THRIVANCE DURING THE PANDEMIC: URBAN INDIGENOUS WOMEN AND MENTAL WELLNESS

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By

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Abstract

Prior to colonization, Indigenous people were healthy and thriving. As a result of colonization and its ongoing ramifications, Indigenous peoples' health has deteriorated over the last 600 years, spanning multiple generations. Despite the troubling statistics, Indigenous people are thriving. This project sought to highlight Indigenous women's stories of thrivance during the pandemic and through events of historical loss and asked the question, *how are Indigenous women coping and thriving with mental wellness during the COVID-19 pandemic?* Using a survey methodology and the Indigenist Stress Coping Model (ISCM), the following findings emerged: (a) Indigenous women thrive in the company of Indigenous women, (b) Indigenous women thriving involves healing and (re)connection, (c) Land has helped women cope and thrive during the pandemic, and (d) Availability of access to services, the healing relationship with a health care provider, and culturally appropriate care both facilitators and barriers to one's ability and desire to access mental health services.

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And finally, I would like to thank my mom and dad for their constant support, encouragement, and love throughout my graduate studies.

Dedication

Dedicated to my late grandmother, Jean Matilda Smith (née Bignell) (1929-1965) of Opaskwayak Cree Nation.

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Glossary

Access: The definition of *access* used for this project stems from Higgins et al.'s (2017) following definition of *access*: "… the ability of the patient to obtain information, guidance, and tools to secure consistent, high quality appropriate care. This includes patient functional literacy as well as institutional resources adapted to the patient's geographical location, cultural background, and socioeconomic level" (p. 34).

Culturally appropriate: The definition of *culturally appropriate* stems from this author's interpretation based on the literature provided. *Culturally appropriate*, means rooted in Indigenous frameworks, worldviews, and practices.

Engagement: The definition of *engagement* used for this project stems from Higgins et al.'s (2017) following definition of patient engagement: "… the desire and capability to actively choose to participate in care in a way uniquely appropriate to the individual in cooperation with a healthcare provider or institution for the purposes of maximizing outcomes or experiences of care" (p. 33).

Healing relationship: The healing relationship is an emotional bond of trust, caring, and respect; agreement on the goals of therapy; and collaboration on the "work" or tasks of the treatment (Bordin, 1959).

Historical Loss: Historical loss refers to "the extent to which Indigenous individuals think about the loss of their culture, land, and people stemming from European colonization," as well as how these thoughts affect them (Armenta et al., 2016, p. 2). Furthermore, "HL [Historical Loss] is rooted in a history of colonization but represents a contemporary experience, as it involves the ongoing thoughts of many Indigenous people within today's society" (Armenta et al., 2016, p. 2).

Indigenous: *Indigenous* is an umbrella term for First Nations (status and non-status), Métis and Inuit. "Indigenous" refers to all of these groups, either collectively or separately, and is the term used in international contexts, e.g., the 'United Nations Declaration on the Rights of Indigenous Peoples' (UNDRIP). (Office of Indigenous Initiatives, n.d.)

Land-based healing: In this paper, *land-based healing* draws on Johnson-Jennings et al.'s (2020) definition of "[re]connecting to the land and centring the land in order to conduct healing or health interventions" (p. 5).

Mental wellness: *Mental wellness* is described as, "From an Indigenous perspective, mental wellness is something that can be understood holistically. Factors like physical, spiritual, and emotional well-being, as well as connection to culture, and the land all play a role in mental wellness (First Nations Information Governance Centre, 2018, as cited in Native Women's Association of Canada, n.d.).

Strengths-based: For the term *strengths-based,* this paper draws on Hammond & Zimmerman's (2012) explanation, "Rather than the traditional perspective of engaging a person with a problem

orientation and risk focus, a strength-based approach seeks to understand and develop the strengths and capabilities that can transform the lives of people in positive ways" (p. 1).

Thrivance: It is defined and described as "moving towards supporting existing health and well-being as guided by OI [Original Instructions] and the community" (Walters et al., 2020, p. 4) and being "more than survival" (Medina, 2021, p. 91).

Traditional medicine: *Traditional medicine* is defined as, "… the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness" (World Health Organization, 2013).

Urban: The definition of *urban* is in accordance with the definition used by Statistics Canada (2011) who define urban areas as "having a population of at least 1,000 and a density of 400 or more people per square kilometre" (para. 2).

Wellbeing/Wellness: In this paper, *wellbeing/wellness* refers to "a lifestyle approach that adds element of spirit to the body and mind; an attitude a person has towards their health, while striving towards a balance of body, mind and spirit throughout one's entire life" (Indigenous Services Canada, 2018, p. 7).

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Chapter I: Introduction

Positionality Statement

Tansi. Jacqueline Smith nitisinikáson. Opâskwayâk iskonikan ohci nína. In adhering to Indigenous protocol, I would like to introduce and situate myself within this research before beginning. Hello. My name is Jacqueline Smith, and I am Swampy Cree from Opaskwayak Cree Nation. Like many Indigenous scholars, my life experiences as an Indigenous person have led to where I currently am in my post-secondary education and, more specifically, to my research question focusing on Indigenous women and mental health.

My decision to focus on Indigenous women and mental health came about after embarking on my own healing journey and reconciling with my Indigenous identity. It was not until my university years that I started to critically think about what it meant for me to be Indigenous. In learning about my own history (as it was not taught in public schools growing up or in the university classes I was taking), I came to understand the historic and current effects of ongoing colonialism. In this discovery, I was drawn to the health implications we have experienced and found myself particularly interested in our interactions with mental health services. As a result, when I reached grad school, I decided to focus my research on mental wellbeing and Indigenous women. Furthermore, living as a post-secondary student in an urban centre, I wanted to personally examine a context similar to my own; thus, the project became focused on Indigenous women from a post-secondary community living in urban centres.

Context

At the time of this project, the COVID-19 pandemic is entering its third year. Additionally, Canada's identity as a country of benevolence is being challenged as communities unearth and discover mass and unmarked graves from the days when Indigenous children were

forced to attend residential schools; as a result, the general public is beginning to recognize aspects of our violent, colonial past that we Indigenous people have always known. The past three years have been tumultuous for many, and health services are being pushed beyond capacity. More specifically, mental health issues have exacerbated during this time. Statistics Canada found that 94% of people who identified as having one of three mental disorders stated they were negatively impacted by the COVID-19 pandemic (Statistics Canada, 2021b). A decline in mental health in the overall population is also apparent as fewer Canadians claim "excellent or very good mental health," a 13% drop between 2019 and 2020 (Statistics Canada, 2020a). More specifically, 60% of Indigenous survey participants claimed poorer mental health since the beginning of the pandemic (Arriagada et al., 2020). Stress and anxiety were also heightened for Indigenous women (compared to Indigenous men) during this time with 46% of Indigenous women stating their days were "quite a bit stressful" or "extremely stressful," as well as 48% of Indigenous women reporting symptoms of anxiety (Arriagada et al., 2020). As evidenced, the pandemic either exacerbated or triggered negative emotions and reactions among Indigenous women.

Despite these statistics, Indigenous people in Canada are flourishing in a variety of educational and professional pursuits. In fall 2021, the University of Manitoba's Max Rady College of Medicine saw 17 Indigenous students begin medical school, the highest recorded number yet. Additionally, the number of Indigenous women with post-secondary qualifications has increased in recent decades and continues to do so (Arriagada, 2021). Amato (2020) also reports that Indigenous businesses are growing at five times the rate of non-Indigenous businesses, with Indigenous women starting businesses at twice the rate of non-Indigenous women. Hence, more and more Indigenous women are flourishing in our society.

Urban Indigenous populations numbers are rising as more people move to the city for location-specific opportunities, including attending post-secondary studies (National Association of Friendship Centres, 2021). Indigenous enrolment in post-secondary has steadily increased for years (Arriagada, 2021) and is currently approximately 10.65%[1] among some of the major universities in the Prairie and Western provinces (University of Saskatchewan, n.d.; University of Manitoba, 2022; University of Alberta Students' Union, 2021; University of Regina, 2022; University of Winnipeg, n.d.). However, this statistic should be taken with caution as being counted as an Indigenous student relies on the student self-identifying as Indigenous, with no community connection required (diverging from Indigenous protocols). This is problematic and can culminate in 'pretendians' taking spots, jobs, and funds meant for Indigenous people (at both the student and faculty level) (APTN News, 2022). Additionally, many Indigenous students may choose not to identify due to fear, shame, and stigma. At the same time, it is safe to assume that a growing number of Indigenous persons are occupying urban academic spaces during the pandemic, many of whom may need mental health services.

Project Summary

This exploratory research project focuses on Indigenous[2] women's engagement[3] with urban[4] mental health services in the context of a post-secondary institution located in the Prairie province of Saskatchewan of what is currently known as Canada. Current research shows, when compared to culturally based practices, mainstream mental health services are less effective for Indigenous populations in Canada (Dickerson et al., 2014; Hadjipavlou et. al., 2018; Radu, 2014;

[1] Based on author's research and calculations based on the following percentages: University of Saskatchewan, 14%; University of Manitoba, 8.45%, University of Alberta, 4.1%, University of Regina, 14.7%, and University of Winnipeg, 12%. See Bibliography for detailed list of sources.
[2] See Glossary for definition of 'Indigenous.'
[3] See Glossary for definition of 'engagement.'
[4] See Glossary for definition of 'urban.'

Schiff, 2006; Snowshoe and Starblanket, 2016). This exploratory project's research question is: *How have women coped and thrived with mental wellness during the COVID-19 pandemic?*

This project surveys Indigenous women to explore the relationship between ethnic identity, historical loss[5], and their engagement with mental health services in urban centres while also promoting the notion of thrivance[6] among Indigenous women. Through the theoretical framework of Walters and Simoni's (2002) Indigenist stress-coping model, this project examines experiences with mental health services (or mental wellness) in urban centres (during the pandemic) in Canada and identifies contributing factors that encourage or deter Indigenous women's use of these services, as well as their ability to thrive. This project's findings are:

1. Indigenous women thrive in the company of other Indigenous women.
2. Indigenous women thriving involves healing and (re)connection.
3. Land has helped women cope and thrive during the pandemic.
4. Availability of access to services, the healing relationship with a health care provider, and culturally appropriate care both facilitators and barriers to one's ability and desire to access mental health services.

Before continuing, it is important to explain the complicated and problematic use of the term "ethnic identity." Stevenson (1998) effectively argues that the term "ethnic" in Indigenous discourse is damaging to the term "Indigenous" for several reasons, including its oversimplification of Indigenous people as the same to other minorities, as well as how its usage upholds colonial power because it is a given categorization and not how we (Indigenous people) identify. While there are similarities between Indigenous people and other minorities, there are also exceptional considerations to be given when discussing Indigenous identity that are not

[5] See Glossary for definition of 'historical loss.'
[6] See Glossary for definition of 'thrivance.'

applicable to other groups, such as our nation status and our relationship to the land. The inclusion of these considerations is so crucial that to omit or ignore them would be devastating for Indigenous nation status and our rights as the original inhabitants of this land. Therefore, according to Stevenson (1998), the term "ethnic" in relation to Indigenous identity should be avoided. This issue is complicated in post-secondary studies as "ethnic identity" is the preferred nomenclature in western academia and it is no coincidence that this "preferred" term upholds colonial expectations, just as Stevenson (1998) pointed out. Therefore, where possible, because many psychological measures continue to use this term, this project will reject the terminology of "ethnic identity" and instead opt for the more culturally appropriate, "Indigenous identity" or "cultural identity."

Objectives

This exploratory research has two aims:

1. Determine how Indigenous women have thrived and experienced mental health services.
2. Determine perceived barriers and facilitators to desired levels of care.

Potential Significance

This project is a response to calls to actions, recommendations, and suggestions identified at a national level, such as through the Truth and Reconciliation Commission (TRC) and the Native Women's Association of Canada (NWAC). In 2007, the NWAC identified a number of recommendations with the goal of improving Indigenous women's health, while also noting the value of incorporating culturally based practices, referred to as *traditional ways of healing* or *traditional medicine.*[7] The focus of this project has the potential to generate a response to three of their recommendations:

[7] See Glossary for definition of 'traditional medicine'.

> 10. Research how traditional healing can be effectively combined with other health services to treat mental health and Indigenous patients;
>
> 11. Focus research enquiry on and identify how Aboriginal women may better access traditional healing;
>
> 12. Research and publicize programs that work, whether these are traditional healing alone or a combination of traditional healing and western medicine; (NWAC, 2007, p. 3)

This project also has the potential to address one of the TRC's Calls to Action (2015b):

> 19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services. (pp. 2-3)

Researchers have identified several concerns with mental health and Indigenous peoples within specific places. For instance, Hop Wo et al.'s (2019) research identified:

> … that there are unique mental health issues Indigenous people face when attending post-secondary education. Further research would need to be carried out to determine those specific challenges, which could range from disconnection from community, culture and family to factors related to the environment on campuses (p. 270).

Therefore, this study aims to further identify and discuss the specific mental health challenges[8] Indigenous women face in an urban post-secondary community using a survey, exploratory method, and analysis of 61 Indigenous women's responses.

Structure of Thesis

This thesis is structured through several chapters and utilizes a strengths-based[9] perspective and the concept of historical loss to contextualize non-biological influencers on Indigenous health. Chapter II will include contextualizing the findings within the present literature and expanding on the previously established facilitators and barriers to engaging with urban mental health services. Chapter III will provide methodological details for this project, including the reasoning behind the chosen methodology and theoretical framework, and Chapter IV will present the findings. Chapter V will provide discussion and analysis on the findings. Chapter VI will summarize findings and provide recommendations for future research. Based on current findings, I hypothesize that Indigenous women used culturally based practices during the pandemic to facilitate mental health. I further hypothesize that the pandemic led to an increase in mental health stressors, such as isolation, and to a decrease in access to culturally appropriate care.

Chapter II: Literature Review

Introduction

Adelson (2000) writes, "… health is political. By this I mean that health takes on a particular, and particularly charged, meaning when understood within its historical, cultural, and

[8] 'Mental health problems' refer to less severe problems that, on their own tend to cause less impairment in day-to-day functioning but can still greatly affect a person's quality of life." (Nelson, 2012, p. 3)
[9] See Glossary for definition of 'strengths-based.'

social context" (p. 9). The truth of this statement is evident in the denigration of Indigenous peoples' health since contact. Indigenous people were healthy and thriving prior to colonization. As colonizers moved West, Indigenous peoples' health became the target of the colonial system, displacing Indigenous peoples from their homelands and cutting off their food supplies (Daschuk, 2013; Kelm, 1998). Generations later, we are still recovering from this attack on our health and other violent colonial practices, including forced relocation, non-consensual bodily experimentation, exploitive research, environmental racism, and genocide, among others.

Settler colonialism has various definitions. For this project, I draw on Tuck & Yang's (2012) description of settler colonialism:

> Within settler colonialism, the most important concern is land/water/air/subterranean earth… 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. This violence is not temporally contained in the arrival of the settler but is reasserted each day of occupation (p. 5).

Residential schools are often cited as a main source of negative learned behaviour, as well as a cause of mental and physical health problems among Indigenous people, however it is not the only settler colonial institution that has contributed to these issues. Environmental racism, especially, has led to contaminated water sources in various communities and lack of access to health care and healthy lifestyle practices. Through systemic racism and ongoing settler colonialism, Indigenous communities in Canada, and elsewhere, continue to face compounding health inequities.

It is well-established that Indigenous health research without non-biological considerations lacks the context needed to accurately assess and present Indigenous health (Czyzewski, 2011; Greenwood & al., 2018; Kelm, 1999; Nelson, 2012). Relying solely on biology incorrectly presents Indigenous people as biologically unwell, deficient, or lacking. This reliance not only perpetuates the narrative that Indigenous bodies are inherently unhealthy but can also lead to the internalization of these ideas by Indigenous people. When this occurs in the identity-forming stages of life, it can cause a negative view of oneself (Anderson, 2016) or internalized oppression. Internalized oppression is described in the following: "Because oppression is institutionalized in society, target group members often believe the messages and internalize the oppression … when believe the stereotypes they are taught about themselves… tend to act them out … perpetuate … reinforces the prejudice" (Mussell, 2005, p. 16 as qtd in Graham, 2020). Therefore, these misrepresentations of health contributors go beyond the harmful effects of deficit discourse and can affect Indigenous people directly.

Indigenous health, for the most part, is being 'measured' through western expectations and definitions of what 'health' is. This measurement is problematic because it does not align with Indigenous conceptions of health and wellness which, briefly described, are relational and holistic. Western conceptions of health places the blame of health disparities on Indigenous peoples' biology and lifestyle choices, thereby, disregarding historical and contemporary contexts. Jennings et al., (2018) describe Indigenous perspectives of health in relation to western perspectives in the following way:

> The linear worldview is secular in nature, and rooted in Western European, and cause-and-effect logic. In comparison, a relational worldview reflects AI [American Indian] culture and recognizes events in relation to all others. In its relational worldview, AI

> health is a function of balance between multiple interrelating elements, including spiritual forces (pp. 355-356).

Hence, this project aims to reshape these narratives by focusing on one's context and non-biological considerations for mental health using a strengths-based approach.

Approximately 60% of Indigenous peoples in Canada live in urban areas (and is increasing).[10] The context of this exploratory study acknowledges that, compared to rural/on-reserve areas, urban[11] centers are areas with an increased number of and proximity to both general and specialized health services. In addition to health services, urban areas have increased access to socioeconomic opportunities such as housing availability and post-secondary studies, a partial explanation for the growing trend of Indigenous populations who reside in urban areas. Furthermore, the population of Indigenous women exceeds that of Indigenous men in urban areas (Place, 2012; Statistics Canada, 2017). Despite the seeming advantage of having proximity/accessibility, there remain barriers for urban Indigenous women accessing health services (Lavoie et al., 2015). The extant literature on mental health among Indigenous persons includes examining both on-reserve and off-reserve health services. However, the former far exceeds the latter (Nelson & Wilson, 2017) and is well-established as being inaccessible, limited, and primarily operating within a western framework with few considerations for Indigenous perspectives (Gracey & King, 2009; Lavoie et al., 2015; National Collaborating Centre for Indigenous Health, 2019; Nelson, 2012). Therefore, as the urban Indigenous female population continues to grow, it is necessary to explore and assess the utilization of mental health services to fill this gap.

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[10] Deriving from the 2016 Census, author's calculations are based on Indigenous Service Canada's *Annual Report to Parliament 2020* and percentages of 45% status, 76% non-Status, 50% Inuit, 70% Métis in urban areas.

[11] As researchers have done previously, it must be acknowledged that urban/rural is not synonymous with off-reserve/on-reserve, although they are frequently used interchangeably (Place, 2012).

This literature review identifies common facilitators and barriers to engaging with health services among Indigenous populations in North America, with a specific focus on Indigenous women in Canada. It further explores the connection between Indigenous women and urban mental health services (non-specific to on- or off-reserve), as well as how the concepts of cultural (ethnic) identity and historical loss play a role. The project expands on these findings as well as provides a critical analysis of existing and relevant literature; therefore, justifying the value and timely contribution of this project. Given that Indigenous conceptions of health are often framed in terms of being holistic, balanced, and interconnected (Grandbois, D., 2005; King et al., 2009; Saskamoose et al., 2017; Stewart, 2008; Struthers et al., 2004), the reviewed literature is a reflection of overall well-being and not solely mental health. Consequently, this research will examine mental health as interconnected with Indigenous health studies, which considers culture, environment, history, political systems, and social justice.

Health disparities

Research shows that Indigenous populations, compared to non-Indigenous populations throughout the world, face a significant gap in health status surrounding both physical and mental health needs (Anderson et al., 2016; Axelsson, et al., 2016; Gracey & King, 2009; King et al., 2009; Pulver et al., 2010; Stephens et al., 2016; United Nations, 2018). Furthermore, health services that are available are often bound within westernized notions of healing and inaccessible and largely inefficient at treating Indigenous populations (Anderson, et. al., 2006; Bodeker & Kariippanon, 2020; Gone, 2013; Lavalley et al., 2020; Montenegro & Stephens, 2006; Stephens, et. al., 2006; Struthers et. al., 2004; United Nations, 2013). On a physical level, Indigenous women have higher rates of diabetes, HIV, and poor heart health than non-Indigenous women (Diffey et al., 2019; Halseth, 2013). The gap continues as 73% of deaths among Indigenous

women between 1991 and 2006 were avoidable,[12] compared to 67% of non-Indigenous women's deaths (Park et al., 2015). These rates may be due to a lack of health care access and/or proper referrals. For instance, a study published in 2016 using data from the 2012 Aboriginal Peoples Survey (APS) showed approximately 16% of Indigenous women were unlikely to receive health care services when needed, compared to 13% of non-Indigenous women (Arrigada, 2016). Additionally, life expectancy is also 8.6 years shorter (78.7 years vs. 87.3 years) for Indigenous women than non-Indigenous women (Tjepkema et al., 2019).

While statistics on Indigenous women's mental health is limited, estimates can be extrapolated from much of the current research and data on general health. In Canada, women, in general, are found to be almost twice as likely to experience depression than men (Pearson et al., 2013). Drawing on the 2012 Aboriginal Peoples Survey and the 2012 Canadian Community Health Survey (CCHS), Arriagada (2016) found that 22% of Aboriginal women (off-reserve) compared to 12% of non-Aboriginal women reported lifetime thoughts of suicide, thereby demonstrating the continued health disparity. Contrasting these statistics, it is worth mentioning positive findings including that 58% of Indigenous women self-reported to be in "excellent or very good mental health" in 2012 (compared to 72% of non-Indigenous women) (Arriagada, 2016, p. 24). While the gap between Indigenous and non-Indigenous women is evident, the strength and resiliency of Indigenous women is also apparent, as this thesis shows.

Beyond colonialism and racism as social determinants of health

Social determinants of health (SDoH) refer to the socio-economic conditions that contribute to one's overall health. SDoH have, overwhelmingly, been identified as contributors

[12] "Avoided mortality refers to deaths that potentially could have been averted through effective prevention, public health policies, and/or provision of timely and adequate health care." (Canadian Institute for Health Information, 2012 as qtd in Park et al., 2015)

to overall health (Nelson & Wilson, 2017). In regard to Indigenous women in Canada, SDoH have been seen to influence Indigenous women's health in terms of increasing both physical and mental health concerns at a higher rate than non-Indigenous women (Halseth, 2013). SDoH challenge the mainstream perspective that an individual's health is determined solely by biology and lifestyle choices and indicate that health is significantly influenced by social factors beyond the individual's control (Adelson, 2000; Czyzewski, 2011; Greenwood et al., 2018; Kelm, 1999). This perspective allows room for concepts such as identity and historical loss to be factored into one's overall health. Researchers have identified ongoing colonialism and colonial structures as one of the major causes of the health gaps and have called for a more critical investigation, use, and acknowledgement of colonialism as a major health contributor (Czyzewski, 2011; Kelm, 1999; Lavallee & Poole, 2010; Nelson & Wilson, 2017).

Current health disparities experienced by Indigenous populations are also found to be intergenerational. According to Brave Heart (2003), "Forced assimilation and cumulative losses across generations, including language, culture, and spirituality, contributed to the breakdown of family kinship networks and social structures. This historical legacy and the current psychosocial conditions contribute to ongoing intergenerational trauma" (p. 8). Therefore, one does not need to directly experience a traumatic event to experience the negative effects of the event. While not the only contributor, residential schools are often cited as a main source of learned behaviour; Indigenous children were removed from positive parental figures and, as a result, were unable to learn how to be positive parental figures themselves. Indigenous children were also discouraged to use culturally based practices and subsequently were unable to cultivate a healthy Indigenous identity. Furthermore, after leaving the schools, many students did not have a positive way of coping with the trauma that they experienced at the schools and coped through self-destructive

means. The secrecy and shame of the residential school experience led to many Indigenous families recreating cycles of self-harm, abuse, and violence (Fontaine, 2010; Kirmayer et al., 2003; Methot, 2019; Sellars, 2012; Truth and Reconciliation Commission of Canada, 2015a). This is just one example of social determinants of health and the ways in which non-biological factors can influence a person's health. Without the context of the residential schools and other colonial and oppressive systems, the misunderstandings and misperceptions of Indigenous health status are likely to continue.

There is also a correlation between the wellbeing of an individual's social community and their individual health. The Community Well-Being Index (CWB) measures the social and economic status of a community including housing, income, education, and employment (Oliver et al., 2016). Findings show that in communities with a below average CWB score, both Indigenous men and women were at increased risk of hazard of death; however, Indigenous women's risks was 3% higher than Indigenous men (Oliver, et al., 2016). As mentioned, the physical entity of an individual is interrelated to their mental entity, and therefore, the physical wellbeing of Indigenous women must also be considered while investigating mental health. For this reason, it is worthwhile to explore physical health via geographical context, such as urban spaces, when examining Indigenous health.

Urban context and healing experiences

It is well established that on-reserve health services are significantly limited, with Indigenous populations often having to travel to "the city" when requiring medical attention, particularly for specialists. Urban areas are known to have "better" or improved access to health services, including mental health services, and, therefore, are assumed as efficient and are less subject to critique. Indigenous peoples living in urban areas and their mental health has been less

explored in the current literature. As mentioned, out of the country's Indigenous population, 60% live in urban areas.[13] As more and more Indigenous people move to urban areas, it is necessary to understand their needs, experiences, and socio-economic status.

Johnson-Jennings et al., (2020) define land-based healing as "[re]connecting to the land and centring the land in order to conduct healing or health interventions" (p. 5). As the urgency for land-based healing continues to grow, we must re-consider what we mean by "land." "Land" is usually seen as something separate from urban spaces, or "natural." However, as urban Indigenous populations increase, it is worthwhile to consider land as urban. Often there is a push to "go out on the land" or "away from the city," because there are less modern-day distractions and influences, such as cell phone service, highways, and noise pollution. However, if we only consider land as "away from the city," we are saying that land is not accessible to urban Indigenous populations. I would like to consider land as urban. More recently, scholars have begun to challenge the idea that "the land" can only be found outside of urban spaces. According to Lee (2020), "land is everywhere." Methot (2019) adds to this with "Developing a connection to the natural world is possible anywhere" (p. 235). Land-based healing in urban centres is a new area of research, as can be seen in Yellowknife, Northwest Territories where "the first urban land-based healing camp" (Redvers et al., 2021, p. 322) opened in 2018 with positive results when comparing participants' feelings before and after participation (Redvers et al., 2021). This urban land-based healing camp is presented as an alternative to when urban populations are lacking "access to full land-based wilderness sites." (Redvers et al., 2021, p. 334) Therefore, as urban Indigenous populations continue to grow, we must reconsider what it means to "go out on the land" if we want urban Indigenous populations to have access to land.

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[13] Deriving from the 2016 Census, author's calculations are based on Indigenous Service Canada's *Annual Report to Parliament 2020* and percentages of 45% status, 76% non-Status, 50% Inuit, 70% Métis in urban areas.

Indigenous identity and culture as treatment

To restate, the term "ethnic" is contentious in Indigenous Studies. Identity in general has roots in western psychology, such as Erikson's theories of Identity Development, which are rooted in Erikson's exploitation of the Yurok and Pueblo tribes with whom he spent time. Indigenous identity is separate from western concepts of identity and needs to be considered on its own, as the two are not mirrors of each other (nor are they completely different). Further, western psychology has taken several concepts from Indigenous groups (as seen in the Erikson reference). Therefore, although the nomenclature in the psychology field utilizes the term "ethnic identity," this project opts to use the term Indigenous identity as a form of resistance against western rhetoric and to maintain the uniqueness of Indigenous identity previously acknowledged by Stevenson (1998), who states that the term "ethnic" "disregards and undermines our legal and political uniqueness, our histories, our relationship to the land, and our goals" (p. 40).

Chandler & Lalonde (1998) argued that cultural continuity can serve as a protective factor against youth suicide epidemics in British Columbia. Kirmayer et al., (2003) expanded on cultural continuity and its variations stating that "all [forms] depend on a notion of culture as something that is potentially enduring or continuously linked through processes of historical transformation with an identifiable past or tradition." (p. S18). While cultural continuity is Chandler & Lalonde's (1998) preferred term, the concept of culturally based practices can also be used in contrast to mainstream services. Culturally based methods of treatment have generated a more positive response among Indigenous populations including promoting cultural continuity in their frameworks. Some examples include sweat lodges, drumming, Elder interaction, *eyininiw mistatimuwak* (Indigenous horse-based healing), and land-based healing (Dickerson et al., 2014; Hadjipavlou et. al., 2018; Johnson-Jennings et al., 2020; Radu, 2014; Schiff, 2006;

Snowshoe and Starblanket, 2016). The positive outcomes of these practices have led researchers to consider and argue for culture-as-treatment, especially in regard to mental health (Bodeker & Kariippanon, 2020; Gone, 2013; Gray & Cote, 2019; Kirmayer et. al, 2003). Similar frameworks have been identified as culture-as-resource, culture-as-cure, and culture-as-intervention (Cross, 2003; Connell, 2019; Fiedeldey-Van-Dijk et al., 2016). Therefore, it is reasonable to assume that culture continuity in the form of culturally based practices has a role to play in the discourse of Indigenous health services and treatment.

Culturally based practices have the ability to re-establish and nurture a relationship with one's Indigenous identity, an important contributor to one's mental health. Loss of identity is attributed to dehumanizing colonial practices, such as residential schools, the Sixties Scoop, banned cultural practices and language, as well as definitions of identity defined through the colonial *The Indian Act* (1876). Caring for one's Indigenous and cultural identity is "what healing is about" (Stewart, 2008, p. 52). Drawing on his father's work, Wilson (2008) describes Indigenous identity as being:

> … grounded in their relationships with the land, with their ancestors who have returned to the land and with future generations who will come into being on the land. Rather than viewing ourselves as being *in* relationship with other people or things, we *are* the relationships that we hold and are part of (p. 80).

Colonialism disrupted relationships to the land through forced removal, loss of territory, implementation of colonial boundaries, and environmental destruction. Therefore, to disrupt relationships to the land is to also disrupt relations to one's individual and collective identity as well as one's health and wellbeing. However, as this affects the collective, Avalos (2021) also

states that “historical trauma is a relational wound… healing historical trauma is also relational” (p. 16).

Duran (2006) creates an interesting parallel between a medical diagnosis and a naming ceremony stating, “The patient goes through a diagnostic process that she perceives as a naming ceremony that literally gives her an identity of pathology” (p. 31). Overmars (2010) continues, claiming that both “elicit a sense of identification with the name given to an individual” (p. 82). Dupuis-Rossi (2020) adds that medical diagnoses lead to “Indigenous clients and patients [being] left to carry a diagnostic “name” as the manifestation of their own personal deficit” (p. 111). Elliott (2019) uses her own experience to emphasize this:

> It’s easy to tell a person who has a physical illness that they are not their cold, or their diabetes, or their stroke. Their illness is something that happens to them, affects their life — sometimes in incredibly difficult ways — but it still isn’t *them*. It’s harder to make that distinction when you have a mental illness that completely changes the way you express your personality, the way you interact with others, the way you see the world. Where do you end and where does your sickness begin? (p. 93)

Therefore, mental health and identity can be deeply intertwined. Given the disruption of healthy identity development among Indigenous populations, it is reasonable to assume some individuals would base their identities on their illness. As Linklater (2012) notes, “many people did not have the opportunity to develop strong Indigenous identities and, as such, many of the identity forming customs became replaced by external beliefs and practices” (p. 113). Narratives have perpetuated the idea that Indigenous populations are destined to be ill. As seen in this literature review, it is true that Indigenous populations experience health issues at a greater amount than

non-Indigenous populations. However, there are also narratives of healing that need to be highlighted as well. Indigenous people are amid a resurgence. The data gathered from this project's survey shows that Indigenous women are taking steps to take control of their health and well-being, as well as improve their life satisfaction.

Relationality continues to inform Indigenous perspectives on Indigenous health. According to Linklater (2014), interconnection in Indigenous health "begins with a person's Spirit and encompasses everything that culminates in a person, such as their emotional, mental and physical parts of the self, and furthermore, how they are situated among their family, community, nation and all of Creation" (p. 75). Therefore, Indigenous healing is not only an individual experience (as often observed in mainstream health services) but a collective experience connected to the relations of past, present, and future (Johnson-Jennings et al., 2020). Therefore, improving health services for Indigenous people means making space for all relations, and thinking beyond the individual person, and beginning to include community and other connections the individual holds.

Researchers have called attention to the controversial idea of Indigenous identity as dependent on DNA (Gonzalez & Kertétz, 2020; Leroux, 2019; Tallbear, 2013). With the increase of DNA testing kits, there has been an influx of individuals claiming Indigenous identity. Many Indigenous people do not see these tests as a valid confirmation of Indigenous identity and state that such a perspective adheres to the western concept of identity as defined by the measurable ethnicities in one's blood (blood quantum). While opposed to Indigenous identity being determined solely on DNA, genes, and blood, there is an Indigenous perspective that takes these factors into consideration and places them in the context of intergenerational relationships and historical loss. As Elliott (2019) explains, "Until now, it never occurred to you that genes could

be toxic, planting illness like landmines in your child" (p. 37). Therefore, while it is imperative to be critical of the role DNA/genes/blood quantum plays in determining Indigenous identity, it is also necessary to consider the role of DNA/genes in the inheritance of intergenerational trauma and historical loss. As Redvers (2019) writes, “Genes are not your destiny, but they are your tendency” (p. 41), continuing, “and you therefore have the power to work with this tendency only as far as you have the knowledge and the awareness to proceed" (p. 41). Therefore, while there are genetic predispositions at play, there are also ways of challenging these seemingly inevitable realities. And the journeys of acquiring “the knowledge and the awareness to proceed” are evident in the answers of the participants in this project’s survey as they embark on their own healing and learning journeys.

Furthermore, as beneficial as they are, researchers’ critique that many culturally based practices that ameliorate symptoms of poor health do not address the more deeply rooted issues of “colonization and identity disruption” (Lavallee & Poole, 2009, p. 275). Western guided programs, in particular, need to be careful to avoid the superficial “tagging on a feather” (Walters et al., 2020, para. 3) approach and instead aim towards culturally aware practices that are implemented in a meaningful way. Therefore, while it is important to acknowledge the value, effectiveness, and the inclusion of culture and identity as foundational elements in Indigenous healing, it is also important to remain critical and aware of their limitations.

Combining western and Indigenous conceptions of health

Western and Indigenous conceptions of health are often portrayed as a dichotomy, separate and opposite (Grandbois, 2015; Nelson & Wilson, 2017; Redvers, 2019). However, the reality is that there are benefits to both sides, and the two can be united in a way that has been proven to be beneficial; some centres in Canada have integrated Indigenous ways of healing into

their treatment plans with positive results (Allen et al., 2020; Beaulieu & Reeves, 2022; Redvers et al., 2019). In fact, Indigenous peoples have been known to blend approaches since the introduction of western medicine (Kelm, 1998). It was only after the process of assimilation was underway that the eradication of Indigenous healing practices began to take place. It should also be mentioned that, historically, western medicine is extractive and appropriates from Indigenous culture. Many forms of western medicine have origins in Indigenous healing (Trotti, 2001). Yet, as mentioned, Indigenous health frameworks have always taken what may be useful from both western and Indigenous medicine and blended the two. Both approaches continue to be utilized by Indigenous peoples and hold utility for individuals today.

Indigenous women healing and thriving

Indigenous women's trauma and healing journeys have been well-documented recently in memoirs such as Elliott's (2019) *A Mind Spread Out on the* Ground, Knott's (2019) *In My Own Moccasins*, and Mailhot's (2018) *Heart Berries*. These memoirs (among other literature) challenge the deficit discourses and, instead, are a representation of the strength and resilience of Indigenous women (Anderson, 2016; Brown, 2016; Fuller-Thomson et al., 2020; de Finney, 2017). Prior to colonization, Indigenous women were the leaders of their homes and "Indigenous cultures often framed womanhood as a sacred identity…" (Anderson, 2016, p. 33) as they held important roles as life producers, culture keepers, mothers, and grandmothers, and had strong ties to the land.

Before colonization and the introduction of patriarchal societies, women were leaders (in their own right). Menstruation was viewed as a representation of female power as was the birthing process, or women as life producers (Moloney, 2008; Murphy, 2011; Risling Baldy, 2017). Indigenous women held power in pre-colonial society. Furthermore, Indigenous women

were important and valued because of their ties to the land. Since colonization, Indigenous women have been oppressed and objectified through a colonial lens. According to 2018 data from Statistics Canada, approximately six in ten Indigenous women reported experiences of (intimate partner) violence (Heidinger, 2021). Further, Indigenous women are 12 times more likely to go missing than non-Indigenous women (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Since colonization, Indigenous women have experienced historical loss in ways unique to their experience as women. The loss of their power, status, and respect continues today as we can see both in and outside Indigenous communities. As of 2019, less than 20% of First Nations chiefs and 30% of First Nations counsellors in Canada were women (Statistics Canada, 2021a). In 2021, RoseAnne Archibald was the first woman elected as the Assembly of First Nations' national chief since its establishment in 1982 (Deer, 2021). These statistics are indicators of a potential resurgence of Indigenous female leadership on the horizon.

During the COVID-19 pandemic, Indigenous populations experienced an increase in mental health risks and barriers to treatment. Burnett et al., (2022) reported that 40% of Indigenous populations experienced depression, and 45% experienced anxiety during the pandemic. Furthermore, many Indigenous persons experienced lack of access to mental health services, more so during the pandemic (Hahmann & Kumar, 2022). Urban Indigenous women and their needs, particularly during a pandemic, need to be better understood in order to increase services.

Indigenous women's strength is evidenced by their survival, in spite of attempts at their decimation at the hands of colonial powers and structures, such as forced sterilization, patriarchy, and *The Indian Act*. *The Indian Act* not only discriminated against Indigenous women through its patriarchal control of Indian status rights, but physically separated them from their communities,

families, and culture (all of which are known contributors to one's health) when they married outside of their reserve (or to a non-Indigenous male). This separation furthered the likelihood of historical loss and identity disruption (and its effects) for future generations (Richmond & Cook, 2016). While it is important to acknowledge the experiences and legacies of historical loss, intergenerational trauma, and collective trauma, it is equally important to acknowledge the narratives of strength, love, and resilience in Indigenous women (Johnson-Jennings et al., 2020). Strengths-based narratives could challenge the overwhelmingly dominant narrative of deficit that fates Indigenous people to be unwell (de Leeuw et al., 2010). These narratives are not only found in society's view of Indigenous people but can be internalized as well, especially in situations where identity has not had the opportunity to flourish and grow in a healthy way. As Linklater (2014) notes, "Many of the concerns related to diagnoses and identity have arisen with clients who perhaps did not have a strong identity to begin with" (p. 113). Therefore, this project is contextualized within the themes of Indigenous identity and historical loss, as well as culturally based practices, to challenge the deficit discourse and utilize a strengths-based approach.

Conclusion

As the literature shows, colonialism is pervasive in the health care system and serves as a huge barrier to quality health care for Indigenous populations, even with increased geographic proximity to care. With the ongoing increase of female Indigenous population in urban areas, as well as narratives of cultural continuity and healing from colonization, there exists a critical need for urban mental health services and access in order to address ongoing disparities. In doing so, it is also of the utmost importance to push back on the deficit discourse that has dominated Indigenous research and move towards strengths-based narratives. Consideration of the unique,

underexamined experience of being Indigenous and female in an urban setting will be examined in this study. This project and its survey on Indigenous identity, historical loss, and Indigenous thrivance is a response to high needs, Indigenous healing, and literature gaps. Furthermore, this project's use of measurements including cultural (ethnic) identity, satisfaction with life, and historical loss (and associated symptoms) further contextualize the hypothesis that culturally based practices result in positive outcomes for Indigenous people.

Indigenous cultures vary widely, but most, if not all, share the experience of historical loss. Not only on a national level, but a global scale. Indigenous people have had their languages, culture, and their ancestors taken from them. These losses continued via the residential school system and currently continue through the child welfare system (McKenzie et al., 2016). This project sought to determine the frequency of historical loss in its sample population, as well as its associated symptoms. Additionally, it was interested in exploring how its sample population experienced historical loss using an established measurement. Moreover, this project examined how culture-as-treatment and culturally appropriate services were utilized in the mainstream culture during the pandemic. In particular, the research question, "*how have women coped and thrived with mental wellness during the COVID-19 pandemic*," was asked.

Chapter III: Methods

Indigenous Advisory Council

Prior to the start of this research, an advisory council was developed using a culturally appropriate offering and invitation. Upon acceptance, the advisory council was comprised of one Elder, one community member, and one mental health services user, all identifying as Indigenous urban-residing women. They were chosen because of their knowledge and experience

in community. The advisory council was consulted throughout the research development, design and during dissemination of findings. They provided feedback and guidance per the development of the protocol, survey questions, and analysis.

Theoretical Framework

This project utilized Walters and Simoni's (2002) Indigenist stress-coping model (ISCM) to guide the research design, as well as to analyze and interpret the data gathered from the survey. The ISCM is designed specifically for research with Indigenous women and connects the broad themes of stress, coping, and health outcomes. For this project's research, the ISCM framework connects past with present and allows for non-biological influencers, such as historical loss, to be considered and explored as important variables when discussing health. While non-biological influences on health are well-established in Indigenous health, these contributors extend beyond the often-recognized social determinants of health and can include community wellness (Oliver et al., 2016), health of the environment (Cajete, 2000), and "intergenerational solidarity" (Elder interaction) (Viscogliosi et al., 2022) as health contributors.

Furthermore, the ISCM has the potential to reshape dominant narratives of Indigenous health through its acknowledgement of the unique experience of Indigenous women and the connection to their health in a colonial system. The ISCM is an appropriate tool for this project as it accounts for colonialism, mental health, and cultural buffers (such as culturally based practices) including identity and peer support. It has been used effectively to examine mental health among Indigenous women in North America (Johnson-Jennings et al., 2020; Walters et al., 2011). Hence, this exploratory project was built around ISCM and narratives as an effective approach to answering the proposed research question.

Methodological Approaches

This project utilized a mixed methods approach to its data collection. Given the context of COVID-19, both qualitative and quantitative data were obtained using Survey Monkey via an online survey. This project identified willing participants who met the following criteria: (a) self-identified as Indigenous, (b) were ages 21 years and above, (c) lived in an urban centre and either went to school or worked at an academic institution, and (d) sought mental health services in an urban centre in the last two years. Initially this project had intended to conduct one-on-one interviews, but the 2020 COVID-19 pandemic made this too risky of an option for participants. Ultimately, I incorporated an online survey approach, because it was safer and more accessible for all those involved. The justification for participants to be a minimum of 21 years relates to Erikson's (1968) Stages of Psychosocial Development, the fifth stage in particular, identity vs. confusion. While Erikson's stages do not refer to specific age ranges, identity development is commonly cited as occurring in one's adolescence and early adulthood and, therefore, can be seen as solidifying into one's twenties (Arnett, 2000; Jankowski, 2013; Waterman, 1988). Consequently, a minimum age of 21 is an acceptable choice as it relates to identity. Furthermore, mental health access varied during the pandemic. For example, many Indigenous populations had difficulty accessing ceremonies and mental health services because of the pandemic restrictions for interprovincial travel and or gathering. At the same time, mental health services were made more available at some institutions, such as academic sites, because they used telehealth. To control for ability to access both Indigenous and western services via telehealth, this convenience sample was limited to Indigenous women who worked or studied at an urban post-secondary institution, which continued to offer both virtual Indigenous Talking Circles and groups and mental health services via telehealth to staff, faculty and students.

After ethics approval was acquired, recruitment procedures included sharing the survey via Survey Monkey through the post-secondary institution's web portal, a service available to students, faculty, staff, alumni, and the post-secondary community only. Therefore, the participant pool is comprised almost entirely, if not completely, from the post-secondary community. As with all online surveys, there is a slight possibility, and limitation, that the link to the survey was provided to somebody outside of the targeted pool, who may have taken this survey. The online announcement included a recruitment poster and a positionality statement as two attached digital documents. Based on prior online surveys in higher education settings, a presumed response rate was expected of 78% (Saleh & Bista, 2017). With more than 3482 self-identifying Indigenous students alone, not counting faculty or staff, at the post-secondary institution, we aimed to reach at least 89 Indigenous women with anticipated attrition to be higher than usual due to COVID-19. After recruitment and consenting participants, this exploratory study had a final count of 61 responses. An initial 85 participants progressed to the first question. 61 participants consented to the study and completed it.

Data Analysis

This exploratory project utilized bivariate descriptive analysis including two-tailed t-tests (Kanji, 2006). Furthermore, the open-ended questions in Part III of the survey were analyzed using a descriptive coding process, or, more specifically, the constant comparison coding method, in which the process flowed from raw data, to preliminary codes, to final code (Saldaña, 2015). Descriptive coding allowed for me to identify and categorize common themes from the participants' responses. Additionally, I continuously refined the identified themes as the project progressed. In conjunction with the Indigenist stress-coping model (Walters & Simoni, 2002),

this approach to the project's data analysis created space for findings on Indigenous women's health and the barriers and facilitators they experience in Canada's health system.

Survey Structure

The survey consisted of three sections that provided data later analyzed to understand their relationship using Walters and Simoni's (2002) Indigenist stress-coping model. Part I of the survey (See Appendix B) established measures of cultural identity and historical loss through systems of measure, including Phinney's (1992) Multigroup Ethnic Identity Measure (MEIM), Diener et al.'s (1985) Satisfaction with Life Scale (SWLS), and Whitbeck et al.'s (2004) Historical Loss Scale (HLS) and Historical Loss Associated Symptoms Scale. The Historical Loss Scale (HLS) developed by Whitbeck et al., (2004) is described as "a standardized measure that assesses the frequency with which Indigenous individuals think about the losses to their culture, land, and people as a result of European colonization" (Armenta et al., 2016, para. 4). Additionally, Whitbeck et al., (2004) developed a Historical Losses Associated Symptoms Scale, which measures the frequency of emotional responses to these losses. Using these two measurements allowed this project to generate themes and connections between the losses resulting from colonialism and its emotional effects in current populations today. Phinney's original 20 question survey was decreased to 12 questions, as had been done in previous studies (Roberts et al., 1999). The reasoning for this change was that the omitted questions focused on attitudes and orientation to other groups, a topic outside of this study's focus. Using a measure labeled "ethnic identity" was a limitation due to the valid measures utilized among Indigenous people. However, prior research does indicate strong correlation and overlap with cultural identity (Coleman et al., 2003).

Part II of the survey (See Appendix C) used closed-ended questions in the form of checkboxes. Common barriers and facilitators, as determined from the literature review in relevant studies, were presented (Grandbois, 2005; Hadjipavlou et al., 2018; Isaacs et al., 2010; Lavalley et al., 2020; Stewart, 2008; Stout, 2010; Vukic, 2009). Participants were asked to select five barriers that have the biggest influence on their ability and decision to not access mental health services. Conversely, participants were also asked to select five facilitators that have the biggest influence on their decision to access mental health services. The intention of the checkbox selection was to provide participants with the opportunity to identify specific individual facilitators and barriers to mental health care for urban Indigenous women. General structural factors such as racism, discrimination, and stigma are already known barriers for Indigenous people trying to access not only mental health services but all health services (Ahmed et al., 2007). Therefore, this project, instead, sought to focus on individual level barriers within the checkbox questions and gave specific individual options of possible barriers and facilitators.

Part III of the survey (See Appendix D) used open-ended questions. It was important to include open-ended questions, as this provided participants with the opportunity to answer some of the survey's questions in their own words and submit answers outside of those seen in the literature. It would further allow for capturing multilevel factors that influence the individual accessing care. While in-person interview methods were initially preferred, given COVID-19 restrictions, the women's answers to the open-ended questions proved to provide fruitful and reflective perspectives as well. Questions were, in part, developed by the myself and also derived and adjusted for context from other theses and dissertations on Indigenous health and wellness (Allan, 2013; Brown, 2019; Connell, 2019; Hackett, 2018; Monchalin, 2019; Ruru, 2016).

Chapter IV: Findings

This project's findings included data from the participants' surveys on cultural (ethnic) identity, satisfaction with life, and historical loss (and associated symptoms). This section presents these findings, as well as introduces the outcomes of the project's closed and open-ended questions. From the closed and open-ended questions, themes of *relationships*, *time*, and *knowledge and (re)connection* emerged. Facilitators, such as consistent care from the same health care provider(s), and barriers, such as bureaucracy, were also recognized through thematic analysis (or descriptive coding).

Participants

This study aimed for 89 survey responses and had a final count of 61 participants during COVID-19 lockdowns and restrictions, which likely hampered results. Eighty-seven potential participants initiated the eligibility question. Four potential participants were excluded as they did not identify as being Indigenous. Four potential participants were excluded based on age (younger than 21 years). Thirteen potential participants were excluded if they had not used mental health services in the last two years. Twelve potential participants were excluded because they did not live in an urban centre. As one disqualifier did not immediately remove the potential participant from the survey, it is possible multiple disqualifiers could be applied to the same potential participant. Therefore, the amount disqualified from the survey ranges between 13 and 37. In any case, 61 participants identified as women and progressed to consent and answering the questions. The final required question of the survey had 51 responses. Therefore, approximately 10 participants began the survey but did not complete the final question. As these 10 participants stopped responding at the various parts of the survey, the following findings are based on a decreasing number of responses that starts with 61 responses, then decreases to 51 for three questions, meaning that their data was averaged.

Cultural (Ethnic) Identity

The study sample included Indigenous women who highly identified as Indigenous (80%). The sample was further divided by satisfaction with life, where a slight majority identified as low (50.8%) and just below half identified high (49.2%). Furthermore, over half of participants (59%) identified with low historical loss. The mean of cultural identity for the 61 participants on the MEIM was 3.32 (on a scale of 1-4), indicating a majority of participants with high cultural (ethnic) identity. The number of respondents who scored high was 49 and the amount who scored low was 12. Cultural identity (MEIM) is positively correlated with barriers to culturally appropriate care ($p = .022$) and also positively related to facilitators of culturally appropriate care ($p = .012$). Using two-tailed independent t-tests, there were group differences between those high and low MEIM whereby those who had high cultural identity were more likely to see barriers to culturally appropriate care ($p = .005$) and also more likely to identify culturally appropriate care as a facilitator ($p = .014$). The Cronbach's alpha values for the MEIM was excellent ($\alpha = 0.9$). For statistics, the distribution of the MEIM values was positively skewed. See Figure 1.

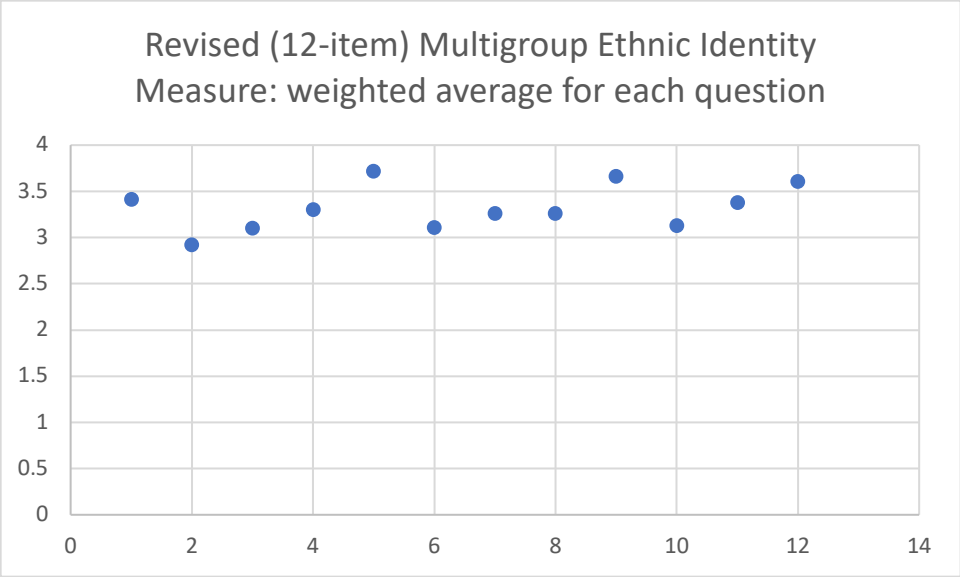

Figure 1. MEIM results positively skewed
Note: Weighted average for each question

Satisfaction with Life Scale

Participants answered the Satisfaction with Life Scale measurement by answering statements and submitting a response on a Likert scale from 1-7 (1= strongly disagree and 7= strongly agree). The mean for the Satisfaction with Life Scale was 4.43 with a nearly equal division of participants scoring high (49.2%) and low (50.8%). The possible cumulative score ranged from 5 to 35 with participants averaging 22.2, indicating that they were *slightly satisfied*. The Cronbach's alpha values for the Life Satisfaction Scale was good ($0.9 > \alpha \geq 0.8$). Life satisfaction is negatively correlated with both barriers to the healing relationship and facilitators to the healing relationship.

As seen in Figure 2, nearly one-third of participants selected *slightly agree* with the first four items: "In most ways my life is close to my ideal," "The conditions of my life are excellent," "I am satisfied with my life," and "So far I have gotten the important things I want in life." Nearly one-third of participants selected *slightly disagree* for the final phrase "If I could live my life over, I would change almost nothing."

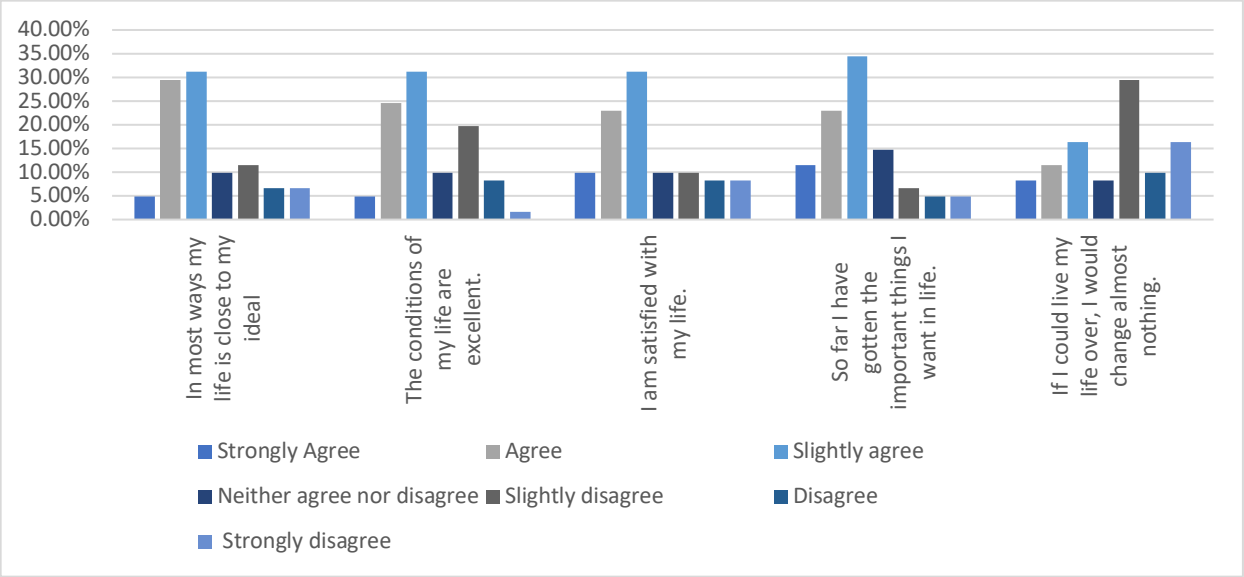

Figure 2. Percentages of self-reported life satisfaction

Historical Loss and Associated Symptoms Scale

The mean for Historical Loss was 2.69. Of the 59 remaining participants (two less than the 61 in the previous measure), 24 scored high and 35 scored low. The Cronbach's alpha values for the Historical Loss Scale was excellent ($\alpha \geq 0.9$). Historical Loss correlated positively with being more likely to seek mental health as based on the healing relationship ($p = .013$); such that those who expressed more historical loss were more likely to see the healing relationship as important to receiving care. This can be seen within the open-ended answer given as follows:

> I think a comment I would also like to make is regarding the impact of national and global crises or events on the mental health of Indigenous women (really, people in general). After the verdict of Colten Boushie, I could not bring myself to leave the house or even step foot on-campus. I wailed in grief for Colten and his family when I read Gerald Stanley was "not guilty." Additionally, the continued searches and discoveries of the unmarked graves of children at old residential school sites has had

> me crying several times and constantly praying with our people all over Turtle Island.

This quote represents how participants found it harder to cope during the pandemic with ongoing trauma. Meanwhile, those who had higher historical loss also had significantly negative association with culturally appropriate care ($p = .003$). In other words, those who reported greater historical loss were less likely to endorse cultural appropriate care as a facilitator. This may be because when the loss was great, they did not have access to as much culturally specific health frameworks.

At the same time, historical loss affected many in the study. As visible in Figure 3, out of 59 participants, nearly 40% stated they thought about "The losses from the effects of alcoholism on our people" *several times a day*. One-third, or approximately 33%, said they thought of "The loss of our family ties because of residential school" and "The loss of respect by our children for traditional ways" on a *daily* basis. Further, 40% of participants said they thought about "The loss of our language" on a *weekly* basis. Less than 10% claimed to *never* have thoughts about any of the historical losses presented.

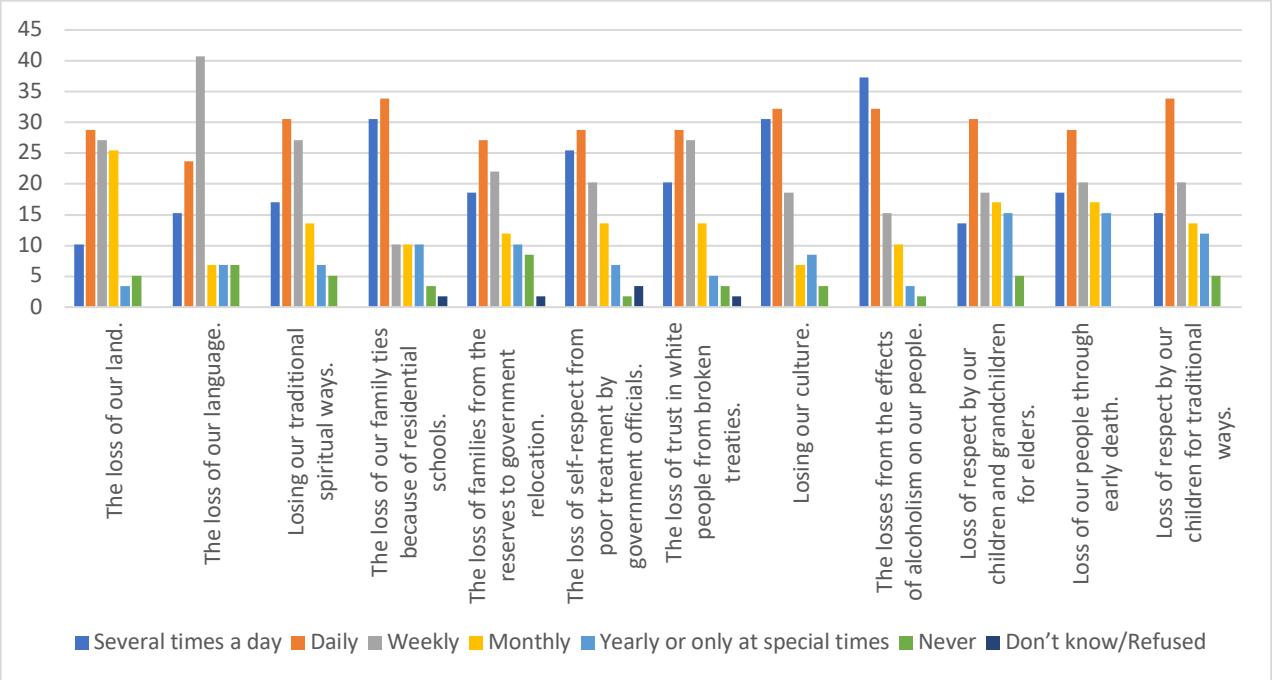

Figure 3. Percentages of self-reported historical loss

As visible in Figure 4, over half of the 58 participants stated they *often* felt "sadness or depression" when thinking about these losses. Another half of participants said they *often* felt "anger" and "a loss of concentration" when thinking about these losses. Furthermore, 38% stated they *sometimes* felt "fearful or distrusted the intent of white people." About 25% stated they *always* felt "anxiety or nervousness." Another 25% of participants claimed to *never* feel "rage" when thinking about these losses. As well, nearly 25% of participants claimed to *never* "feel like avoiding places or people that remind you of these losses."

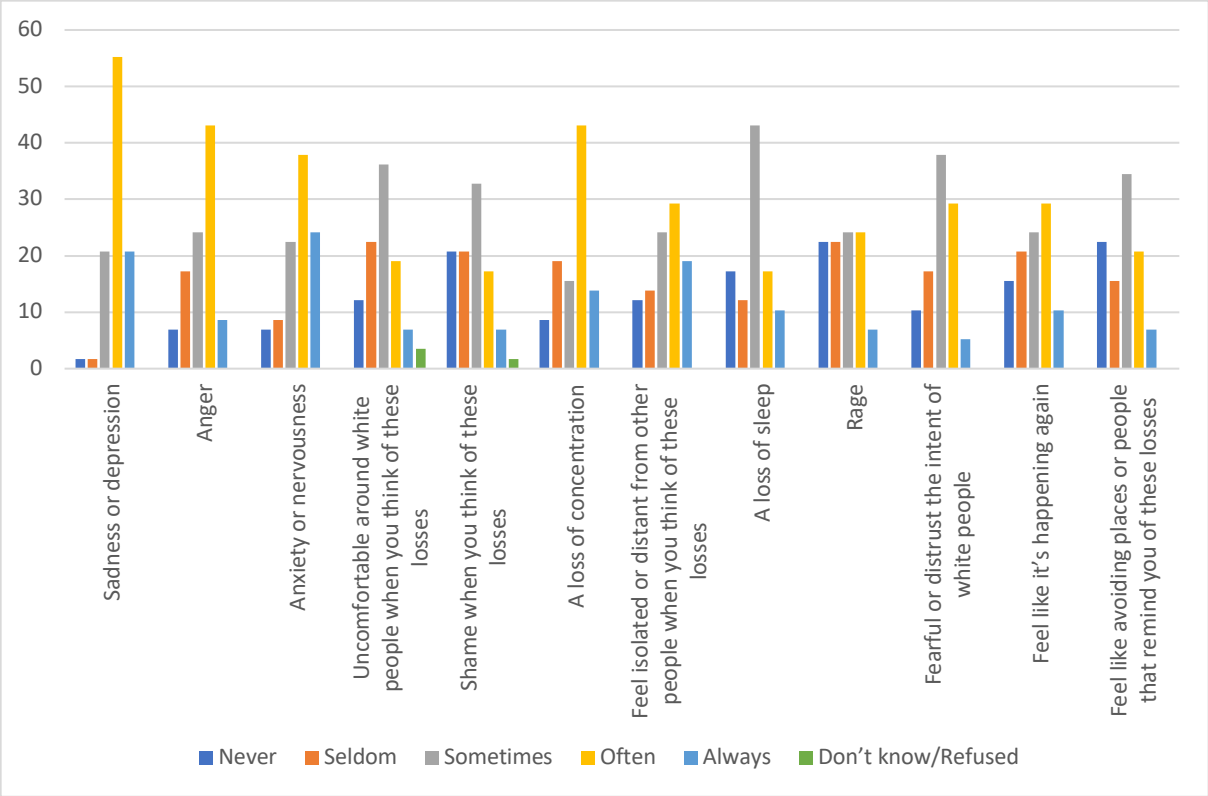

Figure 4. Percentages of self-reported associated symptoms with historical loss

Facilitators and Barriers

The closed-ended questions can be divided into the following three themes, barriers and facilitators to: access, the healing relationship,[14] and culturally appropriate care. As seen in Figure 5, the three most identified barriers were: (a) Lack of trust in the health care system or previous negative experiences with the health care system (82% of participants); (b) Bureaucracy such as forms, waitlists, referrals, or having to meet certain criteria to be considered for services (72% of participants); and (c) Lack of knowledge in historic or contemporary Indigenous issues; feelings of having to educate others on Indigenous issues (61% of participants). In addition to trust, bureaucracy, and knowledge on Indigenous issues, participants had the opportunity to identify any other barriers not listed. One participant stated, "The physical institutional building

[14] See Glossary for definition of 'healing relationship'.

that I just don't like being in." Other highly rated barriers included lack of culturally appropriate treatment and services, as well as lack of validation about illness or lack of input in treatment decisions.

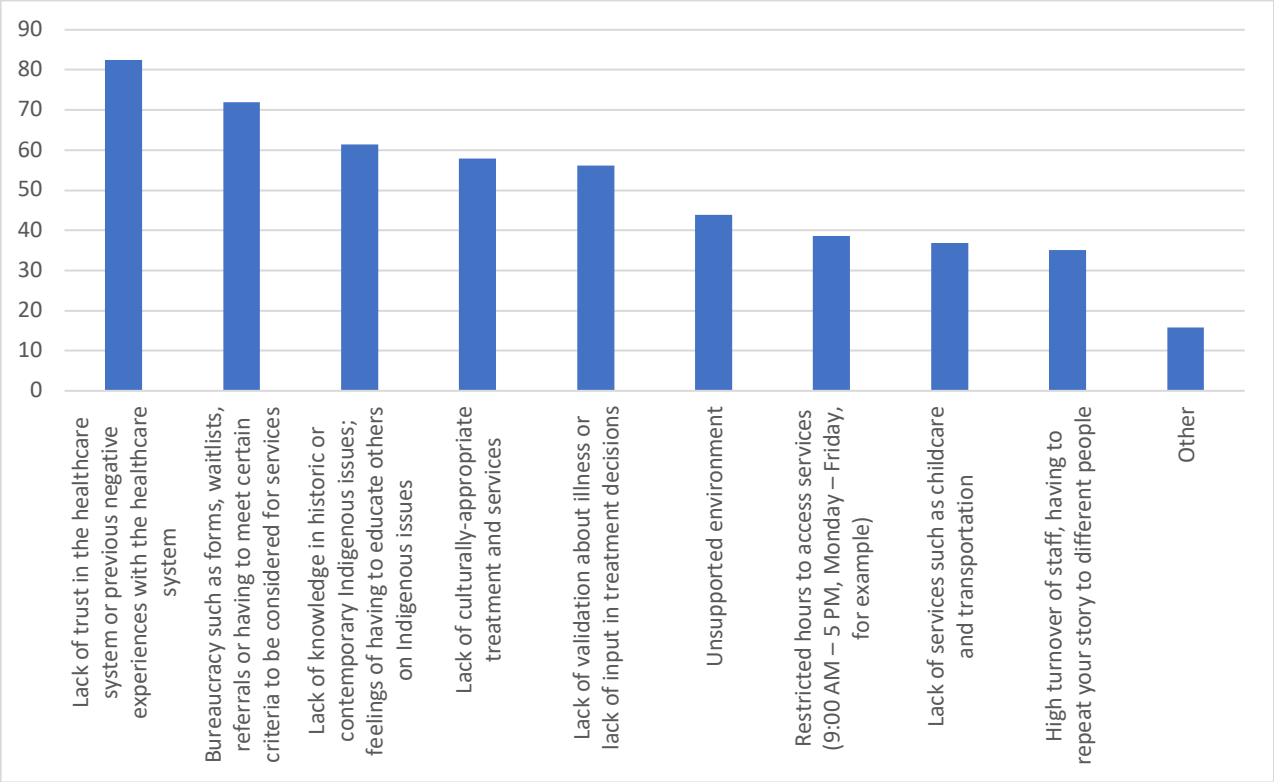

Figure 5. Percentages of perceived barriers to accessing mental health services

As seen in Figure 6, the three most-identified facilitators to accessing mental health services were: (a) Seeing the same health care provider consistently; not having to repeat your story to multiple people or "start over" with someone new (86% of participants); (b) Indigenous people working in health care positions such as doctors or counselors (74% of participants); and (c) A positive first experience, a comforting and welcoming environment, friendly staff (63% of participants). Other top-rated facilitators included workers who were knowledgeable in Indigenous issues, as well as the option for culturally appropriate treatments and services. Participants were again provided with the opportunity to identify any other facilitators not listed. One participant added, "Indigenous ceremonies as valid forms of healing."

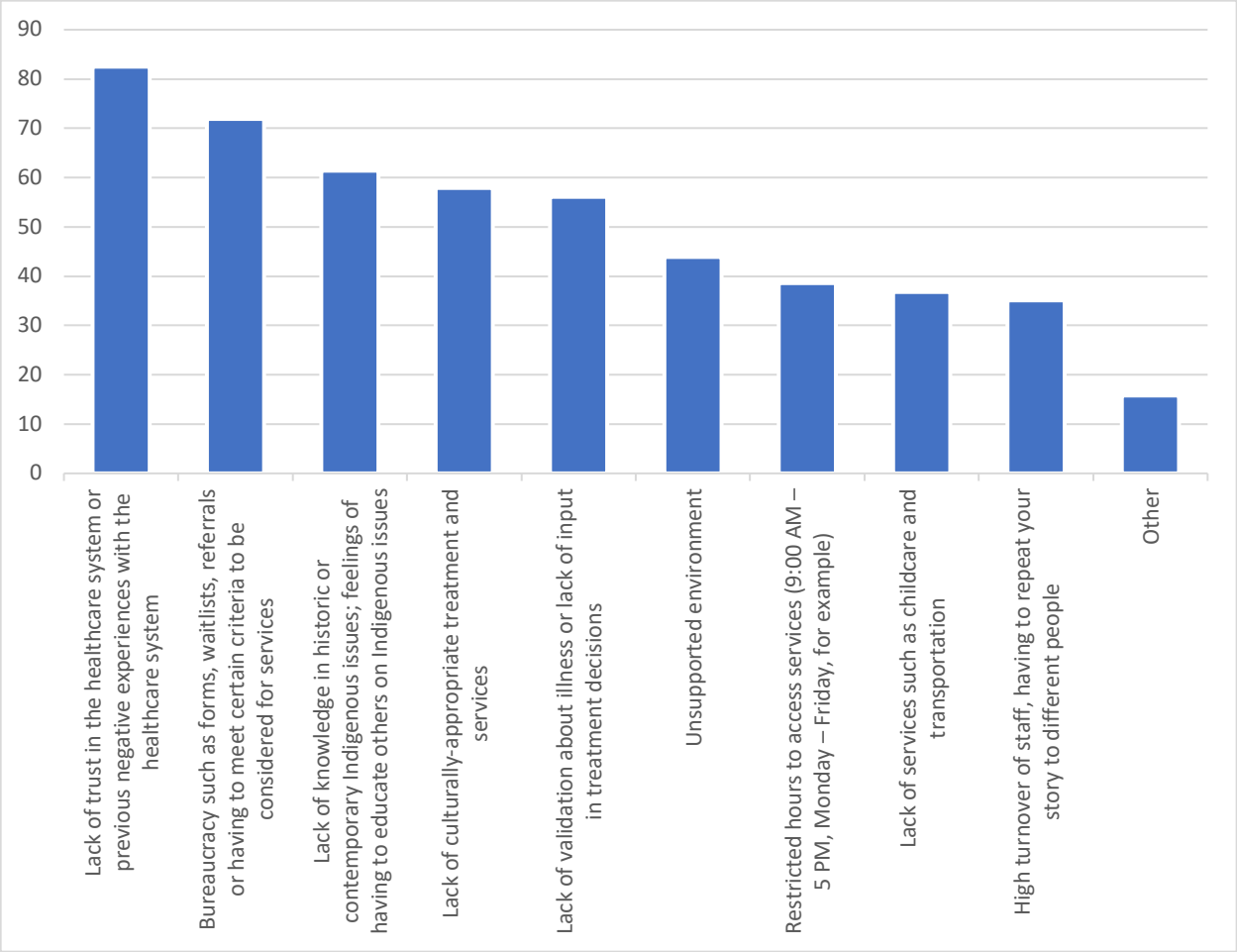

Figure 6. Percentages of perceived facilitators to accessing mental health services

Open-Ended Questions

The findings of the open-ended questions are as follows:

1. *"What helps you maintain and/or improve your mental health and wellbeing in the city?"*

The first open-ended question had 51 responses. Treatment (western and traditional) were identified in the following statements: Self-care such as "I also take antidepressant medication every day to manage my anxiety and depression." and "Medication and counselling." Land-based healing was also endorsed as shown in the following quote: "Attending ceremony and being able to travel back to the land are also major reasons for my ability to maintain not just my mental health, but overall wellbeing." Many participants cited their relationship with their

providers through regular appointments with a counsellor or psychologist as integral to maintaining their mental health and wellbeing making various statements, such as, “A consistent councillor who schedules within an acceptable time-frame”; “Keep in contact with my psychologist regularly”; “I have a counsellor that I talk to weekly …”; “Seeing a mental health therapist consistently”; and “Maintaining regular visits to my mental health care team.” As evidenced, when referring to engagement with mental health care practitioners, it was often mentioned that these appointments had some sort of consistency or regularity.

Traditional practices were also mentioned: “…traditional practices involving ceremony and plant based medicines”; “…access to ceremony (sweats, pow wow dancing lessons, smudging sessions).” Similarly, participants mentioned being able to relate with others in their various communities: “Having other Indigenous people I can relate too [sic]”; “My connection and discussion with other Indigenous women over the daily struggles we face in urban [city name]… .”

Community was also identified with statements such as, “Connecting with my community” and “Frequently taking trips back home to the reserve.” Going home was also identified as a way of maintaining and/or improving their health and wellness in the city with one participant stating, “the ability to go home to my First Nation.”

2. *“If relevant, what types of traditional Indigenous medicines or practices do you use to maintain your health and wellbeing?”*

The second question was optional, and 40 participants provided a response. Overwhelmingly, smudging was identified as a practice the participants frequently engaged in. Twenty-four participants used the word ‘smudge’ or some variation of the word. Sweats and the four types of medicine (sweetgrass, sage, tobacco, and cedar) were also frequently mentioned.

3. *"How would you describe your relationship to the land/Mother Earth (and how it relates to your health and wellbeing)?"*

The third question had 51 responses. The third question identified a spectrum of relationships between the participants and the land. Some women claimed to have a positive relationship with land/Mother Earth stating: "My relationship with Mother Earth is where I get the majority of my healing from. Land based healing and grounding through ceremony." Others said, "Mother Earth is my mother" and "She helps heal and comfort me." Some women were in the process of improving their relationship with Mother Earth stating: "I am just learning about our land and i feel a deeper connection helping more figure out who I am" and "My relationship with Mother Earth is strained, as I am now beginning to come back to my culture I had almost lost."

4. *"What keeps you thriving as an Indigenous woman?"*

The fourth question had 51 responses. The fourth question identified relationships, the future, and knowledge and (re)connection as themes. Relationships were further analyzed to relationships with other Indigenous women, ancestors, and the land. Participants found support in the living things around them as well as witnessing others thriving. One participant stated, "Seeing other Indigenous women thriving as well." While others said, "Other strong Indigenous women in my life." Many stated they were on an ongoing journey of learning about their Indigenous culture and identity.

5. *"What is your vision of mental health and wellbeing for the future generations of Indigenous women?"*

The fifth question had 51 responses. Participants identified recognition and validation and an increase in Indigenous health care providers as part of their vision for the future. One

participant stated, “When we aren’t seen as statistics anymore, when police are punished for the crimes that they do to us, where we actually start giving care and attention and resources to us.” Others said, “I hope that future generations of Indigenous women are treated fairly and feel respected/safe when dealing with their mental health and wellbeing”; “There should be more Indigenous people working in the mental health field”; and “I believe it is crucial to have more Indigenous counsellors. …”

Finally, there was an open answer area for participants to share anything they wanted to but that was not covered in the survey. Fifteen participants provided additional information including appreciation for the study and hope that it would initiate positive change. This space was also used for participants to further expand on their experiences with mental health as Indigenous women.

Themes

From the survey, the following themes, as they relate to this project’s aims on identifying and understanding Indigenous women’s experiences with mental health services in urban areas and understanding on how Indigenous women are coping and thriving with mental wellness during the COVID-19 pandemic, were identified using thematic analysis: *relationships*, *time*, and *knowledge and (re)connection.*

Relationships

Relationships with family (ancestral, present, and future), other Indigenous women, land, and health service providers were identified as a theme in this project. In response to what kept them thriving, one participant answered “My family, children, grandchildren. Knowing the strong women that came before me never gave up so I can’t either.” Another participant cited other Indigenous women as their motivation for thriving stating, “Seeing other Indigenous

women thriving as well. Finding my own circle of women that I trust that can help me when I fall down, and I can reciprocate the same with." This was further echoed by another participant who stated, "Community with other Indigenous women." One participant wrote, "Other strong Indigenous women in my life. A community of care. Knowing I have Elders, Aunties, and Leaders who always have my back. Good food. Boss beaded earrings … and jokes." There was also an emphasis on the wellbeing of the collective; e.g., "Helping to take care of our community helps my mental health." and "My future role as a leader within my community and beyond, motivates me to continue on my path to healing and awareness." In response to what kept them thriving, one participant shared "Knowing I want to support my community better."

Relationships to land were mentioned by participants as well. Many participants referred to the land as having a calming effect ("so important to calming my anxiety") or grounding. Land was identified as beneficial as many participants mentioned going outside and being near nature as positive for their wellbeing. Furthermore, daily walks and other types of movement (e.g. yoga, gym), were also identified as helpful for maintaining and/or improving mental health and wellbeing. When asked about their relationship to land/Mother Earth, many participates cited a positive relationship and deep connection with the land. For example, one participant said, "Being closer to the land gives me a sense of relief that nothing else can." While another participant said, "My relationship with Mother Earth is where I get the majority of my healing from." Some still cited a poor or absent relationship with land/Mother Earth with one participant saying, "I feel disconnected because I am not as in touch with my culture as I was when I was young and living on the reserve." And others described their relationship as "Non-existent" or "I wish my bond with Mother Earth was stronger, I often feel more connected when I am outdoors and much of my stress is reduced when I spend a significant time outside." However, in some

instances, when participants expressed a poor relationship with the land/Mother Earth, they also expressed that they were actively working on that relationship and changing it into a positive connection. One participant stated, “It has been rocky in the past, but as I become more connected with my cultural identity I and [sic] building a relationship.” Another participant shared, “My relationship with Mother Earth is strained, as I am now beginning to come back to my culture I had almost lost.” Another shared, “I am just learning about our land and I feel a deeper connection helping more figure out who I am.”

Relationships with health care providers, particularly Indigenous health care providers, were mentioned with participants describing a desire for an increase in Indigenous service providers in mental healthcare settings: “There should be more Indigenous people working in the mental health field.” And another participant stated, “In the future I think and hope there is an increase in Indigenous professionals helping future generations of Indigenous women.” Another shared, “I would love to see Indigenous people as the ones who are caring for ourselves and that there are more Indigenous caregivers than now.” One participant expanded in this statement:

> I envision more Indigenous women who have worked on their own healing journey and can help others in a professional capacity. We need more mental health service providers who are equipped to respond to the mental health needs of our communities. There is a growing need to address the high rates of addiction, suicidality and mental illness in Indigenous communities, which are all direct results of trauma from colonial policies.

Time

In terms of time, consistency was identified as a theme in relation to this project’s aims of identifying facilitators and barriers as well as exploring Indigenous women healing and thriving. One response stated, “Seeing a mental health therapist consistently.” Making sure to engage in

certain activities on a regular basis, even daily, another participant wrote, “I make a point of getting in daily exercise to try and help with anxiety and depression.” Another participant stated that they, “regularly participate in Nehiyaw ceremonies such as sweat lodge, smudging, sundances and other ceremonies as well as utilize plant based medicines.” Another participant stated, “Mother Earth is my mother. I do my best to acknowledge and thank her every day.” Still others spoke of their ancestors, current, and future generations as being important to wellness: “My family, children, grandchildren. Knowing the strong women that came before me never gave up so I can’t either”; “My ancestors. The thought of them and what they go through, I want to be a strong, educated Indigenous woman.” These responses further align with previously mentioned concepts of relationality in Indigenous worldviews.

The closed answered questions also highlighted time in the form of consistency with “Seeing the same healthcare provider consistently; not having to repeat your story to multiple people or ‘start over’ with someone new” as the top-rated facilitator. Finally, one participant shared their vision of future mental health for Indigenous women saying, “I would like to see more accessible mental health and wellbeing services for on and off reserve Indigenous women. When I say accessible, I mean 24/7 services. It may be demanding, but I think that it would benefit Indigenous women.”

Inherent within the findings was an envisioning for the future for wellness. Similar to this project’s refusal of deficit discourse, many Indigenous women participants identified not being seen as victims as part of their vision for future wellness. Some quotes included, “Instead of used, abused and seen as objects. Women are sacred and somewhere along the lines of society, we lost this vision”; “I envision a world in which Indigenous women are not afraid to get help”;

"To be heard and not turned down or pushed to the side. It feels difficult to talk about my feelings as a [sic] Indigenous woman."

Knowledge and (re)connection

Participants noted that their healing journeys involved learning more about particular subjects, including their culture. Education and knowledge on Indigenous history and issues among health service providers was also cited as a facilitator to accessing mental health services. By increasing their education and knowledge, some participants referred to the process as (re)connection to their culture, land, etc. For example, "Continuing to learning [sic] about my culture and the relationship of women within in [sic] it. The more I know and participate gives me confidence in who I am." Other participants stated, "Connecting back to my Indigenous ways of knowing during my studies. Such as learning my lost language" and "Wanting to learn more about First Nations culture in Canada."

Chapter V: Discussion

> Relationality, through Indigenous worldviews, acknowledges the deep understanding that all living things are in ethical relations with other people, plants and animals, ancestors, and the natural world. Relationality ensures the thrivance (more than survival) of our ecological and sociological future, connecting all of us in the vast web of life (Medina, 2021, p. 91).

This exploratory research aimed to identify and understand urban Indigenous women's experiences with mental health services in urban areas as well as understand how they are coping and thriving with mental wellness through events of historical loss and a global pandemic. The research question was: *How have women coped and thrived with mental wellness during the COVID-19 pandemic?* The data from this project was analyzed and identified themes including *relationships*, *time*, and *knowledge and (re)connection*.

Our findings indicate a high identification of being Indigenous, despite the disruption in identity from colonialism. This finding is significant because it correlates to prior research findings that established that identity is strongly related to wellbeing, including mental wellness (Stewart, 2008). The positive correlation with high cultural identity and barriers and facilitators to culturally appropriate care could indicate an increased need for culturally appropriate care. This correlation would be in line with the literature demonstrating the benefits of culturally relevant practices as it relates to wellbeing (Baldwin et al., 2021; Bodeker & Kariippanon, 2020; Chandler & Lalonde, 1998; Gone, 2013; Gray & Cote, 2019; Kirmayer et. al, 2003). Based on these findings of ongoing racism and oppression, not only does treatment need to be culturally appropriate for urban Indigenous women, but all needs to be anti-racist.

Given that just over half of the women did indicate being only slightly satisfied with life, this aligns with the concept of Indigenous women reaching out to health services as a method of increasing their life satisfaction, as well as actively making decisions that positively affect their lives. This decision-making could also be an indicator of Indigenous women embarking on life journeys that move them from surviving to thriving, based on the definition provided by Higgins et al., (2017): “the concept of patient engagement can be defined as the desire and capability to actively choose to participate in care in a way uniquely appropriate to the individual in cooperation with a healthcare provider or institution for the purposes of maximizing outcomes or experiences of care” (p. 33). Furthermore, patient engagement can “lead to increased activation, empowerment, participation, or involvement, as well [as] the anticipated health outcomes” (Higgins, 2017, p. 31). Given that all these women identified as having engaged in mental health services, it is reasonable to assume they were taking these steps to improve their health outcomes and, thus, increase their overall life satisfaction as “high levels of life satisfaction … are related

to a wide range of important life outcomes, such as physical and mental health …" (Pavot & Diener, 2008, p. 141). Therefore, while the majority of women's life satisfaction may have coded as *slightly satisfied*, they were also actively engaged with activities that could increase their life satisfaction. For many participants, this was an active and ongoing endeavor.

Our findings related to caring less about the healing the relationship the more satisfied one is with life imply that life satisfaction may mean one has more social supports, which in turn means that one does not need a strong relationship with their health care provider. This is concurrent with the literature that shows Indigenous people who are satisfied with life, whether they have histories of trauma or not, have higher social and emotional supports (LaBrenz et al., 2021). Additionally, it could mean that these participants who are more highly satisfied are better suited for online therapy or self-help, as opposed to mainstream mental health services involving an in-person one-on-one therapeutic relationship.

Historical loss also figured prominently in the findings and as a potential barrier to seeking mental health care. Whitbeck et al.'s (2004) work on historical loss states that, "The most important is the sense that the losses are not confined to a single catastrophic event. Rather they are ongoing and present" (p. 120). In the survey, the additional remarks related to historical trauma emphasizes that the pandemic not only increased isolation, but unfolding events (i.e., Colten Boushie, and the residential schools) also increased anxiety and perhaps isolation. As related to the ISC model, increased historical loss and trauma has the potential to exacerbate mental health needs. These findings imply that experiencing increased historical loss may lead some Indigenous women to not seek out culturally appropriate care, as perhaps they do not know what this means. However, the literature indicates that more culturally appropriate care may be needed to increase cultural connectedness and identity, and thereby improve mental health

wellbeing (Baldwin et al., 2021). Hence, there may be a disconnect between those who may need culturally appropriate services most and their access to these services.

Barriers

The findings imply that Indigenous women in academic settings experience barriers to seeking mental health care based upon lack of access, lack of a positive healing relationship, and culturally appropriate care. Our findings first identify the lack of a positive healing relationship as a barrier to seeking mental health care among Indigenous women. The healing relationship has been defined as an emotional bond of trust, caring, and respect; agreement on the goals of therapy; and collaboration on the "work" or tasks of the treatment (Bordin, 1959). However, Indigenous persons are known to experience high rates of provider discrimination in the exam room (Ahmed et al., 2007; Johansson et al., 2006; Johnson-Jennings et al., 2018). Mistrust corresponds with the increasingly well-known poor and fatal experiences with the health care system for Indigenous peoples. Furthermore, racial concordance with health care providers, or having Indigenous providers, has been found as needed (LaVeist & Nuru-Jeter, 2002; Saha et al., 1999). The findings imply the need for more education to develop health care practitioners, which aligns with the TRC's 94 Calls to Action (2015b) which included education for those in medicine and nursing:

> 24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism (p. 3).

While important, education has its limits. Neufeld et al., (2022) found that having historical knowledge about the history of Indigenous peoples, particularly when it comes to residential school history, increases empathy among the learners. However, Elliott (2019) states, "Empathy has its limits – and contrary to what some may think, it is possible to both have empathy for a person and still hold inherited, unacknowledged racist views about them" (p. 43). Therefore, while education is imperative (and desired by participants for health care workers and staff), it is critical to assess whether or not it is enough to lead to the meaningful and tangible change necessary for reconciliation and decolonization. And if it is not, we must ask what else we can do to reconcile and decolonize health care.

Facilitators

Facilitators can also be grouped into the same following three themes: access, the healing relationship, and culturally appropriate care. Consistently seeing the same health care provider is a lesser identified facilitator in the literature but featured predominantly in the closed-answer section of this project's findings. The research that does exist on the subject identified that consistency with the same health care provider resulted in lower mortality rates (Gray et al., 2018), demonstrating the importance of this facilitator. A desire to increase Indigenous health care providers not just for the sake of representation, but because research shows racial concordance in health care settings, is associated with improved communication (Shen et al., 2018). However, there is also evidence of marginalized groups being treated with less respect from health provider and staff even when in a concordant relationship (Blanchard et al., 2007), though this is minimal in the literature and has yet to appear to be the case for Indigenous populations. Rimondini et al. (2019) found that "the first impression has a strong impact on positive and negative judgements on doctors' communication approach and may facilitate or

inhibit all further interactions" (p. 1413), corresponding with the participants who identified "A positive first experience, a comforting and welcoming environment, friendly staff" as a facilitator to accessing mental health services.

Themes

Relationships

One may think that urban Indigenous populations lack relationship to community by not being on a reserve. However, gathering creates community and Indigenous people are good at creating community. In the context of this specific post-secondary setting, Indigenous student centre(s) provide one way of forming community. The post-secondary institution focused on in this project has an Indigenous student centre that participants identified as beneficial to their wellbeing. It is also known that there are Indigenous communities within disciplines: Indigenous business students, for example. There are also Indigenous student councils at the post-secondary level. Urban Friendship Centres are another way urban Indigenous populations have found community. Therefore, while Indigenous populations may be moving to the city and not living on their reserve, they can form community in urban centres.

With ancestral, present, and future generations

The concept of relationality and its relevance to the participants was evident as they cited ancestral, present, and future generations as motivation to heal and thrive. The inclusion of ancestral, present, and future generations in the narrative of healing further demonstrates that healing is not an individual experience, contrary to the mainstream perspective. From an Indigenous worldview, health and healing is a communal and holistic experience and does not separate itself from ancestral, present, or future ties to ancestors (Vukic et al., 2011). Health care providers should consider this when engaging with

Indigenous clients and understand that the choices we make regarding our health are made with our past and future ancestors in mind.

While healing is a communal experience, it *is* individual in the fact that healing journeys are unique, and no journey is the same. This is echoed by Cajete (2000): "In any healing process, many things take place at various levels, and every healing process is unique. An herb used to cure a particular malady may be totally ineffective in another case of the same malady" (p. 126). Graham (2020) also states healing is an "individual path for everyone" (n.p.). This goes against prescriptive western medicine, though there is a recent movement towards more individualized care in mainstream medicine (Miles & Loughlin, 2011).

With other Indigenous women

Several participants mentioned other Indigenous women as a source of motivation to thrive or maintain and improve their health and wellbeing. If Indigenous women thrive in the company of Indigenous women, then there need to be safe spaces for Indigenous women to gather. Forming community in the context of this project took the form of finding other Indigenous women who were making positive changes in their lives. As one participant wrote, "Seeing other strong Indigenous women achieving their dreams and making positive changes!" kept her thriving. Maracle (2021) writes, "Reorienting oneself towards a community, and being connected to said community, can be an excellent way to continue on the healing journey" (p. 24). This is further identified as having a positive influence on mental health as found by Burnett et al., (2022).

As evidenced in participant statements, this guidance also comes from other Indigenous women. One participant shared that they received guidance to thrive by "Spending time with

Indigenous matriarchs as they give me a sense of strength and grounding in times of uncertainty.". Another participant stated, "Staying connected to other like minded women …" In the participants comments, it became clear that relationships to other Indigenous women were integral parts of ensuring their own thrivance and wellbeing.

Anderson (2016) writes, "The guidance that women receive from their mothers, aunts, and grandmothers shapes the way they learn to understand themselves and their positions in the world" (p. 101). I would add, and Anderson (2016) expands on this idea, "Where women have not had mothers, grandmothers, aunts, or sisters in their biological families, they have found and created families and communities of women for support and guidance" (p. 105). Therefore, the creation of these families and communities of Indigenous women is not dependent on individuals lacking matriarchs in their family. Rather, these chosen families (community of women) are extensions of the individual's immediate family.

With land

Historically, Indigenous peoples had strong relationships with the land. This connection has been damaged through capitalism, colonialism, and exploitation. While some participants struggled with their relationship to the land, others flourished and cited the land as a key part of their wellness and healing journey. This is similar to an established, but growing body of academic literature on human-land relationships among Indigenous populations (Dickerson et al., 2014; Hadjipavlou et. al., 2018; Johnson-Jennings et al., 2020; Radu, 2014; Schiff, 2006; Snowshoe and Starblanket, 2016), though this is a relationship that has always been valued and intrinsic to the Indigenous identity. Therefore, there is a spectrum in the type of relationship with the land among the participants and even those with a poor relationship spoke to the fact that they were

working on repairing that relationship to the land, which can be a contributor to one's health.

Land-based spaces and opportunities were also important to healing for the participants. One participant shared, "I'd love more access to the land – to learn more from them. I realize working with the land (i.e. community garden spaces) rejuvenates my well being and supports my mental health." Another participant further endorsed this idea by stating, "Being in nature (physically being grounded) and near water is so important to calming my anxiety."

With health service providers

Relationships with health care providers was established as a contributor to one's accessibility to mental health care services. This aligns with previous literature highlighting the provider-patient relationship as an influencer to one's quality of experience in health care settings among Indigenous women (Liddell, 2023). Communication quality in the provider-patient relationship has also been found to correlate to the level of medical mistrust felt from the patient (Adams & Craddock, 2023). One participant stated their future vision for Indigenous women's mental health included "Indigenous women who have worked on their own healing journey and can help others in a professional capacity." Our findings imply that providers are very important to increasing access to mental health care. It may be possible that by facilitating and caring for Indigenous peoples preferred mechanisms of healing (including western and Indigenous forms of healing), we can improve the representation of Indigenous health care practitioners. As Cajete (2000) writes, "Healers… must also learn about themselves in order to master the art of healing" (p. 126).

As previously established, the findings support that Indigenous people tend to be community-oriented in their views of healing. As such, it is understandable that

participants would wish for healthier communities. We, as Indigenous people, can be of value to our communities by taking the necessary steps towards healing from historical trauma and loss. As Kinsey (2022) writes, “If you are invested in the advancement and progress of your community, a strong sense of self-worth and a clear understanding of your intrinsic value are essential. Caring for ourselves puts us in a better position to advocate for others. Happiness and contentment are integral health-promoting aspects of life” (p. 121). This study’s findings support this desire to help their communities and remain focused on the collective as part of the healing journey.

Our findings further suggest that health care providers and their relationships with Indigenous women are key to help-seeking. This study found that Indigenous women wanted to be seen and respected by health service providers as a valuable part of their vision for future wellness. Similar to this project’s refusal of deficit discourse, many Indigenous women do not wish to be seen as victims as part of their vision for future wellness. This is important for health care service providers to keep in mind in order to provide safe spaces for Indigenous women. The literature suggests that some Indigenous women who participate in traditional healing may have a preference for Indigenous providers and traditional services (Walls et al., 2014).

Time

The construct of time has a role to play in health care as seen in the findings. Wilson et al., (2020) state that “The colonial perception of time … is also an organising principle for education and healthcare, dominated as they are by schedules and appointments” (p. 140). They further add that western conceptions of time are linear and individualized in regards to health (beginning-of-life to end-of-life); whereas, Indigenous conceptions of time and health “stretches

back before colonial times and reaches forward beyond an individual's lifespan" (Wilson et al., 2020, p. 140). Indigenous conceptions of time align with findings stating the participants in this study found themselves thriving when thinking about the ancestral, present, and future generations. "My family, children, grandchildren. Knowing the strong women that came before me never gave up so I can't either," one participant states. Another wrote that "My ancestors. The thought of them and what they go through, I want to be a strong, educated Indigenous woman." This further aligns with previously mentioned concepts of relationality in Indigenous worldviews.

Our study suggests that time is very important to accessing mental health services and in healing. This study found a need for consistent or regular care from the same health care provider(s), but also consistency in regards to the actions they take on a daily basis to maintain their wellness. For mental health, traditional practices such as daily smudges, walks, and other forms of exercise are also seen as helpful. Yet, unfortunately, studies have shown that a significant amount of the Canadian population do not have a regular health care provider (Angus Reid Institute, n.d; Statistics Canada, 2020b), thus leaving the population vulnerable. Additionally, it was found that existing literature was unlikely to identify time as a contributor to one's health and health care experience. Therefore, this study is unique in that sense.

Knowledge and (re)connection

Colonization has disrupted Indigenous peoples' ways of being, as evidenced by shared Indigenous experiences, the literature, as well as the Historical Loss (and Historical Loss Associated Symptoms) Scale used in this project. Reclamation in these ways of being includes healing journeys and (re)connection. For the participants, (re)connection meant (re)learning about different Indigenous topics and practices. This journey of

(re)connection, healing, and knowledge has led to Indigenous women thriving, particularly during the COVID-19 pandemic when the data was collected.

Knowledge on Indigenous issues was not only important for the Indigenous participants, but was expressed as an important element to a positive experience with mental health service providers. Participants spoke to the (re)connection to culture, language, and self as a mechanism for thriving and coping with the effects of colonization and the pandemic. They also spoke to the importance and value of health care workers' own knowledge and education on Indigenous issues and history.

Thrivance

In addition to the definition provided in this project's Glossary, thrivance has also been described as *growing from ancestral knowledges and wisdoms, which then actuates healthful practices and well-being* (Johnson-Jennings et al., 2019; Johnson-Jennings, Billiot, & Walters, 2019; Walters et al., 2020). As seen in this project, there are many ways urban Indigenous women were thriving throughout the pandemic and events of historical loss. It is hopeful that new narratives and research involving Indigenous women (and all Indigenous populations) continue to focus on the notion of thrivance and, at the same time, move away from the all-too-common deficit discourses. Walters and Johnson-Jennings (2023) have developed two frameworks to guide researchers (and community) through this process.

Visualized in Figure 7, thrivance can be described as involving "weaving those survivance and Indigenous knowledge strands (the warp) with the threads of transformative resistance and the power of persistence (the weft) into vibrant fabric of healthful living" (Walters & Johnson-Jennings, 2023, p. 5). In Figure 8, thrivance is envisioned "as a war shield battling through settler colonialism and trauma. *Thrivance*, is the outer weaving (fabric) or braid

(sweetgrass) that surrounds and upholds indigenous and decolonizing actions-enacted to grow Indigenous healing and health" (Walters & Johnson-Jennings, 2023, p. 26). The participants in this project have demonstrated their use of the warp, the weft, and the war shield as they transformed previous narratives of historical trauma and ongoing harms of the COVID-19 pandemic into narratives of strength, resilience, and thrivance.

Figure 7. Thrivance weaving (Walters, K. L., & Johnson-Jennings, M., 2023)

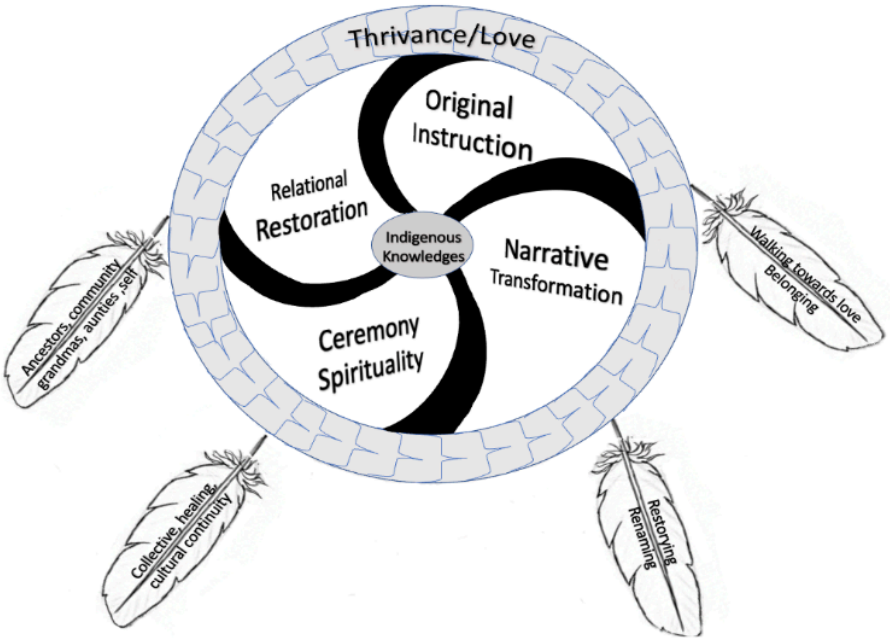

Figure 8. Thrivance (Walters, K. L., & Johnson-Jennings, M., 2023)

Conclusion

In conclusion, this project contributes to ongoing research while also addressing under-researched areas in the field of Indigenous Studies and Indigenous health regarding urban Indigenous populations and strengths-based narratives of thrivance. It is also well-established that on-reserve health services, when not rooted in Indigenous culture, often fall short to improving health circumstances. Urban health services are less researched and require their own studies as the experiences, barriers, and facilitators are unique and separate from those one might experience on-reserve. For instance, land-based healing remained important for Indigenous women despite not living what is typically known as “close” to the land. As the urban Indigenous population increases, it is imperative to assess the usefulness of urban health services and adjust accordingly as well as rethink what “land” is in an urban context. Therefore, this

strengths-based project is a timely contributor to current and future areas of research in the fields of Indigenous health, Indigenous healing, and the urban Indigenous experience.

This mixed methods research sought to explore mental wellness, coping, and thriving during the COVID-19 pandemic and through events of historical loss. In order to answer the research question, a survey method approach was used. In adhering to strengths-based narratives, the findings of this study demonstrated Indigenous women thriving and succeeding in their lives. This is the result of past and present generations healing from colonialism, which may support future healing for Indigenous populations, as healing is accumulative, as stated by Morgan and Freeman (2009):

> In most Native nations, it is understood that the power of healing comes from a spiritual source and is given to the people. In this sense, it is a renewable resource; i.e., the more the healing is received, the more there is to give… Traditional healing seeks to make things whole – the people, the culture, and the community (p. 90).

Limitations

Indigenous counselors, psychologists, and Indigenous forms of treatment are not a magic fix. A western-based practitioner (and western forms of treatment) might be an Indigenous individual's best option for a number of reasons, including this project's identified facilitators: established, trusting relationships or a previous positive experience. It is also noted that it should not be assumed that every Indigenous woman wants traditional medicine. As seen in this study, Indigenous women benefit immensely from western health care and participants were in favour of amalgamating western and Indigenous health care. Participants even indicated that they wanted more Indigenous women to reach out to mainstream services and get access to the services they believed might benefit them.

While there are specialized mental health services in the form of mental health counselors, psychologists, psychiatrists, and psychiatric nurses, there are also generalized health service providers, such as family physicians or social workers, who assist with mental health issues. The survey undertaken by this project did not provide an explicit distinction between the two types of services and, thus, participants were required to use their own definition of mental health services. Given the responses of the open-ended questions, many participants used terms such as 'counselling' and 'psychologists' to refer to the mental health services they utilized. Therefore, while this project did not abide by a confined definition of "mental health services", participants demonstrated their understandings and definitions of mental health services to refer to both generalized and specialized services.

Other limitations to the study include the lack of generalizability given the small population size. Despite various outreach by the myself, only 51 participants completed the survey to the very end. While this is less than the original goal, it was also decided that it was satisfactory and an acceptable amount for a Master's thesis project. Demographic information based on the participants was also minimal. Furthermore, this study was conducted during the context of COVID-19 and collectively traumatic events happening in the province and the nation, which likely affected response rates. Furthermore, due to trying the isolate confounding variables, this study only focused on urban Indigenous women who were working or studying at an academic institution that offered mental health services throughout the COVID-19 pandemic. Hence, this study may have been unduly influenced by context. However, this is the first study to examine help-seeking attitudes among urban Indigenous women and did so during a stressful time period.

Future Research

Psychedelics

At the time of writing, psychedelics (e.g. psilocybin mushrooms, *Lophophora williamsii* [peyote]) and anesthetics (e.g. ketamine) are becoming increasingly used as a mental health treatment. However, research in its effectiveness remains limited and knowledge of its effect on Indigenous populations remains scarce (Argento et al., 2022; Muscat, 2021). In the research that does exist, Indigenous women show interest in psychedelic treatment, especially in instances where they have previously experienced barriers accessing "psychotherapy" (Argento et al., 2022). Future research would benefit from this continued exploration.

Humour

Burnstick (as qtd. in Winkler, 2017) says, "The Truth and Reconciliation Commission missed the boat on humour ..." continuing that "There are four really important parts to the healing process, based on what the Elders have told me. There's prayer, sharing, crying, and laughing. If you do those four things, you will heal over hardship, loss, and grief. The TRC had those gatherings, they shared, prayed, cried, but there was no laughing, no closure, no healing."[15] Humour as a tool for wellness was also cited by the participants in this study who identified "jokes," "laughs," and "laughter is good medicine" as ways of thriving or as important to their mental health and staying well. Future research in Indigenous humour's role in healing would be most interesting.

Decolonization and mental health

Earlier, this study acknowledged the deficit discourse that has dominated research on Indigenous people, and therefore, this project opted for a strengths-based approach. We can take a similar approach when it comes to the concept of "difference"/illness. I propose that difference

[15] This quote was previously highlighted by Redvers (2019), p. 160, 162.

does not have to be a bad thing. In fact, it has been said (including among Indigenous groups) that difference (such as having a mental illness) can be a gift because these individuals have a unique perspective on the world (Salisbury, 2021; Taitimu et al., 2018). Nelson (2012) writes about the "medicalization of difference" as "those who are seen as deviating from certain specific norms are given labels of mental disorder" (p. 8). Of course, it has also been stated that "Being othered throughout your life … [takes] a natural toll on your mental well-being" (Kinsey, 2022, p. 26). However, recontextualizing what it means to be "different" can be one way of changing the narratives around deficit discourses and being othered.

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Appendix

Appendix A: Participant Criteria

Participant Criteria

a. Do you self-identify as Indigenous? Y/N
b. Which best describes your current gender identity?
    a. Woman
    b. Man
    c. Two-Spirit
    d. Other gender (e.g. gender fluid, non-binary)
c. Are you 21+ years? Y/N
d. Have you accessed mental health services in an urban centre in Saskatchewan in the past 2 years? Y/N
e. Do you currently live in an urban centre in Saskatchewan? Y/N

Appendix B: Measurements

Revised (12-item) Multigroup Ethnic Identity Measure

This survey is used to measure ethnic identity.

Please fill in: In terms of ethnic group, I consider myself to be _____

Using the 1 - 4 scale below, please select the corresponding number you feel best represents how much you agree or disagree with each of the following statements.

(4) Strongly agree; (3) Agree; (2) Disagree; (1) Strongly disagree

1. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.

2. I am active in organizations or social groups that include mostly members of my own ethnic group.

3. I have a clear sense of my ethnic background and what it means for me.

4. I think a lot about how my life will be affected by my ethnic group membership.

5. I am happy that I am a member of the group I belong to.

6. I have a strong sense of belonging to my own ethnic group.

7. I understand pretty well what my ethnic group membership means to me.

8. To learn more about my ethnic background, I have often talked to other people

about my ethnic group.

9 I have a lot of pride in my ethnic group and its accomplishments.

10. I participate in cultural practices of my own group, such as special food, music,

or customs.

11. I feel a strong attachment towards my own ethnic group.

12. I feel good about my cultural or ethnic background.

Satisfaction with Life Scale (SWLS)

The Satisfaction with Life Scale is used as an opportunity for individuals to assess their overall wellbeing. Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, please select the corresponding number you feel best represents how much you agree or disagree with each of the following statements.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

____ In most ways my life is close to my ideal.

____ The conditions of my life are excellent.

____ I am satisfied with my life.

____ So far I have gotten the important things I want in life.

____ If I could live my life over, I would change almost nothing.

Historical Loss Scale

This Historical Loss Scale measures the frequency with which Indigenous individuals have thoughts about historical loss such as loss of culture, land, familial connection, and others, as a result of colonization. Please select the corresponding number you feel best represents your experience.

		Several times a day	Daily	Weekly	Monthly	Yearly or only at special times	Never	DK/REF (Don't know/refused)
A	The loss of our land	1	2	3	4	5	6	9
B	The loss of our language	1	2	3	4	5	6	9
C	Losing our traditional spiritual ways	1	2	3	4	5	6	9
D	The loss of our family ties because of residential schools[16]	1	2	3	4	5	6	9
E	The loss of families from the reservation to government relocation	1	2	3	4	5	6	9
F	The loss of self-respect from poor treatment by government officials	1	2	3	4	5	6	9
G	The loss of trust in white people[17] from broken treaties	1	2	3	4	5	6	9
H	Losing our culture	1	2	3	4	5	6	9
I	The losses from the effects of	1	2	3	4	5	6	9

[16] 'Boarding schools' changed to 'residential schools'
[17] Rephrased from "The loss of trust in whites from broken treaties".

	alcoholism on our people							
J	Loss of respect by our children and grandchildren for elders	1	2	3	4	5	6	9
K	Loss of our people through early death	1	2	3	4	5	6	9
L	Loss of respect by our children for traditional ways	1	2	3	4	5	6	9

Historical Losses Associated Symptoms Scale

Now I would like to ask you about how you feel when you think about these losses. Below are some examples of possible emotions. Please select the corresponding number you feel best represents your experience.

		Never	Seldom	Sometimes	Often	Always	DK/REF (Don't know/refused)
A	Sadness or depression	1	2	3	4	5	9
B	Anger	1	2	3	4	5	9
C	Anxiety or nervousness	1	2	3	4	5	9
D	Uncomfortable around white people when you think of these losses	1	2	3	4	5	9
E	Shame when you think of these losses	1	2	3	4	5	9
F	A loss of concentration	1	2	3	4	5	9
G	Feel isolated or distant from other people	1	2	3	4	5	9

	when you think of these losses						
H	A loss of sleep	1	2	3	4	5	9
I	Rage	1	2	3	4	5	9
J	Fearful or distrust the intent of white people	1	2	3	4	5	9
K	Feel like it is happening again	1	2	3	4	5	9
L	Feel like avoiding places or people that remind you of these losses	1	2	3	4	5	9

Appendix C: Closed-Ended Questions

Below are some examples of barriers to accessing mental health services. Based on your knowledge and experience, which five do you consider to be the most influential in one's decision or ability to **not access** mental health services? Answers are in no particular order.

a. Lack of trust in the health care system or previous negative experiences with the health care system
b. Restricted hours to access services (9:00AM-5:00PM, Monday-Friday, for example)
c. Lack of validation about illness or lack of input in treatment decisions
d. High turnover of staff, having to repeat your story to different people
e. Bureaucracy such as forms, waitlists, referrals or having to meet certain criteria to be considered for services
f. Lack of culturally appropriate treatment and services
g. Unsupportive environment
h. Lack of services such as childcare and transportation
i. Lack of knowledge in historic or contemporary Indigenous issues; feelings of having to educate others on Indigenous issues
j. Other

Below are some examples of facilitators to accessing mental health services. Based on your knowledge and experience, which five do you consider to be the most influential in one's decision or ability to **access** mental health services? Answers are in no particular order.

a. Indigenous people working in health care positions such as doctors or counselors

b. Seeing the same health care provider consistently; not having to repeat your story to multiple people or “start over” with someone new
c. Knowledge and understanding of historic and contemporary Indigenous issues; not having to educate the health care providers
d. Flexibility in working hours (Outside of 9:00 AM - 5:00 PM, Monday-Friday)
e. Encouragement, support, and acknowledgment of progress
f. Established trust in health care providers
g. Culturally appropriate treatments and services
h. Provision of services such as childcare and transportation
i. A positive first experience, a comforting and welcoming environment, friendly staff
j. Other

Appendix D: Open-Ended Questions

Please review the following questions and answer accordingly based on your experience and comfort level. Feel free to be as brief or as descriptive as you like. A good aim is 3-5 sentences, but you may write more or less.

1. What helps you to maintain and/or improve your mental health and wellbeing in the city?
2. If relevant, what types of traditional Indigenous medicines or practices do you use to maintain your health and wellbeing?
3. How would you describe your relationship to the land/Mother Earth (and how it relates to your health and wellbeing)?
4. What keeps you thriving as an Indigenous woman?
5. What is your vision of mental health and wellbeing for the future generations of Indigenous women?
6. Please use this space to share anything you wanted to discuss but was not covered in this survey.

Appendix E: Ethics Approval

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB) 04-Aug-2021

Certificate of Approval Amendment

Application ID: 2626

Principal Investigator: Michelle Johnson-Jennings Department: Department of Indigenous Studies

Locations Where Research Activities are Conducted: City of Saskatoon, Saskatchewan, Canada

Student(s): Jacqueline Smith

Funder(s):

Sponsor: University of Saskatchewan

Title: Mental Health Services and Ethnic Identity: Indigenous Women in Urban Spaces

Approved On: 04-Aug-2021

Expiry Date: 15-Jul-2022

Approval Of: Behavioural Amendment Form: 29-July-2021

Amended Survey: 4-August-2021

Acknowledgment Of:

Review Type: Delegated Review

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TPCS 2 2018). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this project, and for ensuring that the authorized project is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the project remains open, and upon project completion. Please refer to the following website for further instructions: https://vpresearch.usask.ca/researchers/forms.php.

Digitally Approved by ***Diane Martz, Chair, Behavioural Research Ethics Board***
University of Saskatchewan

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB) 07-Jul-2022

Certificate of Re-Approval

Application ID: 2626

Principal Investigator: Michelle Johnson-Jennings Department: Department of Indigenous Studies

Locations Where Research Activities are Conducted: City of Saskatoon, Saskatchewan, Canada

Student(s): Jacqueline Smith

Funder(s):

Sponsor: University of Saskatchewan

Title: Mental Health Services and Ethnic Identity: Indigenous Women in Urban Spaces

Approval Effective Date: 15-Jul-2022

Expiry Date: 15-Jul-2023

Acknowledgment Of: N/A

Review Type: Delegated Review

* This study, inclusive of all previously approved documents, has been re-approved until the expiry date noted above

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2 2014). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this project, and for ensuring that the authorized project is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the project remains open, and upon project completion. Please refer to the following website for further instructions: https://vpresearch.usask.ca/researchers/forms.php.

Digitally Approved on behalf of the Chair
Behavioural Research Ethics Board
University of Saskatchewan

Appendix F: Recruitment Poster

Department of Indigenous Studies
University of Saskatchewan

PARTICIPANTS NEEDED FOR RESEARCH ON INDIGENOUS WOMEN AND MENTAL HEALTH SERVICES

We are looking for volunteers to take part in a study of:
Indigenous women and their experiences with mental health services in urban spaces.

As a participant in this study, you would be asked to: complete an anonymous computer-based survey based on your experiences.

Your participation would involve 1 session,
which is approximately **20 minutes**.

If you self-identify as an Indigenous woman, aged 21+, who has used mental health services in an urban setting in the last two years, and are willing to anonymously share your experiences, please visit the following link to complete the survey.

https://www.surveymonkey.ca/r/3CB7C9M

In appreciation for your time and as a token of our gratitude, you will have the opportunity to enter a draw for 1 of 5 gift cards.

If you have any questions, please contact:

Jacqueline Smith
Email: jas024@mail.usask.ca
at
Department of Indigenous Studies

This study has been approved by the University of Saskatchewan Behavioural Research Ethics Board

UNIVERSITY OF SASKATCHEWAN | usask.ca

Appendix G: Positionality Statement

Tansi. Jacqueline Smith nitisinikáson. Opâskwayâk iskonikan ohci nína. Hello. My name is Jacqueline Smith. I am Swampy Cree from Opaskwayak Cree Nation in Treaty 5 territory. I am currently a Masters student in the Department of Indigenous Studies and my research focuses on Indigenous mental health. More particularly, my research is on urban Indigenous women and their unique experiences when interacting with mental health services.

Kinanâskomitin, thank you for your interest in this study.

PANEL ON RESEARCH ETHICS

Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Jacqueline Smith

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **24 April, 2017**