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Centering Indigenous Voices to Inform the Delivery of Culturally-Appropriate Mental Wellness Services

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Centering Indigenous Voices to Inform the Delivery of Culturally-Appropriate Mental Wellness Services

by

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Abstract

Colonization and ongoing colonial policies and practices have shaped a mental healthcare system rooted in racism. A systemic lack of awareness and response to the transhistorical impacts of colonization have resulted in the perpetuation of mental wellness services that are not culturally-appropriate. Utilizing an anti-colonial theoretical framework, the purpose of this study was to explore if Indigenous peoples were receiving mental wellness supports that were responsive to their needs. A storytelling methodology was used with five participants from permanent supportive housing (PSH) buildings to share their experiences of mental wellness including homelessness and alcohol use. The stories revealed profound resistance to ongoing colonization. Further analysis of stories identified the absence of available supports, cultural connection, and supportive staff relationships in PSH buildings. Together, these results suggest participants are not receiving mental wellness supports that are culturally-appropriate. Using the Truth and Reconciliation Calls to Action as a framework for change, agencies can actively work towards providing culturally-appropriate mental wellness supports by: 1) increasing the availability of supports; 2) ensuring access to culture and connection; 3) re-evaluating hiring policies; 4) providing ongoing training; and 5) transforming to relationship-based care. Ultimately, this shift towards anti-colonial mental wellness services will result in disrupting colonial systems, policies, and practices; however, without the leadership and self-determination of Indigenous peoples themselves, there will be no real change in the provision of culturally-appropriate services.

Acknowledgements

I want to acknowledge the courage, openness, and willingness of each storyteller. Thank you for sharing your joy and pain with me.

I am deeply indebted to Elder John Chief Moon for his wisdom, knowledge, and support throughout this journey.

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To all my friends and family, especially Kevin, mom, and dad, I am so grateful for your love, support, and reminders to K.I.S.S.

Dedication

For my uncle David, who taught me there is always time to do a little dance. I miss you every day.

For all the storytellers who never got to tell their story, I dedicate this to you.

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Chapter 1.0: Introduction

Colonization has significantly impacted the well-being of Indigenous peoples in Canada. The consequence of colonization on the mental wellness of Indigenous peoples is profound and has resulted in the loss of cultural identity, enduring patterns of abuse, intergenerational trauma, and disproportionate rates of depression, suicide, homelessness, and substance use (Bellamy & Hardy, 2015; Kirmayer et al., 2003; Pauly et al., 2018; Thistle, 2017). Mental wellness services grounded in colonial understandings of health and wellness dismiss the importance of Indigenous knowledge and ways of healing. Furthermore, when agencies and staff who work with Indigenous people are not aware of the legacy of colonization or do not choose to approach this legacy in anti-colonial ways, colonization, racism, and health inequities continue to be perpetuated.

The seed for this study was planted while I was employed at a local mental health agency in 2017. As an undergraduate psychology student at the time, I was approached by a supervisor to "Indigenize" our mental health program after he found out I was completing a minor in Indigenous studies. The term "Indigenize" can refer to "naturalizing Indigenous knowledge systems and making them evident to transform spaces, places, and hearts" (Antoine et al., 2018, p. 6). It is important to note that Indigenization does not mean simply adding Indigenous content to an already established program or "changing something Western into Indigenous" (p. 6). Instead, it is a "deliberate coming together of these two ways of knowing" (p. 6). I was initially thrilled at the opportunity and my ego swelled with a sense of purpose and pride. However, I quickly realized it was not my place nor could I appropriately Indigenize anything

because I am not Indigenous. I realized what I, and the agency, needed to do was begin the process of decolonization.

The term "decolonize" refers to the "deconstructing of colonial ideologies of the superiority and privilege of Western thought and approaches" (Antoine et al., 2018, p. 6). This involves a critical reflection of one's thoughts, actions, and relationships with Indigenous people. It means challenging the status quo of Western power, domination, and superiority and becoming aware of one's "misconceptions, prejudice, and assumptions about Indigenous peoples" (p. 6). I spent my time reaching out to Indigenous organizations in the city and surrounding Indigenous communities to start building genuine relationships. After multiple conversations with my supervisor advocating for the need to hire Indigenous staff were ignored, the day finally came when I quit on the spot. Although at the time I felt like my hope of supporting Indigenous people on their mental health journey had been crushed, my passion was quickly reignited upon acceptance into graduate school, albeit in a profoundly deeper and more transformative way than I would have ever thought possible.

I hope this study will help inform best practices for agencies in their endeavor to provide culturally-appropriate mental wellness supports to Indigenous peoples in an anti-colonial, ethical, and respectful way.

1.1 Background

Colonization and ongoing colonial policies and practices are significantly impacting the mental wellness of Indigenous peoples (Kirmayer et al., 2003; Nelson & Wilson, 2017, 2018). A lack of culturally-appropriate mental wellness supports grounded in Indigenous knowledge undermines the significance of Indigenous ways of knowing

while dismissing their importance (Stewart, 2008). Moreover, health and wellness in Western context and practice is fundamentally different from an Indigenous perspective, resulting in a lack of appropriate healing resources for Indigenous peoples and the continuation of health inequities that perpetuate poor health outcomes (Browne, 2017; Lavallee & Menzies, 2014).

Negative healthcare experiences are pervasive for Indigenous peoples in a colonial system that has been shaped by policies rooted in racism, while a systemic lack of awareness and response to the transhistorical impacts of colonization has resulted in the perpetuation of stereotypes, discrimination, and inhumane treatment (Goodman et al., 2017; Hole et al., 2015; Stewart, 2008). Moreover, research reveals non-Indigenous mental healthcare workers struggle to provide culturally safe and appropriate mental healthcare services to Indigenous people due to feelings of discomfort, separateness, and adherence to the colonial biomedical model of wellbeing (Molloy et al., 2018). Furthermore, research suggests non-Indigenous mental healthcare workers feel pessimistic that non-Indigenous mental healthcare services can imbed cultural competency, cultural safety, or cultural awareness in a truly authentic way (Molloy et al., 2018). For true change to happen, agencies and staff who work with Indigenous peoples must start acknowledging the transhistorical impacts of colonization and respond in anti-colonial ways.

Following the death of Joyce Echaquan in a Quebec hospital in 2020, Dr. Barry Lavallee was interviewed and articulated how Canadians continue to actively refuse to respond when Indigenous peoples die from colonized systems and racism (Lavallee, 2020). Moreover, he purported that white fragility results in non-Indigenous people

putting the onus of racism back on Indigenous people by suggesting Elders need to do more training around cultural competency, safety, values, and traditions. Dr. Lavallee argued that although Canada cannot change its hard drive, there are good, non-Indigenous allies working alongside Indigenous peoples in the fight to shift the ongoing impacts of colonization and racism. Although uncomfortable for some non-Indigenous people, engaging with Indigenous peoples in this fight must be done authentically and focus on building relationships, practicing humility, remaining accountable, decolonizing one's thinking, and challenging one's power, position, and privilege (Anderson, 2019; Kilian et al., 2019; Regan, 2010).

Canadians have a moral and ethical responsibility to learn about colonization and the history of mistreatment towards Indigenous peoples (Carlson, 2017). Furthermore, Canadians have a responsibility to take these learnings and translate them into real action. For example, the Truth and Reconciliation Commission of Canada created 94 Calls to Action to guide Canadians on the journey towards healing the relationship between Indigenous and non-Indigenous people (TRCC, 2015a). Similarly, challenging colonization through an anti-colonial lens ensures solutions are informed by Indigenous voices, prioritize Indigenous resistance to colonization, and hold the colonizer accountable (Kempf, 2009).

1.2 Purpose of Study

The purpose of this narrative inquiry was to: determine the experiences of Indigenous peoples when seeking mental wellness services in Calgary; understand the perpetuation of colonization and racism in the delivery of mental wellness services; and ensure Indigenous voices were used to inform how colonization and racism can be

resisted. The research questions guiding this study were as follows: 1) What are the experiences of Indigenous peoples when seeking mental wellness supports in Calgary? 2) How do Indigenous peoples experience access and support when seeking mental wellness supports in Calgary? In addition to the stories shared by participants, my own story is woven throughout this thesis to highlight the challenges I faced as a non-Indigenous settler engaging in research with Indigenous peoples.

It is important to note that this study is a small component of a larger project evaluating the implementation of an Indigenous-specific managed alcohol program. A managed alcohol program is a harm reduction strategy used to mitigate harms associated with homelessness and alcohol use disorder (Pauly et al., 2018). Evaluation of managed alcohol programs in Canada suggest there are tremendous positive outcomes associated with these programs including a better quality of life, better access to primary healthcare services, stable housing, and important social, cultural, and community connections (Pauly et al., 2018; Podymow et al., 2006; Vallance et al., 2016). Since 2012, the Calgary Aboriginal Standing Committee on Housing and Homelessness (ASCHH) has been focused on and committed to providing culturally relevant healing resources to the Indigenous community including research into the development of the Indigenous-specific managed alcohol program. Additionally, the Greater Victoria Coalition to End Homelessness launched the Aboriginal Coalition to End Homelessness (ACEH) in 2015 with priorities of creating opportunities to develop more effective health, social support, and housing systems while supporting the advancement and engagement of Indigenous peoples. Through co-design, co-development, and engagement with Elders and Knowledge Keepers, both Calgary and Victoria secured Canadian Institute of Health

Research (CIHR) funding in April 2020 for the evaluation of an Indigenous-specific managed alcohol program for the homeless Indigenous population.

1.3 Situating Myself

As a white, non-Indigenous settler completing a thesis that explores colonization, racism, and the lived experience of Indigenous peoples in seeking mental wellness support, it took me a very long time to even begin to understand what my role was. As a graduate student, I was acutely aware of the exploitation of Indigenous peoples in health research and the myriad of publications that focused on the deficits of Indigenous peoples while ignoring the complicity of settlers in reinforcing colonization and racism. Throughout my thesis, I continually checked my motivation for why I was doing this and kept coming back to one word: accountability. I saw my role within this study as finding ways to hold myself and those around me accountable to the perpetuation of colonization and racism. It was about challenging my deeply engrained assumptions, behaviours, and attitudes towards Indigenous peoples and recognizing where I was actively participating in behaviours that harmed them. I acknowledge that this process was extremely challenging, anxiety-provoking, and overwhelming at times. I was uncomfortable, embarrassed, and ashamed in those moments when I was confronted with my own complicity in colonization and racism, which I discuss in detail in the following section.

1.4 Finding My Footing in Anti-Colonial Theory

Theory is crucial to establishing a strong foundational framework that guides researchers throughout the research process, serving as a reminder of the chosen lens used to examine, analyze, and disseminate complex social processes. This study explored how colonization and racism continue to be perpetuated within the mental healthcare system by

talking with Indigenous people who have lived experience. Given this, an anti-colonial theoretical framework rooted in resistance and accountability was utilized to ensure Indigenous voices were centered. Research with Indigenous peoples must be decolonized and anti-colonial theory provides a strong foundation to ensure the oppressor is held accountable in the anti-colonial struggle by demanding an interrogation of one's power, privilege, and participation in supporting ongoing colonial systems (Kempf, 2009).

Anti-colonial theory is action-oriented, informed by the knowledge of those who are oppressed, and grounded in the belief that oppression can be conquered through the mental, physical, emotional, and spiritual abilities of those who have been oppressed (Kempf, 2009). Anti-colonial theory resists, interrogates, and examines the impacts of colonization and oppression, purporting that colonization is transhistorical, pervasive, and ongoing. Moreover, anti-colonial theory critiques how the perpetuation of colonial policies, practices, and ideologies are understood and misunderstood by highlighting the voices of those who have been colonized (Kempf, 2009). Simmons and Dei (2012) suggest the "anti" in anti-colonial "carries with it a radical critique of the dominant, as the colonial oppressor whose antics and oppressive practices continue to script the lives of the subordinate and colonized…" (p. 68), reinforcing how imperative it is that the oppressor is actively present in the anti-colonial struggle. The oppressor can engage with the anti-colonial struggle by continually interrogating their power and privilege, resisting norms of power and dominance, and staying accountable in helping to eliminate the impacts of colonization through wide system transformation (Kempf, 2009; Simmons & Dei, 2012).

Given my role as part of the colonizer and oppressor group, I could not proceed on this thesis journey without taking a critical look at how I have perpetuated racism and been complicit in colonial systems and actions that continue to silence and harm Indigenous peoples. This was challenging and will continue to be challenging because this will be a lifelong journey for me. Carlson (2017) outlines principles for employing an anti-colonial methodology for non-Indigenous researchers when engaging with Indigenous peoples including: the importance of resisting colonialism; staying accountable to all relations; practicing reciprocity; engaging with community; and remaining reflexive by critically engaging with one's social position. Below, I touch on three principles that were most challenging to me, using Carlson (2017) for guidance:

Resisting and Subverting Colonialism: I am only just beginning to investigate colonization and racism and how I have been complicit in oppression, control, domination, and power. I continue to be presented with opportunities that challenge my own lived experience, privilege, and the benefits I have received from living in a colonial society. While doing my thesis, I had an experience where I heard someone refer to Indigenous peoples as "drunks." Although inside I knew what I was witnessing was wrong, I stood there silent and watched it happen without saying a word. I did not resist or subvert racism or harmful behavior in that moment and I am embarrassed and ashamed I did not react. If I could go back, I would do it differently. For example, within the anti-colonial framework I am responsible for pushing back against colonial arrogance and mentalities that perpetuate harmful stereotypes. Putting theory into action would have involved having a discussion with this person to challenge their thinking and encourage them to engage in the process of self-reflection.

Practicing Reciprocity: Navigating my role as a researcher in the context of trying to conduct research that is relational and reciprocal was extremely challenging. As data collection started, I was overwhelmed with the need to immediately fix the situation. I felt inspired by the courage and vulnerability of the participants and wanted to help them. I reacted out of anger and believed practicing reciprocity meant placing blame and trying to implement changes as soon as possible. The boundary between researcher and reciprocity in relational research is still blurry to me. I care deeply about the participants I engaged with and I think of them often, especially considering the results and outcomes from this study. I have spoken with some of them on the phone and want to continue to reach out and engage with them to see how they are doing; however, I am confused about whether this is ethical or appropriate. For me, this conflict highlights how important it is to ensure I continue working with Indigenous peoples for support and guidance. I will continue to have dialogue with Elder John Chief Moon and other Elders and Knowledge Keepers to address this struggle.

Participatory and Community-based Methods: Although I had anticipated being a part of an overall managed alcohol program Elder Advisory Circle for guidance, direction, and support for this study, COVID-19 halted the creation of this circle. Consequently, while in the middle of completing my thesis, data collection for the managed alcohol program was put on hold. Without the support and guidance of the Indigenous Elders and Knowledge Keepers that had advocated for the managed alcohol program to begin with, the research team decided it was best to wait until this could be arranged. This left me feeling extremely anxious and overwhelmed as I tried to navigate my own data collection and make sure I was proceeding in a good way. This experience

highlighted the importance of participatory and community-based methods while also revealing how challenging it can be to have multiple partners, agencies, and individuals working on a research project in community. It revealed how important it is to have a formal partnership or memorandum of understanding to ensure expectations are understood and agreed upon by all research team members. Finally, this experience compelled me to reach out on my own to Elder John Chief Moon for support and guidance, which I discuss in more detail below.

1.5 Ethical Engagement

Due to the ongoing impacts of colonization and a disturbing history of exploitative research conducted *on* Indigenous peoples, it was crucial that I approached this study in a respectful and ethical way. Before I even began, I attended an ASCHH meeting in March 2020 to present an overview of my proposed study, which the committee approved. As ASCHH is the owner of the overall managed alcohol program project, it was important that I get their approval and validation that my proposed project was of value to them. As previously discussed, I felt concerned and unsettled about proceeding without the guidance of the Elder Advisory Circle. I reached out to Elder John Chief Moon with whom I had connected previously and he graciously offered to support me on my research journey. I am so grateful for his guidance and support, having spent many hours walking through Fish Creek Park with him, listening intently and trying to absorb every word. One afternoon while we were discussing racism and the profound impact systemic racism continues to have on Indigenous peoples, I said "John, I don't know how to go forward in the right way. How do I start to shift things?" He stopped walking, looked directly into my eyes, and said "Dialogue – we keep having dialogue." His response was

so simple yet so powerful and I have embraced those words wholeheartedly. He has provided mentorship and guidance throughout this study and I would not have been able to complete this thesis without him.

In addition to the support and mentorship from Elder John Chief Moon, I reviewed the First Nations Information Governance Centre published the Ownership, Control, Access, and Possession (OCAP) guidelines to ensure research conducted with First Nations is respectful and appropriate (OCAP, n.d.) The tenets of OCAP work in conjunction with one another and explicitly state that First Nations communities own, control, manage, and protect their knowledge, data, and information. Furthermore, OCAP provides suggestions for conversations that must be had when embarking on research with Indigenous peoples such as outlining publication expectations, creating a communication strategy between the research team, and establishing a formal partnership or memorandum of understanding. Similar to OCAP, the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2) includes a chapter on how to conduct research with Indigenous peoples in Canada (CIHR, 2005). The TCPS 2 framework for engaging in research with Indigenous peoples highlights the importance of collaboration, relationship building, and engagement between researchers and the community.

Finally, literature suggests authentic engagement and relationship building are crucial to undertaking Indigenous health research as a non-Indigenous person. Kilian et al. (2019) explored the process of non-Indigenous researchers engaging with Indigenous people and found four crucial themes: 1) the importance of relationship building; 2) the reflexivity required by the non-Indigenous researcher; 3) inconsistent application of

ethical engagement frameworks; and 4) the role of institutions as barriers and facilitators to ethical engagement, while identifying relationships, trust, humility, and accountability as the pillars to ethical engagement. Furthermore, Anderson (2019) argues non-Indigenous peoples must conduct Indigenous health research that is anti-racist and anti-colonial while being willing to actively give up one's power and privilege to Indigenous peoples themselves. Anderson (2019) purports "The intentions of non-Indigenous researchers are not relevant to reconciliation — only their impacts and outcomes are", suggesting non-Indigenous researchers must continually examine their motivation for conducting Indigenous health research while also remaining accountable to the Indigenous people they are working with. In this study, I took up these principles by giving up control during interviews with participants and providing space for them to speak freely about their experiences as they saw fit. This was uncomfortable but imperative to ensure the outcomes of this study were guided and led by Indigenous people rather than a research question I sought to answer. Furthermore, I continued to engage in dialogue with Elder John Chief Moon throughout the research process and pursued humility by continually seeking guidance and support from Indigenous people and others around me.

1.6 Thesis Layout

Chapter 2 provides an overview of the literature referenced on colonization, racism, the overrepresentation of Indigenous peoples in homelessness and problematic alcohol use, and mental health, wellness, and healing from a Western and Indigenous perspective. Chapter 3 discusses the storytelling methodology and outlines the methods including interview setting, participants, data collection, and data analysis. Chapter 4 presents an

overview of my interactions with each participant, followed by their stories, background context, and a personal reflection. This chapter concludes with the story among the stories. Chapter 5 further explores the stories by noting what colonization and racism have silenced. Chapter 6 provides a discussion of the results and notes the limitations of the study. Finally, Chapter 7 presents the study conclusions.

Chapter 2.0: Literature Review

In this chapter, I provide a brief overview of colonization and racism. Next, I discuss how colonization and racism are social determinants of health that have contributed to health inequities like disproportionate rates of homelessness and problematic alcohol use in the Indigenous population. Finally, I explore the understanding of mental health and wellness from a Western and Indigenous perspective and examine how understandings rooted in Western perspectives result in a lack of safe and culturally-appropriate mental healthcare services.

2.1 Colonization

Colonization and ongoing colonial policies and practices have significantly impacted the health and wellness of Indigenous peoples in Canada. Colonization has been defined multiple ways in the literature; however, common threads include imposition, power, domination, and control. Loomba (2015) describes colonialism "as the conquest and control of other people's land and goods" (p. 20) as European settlers utilized a variety of techniques to establish dominance and restructure economies to ensure the growth of European capitalism. Similarly, Kelm (1998) defines colonization as a process that includes "geographic incursion, socio-cultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services…." (p. 124), while Dei and Kempf (2006) suggest colonialism requires the colonizer to establish systems of dominance and imposition over those who are colonized, resulting in power hierarchies that dictate the production of knowledge and identity. Finally, Kempf (2009) describes colonization as a process where abstract sites of oppression, such as race and ethnicity, become concrete sites of oppression, such as

structural or institutional, result in privileging certain groups and individuals while disadvantaging other groups and individuals.

Regardless of the definition, colonization has had profound effects on Indigenous peoples' health and wellness. European settlers believed Indigenous peoples were inferior, savage, and unequal to the white man, viewing Indigenous cultural, political, social, and spiritual ways of knowing as uncivilized and barbaric (Gunn, 2015). As a result, the government established the Indian Act in 1876, a race-based act created with the mandate of controlling, assimilating, and eradicating the Indigenous population. Shockingly, it is still the only active Indigenous-specific federal legislation in Canada (Indian Act, Revised Statutes of Canada, 1985, c. 1-5). To rectify the "Indian Problem" and maintain their power and control, the federal government imposed numerous inherently racist provisions under the Indian Act that "gave way to punitive rules, prohibitions and regulations" that dehumanized Indigenous peoples and caused innumerable suffering (Joseph, 2018). One such provision was the attempt to assimilate and control the Indigenous population through the creation of segregated Indian hospitals.

Under the Indian Act, the apprehension of Indigenous peoples deemed "sick" was legal and resulted in doctors, Indian Agents, and the government exploiting this clause by "declaring individuals contagious" as a "good means of control" while continuing with the goal of decimating the Indigenous population (Geddes, 2017, p. 13). In fact, residential schools worked closely with the segregated Indian hospitals, often sending students over to guarantee full funding while ensuring the "captive clientele of guinea pigs" (Geddes, 2017, p. 89). Guinea pigs indeed, children within these segregated hospitals were at the mercy of unethical, appalling, and cruel mistreatment and care.

Lived experience from survivors of segregated hospitals sheds a small light onto the atrocious treatment they received including: the experimental testing of the polio vaccination; mysterious injections; radioactive injections; cutting of the ribs to remove parts of the lung; forced sterilization; severe malnourishment; nutritional experiments; and violent physical and sexual abuse (Geddes, 2017). The trauma resulting from the experiences within these racist segregated hospitals has resulted in humiliation, ongoing devastation, dysfunction and disruption, and a gross mistrust of the western, biomedical systems of health. Thus, Indigenous peoples continue to experience health inequities due to the transhistorical impacts of colonization and racism.

2.2 Racism

Racism can be understood as "organized systems within societies that cause unavoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups" (Paradies et al., 2015, p. 2). Racism operates to disadvantage and advantage certain groups through multiple avenues including systemic, interpersonal, and epistemic racism (Allan & Smylie, 2015; Paradies et al., 2015), as briefly described below:

- Systemic racism: enacted through systems, structures, institutions, and policies to reinforce inequalities and result in social exclusion, isolation and a lack of participation and/or access to systems such as health;
- Interpersonal racism: micro-aggressions and discriminatory treatment of another individual in various settings or in everyday relations in the healthcare setting; and

- Epistemic racism: believing one group is superior to another group including privileging knowledge from a western perspective and dismissing and ignoring Indigenous ways of knowing within the healthcare system.

A review of the history of health and Indigenous peoples reveals just how embedded racism is in Canadian institutions. As Geddes (2017) posits, the establishment of segregated Indian hospitals was fueled by systemic racism, and it is systemic racism that continues to shape and drive the health inequities faced by Indigenous peoples in the healthcare system today. Research suggests Indigenous peoples experience racism and discrimination within the healthcare system at an alarming rate because the health system perpetuates the concepts of colonization and whiteness, resulting in an environment that ignores the structural, social, and historical factors that have impacted Indigenous health (Browne et al., 2011; Goodman et al., 2017; Nelson & Wilson, 2018). By exploring historical race-based health policies and practices, one can begin to understand how deeply entrenched racist and discriminatory attitudes, actions, and behaviors are within the healthcare system and why it is vital these historical factors are not ignored.

Indigenous peoples experience racism and discrimination at alarming rates. Goodman et al. (2017) argue the Canadian healthcare system is rooted in Eurocentric norms and values, those of white middle-class men, resulting in an environment that ignores the structural, social, and historical factors that have impacted Indigenous health. Although policies may be in place that acknowledge cultural competency and/or cultural safety, research reveals a gap when translating policy to practice. For example, a study by Mcgough et al. (2018) revealed mental health workers felt unprepared putting the tenets of cultural safety into practice, while Molloy et al. (2018) found that mental health nurses

believed policies and mandatory training changed nothing, feeling pessimistic that white mental health services could imbed cultural safety or awareness in a true, respectful, and authentic way. Similarly, Hole et al. (2015) found Indigenous participants believed training on cultural safety did not change the way care was delivered, highlighting the need to broadly implement cultural safety policy into practice. Researchers suggest future research should explore how cultural safety can be implemented beyond a superficial level while examining how patterns of power, paternalism, and racist discourse continue to perpetuate dehumanizing policies and practices (Browne, 2017; Goodman et al., 2017).

Utilizing participants with lived experience, Goodman et al. (2017) explored healthcare experiences of Indigenous peoples living in Vancouver's Downtown Eastside. Results revealed stereotypes such as "the drunken Indian", as well as myths of Indigenous peoples being freeloaders or being incapable of parenting, were insidious during interactions with service providers. Participants indicated feeling stigmatized, discriminated against, and treated as unworthy by healthcare providers due to deeply engrained assumptions surrounding appearance and substance use. Researchers have suggested that racism and preconceived ideas of what constitutes Indigenous identity intersect to continually reinforce discrimination in healthcare settings (Browne, 2017; Goodman et al., 2017). Similarly, Nelson and Wilson (2018) explored the barriers Indigenous peoples face when accessing healthcare in Prince George, British Columbia. Results suggested participants experienced discrimination due to their Indigenous status, appearance, and identity. Moreover, Browne et al. (2011) found Indigenous participants felt judged by service providers for being Indigenous, living in poverty, and seeking out supports from hospitals. In 2020, British Columbia reported on racism in their healthcare

system, finding that systemic racism was disturbing and widespread with the problem being "widely acknowledged by many within the healthcare system, including those in positions of authority" (In Plain Sight, 2020, p. 2). In sum, overwhelming evidence reveals Indigenous peoples continue to experience racism and discrimination due to the perpetuation of colonial policies, practices, and attitudes.

2.3 Colonization and Racism as Social Determinants of Health

As Allan and Smylie (2015) posit, "social determinants of health emphasize the fundamental role of colonization, racism, social exclusion and a lack of self-determination in the alarming disparities in Indigenous and non-Indigenous peoples' health" (p. 7). Colonization and racism continue to profoundly disrupt Indigenous culture and worldviews, resulting in ongoing trauma and imbalances in mental, cognitive, behavioural, social, and physical challenges for both individuals and communities (Thistle, 2017). The impact of colonization on Indigenous people's health is profound and includes a loss of cultural identity, enduring patterns of abuse, intergenerational trauma and disproportionate rates of depression, homelessness, and substance use (Bellamy & Hardy, 2015; Brave Heart, 2003; Kirmayer et al., 2003; MacDonald & Steenbeek, 2015; Statistics Canada, 2016;). In fact, Kirmayer et al. (2003) suggests the prevalence of poor mental health in the Indigenous population is a direct result of assimilative policies, while Brave Heart (2003) purports historical trauma resulting from colonization rears itself in issues such as substance abuse, mental illness, and suicide among many other conditions. As Richmond and Cook (2016) argue, policies developed based on race and ethnicity "have allowed the entrenchment of racism into the policies and procedures of a suite of organizational structures affecting the daily life and

wellbeing of Aboriginal people, including education, healthcare, justice, economic development, governance and economic development" (p. 8). Deeply imbedded racist thoughts and behaviours continue to produce "impenetrable systemic and societal barriers, such as a lack of affordable and appropriate housing, insufficient and culturally inappropriate health and education services, irrelevant and inadequate employment opportunities, and a crumbling infrastructure in First Nations, Inuit, and Métis communities" (Thistle, 2017, p. 7).

2.3.1 Homelessness

From a Western perspective, homelessness is often viewed as an individual problem and understood as simply lacking a roof over one's head (Thistle, 2017). The overrepresentation of Indigenous peoples in homelessness and their experiences of marginalization, power inequities, racism, and discrimination suggest homelessness must acknowledge the historic and systemic factors that have impacted Indigenous peoples (Oelke et al., 2016; Patrick, 2014; Thistle, 2017). Thus, Indigenous homelessness can best be understood as "the outcome of historically constructed and ongoing settler colonization and racism that have displaced and dispossessed" traditional governance, worldviews, and stories (Thistle, 2017, p. 6). Furthermore, Indigenous homelessness is multi-faceted and complex and includes "individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages, and identities" (ASCHH, 2012; Thistle, 2017, p. 6). The loss of culture and connection has had significant impacts on Indigenous peoples. In connection with homelessness, "external and foreign factors contribute greatly to rural and urban Indigenous homelessness by neglecting and starving healthy Indigenous relationships:

personal, social, cultural, spiritual and political. These factors are not innate to Indigenous cultural practices; they are instead external and state driven, imposed on, rather than generated by Indigenous cultural practices" (Thistle, 2017, p. 8). Thistle (2017) outlines 12 dimensions of homelessness as follows:

- Historical Displacement and Homelessness: being displaced from pre-colonial Indigenous lands;
- Contemporary Geographic Separation Homelessness: separation from Indigenous lands, after colonial control;
- Spiritual Disconnection Homelessness: separation from Indigenous worldviews or connection to the Creator or equivalent deity;
- Mental Disruption and Imbalance Homelessness: an imbalance of mental faculties, experienced by Indigenous individuals and communities caused by colonization's entrenched social and economic marginalization of Indigenous peoples;
- Cultural Disintegration and Loss Homelessness: complete dislocation and alienation from culture and from the relationship web of Indigenous society known as "All My Relations";
- Overcrowding Homelessness: people per dwelling exceeds the national average and contributes to unsafe, unhealthy, overcrowded living conditions;
- Relocation and Mobility Homelessness: travelling over geographic distances between urban and rural spaces for access to work, health, education, recreation, legal and childcare services; to attend spiritual events and ceremonies; to have access to affordable housing; and to see family, friends and community members;

- Going Home Homelessness: individual or family who has grown up or lived outside their home community for a period of time, and on returning "home," are often seen as outsiders, making them unable to secure a physical structure in which to live, due to federal, provincial, territorial, or municipal bureaucratic barriers, uncooperative band or community councils, hostile community and kin members, lateral violence and cultural dislocation;
- Nowhere to Go Homelessness: a complete lack of access to stable shelter, housing, accommodation, shelter services or relationships; literally having nowhere to go;
- Escaping or Evading Harm Homelessness: fleeing, leaving, or vacating unstable, unsafe, unhealthy, or overcrowded households or homes to obtain a measure of safety or to survive. Young people, women, and LGBTQ2S people are particularly vulnerable;
- Emergency Crisis Homelessness: Natural disasters, large-scale environmental manipulation and acts of human mischief and destruction, along with bureaucratic red tape, combining to cause Indigenous people to lose their homes because the system is not ready or willing to cope with an immediate demand for housing; and
- Climatic Refugee Homelessness: Indigenous peoples whose lifestyle, subsistence patterns and food sources, relationship to animals, and connection to land and water have been greatly altered by drastic and cumulative weather shifts due to climate change. These shifts have made individuals and entire Indigenous communities homeless.

A lack of connection translates into a lack of home (Gasparelli, 2014). Thus, Indigenous homelessness is multifaceted and requires a multidimensional approach when designing and delivering programs that are culturally responsive to the needs of the Indigenous population (Thistle, 2017). One innovative approach to homelessness has been the creation and implementation of housing first programs. The housing first approach supports individuals who are homeless and living with mental health concerns by providing immediate access to housing and connection to supports regardless of housing readiness (Goering et al., 2014). The five guiding principles of housing first include: 1) immediate access to housing; 2) consumer choice and self-determination; 3) recovery oriented; 4) individualized and person-driven supports; and 5) social and community integration (Goering et al., 2014). Housing first programs include several models of housing and case management, one of which is called permanent supportive housing (PSH). According to the Calgary Homeless Foundation (CHF) Resource Guide (2018), a PSH is defined as follows:

> A long-term supportive housing model that targets individuals who experience chronic homelessness and are highest or most complex needs; they experience extreme difficulty exiting homelessness on their own due to multiple barriers, (e.g., substance use, mental illness, high rates of trauma, developmental disability, and cognitive impairment), in addition to housing cost and financial barriers. Individuals are offered access to a range of support services - although participation is not always required. (p. 2)

CHF states that PSH buildings in Calgary adhere to the housing first philosophy and principles of providing appropriate wrap-around supports including: cultural connection;

regular programs such as art and cooking classes; and volunteer, employment, and recreational programming. Furthermore, CHF indicates that staff at PSH buildings have high levels of cultural competence and individualized client care is supported through self-determination (CHF, 2018).

2.3.2 Alcohol

Perhaps one of the most toxic stereotypes that continues to perpetuate is the myth of the "drunken Indian", having roots in the provision under the Indian Act that prohibited the sale of intoxicants to Indigenous peoples. Access to alcohol was controlled by and used as a bartering tool by superintendents, commissaries, interpreters, and missionaries prior to the prohibition of alcohol in 1884 (Joseph, 2018). Once outlawed, it was illegal for Indigenous peoples to use and purchase alcohol, or visit any establishment where alcohol was present, while those caught selling alcohol to Indigenous peoples were also punished. A consequence of this provision was that the selling and purchasing of alcohol was forced to the black market, resulting in Indigenous peoples hiding their alcohol and consuming it rapidly to avoid punishment (Joseph, 2018). Stereotypes resulting from this policy to practice include myths of the "drunken Indian", Indigenous peoples cannot handle their alcohol, and Indigenous peoples can't metabolize alcohol, all of which are still extremely prevalent in society (Campbell, 2008; Joseph, 2018). Not only did false narratives surrounding alcohol use persist, the federal government allowed Indigenous peoples to consume alcohol if they became enfranchised, meaning "to become a Canadian citizen and cease to be an Indian" (p. 108), suggesting the prohibition of alcohol was used to control and define the Indigenous identity through race, alcohol and citizenship (Campbell, 2008).

Some Indigenous people believe abstinence-based models are the only solution to counteract problematic alcohol use because alcohol has destroyed their traditional way of life (Mushquash, 2014). Moreover, it could be believed alcohol is a spiritual entity in which "alcohol spirits" replace the spirit residing in Indigenous people and their connection to people, culture, and Creator (Duran & Duran, 1995; McCormick et al., 2014). Conversely, proponents of harm reduction see problematic alcohol use along a continuum of care with the goal of reducing harms associated with alcohol use (Mushquash, 2014). Harm reduction "respects the client's personal goals for treatment" (Mushquash, 2014, p. 210) while demanding "we put aside our assumptions about who can be helped and how healing happens" (Distasio et al., 2019, p. 48). Today, there is conflict between abstinence-only approaches versus harm reduction approaches; however, as Wardman (2014) explains, the two are not mutually exclusive. Rather, "common to both approaches is the goal of assisting individuals and communities with the harms they are experiencing because of problematic substance use" (Wardman, 2014, p. 109).

2.4 Culturally-Appropriate Mental Wellness Supports

Through an Indigenous lens, culture can be understood as "the whole complex of relationships, knowledge, languages, social institutions, beliefs, values, and ethical rules that bind a people together and give a collective and its individual members a sense of who they are and where they belong" (Mussell, 2014; RCAP, 1995, p. 25). Indigenous culture values relations with all beings and as such, mental wellness is relational and social, grounded in principles of "connectedness, togetherness, holism, and cultural ways of knowing" while individual wellness is "strongly connected to the health and wellness

of the family and the community" (Mussell, 2014, p. 190). Moreover, Distasio et al. (2019) suggests, "Culture is about more than cultural teachings or practices; it is about connection—to self, family, community, nature, and nation" (p. 48). The terms mental illness and mental health are not included in traditional Indigenous languages and have negative connotations attached to them that focus on deficits instead of strengths (Mussell, 2014). Instead, Mussell (2014) posits the term mental wellness is most appropriate from an Indigenous perspective as it focuses on wholeness, strength, and a balance of mind, body, and spirit. Mental wellness is rooted in Indigenous culture and incapsulates a connection to one's cultural identity and is defined and shaped by the cultural values of Indigenous peoples themselves (Mussell, 2014). It is important to note that there is not a homogenous Indigenous culture; therefore, there will not be a singular approach to mental wellness and healing. Although Indigenous cultures may share commonalities and core values, there are multiple diverse perspectives and worldviews on mental wellness and healing (Mussell, 2014).

The understanding of mental wellness from a Western perspective is distinctly different from an Indigenous perspective. The Government of Canada characterizes mental illness as "alterations in thinking, mood or behaviour associated with significant distress and impaired functioning" (Government of Canada, 2020). Often, the approach to diagnosing and treating mental illness follows the Diagnostic and Statistical Manual of Mental Disorders (DSM) which adheres to a biomedical model that focuses on checklist symptoms, behaviours present, and the use of medication and/or psychotherapy as solutions (APA, 2000). Comparing a biomedical model of health and wellness to an Indigenous perspective that values the restoration of culture, there is a major disconnect

between the understanding of mental wellness, resulting in the absence of culturally-appropriate supports available in mainstream mental health treatment. Indigenous peoples who seek treatment or support for mental wellness concerns struggle to find resources that honor Indigenous epistemologies (Stewart, 2008). Furthermore, a literature review conducted by Nelson & Wilson (2017) revealed "mental health practices as they currently exist are rooted in a colonial system and therefore do not adequately take the perspectives of their Indigenous clients into account" (p. 97) suggesting education on and incorporation of Indigenous perspectives within the healthcare system is required. Moreover, Stewart (2008) argues the effects of colonialism are a "major mental health issue for Native clients today" and institutions must re-examine and modify "the paradigm of mental health to include Indigenous cultural conceptions" to create lasting change and support the promotion of healing (p. 55).

Often, agencies respond to this inclusion of culture by offering staff cultural competence or sensitivity training. A growing body of literature indicates that cultural competence frameworks may represent acts of tokenism, reinforce perceptions of "Otherness", fail to challenge structural power imbalances, and ignore the effects of trauma and racism (Danso, 2018; Fisher-Borne et al., 2014; Herring et al., 2013; Johnson & Munch, 2009; Pon, 2009). As Regan (2010) purports, it is imperative that non-Indigenous people learn about the history and impacts of assimilation, recognize the resilience in those who continue to resist colonization, and engage in a deeply critical reflection of themselves. Focusing solely on cultural competency is a process of Othering and by overlooking the role of the settler, "it prevents us from acknowledging our own need to decolonize" (Regan, 2010, p. 11).

Similarly, to provide culturally-appropriate supports Mussell (2014) argues that services must focus on people's strengths and requires staff to engage in critical self-reflection to understand the broader historical and social impacts that have led an Indigenous person to where they are. Practitioners must take accountability in challenging traditional ways of providing services by modelling honest and respectful behaviour, allowing people to talk and actively listening to them, becoming familiar with Indigenous traditions and history, taking the time to understand different viewpoints, and building genuine, long-term relationships with Indigenous people (Mussell, 2014).

2.5 Summary

Colonial and racist policies and practices continue to have profound impacts on the mental wellness of Indigenous peoples including disproportionate experiences of homelessness and problematic alcohol use. The understanding of mental wellness from an Indigenous perspective is distinctly different from a Western perspective, resulting in a lack of culturally-appropriate mental wellness supports. Policy makers, organizations that provide funding to agencies, leadership teams, and staff themselves must be held accountable. Each of these must engage in uncomfortable and unsettling reflections of how they may be perpetuating colonial and racist policies, practices, and behaviours that continue to harm Indigenous peoples they serve.

Chapter 3.0: Methodology

This chapter provides an overview of my research methodology and associated methods. First, I discuss the use of storytelling as my chosen methodology. Then, I provide an overview of the methods I used during participant interactions and for data collection, followed by a discussion around how data was analyzed, interpreted, and presented.

3.1 Storytelling

"Story as methodology is decolonizing research." (Kovach, 2009, p. 103)

In alignment with an anti-colonial theoretical framework, the decision to utilize storytelling as a methodology was purposeful and intentional for three reasons. First, anti-colonial theory is informed by "knowledge of the oppressed" (Kempf, 2009); therefore, I felt it was most appropriate to gather knowledge from participants who were experts through their own lived experience. Second, anti-colonial theory demands accountability from the oppressor; thus, we must listen and be led by those who have been oppressed. Third, I wanted to challenge the fact that "the research that influences policy and shapes practices that impact Indigenous communities emerges from Western, not Indigenous, knowledges or forms of inquiry" (Kovach, 2009, p. 13); therefore, I chose storytelling as a valid form of inquiry and truth telling as the foundation for holding the oppressor accountable.

Storytelling as a decolonizing methodology is profoundly powerful, contributing "to a collective story in which every Indigenous person has a place" (Smith, 2012). Kovach (2009) suggests there is an "interrelationship between narrative and research within Indigenous frameworks" (p. 94). The richness and depth of narrative inquiry

cannot be captured by a single, universal definition; however, a defining feature of narrative inquiry is understanding and exploring the true, lived experiences of human beings (Clandinin, 2013; Kovach, 2009; Riessman, 2008). Within an Indigenous methodology, storytelling is a traditional and valid way of producing and sharing invaluable insight, wisdom, and knowledge based on principles of reciprocity and relationality (Baskin, 2005; Kovach, 2009; Wardman, 2014; Wright et al., 2016). The storytelling process is a dynamic approach in which the storyteller takes control (Creswell & Poth, 2018; Kovach, 2009; Riessman, 2008). Riessman (2008) explains how giving power over to the storyteller to guide the direction of the dialogue "requires investigators to give up control, which can generate anxiety" (p. 24); however, giving up control addresses the power imbalance between the researcher and the storyteller. Both the researcher and the storyteller are active participants in the conversation, creating a relationship that is reciprocal and mutually beneficial while demanding the researcher fully engage, listen with intent, and remain attentive throughout the story (Kovach, 2009; Riessman, 2008). As Kovach (2009) explains, "story and Indigenous inquiry are grounded within a relationship-based approach to research" (p. 98).

3.2 Methods

3.2.1 Storytellers

In total, five residents from three separate permanent supportive housing (PSH) buildings agreed to share their stories with me. All five were part of the larger managed alcohol program evaluation project. I met with each participant face-to-face at their building of residence; however, due to COVID-19 protocols, each of us wore a mask and sat 6 feet away from each other. After reviewing the informed consent process and

explaining the purpose my of research, each participant was given a $20 gift card and gifted a pouch of tobacco. The gifting of tobacco was suggested by Elder John Chief Moon to honor the relationship each participant and I were embarking on and to acknowledge their courage, openness, and willingness to share their story with me.

3.2.2 Collecting the Data

Participants were invited to share their stories by engaging in a semi-structured interview. I had prepared an episodic interview guide (Appendix A) to help direct the interview; however, following the first interview I realized the guide was not congruent with my theoretical grounding or methodological choice. Although the interview questions were meant to be helpful and probing, they ultimately shaped how I wanted the interview to unfold, what knowledge I wanted to gather, and how the story should be organized. As Kovach (2009) explains, highly structured interviews dismiss the relational aspect of research, instead suggesting that an open conversation "shows greater respect for the participant's story and allows research participants greater control over what they wish to share" (p. 125). Indeed, once I was able to give up control and stop trying to fit a participant's story into my research question, I was able to "intuitively respond to the stories, to share as necessary [my] own understandings, and to be [an] active listener" (p. 125). As such, each interview began with an opening question asking the participant to share their story of homelessness and alcohol use, and from there, conversation, dialogue, and story were shared as directed by the participant. Probing questions were asked for clarification when required. The interviews were recorded on a smartphone for transcription purposes. In addition to completing interviews with participants, data was collected through observations made during my time spent at the PSH buildings. Data

collection was further supported by fieldnotes and a research journal used throughout the data collection process.

3.2.3 Analyzing and Interpreting the Data

> *"The presentation of story in research is an increasingly common method of presenting data. Interpreting meaning from stories that do not fragment or decontextualize the knowledge they hold is more challenging." (Kovach, 2009, p. 131)*

Following completion of the interviews, I felt unsettled and unsure of how to proceed in an ethical or respectful way while analyzing and interpreting what I had heard. How could I, as a privileged, white, educated woman completing a thesis project, represent the rawness, vulnerability, beauty, and emotions that were shared between each participant and myself? I reached out to Elder John Chief Moon and asked him "What do I do with all of this now?" He simply said, "Honor their stories and use your privilege to be their mouthpiece." With that in mind, I began the analysis and interpretation process reminding myself of my chosen theoretical framework and proceeded with an open heart and an open mind.

Although Creswell and Poth (2018) argue the heart of qualitative data analysis is in coding and categorizing of the data, Kovach (2009) purports this aggregation and decontextualization of data does not support the holistic meaning-making process within an Indigenous methodology. After considerable time spent grappling with the tension between different methodologies, I decided to follow the guidance of Kovach (2009) and utilize a mixed-method approach. For the current study, it is important to note the term mixed-method does not refer to a combination of qualitative and quantitative data collection and analysis, but rather an "approach that offers both interpretive meaning-

making and some form of thematic analysis" (Kovach, 2009, p.131). As such, the storytelling methodological approach was guided by the data analysis spiral method (Creswell & Poth, 2018; Figure 1), while the thematic analysis was guided by Riessman's (2008) approach to narrative inquiry.

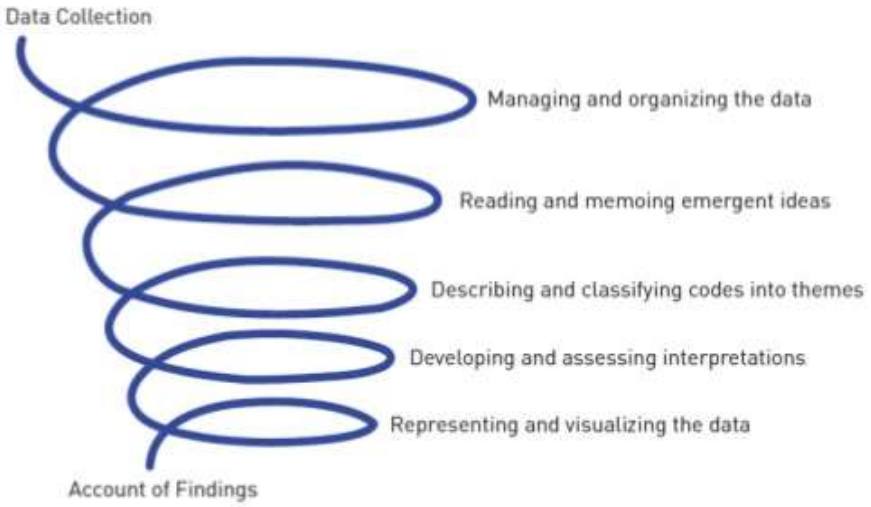

Figure 1. Data analysis spiral (Creswell & Poth, 2018)

Grounded in anti-colonial theory, it was critical that the stories were highlighted and placed front and center in the analysis. I chose to engage in the analysis process using a data analysis spiral approach which allowed me to move through the process in a more fluid and circular approach, rather than a linear or rigid approach (Creswell & Poth, 2018). As Creswell & Poth (2018) explain, the data analysis spiral includes managing and organizing data, reading and memoing emerging ideas, describing and classifying codes into themes, developing and assessing interpretations, and finally, representing and displaying the data.

Building on the data analysis spiral method with regards to a storytelling methodological approach, I listened to the recorded interviews and re-read the transcripts multiple times to continually situate myself in the moment of when the stories were told.

This helped me ensure I was honoring their stories. Transcripts were analyzed, interpreted, and condensed using a chronological approach that focused on past, present, and future events and epiphanies identified by each participant (Creswell & Poth, 2018; Kovach, 2009; Riessman, 2008). The interview transcripts were condensed and presented in a story form that focused on key moments, memories, or epiphanies of where the participant used to be, where they are now, and where they see themselves in the future. Kovach (2009) suggests the meaning-making process of the story includes context as "the truths of the stories are held within the life context of the storyteller" (p. 131).

Following completion of the stories, I once again grounded myself in anti-colonial theory and examined what was notably present and absent from the stories. I initially utilized NVivo to help make sense of the stories; however, I ultimately ended up journaling to organize my thoughts because I felt too far removed from the rawness experienced with each interview. Through journaling, reading, and comparing stories, it became evident there were commonalities between the stories in terms of what was present and what was absent. Thus, I used a thematic analysis framework to guide the emergence of common themes (Riessman, 2008).

In sum, I ensured each story was honored by continually returning to the transcripts with care and intentionality. This kept me grounded in what each person had actively shared, rather than in what I thought I had heard. I also honored each participant's courage and willingness to share their stories with me by gifting them tobacco. Finally, as of this writing, three of the five participants have approved how their story has been interpreted and presented (as discussed in more detail in Chapter 4).

My privilege as a graduate student allowed me to utilize this thesis as a platform to honor and center the voices of Indigenous people in their experiences of accessing mental wellness supports. By putting those with lived experience at the heart of this study, Indigenous voices have informed how agencies can provide safe and culturally-appropriate mental wellness services for Indigenous people.

Chapter 4.0: Centering Indigenous Voices Through Story

This chapter presents each story front and center, followed by the context in which the interview took place, and a reflection based on my journaling. It is important to note that pseudonyms have been used in lieu of real names. Each participant chose their own pseudonym and I have presented the stories in alphabetical order according to these pseudonyms. At the time of this writing, I have not been able to connect with Participant(1) and Participant(2), as explained further in their reflection sections. Finally, this chapter concludes with the story within the stories. Table 1 presents a brief overview of my interactions with each participant.

Table 1: Interactions with Participants

Storyteller	**Number of Interactions**	**Date/Context of Interactions**	**Length of Interactions**	**Story Approved?**
Bright Thunder	3	1) January 12, 2021: In person completion of managed alcohol program surveys. 2) January 19, 2021: In person interview. 3) February 25, 2021: Telephone conversation to review and approve story.	30 minutes 70 minutes 12 minutes	Yes

Storyteller	Number of Interactions	Date/Context of Interactions	Length of Interactions	Story Approved?
Edward	2	1) February 5, 2021: In person completion of managed alcohol program surveys and interview. 2) February 25, 2021: Telephone conversation to review and approve story.	25 minutes 9 minutes	Yes

Storyteller	Number of Interactions	Date/Context of Interactions	Length of Interactions	Story Approved?
Morphis	3	1) January 28, 2021: In person completion of managed alcohol program surveys and interview. 2) February 24, 2021: Telephone conversation – cut short due to phone connectivity issues. 3) March 10, 2021: Dropped off a copy of story in person for review and approval.	75 minutes ~5 minutes ~2 minutes	Yes

Storyteller	Number of Interactions	Date/Context of Interactions	Length of Interactions	Story Approved?
Participant(1)	2	1) February 5, 2021: In person completion of managed alcohol program surveys and interview. 2) February 25, 2021: Telephone conversation – tried multiple times but cut short due to phone connectivity issues.	20 minutes ~ 5 minutes	No

Storyteller	Number of Interactions	Date/Context of Interactions	Length of Interactions	Story Approved?
Participant(2)	2	1) January 12, 2021: In person completion of managed alcohol program surveys. 2) January 28, 2021: In person interview. 3) February 25, 26, 2021: Attempted multiple telephone conversations, but Participant(2) wasn't available.	15 minutes 25 minutes ~10 minutes	No

4.1 The Story of Bright Thunder

On a journey of self-forgiveness, Bright Thunder's experience of homelessness began as a young child in foster care. Subject to abuse, combined with not knowing who his family was or where he came from, left him feeling lost and unable to cope. He sought refuge in alcohol and made numerous attempts to run away, although he admits he never really knew where we was running to. Even after connecting with his family, he never fit in and felt like the black sheep.

With 3 years sobriety, he eventually left his home community in 1997, returning for a short time in 2000 to attend a Native Alcohol and Addictions Program. Following graduation, he returned to his home community, but started drinking again and quickly realized he did not belong. A cross-country bus trip took him through Montreal, Toronto, Winnipeg, Regina, Edmonton, and eventually Calgary in 2004/2005. He landed at a local shelter, quickly learning the street language and becoming part of a crowd where he became both protected and a protector. He often camped outside the shelter with a shopping cart and sold drugs, resulting in him being barred from the shelter and ending up in prison. Today, Bright Thunder has his own apartment; however, he wants to leave the building because he feels bad spirits around him, has no connection to Indigenous culture, and is unable to talk to anyone except his Creator.

Bright Thunder has a long relationship with alcohol and treatment centers, although he realizes his past attempts at healing have been centered around blaming others, rather than looking at himself. He admits he has never found the courage to talk about the most important thing that weighs heavily on his heart. He is fearful that people will think he has lost his mind; however, at this point in his journey, he realizes how important it is to share this fear if he wants to find a way to forgive himself. He finds comfort in the Serenity Prayer and wants to study the bible. He smudges, prays before bed, and has come to believe that whatever God is, it is up to him to accept it. His dad passed away four years ago and prior to his passing, Bright Thunder was able to see him one last time. While he was glad to spend time driving his dad to a wilderness area, taking him around town, and visiting with his dad's old friends, he realized he did not want to be trapped in his own mind like his dad was. Looking back on his life, Bright Thunder

reflects on the hand drum he once made which represents his life story. The hand drum was blessed with tobacco and he describes the experience as something he never thought he would see; the tobacco on the drum danced, danced all around, meaning the drum, his life story, and his home, had been born. He gave that drum to his parents, having found solace within himself to accept the past and what he could not change, saying he gave his parents more love than they ever gave him.

Today, Bright Thunder says its time to take baby steps towards quieting down and breathing, making the best of the life he has left to live. He chooses to see the good in everything and wants to use his lived experience to help youth who are struggling with alcohol. He wants to be a storyteller, working for himself and traveling to other communities to help others and show them the ropes. He wants to attend college again and study something around mental health and wellness. Finally, Bright Thunder finds passion and joy in being creative and wants to start sewing again. He hopes to attend treatment at an Indigenous treatment facility to start his healing journey and looks forward to focusing on himself this time around. He is done looking at the past and is ready to focus on the future.

4.1.1 Context

My initial meeting with Bright Thunder was facilitated by an introduction with my building contact. We initially met in-person on January 12, 2021 to complete surveys for the managed alcohol program evaluation. Following completion of the surveys, he agreed to participate in an interview for the current study. We met for a second time in-person on January 19, 2021. Our conversation lasted 50 minutes and took place in a private communal kitchen around a large dining table. COVID-19 protocols were in

place; thus, both of us wore face masks and sat at opposite ends of the table. The conversation was audio recorded for transcription purposes. Due to ongoing COVID-19 safety concerns, our third conversation was over the telephone on February 25, 2021 and lasted 12 minutes. I read Bright Thunder the story I had written for his approval. He approved and stated numerous times the story was perfect, asking if he could have a copy for himself. I had a copy of his story printed and bound, which I dropped off along with a personalized gift.

4.1.2 Reflection

I found Bright Thunder to be very engaged with me. I think of Bright Thunder often. Reflecting on my field notes, I simply noted "what a beautiful soul" following our interview. I was taken aback by his positive outlook on life, his ability to see the good in the bad, and his hopes for his future which included going back to school and sharing his story with youth. My interview with Bright Thunder left me grappling with the blurry boundary between the Western-based researcher role and the relational/reciprocal nature of research within an Indigenous paradigm. I felt extremely frustrated that Bright Thunder was not getting the supports he wanted and my immediate response was to jump in and fix the situation. I spent the next few days stewing in my anger, silently pointing fingers, and placing blame on those who I thought had failed. After journaling and having conversations with people closest to me, I realized it was not my responsibility to fix the situation nor was it appropriate as a researcher. I was reminded that the purpose of doing my thesis was to shine a light on where gaps exist while navigating my own anti-colonial journey.

4.2 The Story of Edward

Edward's experience of homelessness includes time spent in Seattle, living on the streets and sleeping outside. He formed many relationships and connections with others living on the street, drinking together, and breaking into taverns to get at the wine. Edward seemed to have a gift for panhandling, telling others "you just gotta know how to talk" when others asked him how he always had a bottle. After Seattle, Edward went back to Vancouver and experienced the loss of a woman he was with as she passed at a young age.

Edward's relationship with alcohol began in his early teens when he attended residential school. He has tried to stop drinking in the past and when asked what he wants, he says he wants to quit drinking, but it is not easy. He believes his art can help with stopping drinking, and he also believes that access to culture and Elders would help, although he does not have such access at his current residence. Edward currently lives in his own apartment having been moved from the shelter downtown about a year ago and although he says staff are usually around to support him, there was nobody around to help him on the day of our conversation when he needed it.

His grandfather was famous and Edward talks about his own amazing skills and accomplishments in track and field, taking top honors in long distance. He excelled in long distance, saying nobody could keep up with him. He reflects on his family members that have gone, including his sister who passed away from cirrhosis of the liver, and how much he misses them. He has one brother left to whom he is very close and talks about how much of a traveller his brother is, getting married in New York and now back living at their home community.

Today, Edward finds comfort and joy in doing bead work, especially necklaces, and has been doing it since he was 14 years old. Inspired by art from back home, he enjoys using colors that represent the sun and the sky, especially turquoise. He has a wrist injury and lately, the pain of his wrist gets in the way of him being able to do his art but he thinks one day, he'll get back into it. He wants to stick with his art and keep going the right way. He believes he is on the right track and feels like a real person instead of an alcoholic.

4.2.1 Context

We were originally scheduled to meet on January 21, 2021; however, a COVID-19 outbreak in his apartment building pushed our meeting back. Edward and I met on February 5, 2021 to complete surveys for the managed alcohol program evaluation. He agreed to participate in an interview for my thesis at the same meeting. We met in a communal kitchen area and sat across from each other at a large kitchen table. Our conversation lasted 17 minutes and was audio recorded for transcription purposes. Due to COVID-19 protocols, both of us were masked up and sat a fair distance apart from one another. Our second conversation took place over the phone on February 25, 2021. I read Edward his story which he wholeheartedly approved, noting it was extremely inspirational for him to hear it. He asked if he could have a copy because he really wanted to share it with his brother. I had a copy of his story printed and bound, which I dropped off along with a personalized gift.

4.2.2 Reflection

I went into my meeting with Edward feeling uncomfortable because my building contact did not facilitate an introduction between the two of us. This was in stark contrast to interactions at other buildings where my contacts had initiated an introduction between

myself and the participants, confirming the participant was comfortable being with me alone. Our conversation lasted 17 minutes. I was struck by the joy he emitted when talking about his exceptional track and field skills and his joy for beading. Following our interview, I felt angry and frustrated that Edward was not getting access to the supports he said he wanted. Since my time with Edward had been quite short, I struggled with writing a cohesive story that represented his journey; however, when I read his story back to him for approval, my concerns were alleviated. In fact, when I finished reading him his story, he kept repeating how perfect it was and how inspiring it was for him to hear it. It was those words that continue to make me smile and reflect on how grateful I am to have had the opportunity to meet with Edward. We agreed to meet again face-to-face at his residence "when the sickness is gone", as Edward describes COVID-19.

4.3 The Story of Morphis

Reflecting on her experience of homelessness and alcohol use, Morphis wonders how any of it even happened. She grew up in an alcoholic household and both of her parents attended residential school. Her dad was abusive and forbid Morphis from learning about her culture or talking in her language, forcing her instead to be like the white kids. Morphis eventually turned to alcohol and as an adult with a family of her own, her drinking progressed. Trying to hide it from her family, Morphis would drink only when her children were at school, but over time, her drinking became worse and worse. Feeling stressed out and guilty, things began to unravel for her, and with the loss of her mother, nowhere to go, and no one to turn to, her children were taken away from her and she ended up on the streets.

Living on the streets was extremely difficult and often left her in a state of hopelessness and desperation. She felt unsafe and scared, fighting every day just to survive. While homeless, Morphis met a man and although he was manipulative and abusive towards her, she finally felt protected. As her time on the streets went on, she began to feel lower and lower, trapped in a vicious cycle of drinking to get rid of that desperate, lonely feeling. Alcohol was the only way to handle the streets and she did not care anymore, missing appointments, ignoring her children, and racking up transit non-payment and shoplifting charges. Morphis wanted help but felt there was nowhere to go and nobody to help her. Trips to the hospital left her out on the streets, and anytime she reached out, she was either given no information or placed on a waiting list, be it for resources, housing, or detox, with no follow up. She began to think that nobody actually cared.

After 5 years of living on the streets, Morphis was approached by a caseworker at a local shelter who told her they had an apartment for her. She was overjoyed she finally had a home and decorated the walls, bought books and a deep freeze, and started feeling better about herself. She has called it her home for 3 years now but even with a roof over her head, she still very much struggles with her drinking today. She feels deeply ashamed when she drinks. Morphis misses her parents and her grandparents and often wishes she could learn more about her culture. In fact, Morphis feels with the support of an Elder, she could stop drinking. She wants to connect with an Elder that will not judge her for not knowing her culture, but rather, take her hand, listen, talk with her, and tell her stories.

Morphis finds so much joy in being with her grandchildren. In order to be there for them in a good way, she realizes she wants to start looking after herself, making herself a

priority. She wants to make new, healthier relationships, have new places to go, visit and learn from Elders, make friends that do not drink, and start doing different activities and hobbies. She prays everyday to be healthy and not think negative thoughts, because it is when she is in the depths of sadness that she drinks. Morphis is an avid reader and loves to read self-help books. She gets excited when she can make things such as dreamcatchers and porcupine quill earrings. With baby steps, she hopes that soon, with the help of Elders and learning about her culture, she will get on a good path for herself and her family.

4.3.1 Context

Morphis and I met on January 28, 2021 to complete surveys for the overarching managed alcohol program evaluation, at which time she also agreed to participate in an interview for my thesis. Our meeting took place inside her apartment once my building contact had introduced us and asked her if she was okay being alone with me. As per COVID-19 protocols, both of us wore face masks and sat across from each other. Our conversation was audio recorded for transcription purposes and lasted 48 minutes. Our second in-person meeting was originally scheduled for February 24, 2021; however, out of an abundance of caution with ongoing COVID-19 concerns, we decided to talk on the phone. Morphis did not have a direct phone line so I called the main building and was transferred to the phone in her room. Unfortunately, our call kept getting disconnected and when I finally did get through, she apologized and said she was not in a good place and did not feel like talking. She said she felt bad because she had been looking forward to our chat and I told her it was no problem at all. I gave her my phone number and told her she could call me whenever she was feeling better. I dropped off a copy of her story

for her to review in addition to a personalized gift. It was confirmed through email that Morphis approved her story.

4.3.2 Reflections

I was immediately captured by the warmth of Morphis's apartment with the pictures on the wall, the blanket on her bed, and the coziness of her space. She had only been there a short time as a fire at her original apartment had temporarily displaced her. She was very much looking forward to when she could go back to her own home again and spoke of how her self-esteem had improved since having a place to call her own. While I was with her, one of her friends knocked on the door and asked if she wanted to go for a coffee, at which point Morphis said yes but after she was done meeting with me. She was open and honest with me and our conversation was filled with tears and laughter. She said numerous times that all she wanted was to stop drinking, yet she did not know how to and wanted the help of Elders. Reflecting on my field notes, I left the interview feeling upset that she did not have access to the art and cultural support she wanted. Furthermore, I wrote down "why is she in PSH?", thinking to myself that with proper supports, she would be flourishing, not floundering.

4.4 The Story of Participant(1)

Although his name is [confidential], people call him by a different name, one that he does not appreciate or understand. He wishes people would call him by his real name. He is a fluent speaker of his language, eager to teach those around him words and phrases while sharing the history of his home community. In addition to his language, he speaks fondly of his home community. He currently has a roof over his head; however, he does not

consider it his home. He has friends in the building and staff support him pretty well, but he is only at home when he is at his home community.

He has been homeless and drinking for 26 years and although he has asked staff to reach out to his home community for help, they have either not done so or nobody has called back yet. All he wants to do is go back home to his home community and hopes to find the money to buy a bus ticket back. Everyone knows him back home and he wants to see his sister, who cares deeply for him and will run and give him a big hug once he finally gets back home.

4.4.1 Context

Our initial meeting was scheduled for January 21, 2021; however, a COVID-19 outbreak in his apartment building pushed our meeting back. I met with Participant(1) on February 5, 2021 to complete surveys for the managed alcohol program evaluation at which time, he agreed to participate in an interview for the current study. Our conversation lasted 16 minutes and took place in a communal kitchen around a large dining table. COVID-19 protocols were in place and we both wore facemasks and sat at opposite ends of the table. The conversation was recorded for transcription purposes. Due to ongoing COVID-19 safety reasons, our second conversation was to be held over the telephone on February 25, 2021. Connection and transfer issues resulted in us not being able to connect after multiple tries. At the time of this writing, I have not been able to connect with Participant(1) to read him his story.

4.4.2 Reflection

I felt very uncomfortable meeting with Participant(1) as a lack of engagement by my building contact in facilitating an introduction left me feeling awkward. My building

contact did not greet me when I first arrived, did not introduce the participant and I, nor did she ask the participant if he was okay alone with me. Furthermore, the communal kitchen area was not private which meant a staff member kept interrupting our conversation by coming in and out of the kitchen. Interestingly, Participant(1) kept saying staff said they would get him a coffee, which they never did. Participant(1) was a man of few words and did not share very much; however, he was eager to teach me words and phrases in his traditional language. This was somewhat muffled by his face mask and resulted in me not being able to fully understand what he was saying. Writing a story from my interview with Participant(1) was challenging and at the time of this writing, I have not been able to connect with him for his approval.

4.5 The Story of Participant(2)

He does not like to talk much about himself, instead asking other people questions and engaging in conversation. He is currently living in his 6th home since coming to Calgary and loves his current residence because it is clean and quiet. His past experience with homelessness has left him wondering where he will go after this. He came to Calgary for the sole purpose of looking for someone and will most likely end up back in another city and back to living the life of a gangster, which he says is all he knows.

He does not want to talk about his life, or rather, feels he cannot talk about his life because nobody would believe him. He does not want to share the ugly or worst parts of his life even though he knows it is killing him inside. He often wonders about life and death, what life is like on the other side. He is afraid of death, afraid of God condemning him and sending him to hell. He shares something very close to him that he asks not be repeated, which it will not.

He misses his dad, describing him as a very good man. He wishes he could see his mom alive again because he misses her, too. He has a long relationship with alcohol and has been drinking too much lately. He really wants to quit and prays to God everyday for the strength to stop drinking, hoping one day for a miracle. His attempts to quit drinking in the past haven not worked, and he believes if he keeps praying to the good God up there, he will finally stop drinking.

4.5.1 Context

I initially met with Participant(2) on January 12, 2021 to complete surveys for the managed alcohol program evaluation project. My building contact introduced us and asked if he was okay meeting alone with me, which he was. Following completion of the surveys, he agreed to participate in my thesis and we arranged to meet again on January 19, 2021. He was not feeling well on that date so our meeting was pushed back until January 28, 2021. We met in the private communal kitchen area and adhered to COVID-19 protocols by sitting far apart from each other and wearing face masks. Our conversation was audio recorded for transcription purposes and lasted 19 minutes. Our third meeting was to take place on the phone on February 25, 2021; however, when I phoned to speak with him, he was not home. Follow up with staff revealed he had recently lost a very close friend in the PSH building and was not in a great state of mind. I have not been able to connect with him at the time of this writing.

4.5.2 Reflection

My conversation with Participant(2) was extremely challenging and pushed me completely out of my comfort zone. I was not prepared for the personal information he shared with me. I realized very quickly that although my original intent for the visit was

for my thesis, that purpose was overshadowed by a deeper need for me to be a good human being and just listen to whatever he wanted to share with me. He did share something with me that was very hard to hear and asked that I never repeat it, and I will not. In the end, he asked if I would come back and see him again because he liked talking with me. It was a very humbling experience and reaffirmed the need to focus on the relational and reciprocal nature of research rather than solely seeking answers to a research question for research purposes only. Interestingly, Participant(2) is the only participant who asked me questions about myself such as how I was doing, what I was doing for my thesis, and what I enjoyed in life.

4.6 The Story within the Stories

It is hard to admit but important to note that I came into these interviews with biases and assumptions about the participants, particularly with respect to the severity of their mental health and addiction issues. I was under the impression that PSH residents were not capable of very much and just happy to have a place to live. I was taken aback by the aspirations, hopes, and dreams that each person shared with me. I found myself wondering if PSH buildings were keeping people stagnant and came to understand the profound impacts of the limitations placed upon individuals by myself and others. Therefore, by looking within and among the stories, the common thread of resistance was present. These threads of resistance included resisting the limitations placed upon them by others, being wary of participating in research, and continuing to speak their language and practice their culture despite not having access to it.

4.6.1 Resistance

I was truly in awe of the strength, determination, and perseverance shared, which to me encapsulated their resistance against succumbing to the limitations and stereotypes placed upon them by ongoing colonization, racism, and stereotypes. Some spoke of wanting to make positive changes in their lives, shifting their attitudes and mindset:

"Whatever negative is thrown at me, I turn it into positive."

"Even though what happened… I learned to accept it, you know, and to accept the things I cannot change, and you know, move on with it. Maybe if I would've continued, I probably would have put him down a lot, you know, and I wouldn't be able to... So, I just let it be. Instead of that, I gave them more love than they ever gave me."

Others spoke of having hopes, dreams, and aspirations for their future:

"To be around healthier people, do different things than what I was, what I've been doing, like not going to the same places, having some other place to go, like to, to talk, like to visit with people and stuff. You know, that aren't drinking, make some new friends that don't drink, different activities or hobby or something like that. Keep busy. And that's all I can see so far, but that's, it's easy to say, but I know it's hard to do."

"Right now I'm 54, but I'm just thinking you know I am not getting any younger. You know. So, I just straightened out, you know. What if I don't have much to live for, long to live and I want to make the best of it. I want the best."

Interestingly, although at the time I was disappointed that some of the interviews did not last very long, I realize now that it may have been because some participants were resisting the very idea of participating in a research study. Short answers and a lack of engagement may have been an act of resistance in itself. In hindsight, I was very naïve in

thinking every participant would be open and willing to engage in deeply personal conversations, and looking back on it now, I admire the fight and resistance they showed:

"Whoa, this is not my home."

"Why do they call me that?"

"[L: Is there anything else you want to share with me about you and your life?]

I got nothing to say."

Finally, speaking in their own language, talking about art, reminiscing about their families, and wanting connection to Elders and culture all signify acts of resistance against colonization. The stories provide a closer look into the lived experience of Indigenous people in seeking mental wellness supports. A more critical look within and among the stories reveals they are not getting the supports they need to flourish and grow in ways they want.

Chapter 5.0: Engaging with the Stories: What Has Colonization Silenced?

"Where anticolonialism is a tool used to invoke resistance for the colonized, it is a tool used to invoke accountability for the colonizer." (Kempf, 2009, p. 14)

Whereas the previous chapter centred Indigenous voices by sharing their stories, this chapter uses those stories to inform what has been silenced through the perpetuation of colonization and racism. Specifically, this chapter explores how access to support, connection to culture, and supportive staff relationships may be lacking within PSH buildings.

5.1 Access to Support

Interviews with participants revealed they wanted to stop drinking altogether but did not have access to the supports they wanted. They spoke of wanting access to treatment centers, connection to their home community, access to an Elder and culture, and religious support to help them address their problematic alcohol use:

"My goal is to go to treatment, you know, to leave this building. I want to be out of this building."

"Treatment and everything, it kind of scares me, but I did see where I want to go because I'm scared to deal with some things, you know, its like, maybe I can (inaudible). The most complicated thing is there are two things I am gonna use. Treatment plus church, you know, talk to the priest about the most important things."

"[L: What support do you think you would need to stop drinking?] (pause, deep sigh) Well, if I could talk to an Elder."

"[L: Have you ever reached out for help {for your drinking?}] Yeah. I told them [the staff] to phone [home community], but they haven't shown up yet."

"Lately, I just been drinking too much. I gotta quit, for real, I gotta quit."

"I would like to quit, but it is not easy. Drinking I am talking about. [L: What would help you?] I don't know. Maybe I'll just stay with my art."

5.2 Connection to Culture

Conversations highlighted a disconnection from their culture, including access to Elders, ceremonies, and traditional art. They spoke of wanting to talk with an Elder yet not having access to one:

[L: Are you able to access like cultural supports elders and stuff here? Would that help you?] Yeah, that would help me. [L: And can you get that here?] (shakes head, lifts shoulders) No."

"[L: Do Elders ever come here?] No."

In some cases, participants wanted to build their connection to their culture but felt embarrassed about how little they knew:

"I miss my mom and dad (tears), my grandparents are gone. I never really got a chance to, you know, really ask them questions or be taught, anything, because my parents were from residential school and my dad, well, he was so mean and everything, abusive, and they were both alcoholics. My dad wouldn't even allow my mom to speak to us in our language, we weren't allowed, we were supposed to be like white kids and he wouldn't let us grow up on the reserve, and so we, I didn't learn anything. I'd like to slowly learn without, you know, feeling like a dummy. (laughter) Native studies for dummies. (laughter)"

In addition to Elders, some spoke of the joy that art brought them and their desire to get back into making and creating things:

"I would like to do arts and crafts again, a hobby, you know, look for a different hobby. I'd like to start making things. [L: Like what?] Sewing."

"I do a lot of bead work. [L: What do you make] Oh, necklaces. [L: Tell me about that. Like how long have you been beading?] Oh, I was in my teens. 14 years old. That was way back. I was looking at this art from back home, and thought geez I like the color. The sky and the sun, that's what I use, that color. Turquoise. Oh, one day I'll get back to it."

"If I had a craft to do, I would do it, like, I could distract myself."

"[L: Is there anything in your life that brings you joy?] If I make something like a craft. [L: What do you like to make?] Well, I used to make dream catchers."

"Yeah. I wouldn't mind learning something like that. I'm not like a draw artist drawer. Like I'm not like that. I know I can't draw, just stick people (laughter.)"

5.3 Supportive Staff Relationships

Observations at PSH buildings suggested a lack of care and support from some staff members. For example, I observed a staff member insist a resident participate in the managed alcohol program and my thesis because they thought "it would be good for them." The staff member repeatedly ignored the resident's answer of no, resulting in the resident finally yelling, *"I am not a child. Stop treating me like one."* Similarly, interviews revealed a lack of trust with staff. For example, one participant asked that I not share anything he had said with staff members. Moreover, another participant said I could call him by his real name while noting he had PSH staff call him a different name. Finally, some participants indicated they had nobody to talk to at the PSH buildings and asked if I could come back to talk:

“Oh my God. It's like there's hardly anybody that I could talk to around here. You know, I just have the Creator, you know, it's the only way, you know, [inaudible], I swear to God, I would have lost my mind.”

“Will you come again?[L: Yeah, I'll come see you again.] Okay for sure this time, I won't hang up the phone. I like talking with you.”

Chapter 6.0: Discussion

In one of our many conversations, Elder John Chief Moon said that although peoples' hearts may be in the right place, sometimes research with Indigenous people does not translate into action or change. He explicitly encouraged me to try hard to change this; therefore, I have utilized the Truth and Reconciliation Calls to Action as a framework to hold individuals and agencies accountable. This chapter begins with a brief overview of what the TRC Calls to Action are. Next, each finding of the current study is linked to a specific TRC Call to Action while demonstrating how it aligns with anti-colonial principles. Finally, this chapter concludes with a discussion about self-determination being the foundation on which change will happen.

6.1 The Truth and Reconciliation Calls to Action

The Truth and Reconciliation Commission of Canada was established in 2008 with a mandate to "reveal to Canadians the complex truth about the history and the ongoing legacy of the church-run residential schools" and "inspire a process of truth and healing" between Indigenous and non-Indigenous peoples (TRCC, 2015b, p. 23). Truth-telling and educating non-indigenous Canadians is crucial in disrupting colonial knowledge systems; however, education must be paired with meaningful actions towards change (Czyewski, 2011; Jewell & Mosby, 2019). Thus, the Calls to Action were developed as tangible action items that Canadians could use to help repair trust, make amends, and work towards real, societal change (Jewell & Mosby, 2019). The purpose of using the TRC Calls to Action as a guide for the current study is to illustrate a clear path forward for how agencies can provide culturally-appropriate services while challenging the delivery of colonial policies and practices.

6.1.1 Availability of Mental Health Supports

The importance of listening to and providing individuals a choice on their healing journey is reflected in the TRC's Call to Action #19, which calls for the need to consult with Indigenous peoples to establish "*the availability of appropriate health services*" (TRCC, 2015a, p. 3). This Call to Action emphasizes the responsibility agencies have in asking and actively listening to individuals they serve what supports they need and ensuring those supports are available and accessible. Ensuring appropriate health services are available embodies anti-colonial theory in its pursuit to restore Indigenous self-determination and autonomy by resisting the Eurocentric imposition of what is deemed to be appropriate (Carlson, 2017; Simmons & Dei, 2012).

Results from this study suggest the PSH buildings may not currently be offering appropriate mental health supports with regards to problematic alcohol use. Participants reported wanting to stop drinking altogether yet not having the supports to do so. Participants were varied in how they wanted to stop drinking, ranging from attending a treatment centre, speaking with an Elder, staying connected to art, or reaching out to their home community for support. Although most participants said they wanted Elder support to stop drinking, the only option available to them at the PSH building was participating in the managed alcohol program. This finding illustrates the importance of PSH staff having individual discussions with residents to determine what supports are most appropriate to address problematic alcohol use. Furthermore, this finding highlights the role that agencies have in developing or providing access to services that are responsive to individual needs. It is important to note that healing is a highly unique journey. Mental health supports cannot be developed as "one size fits all." For instance, the polarized

debate between abstinence-based approaches vs harm reduction approaches to alcohol use highlights the importance of ensuring a wide range of mental health supports are available (Lee et al., 2011). Individuals must be given the choice to decide what works best for them and be supported in their decisions. This speaks to the critical importance of the larger ongoing Indigenous-specific managed alcohol program evaluative project in determining if the managed alcohol program is an appropriate option for residents in a PSH building. Participants in the current study wanted to stop drinking; therefore, it will be interesting to see if participants in the managed alcohol program stop drinking altogether once they have access to the cultural supports they have identified as wanting.

6.1.2 Inclusion of Culture and Connection

The importance of addressing culture and connection in agency operations is reflected in the TRC's Call to Action #22, calling for those in the health-care system "*to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients"* (TRCC, 2015a, p. 3). This Call to Action addresses the responsibility agencies have in ensuring culturally-appropriate healing supports are provided for Indigenous people and asks that agencies acknowledge and validate Indigenous ways of knowing and healing (Carlson, 2017). The inclusion of culture and connection is significant to anti-colonial theory in that it exemplifies a reclamation of Indigenous identity, self, and culture, and prioritizes "the understanding of local Indigenousness" (Simmons & Dei, 2012).

Participants in the current study reported having no connection to Elders, ceremony, or traditional healing. At first, I believed this to be the case because of the

restrictions and impacts of COVID-19, but found otherwise after further exploration. A search of the agencies' social media channels revealed Indigenous cultural supports are currently being offered (and have been offered throughout COVID-19) through smudging with the outreach team, drum circles at a temporary shelter location, an Indigenous-specific cultural healing program for those in detox, and Elder visits at the main shelter location. I did notice posters up at several of the PSH buildings that mentioned off-site opportunities to engage in a sweat lodge or a drum circle; however, when I asked participants if they were aware of these opportunities, they said no. There is no indication of culturally-appropriate supports being actively and effectively offered for residents at PSH buildings, suggesting a gap in the inclusion of culture and connection at these sites. These findings illustrate the need to establish culturally-appropriate supports specifically at PSH sites that are grounded in Indigenous ways of knowing.

Agencies that support Indigenous peoples must be action-oriented in providing culturally-appropriate supports by collaborating with Elders and recognizing them as integral members of the team. Elders are vital in supporting Indigenous people in culturally-appropriate ways as they hold specialized knowledge, share different cultural teachings, counsel in appropriate ways, speak Indigenous languages, keep traditional knowledge, act as role models and teachers, and are recognized for their ability to guide with their wisdom (Manitowabi, 2014). Although residents of PSH buildings may already have access to doctors, nurses, social workers, or addictions workers, they must have access to an Elder as readily as they have access to other supports. Additionally, residents should have access to a variety of Elders according to their ancestry. For example, an

individual who is Cree may not be comfortable talking with an Elder who is Blackfoot; therefore, it is important to have access to Elders from various Indigenous communities.

6.1.3 Hiring Policies

The importance of re-evaluating hiring policies in agencies is reflected in the TRC's Call to Action # 23(i) which calls to "*increase the number of Aboriginal professionals working in the health-care field*" (TRCC, 2015a, p. 3). This Call to Action recognizes the significance of Indigenous people and the knowledge they bring as valued team members. Moreover, it invites agencies to engage in the process of humility, and represents anti-colonial theory in its resistance against Indigenous erasure through the recovery of Indigenous ways of knowing (Carlson, 2017; Simmons & Dei, 2012). Hiring Indigenous staff and Elders is imperative as they "bring distinct knowledge, perspectives, and skills to the agency and services they provide" (Distasio et al., 2019, p. 40). This may mean shifting away from the colonial, normalized process of a job posting that seeks individuals who fit specific qualifications and requirements within PSH buildings. For example, challenging the colonial idea that knowledge in terms of a diploma or a degree is superior to Indigenous knowledge and ways of knowing must be re-evaluated. This re-evaluation can be aided by including Indigenous people in the hiring process. Non-Indigenous agencies must build connections with Indigenous agencies to support the hiring of Indigenous people. In Calgary, this could include building relationships with the RIEL Institute for Education and Learning, the Nechi Institute, Iniskim Centre at MRU, Iniikokaan Centre at Bow Valley College, and Writing Symbols Lodge at U of C.

In addition to increasing the number of Indigenous staff, care and attention must be paid when hiring non-Indigenous staff. As highlighted in the results, the perpetuation of racism through stereotypes such as Indigenous peoples as "drunks" is present and results in an environment that is not safe. Although hard to quantify, Distasio et al. (2019) purport staff must have a deep understanding of the history of Indigenous peoples and approach their work with patience and compassion instead of preconceived notions and judgements. It is also critical that staff are open and willing to engage critically in unsettling dialogue and be comfortable navigating Indigenous and Western worldviews (Distasio et al., 2019; Regan, 2010). Agencies must re-evaluate who they hire and re-consider the qualifications they look for. For some agencies, this means essentially changing the position's requirements to prioritize "kindness, empathy, and understanding first and foremost, followed by other job-related skills" (Distasio et al., 2019, p. 40).

6.1.4 Ongoing Training

The necessity of ongoing anti-colonial training for those who work with Indigenous people is highlighted in the TRC's Call to Action #23(iii), which calls for cultural competency training for all healthcare professionals. Furthermore, Call to Action #24 calls for healthcare professionals to learn about "*the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices*" (TRCC, 2015a, p. 3). These Calls to Action reiterate the need for non-Indigenous people and agencies to engage in critical self-reflection continually. Anti-colonial theory is embodied in this Call to Action as it demands the oppressor interrogate their privilege and "be prepared to

invoke and act on their complicities and responsibilities through a politics of accountability in order to bring about change" (Simmons & Dei, 2012, p. 76).

According to the CHF Standards of Practice of Case Management for Ending Homelessness (CHF, 2020), staff at the PSH buildings receive "a minimum of 6 hours of Indigenous Awareness Teachings within 9 months of hire" (p. 37). These 6 hours may be spent attending cultural events or workshops, visiting interpretive centres, participating in experiential learning opportunities, or meeting with Elders, Knowledge Keepers, or other guest speakers. Furthermore, CHF states that staff have access to training that addresses "some or all" issues, including colonization, residential schools, the Indian Act, and effects of trauma and systemic racism. Although agency staff are mandated to participate in some form of Indigenous-specific training, results from the current study suggest PSH staff members may not be receiving adequate training that encourages a deeper self-exploration of one's complicity in colonization and racism.

Although providing a foundational understanding of Indigenous Awareness is a starting point and may plant an important seed, this level of education and training is not enough. Furthermore, although some staff may have post-secondary education in professionalized accredited programs such as social work, not all staff will have had this type of education. Therefore, it is an agency's responsibility to ensure the staff they hire are provided ongoing, transformative, and experiential learning opportunities that go much deeper than Indigenous awareness or cultural competence. This may be unsettling and uncomfortable for staff; however, "non-Indigenous people must be responsible and accountable for undertaking their own decolonization" (Craft et al., 2020, p. xiii). The process of engaging in uncomfortable self-reflection and uncovering one's complicity in

colonial and racist actions requires cultural humility. Cultural humility aligns well with an anti-colonial framework in that it embraces accountability "not only on an individual level, but also on an institutional level" (Fisher-Borne et al., 2014, p. 172). Cultural humility acknowledges the power hierarchy within the typical case manager/client interaction and urges providers to engage in critical self-refection in how they have been complicit in perpetuating racism, albeit intentional or unintentional (Fisher-Borne et al., 2014; Tervalon & Murray-Garcia, 1998). It encompasses an honest look at oneself and at being complicit in perpetuating racism and discrimination. It is about acknowledging all the emotions that one may feel as they learn about injustices, including shock, guilt, sadness, anger, outrage, denial, and justifications.

Building off Regan's (2010) argument that settlers need to be engaged in ongoing, critical self -reflection that challenges their thoughts and actions, agencies could establish a monthly speaker series session. If relationships and partnerships are built with Indigenous people and community agencies, finding speakers or educators to come in and participate in the speaker series sessions will happen organically. For example, on the first Tuesday of every month, a speaker could come in for a lunch and learn for PSH staff. Staff could keep a journal of their thoughts, feelings, questions, challenges, defences, and learnings from the session. On the third Tuesday of the month, a sharing circle would be held with the speaker and PSH staff, where a discussion about the previous learning session would occur. The point of the follow-up circles would be to start unlearning deeply held beliefs and challenging ones' thoughts. As previously discussed, if staffing policies are in place to ensure that staff being hired are brought

onboard for their compassion and kindness, it will ensure staff are more open and willing to engage in unsettling and uncomfortable processes.

6.1.5 Relationship Building

The importance of building relationships with individuals is reflected in the TRC Call to Action #20, which highlights the need to "*recognize, respect, and address the distinct health needs*" of Indigenous peoples living off-reserve (TRCC, 2015a, p. 3). This Call to Action highlights the importance of establishing a genuine relationship between staff and those they serve so that health needs can be realized and respected. Anti-colonial theory is personified in this Call of Action as it resists the colonial dominant-subordinate relationship and reclaims "the authenticity of local voice and intellectual agency" of Indigenous people (Simmons & Dei, 2012, p. 75).

Relationships are at the crux of Indigenous peoples' receiving care that is culturally-appropriate. Through an Indigenous lens, relationships are significant to a person's well-being (Hart, 2014); therefore, transforming the typical client/manager power hierarchy into an equal relationship is integral to transformative change. Staff must see Indigenous residents as human beings that are worthy and capable of great things. Observations at PSH buildings and conversations with participants suggest relationships may not be nurtured or fostered in the PSH environment. Staff must challenge their understanding of their job role and utilize their privilege and position to build real relationships with the residents. This could include having conversations about the resident's aspirations and goals, questions about their hobbies and what they like to do, discussions around family and memories, and an overall authentic engagement in knowing more about the person. Distasio et al. (2019) explain that having honest,

authentic conversations with residents is crucial as "through relationship-building and walking with the person comes a recognition that someone cares. Accepting that someone cares can lead to acceptance of a renewed sense of community" (p. 46). The ability to engage in this would be supported by the ongoing anti-colonial education and training that staff members would be receiving.

In a PSH setting, relationship-centered care is the foundation for providing appropriate and responsive care. As Thistle & Smylie (2020) state, Indigenous people who have experienced homelessness have "an invaluable gift that can enrich lives and physicians' toolkits and be applied to helping and healing in community" (p. e258). The same idea of using the lived experiences of Indigenous peoples to enrich the toolkits of those who provide mental wellness supports in PSH buildings can be applied. Agencies could provide space and time to hold sharing circles for staff and residents. These circles could be facilitated by an Indigenous staff member, an Elder, or someone who is able to respect and guide the sharing session appropriately. Each sharing circle could discuss a different topic chosen by the group. Having staff and residents engage in sharing circles together could encourage staff to see residents as human beings, not just clients, and work towards building supportive instead of imposing relationships. Other ideas for prioritizing relationship-based care include having staff and residents attend weekly or monthly lunch and learns where either a staff member or a resident talk about their culture, their connection to the land, and their ancestry, hold "show and tell" sessions where residents can share something meaningful to them, and/or have residents lead an art or a cooking class that staff are invited to take part in.

6.2 Self-Determination: The Foundation for Change

As proposed, the TRC Calls to Action can be utilized to hold agencies accountable in ensuring appropriate supports are available, providing access to culture and connection, hiring more Indigenous staff, providing ongoing training, and shifting to relationship-based care. Although the TRC Calls to Action can help agencies examine their current mental wellness service delivery, Indigenous peoples must lead and guide this process. In fact, Call to Action #43 specifically calls to "*fully adopt and implement the United Nations Declaration on the Rights of Indigenous Peoples as the framework*" for repairing the relationship between Indigenous and non-Indigenous people. The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) recognizes "*the urgent need to respect and promote the inherent rights of Indigenous people*" and affirms "*the fundamental importance of the right to self-determination of all peoples*" to determine and freely pursue "*social and cultural development*." (UNDRIP, 2008, p. 3).

Regarding health, Article 23 of UNDRIP (2008) includes Indigenous peoples' right to "*be actively involved in developing and determining health, housing and other economic and social programmes affecting them*." Similarly, Article 24(1.) affirms Indigenous peoples "*have the right to their traditional medicines and to maintain their health practices*" while having the right "*to access, without discrimination, all social and health services.*" Finally, Article 24(2.) states Indigenous peoples "*have an equal right to the enjoyment of the highest attainable standard of physical and mental health*."

Both the TRC Calls to Action and UNDRIP draw attention to the inherent right for Indigenous peoples to self-determine. A lack of self-determination has contributed to poor mental health outcomes such as high rates of suicide, depression, and alcoholism,

and ongoing insecurity and despair for Indigenous peoples (Halseth & Murdock, 2020). Indeed, research suggests self-determination is the most important determinant of health and has been associated with positive health outcomes (Auger et al., 2016; Oster et al., 2014; Reading & Wien, 2009). Thus, it is imperative Indigenous peoples have the right to self-determine and control their own health programs and services. Without self-determination and control, Saulnier (2014) purports colonization will continue to contribute to poor health outcomes and remain a barrier. To embody anti-colonial theory means to support and practice Indigenous resistance to ongoing colonization. As Hart et al. (2017) suggest, non-Indigenous people must:

> Ensure that their actions do not reinforce colonial oppression, such as when they claim they are doing 'what is right' for the colonized. Their actions must always support Indigenous peoples' self-determination, and it is always Indigenous people who determine 'what is right' as anti-colonial action. (p. 334)

6.3 Limitations

There were significant limitations in this study that warrant discussion. First and foremost, this study took place during the COVID-19 pandemic and required flexibility and adaptability to everchanging public health guidelines. The pandemic brought with it the urgency to keep PSH residents safe and support them as quickly as possible. Therefore, it is unknown if or how agency resources, staffing, and finances were directed towards supporting COVID-19 efforts, or if this impacted the delivery of mental wellness supports. Future studies could expand the scope of participants to include agency staff and funding organizations to understand service provision without the impacts of COVID-19.

Second, to be eligible to participate in this study, participants needed to be a part of the overarching managed alcohol program evaluation project. Thus, Indigenous residents within the PSH buildings that were not on the managed alcohol program could not participate in the study. Future research could explore if Indigenous peoples not on the managed alcohol program had similar experiences with accessing culturally-appropriate mental wellness services.

Finally, only three PSH buildings managed by one local agency were included in this study. In Calgary, there are many agencies and PSH buildings that support Indigenous people and it would be interesting to expand this project to determine if experiences are the same across multiple agencies and PSH buildings.

Chapter 7.0: Conclusion

Colonial policies and practices rooted in racism have profoundly shaped non-Indigenous peoples' attitudes and actions towards Indigenous peoples, resulting in an ongoing lack of anti-colonial, culturally-appropriate mental wellness supports. Using the TRC Calls to Action can help keep agencies accountable in their efforts to support Indigenous people. Appropriate responses could include increasing the availability of supports, ensuring access to culture and connection, hiring Indigenous staff, educating staff, and transforming to relationship-based care. Specific to PSH buildings, educating staff on Indigenous peoples' inherent right to self-determine would help staff step back from imposing their own westernized notions of healing onto a resident. Additionally, Indigenous residents must have a consistent and ongoing connection to their culture and Elders to ensure they are receiving care that supports them in the best way possible. Individuals who are hired to work in PSH buildings must be kind, compassionate, and willing to engage in unsettling conversations that challenge their thinking and go deeper than simply becoming culturally competent. Non-Indigenous agencies must focus on collaborating and partnering with Indigenous agencies and services to build authentic relationships with those in the community that can provide responsive supports to Indigenous people.

In sum, providing culturally-appropriate mental wellness supports to Indigenous peoples requires a radical transformation of the current environment. This will be a long-term process that must entail individuals who are committed and dedicated to being fully engaged in the transformation.

7.1 Going Forward: Putting Anti-Colonial Theory into Action

Although this may be the end of my thesis in written form, it is the point from where I continue to walk forward with hope, an open heart and mind, and humility. I am committed to engaging in anti-colonial practices and reflecting on my actions and behaviours. I continue to work on building authentic relationships with the Indigenous community. For example, I was participating in a weekly family drum and sharing circle led by a local Indigenous agency. This engagement has been moved online due to COVID-19; however, it will return to in-person when public health guidelines allow. Additionally, I continue to regularly engage in conversation with Elder John Chief Moon and consider him a friend and a mentor. I am always looking for opportunities to discover more about Indigenous culture and ways of knowing by participating in various ceremonies and events. I frequently attend webinars and on-line educational sessions that explore anti-racism, Indigenous health, decolonization, reconciliation, and ethical research, all of which continually challenge my thinking.

These are all small steps towards putting anti-colonial theory into action; however, there is significant room for me to learn and grow. For example, with regards to calling out actions and behaviours that are colonial and racist in both myself and others, I must find ways to embrace the discomfort and stand with Indigenous peoples in resisting colonization and racism. As Elder John Chief Moon said, I must continue to have dialogue. It is through these conversations that I will continue to pursue humility, talk less and listen more, look for teachable moments, sit in the discomfort, and find ways to actively apply the anti-colonial principles of resistance and accountability.

This research project has been a deeply personal and transformative journey. I look forward to continuing to engage with Elders, Knowledge Keepers, and Indigenous peoples as I go forward one foot in front of the other.

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Appendix

Appendix A: Interview Guide

Episodic Interview Guide (* utilizing Mueller, 2019 as a general guideline) (** probing questions may be added when needed) (*** prior to the start of the interview, the informed consent process will be reviewed with the participant which will include an overview of the study, what they should expect, and their right to withdraw at any point)

Thank you for agreeing to share your story with me. I am very grateful for your time and I want to share with you that I have been given the blessing of an Elder to be here with you today. At this point, I am interested in hearing about your lived experience in homelessness and accessing mental health services. Before you share your story, I want to understand what homelessness and mental health mean to you.

1. Can you tell me what "homelessness" means to you?
    a. Can you expand on your experiences of homelessness, based on what it means to you?
2. Can you tell me what "mental health" means to you?
    a. Can you expand on your experiences of mental health, based on what it means to you?

At this point, I would like for you to recount some of your experiences around homelessness and mental health and when they began.

3. Please tell me your story of homelessness and accessing mental health services in Calgary, in as much detail as possible, including:
    a. Experiences of racism or discrimination
    b. Positive experiences
    c. Negative experiences
    d. Inclusion of culture
4. How could mental health services support you on your journey in a better way?
    a. Tell me what YOU would want to see.
    b. Imagine you had access to supports that were completely inclusive – what would that look like?
5. Has your story ended?
    a. If yes, can you expand on when and how it ended?
    b. If not, can you expand on what the end looks like for you?
6. Is there anything else you would like to add? Anything of importance for you we forgot to talk about? Is there anything else you think I need to know about?
7. Do you have any questions for me?