Powerful Communities, Healthy Communities

A Twenty Year Journey of Healing and Wellness

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Colonization, healing, and resilience reveal themselves to me. As Survivors, we ride waves of vulnerability for a lifetime and for generations. We were subjected to real risk factors including hunger, loneliness, ridicule, physical and sexual abuse, untimely and unseemly death. As we struggle to throw off the shackles of colonization we lean heavily toward healing, and resilience becomes our best friend.

Madeleine Dion Stout
A Survivor Reflects on Resilience (2008)

Introduction

Twenty years is a mere whisper in the histories of the First Peoples of Canada. It marks the time we see a new generation born and grow into adulthood and it is a period long enough for societal change to be felt. Twenty years ago it was the dream for positive societal change that framed the release of the Royal Commission on Aboriginal Peoples' (RCAP) final report (1996). The Commissioners and those that supported their work, concluded that profound changes were required to repair the relationship between Canada and First Nations, Inuit and Métis peoples. The starting point, they argued, "is recognition that Aboriginal people are not, as some Canadians seem to think, an inconsequential minority group with problems that need fixing and outmoded attitudes that need modernizing. They are unique political entities, whose place in Canada is unlike that of any other people." (1996a) The Commission called for the entrenchment in daily Canadian life of the principles upon which the Constitution and the treaties were formed. At the outset of their work, the Commissioners asked: "What are the foundations of a fair and honourable relationship between the Aboriginal and non-Aboriginal people of Canada?" Through talking and listening to Inuit, Métis and First Nations peoples, they sought to answer this question and in doing so, the Commissioners determined twenty years to be a reasonable time frame in which much of the collective work that needed to be done by Federal and provincial/territorial governments, First Nations, Inuit and Métis peoples and Canadians generally, could be established or completed (1996a). The RCAP Commissioners believed that a conceptual shift driven by sincere commitment by governments, and hard work and perseverance by the entire country would bring about a renewed relationship between non-Indigenous Canadians and the First Peoples of this land.

A focus on healing and wellness in Indigenous communities and Indigenous led practices for addressing inter-generational trauma, addictions, and mental illness were central to the path forward described by the Commission (1996b). Twenty years later, our paper asks the following questions: How did this journey unfold for our people?; What can we learn from RCAP and the past twenty years about addressing mental health, healing, and reconciliation? How can the past twenty years inform the implementation of the *Calls to Action* (2015) of the Truth and Reconciliation Commission of Canada in areas of mental health and healing? and, "What is our path today and what will it be for the next generation?

The following pages are an initial draft of a more comprehensive paper that our team will produce following the Winnipeg RCAP conference. In the draft presented here, we focus on the national influence of RCAP in areas of Indigenous mental health, wellness and healing. However, a fuller analysis that privileges the voices of Indigenous communities to tell their stories about the past twenty years is necessary to fully understand what has happened. In our consideration of the past twenty years, we highlight the role of the Aboriginal Healing Foundation (AHF) and the Indigenous "healing movement," as examples of Indigenous self determination in mental health, wellness and healing work.

Following an Indigenous path of healing and reconciliation, this paper is driven by Indigenous passion for change and a better future and not by a Western academic voice. Despite the architects of the paper being located in universities and other national organizations, the paper is written from the warm and embracing shadows of our Indigenous mentors; individuals such as Marlene Brandt Castellano, Gail Valaskakis, William (Bill) Mussell, Joseph Couture, Ed Connors, Paul Hanke, Lorna Williams, Jim Dumont, Gaye Hanson, Carol Hopkins, Brenda Restoule, Madeleine Dion Stout, Willie Ermine, Jo-Anne Episkenew, Cora Pillwax Weber, Maria Campbell, Cindy Blackstock, Cynthia Wesley-Esquimaux, Reg Crowshoe, and Joan

Glode, to name only a few. These individuals pushed Canada to think critically about the relationship First Nations, Inuit and Métis peoples have to Canadian health care systems, health care training, and to Western medicine. They also drew attention to the intersections between social inequities and health, social welfare, legal, justice and educational systems. Our mentors educated the country about the importance of Indigenous languages, healing practices, traditional medicines, and ways of knowing and being, as central to health, healing and wellness. They mentored the next generation to proceed in constructive and meaningful ways and to have the moral courage to speak at all times with strong Indigenous voices. It is the collective wisdom of our mentors, many of whom were deeply involved and committed to the RCAP and the healing movement, that shape the voice of this paper.

Twenty Years: From the Royal Commission on Aboriginal Peoples to Truth and Reconciliation

The optimism currently felt across Canada resulting from the release of the Truth and Reconciliation Commission of Canada's (TRC) final report (2015) is unfortunately overshadowed by the striking similarities between the RCAP recommendations provided 20 years ago and the *Calls to Action* provided by the TRC. Both reports are compelling arguments for change and both Commissions point to historical mistreatment and unaddressed inequities experienced by First Nations, Métis and Inuit peoples. A comparison of the *Calls to Action*, and a review of the RCAP recommendations for "Health and Healing," in Volume 3 (1996b) is a sobering exercise, specifically because Indigenous peoples across Canada have dedicated the past twenty years to efforts that create and sustain strong mental health and healing supports in their communities.

Twenty years ago, RCAP documented the devastating impacts of colonization on the emotional, psychological, spiritual and physical wellbeing of Inuit, Métis and First Nations peoples. The extensive report presented a wide ranging scope of statistical evidence and personal experiences detailing the considerable health and social disparities that existed between non-Indigenous and Indigenous populations at the time. The RCAP report also raised awareness regarding the legacy of the Indian residential school system and other aspects of colonization in contributing to the development and perpetuation of inequities, which has since been supported by accumulating empirical evidence (Bombay, Matheson, Anisman, 2014; Whitbeck & Walls, 2012). At the time, RCAP concluded that previous attempts to close health gaps had failed because of the unique and complex causes of ill health experienced by Indigenous peoples. They concluded that "substantial improvements in the health and welfare of Aboriginal people would not be accomplished by tinkering with existing programs and services" (RCAP 1996:203). The final report provided compelling and evidentiary reasons to increase healing and wellness resources for Indigenous communities—reserve, rural, remote and urban.

In weighing the final reports of the RCAP and TRC to determine where we were 20 years ago and where we are today as a country, suggests that we have not in areas of healing, mental health and wellness made the sustained and substantial gains that were thought possible. This is not to suggest that as a country we stood still. Rather, there have been many notable gains, and some of those gains have been lost; there have been lessons learnt, possibilities realized, and promises broken. For Indigenous peoples, the journey of the past twenty years has been full of promise but marked by the unpredictability of the ebbs and flows of public opinion and of governments who despite their promises, appear to be reluctant participants in real and sustainable change. Added to the challenge are health care systems (health regions, hospitals,

clinics, outreach services, health sciences training, research) that refuse to embrace sweeping reform in which Indigenous people are full participants in decision making and health care planning for their people. As noted in the RCAP report, "despite the extension of medical and social services (in some form) in every Aboriginal community...and the large sums spent by the Canadian governments to provide these services... Aboriginal people still suffer from unacceptable rates of illness and distress. The term crisis is not an exaggeration." (1996:10). The departure from sole reliance on biomedical approaches to culturally safe and relevant mental health promotion, prevention and treatment for Indigenous peoples found in RCAP has yet to be enacted. While notable advances such as the *First Nations Mental Wellness Continuum Framework* (http://nnapf.com/first-nations-mental-wellness-continuum-framework/) are helping to redirect governments' understanding of Indigenous mental health and provide support for culturally safe Indigenous driven frontline services and supports, the same troubling statistics and stories, and calls for new and innovative solutions expressed by RCAP are currently echoed in the *Calls to Action* provided by the TRC (2015). Available reports and analyses provided over the past 20 years demonstrate that many of the mental health service and disparity gaps are not narrowing for Indigenous peoples, and some are increasing (Bombay et al., 2016; Gracey & King, 2009; RCAP, 1996).

Recognizing the continuing health and social disparities in Canada, the TRC report provides 94 *Calls to Action* "to redress the legacy of residential schools and advance the process of Canadian reconciliation" (2015). The *Calls to Action* include wide-ranging and concrete recommendations to improve the quality of life of Indigenous peoples living across Canada. Among these is *Action* 19, which calls on the federal government to "close the gap in health outcomes", and to make it a priority to monitor health related issues among the various Indigenous groups in Canada. Both now and 20 years ago, evidence is clear that improving the health of Indigenous peoples requires implementing new strategies to improve health care delivery for Indigenous peoples, while also addressing the larger social and economic disparities that are the legacy of colonization. Nowhere is this truer than in mental health care, where the scale back or stagnation of funding for community healing, and mental health and addictions prevention, and treatment has occurred despite elevated rates of suicide, addictions, depression and other forms of mental and social distress persisting across Indigenous communities at unacceptable levels.

The TRC also calls for the federal and provincial/territorial governments to commit to reduce the gaps in the child welfare system (*Call 1*), the education system (*Call 7*), the justice system (*Call 30*), and to address inequities related to other social, cultural, economic, and political determinants of health among Indigenous populations in Canada (TRC, 2015). Inequities in these and other areas are the main source of mental health disparities within Canadian society, and are compounded by the need for significant improvements to health care delivery and mental health promotion for Indigenous peoples (Marmot & Allan, 2014; World Health Organization, 2015). For this reason, additional TRC *Calls to Action* (18, 20, 21, 22, 23, 24) were generally aimed at providing equitable access to quality and culturally-safe health care services and health promotion programs.

Since 2001, increasing evidence has accumulated that much can be done to reduce gross health inequities – which must include addressing the social determinants of mental health – including the provision of universal health care designed to be equitable in both access and outcomes (Marmot & Allan, 2014). Beyond the compelling moral, social justice, and in some cases legal reasons for implementing the TRC *Calls to Action*, there is increasing evidence in

support of economic reasons for prioritizing investments in a concerted and holistic effort to reduce health disparities that have substantial human and economic costs. When individuals are healthy they are able to contribute more fully to the economy and are less reliant on health and social services (Braveman, Egerter, & Mockenhaupt, 2011). As recognized in 2001 by WHO, "appropriate investments in improving health can provide an important set of instruments for poverty reduction and economic growth" (2001:3). Although detailed financial and economic analyses are difficult to provide because of the complex interrelationships that exist between numerous health determining factors, there exists sufficient evidence "to show that many interventions are efficient, equitable, and effective when decided and delivered in the right way" (Marmot & Allan, 2014).

The contribution of RCAP to major developments in mental health, wellness and healing

Over its mandate, the RCAP held 178 days of public hearings, visited 96 communities, consulted experts, commissioned research studies, and reviewed past inquiries and reports (1996a). The five volume report provided Canada with a comprehensive analysis of Métis, First Nations and Inuit peoples' experience of colonization, the contemporary realities in which they were living, and a set of recommendations that mapped a new and distinct path for the future of Indigenous and Settler relations. Recognition of Indigenous self-determination and nation to nation relationships frame much of the reports' analysis, this includes the Commissioner's recommendation that "Governments recognize that the health of a people is a matter of vital concern to its life, welfare, identity and culture and is therefore a core area for the exercise of self-government by Aboriginal nations" (1996b:Chpt3 Health and Healing # 3.3.2).

The recommendations in Volume 3 under "Health and Healing" focused significant attention on infrastructure and governments committing resources for the development of a system of Aboriginal healing centers and lodges across Canada that would foster holistic and culture-based health and wellness services. Along with this came an emphasis on Aboriginal human resources "compatible with the new system, its values and assumptions." (RCAP 1996b, Vol 3, Chpt3 Health and Healing #s 3.3.5, 3.3.6). All of the recommendations included First Nations, Inuit and Métis, with special emphasis given to Métis (#s 3.3.9), urban, rural and settlements (#3.3.9), treaties (#3.3.9), and Aboriginal women's organization (#s 3.3.13, 3.3.15).

In its recommendations, the RCAP began with the idea that Aboriginal self-government would be established across social, economic and political spheres (1996a). As such, health care would eventually be delivered under Aboriginal jurisdiction, with a framework being developed in the interim "whereby agencies mandated by Aboriginal governments or identified by Aboriginal organizations or communities could deliver health and social services operating under provincial and territorial jurisdictions." (1996b: Chpt3 Health and Healing # 3.3.3.). The Commission spent considerable time in its recommendations on the establishment of policies, legislation, regulations, and funding that addressed gaps in the health care system, broke down jurisdictional barriers between and within governments, pooled resources and provided adequate funding to improve health outcomes across all Indigenous communities (#3.3). Aboriginal control, recognition of diverse Indigenous cultures and histories, an increase in Aboriginal human resources, and extension of practices of traditional healing and their application to contemporary Aboriginal health and healing problems, were woven throughout the recommendations (1996b).

Specifically, in addressing intergenerational trauma, addictions and mental illness/distress, emphasis was placed on holistic models of healing and promotion of wellness

and healthy lifestyle choices (#3.3). Castellano, Archibald, and DeGangé (2008,2) point out that the hearings, research, and the RCAP reports specifically brought into public view the devastating effects of the residential school system. The Commission wrote: "No segment of our research aroused more outrage and shame than the story of the residential schools…the incredible damage—loss of life, denigration of culture, destruction of self-respect and self-esteem, rupture of families, impact of these traumas on succeeding generations, and the enormity of the cultural triumphalism that lay behind the enterprise—will deeply disturb anyone who allows the story to seep into their consciousness and recognizes that these policies and deeds were perpetrated by Canadians no better or worse intentioned, no better or worse educated than we are today…It is also evident of the capacity of democratic populations to tolerate moral enormities in their midst." (Royal Commission on Aboriginal Peoples, 1996:601-602 quoted in Castellano, Archibald & DeGangé 2008,2).

The accounts given by Survivors of the residential school system to Commissioners not only brought to the forefront the intergenerational impacts of government policies, and from which the Commissioners argued for a more extensive public inquiry into the residential school system, but it also highlighted the damning effects that government policies generally had on the health and wellbeing of Indigenous peoples. In fact, government policies, as described in the RCAP, are arguably the most harmful determinant of mental health, and health generally, for Indigenous peoples across Canada, with rates of addictions and mental illness/trauma being some of the most devastating intergenerational impacts resulting directly from government policies. The Commissioners wrote:

Successive governments have tried - sometimes intentionally, sometimes in ignorance - to absorb Aboriginal people into Canadian society, thus eliminating them as distinct peoples. Policies pursued over the decades have undermined - and almost erased - Aboriginal cultures and identities. This is assimilation. It is a denial of the principles of peace, harmony and justice for which this country stands - and it has failed. Aboriginal peoples remain proudly different. Assimilation policies failed because Aboriginal people have the secret of cultural survival. They have an enduring sense of themselves as peoples with a unique heritage and the right to cultural continuity. This is what drives them when they blockade roads, protest at military bases and occupy sacred grounds. This is why they resist pressure to merge into Euro-Canadian society - a form of cultural suicide urged upon them in the name of 'equality' and 'modernization'. Assimilation policies have done great damage, leaving a legacy of brokenness affecting Aboriginal individuals, families and communities. The damage has been equally serious to the spirit of Canada - the spirit of generosity and mutual accommodation in which Canadians take pride (1996a).

In the late 1990s into the first decade of the new millennium, the RCAP report motivated and created momentum within governments to fund healing and wellness initiatives and to commit to reducing rates of addiction and mental illness/distress across Indigenous communities; reserve, settlement, remote, rural and urban. As Wayne K. Spear writes in his manuscript documenting the history of the Aboriginal Healing Foundation (AHF), the period following the release of the RCAP up to 2007 was a unique, albeit brief, period when Indigenous people were involved at a high-level in the design of policy instruments (2014:4). It was not business as usual in Ottawa. At the center of this, was the creation of Indigenous-led and Indigenous designed national bodies such as the AHF and the National Aboriginal Health Organization

(NAHO). While these organizations were not without their critics and were influenced by governments in setting their mandates, optimism and recognition that the country was taking a new direction spread across Indigenous nations. With this came funding for new mental health and healing initiatives, and Indigenous communities and organizations rose to the challenge, championing local community-based healing work.

At the center of mental health care reforms that Indigenous peoples have advocated for over the past twenty years, is addressing inter-generational trauma and the need for sustainable healing and wellness supports. Addressing addictions and suicide are two top priorities, with new forms of illicit drugs and gambling presenting new challenges in treating addictions, and suicide, particularly among youth. Indigenous health care leaders have also advocated for improvements to health care systems including, better access to mental health and addiction therapists and other care supports, and addressing barriers and gaps in services, including reducing governmental jurisdictional barriers to care.

The Indigenous concept of "cultural safety," and its application to everyday mental health care and addictions, highlighted the need for Indigenous languages and traditional healing practices and medicines to be entwined in mental health and healing pathways for Indigenous peoples, and for greater awareness on the part of non-Indigenous health care providers of historical Indigenous/Settler relations and the intergenerational trauma resulting from colonization (ref). Addressing acts of racism and systemic racial discrimination were, and continue to be, battles that Indigenous peoples fought across the human service sector, with racism been shown to be directly correlated with inadequate patient care and poor health outcomes for our people (Allan & Smylie 2015).

Established Indigenous organizations such as the National Native Addictions Partnership Foundation (now Thunderbird Partnership Foundation), Aboriginal Nurses Association of Canada, National Associations of Friendship Centres, Native Physicians Association of Canada, and the Native Mental Health Association of Canada (now First Peoples Wellness Circle) expanded their work with new resources and driven by the direction described by RCAP. National and regional Indigenous political bodies, such as the Assembly of First Nations, Métis Nation of Canada, Inuit Tapiriit Kanatami, the Native Women's Association of Canada and the Aboriginal Peoples Congress partnered with Indigenous organizations, creating significant momentum for improved mental health care and healing across Canada.

Indigenous artists, writers, actors, and musicians were also influenced by the release of the RCAP report, and over the past twenty years have been instrumental through their creativity and activism in inspiring the country's thinking about healing and reconciliation. Specifically, they explored ideas and issues related to identity, colonization, healing, land, language, intergenerational trauma, resilience, and racism. Their work changed the national landscape, including raising public awareness both within and beyond Indigenous communities, drawing attention to injustices and inequities, and challenging government policies and treatment of Indigenous peoples (Episkenew 2009).

Drawing upon their diverse voices and vantage points as activists, leaders, traditional knowledge keepers, health care providers, innovators, researchers, and educators, First Nations, Inuit and Métis peoples have woven new narratives for community, family and individual healing, self determination, and cultural revitalization. Twenty years later, it is apparent that the structural, legislative, policy, political, economic, and social changes described in the RCAP reports have largely been unrealized, and where sustainable gains have been made, this is often because of successful, albeit lengthy, legal battles (Ralston Saul,2014). Disparities contributing

to mental distress have not decreased in many Indigenous populations and they continue to be driven by compounding and persisting negative social determinants such as poverty, unemployment, over crowding, and the child welfare system.

The past 20 years, has however, seen Indigenous peoples across generations and through their cultures, languages, art, political involvement, education, research, and national and international forums, disrupt, resist, reinvent, and re-establish the relationship that they have with the rest of Canada. Significantly more awareness exists across Canada about the inter-generational impact of government policies on the lives of Indigenous peoples, most specifically the impact of the residential school system. The strength, wisdom and voices of Survivors has truly transformed Canada and we have crossed a threshold as a country where it is impossible for governments at all levels to ignore what happened and to disagree with calls from Indigenous leaders that profound change is necessary.

Canada has also adopted the *United Nations Declaration on the Rights of Indigenous Peoples* and implementation of the TRC *Calls to Action* are being taken up across the country by different levels of government, health authorities, educational institutions, child welfare systems, and justice. If reflecting on the work of RCAP teaches us anything as we move forward, it is that as Indigenous peoples we must be vigilant that shifts in political power (federally and provincial/territorial) do not make us vulnerable to our efforts being dismantled or coopted by governments. New agreements between Indigenous leadership bodies and federal, provincial and territorial governments concerning resource allocation for mental health and addiction services, community-based healing, and addressing inter-generational trauma must be based upon reflection of the past twenty years and the success of, and challenges faced by Indigenous self-determined bodies such as the AHF, NAHO, and Thunderbird Partnership Foundation. All four national political parties represented in the House of Commons must agree that when evidence of growing momentum in community healing, reduction of addictions, improvements to mental health, wellness, and addressing inter-generational trauma occurs and evidence of successful outcomes is provided by self determined Indigenous bodies, that these gains are not vulnerable to being dismantled and undermined when changes in federal leadership occurs. Both RCAP and the TRC argue for Indigenous leadership and self determination as necessary for Canada to address our destructive colonial legacy. We now turn our attention to the work of the Aboriginal Healing Foundation and lessons learnt from our recent past.

Lessons from our Recent Past: The Aboriginal Healing Foundation

The Aboriginal Healing Foundation (AHF) began its work in 1998 and was the largest funded healing initiatives created to address the recommendations of RCAP. The AHF was created through a contribution agreement of 350 million dollars between a nationally representative board of directors comprised of Métis, First Nations and Inuit peoples and the federal government. The Foundation was set up as a not-for-profit organization which operated at arms length from Government and the representative Aboriginal organizations. In describing its mission, the AHF wrote:

We see our role as facilitators in the healing process by helping Aboriginal people and their communities help themselves, by providing resources for healing initiatives, by promoting awareness of healing issues and needs, and by nurturing a broad, supportive public environment. We help Survivors in telling the truth of their experiences and being heard. We also work to engage Canadians in this healing process by encouraging them to walk with us on the path of

reconciliation. Ours is a holistic approach. Our goal is to help create, reinforce and sustain conditions conducive to healing, reconciliation, and self-determination. We are committed to addressing the legacy of abuse in all its forms and manifestations, direct, indirect and intergenerational, by building on the strengths and resilience of Aboriginal peoples (www.ahf.ca).

At the end of its mandate the AHF had funded over fifteen hundred community-based projects over a 15-years period (Spear, 2014). The AHF adopted a two-pronged research program to establish an evidence base for Indigenous community healing and distributed to Indigenous communities, organizations and government across the country a strong evidence base for community based healing and comprehensive reviews of important healing, mental health and addiction topics. (Castellano & Archibald APR volume IV pp 69). Castellano and Archibald describe the AHF as working as a liaison between mainstream resources and Aboriginal peoples with an Aboriginal board of directors steering its mandate (Castellano & Archibald APR volume IV pp 69).

The AHF partially responded to RCAP's recommendation for "the development of a system of Aboriginal healing centers and healing lodges under Aboriginal control as the prime units of holistic and culture-based health and wellness services" (RCAP 1996b, 214). RCAP envisioned healing centers that followed a holistic vision of health rather than a traditional biomedical model emphasizing treatment for specific illnesses. The healing center model advocated by the Commissioners included traditional healers, Elders, community health representatives, interpreters, nurses, doctors, and other health professionals, and could be modified to suit the needs of specific communities (RCAP 1996b). RCAP (1996b) also emphasized that many Indigenous peoples wanted access to healing services that were grounded in their traditional practices and delivered within their communities. Funding community-driven healing initiatives was a core principle of the AHF (DeGagné, 2014). From 1998 to 2014, the AHF was the primary national funder of initiatives aimed at promoting well-being and healing among Residential School Survivors and their families, including funding 12 healing centers across the country (AHF, 2014). Residential adult and youth treatment centers for addiction also provided addictions and healing support during this time through programs such as the National Native Alcohol and Drug Abuse Program (NNADAP), the National Youth Solvent Abuse Program (NYSAP), and, Métis Addictions Council. High need continues to exist in all regions of Canada for addictions services for Indigenous peoples, with pressing need recently identified in Nunuvut for a residential mental health and healing center. With new highly addictive and lethal illicit drugs emerging across Canada, and an increase in gambling across Indigenous communities, the demand for in-patient and outpatient addiction and healing services is still high.

Despite its success, the AHF faced organizational challenges, particularly in regards to what some Residential School Survivors interpreted as its narrow mandate. Some Survivors felt the AHF should provide funding to revitalize language and culture, rather than focusing so much of its mandate on projects that addressed the harms caused by physical and sexual abuse experienced by students who attended residential schools (Spear, 2014). Despite political and institutional barriers that narrowed the scope of what the AHF could fund, there were numerous types of projects eligible for AHF funding: healing services, prevention and awareness initiatives, healing capacity training, knowledge building, needs assessments, legacy funding, conferences, and project design (AHF, 2003). However, reflecting upon the level of need, service

providers encountered within Indigenous communities, almost three-quarters (70.9%) of the AHF's funding was allotted to community-based healing projects (AHF, 2014:17).

Over its 15 year mandate the reach and impact of the AHF projects was significant. For example, it is estimated that over 200,000 Indigenous people participated in AHF funded programs between 2000-2004, of whom about two-thirds had never participated in any previous healing activities (Castellano, 2006:201). Residential School Survivors accessing AHF-funded projects preferred to access traditional healing supports such as Elders and ceremonies, and found these services to be the most critical to their overall well-being (AHF, 2003, 2014). One of the notable impacts reported in case studies of funded projects, was that the "silence" and shame surrounding residential school abuses were being broken, creating safe community and family environments for healing. The wide spectrum of benefits reported by participants speaks to the innovative approach adopted by many of the AHF-funded community-driven initiatives. Reported individual impacts ranged from improved family relationships, increased self-esteem and pride, achievement of higher education and employment, and the prevention of suicides. Reported community impacts included, growth in social capital indicators such as volunteerism, informal caring networks, and cultural events (AHF 2014).

A later assessment was undertaken by DPRA Canada in collaboration with T.K. Gussman Associates, on behalf of Indian and Northern Affairs Canada (INAC), of 20 AHF community-based initiatives for the period April 2007 to May 2009 (INAC, 2009). This evaluation revealed that the AHF-funded healing programs were effective in contributing to individual and community healing. Importantly, the INAC report (2009) found that program enrollment grew by an average of 40% for the AHF projects, and that the healing initiatives were particularly successful in engaging hard to reach groups, including men and youth, suggesting that the availability of culturally relevant healing led more individuals to seek assistance (2009:23). Indeed, 62% of program participants reported that AHF healing projects were either the most important factor in their healing or contributed "quite a bit", and a further 53% stated that their participation in AHF programming led them to connect with other sources of healing and/or therapeutic interventions (INAC, 2009:26).

Despite the recognized successes of AHF-funded programs, the needs in communities extended beyond the financial resources that were available. In this regard, by 1999 the AHF had received eligible applications from communities across Canada that would have cost over a billion dollars to fund (AHF, 2014). The number of AHF healing projects reached its peak at 249 projects in 2003-04 (AHF, 2016), at which time most of the resources were being allocated towards healing initiatives. However, only 11% of service providers reported feeling confident that they were reaching individuals who had the greatest need for healing (AHF, 2003). Approximately 36% of funded healing initiatives had waiting lists, and program staff stated that many Survivors were unable to receive care due to this and other limitations (AHF, 2006a).

Based on the study conducted by INAC with the 20 AHF initiatives, 99% of those who participated in the assessment asserted that individuals and communities still required a great deal of healing (INAC, 2009, p. 44). The INAC report (2009) concluded that these projects were significantly under-resourced and were only able to address a minority of issues faced by the populations they were serving. Addressing the health and healing needs of individuals and families who were inter-generationally affected and of Indigenous youth were two particularly critical issues that were highlighted as not adequately being addressed (INAC, 2009). The assessment also called for continued funding support and further assessment of initiatives into the post-Indian Residential School Settlement Agreement era (INAC, 2009).

When a government evaluation of AHF programs was completed in 2010, as required by the Settlement Agreement, it recommended ongoing funding. Despite this and other calls for continuation of the AHF funding, a wind-down strategy was implemented. The closure of the AHF had devastating impacts on the healing journeys of Survivors, their families and communities (AFN, 2013). It is clear from the work of the AHF, and more recently the TRC, that a dire need exists across Canada for healing initiatives for Residential School Survivors, their families and their communities. Expanding upon this argument we would add that targeted healing initiatives for Survivors of the "60s scoop" and child welfare systems, generally are also needed.

Indigenous health care leaders and providers argue that communities lack adequate resources (services and human resources) to address individual and community trauma associated with residential schools and other colonial impacts (Macmillan & Glode-Desrocher, 2016; Bombay, 2014). Social and geographical location further complicates the challenge of providing adequate services to high risk individuals, as does the vulnerabilities healing programs experience as the result of inadequate and short-term funding practices of governments. Similar to programs funded by federal and provincial/territorial governments, the AHF required projects to provide activity, outcome and financial reporting on the projects they funded. However, as an organization, the expertise within the AHF and the flexibility within their oversight of projects meant that they were able to work more effectively with the projects they funded than did traditional government funding models. The AHF was able to work with communities to fine-tune and modify projects as required in order to maximize their impact for participants and communities. This approach was different than traditional government funding approaches, which tends to be rigid and inflexible in dealing with programmatic and budget adjustments.

Even today, many Indigenous people do not know their family history in relation to residential school attendance – or only recently found out. The lack of knowledge surrounding family and community histories related to the residential school system speaks directly to the importance of funding for educational initiatives surrounding the historical and contemporary impacts of residential schools alongside direct therapeutic programs. In this regard, the AHF highlighted the critical need for legacy activities to assist communities in making sense of the history of the residential school system and historical trauma. To identify the contemporary impacts of the residential school system found within Indigenous communities, "recovery of awareness" is an integral goal of the healing process (Wesley-Esquimaux & Smolewski, 2004, p. 78). Along with the positive impacts of AHF projects identified by healing participants in the INAC study, they also expressed concern about the implications of dealing with centuries of unresolved grief and the consequences of AHF funding being discontinued (INAC, 2009, p. 44).

The majority of AHF-funded programs had no alternative funding sources and were forced to shut down. Although the AHF recommended that healing initiatives receive at a minimum ten years of sustained core funding to begin adequately addressing the needs of communities and ensure continuity of care (Castellano, 2006), current funding structures for mental health services and healing are most often designed as short term crisis-based interventions that limit the ability of Indigenous communities to offer services that address long-term healing goals (Lane, Bopp, Bopp, & Norris, 2002). In their final report and after 15 years of funding community-based programs, the AHF noted that "we are still living with the legacy of the residential school, as we knew we would" (2014, 4). The anticipated discontinuation of AHF community healing was described as "catastrophic", "disastrous", with one participant succinctly stating that "we had 100 years of abuse and 12 years of healing" (INAC, 2009:49).

The challenges facing survivors, their descendants, and their communities are complex and varied. Indigenous peoples view individual and collective healing as an ongoing process that requires supports and services far beyond the fifteen-year mandate given to the AHF (Bombay et al., 2014; DeGagne, 2007; Reimer et al., 2010; Waldram, 2014). The reasons the AHF's mandate ended is not because it did not justify the widespread benefits it had achieved for Indigenous peoples. Rigorous scientific and community-based evaluations clearly demonstrated the high level of effectiveness and potential achieved by the AHF in its short mandate. Rather, despite national lobbying by Indigenous peoples, the Conservative government ignored the evidence supporting a renewal of the AHF's mandate. Instead resources for mental health/healing once again fell under the administration of First Nations and Inuit Health Branch, Health Canada, and the collective capacity, experience, and knowledge held within the AHF lost.

For many communities, a culture of silence surrounding residential school experiences persisted, and many Survivors were still hesitant to share their experiences (McMillan, 2013). For some, the TRC hearings were the first time they publicly discussed what occurred within the schools they attended. Although the Settlement Agreement represents an important step in the healing process, aspects of it have been spiritually and emotionally difficult for Survivors and their families (Reimer et al., 2010). The TRC has completed its mandate, but Survivors and their communities are still working towards addressing the spiritual, emotional, physical, and mental harms stemming from residential schools. Whether the creation of a new national organization similar to the AHF is the right direction for our country is yet to be determined as we tackle the implementation of the TRC's *Calls to Action*. What we do know is that First Nations, Inuit, and Métis people are best positioned to make the decision about what is best for their communities and families. If governments and political parties across Canada, most especially the federal government and parties, are truly committed to reconciliation than they must move quickly and efficiently to work with Métis, First Nations and Inuit leader towards an Indigenous self determined path(s) forward.

Indigenous Ways of Healing and Helping

As a result of colonization and the history of chronic exposure to individual and collective traumatic events, healing has become an important concept that is significant to the mental health and well-being of Indigenous peoples in Canada and internationally (Robbins & Dewar, 2011; Wadden, 2009; Waldram, 2008). RCAP (1996) defined Indigenous healing as, "personal and societal recovery from the lasting effects of oppression and systematic racism experienced over generations" (p. 109), and has similarly been described as a "journey" and "ongoing process" by Residential School Survivors and Indigenous peoples generally (Quinn, 2007; Reimer et al., 2010; Waldram, 2008; Wilson, 2003). Because the cultural genocide experienced by Indigenous peoples has contributed to health inequities, activities that strengthen and support various aspects of Indigenous cultures and identities are an important component of healing and wellness (Bombay, Matheson, & Anisman, 2010; Lavallee & Poole, 2010; McCabe, 2007; Morrisette, 2003). Indigenous healing is often concerned with the reparation of social relations, such as familial and community bonds that have been effected by the legacy of colonization, particularly the residential school system (Waldram, 2014).

In the past twenty years, Indigenous peoples across Canada have engaged whole heartedly in healing and helping activities. The "healing movement" did not happen as the result of RCAP, however the RCAP gatherings and final report greatly contributed to national awareness and understanding that to move forward, healing was central for Indigenous peoples

and the country generally. In his assessment of the importance of Indigenous healing work, Waldram argues that the Indigenous healing movement is "perhaps the most profound example of social reformation since Confederation" (7). He writes:

The potential impact of the movement—for all Canadians and especially Aboriginal people—is profound. The efforts to restabilize Aboriginal societies after centuries of damaging government policies continue to revitalize individuals and communities that, in turn, contribute to a healthy and vibrant future. (7).

The Indigenous healing movement is not however, a "pan-Indigenous" movement as some have suggested, rather it is collective Indigenous awareness that at its core holds truth telling, acknowledgement, forgiveness, courage, and reconciliation as its foundation. The healing movement is a unique complex cross-cultural transformative movement grounded in diverse Indigenous world views and the hard work of dedicated Indigenous leaders, Elders, healers, front-line workers and, volunteers. Over the years, national institutions such as the Aboriginal Healing Foundations, Thunderbird Partnership Foundation (formerly the National Native Addictions Partnership Foundation), Truth and Reconciliation Commission of Canada, First Peoples Wellness Circle, the Native Human Service Program, and the Salishan Institute Society (Mussell 2014: 193) have reinforced the movement, however at its heart, the movement draws its enduring energy from grassroots dedication and local relevance. The essence and purpose of the healing movement *is* wholly Indigenous, deriving its momentum from the cultural, linguistic and historical diversity of Inuit, First Nations and Métis peoples and the shared teachings provided by the land, sentient beings, and the elements. It is self-determined, bold, loving, and embracing.

The distance between local healing and and a national movement of healing is minimized by a shared understanding by First Nations, Métis and Inuit peoples that collective healing for all Indigenous peoples must occur. The deep wounds of colonization require healing and reconciliation for First Nations *and* Métis *and* Inuit to be equally prioritized by governments and supported across the country. This is the direction given by RCAP and is fundamental to reaching the goals set out by both RCAP and the TRC. Both RCAP and the TRC also argues that non-Indigenous Canadians too must deal with Canada's colonial past if we are to move forward as a country. For over a century the central goal of government policies directed towards First Nations, Inuit and Métis peoples was "cultural genocide. The coercive measures adopted by governments did not however, achieve this goal and Inuit, Métis and First Nations peoples have not surrendered their Indigenous identities and rights. They have however, been left with a legacy of pain, damage, and trauma that requires national and local recognition and support by Indigenous and non-Indigenous Canadians alike, for recovery to occur. (TRC 2015:8). The TRC concludes:

For many Survivors and their families, this commitment is foremost about healing themselves, their communities, and nations, in ways that revitalize individuals as well as Indigenous cultures, languages, spirituality, laws, and governance systems. For governments, building a respectful relationship involves dismantling a centuries-old political and bureaucratic culture in which, all too often, policies and programs are still based on failed notions of assimilation. For churches, demonstrating long-term commitment requires atoning for actions within the residential schools, respecting Indigenous spirituality, and supporting Indigenous peoples' struggles for justice and equity. Schools must teach history in ways that foster mutual respect, empathy, and engagement.

All Canadian children and youth deserve to know Canada's honest history, including what happened in the residential schools, and to appreciate the rich history and knowledge of Indigenous nations who continue to make such a strong contribution to Canada, including our very name and collective identity as a country. For Canadians from all walks of life, reconciliation offers a new way of living together (2015:126).

The present day challenge, William Mussell argues, is that Indigenous peoples are diverse and their lifestyles fit somewhere on a continuum between "somewhat traditional" and "mostly Western." Mussell observes that because acculturation over the past four and five generations emphasized materialism and individual rights, the mutual aid and togetherness traditionally characteristic of Indigenous cultures and societies is greatly undermined (Mussell 2014:192). It is largely recognized that most Indigenous families and communities cannot or may not want to, return to life on the land and traditional subsistence activities to heal and recover, however the corrosive effects of widespread poverty and economic marginalization means that many Indigenous people and their communities are unable to fully participate in Settler society either. Kirmayer, Tait and Simpson write, "the presence of mass media even in remote communities makes the values for consumer capitalism salient and creates feelings of relative deprivation and lack where none existed before. Even those who seek solidarity in traditional forms of community and ways of life find themselves enclosed and defined by a global economy that treats 'culture' and 'tradition' as commodities or useful adjectives in advertising campaigns (2009:14).

Diversity in religious beliefs and the complex relationship that Indigenous peoples have with Christianity and the Church stemming from their experiences with the Residential School System and other colonial involvement of the the Church, further complicates Indigenous identity and ways of being "Indigenous" in contemporary Canadian society. Tensions between those who practice Indigenous spirituality and traditions and those individuals who are faithful to Christianity can divide communities and create social barriers for collective healing to occur. Government policies that apply various status identifiers onto Indigenous identity such as "Registered Indian" "Status Indian", "non-Status Indian", and "Aboriginal," also create identity and jurisdictional confusion and further complications for those individuals and families seeking help.

The complexities which contribute to Indigenous identity and how individuals and groups choose to conceptualize and participate in forms of healing and recovery are also challenged by health care systems that generate prevention, treatment and recovery models for mental illness and distress outside of Indigenous communities. Across Canada, Indigenous peoples participate in biomedical and Indigenous forms of healing, and it is not uncommon for Indigenous peoples to draw upon healing approaches from across a spectrum of culturally-based healing practices. In addressing the helping professions (social work, psychology, nursing, counselling and medicine), Hart argues that in order for the helping professions to support Indigenous peoples to address the intergenerational impacts of colonization, they must take on a more nuanced understanding that Indigenous peoples, like other Canadians, express themselves in diverse and complex ways, depending on where in the society they are socially, culturally and linguistically located. He argues that regardless of the apparent diversity across Indigenous groups, deep rooted Indigenous understanding of ways of being are present even when not apparent to outsiders (2014: 81-82).

Considering the wide variations in rates of mental illness and addictions across Indigenous communities directs us to the importance of considering the diverse landscape of

local contexts and the different ways that groups respond to the persistent and oppressive stresses of colonization, sedentarization, bureaucratic surveillance, and technocratic control (Kirmayer, Tait & Simpson 2009:20). Elevated rates of emotional distress and problems like depression, anxiety, substance abuse, and suicide are intertwined with individual identity and notions of place and belonging, which in turn are strongly influenced by collective processes at the level of band, community, or larger political entities (Kirmayer, Tait, & Simpson 2009:20).

Wesley-Esquimaux and Smolewski (2004), argue that a central theme of the healing movement has been the recognition by Indigenous peoples that they need to overcome learned social helplessness, commonly manifested as substance abuse, self-harm, violence and disengagement. They write:

> Today's Aboriginal people of North American, like many other dispossessed and colonized groups, constantly have to re-negotiate their cultural and political identities, and their historic memories, vis-à-vis a legal and economic context created for them by a non-Aboriginal government…In this climate of revival and change, it is vitally important to understand the mechanisms by which practice (Aboriginal people's lives, today and in the past) and identities (how Aboriginal people interpret themselves and their positions in the world outside their communities) are linked with past events and past experiences. This understanding is far more important to the healing process necessary for Aboriginal people to regain lost social and cultural selves than just finding a handy (albeit empty and dry) definition for the underlying fabric of these identities and practices used when dealing with their non-Aboriginal counterparts (2004:83)

A common understandings held by Indigenous peoples is that "healing" is a life long journey that is traveled in everyday life (Fletcher & Denham 2008:101). The "journey" or the "path" undertaken is meant to be transformative, from a place of pain to a better life. However, it is understood that the journey is difficult and without end, and every person must be vigilant in their self care and care for others. Equally, healing is conceptualized as a shared journey, one in which individual healing blends with collective healing of family, community and nation. This is commonly the misunderstanding made by governments and Western trained health care providers about the experience of mental illness and addictions in Indigenous communities. While one does not need to be mentally ill or addicted to choose a path of healing, for those who live with mental illness or additions, a shared journey, one characterized by collective understanding and communal caring, is most often the most meaningful and efficacious. The tendency of Western medical systems and governments to marginalize the importance of collective healing speaks to a lack of understanding of what intergenerational trauma is, how it is experienced and how individuals and families reconcile it to live meaningful lives.

In studies that examine healing across Inuit, Métis and First Nations communities, pressure exists to idenitfy "best practices" as a way to identify approaches or interventions that work and that can be transferred to other Indigenous groups. This is driven by several factors both from within and outside of the Indigenous communities and organizations. For example, in discussing the concept of best practices, Kenn Richards states:

> The problem with "best practice" as I've been experiencing it, is that it comes out of research that is decidedly non Aboriginal. We have to convince academics and particularly funders that there are alternative forms of practice…But best practices clearly need to be developed within

the context in which you are going to apply them at the end of the day, and I think we have a long way to go with respect to that" (quoted in AHF, 2006c:6)."

What Richards points out is an ongoing tension between Indigenous healing approaches that believe healing is both an individual and collective journey, therefore responses to individual and social suffering must be grounded in the everyday context in which people live. This contrast with Western understanding of healing, in which the treatment of an individual's mental distress and illness is through individualized care plans involving combinations of pharmacological interventions, institutionalization, and generic treatment approaches outside of the family and that are proven to relieve symptoms and promote recovery.

Over the past twenty years, this tension has not subsided however, through Indigenous led initiatives and evaluative processes, a much better understanding of what constitutes successful healing approaches for Indigenous peoples exists (e.g. work of the AHF, Thunderbird Partnership Foundation, RHS). Indigenous peoples, as stated above, are very adept at drawing from diverse healing approaches, commonly thinking nothing of blending traditional, Western and other forms of healing to create meaningful supports and interventions. In areas of mental health and addictions this is particularly true, where the blurring of knowledge and practice boundaries over the past twenty years has occurred in favour of prioritizing the needs of individuals, families and communities. Traditional healing, medicines, and spirituality commonly co-exists in Indigenous communities with drug-based therapies, harm reduction interventions, and psychiatric and mental health services. In some instances, "alternative" or "complementary" medicines and treatments are adopted or modified to fit with local healing methods thereby expanding the options that people have on their healing journey.

Promising Practices

Twenty years after the release of RCAP, elevated rates of mental and social distress across Indigenous communities persist, however, many gains have been made through community based healing, recovery, and treatment. Although there are diverse healing practices both within and between the diversity of Indigenous cultures and communities, there are some key healing concepts and practices shared among nations (AFN, 2014). In this regard, traditional perspectives of Indigenous health and healing are grounded in ideas of holism, that integrate a person's spiritual, physical, mental, and emotional states in balance with their physical and spiritual environments (Hunter, Logan, Goulet, & Barton, 2006; McCormick, 1996; RCAP, 1996). Traditional ceremonies occupy a critical role in healing systems, and are important for connecting Indigenous peoples with their spirituality and promote healing (Hart, 2014). For many Indigenous societies, Elders are invaluable in processes of healing, they are the keepers of special knowledge and teachings, and are able to provide guidance and counselling to community members (Manitowabi, 2014).

In discussing suicide, Bodnar writes, "for an explanatory model to be effectives as a basis for finding solutions, it must encompass an understanding of the multiple challenges for Aboriginal people and the risk and protective factors at both the individual and community levels" (2014:287). NAHO describes a staged approach whereby interventions move through 3 phases of innovation and achievement: good ideas, better or improved practices, and best practices. The criteria for achieving a best practice includes: impact, sustainability, responsiveness, client focus, including gender and social inclusion, access, coordination and integration, efficiency and flexibility, leadership, innovation, potential for replication, health and

policy issue identification or resolution; and capacity for evaluation (Mable 2001 quoted in AHF 2006c:5-6).

The AHF adopted the term “promising healing practices” in their research and evaluation of community-based healing projects and identified the following key characteristics that make a healing practice successful: “values and guiding principles that reflect Aboriginal world view; a healing environment that is personally and culturally safe; a capacity to heal represented by skilled healers and healing teams; an historical component, including education about residential schools and their impacts; cultural interventions and activities; and a diverse range and combination of traditional and contemporary therapeutic interventions (AHF 2006c:15)

Changes to Research in Mental Health and Healing Research

Indigenous peoples are generally conflicted about mental health and healing research, particularly with the idea of outside academic or government researchers entering their private and communal spaces to collect data about local and traditional healing practices and the mental health status of individuals and communities. The idea that Western trained academics have the required insight and experience to correctly interpret and analyse the data they collect, and to recommend directions for positive changes that are meaningful and relevant to Indigenous peoples draws at best skepticism but more commonly out right hostility that associates Western research approaches with other forms of colonial oppression.

The creation of the Institute for Aboriginal Peoples’ Health (IAPH) in 2001 as one of the 13 Canadian Institutes of Health Research was therefore, a notable gain for Indigenous peoples in mental health, addictions and community healing research. Under the leadership of Dr. Jeff Reading, the IAPH created a network of provincial and regional university-based Indigenous health research centres under the *Aboriginal Capacity and Developmental Research Environments/Network Environments for Aboriginal Health Research* programs that supported Indigenous self-determination in research and drove the expansion of community-based research projects and training of Indigenous researchers across the country (IAPH reports). At the time, IAPH was the first and only national institute in the world focused on improving the health of Indigenous peoples. Almost all of the Centres identified Indigenous healing, mental health and addictions as one of their priority research areas, with one Centre, the National Aboriginal Mental Health Research Centre focused entirely on Indigenous mental health and addictions.

The First Nations Information Governance Centre also emerged as the result of fierce efforts by First Nations to gain national control of health data governance. Out of this effort emerged two important gains, the First Nations Regional Health Survey (FNRHS, or RHS for short) and OCAP™. The RHS and OCAP are the cornerstones of First Nations self determination in national data collection, analysis and governance and the RHS is the only First Nations-governed, national health survey in Canada. Its cultural framework is a four directions framework and “embodies a ‘total person’ and ‘total environment’ model which includes: The individual’s spiritual, emotional, mental and physical well-being; Their culture’s values, beliefs, identity, and practices; Their community and their relationship to the physical environment; and, Their connectedness to family” (RHS National Team, 2007:139). The RHS is implemented explicitly in keeping with the First Nations Principles of OCAP™ - Ownership, Control, Access and Possession (2012 FNIG) and collects information about on reserve and northern First Nations communities based on both Western and traditional understandings of health and well-being.” (http://fnigc.ca/our-work/regional-health-survey/about-rhs.html assessed October 16, 2016). The RHS is currently in the 3rd phase and brings to our national understanding a holistic

analysis of individual and community wellness that guides mental health, addictions and community wellness priorities for FN communities.

Similarly, Inuit and Métis have created their own ethical guidelines for research. This process was partially facilitated by the National Aboriginal Health Organization (NAHO), however Inuit and Métis have not secured the same level of national funding, organization and infrastructure as First Nations, and appear to have their greatest strength in research ethics applied at regional and local levels. The *Nipingit* was a joint program of the Inuit Tuttarvingat of the National Aboriginal Health Organization and Inuit Tapiriit Kanatami (ITK) and set the foundation for Inuit-specific research guidelines. The Métis Centre at NAHO, similarly developed promising practices for research ethics with Métis peoples, and in recent years some provincial Métis bodies particularly in Manitoba and Ontario, have developed and implemented their own guidelines.

The heightened awareness of the importance of Indigenous self determined research that places the research priorities of Indigenous peoples as the center, transformed the ways in which mental health research was undertaken with Indigenous peoples. Rather than focusing on mental and social illness, deficits, diagnoses, and symptoms only, Indigenous communities called for research that studied the resilience and healing journeys of Indigenous peoples.

Reductionist studies documenting rates of maladaptive behavior and symptoms of mental illness were rejected for research studies that were grounded in holistic understanding of the person and their connection to family, community, land, spirit and history. Indigenous communities and academics also challenged Western research processes by advocating for Indigenous community members to be full partners on national research grants, employing and writing about Indigenous research methodologies, and moving to innovative and more effective knowledge translation tools such as video, publishing and presenting at conferences with community members and organizations, writing joint-policy documents with Indigenous research partners, and using social media to disseminate results. While momentum in transforming research was at its height in the 1st decade of this century, unfortunately the loss of the National Aboriginal Health Organization and changes to the governance of the Canadian Institutes of Health Research (CIHR) have diminished the abilities of Indigenous communities and leaders to argue for self-determination in research. The privileging of large scale national research initiatives such as CIHR's Strategy for Patient-Oriented Research, has resulted in Indigenous community stakeholders and academics hanging off the margins of large scale research initiatives most often led by researchers and universities who are ill-equipped, and at times unwilling, to understand the complexities of Indigenous peoples' relationship to research. Indigenous self determination in research is both a moral (e.g. to counter the negative and destructive history of research in Indigenous communities) and practical (higher investment and participation of Indigenous stakeholders) necessity to produce research that contributes to the reduction of health disparities and improved services and care for Indigenous peoples.

Conclusion

For the past twenty years, Indigenous peoples across Canada have reinforced cultural understandings of wellness and healing as being the cornerstone for their future. Wellness and healing are not only related to individual and collective physical, emotional, psychological and spiritual existence, but also to the environment in which people live. The revitalization of Indigenous languages, cultural practices and traditional worldviews has positively reinforced a strong sense of individual and collective healing and wellness that has given rise to

transformation across the country. In this paper we have discussed how some of this process has unfolded, the gains made, the challenges faced, and the reflection that so much more needs to be done. Our paper as an initial draft, only touches upon the depth of complexity of the healing journey that First Nations, Métis and Inuit peoples have been on over the past two decades. Our intention was not to capture all that has happened but rather to point to where RCAP had the most influence and to give some insight into what has unfolded. While much has been accomplished and much has changed, we conclude that in the end RCAP was a missed opportunity for our country, one that had great potential to positively change our country's future. We further conclude, that Indigenous people were ready at the time of the release of the RCAP report to accept the challenges put forward, however despite their tireless efforts, dedication and commitment, the rest of Canada did not embrace the urgent and necessary changes that were required. As we examine and consider a new set of actions, those of the TRC, we conclude by asking whether Canada is ready to truly embrace the 94 *Calls to Action* put forward by the TRC? The suicide deaths of six young First Nations girls in northern Saskatchewan over the weeks that our paper was drafted, is a sobering and powerful message from our youth that Canada must take seriously the challenge before it. At all levels of government, leadership is required that is not afraid to commit whole heartedly, not afraid to support Indigenous peoples to be strong, and not afraid to walk into the future with Indigenous nations.

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