INDIGENOUS YOUTH MENTAL HEALTH IN CANADA: A WPR APPROACH TO CANADA'S (IN)ACTION IN RESPONSE TO SUICIDE CRISES

VICTORIA FRANCAVILLA

Supervisor's Name: Dr. Marina Morrow
Advisor's Name: Dr. Sean Hillier

Supervisor's Signature: ____________________
Date Approved: ____________________

Advisor's Signature: ____________________
Date Approved: ____________________

A Major Research Paper submitted to the Graduate Program in Health in partial fulfilment of the requirements for the degree of

Master of Arts
Graduate Program in Health
York University
Toronto, Ontario, M3J 1P3

October 2020

Table of Contents

Title Page
Table of Contents....1
Abstract....2
Introduction....3
Background & Rationale....6
Crown-Indigenous Histories: How We Got Here....9
Indian Act and Surrounding Policies & Practices....10
Immediate Impact of Colonial Policy - Physical....11
Cultural/Spiritual Impacts....12
Psychological/Emotional Impacts....14
Intergenerational Impact - Heteropatriarchy....15
Land & Life....17
Literature Review....18
Community Driven Research and Implementation....19
Critical Suicidology....21
Dominant Narrative....23
Mental Health Outcomes....24
Counter/Alternative Narratives....25
Government of Canada's Reaction/(In)Action....29
Theoretical Orientations & Methodologies....32
Key Research Questions....33
Methods....34
Carol Bacchi's WPR....34
Analysis of MHCC 2016 Strategy....36
What is Being Said?....40
What is Not/Really Being Said?....41
Discussion....44
Factors affecting Indigenous Mental Health Outcomes....46
MHCC Strategic Decision #5: Indigenous Youth....47
Potential for Progression/Digression....47
Conclusion & Ways Forward....48
Acknowledgements....51
References....52

Abstract

Across Canada, Indigenous Peoples have been resilient to active colonization for more than 400 years, all the while upholding their traditional values, systems, and ways of being. However, despite this resilience, Indigenous youth experience disproportionate and elevated rates of negative mental health outcomes, including elevated rates of suicides.

Canadian mental health policy has not been responsive to the needs of Indigenous youth, often ignoring the specific needs of Indigenous communities in documents that are meant to guide programming and responses. In this Major Research Paper (MRP) I review one such key document - the Mental Health Commission of Canada's (MHCC) 2016 recommendations in its report titled *The Mental Health Strategy for Canada: A Youth Perspective*. This document is the broadest reaching and most current official document addressing the issue of First Nations, Inuit, and Métis (FNIM) youth mental health at a Federal level. By analysing the narrative used throughout this document one can learn how the solutions proposed may actually be failing to address the root causes of the issue at hand. Using Carol Bacchi's WPR (What's the Problem Represented to be?) approach, it will become evident as to why these responses are not wholly conducive to achieving better mental health outcomes for Indigenous youth. Following this discussion, I will highlight the progress that is being made in various Indigenous communities in a variety of culturally relevant, safe, and sensitive ways. Communities who are thriving and who are working towards positive change for youth are the experts in this case, as they have the knowledge and are taking up practices which are created from themselves, not for them. These practices have the potential to influence policy, as they are paving the way for a better response in cases of Indigenous youth suicide. When systems are put in place that truly benefit the community, this has a profound effect by influencing community members, researchers, academics, and policymakers alike, and also highlights the shortcomings of existing governmental action. As a non-Indigenous person, I engaged in reflexivity throughout my research and situate myself as an ally.

Introduction

Colonization is very alive and well today, and can be seen in the practices and outcomes in social services such as the child welfare and foster care systems, the increased mass incarceration of Indigenous men and women, impacts of the Sixties Scoop, and ongoing issues around Status and poverty. Indigenous populations in Canada are increasingly marginalized and discriminated against both overtly and covertly, through engrained practices and biases in medicine and science, in law, and in academia. This is why it is imperative that Canada acknowledge that colonization is not a historical relic to be reflected upon with rose coloured glasses. This is insufficient if the Government of Canada is trying to move forward on a path of reconciliation and truly decolonize the relationship with Indigenous Peoples in Canada. In order to effectively move forward, we must also unpack what has already occurred and what is being done about it. As is highlighted throughout the literature, Indigenous youth suicide is significantly higher than their non-Indigenous counterparts. According to the findings from the 2011 Canadian Census Health and Environment Cohort (CanCHEC) regarding suicide among Indigenous individuals (2011-2016), it is noted that the suicide rate for children and youth to be 10 times higher among males and 22 times higher among females between 2005 and 2007 in areas with a high percentage of First Nations people (Statistics Canada, 2016). These rates are nearly twice as high among First Nations people living on reserve than among those living off reserve.

In this MRP, I will begin with a brief discussion of Crown-Indigenous histories in Canada, painting a picture of how a plethora of factors has and continues to play a role in shaping Indigenous youths' mental health outcomes. Through the Indian Act and its

accompanying practices such as Indian Residential Schools (IRS), ongoing legacies such as the Sixties Scoop, and crises we face today such as Missing and Murdered Indigenous Women and Girls (MMIWG), disproportionate incarceration of Indigenous men and boys, and the number of Indigenous children in the foster care system, there is no one simple answer to the question: why are Indigenous youth attempting and completing suicide at higher rates than their non-Indigenous counterparts? By critically analysing relevant literature in suicidology, popular media, academia, and public discourse, one can contrast this narrative with community-driven, holistic frameworks of what it means to practice mental wellness in Indigenous communities. In order to better understand the failings of Canadian mental health policy with respect to Indigenous youth, I will utilize Carol Bacchi's WPR (What's the Problem Represented to be?) framework, to critically unpack the 2016 report laid out by the Mental Health Commission of Canada titled *The Mental Health Strategy for Canada: A Youth Perspective.* From this analysis, some policy recommendations are gathered and suggestions for future research are put forth, in order to truly attempt to address the situation of Indigenous youth suicide in Canada.

Even though the overall Indigenous youth suicide rate is higher than the rate of their non-Indigenous counterparts, it is important to point out that not every Indigenous community in Canada is experiencing high numbers of suicide. For example, Between 2011 and 2016, suicide rates in First Nations individuals were three times higher than in non-Indigenous people (Kumar & Tjepkema, 2019), but some communities can be impacted moreso than others. In fact, there are marked differences between provinces, regions, and even between Indigenous communities belonging to the same geographical region. However, it is, without question, documented that Indigenous populations in Canada are experiencing an alarmingly high rate of suicide, especially in young FN males. In actuality, this problem may be more widespread and immersive than what reports show. One reason for this is that

the national data on suicide rates for Indigenous People in Canada only include “registered” (or “status”) Indians and Inuit, leaving out non-status Indigenous People and Métis. Therefore, deaths by suicide of individuals who are not included in these groups are not included in these government reports. As well, accidental deaths are four to five times higher among Indigenous groups (compared to the non-Indigenous Canadian population). This means that an unknown number of deaths by suicide are being incorrectly recorded as accidental or unclassifiable, thereby contributing to the underestimation of true Indigenous suicide rates at the national level. This is problematic, because without knowing the true scope of the problem, it not only does a disservice and injustice to the health of Indigenous Peoples, but it makes it harder for advocates and policymakers to enact change on these matters.

Before discussing a culture or group of people, one must situate themselves in the right context by using the right terminology. By using the term Indigenous Peoples, it is encompassing the multiple groups of first peoples who are located within modern-day Canada, which include First Nations, Inuit and Métis. One may often come across the term Aboriginal[1], which is a term rejected by Indigenous Peoples, but its use is still prevalent along with the term “Indian”, as policies outlined in the British North America (BNA) Act and the Indian Act are still enforced today. The Indian Act also distinguishes between Status and Non-Status Indians; a practice which is still in place today, historically making the Government of Canada the arbitrary gatekeeper of peoples heritage, but contemporarily by controlling access to lands, resources, and entitlements. In addition, the Constitution Act of

[1] The term “Aboriginal” refers to the first inhabitants of Canada, and includes First Nations, Inuit, and Métis Peoples. This term came into popular usage in Canadian contexts after 1982, when Section 35 of the Canadian Constitution defined the term as such. Aboriginal is also a common term for the Indigenous Peoples of Australia. When used in Canada, however, it is generally understood to refer to Aboriginal peoples in a Canadian context. However, this is not a name Indigenous Peoples have given themselves. Therefore, I utilize the term Indigenous and First Nations specifically. While “First Nations' ' refers to the ethnicity of First Nations Peoples, the singular “First Nation” can refer to a band, a reserve-based community, or a larger tribal grouping and the status Indians who live in them (https://indigenousfoundations.arts.ubc.ca/terminology/).

1982 still uses the term Aboriginal to describe the three groups of Indigenous Peoples in Canada. However, throughout this MRP, unless otherwise stated, the term Indigenous Peoples will be used as an umbrella term to encompass all three groups, their descendants and ancestors who have caretaken this land since time in memorial.

Many Indigenous communities have declared states of emergency over the number of suicides, and have declared them as crises. One example being in 2016, the First Nation of Attawapiskat received international media attention after it declared a state of emergency following nearly a dozen suicide attempts in one night, including one by an 11-year-old. In the months before that, there were 100 other suicide attempts. The Government of Canada has responded to these states of emergency in a number of ways, such as providing increased funding for programming or sending in Western trained medical doctors and practitioners to the communities. This paper will argue that the ways in which Indigenous youth are described as being "at risk" of dying by suicide in the current literature is problematic and contrast this understanding with culturally aligned understandings of resiliency, autonomy, and self-determination. As well, I seek to address just how policies have the ability to create further problems through the language they use to 'solve' said 'problems'. "At risk" dialogue, meaning concrete and overt language, is present in popular culture, media, various types of literature, film, official government documents, etc. "At risk" discourses, which take up these dialogues, are pervasive and overarching, and this narrative has effectively shaped public perception of Indigenous youth, and informs the work of educators, lawmakers, policymakers, health care workers, and the youth themselves. These discourses stereotype Indigenous youth as being in a perpetual state of vulnerability with limited agency and autonomy; they are perceived to be a victim of their surroundings, and by nature of being Indigenous, they are prescribed a life of hardships which could place them in harm's way. In

the case of Bacchi's work, discourse is about how language shapes how we think and how knowledge comes into being through language and is imbued with power.

Background & Rationale

In order to unpack the issue of Indigenous youth suicide and uproot discourses surrounding Indigenous youth mental health (centred around Status youth living on reserve), we must understand the effects and repercussions of colonization; both historically and contemporarily. Indigenous Peoples who reside in modern day Canada have always shown strength, determination, and pride in their youth, and youth are an integral part of these communities across Canada (TRC, 2015). The effects of historical and ongoing "socio-political impacts, including diminished self-determination, historical loss of traditional land, language and culture as well as social exclusion, must be considered to fully understand changes in Indigenous Peoples' health." (Hackett et al., 2018, p. 421). Due to ongoing socio-political, environmental, and economic strain, many Indigenous youth are still deeply affected in ways that are spiritually, mentally, and physically damaging.

In 2016, the Mental Health Commission of Canada (MHCC) released its thirty-seven-page framework to address mental health issues pertaining to youth, titled *The Mental Health Strategy for Canada: A Youth Perspective.* The Mental Health Commission of Canada is a national non-profit organization created by the Canadian government in 2007 in response to a Senate committee tasked to study mental health, mental illness, and addiction, and offers a host of resources, tools and training programs aimed at increasing mental health literacy and improving the mental health and well-being of all people living in Canada. They have specific strategies regarding e-Health, seniors, and Indigenous populations.

By engaging with this document through a Critical Discourse Analysis, utilizing Carol Bacchi's WPR (What's the Problem Represented to be?) approach, it is clear that the Government of Canada, along with the MHCC are not walking with both feet on the path

towards reconciliation. Health does not exist in a vacuum, a simple call for these youth to be re-immersed in their ‘culture’ on its own is not sufficient in addressing the mental health needs of Indigenous youth, who face disproportionate structural and systemic barriers in relation to their non-Indigenous counterparts, such as a discriminatory practices in child welfare, medical care, and employment fields. By saying that a call to return to culture is not sufficient, I mean that one cannot prescribe a youth in question to participate in a healing circle and his mental health will be restored. One cannot simply engage in traditions and culture without surrounding supports in place from various levels throughout the community and government at large to focus on resilience as opposed to risk. Risk and resilience dialogues have often been at odds with each other, vying for the *right* way to approach issues of Indigenous youth mental health, but risk-centred approaches are often utilized. The shortcomings of the MHCC document, while being a positive strategy with good intentions, speak volumes as it effectively serves to further widen the gap in mental health disparities Indigenous youth face. Although the report is understood as a move towards reconciliation, Arthur Manuel and Grand Chief Ronald Derrickson maintain that:

> ...the term ‘reconciliation’ now covers any and all manipulations or diminution of our rights and title. The government and the Canadian people have really fallen in love with reconciliation. They do not seem to understand the concept but they truly love that word. (Manuel, A., Grand Chief Ronald Derrickson, 2017, p. 200).

The MHCC youth mental health strategy, while well-wishing, does not truly recognize what it means to reconcile, meaning land, title, and rights included. By this, I mean truly engaging with Indigenous Peoples in a more meaningful way that is not just performative but also makes structural changes such as repatriating land rights and access to hunting and fishing rights; it means coming to agreed upon consensus amongst Indigenous Peoples on what Status means for them; it means investing in schools and infrastructure in communities, implementing plumbing and housing installation or upgrades; addressing the fact that colonisation is an ongoing process, not something that faded into our history books.

The list could go on. Therefore, a pan-Indigenous mental health strategy is not optimal as not all Indigenous youth can be clumped into the same category. Not all Indigenous communities face mental health crises and not all Indigenous youth are “at-risk”, so implementing mandated screening measures or training programs would be essentializing these youth as all being simultaneously damaged in some way. As well, creating a pan-Indigenous mental health strategy would be reinforcing notions upheld in suicidology literature: that your mental health is something that goes on in your individual brain which may or may not be the fault of your own, and that all of their brains function (or malfunction) in the same way. It also generalizes that Indigenous youth are simple by-products of their surroundings and have no agency when it comes to their wellness and wellbeing. A step in the right direction would be moving away from representations and the framing present in the MHCC Youth Strategy, towards a more community-centric, community-focused, community-led and community-specific discussion and plan to address Indigenous mental health outcomes in Canada.

Indigenous and non-Indigenous Peoples, activists, and scholars alike would agree that there stands a strong link between “colonization and poor health…[this] loss of sovereignty along with dispossession (of lands, waterways, customary laws) has created a climate of material and spiritual oppression with increased susceptibility to disease and injury.” (Durie, 2003, p. 510). In this way, we do not see the negative health outcomes of Indigenous Peoples in a static or individual fashion: it takes a broader scope and encompasses understandings of social determinants on one’s health status, including interactions with government bodies, independent corporations, and global political structures.

Crown-Indigenous Histories: How We Got Here

In contemporary discussions about the health of Indigenous Peoples, one must contextualize outcomes in a way that acknowledges the impact of colonialism and its policies, one being the Indian Act and the enforcement of the Residential School system.

Indian Residential Schools (IRS) have proven to be - and its legacy is still - crippling to the physical, emotional, mental, spiritual, and cultural wellbeing of Indigenous communities (TRC, 2015). IRS in Canada can be understood to have resulted in a loss of culture and identity for many, spanning through generations, which has contributed to the current mental health crises we see in communities today, reflected in elevated instances of suicide among youth. Intergenerational effects are evident, and if we are to tackle these crises, we must first understand the causes of the causes, and why this genocidal history is still relevant today (Wilk, Maltby & Cooke, 2017).

Contemporary mental health strategies need to take into consideration these points and adopt a framework of cultural sensitivity when working in, with, and for any Indigenous communities. Culturally-sensitive research can be defined as "research methods that have been adapted to incorporate knowledge of a cultural group, in particular, their social norms, specialised vocabulary or non-verbal cues such as hand gestures and eye contact" (Banister et al., pp. 2014, 269). These areas of knowledge include worldviews, Indigenous knowledges, Indigenous knowledge of helping, and research from an Indigenous stance, namely radical Indigenism (Hart, 2010). Moreover, accounting for these specific insights and nuances of a certain culture before engaging in research and community work is critical to achieving health equity. This ensures that the wants and needs of the communities themselves are held to the light and are not overshadowed by other disciplines that might have 'the best interest in mind'. By upholding principles outlined in the Truth and Reconciliation Commission of Canada (2008) and the United Nations Declaration of the Rights of Indigenous Peoples (2007)[2], a path towards reconciliation can potentially be paved to address the lasting impacts

[2] Worth noting, although UNDRIP was drafted in 2007, Canada did not sign on to adopting the principles outlined within it until May 2016 - almost a decade after its conception. In addition, Canada has not yet adopted UNDRIP into federal law as of 2020.

IRS and other policies and practices have had, and continue to have, on Indigenous youth mental health today.

Indian Act and Surrounding Policies & Practices

The Indian Act has taken root after a long history of colonialism between European settlers, the British colonies and governments, and Indigenous Peoples. But, in 1876, all acts governing the enfranchisement of 'Indians' were consolidated under the Indian Act. This policy effectively crafted a 'colonized Indian' and constituted the governance and allocation of resources for 'Indians'. The category of 'Indian' and 'Indian Status' was a construct developed to better manage populations and assimilate as deemed necessary. This history is deeply troubling and disturbing, but it is not as antiquated as we think (TRC, 2015).

From the late 1870's up until 1996, Canadian Indian Residential Schools (IRS) were established and enforced throughout most of the country. At its start, the focus was on the projected benefits to Indigenous Peoples, but this system eventually gave way to a more sinister and harmful institution at large, which included practices of forced assimilation and cultural destruction (MacDonald & Hudson, 2012, p. 433). At least 150,000 children passed through these schools, and of these approximately 80,000 survivors remain alive today (CBC, 2015).

In 1920, around the peak of the IRS system, Deputy Minister of Indian Affairs Duncan Campbell Scott argued, "I want to get rid of the Indian problem ... Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian Department" (Miller, 2004, p. 103). Not only did this encourage and emphasize the explicit governmental desire to remove the traditional livelihoods of Indigenous Peoples, but once these children were effectively assimilated, they were to enter "mainstream society primarily as workers and servants" (MacDonald & Hudson, p. 434), if they were to make it out at all. This dark past informs the

harmful discourse for conceptualizing Indigeneity, mental health and disability in contemporary society. This shattered past, and the legacy that it carries today through processes of discrimination and racism towards Indigenous Peoples, reinforces stigma and propagates negative mental health outcomes for Indigenous youth today.

Immediate Impact of Colonial Policy - Physical

Aside from the glaring psychological and emotional impacts of the IRS system and ongoing legacies such as the Sixties Scoop and alarming rate of MMIWG, physical ramifications can be seen in communities today.

> "Beyond the separation from their families and culture, which damaged family and social supports, while at IRS many children experienced neglect, as well as physical, sexual and psychological abuse. Not surprisingly, as a result of these experiences, the capacity of IRS survivors to socialize the next generation to cultural norms and practices, including parenting skills, was profoundly undermined." (Bombay et al., 2011, p. 368).

These "immediate victims [often] experienced physical, social and cultural devastation that might be expected to have intergenerational ramifications." (Bombay et al., 2011, p. 368). These children emerged in a different state, having difficulty forming loving, bonded relationships due to the trauma faced as a result of the IRS system. These children adopted negative coping mechanisms or parenting skills and passed these on through generations. While focusing largely on the impact of IRS, it is critical to also reflect on the ways that these systems and policies (similarly, events such as the Sixties Scoop) have given rise to contemporary crises such as MMIWG, the alarming rate of Indigenous children in the Canadian child welfare and foster system, and the disproportionate rate of incarceration among Indigenous youth. This ongoing project of colonization is critical to the formation and continuation of Canadian state sovereignty, identity, and the larger body politic, which is continually upheld through cultural practices, media representations, and government policy and practice (McKenzie et al., 2016). This is why singularly focusing on IRS obscures "the myriad contemporary manifestations of colonial dominance and inequities which have

profound implications for parenting and family relations" (McKenzie et al., 2016, p. 1). For example, when it comes to physical aspects of health and contemporary situations, one can see the disproportionate rate of domestic violence and sexual assault against Indigenous women and girls across Canada, both on and off reserve, which is some three times higher than non-Indigenous women and girls (Government of Canada, 2018).

Cultural/Spiritual Impacts

Alongside these lasting physical impacts, Indigenous youth are impacted through the colonization of their spiritual and cultural practices. "The removal of children from families and communities was [and is] a lawful government practice, intended to delimit the social and cultural identity of indigenous children" (Elias et al., 2012, p. 1561) by taking them away from the culture, practices, traditions, and customs that made them who they are. They removed them from the physical land they grew up on; land that has deep spiritual and cultural ties and meanings. Furthermore, "by Christianizing, civilizing [to their Eurocentric standards], and then re-socializing these children, the Federal government hoped that these children, and subsequent generations, would contribute economically to a modernizing Canada." (Elias et al., 2012, p. 1561). Without governmental intervention, Indigenous Peoples were seen to be unproductive, not as contributing members to the budding new Canadian society. The eventual goal of the IRS system and other policies, practices, and events (Sixties Scoop, child welfare and foster care systems, incarceration, violence and MMIWG, etc.), was to wipe out Indigenous cultures, and by doing so has damaged the way in which Indigenous and non-Indigenous people alike view the current state of youth mental health in Indigenous communities. Many of the children who have been through the IRS system and other Federal social systems have experienced a loss of culture, language, traditional values, family bonding, life and parenting skills, self-respect, and the respect for others (Elias et al., 2012), and this long history of cultural oppression and marginalization has

contributed to the high levels of mental health concerns found in many communities. This is because traditions and ways of life were displaced and actively suppressed by successive generations of Euro-Canadian missionaries, and governments, which were then later concretely reinforced as a force of cultural oppression through policies of forced assimilation (Kirmayer et al., 2003).

The Canadian government's policy of "...residential schools...have continued to destroy indigenous cultures." (Kirmayer et al., 2000, p. 608) and the legacy they left behind, along with current policies and discourses, are "active attempts to suppress and eradicate indigenous cultures [that were historically] rationalized by an ideology that saw [Indigenous] people as primitive and uncivilized." (Kirmayer et al., 2000, p. 608). For example, through the implementation of the IRS, it disrupted the living out of traditional lifestyles, and related policies made traditional practices illegal/immoral to practice. "Traditional hunting practices [and other culturally relevant practices involved in a spiritually and ecologically centred subsistence lifestyle] are not just means of subsistence, they are sociomoral and spiritual practices aimed at maintaining personal and community health." (Kirmayer et al, 2000, p. 612). The ability to control the way one lives was removed through the Indian Act and its resulting policies and programs. These structural systems dictated a way of life that was alien, and diminished the Indigenous child's sense of identity, stripping them of their culture and leaving them 'between cultures'. Also, this missionizing which led to spiritual bankruptcy (Thatcher, 2004) also undermined traditional Indigenous spirituality and ways of knowing, which in turn undermined Indigenous Peoples capacity to think for themselves, and live out their culture in the meaningful ways they have, long before colonization began. This was not a one-off historical phenomenon; the aftermath of these policies are reflected today in the lasting transgenerational effects we see in many Indigenous communities, but also in the larger body of discourse surrounding the mental health of Indigenous Peoples. Commonly,

post-colonial discourses still resonate with narratives stemming from popular social, medical, and scientific literature which continues to pathologize Indigenous people, and youth in particular (McKenzie et. al., 2016). Although, most Indigenous scholars would maintain that settler colonial countries are not truly post-colonial, as Indigenous Peoples' lives are still governed and constrained by direct colonial policies.

> "Much epidemiological and biomedical research, health policies, and media coverage frames Indigenous [youth] as a homogenous group with higher rates of health and social problems requiring individualized biomedical or psychiatric treatment. These discourses both overlook the diversity of Indigenous communities and render invisible the relationship between Indigenous Peoples social and health conditions and historical and present-day colonial processes, a relationship Indigenous people and allies have repeatedly highlighted" (McKenzie et. al., 2016, p. 8).

Psychological/Emotional Impacts

Children who were forcefully placed into IRS were as young as six years old; a critical time in a child's development in regard to forming a sense of identity and who you are as a person. This is critical because many Indigenous children are disproportionately taken into child welfare custody in Canada today. This has several impacts:

> Low self-esteem and self-concept problems emerged as children were taught that their own culture was inferior and uncivilized, and it is believed that as a result, many residential school survivors suffer from low self-respect, and long-term emotional and psychological effects. (Barton et al., 2005, p. 296).

This led these children to believe that everything they were raised with and taught was Savage or barbaric and that they were in need of educational and religious reform. This highlights the way in which the suffering endured in IRS is still present today through the pervading loss of culture and identity, and in some cases, an inability to situate oneself within their own culture. As a result, customs, practices, traditions, values and norms were not passed down to children, but instead negative parenting styles or parental withdrawal were unfortunately taken up.

Intergenerational Impact - Heteropatriarchy

Another harm to Indigenous identity is the way in which subsequent generations of Indigenous Peoples and settlers alike began to relate to Indigenous women and girls. The authority and the esteemed positions that Indigenous women held in their societies have been severely eroded through federal policies that have disrupted women's roles (Long & Curry, 1998). This normative socialization of violence and mistreatment of Indigenous women and girls through years of colonialism (McGillvray & Comaskey, 1999) has only served to worsen mental health outcomes of Indigenous youth today.

For many of today's generation, this leads to a disconnect between their conceptualizations of themselves in relation to their history, their culture, and the larger society they are situated in. Many urban Indigenous Peoples might have a deep or brief understanding of their heritage but often have no idea what it means, which can lead to poor self-esteem and feelings of alienation (Anderson, 2000). This can be seen to be reflected in the noted "...high rates of suicide and the major correlates of suicide - abuse, poor social support, and difficulty forming and maintaining relationships [for some Indigenous individuals and communities]" (Elias et al., 2012, p. 1561). Stories of survivors are permeated with abuses and harms faced during this time in their collective lives, and how this manifests in contemporary social and health outcomes. "Upon release from [IRS], survivors reported a legacy of alcohol and drug abuse problems, feelings of hopelessness, dependency, isolation, low self-esteem, suicide behaviours, prostitution, gambling, homelessness, sexual abuse, and violence." (Elias et al., 2012, p. 1561), and this chronic stress they may have experienced as attendees may still predispose them to cope ineffectively as they age (Kirmayer et al., 2003).

This has resulted in a loss of self-identity through the essentialization of the "Indian", by way of punishing children for living out their culture and growing into who they are. Failings in government policies, programs, actions, and inactions, have effectively

diminished feelings of self-worth and self-respect, which is reflected in the way some Indigenous youth have turned to negative coping mechanisms to deal with their conflicting and damaged emotions. Lastly, disrupting traditional roles practiced in communities by men, women and youth have decentralized what it means to be an active and contributing member of a given community (Lys, 2018). It has ripped people from their core notions of who they are and what they are meant to be, and how they are meant to interact with the world around them. This has led to internalized racism, abusive behaviours, and poor mental health outcomes, particularly for First Nations youth (The Well Living House Action Research Centre for Indigenous Infant, Child, and Family Health and Wellbeing, St. Michael's Hospital, 2015). This loss of self-identity has also resulted in an overarching loss of self-determination.

When someone is restricted from practicing modes of healing and knowledge transmission and acquisition that their families have practiced for centuries, where does it leave one situated in terms of their sense of belonging? Indigenous knowledge and resources have simultaneously been deemed primitive, ineffective, or mystical, yet on the other hand have become a new fad for consumption, such as with contemporary intellectual property rights for pharmaceutical goods (Drahos & Frankl, 2012). A consumer culture which benefits from the dispossession of people from their lands and restricted access and use of materials is not only damaging to present day Indigenous Peoples, but for future Indigenous communities to come who would now not be able to access what is rightfully theirs.

Past and present colonial violence "directly contributes to the intersecting issues of poverty, unstable and unsafe housing, systemic discrimination, substance misuse, and other individual, family, and community health concerns for Indigenous People" (McKenzie et al., 2016, p. 8), including elevated rates of domestic violence and sexual assault on Indigenous women and girls. Also, the focus on risk within child welfare practices "conflicts with

holistic Indigenous views of wellness, child rearing, family, and community, and many Indigenous organizations resist this narrow view of risk, grounding their policies and practices in Indigenous community and realities" (McKenzie et al., p. 10). This is why heteropatriarchy is so overreaching - it penetrates every aspect of life, including family, employment, housing, and connections to land.

Land & Life

Tied deeply into concepts of culture and spirituality are the relationships between Indigenous ways of living and the land in which they are situated.

> Within settler colonialism, the most important concern is land/water/air/subterranean earth (land). Land is what is most valuable, contested, required. This is both because the settlers make Indigenous land their new home and source of capital, and also because the disruption of Indigenous relationships to land represents a profound epistemic, ontological, cosmological violence (Tuck & Yang, p. 5).

This has not been a solitary event - this practice persists through corporations such as pharmaceutical companies performing research & development work using Indigenous materials today. Patrick Wolfe emphasizes that:

> Settler colonialism is a structure and not an event. In the process of settler colonialism, land is remade into property and human relationships to land are restricted to the relationship of the owner to his property. Epistemological, ontological, and cosmological relationships to land are interred, indeed made pre-modern and backward. Made savage (Tuck & Yang, 2012, p. 5).

This is a process that may pose potentially "grave social and cultural consequences." (Coombe, 2001, p. 108). For many, if not all, Indigenous cultures and communities, "health is a matter of balance and harmony within the self and with others, sustained and ordered by spiritual law and the bounty of Mother Earth...health is viewed as embedded in social relations of power and historically inscribed contexts. Its identification indicates that the natural environment is inseparable from indigenous culture and spiritual health" (Kryzanowski & McIntyre, 2011, p. 113). Therefore, "the accompanying loss of sense of place is significantly associated with weakened cultural identity and diminished community

health" (Kryzanowski & McIntyre, 2011, p. 115). Ultimately, "Indigenous connections to the land are spiritual… [and] decolonization [of these resources and theories] demands the valuing of Indigenous sovereignty in its material, psychological, epistemological, and spiritual forms. (Sium et al., 2012, p. 5).

When these relationships are disrupted and depleted, so too are Indigenous Peoples themselves in every element of their health status and wellbeing. The way in which the Government of Canada has actively, systematically, and consistently been ripping Indigenous Peoples from their lands and their families has ultimately made a lasting imprint on the collective spirit of Indigenous Peoples. One example regarding Inuit communities highlights that family continues to be at the core of Inuit notions of well-being and happiness, and that kinship has been the foundation of social organization (Kral et al., 2014). But, the

> "Government mandated move of Inuit from their traditional family camps on the land into settlements that brought together many unrelated families had profound effects on social structure, community, and family life. Traditional roles could no longer be maintained. Men who had been hunters now became settlement labourers or unemployed welfare recipients...loneliness among youth is thus the result of profound changes in family communication, parenting, and intergenerational relations. This is a form of multigenerational trauma seen in Nunavut, in which youth and their parents tend to avoid each other" (Kral et al., 2014, p. 61).

Not only has this impact been seen historically, but it manifests itself today in the negative health outcomes we see in Indigenous youth, from elevated rates of mental health crises and suicide rates to the lack of access to food and water resources that are so essential for healthy living.

Literature Review

When gathering research and information on the subject of Indigenous youth suicide and the Government of Canada's (in)action, I decided to look into a variety of sources. The literature analysed is predominantly academic in nature, written by scholars from settler-colonial countries in Canada, New Zealand, the United States, and Australia. These countries have large populations of Indigenous groups who were and are colonized in a similar fashion,

and similar trends can be seen throughout the research in this area. However, highlighted throughout are ways in which Indigenous research methodologies differ, and how they can be used to potentially better address the issue of Indigenous youth suicide in Canada. In the literature review, I unpack what I come to understand as the dominant narrative and the counter narrative when it comes to this subject, and ultimately aim to highlight suggestions made by Indigenous authors themselves as it relates to steps forward on this matter. Common themes found in the literature were discussions centred on risk, biology, negative coping mechanisms, and death. In contrast, discussions should perhaps focus on resilience, community, positive factors, and holistic wellness. This is what much of community driven research focuses on instead, with very promising outcomes.

Community Driven Research and Implementation

Communities across Canada, but specifically FN groups in Ontario, are increasingly taking action and refusing to be made to feel like they are meant to deal with these suicides on their own in silence. One example being the Indigenous Youth Future Partnership (IYFP), which "brings together tools and approaches rooted in local Indigenous knowledge and Western science to work together with First Nations communities in the Sioux Lookout First Nations Health Authority (SLFNHA) zone in North Western Ontario" (Gordon & Mattheson, 2018, p. 23). Much like the case of the youth in Attawapiskat who took part in the Walk of Hope, groups of FN youth and their communities throughout Ontario are making their voices heard through collaboration and taking political action in regard to Indigenous youth suicide. Attawapiskat is a prominent example when it comes to this subject, as this community gathered a large amount of attention from news outlets and government officials alike[3].

[3] https://www.thestar.com/news/canada/2016/04/18/how-the-attawapiskat-suicide-crisis-unfolded.html
https://www.cbc.ca/news/canada/sudbury/attawapiskat-suicide-first-nations-emergency-1.3528747
https://pulitzercenter.org/reporting/suicide-crisis-attawapiskat-context-legacy-canadas-residential-schools
https://www.theglobeandmail.com/news/national/attawapiskat-four-things-to-help-understand-the-suicidecrisis/article29583059/
Various articles highlighting the crises in Attawapiskat, peaking in 2006.

Another example of this is the mobilization in the communities of Clearwater County, all coming together after suffering a cluster of nine suicides in six months (Wisepractices.ca., 2020). Community meetings and workshops were organised, which often included all three First Nations in the county: Bighorn, O'Chiese, and Sunchild, to be part of a coordinated effort dedicated to suicide prevention. Their strategy aims to honour cultural diversity while simultaneously honouring and recognizing shared experiences (Wisepractices.ca., 2020).

Another example of a community driven approach to youth mental health and wellness is The Inaugural Feather Carriers: Leadership for Life Promotion initiative, which encompasses a neighbourhood mobilization and collaborative advertising education approach. The initiative was centred in the North Simcoe and Muskoka, Ontario areas in 2015 and came out of a relationship to the land, and requests from FN communities in this region, who had been searching for extra supports and resources associated with suicide prevention. As a result, the year-long Feather Carriers: Leadership for Life Promotion education program was once developed by way of our Founders, with support from nearby Indigenous communities, and Indigenous organizations, such as the Bamaadisiwin Mental Health and Addictions Planning Circle, Barrie Area Native Advisory Circle and Enaahtig Outreach Mental Health Team. Collectively, the coaching program was an approach that speaks to the hearts and minds of people working with Indigenous men and women and

---

Conditions on reserves lag behind those in the rest of Canada in more respects than just suicide and health: Unemployment, lack of access to education and substandard infrastructure are factors too. Attawapiskat declared a state of emergency five years ago over a housing crisis that James Anaya, then UN Special Rapporteur on Indigenous Peoples, said "seems to represent the condition of many First Nation communities living on reserves throughout Canada, which is allegedly akin to Third World conditions." Studies have pointed to economic hardships and the legacy of colonialism as key factors in high Indigenous suicide rates. The January Statscan study, for instance – which reviewed findings from the 2012 Aboriginal Peoples Survey and the 2012 Canadian Community Health Survey – found a strong connection between residential-school experience and suicidal thoughts. Doing more to prevent suicide was one of the recommendations of last June's report by the Truth and Reconciliation Commission on residential schools. Federal Health Minister Jane Philpott said in a statement regarding the Attawapiskat suicide crisis that improving the wellness of Indigenous Peoples will require a focus on improving the socioeconomic conditions they face.

households who are at chance of untimely death, as well as assisting loss survivors. Gathered from all directions, Feather Carriers brings the know-how and experience of the whole community into practice. It builds on the values and beliefs that in this existing time, life is really worth living. As such, the coaching factor of the initiative helps the improvement of neighbourhood leaders via Indigenous know-how and cultural understandings of lifestyle promotion, so they can proceed to promote lifestyles and stop untimely loss of life (i.e. suicide) in our communities (Feathercarriers.com., 2020).

Critical Suicidology

When unpacking the topic of suicide, it is important to take a critical lens to further analyse the issue at hand, thus looking at the literature surrounding critical suicidology. In this literature, one attempts to map discourses surrounding how suicide is most commonly talked about, what the constructed truths around suicide seem to be, what is done in relation to suicide and by whom, who gets to speak their truth in regards to suicide, and what happens to people being identified as being “at risk” of suicide (Marsh, 2010). In typical and dominant suicide research, suicide is assumed to be pathological, a matter of science, and something experienced at the individual level. This dominant assumption, essentially labelling suicide as a phenomenon that takes place in someone’s brain because of their individual chemical makeup, drives research, policy and practice despite being uncreative, repetitive, and reductionistic (Hjelmeland, 2010). These underlying assumptions and their following directives often drive prevention initiatives that are culturally incongruent for many Indigenous communities (Wexler & Gone, 2016). To address this, researchers, community members, and lay people alike have been calling for suicide prevention strategies that consider historical context, social networks, and community resources to be put in place alongside clinical systems of support, so as to best address culturally relevant factors which impact Indigenous youth mental health. The premises here in this dominant literature on

youth suicide, are often the same premises that inform major policies laid out by the Canadian Government.

Many Indigenous communities live a holistic way of life which values kinship ties that are based on values of collaboration and cooperation. Indigenous cultures value the integral roles of both men and women, and gender roles are not as rigid or divisive as they are in contemporary western society (Native Women's Association, 2010). Both men and women alike had, and have, responsibilities to take care of the home, gather and prepare food for the community, and redistribute resources as needed. But due to increasing impacts of colonial encroachment, gender roles relating to traditional land management and harvesting (and increasingly overarching into other aspects of everyday life), have been disrupted, and fishing and planting areas governed by particular families have been encroached upon by settler populations and their development efforts (indigenousfoundations.arts.ubc.ca, 2009).

This impinged on matriarchal or matrilineal traditional practices and values, and imposed a patriarchal, individualistic imperative. As mining jobs were not as accessible or open to Indigenous women, the men were encouraged to become the strong breadwinners of the households, and completely changed the dynamic of Indigenous families (Hall, 2017). This disrupts a sense of self, as roles and responsibilities become displaced, Indigenous Peoples question their place and power in their communities. With the imposition of colonialist and neoliberal agendas, which valued the individual efforts of each person as opposed to the contributions of the community as a whole, shifted the way in which some Indigenous Peoples reflected on themselves and their role in the community. This shifts the ideologies of community-based contributions to individualism. "Self-identity is a result of a developed relationship to the environment as it is perceived by the culture," (Salmon, 2000, p. 1331), and in this way, affects individual mental health outcomes.

Other outcomes can be seen as disruptors to social life and social well-being. For example, negative outcomes stemming from development projects and their impacts on the land include restrictions on outdoor activities including the loss of recreational options, in addition to the potential unpleasant odour and dingy appearance of clothes washed in the local contaminated water supply that can bring discomfort, inconvenience and embarrassment (Morrice & Colagiuri, 2013). These outcomes are rarely accounted for when considering the effect that environmental violence and destruction of land has on people's general well-being, which can disrupt their mental health outcomes.

As land is so intertwined with notions of culture and identity in Indigenous cultures, the destruction of the land is a destruction of Indigenous Peoples themselves. In contemporary discussions of mental health of Indigenous communities and connection to a sense of environmental loss, "the term 'solastalgia' [can describe] psychological distress associated with adverse environmental change [which includes experiencing] feelings of powerlessness and home-sickness that can result from damage, destruction or loss of 'place'." (Morrice & Colagiuri, 2013, p. 76). This is critical, seeing that Indigenous notions of health and wellness are entirely based upon synchronicities, balance, and harmony between all aspects of one's life.

Dominant Narrative

In tandem with government policies, a large body of the dominant literature on Indigenous mental health highlights that religious conversion was used as a culturally assimilative tool. In many cases, this involved suppression or subversion of existing religious beliefs and practices that were integral to the subsistence activities and the structure of families and communities. Survivors of IRS then returned to their communities in a culturally 'betwixt and between' state (Kirmayer et al., 2003), where cultural discontinuity and oppression have been linked to high rates of depression, alcoholism, suicide, and violence in

many communities, with the greatest impact on youth (Kirmayer et al., 2000). This is why it is critical to understand the ways in which a loss of culture is detrimental to the health and well-being of Indigenous Peoples in Canada.

Mental Health Outcomes

Through colonial government policies and racist attitudes, and portrayals in popular media, the way in which larger Canadian society views Indigenous bodies and minds has been skewed to see them as dis-abled. “Dis-abled” as opposed to “disabled” reflects the notion that society itself renders, either physically or metaphorically, individuals as disabled, and that disability is not inherent in the individual, but rather that society is unable to accommodate different needs and ways of living (and unable to understand the circumstances leading up to the way one lives). Also, “dis-abled” nods to the fact that larger discussions of disability lack contextual understanding and historical significance of what it means to have been “dis-abled” and have your ability forcibly taken from you in some way or another.

The current pathologization of Indigenous Peoples as “disabled”, “traumatized” or, “disordered”, allude to the current underpinning in anthropology, psychiatry and psychology which fail to account for colonialism as a root cause for the current state of mental health in many Indigenous communities (Czyzewski, 2012). Indigenous Peoples in and of themselves are not “sick” or “troubled”, but the elevated negative mental health outcomes and higher instances of other health disparities need to be contextualized in the realm of colonialism and subjugation - historically and contemporarily. These ideologies, and the institutions that reproduce them such as psychiatry and child protection, produce further mental harms and illness through the “psychiatrization of people they are meant to support” (LeFrancois, 2013, p. 108).

Representations in popular media and news outlets even today paint the picture that Indigenous Peoples just somehow can’t get their act together (CBC, 2014). Communities in

crisis are more often than not depicted in a negative light, without highlighting the reasons why Indigenous communities are still struggling. But, obviously in reality this is not the case, nor is it that easy. Indigenous Peoples have been subjected time and time again to oppressive and destructive policies implemented by the Canadian government, and this has greatly shaped the way Indigenous Peoples see themselves, and the ways in which some non-Indigenous people view them, which result in increased negative mental health outcomes.

"Essentializing" in the case of discourses about Indigenous minds and bodies, relates to the attributing of perceived natural, essential characteristics to members of specific culturally defined (gender, age, ethnic, "racial", socioeconomic, linguistic...) groups; in this case, Indigenous bodies and minds. When we essentialize others, we maintain that individual differences can be explained by inherent, biological, "natural" characteristics shared by members of a group. Essentializing results in thinking, speaking and acting in ways that promote stereotypical and inaccurate interpretations of individual differences. Essentialist thinking is often anchored in dualistic (two-category, either this - or that) modes of thought. This is particularly damaging, because identity does not exist inherently in a person nor are people biologically determined to be less human than anyone else. Colonial policies and actions have effectively served to dehumanize, essentialize, and dis-able Indigenous minds and lives.

It is no secret, nor it is a surprise that large scale abuse in the system was widespread and severe, with the purpose of wearing away the traditional knowledge, practices, identity, pride of heritage, and language of Indigenous Peoples (Milloy, 1999). This control and regulation resulted in the loss of autonomy over one's body (Kelm, 1998), which rendered many Indigenous children unable to go out into the world with a holistic and nurtured set of life skills and experiences that they otherwise would have attained in their home communities. Any child who is constantly told and reminded that their culture is not worthy

or valid, will grow up suffering from some form of repercussions, aside from the physical harms inflicted in these institutions.

Counter/Alternative Narrative

In contrast to this dialogue, the counter narrative frames this issue in terms of strength-based centred modalities. Discussions focus on resilience, cultural continuity, cultural safety and relevance, and the importance of community involvement. Critical to note is the difference in which Indigenous Peoples and western individuals view the concept of resilience. Traditional resilience can be understood to be a highlight individual process, where in comparison to Indigenous communities, it includes notions of connection and has to transpire through all levels including family, community, etc. As well, resilience in Indigenous communities is largely understood as an active process or a deliberate act; it is an action rather than an adjective used to describe the way people emerge from difficult life situations. In this way, the issue is not the deviance of each youth at hand, it is the collective pain felt by these youth who then feel as if they have no other options. As Chandler & Lalonde highlight, “cultural continuity factors...proved to be strongly related to the presence or absence of youth suicide” (Chandler & Lalonde, 2008, p. 221). Without strengthening the foundation on which these youth are being brought up on, and by pathologizing and stigmatizing them further, improvements will be hindered. In many communities, it is emphasized that not Indigenous communities are affected equally by suicide, including marked differences between FN communities living on reserve and FN youth living in urban centres. In many communities, practices and programs are highly effective at building on protective factors which promote self-esteem, self-determination, and a sense of pride among youth and all community members. Protective factors “are considered to be any variable that is associated with better social and emotional wellbeing outcomes” (Young et al., 2018, p. 2). Operating in this way, communities are able to address the issues they face with autonomy

and direction dictated by their own terms. For many Indigenous cultures, including many First Nations groups, health is conceived holistically and not just as a mere absence of disease. To live a healthy life, one must be balanced in all aspects of their existence, including with the environment and space one occupies. Fostering resilience in this way "operates within the 'ecosystem' in which youth reside" (Gordon & Matheson, 2018, p. 1). Connection to land, to spirit, and to others is critical in feeling secure in your being, and when this balance is off-centred, many Indigenous youth become disengaged and find themselves in positions which are negative for their mental health and wellbeing. As MacNeil highlights, "when the natural balance or harmony in an [Indigenous person's] life is disturbed, illness, death and suicide may result" (2008, p. 4). But, when focusing on framing and addressing the issue of suicide in culturally relevant/safe/relevant ways, outcomes have proven to be promising for many youth and communities across Canada. For example, one community in Nova Scotia has taken up the practice of puppetry, made out of local and traditionally picked materials, in order to promote understandings of cultural continuity and culturally relevant ways of healing for First Nations Mi'kmaq youth (Jacono & Jacono, 2008). Programs like these which "[implement] activities in a natural setting appear to be a promising means of tapping into existing strengths and preventing social problems among youth of these communities" (Janelle et al., 2009, p. S108).

Many scholars have meshed these two viewpoints together and operate from a standpoint conceptualized as two-eyed seeing[4]. By this, one encapsulates understandings and

[4] Two-Eyed Seeing is the Guiding Principle brought into the Integrative Science co-learning journey by Mi'kmaw Elder Albert Marshall in Fall 2004. *Etuaptmumk* is the Mi'kmaw word for Two-Eyed Seeing. He explains *Etuaptmumk* - Two-Eyed Seeing by saying it refers to learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing and learning to use both these eyes together, for the benefit of all. The guiding principle of Two-Eyed Seeing further helps us to acknowledge the distinct and whole nature of Indigenous knowledge and ways of knowing (i.e., such are represented as a whole eye). Similarly, it helps us recognize the distinct nature of Western knowledge and ways of knowing (i.e., such are also represented as a whole eye). At the same time, Two-Eyed Seeing asks that these two eyes work together (i.e., as they do in binocular vision).
It may be that in a particular set of circumstances we will choose to call upon the strengths within Indigenous sciences, whereas in another set of circumstances we might choose to call upon those within the Western sciences. Two-Eyed Seeing can require a "weaving back and forth" between knowledges, and this will draw upon abilities to meaningfully and

methodologies from both traditions, both Indigenous and western, in order to better understand and effectively address the social circumstances that many Indigenous communities are facing, including epidemics of youth suicides. Through the incorporation of both biomedical and traditional understandings of health and mental health, more youth are able to tackle the issues they are dealing with and come out resilient and operate as champions in their communities. This narrative in the literature is not without its flaws, however. Scholars (Kress, 2014; Judge, 2018; Wright, 2019) and activists alike criticize the concept of two-eyed seeing as simply being a co-opting of Indigenous knowledge, and that these opposing viewpoints are simply incompatible. Many, if not most, studies merely determine the presence of mood disorder through health service utilization data, and those data are flawed because they are not truly representative of all Indigenous youth for a variety of reasons, as highlighted in Greenfield et al.'s work on conduct disorder and alcohol use disorder trajectories, predictors and outcomes for Indigenous youth. But important points can be gathered from both ways of understanding this issue, and both have been fundamental contributors to the literature and knowledge we have about this topic. It is noted that "culturally adapted recovery approaches to Indigenous mental illness are thus an important component of closing the gap in Indigenous health" (Nagel et al., 2012, p. 216). However, for this method to be successful, it must not be an additive approach. In order to decolonize knowledge and understandings of mental health and youth suicide among Indigenous youth, it must be executed in a grounded manner which resonates with communities and is created from, and for, Indigenous communities.

respectfully engage in an informed manner in collaborative settings. To help us do this, we have developed the four big pattern knowledge understandings (with visuals) as tools. Read more about our efforts in this regard and about weaving capacity, under co-learning and under integrative science research to highlight the philosophies in our science stories. Two-Eyed Seeing, in that it speaks directly to the setting of collaborative, cross-cultural work, intentionally seeks to avoid the situation becoming a clash between knowledges, domination by one worldview, or assimilation by one worldview of the knowledge of another. (Retrieved from: http://www.integrativescience.ca/principles/twoeyedseeing/).

Keeping in mind that suicide rates amongst Indigenous youth vary greatly from community to community and region to region, common characteristics are worth mentioning. First, consistent with the general population, FN individuals who die by suicide are more likely to be male, young, and single. These suicides are also likely to be associated with alcohol intake. Suicide amongst Indigenous youth are often carried out by highly lethal means (guns and hanging). There is also a tendency for suicides to occur in clusters, where the suicide of one young person may trigger a series of suicides or attempts in the same group of youth or community within a relatively short period of time. It is fair to question why young Indigenous People are experiencing high rates of suicide, especially when compared to their non-Indigenous counterparts. However, due to the complex and dynamic nature of suicide, the answer to this question is not likely to be straightforward. (Centre for Suicide Prevention, 2004).

According to the Centre for Suicide Prevention in their 2004 report titled *Promising Strategies - Aboriginal Youth: A Manual of Promising Prevention Strategies,* the following recommendations would be good base strategies to undertake in the prevention of suicide amongst Indigenous youth:

- reduce depression in young people
- reduce substance abuse in individuals and families
- reduce child neglect and abuse
- reduce the negative impact of a peer's suicide
- improve problem-solving skills among young people
- improve parenting skills and strengthen families
- reduce sensational public communications about suicide
- increase the capacity of communities to be self-determining (Centre for Suicide Prevention, 2004).

As well, incorporating colonialism as a Social Determinant of Health for Indigenous Peoples would acknowledge effects that colonial policies have had historically on them as collective, and also acknowledges that this still has lasting effects today.

Government of Canada's Reaction/(In)Action

In 1990, information about crimes committed within the IRS came to public attention in when Assembly of First Nations (AFN) leader Phil Fontaine publicly shared and announced his history of physical and sexual abuse and encouraged others to come forward with their stories. This gave way for the creation of the Royal Commission on Aboriginal Peoples (RCAP) - to explore these colonial genocidal policies and their effects on Indigenous lives today. During the RCAP's creation process, submissions, such as the AFN's report Breaking the Silence (1994), documented the experiences of 13 survivors and their histories of verbal, physical and sexual abuse. In 1996, the five-volume RCAP report highlighted four main types of harms committed during the colonization process. The first of these concerned the 'physical and sexual abuse in residential schools' (as well as their goals of assimilation and cultural destruction) (Cairns, pp. 77–78). "The report clearly stated problems of neglect, underfunding, and widespread abuse, as well as the "very high death rate" from tuberculosis, 'overcrowding, lack of care and cleanliness and poor sanitation.' Overall, the report was a damning indictment of the government's treatment of [Indigenous] [P]eoples." (MacDonald & Hudson, 2012, p. 433).

In 1998, the federal government released a Statement of Reconciliation, accompanied by a $350 million "healing fund." In 2008, the "Harper government formally apologized in Parliament, regretting that "mistakes" had been made, although he failed to reflect on the wider "colonial social and institutional context which made the IRS possible." (Macdonald & Hudson, 2012, p. 433). "Common experience payments" soon followed, as well as an independent assessment process, designed to compensate survivors. In 2009 the Truth and Reconciliation Commission (TRC) began collecting statements. In 2015, the commission released its report and assembled 94 Calls to Action, or recommendations on how to repair the relationship between the Canadian government and Indigenous Peoples. As of March 2018, just 10 out of the 94 Calls to Action have been completed, highlighting the less than

enthusiastic effort put forth by the Canadian government to work on these goals, one such example being to appoint a public inquiry into the causes of, and remedies for, the disproportionate victimization of Indigenous women and girls (Beyond 94, CBC News, 2019). Some of these Calls to Action which relate to historical aspects and their health impacts include numbers 18, 19, 21, and 66 (TRC, 2015), which are all relevant to addressing the problem of residential schooling and its lasting legacy for Indigenous youth and communities. The vast majority of these calls are unfulfilled, however. But the path forward looks promising, if the Canadian Government is to uphold its position of being a signatory of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), it will reach further than the Indian Act, by following through with the Article's 7 (Collective Rights), 8 (No Forced Assimilation) and 13 (Right to Language) for example (UNDRIP, 2007). These articles relate to the right to life, culture, knowledge, and lifestyle, which all in turn have major impacts on health and wellbeing. In the current literature on Indigenous youth suicide, there are several key policy documents alongside dominant works in larger academia that are of great significance when analysing this issue.

In 2016, the Mental Health Commission of Canada (MHCC) released its thirty-seven-page framework to address mental health issues pertaining to youth, titled *The Mental Health Strategy for Canada: A Youth Perspective.* In this document, a mere four pages (23-26) are dedicated to First Nations youth, although they have some of the highest rates of suicide, instances of mental illness and mental health concerns, and substance use issues across Canada, particularly on-reserves in Ontario. This is in addition to the fact that the Truth and Reconciliation Commission and its accompanying 94 Calls to Action were released a year before, and yet there was no real uptake. These pages claim to highlight the unique needs of all Indigenous individuals, and touches on topics such as the harms of colonization, the meaning of wellbeing, histories of each particular group, and suggestions in regard to efforts

to address the causes of mental unwellness. Although highlighting important concepts such as the effects of poverty, discrimination and the repercussions these factors have, this document speaks of these issues in the past tense - particularly the issue of colonization.

Looking through a lens which highlights the devastating effects of colonial policies such as the Indian Act, through its enforcement of residential schools, one can begin to see contemporary issues in a new light. As well, incorporating colonialism as a Social Determinant of Health (SDOH) for Indigenous Peoples would acknowledge effects that colonial policies like the Indian Act have had historically on them as collective, and also acknowledges that this still has lasting effects today, although the SDOH framework in and of itself is not without its critiques from Indigenous Peoples.

If these principles outlined in UNDRIP and TRC are carried out, the scope of understanding can be broadened when it comes to addressing Indigenous youth mental health today. If we unpack language and how it is utilized in dominant discourse, in government policies, and in healthcare, we can better navigate the issue of Indigenous youth suicide in Canada. Based on the findings in my literature review, I found it to be pertinent to address the framing of this topic, and how this framing itself has the ability to further dictate mental health outcomes for Indigenous youth in Canada.

Theoretical Orientations & Methodologies

As a non-Indigenous person, it is critical to undertake this MRP from a standpoint of reflexivity. At first, I was hesitant about adopting a decolonizing lens through which I will utilize the WPR approach to research, but upon further contemplation I decided adopting a decolonizing lens was the most appropriate operational framework. Because I am a non-Indigenous person, having never worked directly with an Indigenous community, having never consulted or have fostered relationships with community members, I don't find it correct to say I am taking a decolonizing framework. I am a middle class, White, cis-

gendered, university educated female, and with that comes a degree of power which I must acknowledge. I have the privilege of looking at this issue from the outside, and therefore must acknowledge that I will not hold all the answers to the questions posed in this MRP. When using the term lens, I am referring to the filter in which I apply to analyse these issues. By taking on a decolonizing lens, one is situating themselves from the standpoint of individual reconciliation, upholding and shining a light on community-based work and knowledge. For myself, this has been taken up throughout both my undergraduate and graduate studies, through taking courses on Indigenous histories, learning about Indigenous health and wellness, and having discussions in my immediate circles in order to broaden dialogue and expand my knowledge. In order to speak on this topic, it must come from an understanding which I personally do not have, therefore it is essential to refer back to communities and Indigenous youth themselves, through using literature stemming out of such communities or written by Indigenous authors on the subject, and approach the topic with respect and an open heart and mind. My own personal experience with mental health challenges as a young adult myself, allowed me to deeply reflect not just on my own reality, but on the realities of youth from all across Canada who's lives might look different than mine. But, coming from a background in psychology, the underpinnings of my understanding were quite limited when it came to culturally relevant health outcomes for Indigenous youth. This is why it is critical for academics, researchers, scientists, politicians- everyone, really, to adopt a decolonizing lens when trying to understand the deeply complex topic of Indigenous youth suicide in Canada. Decolonizing methodologies such as qualitative Indigenous research methods like sharing circles and Anishnaabe symbol-based reflection (Lavalle, 2009) challenge and critically analyse postcolonial and other Western methodologies as being behind the times in regard to the current state of affairs between the Government of Canada and movements towards reconciliation and decolonization of knowledge. It is situated in a

past-tense, static fashion; therefore, not allowing for current climates to be taken into consideration. This contrast to western policy analysis approaches have created tension in research and in practice, but it is imperative to not rely on western methods alone to look into a topic of this nature, such as Indigenous youth suicide. This is aligned with Indigenous methodologies and conceptualizations of understanding the world and generating knowledge.

In contrast to this debate, the counter narrative frames Indigenous youth suicide in terms of strength-based centred modalities. When focusing on framing and addressing the issue of suicide in culturally relevant/safe/relevant ways, outcomes have proven to be promising for many youth and communities across Canada.

Key Research Questions

When looking into the literature and practices that the Government of Canada has put in place, several key research questions arise. One tool to analyse these documents is by using Carol Bacchi's WPR approach, as it aims to unpack problematic representations in policy or practical frameworks such as the MHCC 2016 Youth Strategy. Here, I seek to address just how policies/Government documents like this have the ability to create further problems through the language they use to 'solve' said 'problems'.In my research I explore several questions:

1. How are Indigenous youth conceptualized vis a vis "risk" discourse and suicide in the MHCC (2016) report?
2. How might suicide in Indigenous youth be conceptualized differently using concepts like resiliency, cultural continuity/safety/relevancy and self-determination, and discourses arising from communities themselves?
3. How are Canada's policy responses addressing issues of Indigenous youth mental health, in particular instances of suicide?

Methods

Carol Bacchi's WPR

The WPR approach operates from an understanding that it is the idea that social problems are 'created' (Bacchi, 2012) or brought into being through discourse and ideology.

For example, in the case of substance dependency and addictions, it can be seen as a problem that is criminal in nature, or it could be considered a public health problem - regardless, how it is represented will influence the corresponding policy solutions proposed. Therefore, by analysing the solution proposed to address something reveals what one considers to be problematic or in need of changing/fixing. This thinking, along with its corresponding policies, documents, frameworks, and strategies such as the MHCC Youth Mental Health Strategy, contain implicit representations of what is considered to be the ‘problem’ (Bacchi, 2012). This is why it is crucial to unpack these documents and discursive materials in order to discern how the ‘problem’ is depicted, and to problematize this representation as being damaging in itself. Following Bacchi’s (2012) list of questions, we can better understand why and how Indigenous mental health is talked about and responded to in the way that it is. I will be following her original set of six questions that are outlined in her paper *Introducing the ‘What’s the Problem Represented to be?’ approach* (2012), and critically reflecting on the MHCC 2016 report. I will ask of the research:

1. What’s the ‘problem’?
2. What presuppositions or assumptions underpin the representation of the ‘problem’?
3. How has this representation of the ‘problem’ come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the ‘problem’ be thought of differently?
5. What effects are produced by this representation of the ‘problem’?
6. How/where has this representation of the ‘problem’ been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced?

These questions inform my research questions through their critical look at language and how it has the ability to imbue power and shape ‘problems’ into being. Although this WPR method challenges what is being said textually, it doesn’t reach far enough in the sense of seeking to rearticulate and shift power dynamics. While shining a light on the power in which this language has, it is important to reinstate the fact that this power, which in this case is held by the MHCC and the Government of Canada, is not static in nature. Power must be shifted into the hands of communities, not lay majorly in the hands of others.

Working through a decolonizing lens to addressing Indigenous youth mental health and suicide seeks to reimagine and rearticulate power, change, and knowledge through a multiplicity of epistemologies, ontologies, and axiologies. “Decolonization [of Indigenous knowledge, resources and practices] cannot take place without contestation. It must necessarily push back against the colonial relations of power that threaten Indigenous ways of being.” (Sium et al., 2012, p. 3). Decolonization brings about the “repatriation of Indigenous land and life; it is not a metaphor for other things we want to do to improve our societies.” (Tuck & Yang, 2012, p. 1). So, to achieve anything close to this, the mentality and framing of the problem has to shift: instead of positioning Indigenous youth as being in a constant state of risk, there lies the opportunity for strength-building and the reclaiming of understandings and approaches to mental health. As well, if Western research methods are to be applied, they must consider factors not taken into account in a western qualitative research setting. So, although the WPR is the method being applied, it is functioning more as a guide than as a set of instructions. The questions will be modified slightly, only in regard to language, to be specifically relevant to this document and to this topic at hand; the format of the questions themselves and the order in which they are unpacked will remain consistent with Bacchi’s work.

Analysis of MHCC 2016 Strategy

1. What’s the ‘problem’?

Quoting directly from the 2016 MHCC Youth Strategy, when it comes to the challenges that Indigenous youth face in regard to their mental health, the MHCC maintains that “we must do something about”:

1. The harms *caused* by colonization, the residential school system, and other policies that *kept* First Nations, Inuit, and Métis *parents from passing their culture and history on to their kids.*
2. How hard it is for people in Canada’s territories and northern or *remote areas to get mental health professionals* to live and work in their communities.

3. How hard it is to access basic mental health services in Canada's *territories and northern or remote areas,* which often results in having to travel outside of one's own community for support.
4. The ongoing impact of racism, poverty, and other systemic issues on *mental and physical wellbeing.* (MHCC, 2016, p. 23 - italics added).

Here, we can see that the problem is constructed to be that Indigenous youth are suffering the harms that were once caused by the historical processes of colonization. This minimizes the fact that colonization is a continuous and ongoing project in Canada, and ignores the plethora of other traumas that have happened and continue to happen. Secondly, it places the responsibility on communities themselves to 'get' 'professionals' to live and work in their communities. More work needs to be done to foster community development so that mental health professionals can stem from within the communities themselves, and therefore better serve the wants and needs of that specific community. Of major importance to note is the fact that not all Indigenous youth who are struggling with mental health issues live in the territories or remote areas. Lastly, the health impacts of racism, poverty and other systemic and structural injustices are far more reaching than just mental and physical wellbeing - it impacts the environment, spirituality, and cultural life as well, which all in turn affect mental and physical wellness.

The problem here is that Indigenous youth are *represented* to be victims of a horrible historical 'mistake'. This notion of Canada making a 'mistake' in the treatment of Indigenous Peoples is a way to deflect blame and responsibility, and uphold the notion of Canada being the good guy' and feeling 'sorry' for what they 'did'; now Indigenous communities are in circumstances of low education, low socioeconomic status, and low possibility for optimal health; when these in fact are not the current realities for many. The problem is also represented to be that practitioners and professionals aren't willing to live and work in these communities, making it impossible for residents to access the care that they need (Ohler, 2018). The problem is a lack of culturally relevant and safe treatments carried out in

interventions provided by outsiders to alleviate the social ills that these communities are facing. All of these "problem representations...*produce* 'problems' with particular meanings that affect what gets done or not done, and how people live their lives" (Bacchi, 2012, pp. 21-22). This is unsettling, as the presuppositions and assumptions made here in the construction of the problem often go unproblematized and are taken as the truth of the matter, when this is clearly not the case.

2. What presuppositions or assumptions underpin the representation of the 'problem'?

The presuppositions and assumptions that underpin this framing is the fact that past and present circumstances are linked by not existing simultaneously; it is assumed that all of the harms were inflicted in the past by mysterious structural bodies, with no responsibility being attributed. Yes, residential schooling and the child welfare system did gravely affect health outcomes, but they *still* do, and their legacies are very much alive. The child welfare system today has more Indigenous children in its grasp than the number of children who passed through residential schools in the 1900's (Sinclair, 2018). It also assumes that these communities are stuck in a perpetual state of dismay and disrepair and that without government intervention there is little hope for redemption and improvement.

3. How has this representation of the 'problem' come about?

This representation of the problem has come about through the dominant discourse on the matter, which greatly shaped public opinion and the way society looks at an issue, and at a group of people. Highlighted previously, the history of Crown-Indigenous relations kicked off the way in which 'the problem' has come about. Through government policies and practices, Indigenous individuals have been legislated into a position of minimal power, restricted movement, diminished ways of life, and disrupted understandings of the world. The problem is represented by outsiders, those looking in who presume to see the problem as its face value; high crime, high death, high dis-order. Also, the psy-sciences and disciplines have

been instrumental in pathologizing everything about Indigenous individuals, including their identities and cultures. Through documents like the MHCC Youth Strategy, this problem representation shifts slightly, but not significantly enough.

4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought of differently?

What is left unproblematic is the fact that these policies, practices, institutions, and mind-set's about Indigenous mental health and Indigenous populations as a whole still persist to this day. What is problematic is the fact that structural factors are mentioned and discussed, but no call for action to meaningfully challenge them is made. As opposed to calling for greater funding for housing supports and developmental sustainability, the solution is thought to be as simple as training new practitioners to go into these communities and practice on them. Instead, efforts could be directed to training community members themselves, and operating from different backgrounds, not relying solely on biomedical conceptualizations and practices.

5. What effects are produced by this representation of the 'problem'?

By representing the problem in this way, it can serve to further stigmatize and pathologize individuals and whole communities. This also focuses solely on the negative and not the positive of what it means to be an Indigenous person. There is no mention of the strength, resilience, ingenuity, and integrity of Indigenous Peoples. The core issues of systemic barriers cannot be meaningfully or substantially addressed if there is no dialogue being shared about the issues. By focusing on each individual or group of Indigenous youth, it erases collective political, social, economic and environmental upheaval that Indigenous Peoples have faced and continue to face. It allows for society to see this issue as something that doesn't relate to or involve them, serving the purpose of "othering" these Indigenous

youth who are dealing with mental health challenges as simply being deviant or a by-product of their communities and families' bad decisions.

6. How/where has this representation of the ‘problem’ been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced?

By being pushed through government legislation, this problem representation is produced, disseminated and defended at the highest levels in our society. For hundreds of years, the government of Canada has been instrumental in the crafting of how we conceive Indigenous mental health outcomes, which in turn informs lower level policy and practice. Through the media, governing bodies, and social institutions such as education, child welfare and healthcare, these representations are further entrenched into society’s collective mind which in turn give rise to some of the social and health harms we see today. To question, disrupt and replace this representation, greater discussion has to be had surrounding protective factors, positive outcomes, and examples from communities themselves. As mentioned previously, programming by and for Indigenous Peoples is what would be more appropriate here. Positive, strength-based lenses must be applied to this issue, along with a postcolonial analysis of how textual materials are discursive in nature and have real world repercussions to their statements (or lack of).

What is Being Said?

The four pages (pages 23-26, MHCC, 2016) detailing and outlines the concerns, ‘problem’, and proposed solutions pertaining to Indigenous mental health, upon first glance, seem to be encouraging and enlightening. The document agrees that these groups of youth have unique needs and are subject to complex social issues which affect their mental health. There is discussion of resilience, self-determination, and a holistic understanding of wellness - all topics which are important and crucial when thinking about how Indigenous youth understand notions of health and healing. It is highlighted that “although suicide is not a

universal problem in [FN] communities, it is a significant challenge in many communities across Canada." (MHCC, p. 23). Indeed, they agree that "mental health and suicide need to be addressed together through the promotion of good mental health for all…[but that] "there is no one-size-fits all answer" (MHCC, p. 23) and that we need to "do something about" (MHCC, p. 23) harms caused by colonization, access to mental health professionals, accessing basic mental health services, and the ongoing impacts of poverty, racism, and multiple systemic and structural issues that impinge on Indigenous youth mental health.

Discussions about the impacts of residential schooling and the child welfare system are combined with current realities of "poverty, poor housing, and a lack of educational opportunities" (MHCC, p. 24). These issues are often siloed and isolated, but it is critical to see the ingrained relationship between the past and the present. As well, the lack of mental health professionals in communities is a dire problem, but progress has been slow in terms of a service continuum that is culturally safe and relevant. Efforts to address these issues must be integrative and coordinated across all levels of government, so as to tackle the root factors like poverty, violence against women, and discrimination. But, seeing as it might not be the most suitable option to create a pan-Indigenous mental health strategy, this MHCC Youth Strategy Strategic Decision #5 (Indigenous Youth Mental Health) can be seen as a starting point. However, as it may seem positive on first glance, when unpacking the dialogue and discursive use of language, we can begin to understand what is not being said, or what is truly being said in this document.

What is Not/Really Being Said?

To begin, MHCC claims that Indigenous communities and cultures have "much to contribute to the transformation of the mental health system in Canada" (MHCC, 2016, p. 23), but why haven't the majority of communities actually been able to? Biomedical discourse, understandings, and treatment approaches are largely implemented by the psy-

sciences (psychology, psychiatry, psychotherapy, etc.) and are central to the dominant body of literature, while simultaneously undermining Indigenous knowledges and epistemologies. So, without concrete incorporation, the mental health system is not able to truly transform in any meaningful way. Yes, it is true that mental health and suicide need to be addressed at the same time, however, promoting and working towards structural equality would also address negative mental health outcomes. The words “caused” and “kept” are used when discussing the ways in which colonization *has* disrupt*ed* Indigenous families from passing on cultures and histories to children, which implies a past tense understanding, ignoring the ways colonization is still an ongoing process for many Indigenous peoples in Canada, through issues such as the alarming rates of MMIWG and children in the child welfare system.

It is asserted just how hard it is to get professionals which are competent and understand the issues of the communities they would be serving, to live and work in remote communities who are experiencing mental health or suicide ‘clusters’ and ‘crises’, which assumes the exclusion of more urban populations, and assumes that these professionals cannot come from within the communities themselves. They assume an external expert will be incorporated into the community, instead of the community working from the inside out. Also, it is maintained that all communities need equitable access to these mental health services treatments and supports wherever they live, which are also appropriate in nature. This is true; however, this too assumes that mental health services are something external that is applicable to populations removed from the treatments origin; it assumes that practices and programs targeting mental health issues do not exist outside of the realm of expertise, professionalism, and biomedicine.

Specifically referring to First Nations, it is stated that “wellbeing is about balancing spiritual, mental, emotional, and physical health…[but] that way of life was nearly destroyed by residential schools and the child welfare system” (MHCC, 2016, p. 24). By using the term

was, again here we see a deflection of responsibility by using past tense to describe ongoing practices of colonization and life disruption by the same systems. Current institutional structures like the child welfare system and correctional services are often populated disproportionately by Indigenous individuals, and this is something that is clearly still ongoing, not something that simply took place in the past with distant peoples. As well, it is clear that these individuals were forcefully made to relocate or were taken away from their homes, but once again, there is no mention made as to *who* is responsible for this (even though we all know who is). In this way, it is missing context, therefore absolving the Canadian government of responsibility and complicity in these issues.

For rural and remote communities, the problem is described as there being a lack of medical and mental health professionals in these locations, therefore leading to negative outcomes. It is maintained that practitioners must be trained to be culturally safe, but this once again assumes that these professionals are outsiders who are trained externally and brought *into* these communities, diminishing any positive strides towards improvement from within the community itself. It presumes that community members are not professional, and that their traditional or culturally appropriate methodologies must be tweaked by Westerners in order to solve the problem. We know that this progress has been slow, but the speed of progression is rarely problematized in this document.

The shortcomings of the MHCC 2016 Youth Strategy, while being a positive strategy with good intentions, speak volumes as they can further widen the gap in mental health disparities Indigenous youth face. By ignoring the fact that the processes of colonization are ongoing and that contemporary responses are needed, the strategies proposed will fail to make meaningful change. Therefore, it can be argued that a pan-Indigenous mental health strategy would not be optimal, as this falls victim to painting Indigenous Peoples and communities as a homogenous group, assuming they all function the same. A step in the right

direction could potentially be moving away from representations and the framing present in the MHCC Youth Strategy, towards a more community-centric, community-focused, and community-led discussion and plan to address Indigenous youth mental health outcomes in Canada, as many communities and scholars alike echo.

In the majority of peer reviewed and grey literature alike, the discussions focusing on the issue of Indigenous youth mental health, and in particular the phenomena of suicide crises, seems to be focused on the individual youth themselves and are devoid of social/political/historical context (Redvers et al., 2015). The dominant discourse dictates an “at-risk” mentality of understanding (or trying to understand) why young Indigenous people commit suicide at the rates they do in some communities (The Aboriginal Healing Foundation Research Series, 2007). However, this narrative often speaks of this group as homogenous; it assumes, for example, that every First Nation community, particularly on reserves across Canada, are equally susceptible and vulnerable to suicide crises due to the nature of them being in the circumstances they are. This, as we know, is not the case.

As critical race theory echoes, this is a function of tensions between predominantly White dominated sciences throughout the 1900’s and the power differentials placed upon Indigenous Peoples. Critical race theory attempts to explain “how social stressors linked to roles and social location converge to influence psychological vulnerability, which is variable among individuals because of appraisals and learned ways of coping and adaptation” (Brown, 2003, p. 294). This resonates today as forces of racism and discrimination in health care and social life is still prominent and damaging. This racial stratification “produces mental health problems to the extent it generates stressful circumstances and cognitive states conducive to emotional distress” (Brown, 2003, p. 295). This not only further stigmatizes communities and individuals as a whole, but also entrenches these ideas into real life practices of biomedicine, psychiatry, law enforcement, and education and other structural forces in our societies.

Studies looking into suicide are often done at the individual level and are questionnaire based, focusing on the negative aspects in one's life. By framing these youth as being "at-risk", it ignores any positive attributes or qualities youth possess, and once again homogenizes all Indigenous youth with behavioural and/or substance use issues as being in a risky situation. This viewpoint and assumptions that accompany this "persistent focus on the negative [are] arguably stigmatising for the [Indigenous] community and [have] generated little knowledge about the factors associated with good mental health among [Indigenous] people" (Williamson et al., 2016, p. 2). Also, by framing the situation of suicides among Indigenous youth in Canada in these terms, it effectively erases all social/political/economic/historical context from which these crises emerge. It ignores the root cases, and pathologizes the individual at hand. It puts responsibility on one's choices and lifestyle factors, without addressing the many structural root cases that fundamentally impact an individual's life. At the same time that life circumstances are addressed, such as experiencing trauma, domestic violence, low socioeconomic status, experiencing the death of a loved one, sexual abuse, living in overcrowded and unstable housing and other risk factors (Axleby-Blake et al., 2013.), treatment options and programs are individual focused and do not address the very problems they are acknowledging. Without incorporating Indigenous understandings of health and mental health, the solution to ending suicide crises among Indigenous youth in Canada is far-fetched.

Discussion

Because health does not exist in a vacuum, a simple call for 'culture' is not sufficient in addressing the mental health needs of Indigenous youth. Risk and Resilience dialogues have often been at odds with each other, vying for the *right* way to approach issues of Indigenous youth mental health, but risk-centred approaches are often highlighted in today's dominant discourse. By framing these youth within a risk-centric dialogue, it paints a picture

of these youth as a whole; youth who need saving because they are bound to head down the wrong path. On the other hand, resilience-centric dialogue recognizes the strengths of these youth and their communities and highlights their agency and self-determination to take up strategies to work towards improving the mental health outcomes for themselves.

It is important to note that “Indigenous models of health and healing place distinct emphasis on the larger social system within which the individual lives. Concepts such as balance, holism and interconnectedness are regarded as keys for healthy living among Indigenous communities around the world.” (Richmond & Ross, 2008, p. 1424). These “tight knit social structures are therefore mediated in important ways by the responsibility of [Indigenous] peoples to their immediate social and physical environments, those which contribute to the balance of good health.” (Richmond & Ross, 2008, p. 1424). This is a stark contrast from western, biomedical conceptualizations of health, which solely focus on physical outcomes in/of the body in most instances, let alone mental, cultural or environmental factors and how these can impact well-being.

As well, other injustices include “water quality and human occupation, health harms and air pollution, asymmetries of power and control, cost inequalities, and socio-demographic effects” (Morrice & Colagiuri, 2013, p. 76) which disproportionately affects Indigenous communities and populations. Instead of approaching a project using a “precautionary principle to avoid and avert harming individuals and communities” (Morrice & Colagiuri, 2013, p. 75), companies and government bodies aid in the advancement of development projects regardless. These projects - more so, their placement on Indigenous lands and reliance on Indigenous labour - are problematic, as they harm Indigenous health.

Factors affecting Indigenous Mental Health Outcomes

Approaches, crafting programs, treatments and interventions which are cognizant of the fact that “colonialism is...the source of historical oppression and the cause of the current

health status of [Indigenous] people" (Hill, 2009, p. 29), these programs and approaches incorporate more from the communities and individuals themselves.

> Links between the history of colonialism, government interventions and the mental health of [Indigenous populations]...[are clear, reflected in the] high rates of social problems, demoralization, depression, substance abuse, and suicide [that are] are prevalent in many [Indigenous] communities... [so] mental health challenges within [Indigenous P]eoples and their communities are rooted within the context of colonization, oppression, and discrimination, the culmination of which is intergenerational trauma" (Auger et al., 2019, p. 189).

The harms done in the past continue to spill into the present because of the lasting devastation they have imparted on parenting, problem resolution, ideologies of the world and the self, etc. Therefore, "in recognition of the need to promote mental wellness, Indigenous leaders and academics have highlighted the importance of holistic, strengths based, community-based wellness initiatives as approaches to promoting individual and community wellness" (Auger et al., 2019, p. 189), as opposed to furthering the colonial conquest by "imposing biomedicalism and its accompanying communities" (Hill, 2009, p. 29). Factors which work against these struggles include "strengthening cultural identity, community integration, and political empowerment, [which has the potential to contribute] to the improvement of mental health in [Indigenous youth]" (Hill, 2009, p. 29).

> Research shows that the majority of [FN youth on reserves] with mental health needs do not obtain formal treatment...due to the fact that mental health services delivered specifically for these communities are largely dependent on the resources and the actions of the respective federal government…[therefore facing] socio economic and geographical barriers…[because] funding for mental health services is extremely limited…[and because of the] significant cultural differences surrounding the therapeutic endeavour" (Moorehead et al., 2015, p. 384).

These reasons are just a few of the structural and systemic factors which result in increased negative mental health outcomes for Indigenous youth in Canada today. Therefore, it is suggested by many that mental health programming and interventions should be congruent with Indigenous cultures, which encapsulate a holistic approach that takes physical, emotional, mental, and spiritual well-being into consideration, all within the context

of history and contemporary events (Graham & Martin, 2016). Services that do become mobilized which incorporate both biomedical and traditional healing methods and methodologies in a clinical, health care setting are relatively new, and require a merging of worldviews in order to develop protocols for service delivery that ensure the integrity of both systems, as this modality has the greatest potential improve Indigenous youth mental health outcomes.

MHCC Strategic Decision #5: Indigenous Youth

In March 2013, the MHCC Youth Council (YC) conceptualized the possibility of rewriting or "translating," from a youth perspective, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. The main aim of this endeavour was to develop a complementary strategy that highlights "the experiences and vision of young people working toward system change, ultimately making the original Strategy a more accessible document to all." (MHCC, 2016, p. 2). Using a critical youth lens, they rewrote all six strategic decisions proposed in the original Strategy, with number five relating to Indigenous mental health. The YC aimed for this document to be more easily accessible to the individuals who they pertain to in the first place, and with this they aided in crafting the 2016 MHCC Youth Strategy.

Potential for Progression/Digression

This Strategy has many pros and cons. Yes, it does acknowledge the need for specific attention into Indigenous youth mental health issues. It does acknowledge social and structural factors that impinge on one's health. It does account for colonization and historical effects that continue to reverberate through generations today. But, by discussing these issues in a vacuum, or by refusing to see them as contemporary issues as opposed to historical one-off's, we are unable to see that the processes of discrimination, racism, marginalization, and colonization are very much alive and well today. This document has the potential to advance

the dialogue and discourse about how Indigenous youth mental health is discussed and approached, with the hopes of leading to improved mental health outcomes. However, as this is not a legally binding document or policy, it is difficult to enforce principles outlined and any relevant calls to action. By crafting this document into legislative practices and policies, there is a greater chance for resources to be mobilized and for communities to be uplifted in these situations.

Conclusion & Ways Forward

The decolonization project in regard to Indigenous mental health seeks to reimagine and rearticulate power, change, and knowledge through a multiplicity of epistemologies, ontologies, and axiologies. Establishing equitable and binding agreements between parties may be the only way to ensure a long-term, sustainable, mutually beneficial relationship. To achieve anything close to this, the mentality and framing of the problem has to shift: instead of positioning Indigenous youth as being in a constant state of risk, there lies the opportunity for strength-building and the reclaiming of understandings and approaches to mental health. In Canada, the viewpoints, worldviews, and epistemologies of Indigenous Peoples must be incorporated into their health care, as this only makes sense. Indigenous youth must stop being pathologized and singled out for partaking in activities that literally *all* youth partake in at some point in their adolescence, such as experimenting with drugs and sex. But, disproportionately, the circumstances in which these Indigenous youth are in are far different from their non-Indigenous counterparts, therefore instead of focusing on their individual risky behaviours, we can better address the social and structural harm that they are being subject to which impinge on their mental health, often leading to self-harming behaviours and suicide. Policymakers, practitioners, researchers, and law people alike must shift their understanding and dig deeper into the textual materials in which they are operating from, as language holds great power to shape lived experiences for Indigenous youth in Canada.

The 2016 *Mental Health Strategy for Canada: A Youth Perspective* document is a step in the right direction, but it is by no means the catch-all solution. In this document, a mere four pages are dedicated to Indigenous youth, although they have some of the highest rates of suicide, instances of mental illness and mental health concerns, and substance use issues across Canada, particularly on-reserves in Ontario. By engaging with this document through a Critical Discourse Analysis, utilizing Carol Bacchi's WPR (What's the Problem Represented to be?) Approach, it is clear that the Government of Canada, along with the MHCC are not walking with both feet on the path towards reconciliation. Because health does not exist in a vacuum, a simple call for 'culture' is not sufficient in addressing the mental health needs of Indigenous youth, who face disproportionate structural and systemic barriers in relation to their non-Indigenous counterparts. As highlighted throughout the literature, risk and resilience dialogues have often been at odds with each other, vying for the *right* way to approach issues of Indigenous youth mental health, but risk-centred approaches are often central. The shortcomings of this document, while being a positive strategy with good intentions, speak volumes as it has the potential to confine understandings and approaches to addressing Indigenous mental health and limit advancement by keeping the ideas we hold about them bounded and static.

In Canada, the viewpoints, worldviews, and epistemologies of Indigenous Peoples must be incorporated into health care, in particular in the form of culturally relevant and specific approaches and programming. Communities must be more involved in deciding what kinds of care they would like to see in their own lives; this is part of reconciliation. These programs would not serve as a blanket healthcare response for all Indigenous Peoples, as each individual identifies at a different level with their culture.

Policymakers, practitioners, researchers, and law makers alike must shift their understanding and dig deeper into the textual materials in which they are operating from, as

language holds great power to shape lived experiences for Indigenous youth in Canada. By taking a step away from an individualized, biomedical-based, analytical approach predominantly used in academic literature to speak about this topic, a decolonizing approach takes a holistic and deeper look at how the problem is constructed. Decolonizing approaches highlight the fact that these are contemporary issues with contemporary causes that mirror historical traumas and experiences. Processes of colonization are ongoing and are manifesting negative mental health outcomes in today's Indigenous youth. By showcasing examples of programs created with resilience in mind from communities and contrasting them with approaches such as the MHCC 2016 report and the responses by the Government of Canada, a decolonizing methodology (such as the Sweetgrass Method) would unpack why these latter strategies are not solving the root causes of the issue at hand.

Therefore, it can be argued that a pan-Indigenous mental health strategy would not be optimal because it does not account for context or community differences, but a step in the right direction would be moving away from representations and the framing present in the MHCC Youth Strategy, towards a more community-centric, community-focused, and community-led discussion and plan to address Indigenous mental health outcomes, including youth suicide, in Canada.

Acknowledgements

I would like to take a moment to sincerely thank Dr. Marina Morrow and Dr. Sean Hillier for their guidance, encouragement, patience, and wisdom throughout this MRP writing process. I have grown significantly as a writer, a student, and as a person through being involved with your work, both during this MRP and through your courses which I had the pleasure of taking. I will continue to incorporate your teachings into my work and life, as they have greatly impacted my views and understandings about numerous topics from social activism to politics to after-class pastimes.

I want to thank my parents, Lou and Vicky, and my siblings, Andrea and David, for always believing in me and supporting me in all my endeavours. You have given me the platform to be myself and pursue my passions, and for that I am forever grateful. You have raised me to be confident, stand up for what I believe in, and stay true to my goals and ambitions. I love you all!

To my fiancé, Eric - thank you for being there through all the days spent watching me work on the computer or furiously highlight articles. You have watched me go through all the stress-crying, and celebrations when I finally got my essays back, and always cheered me on before my multiple presentations. Thank you for always supporting me and pushing me to be the best version of myself I could be. I love you always!

References

Anderson, K. (2000). “Recognition of being: Reconstructing Native womanhood.” Toronto: Second Story Press.

Ansloos, J. (2018). “Rethinking Indigenous Suicide.” *International Journal of Indigenous Health.* 13(2): 8-28.

Auger, M., Crooks, C. V., Lapp, A., Tsuruda, S., Caron, C., Rogers, B. J., van der Woerd, K. (2019). “The essential role of cultural safety in developing culturally relevant prevention programming in First Nations communities: Lessons learned from a national evaluation of Mental Health First Aid First Nations”. *Evaluation and Program Planning*. 72: 188-196.

Axleby-Blake, T. et al. (2013). “A pilot investigation into Aboriginal people’s understandings of depression and anxiety.” *Advances in Mental Health.* 11(3): 293-301.

Bacchi, C. (2012). “Introducing 'What's the Problem Represented to be?'” In Bletas, S., Beasley, C. (Eds) Engaging with Carol Bacchi: Strategic Interventions and Exchanges Adelaide: University of Adelaide Press, pp.21-24.

Banister, C. E. M., Begoray, D. L., Nimmon, L. E., Mills, E. A. J., Durepos, G., & Wiebe, E. 2014, Encyclopedia of Case Study Research Cultural Sensitivity and Case Study, 269–71.

Beyond 94, CBC News. (2018). Retrieved from: https://newsinteractives.cbc.ca/longform-single/beyond-94?&cta=41

Bombay, A., Matheson, K., Anisman, H. (2011). “The impact of stressors on second generation Indian residential school survivors.” *Transcultural Psychiatry*. 48(4): 367-391.

Brown, T. N. (2003). “Critical race theory speaks to the sociology of mental health: Mental health problems produced by racial stratification.” *Journal of Health and Social Behaviour.* 44:292-301.

Cairns, A. (2003). “Coming to Terms with the Past.” In Politics and the Past: On Repairing Historical Injustices, ed. John Torpey. Lanham MD: Rowman & Littlefield.

Centre for Suicide Prevention. 2004. *Promising Strategies - Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies.* Retrieved from: https://www.cmho.org/documents/res-prom-stat-en.pdf

Chandler, M.J. & Lalonde, C. E. (2008). Cultural continuity as a moderator of suicide risk among Canada’s First Nations. In Kirmayer, L. & Valaskakis, G. (eds.). *Healing traditions: The mental health of Aboriginal Peoples in Canada (pp 221-248).* University of British Columbia Press.

Chandler, M. J. & Lalonde, C. E. (2008). Cultural Continuity as a Protective Factor against Suicide in First Nations Youth. Horizons --A Special Issue on Aboriginal Youth, Hope
or Heartbreak: Aboriginal Youth and Canada’s Future. 10(1), 68-72.

Coombe, R. J. (2001). “Economic Relationships in Transition.” *Political and Legal Anthropology Review.* 24(2): 107-117.

Corntassel, J., Bryce, C. (2012). “Practicing Sustainable Self-Determination: Indigenous Access to Cultural Restoration and Revitalization.” *The Brown Journal of World Affairs.* 18(11): 151-162.

Czyzewski, K. (2011). “Colonialism as a Broader Social Determinant of Health.”. 2(1): 1-14.

Daes, E. I. (2001). “Intellectual Property and Indigenous Peoples.” *Proceedings of the Annual Meeting (American Society of International Law.* 95: 143-150.

Dei, G., & Asgharzadeh, A. (2001). “The Power of Social Theory: The Anti-Colonial Discursive Framework.” *The Journal of Educational Thought (JET) / Revue De La Pensée Éducative,35*(3), 297-323.

Drahos, P., Frankel, S. (2012). “Indigenous Peoples’ Innovation and Intellectual Property: The Issues.” in *Indigenous Peoples Innovation, Intellectual Property Pathways to Development.*1-28.

Durie, M. H. (2003). “The Health of Indigenous Peoples: Depends on Genetics, Politics, and Socioeconomic Factors.” *British Medical Journal.* 326(7388): 510-511.

Elias, B., Mignone, J., Hall, M., Hong, S. P., Hart, L., Sareen, J. (2012). “Trauma and suicide behaviour histories among a Canadian indigenous population: An empirical exploration of the potential rise of Canada’s residential school system.” *Social Science & Medicine*. 74: 1560-1569.

Feather Carriers. (2020). Retrieved from: https://www.feathercarriers.com/.

Gordon, J., Matheson, K. (2018). "An holistic approach to promoting resilience and bimaadiziwin among First Nations youth in communities in Northwestern Ontario". *Northern Public Affairs*. 23-28.

Government of Canada, Health Canada. 2013. *National Aboriginal Youth Suicide Prevention Strategy (NAYSPS).* Retrieved from: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/promotion/_suicide/strat-prev-youth-jeunes-eng.pdf

Graham, H., Martin, S. (2016). "Narrative descriptions of miyo-mahchihoyan (physical, emotional, mental, and spiritual well-being) from a contemporary nehiyawak (Plains Cree) perspective". *International Journal of Mental Health Systems*. 18(58): 1-12.

Hackett, P., Liu, J., Noble, B. (2018). "Human health, development legacies, and cumulative effects: environmental assessments of hydroelectric projects in Nelson River Watershed, Canada." Impact Assessment and Project Appraisal. 36(5): 413-424.

Hall, R. (2017). "Diamonds are forever: A decolonizing, feminist approach to diamond mining in Yellowknife, Northwest Territories." (Doctoral Dissertation). York University, Toronto.

Hearn, S., Wanganeen, g., Sutton, K., Isaacs, A. (2016). "The Jekkora group: an Aboriginal model of early identification, and support of persons with psychological distress and suicidal ideation in rural communities." *Advances in Mental Health.* 14(2): 96-105.

Hill, D. M. (2009). "Traditional medicine and restoration of wellness strategies." *Journal of Aboriginal Health.* 26-42.

Hjelmeland, H. (2016). A critical look at the current suicide research. In: J. White, I. Marsh, M. Kral & J. Morris (Eds.), *Critical Suicidology: Re-Thinking Suicide Research and Prevention for the 21st Century*, pp. 31-55. UBC Press.

Ing, N. R. (1991). "The policy of separation and the disintegration of traditional Native families." *Canadian Journal of Native Education*. 8: 71-86.

Institute for Integrative Sciences and Health. 2004. *Two-Eyed Seeing.* http://www.integrativescience.ca/principles/twoeyedseeing/. Retrieved June 25th, 2020.

Jacono, J., Jacono, B. (2008). "The use of puppetry for health promotion and suicide prevention among Mi'Kmaq youth." *Journal of Holistic Nursing*. 26(1): 50-55.

Janelle, A., Laliberte, A., Ottawa, U. (2009). "Promoting traditions: An evaluation of a wilderness activity among First Nations of Canada." *Australian Psychiatry*. 17: S108-S111.

Kelm, M. (1998). "Colonizing bodies, Aboriginal health and healing in British Columbia 1900-50." Vancouver: University of British Columbia Press.

Kirmayer, L., Brass, G. M., Tait, C. L. (2000). "The mental health of Aboriginal Peoples:

Transformations of identity and community." *The Canadian Journal of Psychiatry*. 45(7): 607-616.

Kirmayer, L., Simpson, C., Cargo, M. (2003). "Healing traditions: culture, community and mental health promotion with Canadian Aboriginal Peoples." *Australian Psychiatry*. 11: S15-S23.

Kovach, M. (2009). Indigenous Methodologies: characteristics, Conversations, And Contexts. University of Toronto Press.

Kral, M. J., Idlout, l., Minore, J. B., Dyck, R. J., Kirmayer, L. J. (2014) "Unikkaartuit: Meanings and Experiences of Suicide Among Inuit in Nunavut, Canada". *International Journal of Indigenous Health*. 10(1): 55-67.

Kryzanowski, J. A., McIntyre, L. (2011). "A Holistic Model for the Selection of Environmental Assessment Indicators to Assess the Impact of Industrialization on Indigenous Health." *Canadian Journal of Public Health.* 102(2): 112-117.

LeFrancois, B. A. (2013). "The psychiatrization of our children, or, an autoethnographic narrative of perpetuating First Nations genocide through 'benevolent' institutions". *Decolonization: Indigeneity, Education & Society*. 2(1): 103-123.

Lemstra, M. E., Rogers, M. R., Thompson, A. T., Redgate, L., Garner, M., Tempier, R., & Moraros, J. S. (2011). "Prevalence and risk indicators of depressed mood in on-reserve first nations youth". *Canadian Journal of Public Health, 102*(4), 258-63.

Long, C., R., Curry, M. A. (1998). "Living in two worlds: Native American women and prenatal care." *Health Care for Women International.* 19: 205-215.

Lotz, J. (1977). "Northern Pipelines and Southern Assumptions." *Arctic.* 30(4): 199-204.

Lys, C. (2018). "Exploring coping strategies and mental health support systems among female youth in the Northwest Territories using body mapping." *International Journal of Circumpolar Health*. 77(1).

Macdonald, D. B., Hudson, G. (2012). "The Genocide Question and Indian Residential Schools in Canada." *Canadian Journal of Political Science / Revue Canadienne de Science Politique.* 45(2): 427–449.

MacNeil, M. (2008). "An epidemiologic Study of Aboriginal adolescent risk in Canada: The meaning of suicide." *Journal of Child and Adolescent Psychiatric Nursing*. 21(1): 3.12.

Manuel, A., Grand Chief Ronald Derrickson. (2017). The Reconciliation Swat Team. *The Reconciliation Manifesto: Recovering the Land, Rebuilding the Economy.* (200-203). Toronto, Ontario: James Lorimer and Company Ltd.

Marsh, I. (2015) Critiquing contemporary suicidology. In: White, J., Kral, M., Morris, J. and Marsh, I., eds. *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*. Vancouver: UBC Press. pp. 15-30.

McCreary, T., Mills, S., St-Amand, A. (2016). "Lands and Resources for Jobs: How Aboriginal Peoples Strategically Use Environmental Assessments to Advance Community Employment Aims." *Canadian Public Policy/Analyse de Politiques.* 42(2): 212-223.

McGillvray, A., Comaskey. B. (1999). "Black eyes all of the tme: Intimate violence, Aboriginal women and the justice system." Toronto: University of Toronto Press.

McKenzie, H, A., Varcoe, C., Browne, A. J., Day, L. (2016). "Disrupting the Continuities Among Residential Schools, the Sixties Scoop, and Child Welfare: An Analysis of Colonial and Neocolonial Discourses". *The International Indigenous Policy Journal*. 7(2): 1-24.

Miller, James R. 2004. Lethal Legacy: Current Native Controversies in Canada. Toronto: University of Toronto Press.

Moorehead, V. D., Gone, J. P., December, D. (2015). "A gathering of Native American healers: Exploring the interface of Indigenous tradition and professional practice". *American Journal of Community Psychology*. 56: 383-394).

Morrice, E., Colagiuri, R. (2013). "Coal mining, social justice and health: A universal conflict of power and priorities." *Health & Place.* 19: 74-79.

Morrow, M., Halinka Malcoe, L. (2017). Critical Inquiries for Social Justice in Mental Health. University of Toronto Press.

Nagel, T., Hinton, R., Griffin, C. (2012). "Yarning about Indigenous mental health: Translation of a recovery paradigm to practice." *Advances in Mental Health*. 10(3): 216-223.

Ohler, A. (2018, December 17). Access to Aboriginal doctors a struggle for Indigenous population. Retrieved from: https://globalnews.ca/news/4769750/access-aboriginal-doctors-struggle-indigenous-population/

Promising Strategies - Aboriginal Youth: A Manual of Promising Prevention Strategies. Centre for Suicide Prevention. 2004.

Richmond, C. A., Ross, N. A. (2008). "Social support, material circumstance and health behaviour: Influences on health in First Nation and Inuit communities of Canada." *Social Science & Medicine.* 67: 1423-1433.

Redvers, J., Bjerregaard, P., Eriksen, H., Fanian, S., Healey, G., Hiratsuka, V., Jong, M., Larsen, C. V., Linton, J., Pollock, N., Silviken, A., Stoor, P., & Chatwood, S. (2015). A scoping review of Indigenous suicide prevention in circumpolar regions. *International journal of circumpolar health*, *74*, 27509. https://doi.org/10.3402/ijch.v74.27509.

Salmon, E. (2000). "Kincentric ecology: Indigenous perceptions of the human-nature relationship." *Ecological Applications*. 10(5): 1327-1332.

Sium, A., Desai, C., Ritskes, E. (2012). "Towards the 'tangible unknown': Decolonization and the Indigenous future." *Decolonization: Indigeneity, Education & Society.* 1(1): 1-13.

Sveum, C. (2006). Review of Global Biopiracy: Patents, Plants, and Indigenous Knowledge by Mgbeoji, I. *Syracuse Science and Technology Law Reporter.* 1-17.

Thatcher, R. (2004). "Fighting firewater fictions, moving beyond the disease model of alcoholism in First Nations". Toronto: University of Toronto Press.

The Aboriginal Healing Foundation Research Series. (2007). *Suicide Among Aboriginal People in Canada.* Ottawa, ON: Aboriginal Healing Foundation. Retrieved from: http://www.ahf.ca/downloads/suicide.pdf

The Mental Health Strategy for Canada: A Youth Perspective. (2016). Mental Health Commission of Canada. Retrieved from: https://www.mentalhealthcommission.ca/sites/default/files/2016-07/Youth_Strategy_Eng_2016.pdf.

United Nations Declaration on the Rights of Indigenous Peoples. 2008. United Nations. Retrieved from: https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf.

Truth and Reconciliation Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Winnipeg: Truth and Reconciliation Commission of Canada.

Tuck, E., & Yang, K. W. (2012). "Decolonization is not a metaphor." *Decolonization: Indigeneity, Education & Society.* 1(1): 1-40.

Tuhiwai Smith, L. (2012). Decolonizing Methodologies: Research And Indigenous Peoples. New York, NY. Zed Books Ltd.

Waldram, J. B. (2004). Revenge Of The Windigo: The Construction of the Mind and Mental Health of North American Aboriginal Peoples. University of Toronto Press.

Wexler, L. and Gone, J.(2012).Culturally responsive suicide prevention in indigenous communities: Unexamined assumptions and new possibilities. In: White, J., Kral, M., Morris, J. and Marsh, I., eds. *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*. Vancouver: UBC Press. pp. 56-70.

White, J., Marsh, I., Kral, M. J., Morris, J. (2015). Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century. UBC Press.

Wilk, P., Maltby, A., Cooke, M. (2017). Residential schools and the effects on Indigenous health and well-being in Canada—a scoping review. *Public Health Review.* 38: 8.

Williamson, A., D'Este, A., Clapham, K., Redman, S., Manton, T., Eades, S., Schuster, L., Raphael, B. (2016). "What are the factors associated with good mental health among Aboriginal children in urban New South Wales, Australia? Phase 1 findings from the

Study of Environment on Aboriginal Resilience and Child Health (STARCH)". *BMJ Open.* 1-9.

Wise Practices. (2020). *For Promoting Life In First Nations Communities: Drawing on Community Strengths: What the Literature Says.* Retrieved from: https://wisepractices.ca/wp-content/uploads/2018/03/LR1-drawing-on-community-strengths.pdf.

Wolfe, P. (2006). "Settler colonialism and the elimination of the native." *Journal of Genocide Research.* 8(4): 387-409.

Young, C., Craig, J. C., Clapham, K., Banks, S., Williamson, A. (2018). "The prevalence and protective factors for resilience in adolescent Aboriginal Australians living in urban areas: a cross-sectional study." *Indigenous Health.* 1-7.