples of collaboration agreements and service agreements (i.e. fire, water)

Check out what your provincial/territorial/municipal organization or human rights commission are doing in this regard. They may have additional resources. Some examples include:

- The Union of BC Municipalities identifies a host of resources for municipal-Indigenous reconciliation
- The Alberta Urban Municipal Association offers toolkits, guides and examples
- The Association of Municipalities of Ontario offers webinars on Indigenous issues
- The Commission des droits de la personne et des droits de la jeunesse du Québec publishes *Aboriginal Peoples – Fact and Fiction*, an educational tool designed to promote a better understanding of the realities facing Indigenous peoples

Featured Municipalities

The following section features only some of the many municipalities across Canada that are doing innovative work on reconciliation.

Winnipeg, Manitoba

The City of Winnipeg has taken a unique approach to advancing reconciliation through the creation of an Indigenous Accord that has already been signed by over 80 businesses and organizations. The Accord includes a commitment by signatories to reconvene and report annually on their own reconciliation progress and future goals. The City's Indigenous Relations Division (IRD) provides key leadership and advice to civic programs, services and initiatives, while advancing work on the TRC's Calls to Action. As such, City employees can now participate in Indigenous training courses as part of reconciliation. Winnipeg's Indigenous Youth Strategy, Oshki Annishinabe Nigaaniwak, is designed to provide Indigenous youth with positive opportunities related to employment, literacy and recreation through culturally-appropriate programs and supports. The IRD partners with other civic departments to develop internships, scholarships, camps and other recreation programs. These and other accomplishments of the IRD can be found in the City's Partner Goals & Progress Report.

The City also has an 11-member Citizen Equity Sub-Committee (CEC), under the newly established Human Rights Committee of Council (HRCC), mandated to advise the Mayor and Council on issues of equity and diversity. The CEC developed Winnipeg's Know Your Neighbours Guide and other publications, including an Indigenous Leadership Invitation protocol, approved by Indigenous leaders, to guide City officials on how to effectively and respectfully invite First Nations and Métis leaders to attend events. In that light, Maria Morrison, former Coordinator of the Citizen Equity Committee, is concerned with the toll that reconciliation initiatives can take on Indigenous individuals and communities. While the benefits of non-Indigenous peoples learning about Indigenous cultures enhance social relationships, Indigenous community members have expressed fatigue and emotional stress from repeatedly discussing their colonial oppression experiences or being expected to speak for all Indigenous peoples. Ms. Morrison believes that some of the challenges faced by municipalities in developing and implementing reconciliation initiatives can be mitigated with committed leadership, clear and measurable objectives, and accountability mechanisms.

"Reconciliation is messy. When you start, it may feel like it is getting worse instead of better. Ripping off the bandage opens ugly wounds. If you can do it, there will still be a scar, but it may not hurt so much anymore. We took the bandage off in Winnipeg. Keep trying!"
– Maria Morrison

Whitehorse, Yukon

The City of Whitehorse has been actively advancing relationships with Indigenous peoples for several years. The Moving Forward Together report features municipal and First Nations' leadership, and several of the TRC Calls to Action as areas of focus. The City's advisory committee for the Coalition of Inclusive Municipalities was established to advise City Council and Administration on ways to eliminate racism and discrimination in the development, implementation and operations of the City's plans, policies, services and facilities.

The Kwanlin Dün First Nation, Ta'an Kwäch'än Council, and the City adopted a Declaration of Commitment to further strengthen the relationships among the three governments. The City proclaimed a National Indigenous History Month to honour contributions of First Nations, Inuit and Métis peoples. The City also includes acknowledgement of First Nation traditional territories in electronic signature blocks; has added Southern Tutchone on welcome and traffic signs; and promotes Kwanlin Dün and Ta'an Kwächän artists. The City made it mandatory for staff to complete the Yukon First Nations 101 course offered by the Yukon College. So far nearly 200 employees have taken the course.

As noted by Jocelyn Curteanu, Whitehorse City Councillor, after having addressed many of the TRC Calls to Action for municipalities, the City has shifted focus to relationship-building and ongoing respectful communication and partnerships. The Mayor and Council hold regular intergovernmental meetings with each First Nation to keep the lines of communication open and discuss mutual concerns and initiatives. Councillor Curteanu believes that reconciliation is a journey that starts with an honest acknowledgement of our history, a sincere desire to do better, building trust, and finding common ground to collaborate.

"Commitment and patience are key. We must remain flexible and work to accommodate [Indigenous peoples'] needs."
– Jocelyn Curteanu, Councillor

Montréal, Quebec

The Indigenous presence in Montréal has grown by 177% since the early 2000s. An inhabited and gathering place for First Nations for thousands of years and currently home to the largest Inuit population outside Iqaluit, Montréal has developed a process of reconciliation as part of a government-to-government dialogue and co-construction with the Indigenous community.

The City of Montréal committed itself to reconciliation on National Indigenous Peoples Day in 2016. In 2017, to honour its history and 375th anniversary, while beginning a new chapter in the city's relationship with Indigenous peoples and governments, the Assembly of First Nations Quebec-Labrador in partnership with the City, DestiNATIONS and the Canadian Commission for UNESCO hosted an event celebrating the 10th anniversary of UNDRIP. This included hoisting the new city flag that now incorporates a white pine tree, the "Great Tree of Peace" from the Haudenosaunee culture.

In 2018, the City appointed Councillor Marie-Josée Parent to the Executive Committee, with special responsibility for culture and reconciliation. The first appointee to the position, Ms. Parent is of Mi'kmaq and Acadian heritage and is the first Indigenous city councillor elected in Montréal.

The City also hired a Commissioner of Indigenous Affairs, Marie-Ève Bordeleau. Her role includes leading the development of Montréal's reconciliation strategy, developing awareness training for City staff and officials and advising the Mayor and Council about reconciliation and the implementation of UNDRIP. Importantly, this position came with a budget for training and supporting the Commissioner's mandate. Ms. Bordeleau works with local Indigenous communities and organizations to define reconciliation priorities together and develop solutions for their success. She recommends communities meet at the government-to-government level, taking time to understand each other's needs, vision and expectations. She suggests that if issues are beyond the capacity of the municipality, working with additional levels of government may help develop interconnected solutions.

Montréal hosted the inaugural First Nations and Municipalities Summit on Reconciliation, bringing together mayors and First Nations' chiefs from across Quebec. "There was a lot of talk… about concrete actions versus symbols, like naming parks, restoring truth, restoring different versions of history. And for me, the two work in concert with one another."
– Valérie Plante, Mayor

Val-d'Or, Quebec

The City of Val-d'Or has taken steps to address local racism and discrimination against Indigenous peoples. In 2015, it signed a cooperation agreement with surrounding Anicinabe communities and the Grand Council of the Crees. In 2016, the City created the Committee against Racism and Discrimination, which produced an overview of racism in Val-d'Or (*Aperçu de la situation du racisme à Val-d'Or*) in 2017. The same year, Val-d'Or adopted UNDRIP. The City has participated in meetings of Quebec municipalities and Native Friendship Centres each year since 2016. In 2018 they joined the Coalition of Inclusive Municipalities of the Canadian Commission for UNESCO and adopted an action plan on racism, with input from Indigenous communities. Val-d'Or received the 2016 Collective Intelligence Award award from the municipal healthcare network, the *Réseau québécois des villes et villages en santé* (RQVVS). This award acknowledged the efforts of the City to respond quickly to complaints by local Indigenous peoples about racism. The Réseau also invited the City to share their experience with others.

Val-d'Or has adopted an unequivocal and firm political commitment to engagement with the Indigenous population, assigned a municipal employee to the reconciliation portfolio, pooled the efforts of community stakeholders, and promoted ongoing communication. Results include restored trust, new connections, and a general change of attitude in the population. These efforts have attracted outside attention and provided leadership for others.

Val-d'Or has adopted four paramount values: perseverance, patience, humility and ambition. "It means persevering even in the face of adversity and uncertainty, allowing time for things to fall into place, acknowledging our mistakes and inexperience, and lastly, not being afraid to dream or think big – and then deploy the energies needed to turn dreams into reality."
– Paul-Antoine Martel, City of Val-d'Or Liaison Officer

Conclusion

Transformation of social structures will take time and involve many different approaches. Indigenous communities make up less than 5% of the population of Canada, yet their involvement in reconciliation efforts by municipalities is crucial. Building new relationships is the work that lies ahead. Reconciliation will require open hearts and open minds, and a willingness to look at the world in a way that is more alert to, and respectful of, Indigenous peoples, and their rights and interests. It means honouring treaties and other commitments; it means acknowledging past harms and making a commitment to healing; it means changing the way we interact and the way we think about each other. Communities will benefit from courage, forgiveness, leadership and dedication. How will your community embrace reconciliation?

> "***Reconciliation must support Aboriginal peoples as they heal from the destructive legacies of colonization that have wreaked such havoc in their lives. But it must do even more. Reconciliation must inspire Aboriginal and non-Aboriginal peoples to transform Canadian society so that our children and grandchildren can live together in dignity, peace, and prosperity on these lands we now share***"[15].
> – Truth and Reconcilation Commission of Canada

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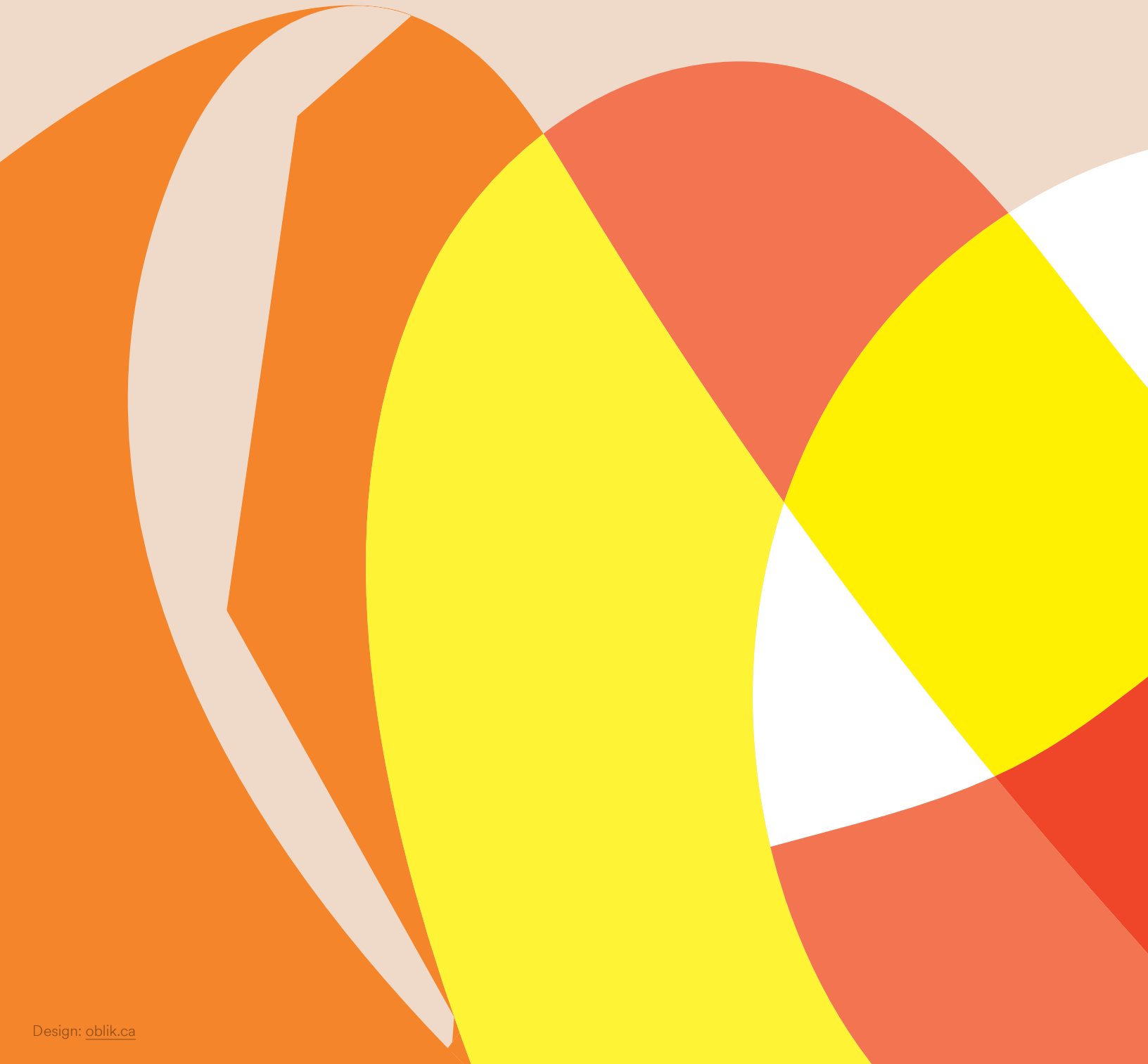

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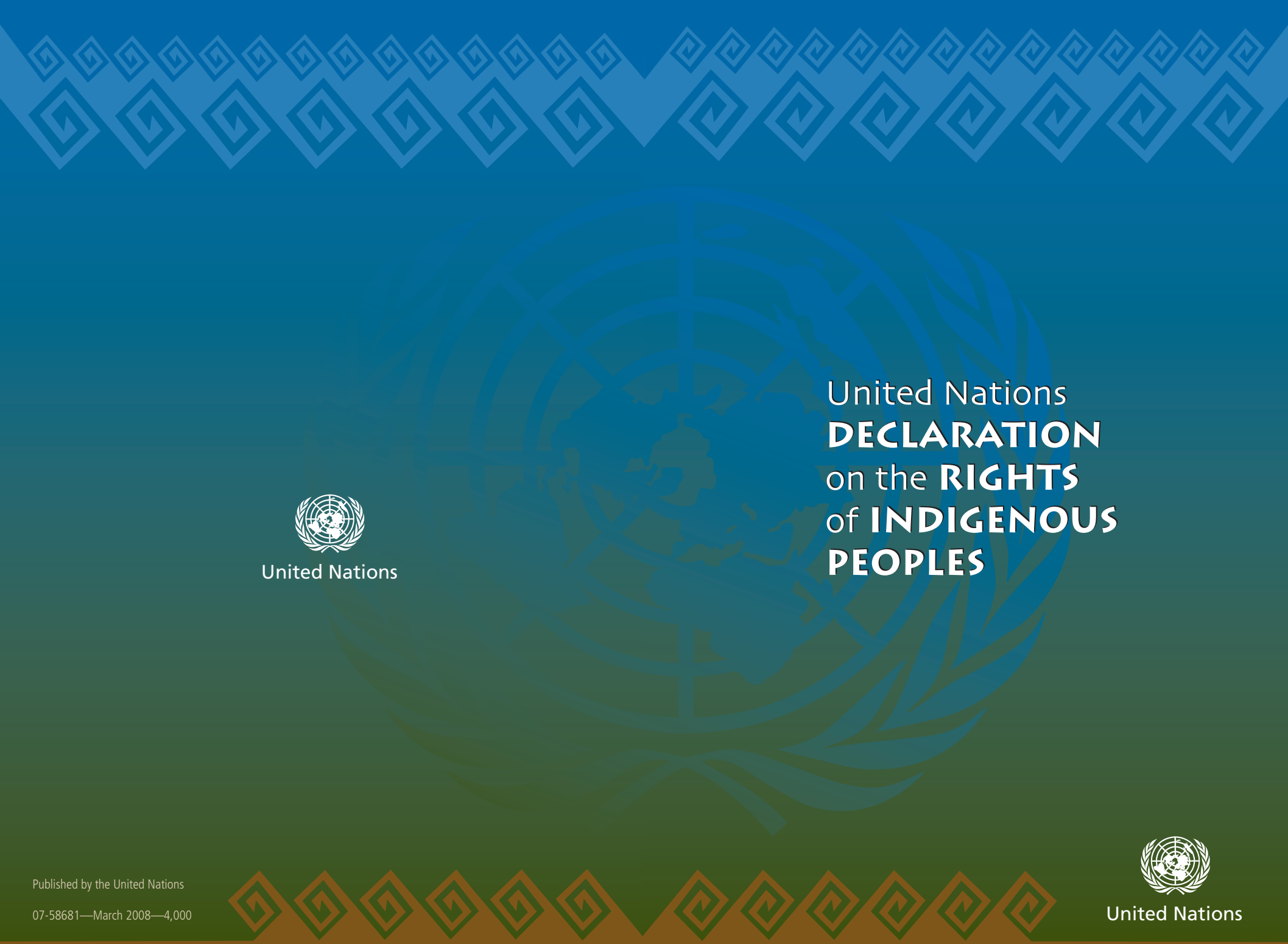

United Nations

United Nations DECLARATION on the RIGHTS of INDIGENOUS PEOPLES

Published by the United Nations

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United Nations

United Nations Declaration on the Rights of Indigenous Peoples

Resolution adopted by the General Assembly

[*without reference to a Main Committee (A/61/L.67 and Add.1)*]

61/295. United Nations Declaration on the Rights of Indigenous Peoples

The General Assembly,

Taking note of the recommendation of the Human Rights Council contained in its resolution 1/2 of 29 June 2006,[1] by which the Council adopted the text of the United Nations Declaration on the Rights of Indigenous Peoples,

Recalling its resolution 61/178 of 20 December 2006, by which it decided to defer consideration of and action on the Declaration to allow time for further consultations thereon, and also decided to conclude its consideration before the end of the sixty-first session of the General Assembly,

Adopts the United Nations Declaration on the Rights of Indigenous Peoples as contained in the annex to the present resolution.

107th plenary meeting
13 September 2007

Annex

United Nations Declaration on the Rights of Indigenous Peoples

The General Assembly,

Guided by the purposes and principles of the Charter of the United Nations, and good faith in the fulfilment of the obligations assumed by States in accordance with the Charter,

Affirming that indigenous peoples are equal to all other peoples, while recognizing the right of all peoples to be different, to consider themselves different, and to be respected as such,

[1] See *Official Records of the General Assembly, Sixty-first Session, Supplement No. 53* (A/61/53), part one, chap. II, sect. A.

Affirming also that all peoples contribute to the diversity and richness of civilizations and cultures, which constitute the common heritage of humankind,

Affirming further that all doctrines, policies and practices based on or advocating superiority of peoples or individuals on the basis of national origin or racial, religious, ethnic or cultural differences are racist, scientifically false, legally invalid, morally condemnable and socially unjust,

Reaffirming that indigenous peoples, in the exercise of their rights, should be free from discrimination of any kind,

Concerned that indigenous peoples have suffered from historic injustices as a result of, inter alia, their colonization and dispossession of their lands, territories and resources, thus preventing them from exercising, in particular, their right to development in accordance with their own needs and interests,

Recognizing the urgent need to respect and promote the inherent rights of indigenous peoples which derive from their political, economic and social structures and from their cultures, spiritual traditions, histories and philosophies, especially their rights to their lands, territories and resources,

Recognizing also the urgent need to respect and promote the rights of indigenous peoples affirmed in treaties, agreements and other constructive arrangements with States,

Welcoming the fact that indigenous peoples are organizing themselves for political, economic, social and cultural enhancement and in order to bring to an end all forms of discrimination and oppression wherever they occur,

Convinced that control by indigenous peoples over developments affecting them and their lands, territories and resources will enable them to maintain and strengthen their institutions, cultures and traditions, and to promote their development in accordance with their aspirations and needs,

Recognizing that respect for indigenous knowledge, cultures and traditional practices contributes to sustainable and equitable development and proper management of the environment,

Emphasizing the contribution of the demilitarization of the lands and territories of indigenous peoples to peace, economic and social

progress and development, understanding and friendly relations among nations and peoples of the world,

Recognizing in particular the right of indigenous families and communities to retain shared responsibility for the upbringing, training, education and well-being of their children, consistent with the rights of the child,

Considering that the rights affirmed in treaties, agreements and other constructive arrangements between States and indigenous peoples are, in some situations, matters of international concern, interest, responsibility and character,

Considering also that treaties, agreements and other constructive arrangements, and the relationship they represent, are the basis for a strengthened partnership between indigenous peoples and States,

Acknowledging that the Charter of the United Nations, the International Covenant on Economic, Social and Cultural Rights[2] and the International Covenant on Civil and Political Rights,[2] as well as the Vienna Declaration and Programme of Action,[3] affirm the fundamental importance of the right to self-determination of all peoples, by virtue of which they freely determine their political status and freely pursue their economic, social and cultural development,

Bearing in mind that nothing in this Declaration may be used to deny any peoples their right to self-determination, exercised in conformity with international law,

Convinced that the recognition of the rights of indigenous peoples in this Declaration will enhance harmonious and cooperative relations between the State and indigenous peoples, based on principles of justice, democracy, respect for human rights, non-discrimination and good faith,

Encouraging States to comply with and effectively implement all their obligations as they apply to indigenous peoples under international instruments, in particular those related to human rights, in consultation and cooperation with the peoples concerned,

Emphasizing that the United Nations has an important and continuing role to play in promoting and protecting the rights of indigenous peoples,

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[2] See resolution 2200 A (XXI), annex.

[3] A/CONF.157/24 (Part I), chap. III.

Believing that this Declaration is a further important step forward for the recognition, promotion and protection of the rights and freedoms of indigenous peoples and in the development of relevant activities of the United Nations system in this field,

Recognizing and reaffirming that indigenous individuals are entitled without discrimination to all human rights recognized in international law, and that indigenous peoples possess collective rights which are indispensable for their existence, well-being and integral development as peoples,

Recognizing that the situation of indigenous peoples varies from region to region and from country to country and that the significance of national and regional particularities and various historical and cultural backgrounds should be taken into consideration,

Solemnly proclaims the following United Nations Declaration on the Rights of Indigenous Peoples as a standard of achievement to be pursued in a spirit of partnership and mutual respect:

Article 1

Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration of Human Rights[4] and international human rights law.

Article 2

Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their indigenous origin or identity.

Article 3

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

Article 4

Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to

[4] Resolution 217 A (III).

their internal and local affairs, as well as ways and means for financing their autonomous functions.

Article 5

Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State.

Article 6

Every indigenous individual has the right to a nationality.

Article 7

1. Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person.

2. Indigenous peoples have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group.

Article 8

1. Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture.

2. States shall provide effective mechanisms for prevention of, and redress for:

(*a*) Any action which has the aim or effect of depriving them of their integrity as distinct peoples, or of their cultural values or ethnic identities;

(*b*) Any action which has the aim or effect of dispossessing them of their lands, territories or resources;

(*c*) Any form of forced population transfer which has the aim or effect of violating or undermining any of their rights;

(*d*) Any form of forced assimilation or integration;

(*e*) Any form of propaganda designed to promote or incite racial or ethnic discrimination directed against them.

Article 9

Indigenous peoples and individuals have the right to belong to an indigenous community or nation, in accordance with the traditions and customs of the community or nation concerned. No discrimination of any kind may arise from the exercise of such a right.

Article 10

Indigenous peoples shall not be forcibly removed from their lands or territories. No relocation shall take place without the free, prior and informed consent of the indigenous peoples concerned and after agreement on just and fair compensation and, where possible, with the option of return.

Article 11

1. Indigenous peoples have the right to practise and revitalize their cultural traditions and customs. This includes the right to maintain, protect and develop the past, present and future manifestations of their cultures, such as archaeological and historical sites, artefacts, designs, ceremonies, technologies and visual and performing arts and literature.

2. States shall provide redress through effective mechanisms, which may include restitution, developed in conjunction with indigenous peoples, with respect to their cultural, intellectual, religious and spiritual property taken without their free, prior and informed consent or in violation of their laws, traditions and customs.

Article 12

1. Indigenous peoples have the right to manifest, practise, develop and teach their spiritual and religious traditions, customs and ceremonies; the right to maintain, protect, and have access in privacy to their religious and cultural sites; the right to the use and control of their ceremonial objects; and the right to the repatriation of their human remains.

2. States shall seek to enable the access and/or repatriation of ceremonial objects and human remains in their possession through fair, transparent and effective mechanisms developed in conjunction with indigenous peoples concerned.

Article 13

1. Indigenous peoples have the right to revitalize, use, develop and transmit to future generations their histories, languages, oral traditions, philosophies, writing systems and literatures, and to designate and retain their own names for communities, places and persons.

2. States shall take effective measures to ensure that this right is protected and also to ensure that indigenous peoples can understand and be understood in political, legal and administrative proceedings, where necessary through the provision of interpretation or by other appropriate means.

Article 14

1. Indigenous peoples have the right to establish and control their educational systems and institutions providing education in their own languages, in a manner appropriate to their cultural methods of teaching and learning.

2. Indigenous individuals, particularly children, have the right to all levels and forms of education of the State without discrimination.

3. States shall, in conjunction with indigenous peoples, take effective measures, in order for indigenous individuals, particularly children, including those living outside their communities, to have access, when possible, to an education in their own culture and provided in their own language.

Article 15

1. Indigenous peoples have the right to the dignity and diversity of their cultures, traditions, histories and aspirations which shall be appropriately reflected in education and public information.

2. States shall take effective measures, in consultation and cooperation with the indigenous peoples concerned, to combat prejudice and eliminate discrimination and to promote tolerance, understanding and good relations among indigenous peoples and all other segments of society.

Article 16

1. Indigenous peoples have the right to establish their own media in their own languages and to have access to all forms of non-indigenous media without discrimination.

2. States shall take effective measures to ensure that State-owned media duly reflect indigenous cultural diversity. States, without prejudice to ensuring full freedom of expression, should encourage privately owned media to adequately reflect indigenous cultural diversity.

Article 17

1. Indigenous individuals and peoples have the right to enjoy fully all rights established under applicable international and domestic labour law.

2. States shall in consultation and cooperation with indigenous peoples take specific measures to protect indigenous children from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development, taking into account their special vulnerability and the importance of education for their empowerment.

3. Indigenous individuals have the right not to be subjected to any discriminatory conditions of labour and, inter alia, employment or salary.

Article 18

Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.

Article 19

States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

Article 20

1. Indigenous peoples have the right to maintain and develop their political, economic and social systems or institutions, to be secure in the enjoyment of their own means of subsistence and development, and to engage freely in all their traditional and other economic activities.

2. Indigenous peoples deprived of their means of subsistence and development are entitled to just and fair redress.

Article 21

1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.

Article 22

1. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.

2. States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination.

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 25

Indigenous peoples have the right to maintain and strengthen their distinctive spiritual relationship with their traditionally owned or otherwise occupied and used lands, territories, waters and coastal seas and other resources and to uphold their responsibilities to future generations in this regard.

Article 26

1. Indigenous peoples have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired.

2. Indigenous peoples have the right to own, use, develop and control the lands, territories and resources that they possess by reason of traditional ownership or other traditional occupation or use, as well as those which they have otherwise acquired.

3. States shall give legal recognition and protection to these lands, territories and resources. Such recognition shall be conducted with due respect to the customs, traditions and land tenure systems of the indigenous peoples concerned.

Article 27

States shall establish and implement, in conjunction with indigenous peoples concerned, a fair, independent, impartial, open and transparent process, giving due recognition to indigenous peoples' laws, traditions, customs and land tenure systems, to recognize and adjudicate the rights of indigenous peoples pertaining to their lands, territories and resources, including those which were traditionally owned or otherwise occupied or used. Indigenous peoples shall have the right to participate in this process.

Article 28

1. Indigenous peoples have the right to redress, by means that can include restitution or, when this is not possible, just, fair and equitable compensation, for the lands, territories and resources which they have traditionally owned or otherwise occupied or used, and which have been confiscated, taken, occupied, used or damaged without their free, prior and informed consent.

2. Unless otherwise freely agreed upon by the peoples concerned, compensation shall take the form of lands, territories and resources

equal in quality, size and legal status or of monetary compensation or other appropriate redress.

Article 29

1. Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. States shall establish and implement assistance programmes for indigenous peoples for such conservation and protection, without discrimination.

2. States shall take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior and informed consent.

3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

Article 30

1. Military activities shall not take place in the lands or territories of indigenous peoples, unless justified by a relevant public interest or otherwise freely agreed with or requested by the indigenous peoples concerned.

2. States shall undertake effective consultations with the indigenous peoples concerned, through appropriate procedures and in particular through their representative institutions, prior to using their lands or territories for military activities.

Article 31

1. Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions.

2. In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights.

Article 32

1. Indigenous peoples have the right to determine and develop priorities and strategies for the development or use of their lands or territories and other resources.

2. States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free and informed consent prior to the approval of any project affecting their lands or territories and other resources, particularly in connection with the development, utilization or exploitation of mineral, water or other resources.

3. States shall provide effective mechanisms for just and fair redress for any such activities, and appropriate measures shall be taken to mitigate adverse environmental, economic, social, cultural or spiritual impact.

Article 33

1. Indigenous peoples have the right to determine their own identity or membership in accordance with their customs and traditions. This does not impair the right of indigenous individuals to obtain citizenship of the States in which they live.

2. Indigenous peoples have the right to determine the structures and to select the membership of their institutions in accordance with their own procedures.

Article 34

Indigenous peoples have the right to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures, practices and, in the cases where they exist, juridical systems or customs, in accordance with international human rights standards.

Article 35

Indigenous peoples have the right to determine the responsibilities of individuals to their communities.

Article 36

1. Indigenous peoples, in particular those divided by international borders, have the right to maintain and develop contacts, relations and cooperation, including activities for spiritual, cultural, political, economic and social purposes, with their own members as well as other peoples across borders.

2. States, in consultation and cooperation with indigenous peoples, shall take effective measures to facilitate the exercise and ensure the implementation of this right.

Article 37

1. Indigenous peoples have the right to the recognition, observance and enforcement of treaties, agreements and other constructive arrangements concluded with States or their successors and to have States honour and respect such treaties, agreements and other constructive arrangements.

2. Nothing in this Declaration may be interpreted as diminishing or eliminating the rights of indigenous peoples contained in treaties, agreements and other constructive arrangements.

Article 38

States, in consultation and cooperation with indigenous peoples, shall take the appropriate measures, including legislative measures, to achieve the ends of this Declaration.

Article 39

Indigenous peoples have the right to have access to financial and technical assistance from States and through international cooperation, for the enjoyment of the rights contained in this Declaration.

Article 40

Indigenous peoples have the right to access to and prompt decision through just and fair procedures for the resolution of conflicts and disputes with States or other parties, as well as to effective remedies for all infringements of their individual and collective rights. Such a decision shall give due consideration to the customs, traditions, rules and legal systems of the indigenous peoples concerned and international human rights.

Article 41

The organs and specialized agencies of the United Nations system and other intergovernmental organizations shall contribute to the full realization of the provisions of this Declaration through the mobilization, inter alia, of financial cooperation and technical assistance. Ways and means of ensuring participation of indigenous peoples on issues affecting them shall be established.

Article 42

The United Nations, its bodies, including the Permanent Forum on Indigenous Issues, and specialized agencies, including at the country level, and States shall promote respect for and full application of the provisions of this Declaration and follow up the effectiveness of this Declaration.

Article 43

The rights recognized herein constitute the minimum standards for the survival, dignity and well-being of the indigenous peoples of the world.

Article 44

All the rights and freedoms recognized herein are equally guaranteed to male and female indigenous individuals.

Article 45

Nothing in this Declaration may be construed as diminishing or extinguishing the rights indigenous peoples have now or may acquire in the future.

Article 46

1. Nothing in this Declaration may be interpreted as implying for any State, people, group or person any right to engage in any activity or to perform any act contrary to the Charter of the United Nations or construed as authorizing or encouraging any action which would dismember or impair, totally or in part, the territorial integrity or political unity of sovereign and independent States.

2. In the exercise of the rights enunciated in the present Declaration, human rights and fundamental freedoms of all shall be respected. The exercise of the rights set forth in this Declaration shall be subject only to such limitations as are determined by law

and in accordance with international human rights obligations. Any such limitations shall be non-discriminatory and strictly necessary solely for the purpose of securing due recognition and respect for the rights and freedoms of others and for meeting the just and most compelling requirements of a democratic society.

3. The provisions set forth in this Declaration shall be interpreted in accordance with the principles of justice, democracy, respect for human rights, equality, non-discrimination, good governance and good faith.

INDIGENOUS CORPORATE TRAINING INC.

Reconciliation the simplest gestures can make a difference

May 05, 2014

We start off this post with the following:

Hi, I'm the Indigenous Corporate Training ChatBot!

As my father, **Chief Dr. Robert Joseph** says in his presentation at one of my Speaker Series, "Sometimes you save lives from the simplest gestures; when your heart is in the right place, a simple gesture can inspire people for the rest of their lives just by knowing that someone else cares." As he says, at about the seven minute point in the video, it can be as simple as smiling and saying hello to an Aboriginal person you meet on the street.

In the pursuit of reconciliation, each and every one of us has a responsibility and the ability to find a way to make a gesture of reconciliation. We have emphasised on this blog (and in our course) the importance of including community outreach in corporate engagement and consultation strategies. Such outreach can include sponsoring community cultural events, offering education bursaries, skills development training, assisting workers with daycare and commuting costs etc.

It is possible, however, to also make a difference on an individual basis - it does not have to be on a grand scale, it does not need a big budget.

At the time of this writing, it is spring which means high school students and their parents are preparing for graduation ceremonies. It's a big moment for many students and a lot of time, effort and money is spent on ensuring the graduation ceremony and gala are memorable. For the girls this means the purchase of a formal gown, shoes, and all the trimmings. For some First Nation graduates, the gown and all the trimmings are simply not financially feasible.

One of our readers recently shared this story with us. She wanted to [illegible] it if there was some way she could financially assist a local F[illegible] student with some of the costs involved in a graduation [illegible] to help a student enjoy the moment and feel proud of what what they had accomplished. She contacted the Friendship Centres but they didn't have a program for this so she contacted the Indigenous Support teacher at a local high

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school and asked him if there were a grad who might need some financial assistance to buy a dress and how this might be arranged. The teacher identified two girls who were graduating, both were financially challenged, and neither able to buy a dress. To make a long story short, the girls are happy with the prospect of going shopping and getting ready for a memorable event as are their families and supporters, and the school is delighted at the outreach from someone in the community. The reader who shared this story with us feels great that she could make a small difference in the lives of these two young women, especially when they are at a such an impressionable age and at a critical time in their lives - high school graduation is the first step to opening the doors of opportunity.

As for myself, I think this is one of those simple life changing gestures that provides an opportunity for people to see good in the world and the good in humanity. Such individual acts of reconciliation can have an impact on the lives and outlook of Aboriginal peoples. It's in all of us to reach out and make a difference in someone's life. To respectfully borrow from the Canadian Blood Services slogan "It's in all of us to give".

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Appreciating or appropriating Indigenous culture?

November 26, 2018

A reader recently asked us a question about talking sticks. We change[d] the question up a little so as to preserve the confidentiality [of]

We don't normally answer questions from readers of ou[r] over 100,000 visitors monthly, doing so would require a small army! We do try to write blog articles that cover a wide variety of Indigenous-related topics that we hope provide practical information to those who are on a journey of

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reconciliation, have run into a situation that might be new to them, or are just interested in learning. But, this particular question about talking sticks is one that hit home as **Bob Joseph**, President of Indigenous Corporate Training Inc., comes from a culture that incorporates the use of talking sticks.

Question:

We are scheduled to have an event here soon, and we would like to ask a question.I saw your blog post on Talking Stick protocol. I am organizing an event for later this month. One of the team members (non-Indigenous) wants to open the meeting with a talking stick exercise. This team member wants to talk about the history of the talking stick (from info that will research from the internet), and then have groups decorate a couple of sticks that will be used for following group discussions. I am interested in your opinion on this exercise. Do you think it sounds inappropriate? I'm not sure who else to ask.

Response:

In answering this question we decided to compile a few thoughts for consideration:

- Not every **culture** in Canada uses a talking stick, the
  language families
- Cultures that don't have talking sticks have other pr
  communication

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- Crests on talking sticks are usually owned by a family and families defend the use of their crests the way Coca-Cola defends its brand
- Each crest has a history/story
- Talking sticks are one of the most ceremonial symbols used in **potlatches**
- There is strict protocol surrounding the usage of images within the community
- There are rules and protocols for how the images appear, where they appear, and in what order they appear, and how they appear
- The type of wood used is symbolic
- The colours used are symbolic

Here are two articles that provide some background on talking sticks.

First Nation Talking Stick Protocol

First Nation Talking Stick Symbolism

Here's an analogous situation: consider the Mace of parliament. The mace is one of the most important ceremonial symbols inherited from the British parliamentary tradition, it is ornate, rich in history and tradition. Would it be ok for a person to hold a meeting, provide materials and ask everyone to create their own mace, decorate it, and use it to open or run meetings?

Why Cultural Appropriation is Disrespectful

In the spirit of **reconciliation**, we say it would be great i
do the research and talk about their understanding of th
also be great to incorporate some research on the appropriate use of culturally significant items. As for creating and painting of talking sticks for use at the

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meeting, I may wish to avoid this step and offer a suggestion of following a similar approach to the ideas behind the talking stick.

Here's an article on the power of sharing culture:

Show them about tribal ways

It's really great to see non-Indigenous people recognizing and appreciating the wisdom and value of Indigenous cultural practices. Keep being curious and continue learning and I'll do the same.

Here's a Pledge of Reconciliation you can download. Please share with peers & pals.

Topics: **Reconciliation**, **Indigenous Awareness**, **cultural appropriation**

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PRINCIPLES

Respecting the Government of Canada's Relationship With Indigenous Peoples

The Government of Canada recognizes that:

1. All relations with Indigenous peoples need to be based on the recognition and implementation of their right to self-determination, including the inherent right of self-government.

2. Reconciliation is a fundamental purpose of section 35 of the *Constitution Act, 1982*.

3. The honour of the Crown guides the conduct of the Crown in all of its dealings with Indigenous peoples.

4. Indigenous self-government is part of Canada's evolving system of cooperative federalism and distinct orders of government.

5. Treaties, agreements, and other constructive arrangements between Indigenous peoples and the Crown have been and are intended to be acts of reconciliation based on mutual recognition and respect.

6. Meaningful engagement with Indigenous peoples aims to secure their free, prior, and informed consent when Canada proposes to take actions which impact them and their rights on their lands, territories, and resources.

7. Respecting and implementing rights is essential and that any infringement of section 35 rights must by law meet a high threshold of justification which includes Indigenous perspectives and satisfies the Crown's fiduciary obligations.

8. Reconciliation and self-government require a renewed fiscal relationship, developed in collaboration with Indigenous nations, that promotes a mutually supportive climate for economic partnership and resource development.

9. Reconciliation is an ongoing process that occurs in the context of evolving Indigenous-Crown relationships.

10. A distinctions-based approach is needed to ensure that the unique rights, interests and circumstances of the First Nations, the Métis Nation and Inuit are acknowledged, affirmed, and implemented.

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7 Tips on Building Relationships with Indigenous Peoples

September 08, 2017

The quality of your relationship with an Indigenous community will be ensured by the effort invested and the integrity of your team. You critical that a respectful relationship is fundamental to th pending business partnership. If you hold onto the conc to-community relationship you are developing as opposed to a business-to-business relationship, then you will be off to a good start.

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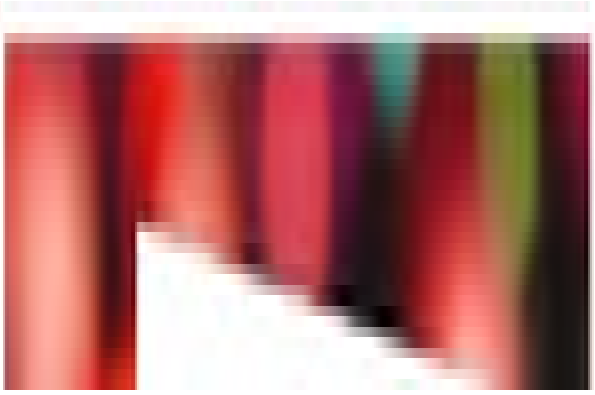

Here are some key considerations to keep in mind when nurturing relationships with Indigenous Peoples:

1. Be trustworthy.

You know what they say about trust: it takes years to build, seconds to break, and forever to repair. In terms of trust in a relationship with an Indigenous community, it is arguably the most important element. If looking at relationship building from the perspective of a resource development proponent, keep in mind that there's a long history of broken promises in terms of environmental protection, employment, revenue sharing, and community benefits. If looking from the perspective of government relations it's a timeline of broken promises that dates back to Confederation.

- **Reflections in 2017 on the 1967 Centennial Speech of Chief Dan George**

Making empty promises to bolster the appeal of your proposal is not a recommended action. Adopt the mantra of "promise less, deliver more."

2. Be transparent.

Transparency is a close cousin to trust. If you aren't tran
the trust you need.

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- Be transparent in your communications right from the start.
- Be transparent about your plans.

- Be transparent when problems arise.

3. Be respectful.

One sign of respect is thoroughly researching the community you want to work with. If you are interested in working with them you should be interested in learning about them, their history, **worldviews,** governance structure, **culture**, traditions, and economy. Developing a genuine understanding of the community means you care enough to devote the time and resources for the research.

4. Be invested.

It takes time and resources to build a relationship with an Indigenous community. You're looking at many visits, meetings, and phone calls over a long space of time. Write this extra activity into your budget.

5. Be involved.

If you have a partnership with a community then be involved in the community. Your relationship is with the entire community - not just the economic development department or the chief and council. Show that your interest is deeper than mere business. Support and attend events. Celebrate with them. And bring your kids so they can learn about the culture along with you.

6. Be patient.

If you have done your research you will know that most development decisions are community based. Also keep in mind that the **connectivity principle** plays a significant role in decision making so don't expect conversations to be ut one subject. An additional factor that affects decision making community to process the requirements of your project very busy with community concerns and events - your p demand on their time and resources, which in a smaller community can be a considerable burden.

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- **Building Indigenous community capacity and the duty to consult**

7. Choose your team carefully.

Ensure the right people in your organization are attending the meetings and ensure there is continuity in who attends the meetings. If the primary contact from your organization moves on, try to ensure his/her replacement is brought up to speed on the relationship/consultation/negotiations prior to them going to their first meeting with the community. Bringing your staff up to speed is not their responsibility. At the risk of sounding self-promotional, I do recommend your staff take **Indigenous cultural competency training** before anyone contacts the community - you only get one chance to make a first impression.

There you have it. Seven quick tips for you to keep in mind when building relationships with Indigenous Peoples.

This little ebook has been downloaded 12,000 times! Grab your copy by clicking image.

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7 First Nation Facts You Should Know

October 11, 2020

Here are seven First Nation facts plus one fun fact to add to your storehouse of knowledge.

1) Number of Nations

There are over 634 recognized First Nations governmen
of which are in the provinces of Ontario and British Columbia. The total population with First Nation identity is more than **850,000** [1]

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2) Creation Beliefs

People everywhere, including First Nations, have their own **creation beliefs**. Each First Nation has its own creation beliefs, told in the form of a story of their ancestors. The Iroquois creation story often includes elements of the earth being formed on the turtle's back with animals and all other creatures providing further guidance when Sky Woman gives birth to First Woman. While creation beliefs may sound unlikely or silly, to put things in perspective, so does the idea of a person walking on water, coming back from the dead or parting the Red Sea.

3) Cultural Diversity

There is not one culture for all First Nations. Each Nation has its **own culture**, customs, beliefs, traditions, and **world views**. Cultural practices, symbols, and belief systems are influenced by each Nation's unique experience on the land and with each other, and are always connected with the Spirit world.

Download our free ebook **Dispelling Common Myths about Indigenous Peoples** in which we debunk 9 myths and provide the realit

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4) Cultural Survival

Cultural survival is the name of the game for First Nations (and Indigenous Peoples in general). The past two centuries have seen an active program of assimilation directed towards First Nation culture via the **Indian Act**. Despite this campaign, which includes relocation from traditional or territorial lands, disastrous **assimilation** programs, **outlawing** of cultural practices, loss of language and customs, First Nation cultures have survived. Every decision made reflects this goal, and according to the **7th Generation** principle, all decisions must include consideration of impacts on community members seven generations into the future, while honouring those who came before. So, next time a community seems to be taking a long time to make a decision, reflect back on this.

5) Connectivity Principle

Many First Nations believe everything is **connected** – th
connected to the mortal world; the sea is connected to t
connected to the **land**. They usually get frustrated by attempts to separate things out. Statements such as "I can't talk you about that as it is not my

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department or line of work" or "I'm here to talk about mining only and not impacts about forestry" should be avoided. Effort will have to be made to be sensitive to the view of **connectivity**. Offer to bring in the person whose department it is if it's not yours. You'll get more co-operation in the long run.

6) The Circle is a Sacred Symbol

In First Nation spirituality the circle is everywhere – the **medicine wheel**, meetings and gatherings are held in circles, **dances** go in circles, drums are round, as are sweat lodges and tipis. The circle is the symbol of the cycle of all forms of life.

7) The American Constitution is based on the principles of the Great Law of Haudenosaunee Confederacy

The Great Law of Haudenosaunee [2] Confederacy is credited as being a contributing influence on the American Constitution, due to Benjamin Franklin's great respect for the Haudenosaunee system of government, which in itself is interesting from the perspective that the United States formed their Constitution not on the principles of European governments, but rather on that of a people considered "savages".

> **Fun Fact - Inventions**
>
> Who invented hockey is hotly contested but one theory is that it was invented by the Mohawks and we're going with this one. Hundreds of years ago, Jesuit priests wrote about the Mohawks playing with a stick and a piece of frozen ice embedded with bones and stones. According to the Jesuit journals, when a player was struck by the "puck" they yelled "Aukie!" meaning, ouch. Other inventions credited to First Nations include the canoe and kayak,

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> darts, lacrosse (forerunner to hockey) petroleum jelly, cough syrup.

[1] 2011 National Household Survey

[2] With thanks to Tasha Hill for pointing out that "Iroquois", which we formerly used, was the name imposed by settlers on the Haudenosaunee Confederacy (updated Oct. 14, 2019)

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December 16, 2021

Office of the Prime Minister | Cabinet du Premier ministre

Ottawa, Canada K1A 0A2

Dear Minister Miller:

Thank you for agreeing to serve Canadians as Minister of Crown-Indigenous Relations.

From the beginning of this pandemic, Canadians have faced a once-in-a-century challenge. And through it all, from coast to coast to coast, people have met the moment. When it mattered most, Canadians adapted, helped one another, and stayed true to our values of compassion, courage and determination. That is what has defined our path through this pandemic so far. And that is what will pave our way forward.

During a difficult time, Canadians made a democratic choice. They entrusted us to finish the fight against COVID-19 and support the recovery of a strong middle class. At the same time, they also gave us clear direction: to take bold, concrete action to build a healthier, more resilient future. That is what Canadians have asked us to do and it is exactly what our Government is ready to deliver. We will work to build that brighter future through continued collaboration, engagement, and the use of science and evidence-based decision-making. With an unwavering focus on delivering results, we will work constructively with Parliamentarians and maintain our strong partnerships with provincial, territorial and municipal governments and Indigenous partners. This decade has had an incredibly difficult start, but this is the moment to rebuild a more resilient, inclusive and stronger country for everyone.

The science is clear. Canadians have been clear. We must not only continue taking real climate action, we must also move faster and go further. As Canadians are increasingly experiencing across the country, climate change is an existential threat. Building a cleaner, greener future will require a sustained and collaborative effort from all of us. As Minister, I expect you to seek opportunities within your portfolio to support our whole-of-government effort to reduce emissions, create clean jobs and address the climate-related challenges communities are already facing.

This year, Canadians were horrified by the discovery of unmarked graves and burial sites near former residential schools. These discoveries underscore that we must move faster on the path of reconciliation with First Nations, Inuit and Métis Peoples. We know that reconciliation cannot come without truth and our Government will continue to invest in that truth. As Ministers, each of us has a duty to further this work,

both collectively and as individuals. Consequently, I am directing every Minister to implement the United Nations Declaration on the Rights of Indigenous Peoples and to work in partnership with Indigenous Peoples to advance their rights.

We must continue to address the profound systemic inequities and disparities that remain present in the core fabric of our society, including our core institutions. To this effect, it is essential that Canadians in every region of the country see themselves reflected in our Government's priorities and our work. As Minister, I expect you to include and collaborate with various communities, and actively seek out and incorporate in your work, the diverse views of Canadians. This includes women, Indigenous Peoples, Black and racialized Canadians, newcomers, faith-based communities, persons with disabilities, LGBTQ2 Canadians, and, in both official languages.

Across our work, we remain committed to ensuring that public policies are informed and developed through an intersectional lens, including applying frameworks such as Gender-based Analysis Plus (GBA Plus) and the quality of life indicators in decision-making.

Canadians continue to rely on journalists and journalism for accurate and timely news. I expect you to maintain professional and respectful relationships with journalists to ensure that Canadians are well informed and have the information they need to keep themselves and their families safe.

Throughout the course of the pandemic, Canadians and their governments have adapted to new realities. Governments must draw on lessons learned from the pandemic to further adapt and develop more agile and effective ways to serve Canadians. To this end, I expect all Ministers to evaluate ways we can update our practices to ensure our Government continues to meet the challenges of today and tomorrow.

The success of this Parliament will require Parliamentarians, both in the House of Commons and the Senate, to work together across all parties to get big things done for Canadians. I expect you to maintain constructive relationships with your Opposition Critics and coordinate any legislation with the Leader of the Government in the House of Commons. As Minister, you are accountable to Parliament both individually, for your style of leadership and the performance of your responsibilities, and collectively, in support of our Ministry and decisions taken by Cabinet. *Open and Accountable Government* sets out these core principles and the standards of conduct expected of you and your office. I expect you to familiarize yourself with this document, which outlines my expectations for each member of the Ministry.

Our platform lays out an ambitious agenda. While finishing the fight against the pandemic must remain our central focus, we must continue building a strong middle class and work toward a better future where everyone has a real and fair chance at success and no one is left behind.

As Minister of Crown-Indigenous Relations, your first and foremost priority is to work in full partnership with First Nations, Inuit and Métis to continue building nation to nation relationships and support self-determination, including supporting First Nations communities as they transition to self-government and move away from the *Indian Act*. Your immediate priority is to provide the necessary supports for communities as they undertake searches of unmarked graves and burial sites at residential schools, and ensure supports for healing and commemoration to preserve and protect the rights and dignity of children who never made it home. It is critical that you lead the work of all Ministers to accelerate the implementation of the Truth and Reconciliation's *Calls to Action* and implement the 2021 Federal Pathway to Address Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA+ People, including providing sustainable resources to the National Centre for Truth and Reconciliation, and advance the 2021 National Action Plan to address missing and murdered Indigenous women and girls and 2SLGBTQQIA+ people.

To realize these objectives, I ask that you achieve results for Canadians by delivering the following commitments.

- Work with the Minister of Indigenous Services to address the history and legacy of residential schools, including by continuing to provide the necessary supports to communities who wish to continue to undertake the work of burial searches at the sites of former residential schools and other federally-run institutions, such as day schools and Indian hospitals.
- Provide funding towards the construction of a permanent home for the National Centre for Truth and Reconciliation and ensure it has sustained financial resources to successfully fulfil its mandate, with dedicated ongoing support for the work on missing children and unmarked graves.
- Continue to lead and coordinate the work required of all ministers to accelerate the implementation of the Truth and Reconciliation Commission's *Calls to Action*. You will be supported by the Minister of Indigenous Services.
- With the support of all relevant ministers, including the Minister for Women and Gender Equality and Youth and the Minister of Indigenous Services, work with First Nations, Inuit and Métis leadership, Survivors, families and communities to address violence against Indigenous women, girls and 2SLGBTQQIA+ people by accelerating the implementation of the Federal Pathway to Address Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA+ People. In addition, work with

Indigenous partners, provinces and territories to support the implementation of the 2021 MMIWG and 2SLGBTQQIA+ National Action Plan.

- With the Minister of Indigenous Services, continue to work with First Nations partners to ensure fair and equitable compensation for those harmed by the First Nations Child and Family Services program and to ensure the long-term reform of child and family services in First Nations communities, including to help children and families stay together and provide First Nations youth who reach the age of majority the supports they need for up to two additional years.
- With the Minister of Indigenous Services, Minister of Northern Affairs, Minister of Housing and Diversity and Inclusion and Minister of Intergovernmental Affairs, Infrastructure and Communities, and in partnership with First Nations, Inuit and Métis communities, continue to make immediate and long term investments to support ongoing work to close the infrastructure gap by 2030, with a particular focus on expediting investments in Indigenous housing, with over half of the funding available by the upcoming summer construction period, while concurrently working to establish Indigenous-led institutions to build housing and infrastructure.
- Continue to support Indigenous-led processes for rebuilding and reconstituting their nations and advancing self-determination, and work in partnership on the implementation of the spirt and intent of treaties, and land claim and self-government agreements with appropriate oversight mechanisms to hold the federal government accountable.
- Support the Minister of Justice and Attorney General of Canada in fully implementing the *United Nations Declaration on the Rights of Indigenous Peoples Act* across government.
- Support the Minister for Women and Gender Equality and Youth in the evaluation process of GBA Plus with the goal of enhancing the framing and parameters of this analytical tool and with particular attention to the intersectional analysis of race, indigeneity, rurality, disability and sexual identity, among other characteristics.
- Work with Indigenous partners and relevant Ministers to accelerate the Recognition of Indigenous Rights and Self-determination processes, with particular focus on reforming federal government structures, notably to support self-determination consistent with the United Nations Declaration on the Rights of Indigenous Peoples.
- Accelerate ongoing work with First Nations to redesign federal policies on additions-to-reserves and the Specific Claims process to provide just and timely resolution, conscious of the need for a fairer and more equitable process, accelerate the resolution of outstanding land claims and, as set out in our

permanent bilateral process, meet regularly with the Assembly of First Nations and rights holders to make progress on First Nations priorities.

- Work with existing and traditional Indigenous governments and leaders, whose nations and forms of governance were suppressed and ignored historically by the federal government, to restore respectful nation-to-nation relations, in the spirit of self-determination, by renewing and updating treaty relationships where they exist, including pre-confederation treaties, and by seeking viable, trusting and respectful relationships where no treaty exists.
- Work with Inuit to finalize a co-developed Inuit Nunangat Policy and accelerate its implementation, continue work to fully implement Inuit land claim agreements and, as set out in our permanent bilateral process, meet regularly through the Inuit-Crown Partnership Committee to make progress on Inuit priorities.
- Continue moving forward on Self Government Recognition and Implementation Agreements with the Manitoba Métis Federation, the Métis Nation of Alberta, the Métis Nation of Ontario, and the Métis Nation of Saskatchewan, and on the Self-Government Framework Agreement with the Northwest Territory Métis Nation, and, as set out in our permanent bilateral process, meet regularly with Métis Nation partners to make progress on Métis priorities.
- Support the Minister of Public Safety in their work with First Nations partners to co-develop a legislative framework for First Nations policing, and on continuing to engage with Inuit and Métis on policing matters.
- Support the Minister of Justice and Attorney General of Canada to address systemic discrimination and the overrepresentation of Indigenous people in the justice system, including the development of an Indigenous Justice Strategy, in consultation and cooperation with provinces, territories and Indigenous partners.
- In close collaboration with the Minister of Indigenous Services, the Minister of Northern Affairs and the President of the Queen's Privy Council and Minister of Emergency Preparedness, work with First Nations and provincial and territorial government partners to strengthen the governance and service delivery for First Nations emergency preparedness, management and recovery.
- In collaboration with the Minister of Environment and Climate Change and the Minister of Indigenous Services, continue to work in partnership with First Nations, Inuit and the Métis Nation to address climate change and its impacts, and chart collaborative strategies.
- Support the Minister of Northern Affairs in continued work with Inuit to improve food security in Inuit Nunangat, including through the Harvesters Support Grant

and the Nutrition North Canada program, amended to make it more transparent and responsive to Inuit needs.

As Minister, you are also responsible for actively engaging with your Cabinet and Caucus colleagues. As we deliver on our platform commitments, it will be important that members of the Ministry continue to collaborate and work constructively to support rigorous and productive Cabinet decision-making. I expect you to support your colleagues in delivering their commitments, leveraging the expertise of your department and your own lived experiences.

To best achieve results for Canadians, Ministers must be rigorous and coordinated in our approach to implementation. I would therefore ask that you return to me with a proposed approach for the delivery of your mandate commitments, including priorities for early implementation. Furthermore, to ensure we are accountable for our work, I will be asking you to publicly report to me, and all Canadians, on your progress toward these commitments on a regular basis.

As we have been reminded throughout the pandemic, adapting to change is not only something government should do, it is something government must do. As you work to fulfil our commitments, I expect you to actively consider new ideas and issues as they emerge, whether through public engagement, your work with Parliamentarians or advice from the public service. I also expect you to work with your Deputy Minister to assess priorities on a continual basis as we build a better future for all Canadians. In addition to achieving results, you are responsible for overseeing the work of your department and ensuring the effective operation of your portfolio.

As you staff your office and implement outreach and recruitment strategies for federally appointed leadership positions and boards, I ask that you uphold the principles of equity, diversity and inclusion. This helps ensure that federal workplaces are dynamic and reflective of the Canadians we serve. You will also ensure your Minister's office and portfolio are reflective of our commitment to healthy and safe workplaces.

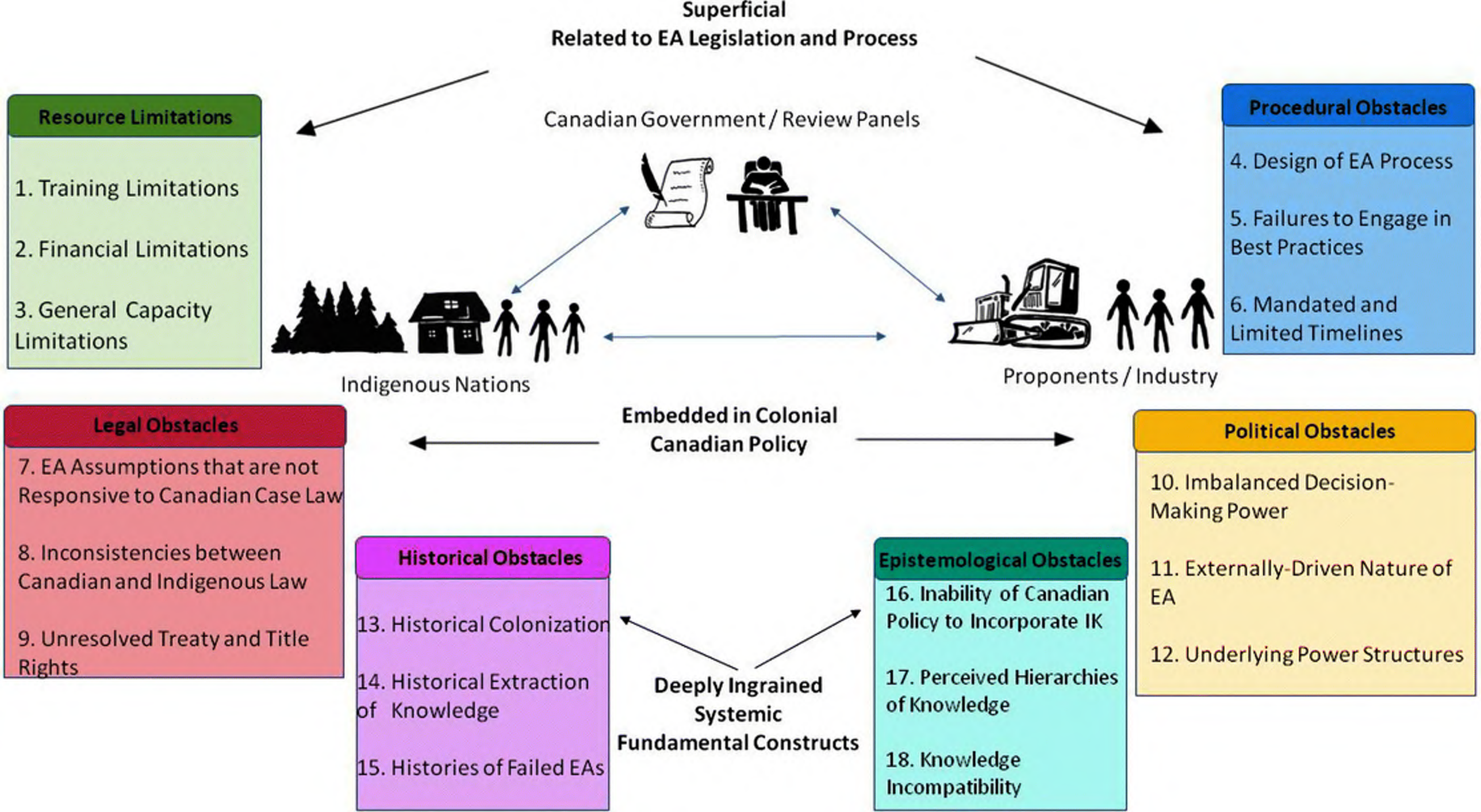
Canadians expect us to work hard, speak truthfully and be committed to advancing their interests and aspirations. When we make mistakes – as we all will – Canadians expect us to acknowledge them, and most importantly, to learn from them.

I know I can count on you to fulfill the important responsibilities entrusted in you, and to turn to me, and the Deputy Prime Minister, early and often to support you in your role as Minister.

Sincerely,

Rt. Hon. Justin Trudeau, P.C., M.P.
Prime Minister of Canada

*This Ministerial Mandate Letter was signed by the Prime Minister in the Minister's first official language.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7. EA Assumptions that are not Responsive to Canadian Case Law
8. Inconsistencies between Canadian and Indigenous Law
9. Unresolved Treaty and Title Rights
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10. Imbalanced Decision-Making Power
11. Externally-Driven Nature of EA
12. Underlying Power Structures
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14. Historical Extraction of Knowledge
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wîcihtotân Mentorship for Indigenous Teachers and School Leaders (/For Members/Professional Development/IndigenousEducationandWalkingTogether/Pages/wîcihtotân-Mentorship-for-Indigenous-Teachers-and-School-Leaders.aspx)
Workshops (/For Members/Professional Development/IndigenousEducationandWalkingTogether/Pages/Workshops.aspx)
Mentorship Programs (/For Members/Professional Development/Pages/Mentorship-Programs.aspx)
Online PD Opportunities and Resources (/For Members/Professional Development/Pages/Online Education.aspx)
Specialist Councils (/For Members/Professional Development/Specialist Councils)
Teachers' Conventions (/For Members/Professional Development/Teachers Conventions)
Workshops and Presentations (/For Members/Professional Development/Workshops-and-Presentations)
Professional Growth Planning (/For Members/ProfessionalGrowth)
Professional Resources (/For Members/ProfessionalResources)
Programs and Services (/For Members/ProgramsandServices)
Talking Points (/For Members/Pages/Talking-Points.aspx)
Political Engagement for Teachers (/For Members/Pages/Political-Engagement-for-Teachers.aspx)
Women in Leadership (/For Members/Pages/Women-in-Leadership.aspx)

Land Acknowledgements / Reconnaissance des territoires

Acknowledging the land is a demonstration of respect and gratitude for Indigenous peoples as the original stewards of the land. To acknowledge the land is an act of reconciliation and contributes towards renewing the relationship between Indigenous and non-Indigenous peoples. Providing a land acknowledgement is not something you just do before an event, but rather a thoughtful and intentional process.

The following are suggested guidelines for acknowledging the traditional territory:

- If possible, the land acknowledgement should be provided as part of the daily opening event (prior to the national anthem) by the host.
- Consider sharing the land acknowledgement specific to your area, or share the general acknowledgement for all Treaty areas within Alberta (used for large events that encompass participation from all areas across the province).
- Consider viewing the Acknowledging Land and People Map resource to determine the appropriate land acknowledgement.

Stepping Stones

THE SIXTIES SCOOP

Planning Your Learning Journey

What is the Sixties Scoop and how can understanding its impacts contribute to reconciliation?

HTTP://ACTIVEHISTORY.CA/2017/10/SELLING-THE-SIXTIES-SCOOP-SASKATCHEWANS-ADOPT-INDIAN-AND-METIS-PROJECT/

Newspaper advertisements for the Adopt Indian and Métis Program, late 1960s, Saskatchewan.

FIRST STEPS

In the 1950s and 60s, compulsory attendance at federally governed residential schools began to be phased out, although it continued for children whose families were deemed "unsuitable" to care for them.[1] Indigenous children were expected to attend the provincial public education stream. This shift was coupled with a 1951 amendment to the *Indian Act* that enabled provinces to deliver child welfare services to Indigenous people where none had formerly existed. Indigenous children went from being forcibly removed from parents to attend residential schools to being forcibly removed from families by provincial child welfare agencies. The underlying root of the forced removals aligned with aggressive assimilation policies. Genocidal tactics of residential schools aimed at "killing the Indian in the child" continued with the transfer of responsibility to provincial child welfare agencies because of existing court structures and provincial policies. These child welfare policies have been identified as racist. The aggressive apprehension of Indigenous children between the 1960s and 80s is referred to as the Sixties Scoop.

Social workers at this time did not require training in working with or understanding the cultural or historical context of Indigenous communities, and often let their biases influence their decisions. Eurocentric views clashed with original child-rearing methods and ways of living that had

> The forced removals directly correlate with socioeconomic impacts such as mental health issues, homelessness, incarceration, "high suicide rate, sexual exploitation, substance use and abuse, poverty, low educational achievement and chronic unemployment."[2]

sustained Indigenous communities for tens of thousands of years. "When social workers entered the homes of families subsisting on a traditional Aboriginal diet of dried game, fish, and berries, [with no running water or electricity] as in typical Euro-Canadian fashion, they assumed that the adults in the home were not providing for their children."[3] Kinship systems rooted in community care were disregarded as negligent. Indigenous women were deemed as unfit mothers, and living off the land as uncivilized.[4] Indigenous original methods of nurturing and living were disrupted and severed through assimilation policies and laws.

Child-rearing methods of shaming, belittling, violence and abuse were instilled at residential schools, thus resulting in a legacy of trauma. Colonization tactics such as the forcible confinement of the reserve system and other methods of oppression inflicted by policies and attitudes "influenced the severity of social problems many communities endured, such as poverty, unemployment, and addiction, [and] some social workers felt a duty to protect the local children."[5]

"Power, privilege and poverty are complexly related to the disproportionate number of Aboriginal children who were removed from their own communities."[6] There was no requirement for workers to inform the community if children were being apprehended or to provide information as to their whereabouts. Disturbing numbers of apprehended children were bounced between non-Indigenous foster homes, placed in institutional facilities, adopted or sold.[7] "Scattering children across the globe undermined identification with the close-knit traditional Aboriginal culture and destroyed its kinship network."[8] Often family members would plead to the courts for the return of the child but would be left empty handed and empty hearted. Many Sixties Scoop survivors as well as families of scooped children continue searching for each other.

While there are stories of foster families nurturing Indigenous children, these families were led to believe that children had been abandoned, impoverished and unwanted by their families. More often, though, many survivors experienced horrific treatment from those in positions of power who claimed to be filling in the role of caregiver. "Slave labor, emotional, physical and sexual abuse was not uncommon, but it was usually covered up, rendered invisible by the lack of social resources and support for Aboriginal families and children, a result of the general social reluctance to publicly acknowledge such abuse at the time."[9]

IMPACTS

Children were expected to assimilate into the culture of the foster or adoptive family while, most often, abandoning their heritage, which may have contributed to an identity crisis and a relationship breakdown between the caregiver and the child.[10] There are cases in which children were told that they were anything but Indigenous.[11] "Conditions of suppressed identity and abuse result in psychological and emotional problems and these impacts may not surface for survivors who learned of their family or culture until later in life."[12] Barriers to attaining socioeconomic equity coincide with the disparity of not fully belonging to either group.[13] Children were forced to disconnect from families rich in love, land, language, status and, most important, ceremony. Some survivors express having nurturing adoptive or foster families and hold no ill feelings toward those who raised them. However, they also experience feelings of confusion and disconnection from their kinship network and cultural ways, as well as feeling guilty about being raised in a nurturing home, unlike the majority that suffered abuse.

Families and communities suffered as well. The loss of children caused mental, emotional and spiritual harm to individuals, families and communities.[14] "Problems of alcoholism, emotional stress and low self-esteem were compounded with the increased formal scrutiny and likelihood that other children would be removed from the family."[15] Often families who "approached child care agencies in search of help for funds to supply food and shelter ended up losing their children … Often times they were forced to relinquish custody

of the child."[16] The apprehension tactics "weakened the traditional family structure, and in doing so, weakened Aboriginal society as a whole." [17] The intergenerational legacy of grief and loss in relation to family, identity, culture, heritage and community continues into subsequent generations. [18]

CHILD WELFARE

In the 1980s, reports by Kimmelman and Johnston recommended sweeping policy changes. Kimmelman affirmed that "cultural genocide has taken place in a systematic, routine manner."[19] The reports, combined with decades of outcry from Indigenous rights advocates such as the Voice of Alberta Native Women's Society and First Nations band resolutions, influenced amendments to adoption laws. Eighteen First Nations child welfare agencies were developed following the 1973 signing of the Blackfoot (Siksika) child welfare agreement, which was the first child welfare agreement with a First Nations community in Alberta.[20]

In 1989, Canada played a key role in drafting the United Nations Convention on the Rights of the Child; yet, in 2007, UNICEF reported that "Canada has been slow to honor its commitment to uphold those rights and ensure the well-being of children." The report featured the dire situation of the Indigenous context.[21]

It wasn't until 1990 that Indigenous Nations had the authority to administer child and family services according to provincial legislations and child welfare standards, although problems reflective of the Sixties Scoop continued. In 2016, the Canadian Human Rights Tribunal, based on a complaint filed by the Assembly of First Nations (AFN) and the First Nations Child and Family Caring Society of Canada in 2007, found that overrepresentation of First Nations children in child welfare was a direct result of discrimination and underfunding of children on reserve.[22] Children's rights advocates such as Cindy Blackstock continue to work tirelessly to uphold and uplift the rights of Indigenous children.

In 2016, the Office of the Child and Youth Advocate (OCYA) released a report that examined the continued overrepresentation of Indigenous children and families in the child intervention system in Alberta.[23] The Alberta Ministry of Children's Services recognized "that the tragic reality of overrepresentation of Indigenous children is the single most critical challenge facing the child intervention system, and is working to make sustainable changes to support positive outcomes, family engagement, cultural connections, and increased community capacity. As this report and others have indicated, there are many complex factors at play that have contributed to the overrepresentation of Indigenous children including the intergenerational trauma of colonialism, the tragic legacy of the residential school system, and the ongoing effects of the Sixties Scoop. These, along with a host of other challenges, have resulted in profound socioeconomic disparities for Indigenous peoples and communities."[24]

RECONCILIATION

"Too many Canadians know little or nothing about the deep historical roots of these conflicts."[25] Currently, there are many more First Nations, Metis and Inuit children in care now than there were during the peak of the residential school era. Some declare the child welfare system to be a contributor to current issues such as the Missing and Murdered Women and Girls epidemic and high incarceration rates across the country. Canada has transitioned from the Sixties' Scoop to the "Millennium Scoop" in relation to the child welfare system.[26] In Alberta, approximately 10 per cent of children are Indigenous, yet approximately 70 per cent of children in care are Indigenous. [27]

On February 14, 2017, a narrowly defined legal settlement for loss of language and culture was announced for First Nation and Inuit survivors of the Sixties Scoop; the Métis Nation were excluded despite their inclusion in the policies of aggressive assimilation. On May 28, 2018, the Alberta government formally apologized to Sixties Scoop survivors as a first step towards reconciliation. Survivors may be compensated financially, yet wellness and healing initiatives to help repair the damage done are also necessary. The child welfare system in Alberta currently works with Indigenous communities to try to alleviate the problems that were evident in the past, although children in care and families continue to need further supports. There is a need for these supports to include Sixties Scoop survivors, because nothing currently exists. Education to build a foundation of knowledge, understanding and empathy will contribute to uplifting survivors and assist in motivating positive changes in policies and attitudes that negatively affect Indigenous children and families.

Under article 2(e) of the UN Convention on Genocide (1948), "forcibly transferring children of the group to another group" constitutes genocide when the intent is to destroy a culture.[28]

Continuing Your Learning Journey

a) *How can educators learn more first-hand stories of Sixties Scoop?*

b) *How does the legacy of the Sixties Scoop fit into the larger journey of reconciliation?*

FURTHER INFORMATION

Sixties Scoop Indigenous Society of Alberta (SSISA) is "A non-profit society formed to represent survivors in Alberta, create dialogue and engagement and develop true reconciliation." www.ssisa.ca/

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Stepping Stones

Stepping Stones is a publication of the Alberta Teachers' Association **Walking Together Project** intended to support certificated teachers on their learning journey to meet the First Nations, Métis and Inuit foundational knowledge competency in the Teaching Quality Standard.

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Walking Together
EDUCATION FOR RECONCILIATION

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For additional resources and information on Walking Together, visit www.teachers.ab.ca.

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