KATOP WASIS SESOMIW NOKALAWIN
MO NAGELAMEG NEOTEETJIT MITJOAATJITJ
NO CHILD LEFT BEHIND

THE FIRST NATION ADVISORY COUNCIL REPORT
TO THE
NEW BRUNSWICK CHILD AND YOUTH ADVOCATE

JULY 2021

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Introduction

In February 2021, Lexi Dakin came to Fredericton's Dr. Everett Chalmers Hospital emergency room with her school Guidance Counsellor when there were concerns about her mental health. She left after eight hours without having received any mental health intervention and died less than a week later by suicide.

On March 5, 2021, the New Brunswick Child and Youth Advocate announced a formal Review into Youth Suicide Prevention and Mental Health Services. The review will investigate the circumstances related to the loss of Lexi's life as well as a broader scope of youth access and experiences of suicide prevention and mental health services, how families are supported in relation to these services, and social and health care needs in relation to youth mental health. As part of the process, three Advisory Councils were established to provide guidance and feedback for the process – Stakeholder, Youth and First Nation Advisory Councils.

The First Nation Advisory Council is comprised of Indigenous and non-Indigenous professionals, service providers and policy analysts (please see Appendix A for a list of Advisory Council members). Members of the Child and Youth Advocates Office participated in meetings as resources as did other representatives from provincial departments and the Regional Health Authorities. Through the review process our Advisory Council heard from First Nation service providers and Indigenous youth during public consultation sessions and experts in Indigenous mental health. We also conducted a literature review on Indigenous youth suicide and promising factors in this area and gained a more comprehensive understanding of the many jurisdictions, structures and parties which play a role in Indigenous youth mental health. Part of this work involved gaining a statistical picture of the demographics and mental health status of Indigenous youth in the province.

This report outlines some of the unique and complex context and jurisdictional circumstances related to mental health services for Indigenous people. The first section, Indigenous Suicide and Mental Health provides an overview of the extent of Indigenous youth suicide in Canada, a model and promising practices for addressing Indigenous youth suicide. In the following section, Towards Effective Mental Health Services for Indigenous Youth, presents steps for improving Indigenous youth suicide beginning with using culture and language as a foundation for services. Culture as Foundation has been recognized as a protective factor in Indigenous youth mental health. This section also outlines the historical evolution of Indigenous health services and its associated jurisdictional complexities and lays out a case for more Indigenous involvement and partnerships in the design and delivery of Indigenous youth mental health services. Challenges in the New Brunswick's public education system and in the criminal youth justice system are briefly discussed. The final section, Building on Progress to Date, calls on future work to be built on recent efforts to improve access and cultural competency of provincial youth mental health and addictions services. The report contains thirteen high level Calls to Action for improving mental health service delivery and outcomes for Indigenous youth in New Brunswick, with a strong Call that a separate, Indigenous-led review in partnership with the Child and Youth Advocate's Office be conducted to give time and space for all Indigenous people on and off-reserve to participate and contribute to the solutions for Indigenous youth. An accompanying report provides a statistical overview of Indigenous peoples in New Brunswick in relation to demographics, mental health related statistics and the social determinants of health.

This Indigenous aspect of the Child and Youth Advocate's review on youth mental health services and suicide prevention is limited in scope. Delivery of mental health services to Indigenous youth is complicated by the jurisdictional lack of clarity and fragmentation of services. More extensive work will be required to fully understand what is needed to improve mental health outcomes for Indigenous youth in the province.

Indigenous Suicide and Mental Health

Between 2011 – 2016, it is estimated that 1,180 Indigenous people in Canada died by suicide. The suicide rate among Indigenous people was three times higher than for non-Indigenous people (24.3 deaths per 100,000 person-years at risk for Indigenous people compared to 8.0 deaths per 100,000 person-years at risk for non-Indigenous people). Suicide rates were highest among indigenous youth between 15 to 24 years of age and higher among First Nations people than non-Indigenous people in most age groups under 45 years of age. The disparities between the suicide rates of Indigenous and non-Indigenous populations were widest among youth up to 25 years of age where Indigenous suicide rates.

For those living on-reserve, the rate of suicidality was about twice as high as for those living off-reserve (34.1 versus 19.5 deaths per 100,000 person-years at risk respectively. Among First Nations people living on-reserve, suicide rates were highest for males aged 15 to 24 years (suicide rate of 78.8 per 100,000 person-years at risk). Suicide rates of Indigenous individuals showed no significant differences between provinces or territories. However, in all jurisdictions, the suicide rates of Indigenous individuals were higher than non-Indigenous rates (Kumar & Tjepkema, 2019).

The picture of the prevalence on Indigenous suicide is incomplete. Population-specific statistics are not readily available and do not capture the full extent of the problem. Provincial, territorial, and federally funded health systems have inconsistent approaches to identifying Indigenous peoples in health information and some provinces, including New Brunswick, do not include ethnic identifiers in administrative or clinical data. This makes it difficult to measure changes in markers for health status at the population level for Indigenous people. In 2017, the Public Health Agency of Canada established the Canadian Suicide Surveillance Indicator Framework (CSSIF) in response to the World Health Organizations' recommendation that all countries develop comprehensive national suicide strategies which integrate a comprehensive suicide surveillance program with policy and interventions. However, the CSSIF does not include mechanisms for tracking Indigenous peoples. Of the approximately 4000 suicides in Canada each year, it is unknown how many were Indigenous. The lack of Indigenous specific suicide data meant that communities, health systems and government cannot effectively assess whether suicides are being prevented as a result of the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) (Pollock et al., 2018).

Elsipogtog First Nation compiled tragic death data between the 30.5-year period of 1990 to 2021 for the purposes of this Review. In these years, the community experienced 159 tragic deaths (e.g., suicides,

death involving alcohol and/or drugs or deaths from tragedies such as car accidents, fires, drownings to infant/child deaths). Suicide was the cause of 33.9% of these deaths and for those who committed suicide, youth between the ages of 0 – 20 years old accounted for 18.5% of deaths, while youth between the ages of 21 – 30 years old accounted for 50% of these deaths. So, 68.5% of suicides in this Mi'gmaq community were by youth under the age of 30 years old (P. Murphy, personal communications, June 8, 2021). At the end of December 2020, the on-reserve population for Elsipogtog was 2,719 people. While further analysis would be required to determine the disparity between Elsipogtog's suicide or tragic death rate compared to that of the general New Brunswick population, the average rate of 5.3 tragic deaths per year (including 1.8 suicides per year) for a small community with many extended family networks has a heavy toll.

In Neqotkuk First Nation, there have been 152 deaths between October 2004 and June 2021 (not including deaths for 2010 and 2017) (D. Sappier, personal communications, June 28, 2021). Further analysis is required to determine what proportion of these deaths were because of suicide or tragic deaths, but this is an average of 9.8 deaths per year in a community that had an on-reserve population of 1,596 at the end of December 2020. The average age for these deaths is 63 years. Even though not all these deaths were tragic deaths, the occurrence of almost one death per month in the community has an impact on the mental health of community members.

Similar to their peers in other jurisdictions, Indigenous youth in New Brunswick are struggling with mental health issues. In the New Brunswick Health Council's (2019) *Student Wellness Survey for Grades 6 – 12 (2018-2019)*, 49 of the 57 indicators related to mental health, tobacco, alcohol and cannabis use for Indigenous students showed poorer circumstances which were statistically significant compared to non-indigenous students. (For further statistical information on Indigenous youth demographics and mental health, see Annex A).

The economic and social impacts of suicide are substantial. Annually, an average of 107 New Brunswickers are reported to die of suicide each year. The New Brunswick rate of deaths from suicide or self-inflicted injuries is currently 38.6 per 100,000 population. However, suicide deaths tend to be under-reported. For each death by suicide, it is estimated that an additional 150 other people are affected to varying degrees. This includes surviving family members, friends, schools and communities. The average economic cost of a suicide in New Brunswick is estimated to amount to $850,000 (Health Canada, 2020, October 8).

Mental health issues among Indigenous peoples are among the most severe of any group in Canada and this is also true for Indigenous peoples in other countries impacted by colonization. Systematic and continuing devastation of the cultural, spiritual, economic, and political systems of Indigenous peoples has led to individual and collective trauma experienced by Indigenous people, historic trauma and intergenerational trauma (Kirmayer, Gone & Moses, 2014). In Canada, it is now widely accepted that adverse government policies such as residentials schools have resulted in legacy effects including disproportionally high mental health problems and trauma among Indigenous people compared to the non-Indigenous population (Sochting et al, 2007; Wesley-Esquimaux & Smolewski, 2004). Even at the time of writing this report, Indigenous people are dealing with the impacts of the recent discovery of 215 unmarked graves at the Kamloops Indian Residential School in British Columbia, 751 unmarked

graves at the Marieval Indian Residential School in Saskatchewan and 182 unmarked graves near St. Eugene's Mission School in British Columbia. These discoveries have retraumatized residential school survivors, their families and communities across the country, and more unmarked graves will be discovered in the coming months and years as work continues to uncover them.

Historical trauma is defined as the "cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from a massive group trauma experiences" (Brave Heart, 2003, pg. 7). Historical trauma results in historical trauma responses (HTR), which is "the constellation of features associated with a reaction to massive group trauma" (Brave Heart, Chase, Elkins & Altschul, 2011, p. 283). HTR includes post-traumatic stress disorder (PTSD) but is broader than PTSD. Whereas PTSD tends to occur in relation to an event that has a beginning and end, trauma for Indigenous people continues daily to the present day (Wesley-Esquimaux and Smolewski, 2004). Indigenous psychotherapist Eduardo Duran describes that trauma was understood by Indigenous people to be a soul wound (Duran, Firehammer & Gonzalez, 2008) and "an injury where the blood does not flow" (Duran & Firehammer, 2016, p. 163). In the past, this "heart sickness" (p. 163) arose from the taking of life during war, which was considered a ceremony. Consequently, healing a soul wound also requires ceremony to address trauma. With colonization, the impacts of trauma were expanded to the collective Indigenous nations on Turtle Island, or North America, as well as other parts of the world (Duran & Firehammer, 2016). In Canada, the Indian Act banned Indigenous ceremonies and made them illegal between 1885 – 1951.

The emphasis on the event and the individual in the definition of trauma in the American Psychiatric Associations' (2013) *Diagnostic and Statistical Manual for Mental Disorders, 5th Edition* (DSM-5) failed to account for long-term, chronic and complex individual and collective trauma (Wirihana & Smith, 2014). Some clinical studies of residential school survivors have found that they are dealing with Complex Post-Traumatic Stress Disorder (PTSD), which again, is different than PTSD and can be a result of prolonged sexual and/or physical abuse in childhood by a person in a position of power and trust (Aguiar & Halseth, 2015). In 2019, Complex PTSD was added to the World Health Organization's *International Classification of Diseases 11th revision (ICD-11)* and comes into effect on January 1, 2022 (WHO, 2021). This term has been expanded to Developmental Trauma Disorder (DTD) or "residential school syndrome" by other clinicians and is associated with substance abuse, poor parenting skills, anger, lack of knowledge of one's own culture (Brasfield, 2001; Wesley-Esquimaux & Smolewski, 2004; O'Neill et al, 2018).

Some scholars have proposed that *intergenerational trauma* is a more meaningful and valid concept that PTSD or complex PTSD. While intergenerational trauma is also as a result of complex, layered and prolonged trauma, it is collective in nature rather than individual. Intergenerational trauma has been defined as "a collective complex trauma inflected on a group of people who share a specific group identity or affiliation…. It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events" (First Peoples Wellness Circle, 2019, p.6).

Scientists have also been studying the transmission of trauma in a first generation to second and subsequent generations and calls it Transgenerational Transmission of Trauma (TTT). Epigenetics is a

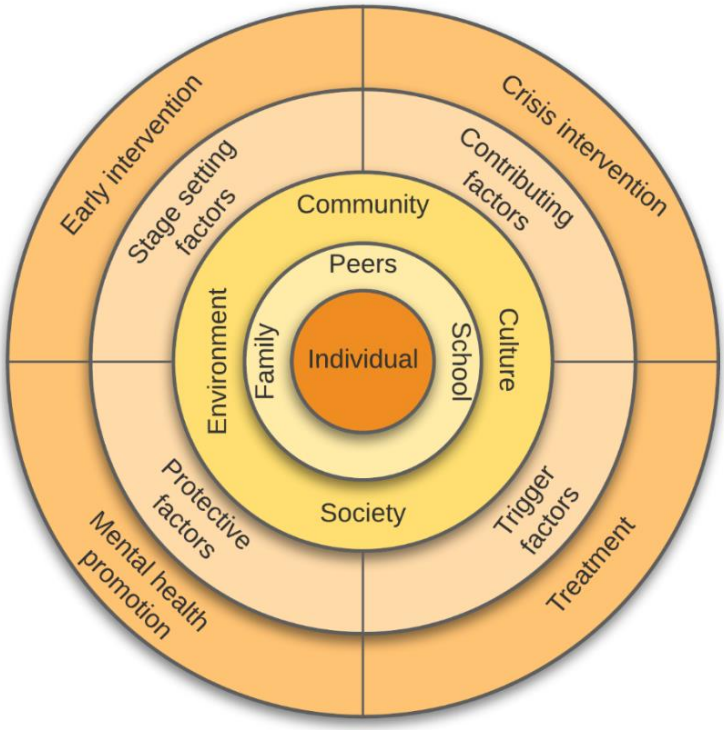
fairly new field in neurobiology and studies inherited changes of gene expression that are not due to changes in the underlying DNA sequence (Kellermen, 2013). Rather, it looks at how environmental factors such as disasters or external stresses can impact the physical, cognitive and psychological development of the unborn child or even successive generations at the cellular level (Johnson, 2012; Kiyimba, 2016). The intergenerational transmission of trauma has long been known among Indigenous Elders who call it "blood memory."

The impacts of trauma and the need for trauma-informed approaches in medical and therapeutic interventions has received increasing attention in mainstream health and mental health fields with the development of evidence-based models of trauma recovery. As a result, organizations and governments have been changing their policies and practices to support these approaches for families and youth (Wilson, Pence & Conradi, 2013). The Government of New Brunswick has also adopted a trauma-informed approach to delivering mental health and addiction services for youth and adults. In May 2021, the Government of New Brunswick and the Regional Health Authorities announced they would also be implementing 21 recommendations related to mental health services and mental health crises. These recommendations will need to be assessed in the future for effectiveness on the frontlines.

Promising Strategies for Indigenous Youth Suicide Prevention

White and Jodoin (2007) propose a model for suicide prevention and intervention with Indigenous youth (see Figure 1).

Figure 1 - Comprehensive Model for Indigenous Youth Suicide Prevention and Intervention



Individuals are surrounded and influenced by other layers such as family, peers and school, community and culture (including historical factors, shared values and language, traditional practices), society (usually mainstream societal values and beliefs but also political or economic factors) and the local and global environment. Each layer holds potential risk or protection. The interaction of several factors over time and across a number of contexts may lead to suicide.

There are four types of risk and protective factors:

- **Stage setting factors** – which set the stage for an individual's vulnerability to suicide (e.g., a family history of suicide);
- **Contributing factors** – that heighten the existing risk (e.g., physical, emotional and/or sexual abuse);
- **Trigger factors** – that act as a trigger for those who are inclined (e.g., feeling disconnected, feeling abandoned or rejected);
- **Protective factors** – are those factors which lessen the risk of suicide (e.g., having a significant adult who can provide nurturing and understanding).

These risk and protective factors are summarized in Table 1.

Prevention and treatment must work hand-in-hand and both play a crucial role in reducing rates of suicide and self-harm among youth. Effective prevention measures are needed to reduce the likelihood of more intense treatment and higher levels of stress and mental health challenges. Mental health promotion targets the whole population and is meant to improve personal well-being or system-

focused interventions to increase social support and belonging (e.g., school or community-based interventions. Early interventions target groups of youth who show signs of early risk to suicide or suicidal behaviour but where a specific risk for suicide has not yet been identified. These types of strategies promote skill-building, social and environmental improvements or the response capacity of helping systems. Crisis intervention is needed when we encounter a youth at extreme risk of self-harm and youth receive treatment when they have a significant levels of mental health distress or suicide ideation.

Table 1 - Risk and protective factors for Indigenous youth suicide

Risk and Protective Factors for Indigenous Youth Suicide

Stage-Setting Factors	Contributing Factors	Trigger Factors	Protective Factors
Individual - Previous history of a suicide attempt - Depression/ psychiatric disorder - Prolonged or unresolved grief	- Rigid cognitive style - Poor coping skills - Alcohol and substance abuse - Sexual orientation being "two-spirited" - Impulsivity - Hypersensitivity - Low self-esteem - Self perception of poor general health - Conflict with the law	- Personal failure - Humiliation - Individual trauma - Developmental crisis	- Good physical and mental health - Creative problem-solving - Personal autonomy - Previous experience with self-mastery - Optimistic outlook - Sense of humour - Strong spiritual or religious faith
Family - Family history of suicidal behaviour/ death by suicide - Family violence/ abuse - Family history of mental health problems - Early childhood loss/separation	- Substance abuse within family - Family instability - Ongoing conflict	- Loss of significant family member - Death, especially by suicide	- Family relationships characterized by warmth and belonging - Adults modelling healthy lifestyle - Realistic expectations
Peers - Social isolation and alienation	- Negative youth attitudes towards seeking adult assistance - Peer modelling of maladaptive behaviours	- Teasing/ cruelty - Interpersonal loss - Rejection - Bullying - Death, especially by suicide	- Interpersonal competence - Healthy peer modelling - Acceptance and support
School - Social isolation and alienation	- Negative youth attitudes towards seeking adult assistance - Peer modelling of maladaptive behaviours	- Teasing/ cruelty - Interpersonal loss - Rejection - Bullying - Death, especially by suicide	- Interpersonal competence - Healthy peer modelling - Acceptance and support

Community - Community "legacy" of suicides - Community marginalization - Political disempowerment - Economic deprivation, unemployment - Isolated geographic location - Lack of proper housing conditions	- Sensational media portrayal of suicide - Access to firearms or other lethal methods	- High profile/ celebrity death, especially by suicide - Conflict with the law/ incarceration	- Opportunities for participation - Evidence of hope for the future - Community self-determination and solidarity ((Chandler & Lalonde, 1998 & 2008) - Availability of resources
Culture - Breakdown of cultural values and belief systems - Loss of control over land and living conditions	- Negative attitude of the non-Aboriginal population		- Strong traditional culture - Enhancing cultural identity and spirituality (Chandler & Lalonde, 1998 & 2008; Fleming & Ledogar, 2008; Garoutte et al, 2003, as cited in Fleming & Ledogar, 2010; Ungar, 2008; Kirmayer, Dandeneau, Marshall, Kahentonni Phillips & Jessen Williamson, 2011; White & Mushquash, 2016)

Risk levels for suicide exist along a continuum from none to high and different prevention and intervention strategies are required along this continuum. Table 2 outlines prevention and intervention strategies "before-the-fact" and "after-the-fact" where "the fact" is the identification or development of suicidal behaviour, suicidal ideation, threats to commit suicide, suicide attempts or other deliberate self-harming behaviours. A comprehensive approach is required to preventing youth suicide and suicidal behaviour (White & Jodoin, 2007, p. 20).

Table 2 - Suicide prevention and intervention strategies for Indigenous youth

Suicide Prevention and Intervention Strategies for Indigenous Youth* (White & Jodoin, 2007)

	Before the fact		**After the fact**	
Primary Target Group	Populations and Groups	Groups at Early Risk	Individuals at Identifiable Risk	Individuals at High Risk
Level of Suicide Risk	None	Low Risk	Medium Risk	Acute (high) Risk
Scope of Intervention	Broad focus on risk and protective factors		Narrow focus on preventing imminent self-harm/death	
Type of intervention	Mental health promotion	Early intervention	Treatment	Crisis Intervention
Key Factors of Influence	Protective factors	Stage-setting and Contributing Factors		Trigger Factors
Promising Strategies	Culture as Foundation; Two-Eyed Seeing Approach (Archibald, 2006; Assembly of First Nations & Health Canada, 2015; White & Mushquash, 2016)			
	Cultural enhancement Community development Peer helping Youth leadership School climate improvement Self-esteem building Life skills training Family support Cultural continuity by promoting positive parenting practices in culturally appropriate and sensitive ways Intergenerational exchange and relationship building (Resnick, 2000, Masecar, 2009) Reducing social inequities (White and Mushquash, 2016)	Traditional healing practices Interagency communication and coordination Community gatekeeper training Public communication and reporting/media guidelines Means restriction School gatekeeper training School policy Suicide awareness education Support groups for youth Increased ability to detect and refer youth-at-risk Increased capacity and responsiveness to deal wit youth-at-risk among families, schools and communities Reduced access to lethal means	Individual assessment/ therapy Family therapy Clinical training Case management	24-hour crisis response Hospital in-patient programs Drug interventions
Intermediate indicators of progress	Increased personal competencies among all youth	Increased ability to detect and refer youth-at-risk Increased capacity and responsiveness to deal with youth-at-risk among families, schools and communities Reduced access to lethal means	Increased coping ability among those receiving help Increased ability to manage future crises and increased willingness to reach out among those who received help	Reduced individual risk for imminent self-harm or death by suicide
Ultimate outcomes	Reduced suicides and suicide behaviour			

*Adapted from White & Joidin (2007)

In their literature review of existing youth suicide programs, Kirmayer, Fraser, Fauras and Whitley (2009) identified several promising practices in Indigenous suicide prevention. These included:

1) **Reducing access to means** – reducing youth access to avenues for committing self-harm or suicide;
2) **School-based programs** to teach youth coping skills; teaching students and teachers how to recognize individuals at risk and refer them to mental health services;
3) **Training youth peer counsellors**;
4) **Training "gatekeepers"** - individuals who come into regular contact with youth (e.g., primary care providers, parents, clergy, teachers, nurses) to recognize and refer youth at risk;
5) **Ready access to a range of mental health services** including counselling and psychiatry;
6) **Mobilizing community** to develop suicide prevention programs and crisis intervention teams;
7) **Culturally appropriate support for families** to support health parenting;
8) **Family and community activities** to bring together elders and youth to share cultural knowledge, values, view;
9) **Ensuring that mass media portray suicide and community problems in appropriate ways**.

They also identified that adapting these promising practices for Indigenous youth requires:

1) **Cultural adaptation of suicide prevention programs –** recognizing Indigenous concepts of mental wellness; involving culture as a protective factor; translating materials into Indigenous languages and using locally relevant examples; community-based approaches involving youth and community members in program planning and development; culturally competent and culturally safe programming and services; and culturally sensitive screening tools and research.

2) **Focus on family and community-based interventions** that strengthen social cohesion and collective well-being of the contexts in which youth live.

3) **Adapting existing suicide prevention training to Indigenous school settings and other venues** to reach youth who are not in school.

4) **Adapting mental health service delivery to the unique needs and circumstances of remote regions** (e.g., use of local professional and non-professional resources, mobile teams, distance support through technology).

5) **Addressing jurisdictional conflicts and gaps** in providing mental health services and continuity of care for Indigenous people on and off-reserve.

6) **Dealing with issues related to confidentiality** in rural and remote communities where service providers and clients are often related or live in closely to each other.

7) **Supporting helpers in rural and remote communities** who face high demands because of the constant need for their services and the close relationships with clients.

8) **Self-determination -** Increased autonomy for First Nation communities in the cultural, social and economic aspects of their lives (Chandler & Lalonde, 1998 and 2008).

Improvements for Mental Health Services in Atlantic First Nations Communities

In 2021, an evaluation of mental health services in Atlantic First Nation communities was completed. The report identified that improvements have been achieved in services and supports for mental health and addictions in Atlantic First Nation communities but there is still a need for:

- Comprehensive, sustainably funded, culturally safe and community-based mental health and addictions systems;
- Accountability to address anti-Indigenous racism and discrimination in provincial health systems;
- Increased support for youth;
- Culturally safe detox, mental health counselling at treatment centres, crisis systems and spaces;
- Improved system management (more staff, better case management, support for policy development, planning and management of service delivery and enhancements to service integration (Levin and Rhymes, 2021).

Towards Effective Mental Health Services for Indigenous Youth

> "Wellness from an Indigenous perspective is a whole and healthy person expressed through a sense of balance of spirit, emotion, mind and body. Central to wellness is belief in one's connection to language, land, beings of Creation, and ancestry, supported by a caring family and environment."
>
> "The most fundamental feature of the Indigenous worldview is the Spirit. Within this reality the spirit is housed within an inclusive concept of body-mind-heart-spirit. In our life within this earth realm these work together in such a way as to be inseparably functioning as a whole. The spirit is always central and always works in relationship to the other levels of being. Spirit is in all things and throughout all things. In the Indigenous worldview we live in a spirit-ual universe and within a spirit-ual relationship."
>
> "Our spirit is at the centre of our being and wants us to live life to the fullest. We connect with our spirit by learning about our identity as a Native person."
>
> Elder Jim Dumont
>
> *National Native Addictions Partnership Foundation (2014), inside cover and p. 6*

Language and Culture as Foundation

Trauma models have only recently taken into consideration the historical and intergenerational trauma and the current experience of Indigenous people by exploring models which focus on the resilience of Indigenous peoples (Fast & Collin-Vézina, 2010). Mental health policymakers are increasingly aware that mainstream mental health programs have largely proven to be ineffective in addressing the needs of Indigenous peoples and youth. Academics and Indigenous researchers recommend that treatment methods consider the historical context of Indigenous peoples, operate from an Indigenous knowledge framework, incorporate intergenerational continuity at the individual and collective levels and are rooted in culture (Kirmayer, Brass & Tait, 2001; World Health Organization, 2005; Archibald, 2006; Williams & Mumtaz, 2007; Ontario Federation of Friendship Centres, 2013).

Programs for Indigenous people must be based on and incorporate elements which consider the unique language, cultural values and traditions of Indigenous peoples and are informed by the Indigenous worldview which is distinct from western approaches (Royal Commission on Aboriginal Peoples, 1996; McCormick, 2000; Archibald, 2006; Kirmayer & Valaskakis, 2009). Indigenous languages are verb-based and oriented towards relationships, processes and transmit the Indigenous worldview. This worldview conceives wellness as being based on a healthy and balanced connection to land, nation, community, family, and the spiritual, emotional, physical and mental dimensions of self which are all interconnected.

The concept of the extended self is unique to Indigenous people and has implications for therapeutic interventions (Makoksis, Shirt, Chisan, Mageau & Steinhauer, 2010; Benning, 2013).

The *Indigenous Languages Act,* S.C. 2019 c.23, received Royal Assent in Canada on June 21, 2019. This Act is intended to support the reclamation, revitalization, maintenance and strengthening of Indigenous languages in Canada and enables Canada to cooperate with provincial or territorial governments, Indigenous organizations or other entities, including entering into agreements or arrangements of providing Indigenous language programs and services in relation to health, education and the administration of justice. Nunavut (*Consolidation of Official Languages Act*, S.Nu 2008, c10) and the Northwest Territories (*Official Languages Act,* RSNWT 1988, C.0-1) are currently the only Canadian jurisdictions to enact legislation that recognizes Indigenous languages as official languages. British Columbia established a Provincial Crown Corporation, called the First Peoples Cultural Council, in 1990 to actively support the revitalization of Indigenous languages, arts and culture and formalized this work through the First Peoples' Heritage, Language and Culture Act (2011).

Efforts to revitalize and strengthen Indigenous languages in New Brunswick have a relationship to mental wellness for Indigenous youth and people. Although limited Indigenous language instruction is available through some New Brunswick public schools, formal recognition, funding and statutory support to reclaim and revitalize Indigenous languages in New Brunswick would strengthen First Nations efforts to achieve positive outcomes in Indigenous youth mental health.

A growing body of literature recognizes that connection to culture and the incorporation of Indigenous concepts of health and mental health are essential to the treatment and prevention of trauma and addictions. Enculturation or the degree of integration within a culture is recognized as a resilience factor among Indigenous people and youth (Archibald, 2006; Castellano, 2006; Fleming & Ledogar, 2008; Fiedeldey-Van et al, 2016; Coll, Freeman, School & Hauser, 2018; Graham, Stelkia, Wieman & Adams, 2021) and includes the three components of family/traditional activities, cultural connection/identification as an Indigenous person and traditional spirituality. Enculturation happens through language, ceremonies and cultural activities. Positive outcomes as a result of enculturation and increased self-esteem include decreased alcohol and substance use, school success, ability to deal with the negative impacts of discrimination and decreased suicidal ideation (Fleming & Ledogar, 2008).

More recently, there have been concerted efforts by the federal, provincial, territorial and First Nation community mental wellness and addiction programs and services to develop a comprehensive client centred continuum of care for Indigenous communities and clients. These efforts have resulted in t*he First Nations Mental Wellness Continuum Framework* (Assembly of First Nations and Health Canada, 2015) and the *Honouring Our Strengths Framework* (Assembly of First Nations, National Native Addictions Partnership Foundation & Health Canada, 2011). These frameworks seek to strengthen community, regional and national responses to mental health and substance abuse. They also have elements in common and are designed to respond to Indigenous peoples across their life span and across groups such as youth, women and clients with mental health issues. Both frameworks are based on the principles of culture as intervention and Indigenous, holistic healing approaches and using a Two-Eyed Seeing approach (Assembly of First Nations, National Native Addictions Partnership Foundation & Health Canada, 2011; Assembly of First Nations & Health Canada, 2015; Marsh et al., 2015). Two-Eyed

Seeing or *Etuaptmumk* is the guiding principle of viewing the gifts of both Indigenous ways of knowing and western science to address local and global issues to promote healthy communities (Bartlett, Marshall & Marshall, 2012).

Organizational evolution is required for Indigenous worldviews, cultural interventions and a Two-Eyed Seeing approach to be implemented in mental health services so that service providers and the mental health system as a whole respond effectively to Indigenous peoples. The mental health system must actively engage with Indigenous peoples and communities to facilitate changes in healthcare structures and processes to achieve meaningful mental health outcomes. It will require both cultural competency of service providers and cultural safety of the system. This will involve service design, policy, human and financial resources, program and service delivery. As described in Thunderbird Partnership's *A Cultural Safety Toolkit for Mental Health and Addiction Workers in Service with First Nations People* (undated),

> Cultural competence requires that service providers, both on and off-reserve, are aware of their own worldviews and attitudes towards cultural differences (cultural humility); and include both knowledge of, and openness to, the cultural realities and environments of the clients they serve. To achieve this, it is also necessary for Indigenous knowledge to be translated in current realities to meaningfully inform and guide direction and delivery of health services and supports on an ongoing basis (p. 3).
>
> Cultural safety extends beyond cultural awareness and sensitivity within services and includes reflecting upon cultural, historical, and structural differences and power relationships within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effective to First Nations people. Application of cultural safety is facilitated through policy, procedures and workflow processes (p.6).

Cultural competency is one component of cultural safety, which is an outcome determined by the client. Cultural safety will involve systemic change and collaboration between the health system and Indigenous peoples (Brascoupé & Waters, 2009).

During the Child and Youth Advocate's public consultation process, Mi'gmaq and Wolastoqey service providers, professionals and people echoed how culture, language, land-based practices and a Two-Eyed Seeing approach are critical aspects for Indigenous mental health and addictions prevention, intervention and treatment programs.

Calls to Action:

1) **The Mi'gmaq, Peskotomuhkati and Wolastoqey languages be formally recognized and supported by provincial legislation which:**
    a. **Recognizes that these languages are the original languages of this territory, that Indigenous language rights are part of the Peace and Friendship Treaties and that these languages are currently endangered;**
    b. **Recognizes Indigenous languages as fundamental and valued in New Brunswick culture and society;**
    c. **Actively supports Indigenous language revitalization through funding and programs provided by the provincial government and/or in partnership with the federal government;**
    d. **Affirms that the reclamation, preservation, revitalization and protection of Mi'gmaq, Peskotomuhkati and Wolastoqey languages are best undertaken by these Indigenous peoples and communities.**

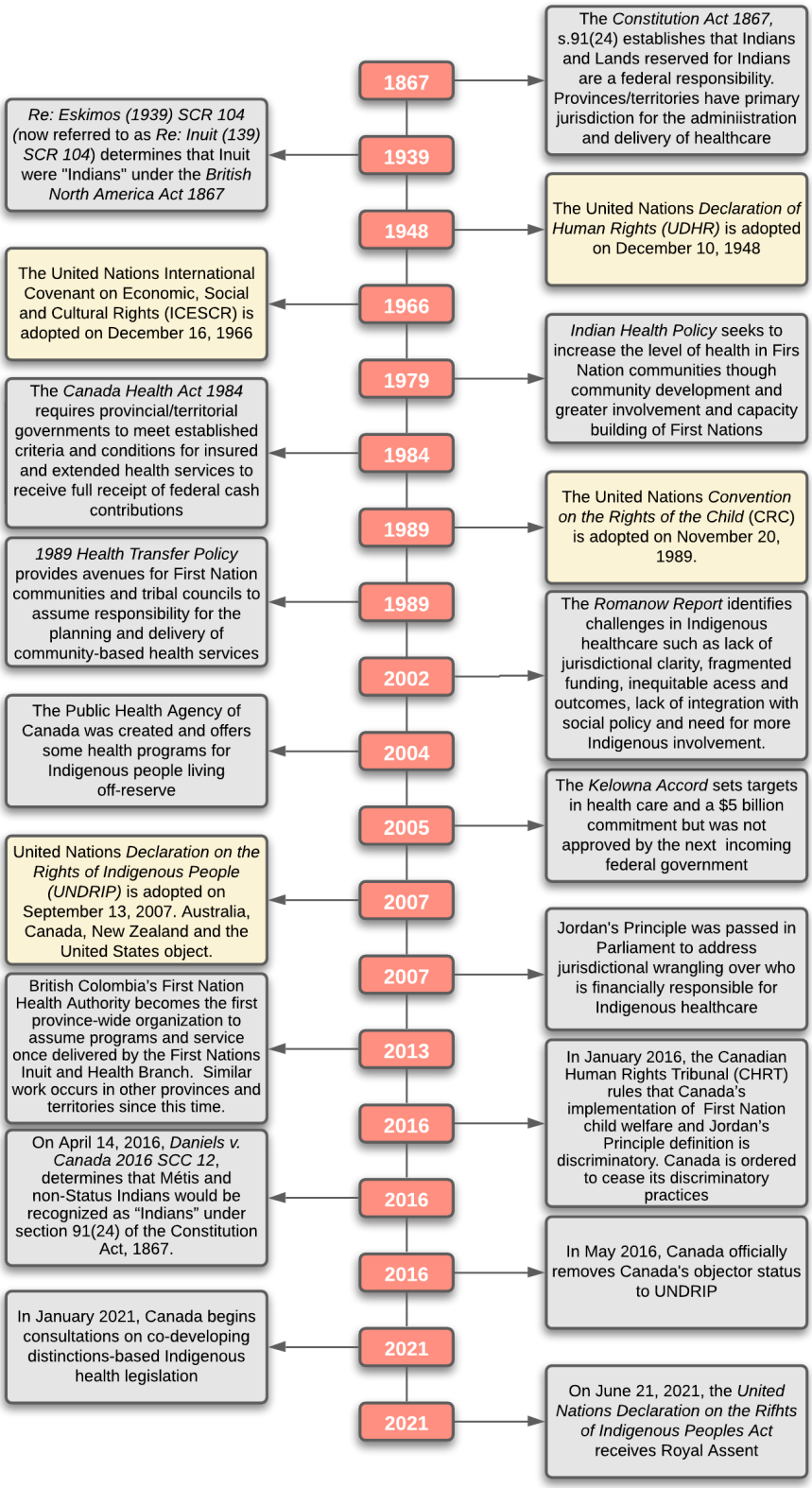
2) **Culture as Foundation and a Two-Eyed Seeing approach should be used as the basis for implementing mental wellness, health and addictions services for Indigenous youth. Culturally relevant services and programming should be available for Indigenous youth and families through:**
    a. **Co-development with Indigenous peoples and communities;**
    b. **Indigenous-led community-based services as part of the continuum of services;**
    c. **Provincial health and mental health programs and services that meet the mental wellness needs of Indigenous people;**
    d. **Enhanced collaboration between provincial health services and First Nation communities and Indigenous organizations to ensure that Indigenous youth have a culturally safe and seamless experience when using health and mental health and wellness services.**

3) **The Province of New Brunswick and Indigenous communities and organizations work together to effect changes in healthcare structures and processes, such as service design, policy, human and financial resources, program and service delivery with the longer-term goal of cultural safety and improved mental health outcomes for Indigenous people.**

Advancing Indigenous Self-Determination in Health

Since Canada was established through the Constitution Act in 1867, there have been several significant developments and influences on Indigenous healthcare. These are highlighted in Figure 2 and further described below.

Figure 2 - Selected highlights in the development of Indigenous healthcare in Canada



International Commitments Related to Indigenous Youth Health and Mental Health

Canada is a signatory to several international frameworks that relate to the health and mental health of Indigenous youth. These include:

- The United Nations Universal Declaration of Human Rights (UDHR) (1948) which states the everyone is entitled to certain rights and freedoms regardless of race, colour, sex language, religion including the ability to participate freely in the cultural life of the community and religious freedom;
- The United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966). This Covenant:
    - Affirms the right to self-determination for all peoples, the ability to freely determine political status and to pursue economic, social and cultural development, irrespective of race, colour, language and religion;
    - Includes clauses on protection and assistance to the family, considered to be the fundamental group unit of society;
    - Identifies that States recognize the right of everyone to enjoy the highest attainable standard of physical and mental health, including for the healthy development of the child.
    - Identifies a right to take part in cultural life and notes governments' responsibilities to conserve, develop and promote culture.
- The United Nations Convention on the Rights of the Child (UNCRC) (1989) which states that:
    - The best interest of the child is the primary consideration and this should be applied irrespective of race, colour, language or religion;
    - Governments shall ensure the survival and development of the child to the maximum extent possible;
    - Governments will respect the right of the child to preserve his/her/their identity;
    - Children have the right to enjoy the highest attainable standard of health;
    - Indigenous children will not be denied the right to practise their own religion or to use their own language;
- The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (2007) which affirms Indigenous peoples' rights to:
    - Self-determination;
    - Maintain and strengthen our social and cultural institutions, while still being able to participate fully in the political, economic, social and cultural life of the State;
    - Practise and revitalize our cultural traditions and customs, spirituality and languages;
    - Participate in decision-making in matters which would affect our rights;
    - Improve our social and economic conditions, including in the area of health;
    - Maintain our health practices and traditional medicines;
    - Enjoy the highest attainable standard of physical and mental health, with governments being required to take the necessary steps to progressively achieving this right;
    - Maintain and strengthen our distinctive spiritual relationship with our territories.

In 2016, the federal government endorsed UNDRIP and on June 21, 2021, the *United Nations Declaration on the Rights of Indigenous Peoples Act*, SC2021, c. 14, received Royal Assent. While the Act

only imposes obligations on the federal government, it will be an important source to interpret both provincial and federal laws.

Federal and Provincial Health Responsibilities Pertaining to Indigenous Peoples

The Evolution of Federal Involvement on Indigenous Health

The Canadian health system consists of many interrelated aspects which are the responsibility of federal, provincial, territorial and municipal governments, Indigenous authorities or the private sector. The fragmented nature of health care has resulted in "a patchwork of policies and programs for Aboriginal peoples" (Lavoie & Gervais, 2010, p.121).

The *Constitution Act 1867*, s.91(24) established that Indians and Lands reserved for Indians fall under federal jurisdiction. In 1929, the Supreme Court of Canada decision, *Re: Eskimos (1939)* SCR 104further determined that the Inuit were "Indians" under the *British North America Act, 1867* and consequently a federal responsibility (Lavoie and Gervais, 2010). In 2016, the Supreme Court of Canada decision, *Daniels v. Canada (2016)* determined that Métis and non-Status Indians would be recognized as "Indians" under section 91(24) of the Constitution Act, 1867. The decision did not require the federal government to provide programs and services to Métis and non-Status Indians but it cannot deny these services on the basis that it has no jurisdiction. At the same time, the decision did not void provincial responsibilities relating to Métis and non-Status individuals (Truesdale, 2016).

The federal government has primary responsibility for a range of heath services for registered Indians living on-reserve and to Inuit living in their traditional territories in Quebec and Labrador. These include public health programs (e.g., health promotion, disease prevention, health protection and health emergency management), home and community care and aspects of mental health and addictions services. The legislative authority for the federal government's obligations for Indian health are contained in Section 73 of the *Indian Act.* The Government of Canada funds or directly provides targeted health programs and services which augment those generally available from the provincial/territorial governments. Only the Non-Insured Health Benefits Program (NIHB) applies to all registered Indians and Inuit, regardless of where they live and is administered by the First Nation Inuit and Health Branch (FNIHB) of Indigenous Services Canada. The Indian Act's regulation-making power does not provide sufficient authority for the development or establishment of a comprehensive public health and health services regulatory framework for First Nations living on-reserve, nor does it outline any obligations (Lavoie & Gervais, 2010; Richmond & Cook, 2016; W. Were, personal communications, June 3, 2021).

There are two publicly available national policies related to Indigenous health. The 1979 Indian Health Policy was a two-page document with the broad objective of increasing the level of health in First Nation communities through a) community development to decrease poverty and poor socio-economic conditions in First Nation communities; b) greater involvement of First Nations in planning, budgeting and delivery of health programs; and c) increasing the capacity of First Nations to play an active role in the Canadian Health Care System and in making decisions affecting their health. The policy identifies the "special relationship of the Indian people to the Federal Government". It further states that the Federal Government's role is mainly in public health on-reserve, health promotion and the detection

and mitigation of environmental health hazards. Provincial governments and the private sectors are primarily responsible for "the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick." First Nation communities play a significant role in health promotion and in adapting health services delivery to the specific needs of their communities (Health Canada, 2007, p. 1). In 1989, the *Health Transfer Policy (HTP)* provided avenues for First Nation communities and tribal councils to assume responsibility over the planning and delivery of community-based health services (Lavoie et al., 2005).

The 2002 Romanow report on Canadian healthcare identified challenges in Indigenous health care, including:

- Lack of clarity on jurisdictional accountability and responsibility for Indigenous health between the federal, provincial and territorial governments resulting from competing constitutional assumptions;
- Fragmented funding for Indigenous health services;
- Inadequate and inequitable access to health services between jurisdictions and between groups of Indigenous people (e.g., registered Indians living on or off-reserve, non-registered Indians, Métis and Inuit);
- Continued disparities in health status for Indigenous people;
- The need for Indigenous people, communities and organizations to be more involved in the planning and delivery of health services;
- The need for health services to be integrated with other aspects of social policy such as education, housing and social services but where efforts for partnership are hampered by legal and administrative obstacles;
- The importance of culturally relevant health care services (Romanow, 2002).

Directions for the way forward in the Romanow report (2002) suggested that health funding for Indigenous peoples should be consolidated and to address the specific health needs of Indigenous people and to improve access to all levels of health services, training and recruitment of Indigenous health professionals. These funds would be managed through Indigenous Health Partnerships with ongoing input from Indigenous peoples on the direction and design of health cares services in communities.
In 2004, the Public Health Agency of Canada (PHAC) was created following the 2003 outbreak of severe acute respiratory syndrome (SARS). The 2003 report of the National Advisory Committee on SARS and Public Health identified that the fragmented nature of jurisdiction relating to Indigenous peoples' health posed a public health risk and created barriers to access. As a result, PHAC offers some health programs for Indigenous people living off-reserve (e.g., the Aboriginal Head Start in Urban and Northern Communities program) (Lavoie & Gervais, 2010).

In 2005, the federal and provincial governments and the five national Indigenous organizations signed the *Kelowna Accord* which set targets to decrease infant mortality, youth suicide, obesity and diabetes by 20 percent in five years and for increasing the number of Indigenous health professionals together with a $5 billion commitment. The *Kelowna* Accord was supported by Prime Minister Paul Martin, but not by his successor, Prime Minister Stephen Harper and as a result, the *Kelowna Accord* did not go forward.

Jordan's Principle was passed in Parliament in 2007 to address jurisdictional wrangling about who was responsible for paying for an Indigenous child's care needs in health, education, early childhood learning and child welfare. The Principle states that the government of first contact must pay for services and resolve disputes later and continues to be in effect today. First Nations children on or off-reserve, with or without registered Indian status are eligible for Jordan's Principle. A similar initiative, *Inuit Child First*, is available for Inuit children through Indigenous Services Canada. On January 26, 2016, the Canadian Human Rights Tribunal (CHRT) ruled that the Canadian government's implementation of child welfare programs and definition of Jordan's Principle was discriminatory. It ordered the federal government to take immediate measures to cease its discriminatory practices and to implement the Principle with its full and proper scope. Since 2016, the CHRT has issued more than 15 additional orders to the federal government on non-compliance. Most recently, Canada filed for a judicial review of the Tribunal's orders on eligibility for Jordan's Principle which was heard in Federal Court from June 14 – 18, 2021 (Palmer, Tepper & Nolan, 2017; Indigenous Services Canada, 2020; First Nations Child and Family Caring Society, 2021).

Further work is currently taking place to advance First Nation-led design and delivery of First Nations health services by First Nation governments and mandated First Nation Health Authorities. In 2013, British Colombia's First Nation Health Authority became the first province-wide organization of its kind to assume programs and service once delivered by the First Nations Inuit and Health Branch. Similar work is taking place in Manitoba, Saskatchewan and Ontario. First Nations in Nova Scotia are laying the groundwork to embark on this journey and New Brunswick First Nations have recently begun the process to explore increased First Nation control and governance over health.

In 2021, the federal government is also engaging Indigenous people, provincial/territorial governments, health professionals and stakeholders on the development of distinctions-based Indigenous health legislation. The process is intended to establish overarching principles as the foundation of health services for Indigenous peoples; support the transformation of health service delivery to increase Indigenous-led health service development and delivery and advance Canada's commitment to reconciliation and a nation-to-nation relationship with indigenous peoples (Indigenous Services Canada, 2021).

First Nation and Inuit Health Branch's Role in Indigenous Healthcare

The federal government states that federal and provincial/territorial governments share some degree of jurisdiction for the healthcare of Indigenous peoples under sections 91 and 92 of the *Constitution Act 1867*. Primary care for First Nations is the responsibility of provinces and their health authorities.

In recognition of the unique status and needs of First Nations and Inuit peoples, the federal government established the First Nations and Inuit Health Branch (FNIHB). FNIHB's programs and services are based on the 1979 *Indian Health Policy* and are not legislated. In the Atlantic region, FNHIB's programs focus mainly on:

- Public health (health promotion, disease prevention, health protection and health emergency management);

- Home and community care;
- Mental health and addictions.

FNIHB provides a limited number of medically necessary, health related goods and services to eligible First Nations and Inuit people that are not provided through other public programs or private insurance plans. However, the Nunatsiavut government provides these to their members through funding received in a block funding arrangement that is part of their Self-Government Agreement.

A grey area exists in terms of provision or primary care services. Although the Constitution Act of 1867 outlines that provincial governments have the primary responsibility for healthcare, the federal government augments primary care services where these are not available through provincial or private health plans.

In the past 20 years, FNIHB has moved away from being a provider of services to being a funder of for services provided by Indigenous communities. FNIHB's current roles are as:

- **Direct service provider** (e.g., environmental health officers and dental therapists);
- **Funder of health services** provided by First Nation communities;
- **Medical insurance benefit provider** through the Non-Insured Health Benefits program (NIHB) (e.g., certain prescriptions, dental services, medical equipment and supplies, mental health counselling);
- **Program and policy development** (e.g., program advice, policy frameworks, support for health system integration between First Nation communities or organizations and provincial health systems);
- **Support for governance, community capacity building and infrastructure** (e.g., health planning, accreditation, capital, e-Health, research);
- **Advocacy and relationship building** (e.g., engagement with First Nations and Inuit people, partnership tables, bilateral and trilateral processes).

FNIHB provides a total of 114 programs to First Nations and Inuit people such as:

- **Health promotion and disease prevention** programs for First Nations on-reserve and Inuit (e.g., health child development, mental wellness and healthy living);
- **Public health protection programs** (e.g., communicable disease control program for First Nations on-reserve and Inuit; environmental public health programming to First Nation communities south of 60^{o} parallel and to some First Nation and Inuit communities in the north;
- **Primary care programs –** in remote Indigenous communities (e.g., nurses). These services are not provided in the Atlantic region.
- **Health infrastructure support** for accreditation, e-Health, Indigenous health human resources, health services integration and health facilities;
- **Non-Insured Health Benefits (NIHB)** (W. Were, personal communication, June 3, 2021).

The Provincial Government's Role in Indigenous Health

The *Constitution Act 1867* divides federal and provincial roles and responsibilities, with provinces/territories having primary jurisdiction over the administration and delivery of health care

services. The *Canada Health Act 1984* is Canada's federal legislation for publicly funded health care insurance. The federal government exercises its jurisdiction over health matters primarily through federal spending power. Through the Act, provincial and territorial governments must meet established criteria and conditions related to insured health services and extended health services to receive their full federal cash contribution through the Canada Health Transfer (i.e., public administration, comprehensiveness, universality, portability and accessibility). The Act requires that all medically necessary hospital, physician and surgical dental services (i.e., insured health services) are covered by provincial/territorial health insurance plans for all eligible residents, including Indigenous peoples. The Act does not specify standards for service delivery as it is provinces' responsibilities to manage their health care systems. Provinces and territories also provide a wide range of services not included in the Act (e.g., long-term care homes) (W. Were, personal communications, June 3, 2021). Between 2012/2013 and 2021/2022, New Brunswick will receive $7.6 billion through the Canada Health Transfer (Department of Finance Canada, 2017).

New Brunswick can also enter agreements for the provision of health services. Section 58(1) of the *Public Health Act* (2012) states that:

> 58(1) The Minister may, subject to the approval of the Lieutenant-Governor in Council, enter into and amend an agreement with
>
> (a) The government of Canada or the government of a state of the United States of America or a department, agency or body under the jurisdiction of that government,
> (b) The government of a province or territory or a department, agency or body under the jurisdiction of that province or territory, or
> (c) A band council as defined in the *Indian Act (Canada)* or a local government,
>
> for the purposes of the organization and delivery of public health programs and services, the prevention of diseases and injuries and the promotion and protection of the health of the people of New Brunswick or any group of them.

One such agreement is the *Canada-New Brunswick Agreement on Home and Community Care and Mental Health and Addictions* (Health Canada, 2020) which is in effect from April 1, 2018 – March 31, 2022. During this period Canada's contribution to the mental health and addictions of the agreement are $39.3 million. The agreement will be renewed for 2022-2027 subject to approval by Parliament and agreement on a new five-year plan between Canada and New Brunswick.

Key directions in the agreement in the delivery of mental health and addictions include:

- A collaborative model of care through an integrated, person-centred approach to service delivery;
- Providing respectful, equitable and high-quality services First Nations and Indigenous peoples through culturally relevant resources, community capacity building, training and knowledge exchange.

Funding is also designated to develop and implement a culturally appropriate and competent framework for delivering mental health services to First Nations youth and adults in the First Nation communities of New Brunswick as well as co-development and implementation of multi-level, First Nations community-led, collaborative, strength-based mental wellness teams. Specific actions pertaining to youth including the funding of integrated service delivery teams customized to the different needs of each First Nation community in New Brunswick regions that require specific, multidisciplinary youth teams in addition to those currently established within the public school system. Information on expenditures related to First Nations in this agreement was available at the time of writing this report.

Section 4(1) (a) of the *Assessment Act,* Chap. A-14 states that:

> Exemptions
>
> 4(1) All real property in New Brunswick is liable to assessment and taxation, subject to the following exemptions from taxation:
>
> (a) real property owned by a church for use as a residence for priests, ministers, rabbis or commissioners and staff officers of the Salvation Army and that portion of other real property owned by a religious organization prescribed by regulation, a church or a religious order and used solely for religious, educational or charitable purposes, including burying grounds and church halls from which only revenue for church purposes is derived;

Land and connection to land is fundamental to the spirituality and languages of First Nations people and linked with Indigenous mental wellness. The provincial government can also exempt real property is primarily used for the purposes of traditional and healing practices such as ceremonies, land-based healing programs and cultural education from property taxes. Excluding lands or facilities used for healing purposes under exemptions in this Act could be considered an example of systemic racism. New Brunswick should recognize that Indigenous spiritual practices are religious practices that are not necessarily carried out in a physical building like a church, and include real property used for Indigenous spiritual purposes under exemptions in the *Assessment Act*.

Improving mental health outcomes through Indigenous self-determination

Inequalities in physical and mental health outcomes are strongly correlated with social and economic status, which in turn are linked to the degree of control people feel they have over their lives. The link between perceived control and health has been established for a wide variety of health conditions, including mental illness, suicides and death from accidents and violence (Marmot, 2004, as cited in Murphy, 2014; Ryan & Deci, 2008 and 2011, as cited in Murphy 2014). Chandler and Lalonde's influential work (1998 and 2008) established that among First Nations people in British Columbia, rates of suicide varied dramatically and were associated with a number of factors termed as "cultural continuity," or the degree of social and cultural cohesion within a community. These included land title; self-government (especially the involvement of women); control of education, policing, child welfare and health services; the presence of cultural facilities to preserve and enrich cultural aspects of the community; and intergenerational connectedness. Those communities with higher degrees of cultural

continuity had lower or zero suicide rates. Colonialism is also recognized as a social determinant of health for Indigenous people (Reading & Wien, 2009; Czyzewski, 2011).

Canada is a signatory to the United Nations *International Covenant on Economic, Social and Cultural Rights* (1966) and *Declaration on the Rights of indigenous People* (2007 which identify self-determination as a right for all peoples. Federal and provincial governments are moving towards co-development of policies, programs and initiatives with Indigenous people. During public consultation sessions for this review process, Mi'gmaq and Wolastoqey service providers, Elders and community members identified the need for community-led and community-based initiatives that would better meet the needs of Indigenous youth and adults. They also identified that existing provincial systems still have more work to do before they are culturally competent or safe, and that further collaboration and partnership is needed. First Nation representatives identified several of these examples, such as:

- Provincial mobile crisis teams that were not equipped to deal with the realities and culture of the community, so instead had to rely on community staff to lead efforts;
- The need for improved collaboration between the RCMP and on-call First Nation crisis teams after hours.

The *Canada-New Brunswick Home and Community and Mental Health and Addiction Services Agreement* (Health Canada, 2020) provides an opportunity for initial steps towards First Nation involvement and self-determination in their health and mental health. The agreement specifies the development of a culturally-appropriate and competent framework for mental health services for First Nations people and co-development of First Nations community-led, collaborative mental wellness teams. Co-development and collaborative implementation would also put into place shared accountabilities and mechanisms for implementing youth mental health services. Lack of clarity regarding jurisdictional responsibility has led to gaps and lack of culturally competent and safe services for Indigenous people. This will continue to be the situation if Indigenous people are not part of developing, delivery and oversight of health services which they use. This confusion was also identified as a challenge by Mi'gmaq and Wolastoqey service providers during this review. Future work involves clarifying these jurisdictional accountabilities and responsibilities.

Calls to Action:

4) **Establish a Tripartite forum and an ongoing process involving Indigenous leaders, Directors and organizations, provincial and federal governments to:**
    a. **Develop a framework for culturally appropriate, competent and safe mental health and wellness services for Indigenous people;**
    b. **Improve access, provision and cultural competency and safety of mental health and wellness services for Indigenous youth;**
    c. **Include First Nation input and oversight on the Indigenous portion of funding and aspects of the Canada-NB Agreement on Mental Health and Addictions;**
    d. **Establish site(s) as Indigenous-led healing centre(s), (e.g., Lonewater Farm) and enable success with provincial property tax reform and long-term core funding for programming, staff training support, etc.**

e. **Provide integration of the provincial ISD teams and the Jordan's Principle staff to better serve the needs of Indigenous children and to create a cohesive jurisdictional approach to ensuring no gaps exist in services to Indigenous children.**

5) **Increase transparency on federal health transfer dollars to New Brunswick and expenditures as these pertain to Indigenous mental health services.**

6) **Flow the First Nation portion of funding from the Canada-NB Agreement on Mental Health and Addictions through the Tripartite Forum.**

Integration of Indigenous-led mental health services

Suicide prevention, life promotion and mental health services for Indigenous youth depends on a comprehensive model of interventions and strategies (White & Joidin, 2007). A continuum of mental health related programming and services for Indigenous youth are provided by various service providers. This continuum includes:

- **First Nations** (through federal and Own Source Revenue funding of programs and services of First Nation health and child welfare services and schools on-reserve). Elsipogtog also operates Eastern Door which offers multi-disciplinary screening, diagnostic, prevention and intervention services that integrate medical and community cultural practices for trauma related conditions like FASD. There are also three Mental Wellness Teams (MWT) in the province that are in development or providing mental health related services, including crisis response for First Nations communities:
    - Mawlugutineg MWT serving the First Nation communities of Ug'piganjig, Pabineau, Esgenoôpetitj, Natoaganeg and Metepenagiag;
    - Oeliangitasoltigo MWT which is serving the First Nation communities of Elsipogtog, Indian Island, Buctouche and Fort Folly First Nations;
    - Wolastoqey MWT serving the six Wolastoqey First Nation communities.

  Access Open Minds was in place in Elsipogtog First Nation and was slated to be expanded with more sites in New Brunswick, including in Tobique First Nation. First Nation-led ISD teams would be similar and complement provincial ISD delivery, but a First Nation-led model may be slightly different. For example, First Nation-led C&Y Teams would include First Nation specific ISD components. These teams would be able to provide services to First Nation children and youth in First Nation schools but be able to transition their services to public schools as these youth transition to the public school system. While the design of services in First Nations Access Open Minds Centres and through the First Nation-led ISD teams would be led by First Nations, they would need to be integrated into the overall, provincial system.

- **Off-reserve Indigenous agencies**, such as Under One Sky Friendship Centre which provides early health promotion and prevention programs for young children and families;

- **Provincial services** through the Network of Excellence which include:

- **Prevention** services through community-based interventions, mental health promotions strategies and early intervention strategies;
- Child and youth mental health services in the province are delivered through an **Integrated Service Delivery (ISD)** model involving the four departments of Health, Social Development, Education and Early Childhood Development (EECD) and the department of Justice and Public Safety (JPS). The ISD model is offered in school/community settings to children and youth up to and including 18 years of age and up to 21 years for those in the public school system. The model uses a trauma-informed approach and offers a "step-up" and "step-down continuum of services which increase in intensity when the child or youth requires it, and decrease when the intensity of services is no longer needed:
    - **Education and Early Child Development** – Education Support Services (ESS) Teams operate in all public schools to assist classroom teachers in the development and implementation of teaching and/or management strategies and coordinate support for students. Principals manage the ESS teams along with at least one Education Support Teacher (EST). Other service providers may be included in ESS teams (e.g., social workers, guidance counsellors, methods and resource teachers) and a member of the Child and Youth teams participates in ESS teams.

    - **Health** – is involved with the Child and Youth (C&Y) Teams and Integrated Clinical Teams (ICT). The C&Y Teams include ESS team members along with professionals from Social Development or Justice and Public Safety when required (e.g., if a youth is involved with child welfare or in conflict with the laws). Each team has a C&Y Coordinator. The ICT teams provide clinical consultation to the ISD Teams and determine whether a child or youth requires "step-up" services such as a community treatment centre or specialized assessment or treatment (tertiary) services (e.g., Child and Adolescent Psychiatric Unit (CAPU), Pierre Caissie Centre or other services).

      Services are delivered through the Horizon Heath and Vitalité Regional Health Authorities (RHAs) (e.g., addictions and mental health services, in-patient care, CAPU, Pierre Caissie Centre and the FASD Centre of Excellence). While the RHAs have responsibility for determining the priorities, delivery and administration of health services for their respective regions, the provincial Department of Health has the responsibility for the provincial health plan, policy and budgets (Regional Health Authorities Act, 2011).

    - **Social Development** provides support to children and youth involved in the provincial child welfare system. They also have primary responsibility for the community "step-up/step-down" treatment centres which provide clinical support and intervention for children and youth in a community residential setting till these services are not required and the youth "steps-down" into community and school-based support services.

- **Justice and Public Safety** is involved with youth mental health services when youth are in conflict with the law and through the New Brunswick Youth Centre in Miramichi which provides secure custody and programming for youth sentenced under the Youth Criminal Justice Act.

- **Private organizations or service providers** such as social workers, psychologists or psychiatrists in private practice, private agencies or non-profit organizations.

First Nation communities and schools were not originally included in the ISD model but through the ISD First Nation Coordinators working in EECD, work is currently taking place to include the First Nation communities and to support Indigenous-led C&Y teams in First Nation communities who desire these.

Table 3 provides a summary of these services by jurisdiction. Not all programs and services available in the province may be included in this table.

Table 3 - Continuum of mental health and suicide prevention programs for Indigenous youth by jurisdiction

Continuum of Mental Health and Suicide Prevention Programs for Indigenous Youth by Jurisdiction				
	Promotion & Prevention	**Early Intervention**	**Assessment and Treatment**	**Crisis Intervention**
Federal Programs (usually delivered by First Nation communities or organizations to community members living on-reserve) *also available to First Nation people with registered Indian status living off-reserve	Building Health Communities (solvent abuse) Brighter Futures NAYSPS – National Aboriginal Youth Suicide Prevention Strategy NYSAP - National Youth Solvent Abuse Program NNADAP – National Native Alcohol and Drug Abuse Program Mental Wellness Teams Maternal & Child Health Child welfare prevention programs (if youth is involved with Child and Family Services) Aboriginal Headstart (on and off-reserve)	NAYSPS NIHB* (22 hours per year of counselling by an approved provider. May be extended on a case-by-case basis) Indian Residential Schools (IRS) Resolution Health Supports Program* Mental Wellness Teams Child welfare programs (if youth is involved with Child and Family Services) Jordan's Principle	NIHB* (22 hours per year of counselling by an approved provider. May be extended on a case-by-case basis. At federal rates of $150/hr) Traditional mental health counselling (recent program) NYSAP - National Youth Solvent Abuse Program NNADAP - Addictions counselling and programming - Residential Treatment* such as Lone Eagle, Rising Sun and Wolastokewiyik Treatment Centres Mental Wellness Teams Child welfare programs (if youth is involved with Child and Family Services) Eastern Door (Elsipogtog) – assessment and development of personal plans Jordan's Principle	Building Healthy Communities NAYSPS Mental Wellness Teams Elsipogtog Crisis Line (but not a 24-hour service)

Continuum of Mental Health and Suicide Prevention Programs for Indigenous Youth by Jurisdiction				
	Promotion & Prevention	**Early Intervention**	**Assessment and Treatment**	**Crisis Intervention**
Provincial Programs and Services (Offered through ISD and RHAs) (including services provided through Canada-New Brunswick Home and Community Care and Mental Health and Addictions Services Funding Agreement)	Community and school based mental health promotion and prevention services FASD Centre of Excellence	ISD - Education Support Services (ESS) Teams	ISD • Child & Youth Teams (C&Y); • Integrated Clinical Teams (ICT)) (for Pierre Caissey and Restigouche Youth Unit) Community Step-Up Treatment Centres Mental Heath Clinics (counselling, group therapies) FASD Centre of Excellence CAPU – Provincial Child and Adolescent Psychiatry Unit Pierre Caissie Treatment Centre (consultation, assessment for youth with severe conduct disorder and behavioural challenges) NB Youth Detention Centre Residential substance abuse rehabilitation programs Restigouche youth unit	Mobile crisis teams • During the day the teams may serve more adults (C&Y teams are available during the day) • After 4.40 pm, the teams serve all ages • The teams are available till 8 pm, 10pn or midnight depending on location. After this time, calls are rolled over to 811 where there can be triage, or assistance via hospital emergency rooms. Hospital based psychiatric services

Continuum of Mental Health and Suicide Prevention Programs for Indigenous Youth by Jurisdiction				
	Promotion & Prevention	**Early Intervention**	**Assessment and Treatment**	**Crisis Intervention**
Other (e.g., off-reserve non-profits, private sector)	Community based mental health promotion and prevention services	Private counsellors, psychologists and clinicians (through NIHB or private insurance or private pay)	Private counsellors, psychologists and clinicians (through NIHB or private insurance or private pay) Portage (youth addiction treatment residential program)	Private counsellors, psychologists and clinicians (through NIHB or private insurance or private pay)

In both the Mi'gmaq and Wolastoqey sessions, First Nation service providers identified that key challenges for mental health service delivery included jurisdictional lack of clarity on whether First Nation mental health services were the responsibility of the federal or provincial governments. Further, they lacked stable, core program funding and sufficient resources to deliver programming to meet the needs of community members (e.g., youth centres, resources and capacity building for cultural-based programs, direct services, improved inter-departmental collaboration within First Nation communities). Funding was project based and subject to changing federal government priorities. Funding was also mostly available for adult mental health programming. Until the recent funding of the three Mental Wellness Teams in the province, funding was also aimed at mental health promotion and prevention services and there was little or no funding available for intervention or crisis response, except for through NIHB benefits to access private counselling services. Yet, there is an urgent need for community-led and community-based mental health programs and services for Indigenous youth. There was also a need for improved collaboration and integration of services with RHAs and the ISD model. These aspects were also influenced by the will of provincial or RHA leadership.

Improved collaboration and service delivery will require a clear understanding of what exists and gaps in service, mechanisms and resources. Mental health and wellness for Indigenous youth involves the health, education, child welfare and justice sectors. The brevity of the current review does not allow a fulsome picture of the many systems that directly impacts Indigenous youth mental health in New Brunswick. This report only touches on Education and Justice, and it does not address mental health and wellness issues related to child welfare at all. Because of the relationship between Indigenous youth mental wellness to self-determination, Aboriginal and Treaty rights, language, culture and the environment, other systems like those related to culture and heritage, the environment and natural resources also impact Indigenous youth mental health.

Call to Action:

7) **Fund a separate review of Indigenous youth mental health services, including a scan on a) jurisdictional gaps in service delivery and integration and b) adequacy of funding and services.**

Creating Positive Education Experiences for Indigenous Youth

The final consultation session for this Review was with Indigenous youth and provided insight into the lack of belonging and support they experience not only in the healthcare system, but more importantly for them, the education system as they spend most of their days in schools. Some of these youth lived in First Nation communities and attended public schools; others grew up and lived off-reserve. In their voices:

> "In mainstream schools, Indigenous education just needs to be louder and be there more."

> "Every school should do that…a youth-friendly place should be helping kids to figure out what's going on with them instead of trying to silence them. Drawing, creating, weighted stuff, different ways for different coping mechanisms."

> "A safe space where we could create crafts and also talk about what is going on in our heads or home life, especially in larger cities."
>
> "Being able to see if someone is giving off signs of suicide. All teachers should have this training. Guidance counsellors don't see everyone. Teachers can pull them aside and ask them, 'What's going on?' It would help a lot."
>
> "There are Guidance Counsellors at school, but there is a stigma about race itself in high schools. Anyone who is a person of colour doesn't get as much attention or there might be stigma, especially Guidance Counsellors at school….Their goal is not to help you, but to help you quiet down. There is a stigma to talk about mental health even in the helping professions. The most they do is give you a stress ball, but they don't actually talk to you about your problem."
>
> "It should be at least someone who cares [who sees you about mental health]. Someone who is Indigenous."

The Student Wellness Surveys conducted by the New Brunswick Health Council also identify that Indigenous youth experience a lower sense of connectedness to their school communities than other youth and less frequently feel that their concerns about bullying are dealt with by school professionals (35% for Indigenous students compared to 43% for other students) (New Brunswick Health Council, 2019). In one of the public consultation sessions for this review, First Nation service providers shared that university researchers had identified racism and bias towards First Nation youth in the public school they attended. However, there was a lack of school leadership and instead, these Indigenous youth had to be taught coping skills to deal with the racism they were experiencing daily, even though they made up most of the school's student population.

It was clear from the consultation with Indigenous youth and service providers that covert racism is prevalent in provincial systems such as health and education and with individuals in the system who provide services directly to youth. Covert racism is often hidden by norms, group membership and/or identity which enables denial of racist acts. Dyson (2006, as cited in Coates, 2011, pp. 20) states that "…it should be clear that although one may not have racial intent, one's actions may nonetheless have racial consequences." Covert racism can operate at the individual or group level. When covert racism is repeated over an extended time, patterns emerge into systemic racism. With systemic racism, covert racism can operate across several societal institutions and structures through intentionality, norms, mechanisms and systems (Coates, 2011).

More Canadians are recognizing the devastating legacy of residential schools, but Indigenous people have lived with this reality and systemic racism daily for generations. Recent actions by the federal government have shown that they are taking systemic racism seriously and are committed to starting the long process towards systems that respect the principles of reconciliation, the self-governing rights of Indigenous nations and are inclusive of all people. Canada has committed to First Nations Education Transformation that honours the inherent right to self-government for the Nations through the negotiation of Regional Education Agreements (REA's).

"REAs are a mechanism to formalize how First Nations have determined the distribution of their core education funding (such as, education service map) in accordance with the Elementary and Secondary Education Program's Kindergarten to grade 12 Terms and Conditions.
Where a First Nation chooses to enter into REA negotiations, that REA will address the following 4 pillars:

- Comprehensive funding arrangements, covering all federal support for First Nations elementary and secondary education, including special education and education supports for languages
- Clear and defined roles and responsibilities of the parties to the REA, including applicable service standards, as determined by First Nations
- Mutual accountabilities mechanisms with clear objectives, performance indicators, and reporting expectations for both the Government of Canada and First Nations education system participants
- First Nations will give direction to outline processes of working with ministries of education to ensure quality education is provided to First Nations students attending provincial, private or territorial schools." (Indigenous Services Canada, 2020, December 11).

Elsipogtog First Nation signed the first REA in Atlantic Canada with the federal government on March 9, 2021 (Indigenous Services Canada, 2021, March 9).

While the federal government has a Constitutional obligation to provide funding to First Nations for education, the Province has a Constitutional obligation to provide quality education for First Nations students that attend provincial schools. In order for Indigenous youth to focus on academics and succeed, they must first experience a sense of overall well-being and belonging at school. The education system must adapt to the diverse needs of all children who attend school from different backgrounds, experiences and well-being foundations. However, the grey area of jurisdictional responsibility and lack of clear legislation and policies pertaining to Indigenous students have resulted in gaps and inequitable educational outcomes for Indigenous youth. For example, although the Department of Education and Early Childhood Development's Policy 309, *French Second Language Programs (2018) "*encourages the revitalization and preservation of First Nation languages in New Brunswick" as a Goal/Principle (p. 2), the policy does not actually speak further on Indigenous languages. Section 7 of the *Education Act*, 1997, Ch. E 1.12, states:

Programs and services in relation to Indigenous education
2021, c.10, s.1
7 The Minister shall prescribe or approve programs and services which
(a) respond to the unique needs of Mi'kmaq and Wolastoqey children, if the Minister has entered into an agreement with a council of a Mi'kmaq or Wolastoqey First Nation under subsection 50(1) or paragraph 50(2)(b), and
(b) foster a better understanding of Indigenous history, culture and languages among all pupils. 2000, c.52, s.10; 2017, c.7, s.1; 2021, c.10, s.1

Education is a right of every child. The Act defines "pupil" to mean "a person who is enrolled in a school established by this Act." Yet, First Nation students must pay tuition, even though First Nation parents who live on-reserve contribute to New Brunswick's taxation system through income taxes (as many work off-reserve) and the Harmonized Sales Tax. As well, First Nation parents who live off-reserve contribute through property taxes. First, the Act makes the provision of programs and services for Mi'kmaq and Wolastoqey children living on-reserve contingent on signed agreements with Mi'kmaq or Wolastoqey First Nation Councils. Second, the majority of Indigenous children and youth are without the programs and services they need as they live off-reserve, possibly in a location away from their home community; are originally from other provinces; or identify as Indigenous but do not have registered Indian status. At the end of 2020, 32.7% of the Registered Indian Population in New Brunswick aged 0 – 24 years lived off-reserve and seven First Nation communities in New Brunswick have more members living off-reserve than on-reserve (David, personal communications, February 2, 2021). In the 2016 Census, 70.9% of Indigenous youth aged 0 – 24 years lived off-reserve in New Brunswick (Statistics Canada, 2018).

Efforts are in place to improve educational outcomes and experiences for First Nation children. New Brunswick's 10-Year Education Plans include specific objectives related to First Nations students. Objective 6 of *Everyone at Their Best (Anglophone sector)* (New Brunswick Department of Education and Early Childhood Development, 2016) is to "meet the needs of First Nation learners and ensure that provincial curriculum is reflective of First Nation history and culture." Similarly, Objective 5 of *Donnons à nos enfants une longueur d'avance (Francophone sector)* (New Brunswick Department of Education and Early Childhood Development, 2016a) is "First Nations – Ensure all students value and understand the culture and history of First Nation People and support First Nation students' identity building." Further improvements and investments are required. Each New Brunswick First Nation community signs Tuition and Education Enhancement agreements with the provincial government. Currently, 50% of tuition fees paid to the provincial government for First Nation students are invested in Education Enhancement Agreements to provide needed programs and services exclusively to students from their respective communities. Decisions on how these funds are spent are made through a joint First Nations-District Committee. However, this model has not worked consistently across the province and addressing systemic racism in education remains a controversial issue. These agreements have also long been in contention between First Nation and provincial governments because of the lack of transparency in how the total amount of these funds are spent. For example, do these funds go towards the benefit of Indigenous students? Or are they funding school infrastructure generally? Further, these agreements will not address the needs of Indigenous students living away from their home communities, off-reserve or those who do not have registered Indian status, who constitute the majority of the Indigenous student population in the public school system. Finally, improved mental wellness outcomes related to their school experience and a sense of belonging in their school communities must be considered and will require investments of efforts and resources.

As Indigenous children spend much of their lives at school, transformation, inclusion and the dismantling of systemic racism are critical for the future wellness of Indigenous people, and of New Brunswickers. It is imperative that the Government of New Brunswick recognize the inherent right of the First Nations to self-government and work with them in a Nation-to- Nation relationship in order to ensure success of First Nations students in the provincial school system. This means control over decisions that affect

Indigenous peoples. It is also imperative that the public education system is inclusive and responds to the needs of Indigenous students.

Calls to Action:

8) **Institute Wabanaki culturally inclusive education policy and legislation at the early learning, secondary and post-secondary levels that upholds the Provincial Government's Constitutional obligations to Indigenous children to provide quality education and includes First Nations people in New Brunswick as residents of New Brunswick with a right to equitable provision of services that is free of systemic racism throughout their education.**

9) **Co-develop success indicators with Indigenous people for Indigenous youth in the education system that measure not only academics, but also the holistic needs of Indigenous youth, including their cultures, languages, access to ceremonial practices and mental wellness.**

10) **Re-invest 100% of the New Brunswick-First Nation Education Enhancement Agreement dollars to provide programming and services for Indigenous children.**

11) **Reinstate the First Nations Ministerial Advisory Committee that was part of the original Enhancement Agreements but has ceased to exist for the past eight years so that recommendations to the Minister will be heard and acted upon.**

Supporting Indigenous Youth in Conflict with the Law

Since 2003, correctional services for youth aged 12 to 17 years at the time of offence have been guided by the *Youth Criminal Justice Act, SC 2002, c1 (YCJA)*. Section 28 on the *YCJA* states that the provisions of Part XVI of the *Criminal Code* apply to the pre-trial detention and release of young persons. Circumstances included in these provisions state that individuals should be released unless there is a need to prevent a continuation or repeat of an offence, protect victims or witnesses, or if the person will not attend court in the future (Criminal Code, Part XVI, Section 498 (1.1). With respect to sentencing, Section 38 (2)(d) of the *YCJA* specify that "all available sanctions other than custody that are reasonable in the circumstances should be considered for all young persons, with particular attention to the circumstances of aboriginal young persons."

Across Canada, youth admissions to both pre-trial detention and sentenced custody have decreased overall between 2004/2005 to 2014/2015 since the introduction of the *YCJA*. In New Brunswick, there was a 13% increase in pre-trial detention for youth and a 60% decrease in youth entering sentenced custody for the same period (see Table 4) (Canadian Centre for Justice Statistics, 2017).

Table 4 - Youth admissions to custody by type of custody, 2014/2015, Canada and New Brunswick

	Youth admissions to custody, 2014/2015					
	Pre-trial detention			Sentenced custody		
	Number	% of total custody population	% change from 2004/2005	Number	% of total custody population	% change from 2004/2005
Canada	6,365	83	-10	1,307	17	-65
NB	258	70	13	108	30	-60

The same downward trend in custody admissions for Indigenous youth has not taken place. Instead, the proportion of admissions by Indigenous youth has been rising. In 2004/2005, Indigenous youth accounted for 21% of admissions to pre-trial detentions for the eight jurisdictions where information was available, including New Brunswick. By 2014/2015, in these same jurisdictions, 36% of youth admissions to pre-trial detention were Indigenous youth representing a 15% increase. This is five times greater than for non-Indigenous youth who represent 7% of pre-trial youth detentions. Indigenous youth also accounted for a larger proportion of admissions to sentenced custody in both 2004/2005 (26%) and 2014/2015 (40%) (see Table 5) (Canadian Centre for Justice Statistics, 2017).

Table 5 - Indigenous youth admissions to custody, 2004/2005 and 2014/2015 by type of custody, Canada and New Brunswick

	Indigenous youth admissions to custody, 2004/2005 and 2014/2015, Canada and New Brunswick					
	Pre-trial detention			Sentenced custody		
	% 2004/2005	%2014/2015	% change in 10-year period	% 2004/2005	%2014/2015	% change in 10-year period
Canada	21	36	15	26	40	14
NB	9	10	1	4	9	5

The latest analysis shows that Indigenous youth continue to be overrepresented in the justice system. In 2018/2019, Indigenous youth were overrepresented in both custody and community supervision arrangements, representing 47% of custody admissions and 40% of community admissions in the reporting jurisdictions. Indigenous youth represented 43% of youth admissions to correctional services while representing 8.8% of the youth population in Canada (Malakieh, 2020).

In New Brunswick, Indigenous youth admissions have remained relatively stable between 1997 to 2016 (all types of statuses including community supervision, pre-trial detention, remand and custodial sentences). The rapid decline among admissions for non-Indigenous youth since 2009/2010 resulted in a slight increase in the percentage of Indigenous youth admissions which peaked at 10.6% in 2015/2016. As Indigenous youth made up 4% of New Brunswick's population aged 12 to 17 years in 2015/2016, they were admitted to the provincial correctional system at nearly twice the proportion of their population (Wiley, Love & Emmet, 2020).

Indigenous youth also represent a greater proportion of youth involved in the criminal youth justice system at all stages. Indigenous youth are 20% more likely to be charged on arrest than non-Indigenous youth (Hogeveen, 20015). They are also more likely to be denied bail, face hurdles in meeting the conditions associated with bail, spend more time in pre-trial custody, be charged with multiple offences (often for administrative violations) and less likely to have legal representation (Hogeveen, 2005; Latimer & Foss, 2005; Clark, 2019). Latimer and Foss (2005) also found that they are likely to receive longer sentences than their non-Indigenous peers, independent of aggravating factors such as their criminal history or the severity of the offence. One fifth (21%) of court cases employing alternative measures involve Indigenous young offenders (Corrado, Kuehn & Margaritescu, 2014).

Indigenous youth are characterized by a risk factor profile which places them at higher risk for offending and being involved with the criminal justice system. Compared to their non-Indigenous peers, they faced higher inter-generational adversity (such as family members who had a criminal record, faced substance abuse problems, or were victims of physical or sexual abuse). These types of family-related adversities increase the risk of being placed in foster care and Indigenous youth also had higher rates of foster care placements. Foster care placements have been strongly correlated with substantially higher involvement with the criminal justice system (Corrado et al., 2014).

When Indigenous youth encounter the criminal justice system, they are faced with biased assessments that increase their likelihood of being sentenced (Minaker and Hogeveen, 2009 as cited in Luo, 2020). Only using a risk factor approach to explain the disproportionate overrepresentation of Indigenous youth in the criminal justice system does not consider the broader socio-political context and impacts of colonization. Judges, prosecutors and defence lawyers have also questioned the appropriateness of using risk assessment instruments and risk-based sentencing for young offenders, particularly for minority groups and Indigenous people. The classification of criminogenic risks and needs contradict the legally mandated principle of proportional sentencing in the *YCJA.* Academics in both Canada and the United States have been calling for a trauma-informed approach to juvenile justice systems which employ a holistic approach (Crosby, 2016; Griffin, Germain & Wilkerson, 2014; Oudshoorn, 2015; Crosby, 2016; Skinner-Osei, Mangan, Liggett, Kerrigan & Levenson, 2019).

There is a growing consensus that Indigenous involvement in the criminal justice system results from the interaction of complex dynamics, such as over-policing, racist laws, politics, a greater level of offending, social disorganization and socio-economic marginalization. Consequently, it is critical to consider the multi-century history of colonization and its intergenerational impacts on Indigenous families and communities as well as attitudinal and institutionalized racism (Kong, 2009; Reitano, 2004; as cited in Corrado et al., 2014; Cesaroni, Grol & Fredericks, 2019; Clark, 2019).

Indigenous youth have expressed that growing up without their culture because of colonization led to an absence of identity, purpose and self as an individual but also in relation to family and community. This made them more vulnerable to high-risk behaviours, such as drinking and experimentation with drugs at an early age that eventually led to contact with the criminal justice system. They described involvement in the criminal justice system as an experience that “robs you of what little identity or cultural connection you might have” and that the criminal justice system lacked the ability to heal or

rehabilitee young Indigenous offenders. The situation was exacerbated by lack of cultural awareness and sensitivity amongst those involved in the criminal justice system (Justice Canada, 2019, p. 10).

Call to Action:

12) **Judges and Crown Prosecutors receive training on Indigenous intergenerational trauma and culturally relevant options for Indigenous youth who are in conflict with the law so they can better identify appropriate extrajudicial sanctions and sentencing options for Indigenous youth.**

Building on Progress to Date

Over the past three years, the Government of New Brunswick has been working with an Indigenous Guidance Team (IGT) to obtain input on ensuring access and cultural safety for Indigenous children and youth accessing mental health and addictions services through the Network of Excellence model. The IGT is comprised of Elders and diverse Indigenous professionals familiar with the four sectors relevant to the Network of Excellence (i.e., health, education, justice and child welfare) as well as with First Nation communities and Indigenous people living off-reserve. The IGT completed their report and recommendations in 2019 and subsequently participated in a process with provincial government representatives to determine whether these recommendations could be implemented in the short, medium or long term. Although it was intended that the IGT report would be presented to Indigenous leadership, Directors and other parties in the province, this has still not taken place. Some of delays were caused by the pandemic. However, as the province makes progress towards Green Phase, the IGT recommendations should be presented as soon as possible to Indigenous leaders, Directors and key organizations to seek input on the recommendations and to develop the partnerships necessary for implementation.

13) **Present the Indigenous Guidance Team recommendations on the Network of Excellence to Indigenous leadership, First Nation Directors of Health, Child Welfare and Education and Indigenous organizations.**

Conclusion

Historical and intergenerational impacts of colonization have contributed to high rates of mental health issues among Indigenous peoples. With suicide rates that far exceed those of their non-Indigenous peers, suicide and mental health continue to be pressing challenges for Indigenous youth in every jurisdiction across Canada, including New Brunswick. Revitalizing language and culture and community-led approaches are seen to be key to improving mental health outcomes for Indigenous youth, as are integrated services between the various jurisdictions providing mental health services for Indigenous youth. These will require commitments and partnerships between First Nations, the federal and

provincial governments as well as private organizations or services. Without these efforts, there will continue to be losses of future Indigenous tradespeople, professionals, artists, scientists, parents and Elders. This will be at a great moral, social and economic cost for Indigenous peoples and for New Brunswick. The spirit of the Peace and Friendship Treaties of this region laid a foundation for cooperation. We live in a small province where we have the gift of diversity and the opportunity for closer collaboration. We must work together for all our future generations. No child left behind.

Summary of Calls to Action

1) The Mi'gmaq, Peskotomuhkati and Wolastoqey languages be formally recognized and supported by provincial legislation which:
    a. Recognizes that these languages are the original languages of this territory, that Indigenous language rights are part of the Peace and Friendship Treaties and that these languages are currently endangered;
    b. Recognizes Indigenous languages as fundamental and valued in New Brunswick culture and society;
    c. Actively supports Indigenous language revitalization through funding and programs provided by the provincial government and/or in partnership with the federal government;
    d. Affirms that the reclamation, preservation, revitalization and protection of Mi'gmaq, Peskotomuhkati and Wolastoqey languages are best undertaken by these Indigenous peoples and communities.

2) Culture as Foundation and a Two-Eyed Seeing approach should be used as the basis for implementing mental wellness, health and addictions services for Indigenous youth. Culturally relevant services and programming should be available for Indigenous youth and families through:
    a. Co-development with Indigenous peoples and communities;
    b. Indigenous-led community-based services as part of the continuum of services;
    c. Provincial health and mental health programs and services that meet the mental wellness needs of Indigenous people;
    d. Enhanced collaboration between provincial health services and First Nation communities and Indigenous organizations to ensure that Indigenous youth have a culturally safe and seamless experience when using health and mental health and wellness services.

3) The Province of New Brunswick and Indigenous communities and organizations work together to effect changes in healthcare structures and processes, such as service design, policy, human and financial resources, program and service delivery with the longer-term goal of cultural safety and improved mental health outcomes for Indigenous people.

4) Establish a Tripartite forum and an ongoing process involving Indigenous leaders, Directors and organizations, provincial and federal governments to:
    a. Develop a framework for culturally appropriate, competent and safe mental health and wellness services for Indigenous people;
    b. Improve access, provision and cultural competency and safety of mental health and wellness services for Indigenous youth;
    c. Include First Nation input and oversight on the Indigenous portion of funding and aspects of the Canada-NB Agreement on Mental Health and Addictions;

d. Establish site(s) as Indigenous-led healing centre(s), (e.g., Lonewater Farm) and enable success with provincial property tax reform and long-term core funding for programming, staff training support, etc.
e. Provide integration of the provincial ISD teams and the Jordan's Principle staff to better serve the needs of Indigenous children and to create a cohesive jurisdictional approach to ensuring no gaps exist in services to Indigenous children.

5) Increase transparency on federal health transfer dollars to New Brunswick and expenditures as these pertain to Indigenous mental health services.

6) Flow the First Nation portion of funding from the Canada-NB Agreement on Mental Health and Addictions through the Tripartite Forum.

7) Fund a separate review of Indigenous youth mental health services, including a scan on a) jurisdictional gaps in service delivery and integration and b) adequacy of funding and services.

8) Institute Wabanaki culturally inclusive education policy and legislation at the early learning, secondary and post-secondary levels that upholds the Provincial Government's Constitutional obligations to Indigenous children to provide quality education and includes First Nations people in New Brunswick as residents of New Brunswick with a right to equitable provision of services that is free of systemic racism throughout their education.

9) Co-develop success indicators with Indigenous people for Indigenous youth in the education system that measure not only academics, but also the holistic needs of Indigenous youth, including their cultures, languages, access to ceremonial practices and mental wellness.

10) Re-invest 100% of the New Brunswick-First Nation Education Enhancement Agreement dollars to provide programming and services for Indigenous children.

11) Reinstate the First Nations Ministerial Advisory Committee that was part of the original Enhancement Agreements but has ceased to exist for the past eight years so that recommendations to the Minister will be heard and acted upon.

12) Judges and Crown Prosecutors receive training on Indigenous intergenerational trauma and culturally relevant options for Indigenous youth who are in conflict with the law so they can better identify appropriate extrajudicial sanctions and sentencing options for Indigenous youth.

13) Present the Indigenous Guidance Team recommendations on the Network of Excellence to Indigenous leadership, First Nation Directors of Health, Child Welfare and Education and Indigenous organizations.

References

Aguiar, W. & Halseth, R. (2015). *Aboriginal peoples and Historic Trauma: The processes of intergenerational transmission.* Prince George, BC: National Collaborating Centre for Aboriginal Health.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorder (5th ed).* Arlington, VA: Author.

Archibald, L. (2006). *Final Report of the Aboriginal Healing Foundation (Vol. III) – Promising Healing Practices in Aboriginal Communities.* Ottawa: Aboriginal Healing Foundation.

Assembly of First Nations, National Native Addictions Partnership Foundation & Health Canada. (2011). *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People In Canada*. Ottawa, ON: Health Canada.

Assembly of First Nations and Health Canada. (2015). *First Nations Mental Wellness Continuum Framework.* Retrieved from https://www.thunderbirdpf.org/wp-content/uploads/2015/01/24-14-1273-FN-Mental-Wellness-Framework-EN05_low.pdf

Bartlett, C., Marshall, M., & Marshall, A. (2012). "Two Eyed Seeing and other lessons learned within a co-learning journey of bringing together Indigenous and mainstream knowledges and ways of knowing." *Journal of Environmental Studies and Sciences,* 2(4), November 2012. DOI: 10.1007/s13412-012-0086-8

Benning T. B. (2013). Western and Indigenous Conceptualizations of Self, Depression, and its Healing. *International Journal of Psychosocial Rehabilitation. Vol 17(2) 129-137*. Retrieved from http://www.psychosocial.com/IJPR_17/Western_and_Indigenous_Benning.html

Brascoupé, S. & Waters, C. (2009). Cultural safety – Exploring the applicability of the concept of cultural safety to Ab original health and community wellness. *Journal of Aboriginal Health,* November 2009, 6-41. Retrieved from https://jps.library.utoronto.ca/index.php/ijih/article/view/28981

Brasfield, C. (2001). Residential School Syndrome. *British Columbia Medical Journal.* Vol. 43, No. 2., 78-81. Retrieved from https://www.bcmj.org/articles/residential-school-syndrome

Braveheart, M.Y (2003). The Historical Trauma Response Among Natives and Its Relationship with Substance Abuse: A Lakota Illustration, *Journal of Psychoactive Drugs*: 35:1, 7-13, DOI: 10.1080/02791072.10399988.

Braveheart, M.Y., Chase, J., Elkins, J. & Altschul, B. (2011). Historical trauma among Indigenous peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs,* 43:4, 282-290. DOI: 10.1080/02791072.2011.628913

Canadian Centre for Justice Statistics (2017). *Trends in the Use of Remand in Canada, 2004/2005 to 2014/2015.* Statistics Canada Catalogue no. 85-002-X. Retrieved from https://www150.statcan.gc.ca/n1/pub/85-002-x/2017001/article/14691-eng.htm

Castellano, M. (2006*). Final Report of the Aboriginal Healing Foundation (Vol. I) - A Healing Journey: Reclaiming Wellness (Vol. 1)*. Ottawa, ON: Aboriginal Healing Foundation. Retrieved from https://www.ahf.ca/downloads/final-report-vol-1.pdf

Cesaroni, C., Grol, C. & Fredericks, K. (2019). Overrepresentation of Indigenous youth in Canada's criminal justice system: Perspectives of Indigenous young people. In *Australian and New Zealand Journal of Criminology,* 52 (1), 111-128. Doi: 10:1177/0004865818778746

Chandler, M. J., & Lalonde, C. (1998). Cultural Continuity as a Hedge against Suicide in Canada's First Nations. Transcultural Psychiatry, 35(2), 191–219. https://doi.org/10.1177/136346159803500202

Chandler, M. & Lalonde, C. (2008). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In Kirmayer, L. & Valaskakis, G. (Eds.). *Healing traditions: The mental health of Aboriginal peoples in Canada (pp 22 –248).* University of British Columbia Press. Retrieved from https://web.uvic.ca/psyc/lalonde/manuscripts/2008HealingTraditions.pdf

Clark, S. (2019). *Overrepresenation of Indigenous People in the Canadian Criminal Justice System: Causes and Responses.* Retrieved from https://www.justice.gc.ca/eng/rp-pr/jr/oip-cjs/oip-cjs-en.pdf

Coates, R. (2011). Covert racism: Theory, types and examples. In R. Coates (Ed.), *Covert Racism: Theories, Institutions, and Experiences* (pp. 121-139). Brill. https://doi.org/10.1163/ej.9789004203655.i-461

Coll, K., Freeman, B., Scholl, S. & Hauser, N. (2018). Challenge and culturally relevant treatment strategies for American Indian youth in therapeutic residential care: A pilot study. *Journal of Child and Adolescent Counseling.* Doi.org/10.1080/23727810.2018.1435580.

Corrado, R., Kuehn, S. & Margaritescu, I. (2014). Policy issues regarding the over-representation of incarcerated Aboriginal young offenders in a Canadian context. In *Youth Justice,* 14(1), 40-62. Doi: 10.1177/1473225413520361

Criminal Code, RSC 1985, c C-46. Retrieved from https://www.canlii.org/en/ca/laws/stat/rsc-1985-c-c-46/latest/rsc-1985-c-c-46.html

Crosby, S. (2016). Trauma-informed approaches to juvenile justice: A critical race perspective. *Juvenile Family Court,* 67 (1), 5-18. Doi:10.1111/jfcj.12052

Czyzewski, K. (2011) Colonialism as a broader social determinant of health. *The International Indigenous Policy Journal,* 2(1). DOI: 10.18584/iipj.2011.2.1.5. Retrieved from https://ojs.lib.uwo.ca/index.php/iipj/article/view/7337/5981

Daniels *v.* Canada (Indian Affairs and Northern Development), 2016 SCC 12, [2016] 1 S.C.R. 99

Department of Finance Canada. (2017). *Major federal transfers.* *https://www.canada.ca/en/department-finance/programs/federal-transfers/major-federal-transfers.html#NewBrunswick*

Duran, E., Firehammer, J., & Gonzalez, J. (2008). Liberation psychology as the path toward healing cultural soul wounds. *Journal of Counseling and Development : JCD, 86*(3), 288-295. doi:10.1002/j.1556-6678.2008.tb00511.x

Duran, E. & Firehammer, J. (2016). "Injury Where the Blood Does Not Flow". *Indigenous Cultures and Mental Health Counselling: Four Direction for Integration with Counselling Psychology*. Ed. Suzanne L. Stewart, Ron Moodly, and Ashley Hyatt. Rutledge Press pp. 108-124.

Education Act, SDNB 1997, c E-1.12. Retrieved from https://www.canlii.org/en/nb/laws/stat/snb-1997-c-e-1.12/latest/snb-1997-c-e-1.12.html#document

Fast, E. & Collin-Vézina, D. Historical Trauma, Race-based Trauma and Resilience of Indigenous Peoples: A Literature Review. *First People's Child and Family Review*. Volume 5, Number 1, 2010, p. 126-136

First Nation Child and Caring Society. (2021). *Jordan's Principle.* https://fncaringsociety.com/jordans-principle

First Peoples' Heritage, Language and Culture Act, RSBC 1996. Retrieved from https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96147_01

First Peoples Wellness Circle. (2019). *PTSD Briefing Note to Public Health Agency of Canada.* Retrieved from https://www.fpwc.ca/current-projects-1

Fiedeldey-Van, D., Rowan, M., Dell, C., Mushquash, C., Hopkins, C., Fornssler, B., . . . Shea, B. (2017). Honoring Indigenous culture-as-intervention: Development and validity of the native wellness assessment TM. *Journal of Ethnicity in Substance Abuse, 16*(2), 181-218. doi:10.1080/15332640.2015.1119774.

Fleming, J., & Ledogar, R. J. (2008). Resilience and Indigenous Spirituality: A Literature Review. *Pimatisiwin*, *6*(2), 47-64. Retrieved from Canadian Institutes of Public Health: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2956755/

Graham, S., Stelkia, K., Wieman, C. & Adams, E. (2021). Mental health interventions for First Nations, Inuit and Métis people in Canada: A systematic review. *The International Indigenous Policy Journal,* 12 (2). Retrieved from https://ojs.lib.uwo.ca/index.php/iipj/article/view/10820

Griffin, G., Germain, E. & Wilkerson, R. (2012. Using a trauma-informed approach in juvenile justice institutions. *Journal of Child & Adolescent Trauma*, 5: 271-283. Doi: 10.1080/19361521.2012.697100

Health Canada. (2007). *Indian Health Policy 1979.* Retrieved from http://caid.ca/IndHeaPol1979.pdf

Health Canada. (2020, October 8). *Canada-New Brunswick Home and Community Care and Mental Health and Addictions Services Funding Agreement.* https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/new-brunswick.html

Hogeveen, B. (2005). Toward "safer" and "better" communities?: Canada's Youth Criminal Justice Act, Aboriginal youth and the processes of exclusion. In *Critical Criminology,* 13: 287-305. Doi: 10.1007/s10612-005-3185-y.

Indigenous Languages Act, SC 2019, c 23, Retrieved from <https://canlii.ca/t/53rgj>

Indigenous Services Canada. (2020, May 29,). *Supporting Inuit Children*. https://www.sac-isc.gc.ca/eng/1536348095773/1536348148664

Indigenous Services Canada. (2020, December 11). *Education Partnerships Program: Regional Education Agreement Component: National Program Guidelines 2020 to 2021. https://www.sac-isc.gc.ca/eng/1607099844356/1607099884431*

Indigenous Services Canada. (2021, January 29). *Co-developing distinctions-based Indigenous health legislation.* https://www.sac-isc.gc.ca/eng/1611843547229/1611844047055

Indigenous Services Canada. (2021, March 9). *Government of Canada signs Regional Education Agreement with Elsipogtog First Nation Education Authority*. https://www.canada.ca/en/indigenous-services-canada/news/2021/03/government-of-canada-signs-regional-education-agreement-with-elsipogtog-first-nation-education-authority.html

Johnson, J. (2012). PTSD and epigenetic research: Decentering the physical body. *Journal of Aggression, Maltreatment & Trauma,* 21:45-66. doi: 10.1080/10926771.2012.632390

Justice Canada. (2019). *Indigenous Youth Roundtables – Overrepresentation of Indigenous Youth in Canada's Criminal Justice System.* Retrieved from https://www.justice.gc.ca/eng/cj-jp/yj-jj/tools-outils/pdf/iyr-trja.pdf

Kellermann, N. (2013). Epigenetic transmission of holocaust trauma: Can nightmares be inherited? *Israel Journal of Psychiatry and Related Sciences*, Vol. 50, No. 1, 33 – 39.

Kirmayer, L.J., Brass, G.M. & Tait, C. L. (2001). The mental health of Aboriginal peoples: Transformations of identity and community. In *The Mental Health of Indigenous Peoples: Proceedings of the Advanced Study Institute May 29-May 31, 2000.* Editors: Kirmayer, L.J., MacDonald, M.E. and Brass, G.M. Montreal: McGill University. Retrieved from https://www.mcgill.ca/tcpsych/files/tcpsych/Report10.pdf

Kirmayer, L. J., Fraser, S.L., Fauras, V. & Whitley, R. (2009). *Current Approaches to Aboriginal Youth Suicide Prevention*. Retrieved from https://youthrex.com/report/current-approaches-to-aboriginal-youth-suicide-prevention/

Kirmayer, L. J. & Valaskakis, G. G. (2009). Preface. In L. J. Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal people. (*pp. viii – xxi). Retrieved from https://www.ubcpress.ca/asset/9291/1/9780774815239.pdf

Kirmayer, L., Dandeneau, S., Marshall, E., Kahentonni Phillips, J., & Jessen Williamson, K. (2011). Rethinking resilience from Indigenous perspectives. *Canadian Journal of Psychiatry*. 56(2), 84-91. Retrieved from https://journals.sagepub.com/doi/10.1177/070674371105600203

Kirmayer, L., Gone, J. & Moses, J. (2014). Rethinking historical trauma. *Transcultural Psychiatry,* Vol51(3), 299-319. doi: 10.1177/1363461514536358. Retrieved from https://journals.sagepub.com/doi/full/10.1177/1363461514536358

Kiyimba, N. (2016). Developmental Trauma and the Role of Epigenetics. BACP Healthcare Counselling and Psychotherapy Journal. October, p. 18-21.

Kumar, B. & Tjepkema, M. (2019). *Suicide among First Nations people, Métis and Inuit (2011-2016): Findings from the 2011 Canadian Census Health and Environment Cohort (CanCHEC).* Retrieved from https://www150.statcan.gc.ca/n1/pub/99-011-x/99-011-x2019001-eng.pdf

Latimer, J. & Foss, L. (2005). The sentencing of Aboriginal and non-Aboriginal youth under the Young Offenders Act: A multivariate analysis. In *Canadian Journal of Criminology & Criminal Justice,* 47 (3), 481-500. Doi:10.3138/cjccj.47.3.481

Lavoie, J. & Gervais, L. (2010). Towards the adoption of a national Aboriginal health policy. *Aboriginal Policy Research Consortium International (APRCi).* 45. Retrieved from https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1399&context=aprci

Lavoie, J., O'Neil, J., Sanderson, L., Elias, B., Mignone, J., Bartlett, J., Forget, E., Burton, R., Schmeichel & McNeil, D. (2005). *The Evaluation of the First Nations and Inuit Health Transfer Policy.* Retrieved from https://publications.gc.ca/collections/collection_2016/sc-hc/H14-191-2006-eng.pdf

Levin, C. & Rhymes, J. (2021). *Evaluation of a Mental Health and Addiction Plan for First Nations in the Atlantic Region.*

Luo, D. (2020). The overrepresentation of Indigenous youth in the criminal justice system: Exposing a problematic reality of imprisoned marginalized groups in Canada. In *The Society: Sociology and Criminology Undergraduate Review*, 5 (1), 69-74. Retrieved from https://jps.library.utoronto.ca/index.php/society/article/view/34006/26076

Makokis, L.J., Shirt, M.V., Chisan, S.L., Mageau, A.Y., & Steinhauer, D.M. (2010). *mâmwi-nehiyaw iyinikahiwewin.* Blue Quills First Nation College Social Science and Humanities Research Council Project. Retrieved from the web: http://www.bluequills.ca/wp-content/uploads/2017/03/BQ_SSHRC_2010_final_report.pdf

Malakieh, J. (2020). *Adult and Youth Correctional Statistics in Canada, 2018/2019.* Statistica Canada Catalogue no. 85-002-X. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2020001/article/00016-eng.pdf?st=BRkC1rXz

Marsh, T.N, Coholic, D., Cote-Meek, S., & Najavits, L.M. (2015). "Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance with substance use disorder in Aboriginal peoples who live in Northeastern Ontario, Canada." *Harm Reduction Journal*. DOI 10.1186/s12954-015-0046-1.

Masecar, D. (2009). Spirit of Life Network: Exploring a wellness promotion framework for First Nations and Inuit communities as part of the National Aboriginal Youth Suicide Prevention Strategy. Ottawa, Ontario: First Nations & Inuit Health, Health Canada.

McCormick, R. (2000). Aboriginal Traditions in the Treatment of Substance Abuse. Canadian Journal of Counselling. Vol. 35:1

Murphy, M. (2014, May 26). Self-determination and Indigenous health: Is there a connection? *E-International Relations. https://www.e-ir.info/2014/05/26/self-determination-and-indigenous-health-is-there-a-connection/*

National Native Addictions Partnership Foundation. (2014). *Connecting with Culture: Growing Our Wellness Activity Guide.* Retrieved from https://cyfn.ca/wp-content/uploads/2016/10/Growing-Wellness-Activity_Guide_DIGITAL_FILE.pdf

New Brunswick Department of Education and Early Childhood Development. (2016). *10-Year Education Plan - Everyone at their best (Anglophone sector).* Retrieved from https://www2.gnb.ca/content/dam/gnb/Departments/ed/pdf/K12/EveryoneAtTheirBest.pdf

New Brunswick Department of Education and Early Childhood Development. (2016). *10-Year Education Plan – Donnons à nos enfants une longueur d'avance (giving our children an edge)(Francophone Sector).* Retrieved from

https://www2.gnb.ca/content/dam/gnb/Departments/ed/pdf/K12/DonnonsANosEnfantsUneLongueurDavance-GivingChildrenAnEdge-FrancophoneSector.pdf

New Brunswick Department of Education and Early Childhood Development. (2018). *Policy 309 French Second Language Programs*. Retrieved from https://www2.gnb.ca/content/dam/gnb/Departments/ed/pdf/K12/policies-politiques/e/309A.pdf

New Brunswick Health Council. (2019). *New Brunswick Student Wellness Survey, Grades 6 – 12, 2018-2019, Feedback Report – Results for Aboriginal/Indigenous (attending public school).* Retrieved from https://nbhc.ca/sites/default/files/publications-attachments/SWS18-19-Results%20for%20Aboriginal%20-%20Indigenous%20Students.pdf

O'Neill L, Fraser T, Kitchenham A, & McDonald V. (2018) Hidden burdens: a review of intergenerational, historical and complex trauma, implications for Indigenous families. *Journal of Child & Adolescent Trauma*. 2018;11(2):173-86. doi: 10.1007/s40653-016-0117-9

Ontario Federation of Friendship Centres (2013). *Aboriginal Mental Health Strategy, June 2013*. Retreived from the Ontario Federation of Friendship Centres website at: http://ofifc.org/sites/default/files/content-files/2013-06-26%20Aboriginal%20Mental%20Health%20Strategy.pdf

Oudshoorn, J. (2015) Trauma-Informed Youth Justice in Canada. Toronto, ON: Canadian Scholars Press. Inc.

Palmer, K., Tepper, J. & Nolan, M. (2017, September 21). Indigenous health services often hampered by legislative confusion. *Health Debate* https://healthydebate.ca/2017/09/topic/indigenous-health/#:~:text=Indigenous%20health%20services%20often%20hampered%20by%20legislative%20confusion,-5%20Comments&text=Share%20on%3A&text=One%20contributing%20factor%20is%20lack,healthcare%20services%20for%20Indigenous%20peoples.

Pollock, N., Healey, G., Jong, M., Valcour, J. & Mulay, S. (2018). Tracking progress in suicide prevention in Indigenous communities: A challenge for public health surveillance in Canada. *BMC Public Health*, 18:1320. Retrieved from https://doi.org/10.1186/s12889-018-6224-9

Public Health Act, SNB 1998, c P-22.4, <https://canlii.ca/t/53p75>

Reading, C. and Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health.* National Collaborating Centre for Aboriginal Health. Retrieved from https://www.nccah-ccnsa.ca/docs/social%20determinates/nccah-loppie-wien_report.pdf

Reference as to whether "Indians" includes in s. 91 (24) of the B.N.A. Act includes Eskimo in habitants of the Province of Quebec, 1939 CanLII 22 (SCC), [1939] SCR 104, <https://canlii.ca/t/fslhl>

Regional Health Authorities Act, RSNB 2011, c217, https://canlii.ca/t/533df

Resnick, M. (2000, February). Protective factors, resiliency and healthy youth development. *Adolescent Medicine: State of the Art Review*. 11 (1)

Richmond, C. & Cook, C. (2016) Creating conditions for Canadian aboriginal health equity: The promise of health public policy. *Public Health Reviews* 37:2, DOI: 10.1186/s40985-016-0016-5. Retrieved from https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-016-0016-5

Romanow, R. (2002). *Building on Values – the Future of Health Care in Canada.* Retrieved from https://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

Royal Commission on Aboriginal Peoples. (1996). *Volume 1 – Looking Forward, Looking Back.* Retrieved from http://data2.archives.ca/e/e448/e011188230-01.pdf

Skinner-Osei, P., Mangan, L., Liggett, M., Kerrigan, M. & Levenson, J. (2019). Justice-involved youth and truama-informed interventions. *Justice Policy Journal*, 16 (2). Retrieved from http://www.cjcj.org/uploads/cjcj/documents/justice-involved_youth_and_trauma-informed_interventions.pdf

Sochting, I., Corrado, R., Cohen, I., Ley, R. & Brasfield, C. (2007). Traumatic pasts in Canadian Aboriginal people: Further support for a complex trauma conceptualization? *BC Medical Journal*, Vol. 49, No. 6, July, August 2007, pp. 320-326. Retrieved from http://www.bcmj.org/article/traumatic-pasts-canadian-aboriginal-people-further-support-complex-trauma-conceptualization

Statistics Canada. (2018). *Aboriginal identity (9), residence by Aboriginal geography (10), registered or treaty Indian status (3), age (20) and sex (3) for the population in private households of Canada, provinces and territories, 2016 Census–25%sampledata*. Statistics Canada Catalogue no. 98-400-X2016154. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GID=0&GK=0&GRP=1&PID=110443&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=122&VID=0&VNAMEE=&VNAMEF=

Thunderbird Partnership Foundation. (undated). *A Cultural Safety Toolkit for Mental Health and Addiction Workers in Service with First Nations People.* Retrieved from https://thunderbirdpf.org/nnapf-document-library/

Truesdale, C. (2016, April 14). Supreme Court of Canada Releases Daniels Decision. *JFK Law* https://jfklaw.ca/daniels-decision/

Ungar, M. (2008). Resilience across cultures. *British Journal of Social Work.* (38). 218-235. Retrieved from https://academic.oup.com/bjsw/article/38/2/218/1684596

United Nations. (1948). *Universal Declaration of Human Rights.* Retrieved from https://www.un.org/en/about-us/universal-declaration-of-human-rights

United Nations. (1966). *International Covenant on Economic, Social and Cultural Rights*. Retrieved from https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

United Nations. (1989). *Convention on the Rights of the Child*. Retrieved from https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

United Nations. (2007). *United Nations Declaration on the Rights of Indigenous Peoples.* Retrieved from https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

Wesley-Esquimaux, C. & Smolewski, M. (2004). *Historic Trauma and Aboriginal Healing*. Ottawa: Aboriginal Healing Foundation.

White, J. & Jodoin, N. (2007) *Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies.* Calgary, Alberta: Centre for Suicide Prevention. Retrieved from https://novascotia.cmha.ca/wp-content/uploads/2020/01/res-prom-stat-en.pdf

White, J. & Mushquash, C. (2016). *We Belong: Life Promotion to Address Indigenous Suicide Discussion Paper.* Retrieved from https://wisepractices.ca/wp-content/uploads/2017/12/White-Mushquash-2016-FINAL.pdf

Wiley, S., Love, H. & Emmett, K. (2020). Indigenous over-representation in Canada's youth correctional system: An assessment of regional variability. In *Canadian Journal of Criminology and Criminal Justice,* 62 (2), 22-43. Doi: 10.31381cjccj.2019-0049

Williams, L. & Mumtaz, Z. (2007). *Being Alive Well: Aboriginal Youth and Evidence-Based approaches to promoting mental well-being*. Prepared by the Prairie Region Health Promotion Research Centre for the National Aboriginal Youth Mental Health Promotion Health Strategy Symposium, FNIHB.

Wilson, C., Pence, D. & Conradi, L. (2013). Trauma Informed Care. *Encyclopaedia of Social Work.* Online Publication Date: November 4, 2013. Retrieved from https://doi.org/10.1093/acrefore/9780199975839.013.1063

Wirihana, R. & Smith, C. (2014). Historical trauma, healing and well-being in Māori communities. *MAI Journal,* Vol. 3, Issue 3, 197-210. Retrieved from http://www.journal.mai.ac.nz/sites/default/files/MAI_Jrnl_3%283%29_Wirihana02.pdf

World Health Organization. (2005). *Promoting mental health: concepts, emerging evidence, practice : a report of the World Health Organization, Department of Mental Health and Substance Abuse in*

collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. World Health Organization. https://apps.who.int/iris/handle/10665/43286

World Health Organization. (2021). Complex post traumatic stress disorder. In *International Statistical Classification of Diseases and Related Health Problems (ICD)(11th Edition).* Retrieved from https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559

Youth Criminal Justice Act, SC 2002, c1, https://www.canlii.org/en/ca/laws/stat/sc-2002-c-1/latest/sc-2002-c-1.html

Appendix A

First Nation Advisory Council Members

Roxanne Sappier (Co-Chair), Director of Health, Neqotkuk First Nation
Natasha Sock (Co-Chair), Assistant Director of Health, Elsipogtog First Nation
Noel Milliea (Elder), Elsipogtog First Nation
Imelda Perley (Elder), Neqotkuk First Nation
Edward Perley (Elder, Neqotkuk First Nation
Hon. Graydon Nicholas, (Co-Chair, Stakeholder Council)
Ron Brun, Mental Health Advisory, Elsipogtog First Nation)
Michael Batchelor, Lead Analyst Indigenous Research and Policy, New Brunswick Health Council
Mariah Deleavey, Youth Representative, Woodstock First Nation
Andrew Dutcher, Child Psychiatrist, Neqotkuk First Nation
Shelley Francis, Executive Director, Mawlugutineg Mental Wellness Team
David Knockwood, Youth Representative, Mi'gmawe'l Tplu'taqnn
Brenda Parks, Governance Coordinator, Wolastoqey Tribal Council
Rena Solomon, Director of Drug and Alcohol, Kingsclear First Nation
Dean Vicaire, Executive Director, Mi'gmawe'l Tplu'taqnn
Patricia Ward, Director of Health, Mawiw Council

<u>Provincial Representatives</u>
Carole Gallant, Director of Youth Services, Vitalité Health Network
Jerry Clarke, ISD First Nation Consultant, Department of Education and Early Childhood Development
Kelly O'Neil Morin, ISD First Nation Consultant, Department of Education and Early Childhood Development
Annie Pellerin, Executive Director (Acting), Addiction and Mental Health Services, Department of Health

<u>New Brunswick Child and Youth Advocate's Office</u>
Norman Bossé, New Brunswick Child and Youth Advocate
Christian Whalen, Deputy Advocate/ Senior Legal Counsel
Gavin Kotze, Director of Systemic Advocacy
Michelle Lepage, Delegate

Appendix B

Glossary

Cultural Blindness

"…attempts (often well-intentioned) to be unbiased by ignoring the fact of a person's race. It is illustrated in phrases such as 'being colour blind,' or 'not seeing race.' However, ignoring cultural differences may make people from another culture feel discounted or ignored; what may be transmitted is the impression that race or culture are unimportant, and that values of the dominant culture are universally applicable. Meanwhile, the person who is culturally blind may feel they are being fair and unprejudiced, unaware of how they are making others feel. Cultural blindness becomes, in effect, the opposite of cultural sensitivity." (Association of Faculties of Medicine of Canada, 2015, p. 4).

Cultural Humility

"A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience." (First Nations Health Authority, 2021, p. 5)

Cultural Awareness

"…observing and being conscious of similarities and contrasts between cultural groups, and understanding the way in which culture may affect different people's approach to health, illness and healing" (Association of Faculties of Medicine of Canada, 2015, p. 3).

Cultural Sensitivity

"…being aware of (and understanding) the characteristic values and perceptions of your own culture and the way in which this may shape your approach to patients from other cultures (Association of Faculties of Medicine of Canada, 2015, p.3).

Cultural Competency

"Cultural competence focuses on the attitudes, knowledge, and skills necessary for providing quality care to diverse populations. Cultural competence requires that service providers, both on and off reserve, have ongoing awareness of their own worldviews and attitudes towards cultural differences. It includes both knowledge of, and openness to, the cultural realities and environments of the clients they serve. To deliver practices that are experience as culturally safe, cultural competence is vital." (First Nations Mental Wellness Continuum Framework, 2015, p. 34).

"…refers to the attitudes, knowledge, and skills of practitioners necessary to become effective health care providers for patients from diverse backgrounds. Competence requires a blend of knowledge and conviction, plus a capacity for action. 'A culturally competent physician considers a patient's cultural background when discussing and providing medical advice and treatment, and communicates effectively

to enable patients to understand their treatment options.'" (Association of Faculties of Medicine of Canada, 2015, p. 3).

Cultural Safety

"Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care." (First Nations Health Authority, 2021, p. 5)

"Cultural safety refers to what is felt or experienced by a patient when a health care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-making and builds a health care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care. Culturally safe encounters require that health care providers treat patients with the understanding that not all individuals in a group act the same way or have the same beliefs." (National Aboriginal Health Organization, 2008, p.19). Cultural safety can be considered an extension to cultural competence on the cultural continuum. As such, cultural safety takes us beyond the following: cultural awareness, the acknowledgement of difference; cultural sensitivity, the recognition of the importance of respecting difference; and cultural competence, the focus on skills, knowledge, and attitudes of practitioners." (First Nation Mental Wellness Continuum Framework, 2015, p. 35).

"Cultural safety goes a step beyond cultural sensitivity (being accepting of difference) to understanding that there exist inherent power imbalances and possible institutional discrimination that derive from h historical relationships with people of different origins. It implies that the care provider has reflected on her own identity and the perceptions of them that others from different cultures may hold. Culturally safe practice implies the ability to keep these differing perspectives in mind whilst treating the patient as a person worthy of respect in her own right" (Association of Faculties of Medicine of Canada, 2015, p. 4).

Cultural Safety Continuum

Cultural safety can be seen as a continuum of knowledges, attitudes and behaviours that begins with cultural awareness (Dell, Firestone, Smylie & Vaillancourt, 2015).

Intergenerational Trauma/Transgenerational Trauma

"Trauma that is transferred from trauma survivors to their children and further generations of their descendants through complex post-traumatic stress disorder mechanisms. The ongoing intergenerational trauma of colonialism has damaged the cultural integrity and holistic health of

Indigenous people and communities. While some events and policies have affected many Indigenous people (separation from the land, dissolution of communities, oppression, Residential School, Sixties Scoop, marginalization, and aboriginalism), it is important to know that some communities have also experienced their own unique traumas. This means that each community will have different needs for their healing journeys." (Thunderbird Partnership Foundation, 2021)

"The intergenerational effects of historical traumatic events can occur through multiple routes and have multiple impacts spiritual, emotionally, mentally, and physically on individuals, families, and collectively as Indigenous community. Indigenous people exposed to discrete or chronic collective trauma experiences; for example, disconnection from original language, homelands, and lineage through forced relocation, residential schools, child welfare and justice systems pass on the impact of these experiences in many ways to the next generation, including genetically psychologically, and behaviourally." (First Nation Mental Wellness Continuum Framework, 2015).

Mental Health

"The state of your psychological and emotional well-being. It is a necessary resource for living a health life and a main factor in overall health." (Public Health Agency of Canada, 2020, as cited in Canadian Public Health Association, 2021)

Mental Wellness

"…a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2005, p. 2, as cited in Canadian Public Health Association, 2021)

"Wellness from an Indigenous perspective is a whole and health person expressed through a sense of balance of spirit, emotion, mind and body. Central to wellness is belief in one's connection to language, land beings of Creation, and ancestry, supported by a caring family and environment." - Elder Jim Dumont (Thunderbird Partnership Foundation, 2020, p. 3)

References

Assembly of First Nations, Health Canada's First Nations and Inuit Health Branch, the National Native Addictions Partnership Foundation, the Native Mental Health Association. (2015). *First Nations Mental Wellness Continuum Framework.* Retrieved from https://thunderbirdpf.org/first-nations-mental-wellness-continuum-framework/

Canadian Public Health Association. (2021). *A Public Health Approach to Population Mental Wellness – Position Statement.* Retrieved from https://www.cpha.ca/sites/default/files/uploads/policy/positionstatements/2021-03-population-mental-wellness-e.pdf

Dell, E., Firestone, M., Smylie, J. & Vaillancourt, S. (2015). Cultural safety and providing care to Aboriginal patients in the emergency department. *Canadian Journal of Emergency Medicine, 2015, 1-5.* Doi: 10.1017/cem2015.100. Retrieved from https://www.cambridge.org/core/journals/canadian-journal-of-emergency-medicine/article/cultural-safety-and-providing-care-to-aboriginal-patients-in-the-emergency-department/6C880C16DA09B50492E13A19F81552FB

First Nations Health Authority. (2021). *Anti-Racism, Cultural Safety & Humility Framework.* Retrieved from https://www.fnha.ca/Documents/FNHA-FNHC-FNHDA-Anti-Racism-Cultural-Safety-and-Humility-Framework.pdf

National Native Addictions Partnership Foundation. (2014). *Connecting with Culture: Growing Our Wellness Activity Guide.* Retrieved from https://cyfn.ca/wp-content/uploads/2016/10/Growing-Wellness-Activity_Guide_DIGITAL_FILE.pdf

The Association of Faculties of Medicine of Canada. (2015). Cultural competence and communication. In D. Donovan a(ed.), *AFMC Primer on Population Health – A Virtual Textbook on Public Health Concepts for Physicians.* Retrieved from https://phprimer.afmc.ca/en/part-i/chapter-3/

Thunderbird Partnership Foundation. (2020). *Indigenous Wellness Framework Reference Guide.* National Native Addictions Partnership Foundation. Retrieved from https://thunderbirdpf.org/wp-content/uploads/2020/10/IWF-Ref-Guide-EN.pdf

Thunderbird Partnership Foundation. (2021). *Definitions and Terminologies.* Retrieved from https://thunderbirdpf.org/definitions-and-terminologies/