Stories of Spirit and the Streets: Indigenous Mental Health, Trauma, Traditional Knowledge and Experiences of Homelessness

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Department of Applied Psychology and Human Development
University of Toronto

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2018

Abstract

Indigenous people in Canada have endured many traumas as a result of the consequences of colonization observed through poor social determinants of health. Homelessness, particularly, has been noted as at a state of crisis for Indigenous people. This study seeks to understand the intersections of homelessness, traditional knowledge and mental health by interviewing sixteen Indigenous homeless people in a large Canadian city. Results revealed some psychological factors, cultural identity and external factors as being integral in the overall experiences of homelessness. The results of this study help identify a need for integrative mental health services that focus on the Indigenous culture as a strength in the promotion of healing and recovery. Specific implications are inclusive of policy and psychological approaches that are based on the needs of Indigenous homeless peoples themselves that can build and improve the current models of mental health care that embrace the Indigenous approaches to mental health and trauma. These results also provide some rich data regarding the actual lived experiences of marginalized people that have been silenced by recognizing the importance of cultural connection and the utilization of Indigenous approaches in the field of mental health and trauma service.
Acknowledgments

Chi meegwetch to the participants who shared their stories with me and to the Indigenous community partner in this meaningful project. A lifetime of gratitude to Dr. Suzanne Stewart, who supervised me throughout this journey and was an incredible mentor, teacher and support and for her patience as well as her tireless efforts in the edits. Thank you to my other committee members, Dr. Roy Moodley and Dr. Charles Chen for their knowledge and continuous feedback. To the volunteers and other members of our research family who helped at the data analysis stage, with a special shout out to Mariam Ayoub. I would also like to extend a very special thank you to my friends and family for their support, love and encouragement through every stage of this journey, especially to my sister Brandie. Finally, I would like to acknowledge my special people in the spirit world who remain my inspiration and motivation; my brother Trevor, whose legacy continues to shine on all the work that I do, and Mom, your keen will, which keeps driving me to achieve, forever.
Dedication

To Dad my role model, my rock, my hero.

In loving memory of

My dear brother, Trevor Elliott

You showed me how to have passion to pursue what I love, and gave me the heartache to fight for all that I believe in
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Chapter 1
Introduction

Canadian Indigenous\(^1\) people are the native inhabitants of what today constitutes as Canada. The European colonization of North America was the beginning of the myriad factors that contributed to significant group traumas of the Indigenous people. Through the aspects of forced relocation and the loss of land; cultural destruction, through the loss of people due to disease, and forced acculturation due to colonial supremacy, the Canadian Indigenous people continue to experience significant oppression. This has occurred through the continued loss of governance and traditional practices within Canada’s Indigenous communities. These experiences of group traumas continue being a chronic factor that has perpetuated through generations of Indigenous people, in form of the poor determinants of health and social issues that can still be observed in Canadian Indigenous communities. These chronic and complex group traumas are thought to be one of the primary contributing factors to the high rates of homelessness that is experienced by many Indigenous people in the current times. Since these traumas are deep-rooted in attempts of cultural extermination, healing and health promotion can be definitely perceived as a reconnection with the Indigenous traditional knowledge as a way of cultural revival.

Canadian Indigenous People

Canadian Indigenous people were the first inhabitants of the land that is today recognized as Canada. The first people lived on all types of terrains spread across the 10 million square kilometres, living off all areas of the land including the Arctic, the prairies, the coasts and everything in between. For thousands of years, these Indigenous people lived and thrived off the natural resources that the area offered. Following the era of colonization, the Indigenous peoples were classified into three distinct groups, viz. the First Nations (Status and non-status), Métis, and Inuit. Statistics demonstrate that in 2006, of those who reported having an Indigenous

\(^1\) Indigenous refers to the original people of a place. In this case, Canada. The term is used interchangeably with the terms, “Native”, “Aboriginal”, and “First People” in the context of the literature; however, it will be presented as “Indigenous” in the context of this dissertation.
ancestry, 60.8% (851,560) identified as the First Nations and there was a rise in their number by as much as 39.3% in the 2016 census data; the 32.3% (451,795) who identified as Métis in 2006 increased by 51.2% in 2016; the 4.2% (59,445) who identified as Inuit in 2006 were increased by 29.1% in 2016; and the 1.9% (26,475) reported themselves as belonging to other Indigenous identities; whereas the remaining 0.8% (11,415) reported multiple Indigenous identities (Statistics Canada, 2013; Statistics Canada, 2017).

According to the 2016 Census Data, Indigenous people in Canada represent approximately 4.9% of Canada’s total population (Statistics Canada, 2017); this figure has spiked from the 3.8% that was reported in 2006 (Statistics Canada, 2009); however, this statistic is very likely to be higher as the census data does not include the homeless and those without a fixed address. Overall, the Indigenous population in Canada has grown by 42.5% since 2006 (Statistics Canada, 2017).

Furthermore, the Indigenous population in Canada is significantly young, where over 50% of the Indigenous population is under the age of 24 years and 40% is under the age of 16 years. The 2016 census data also indicated that the average age of the Indigenous people was 32.1 years old, as compared to the 40.9 years for the non-Indigenous population (Statistics Canada, 2017). The 2016 census data (Statistics Canada, 2017) also recognized that the Indigenous population is not only young but also has also seen a spike in the number of those who are ageing. In 2006, 4.8% of the Indigenous population was 65 years of age and over, whereas, in 2016, 7.3% of the Indigenous population was over 65 years of age.

This young and growing Indigenous population is also becoming increasingly more urban, where a significant number of Indigenous people seem to have migrated from the rural and reserved areas into large cities; this influx began in as early as the 1970s. Census data demonstrates that currently, over half of the total Canadian self-identified Indigenous population live in Canadian cities, which shows a 59.7% increase from 2006 census data and this is expected to grow, according to the demographic trends (Statistics Canada, 2017).

For example, this is especially true for the city of Toronto, where, in 2011, the Indigenous people represented 0.8% of the overall population of Greater Toronto Area (GTA), which was about 5.5 million (City of Toronto, 2013). The Toronto agencies serving the Indigenous communities, however, estimate that the Indigenous population is likely much higher than reported in the
census data to include those living in government housing, shelters and those who are homeless or live on the streets.

**Social Determinants of Health**

Since the time of the first contact with European settlers, Indigenous people in Canada have been facing cultural oppression and social marginalization as a direct impact of colonization through the institutions and actions that have subsequently followed. The initial contact with the European settlers brought many forms of depredation for the Indigenous people, such as the economic, political, and religious institutions of the European settlers that oppressed the Indigenous people on their own lands (Kirmayer, Tait, & Simpson, 2009). Furthermore, the impacts such as infectious disease, warfare and volitions of cultural exile through suppression of the Indigenous identity and culture have also contributed greatly to the devastating history of traumas on Canada’s Indigenous people (Stanner, 1992; Thorton, 1987). The residual effects of this, as along with new traumas, now persist across entire North America.

Over the past century and in the recent years, the Canadian and American government policies have perpetuated the process of oppression and destruction of the Indigenous and Native-American culture and traditional ways of life through the creation of reserves; forced relocation to some remote regions; and the implementation of the Indian Act and Residential School System. Chronic underfunding and poor resourcing of essential services in the reserve and remote areas are the prime examples of continued oppression. This includes a healthcare and education system, as well as the bureaucratic control that continues the supremacist control over the Indigenous communities (Kirmayer, et al., 2009). Many of these historic elements have perpetually and chronically influenced the socioeconomic crises that currently exist in many Indigenous communities; thus, contributing to the poor social determinants of health, including but not limited to low socioeconomic status, unemployment, and limited education.

A historical element that is especially relevant to the poor social determinants of health is the lasting impact of the Residential School System that was put into place by the Canadian Government in conjuncture with the Christian/Catholic church. It is recognized that over the span of a hundred years, about 100,000 Indigenous children, mainly those belonging to the First Nations, were forcibly taken from their homes and put into institutions that were designed with the intentions of providing them with an education suited to the Eurocentric/Christian
denomination. In these regimes, they were denied and punished for speaking their native language, practising their traditions, and speaking of their beliefs. At their height, 80 such residential schools were operating across Canada, with a peak enrolment of over 11,000 students in 1953 (Kirmayer, et al., 2009).

It is recognized that some Indigenous families were open to the educational opportunities that were offered through the Residential School System. Some students even reported having had a pleasant experience while attending the residential school; however, the extent of the physical, emotional, and sexual abuse that was perpetrated against the Indigenous children in many of the residential schools has been well known in the communities. These issues have only recently been acknowledged in the media and publicly recognized by the Canadian Government with a formal apology in 2008 from the former Prime Minister, Steven Harper (Haig-Brown, 1988; Knockwood & Thomas, 1992; Lomawaima, 1993; Milloy, 1999).

Indigenous communities have also had detrimental effects on the child welfare system, especially from the lasting effects of a child apprehension epidemic, which is now recognized as “The Sixties Scoop.” Beginning in the 1960s, resulting from a heightened surveillance and concerns regarding child welfare, many Indigenous children were forcibly taken from their families and communities by the child protection services and placed into foster care. It is recorded that between 30% and 40% of children that were legal wards of the state at the end of the sixties, happened to be Indigenous. This is significant as this rate was 1% in 1959, thus demonstrating a significant change in child custody within the Indigenous communities during this decade (Fournier & Crey, 1997). By the 1970s, about one in four First Nations children were likely to be separated from their parents and many would eventually end up getting adopted into non-Indigenous families (Gough, Trocome, Brown, Knoke, & Blackstock, 2005). In the recent years, it has been acknowledged that many Indigenous children experienced abuse and racism in these settings.

The large-scale effects of the Residential School System and The Sixties Scoop has had some devastating consequences for the Indigenous people, families and communities (Kirmayer, et al., 2009), where many have experienced identity issues in navigating themselves within two very different, yet colliding worlds and the detriment to self-esteem those results. The experiences of physical, emotional and sexual abuse; neglect and incapable parenting; internalized racism,
violence, substance use, criminal behaviour, loss of language and suicide are all common examples of the outcomes (Fournier & Crey, 1997; York, 1990). These factors have been recognized as the consequences of contemporary colonization, which continues to exist in Canada.

Historical and contemporary effects of colonization have resulted in Indigenous people in Canada speaking up, sharing their experiences of loss of land; relocation; cultural genocide; extensive abuse; economic and social neglect; racism; and oppression. These factors have been significant in decomposing their mental health and have also resulted in high rates of poverty, substance abuse, criminal involvement and homelessness – factors that are commonly experienced within the Indigenous communities. The literature attributes the aspects of historical and contemporary colonialism for being the root of the complex mental and physical health disparities that can be observed amongst the Indigenous communities because of the social and economic disadvantages, in comparison to the mainstream Canadian population combined with devastating factors such as cultural oppression and loss.

Research has documented high levels of mental health issues and severe/complex mental illness in some of the Canadian Indigenous communities (Government of Canada, 2006; Kirmayer, 1994; Royal Commission on Aboriginal Peoples, 1996; Waldrum, 1997a; Waldrum, 2006). Majority of the research (Chandler & Lalonde, 1998; Herman-Stahl, Spencer, & Duncan, 2003; McCormick, 2000) that focuses on the Indigenous peoples’ mental health, has examined issues related to their culture, such as: identity, assimilation, cultural loss or retention, cultural discontinuity as deteriorates of mental health and recognizes engagement in cultural practices and language as the primary factors for resiliency and healing.

Rationale

In order to address some of the gaps in the literature regarding the experiences and current mental health needs of the Indigenous homeless, the purpose of this study was to inquire the lived experiences of the Indigenous peoples regarding trauma and mental health issues as they relate to the issue of homelessness. Furthermore, the research aimed to explore the influence of traditional knowledge on trauma healing. As a result, the research question for this dissertation asked, “What are the intersections of trauma, mental health and traditional knowledge for urban Indigenous homeless people?” A primary focus is placed on the traditional knowledge influences
on mental health, well-being, and source of support for the Indigenous peoples who have experienced trauma. Participants were asked the following questions through individual interviews: (1) Tell me about some of your experiences of street involved living or homelessness? What are your key needs? (2) What is your understanding of (First Nations/Métis/Inuit) Indigenous traditional knowledges? How would you define it? Please give examples. (3) What is the intersection between First Nations/Métis/Inuit) Indigenous traditional knowledges and mental health? (4) What supports and challenges does (First Nations/Métis/ Inuit) Indigenous traditional knowledges offer in addressing the life transition needs of urban (First Nations/Métis/Inuit) Indigenous homeless peoples? Please speak to the dimensions of mental health and trauma. (5) What changes would you like to see for urban (First Nations/Métis/Inuit) Indigenous people with respect to traditional knowledge and mental health services and trauma supports. The main goal of this research was to respond to the mental health and traditional needs of urban Indigenous homeless peoples.
Chapter 2
Literature Review

Indigenous homelessness has been recognized as a social consequence of generations of traumas and the poor social determinants of health, as experienced by the Canadian Indigenous people. The roots to these traumas can be found in colonial oppression based on the intent of cultural extermination. Therefore, the influences of traditional knowledge and healing are recognized as being a core component in understanding the resiliency against such trauma and poor health outcomes observed in many Indigenous communities. The connection with culture and traditional knowledge has been identified as the key component in community healing. This chapter will present the literature on Indigenous homelessness, traditional knowledge and trauma. This chapter will also include the current health and healing context and approach for Indigenous communities for overcoming the disparities that are observed in many communities.

This chapter will specifically focus on the high rates of homelessness observed in Indigenous communities as a result of colonization and the intergenerational traumas that have thus ensued. This chapter will also present the traditional knowledge Indigenous healing approaches to the problems of trauma and homelessness. This will include a focus on the strengths of Indigenous communities in the decolonizing process from trauma and homelessness. In order to understand how to heal from trauma and to improve a system that continues to suppress the Indigenous people, the context of the issues is presented from a Canadian systemic lens.

Homelessness

Homelessness affects many Canadians and can have significant health implications including premature death and vulnerability to a multitude of other health problems. People who experience homelessness also face significant barriers that impair their abilities to have access to appropriate health care (Hwang, 2001). Therefore, “absolute homelessness” is defined as the living condition of people without physical shelter who sleep outdoors, in vehicles, abandoned buildings or other places that are not intended for human Habitation” (Hwang, 2001). Further, “relative homelessness” describes the condition of those who do have a physical shelter, but which fails to meet the basic standards of health and safety; these include protection from the elements, access to safe water and sanitation, security of tenure, personal safety, and
affordability (Hwang, 2001). Relative homelessness is also inclusive of conditions of living without a fixed address, including couch surfing and accessing shelters.

**Pathways model of homelessness**

The literature recognizes that there are many definitions as to what characterizes a person’s state of homelessness. Wright (1989) identifies that homelessness is the “Absence of regular and customary access to a conventional dwelling unit” (p.19). Wright (1989) also recognizes a difference between the literal homeless (individuals living and sleeping on the streets), and the marginally homeless (those who have a reasonable claim to a less stable housing situation).

Homelessness can also be defined in the experience or social situation which results in one becoming homeless. Leach (1979) suggested that the homeless could be divided into two groups, which he identified as intrinsic and extrinsic based on the etiological issues leading to an initial state of homelessness. The group labelled ‘intrinsic’ was recognized as one with homeless people whose mental or physical disabilities were the major reasons for their homelessness and predicted their likelihood into experiencing homelessness in their life. Those identified as extrinsic were recognized as being homeless because of their situational factors (e.g. job loss, poverty, etc.). Leach also stated that the two groups require different services and have different needs based on these circumstances of homelessness (McNaught & Bhugra, 1996).

The literature further distinguishes three categories of homeless people: the single homeless, the young single homeless and homeless families. Wright (1989) states that the subgroups of people experiencing homelessness are very different and can be divided according to their social origins, background characteristics and needs. He further classified homeless in distinct groups of homeless families, lone homeless (which were further subdivided into men, women and youth), and then those with special factors such as disabilities, specific ethnicities, education, geography, criminality, extreme poverty and nature. He identified this as the *pathways model* to homelessness, illustrated in figure 1. Wright’s (1989) pathways into homelessness model include types and interaction of various factors.
Mental illness has also been a primary focus in the literature in the context and theory of what brings someone to a state of homelessness. The pathways model recognizes that in addition to mental illness, there are various other individual factors that play vital roles in determining the risk or ‘pathway’ into homelessness.

Individual factors (i.e., unemployment; poverty; substance abuse; disability; age; and various social factors) were recognized as the core components in terms of the pathway into homeless discourse, as experienced by each individual. Gender was also recognized as a significant variable in that men were recognized to be at higher risks for homelessness as compared to women (Rossi, Wright, Fresher, & Withs, 1987); this is especially true in the single homeless categories. Although men were recognized to be at higher risks for homelessness, women were recognized as having higher rates of comorbid psychiatric problems (Marshall & Reed, 1992).

Substance abuse was also recognized as a significant factor in the pathway model of homelessness. In his study, Wright (1987) found that alcohol abuse was 3-5 times higher in the homeless population as compared to the general population; substance abuse problems were likely to worsen the longer homelessness continued. Substance use and abuse were also
recognized as being more prominent in the single homeless groups in comparison to the adults in the homeless family groups. Homeless youth often abuse substances at higher rates than their housed peers. Furthermore, homeless youth report that they use substances to attenuate the negative psychological effects of living on the streets, to reduce depressive symptoms, and to stay awake when they have difficulties in finding a safe place to sleep (Childress et al., 2015).

Marital status was also recognized as a factor, where the majority of homeless people were single or separated. It was proposed that the lack of social ties may be the factor that discourages social stability and thus, increases the one’s risks of becoming homeless (McNaught & Bhugra, 1996).

The literature recognized that a large proportion of the homeless, particularly the young single homeless have come from broken families or have had a contact with social services in their childhood development (Bhugra, 1993). Furthermore, it was also recognized that this could have been due to their incidents of running away from home or being kicked out of the family house.

Age was also identified as being a significant factor in the trajectory of homelessness, where the young age of homelessness onset was found to put one at risk for prolonged and chronic experiences of homelessness. Statistics in the United States from a study conducted by Childress et al., (2015) indicated that in the current times, there is approximately 1.7 million youth who are homeless on any given night. The results from this study support the pathways model to homelessness in that several of the participants of youth-onset homelessness were either kicked out of their homes or ran away from home and grew up out of foster care.

Regardless of the age of homelessness onset, the childhoods of homeless adults are often characterized by their experiences of significantly grave poverty, difficulties in school, residential mobility and exposure to various other stressors or traumatic events (Herman, Susser, Struening, & Link, 1997; Koegel, Malamid, & Burnam, 1995); this is particularly true among the homeless people that experience co-occurring mental illness (Sullivan, Burnam, & Koegel, 2000). It was recognized that one of the earliest identifiable precursors to homelessness may be the concerned person’s placement in out-of-home or foster care as an early introduction to a transient home-life situation. Research also suggests that between 11-36% of youth who are “ageing out” of the foster care system are highly likely to experience street homelessness during their early adulthood and approximately 30% of these people live with family, friends or
acquaintances because they cannot afford independent housing. Many youths are often discharged from foster care homes without a place to live and no support systems in place to provide for them (Brandford & English, 2004; Fowler, Toro, & Miles, 2000; Reilly, 2001).

The literature also suggested that youth who are transitioning out of the foster care system often face other challenges that permeate them with the risk factors for homelessness; these risk factors can include factors like limited education that can negatively impact employability (Courtney & Dworksy, 2006). Youth who are in contact with social services and are transitioning from foster care often experience cumulative traumas, abuse and neglect that coincides with their experience of growing up in turbulent environments (Dworsky & Courtney, 2009). These exposures can also have neurobiological, emotional and social implications that can ultimately have psychological and behavioural outcomes that are often correlated with poor social supports, coping skills, and an increase in their emotional vulnerabilities (DeBellis & Zisk, 2014; Galletley, VanHoof, & McFarlane, 2011). These factors further put the youth at risk for developing substance use issues as well as developing a trajectory of chronic homelessness (Zlotnick, 2009).

Research suggests that homeless individuals who have had childhood histories related to the foster care system were more likely to have mental health disorders as adults (Roos, et al., 2014; Sullivan, et al., 2000). More specifically, the research conducted by Roos and colleagues (2014) studied the health and social outcomes among the homeless adults with mental illnesses, where 75% of the study participants were of Indigenous ancestry. A study conducted by Patterson, Moniruzzaman, and Somers (2015) also identified the existence of a significant relationship between a history of childhood foster care placement with the indicators of social demographic risk, poor mental and physical health outcomes and substance abuse in adulthood. A history of foster care involvement also predicted higher rates of high school drop-out, duration of homelessness, underemployment, and having a mental health disorder diagnosis.

Sexual orientation was also identified as a significantly decisive individual factor in the pathways model to homelessness. Kruks (1991) reported that young homosexual and bisexual males were at an increased risk of homelessness. This research suggested that increased experiences of prejudice, homophobia and discrimination were reflected in those results. Ethnicity was also recognized as a major factor in homelessness. It is important to note, however,
that ethnographic groups and the level of risk to homelessness differed a lot based on the geographic location (McNaught & Bhugra, 1996).

Apart from these and such factors contributing to homelessness, experiencing homelessness or inadequate housing can also impact one’s physical, mental, emotional and spiritual health. Living in such circumstances can also influence one’s senses of identity, purpose and belonging. Housing, in terms of quality, location, affordability and appropriateness have been widely recognized as a powerful determinant of individual health (Bryant, 2003; Krieger & Higgins, 2002; Raphael, 2004; Wilkinson & Marmot, 2003). More specifically, homelessness is recognized as being strongly correlated with mental illness, where some populations in Canada demonstrate high vulnerabilities and risk factors, as seen in the Indigenous communities.

As previously mentioned, Indigenous youth have been overrepresented in the child welfare system. Through continued experiences of racism, oppression and lower socioeconomic status experienced by many Indigenous communities, many youths have grown up in volatile homes with influences of domestic violence; neglect; physical, emotional and sexual abuse; substance use; and poverty. In pertinence with the pathways model of homelessness, it is not surprising that there is a current state of crisis with homelessness for the Indigenous people, and especially for the youth, in Canada.

**Indigenous homelessness**

Monette and colleagues (2009) explain the current state of crisis of Indigenous homelessness in Canada as, “Aboriginal peoples, who share a common legacy of oppression and resilience, experience some of the worst housing conditions in Canada and have an exceedingly difficult time locating affordable housing” (p.42). The problem of housing inadequacy is complicated by notions of systemic racial discrimination and it, therefore, impacts the housing access and available resources (Monette et al., 2009; Walker, 2008).

Homelessness, in particular, has been identified as an important social determinant of health for the Indigenous people; as housing inadequacy and homelessness are recognized to be at disproportionate levels in comparison to the non-Indigenous Canadian population (Smye & Mussell, 2011; Waldram, 2006). Along with the physical detrimental effects that come with inadequate housing, there also are many mental health concerns that one may experience in the
experiences of homelessness. Additionally, mental illness and experiences of trauma can also contribute to various challenges (unemployment, substance use, and family/relationship problems) that play key roles in the experiences of homelessness (Patrick, 2014).

As a population, Indigenous people are the most materially, socially and spatially deprived ethnocultural groups in Canada and are disproportionately homeless and inadequately housed (Patrick, 2014). This situation stems from a variety of reasons including but not limited to: the historical dispossession of Indigenous lands with the relocation of Indigenous people to desolate and remote locations in Canada; colonial- and neo-colonial practices of cultural oppression and erosion; intergenerational/historical traumas; systemic/political racism; governmental policies; and unreasonable economy and housing markets (Patrick, 2014).

These factors have been recognized as the preceptors for the current crisis of homelessness and the high rates of poverty experienced by the Indigenous people living in Canada. Many Indigenous people are choosing to leave the reserve communities in the search of education and employment opportunities and are migrating to larger cities. This is especially true for the increasing Indigenous community that can be observed in Toronto, Canada.

**Indigenous homeless crisis in Toronto**

The city of Toronto is recognized as one of the most diverse and multicultural cities in the world. This developed metropolis is home to approximately 2.48 million people and expands to approximately 5.5 million in the Greater Toronto Area (City of Toronto, 2010). It is a well-recognized fact that Toronto has a concentrated population of Indigenous individuals and families that contribute to the overall Indigenous community in the GTA, likely because of the myriad of culturally specific Indigenous health, housing, education, employment and family services that are available in the area. Community agencies also suggest that a major reason behind this is the numerous job opportunities that are available in the city core (Belanger, Weasel Head, & Awosogo, 2012). There seems to be a disconnect, however, as many youths who do migrate to the city seem uninterested in utilizing and accessing the specific services that are available for them, and instead choose to fall into the cracks and become involved in the street lifestyle which eventually leads them to homelessness (CMHC, 2001).
In Toronto specifically, Indigenous homelessness is at a state of crisis, where individuals who self-identify as Indigenous contribute to 15.4% of the overall homeless population (City of Toronto, 2009). In general, the Indigenous people are a young and fast-growing population in Canada. In Toronto, as the Indigenous community continues to grow, so does the number of young people who are disproportionally living in the homelessness spectrum - ranging from staying with friends/family whilst in search for affordable housing (couch surfing), to living on the streets.

To address this concern, a Street Needs Assessment was conducted in 2009 by the City of Toronto. At the end of the assessment, it was recognized that there was a need for an Indigenous homelessness strategy to increase the research and funding as a priority to improve upon the specific services for Indigenous people. This was indicated as a priority, as many available services are being underused by the Indigenous community within Toronto and the GTA. This has been recognized as an endemic crisis since the population continues to rise with Indigenous young people moving to Toronto looking for opportunities to improve their quality of life (RCAP, 2004). The advancement of this strategy is important in reducing the amount of Indigenous youth who are or at risk of homelessness, as research demonstrates how specific programming provides the most effective supports in protection against homelessness. This strategy, however, has had limited success in terms of outcomes within Toronto (Belanger et al., 2012). This gap is likely due to the limited knowledge that the society has on the needs of the Indigenous population. It is likely that the Indigenous people have specific perceptions and preferences towards a strategy preventing homelessness. These strategies are likely inclusive of the Indigenous community’s unique histories that have contributed so greatly to the social determinants of poor health that are currently unaddressed by the City of Toronto’s plan.

Research conducted by Stewart and Teekens (2013) explored this gap within the current literature and policy. The results indicated a strong relationship between homelessness, mental health and addictions. It was recognized that although the participants had accessed mental health services from both mainstream and Indigenous approaches, many barriers still remained untouched in term of accessing relevant healing resources such as: being cycled through the system, cultural protocols around abstinence, and limited access to Elders. Many participants, however, recognized a connection with the Indigenous culture as a source of personal healing and recovery from the mental health issues and experiences of trauma.
The presence of psychological symptoms has been strongly correlated with the experiences of trauma (Banyard, Williams, & Siegel, 2001; O’Donnell, Creamer, & Pattison, 2004; Singer, Menden Anglin, & Song, 1995). Psychological distress and experiences of trauma are also found to have close relations to coinciding factors such as addictions, criminal behaviour, and homelessness. This is especially true for the Indigenous people who have disproportionate rates of mental health issues, addictions, incarceration, and homelessness.

**Trauma and mental health**

Psychological distress and mental illness have many presentations, prognoses, characteristics, and severities. Although many psychological disorders can be broadly clustered into various domains, as has been done in the Diagnostic and Statistical Manual of Mental Disorders - the fifth edition, published by the American Psychiatric Association (2013), the history, context, biology, and expression of psychological distress is unique for each individual. This is especially true in understanding the psychological complexities that ensue for one, or even a group that has experienced or continues to experience significant and chronic trauma(s).

**The trauma continuum**

Personal experiences are unique for everyone and are one of the primary components of what contributes to the formation of memories, influences the behaviour, and promotes learning. The human psyche is flexible in processing the external and internal stimuli from experiences to make the interpretations (Courtois & Ford, 2013). There are many other biological systems such as the limbic system that is involved in this process of interpreting information in combination with emotions (such as in fear responses). Biological vulnerabilities are likely to make an individual sensitive to this type of processing system. When combined with the over-stimulation of this system, especially in the process of activation of information and emotions that are difficult to cope with (i.e., fear, sadness, anger, shame, guilt), the psyche loses its ability to balance (Courtois & Ford, 2013). The result is displaced emotions in the form of symptoms and presentations that represent the psychological difficulties and mental illness. One example of this is experiencing a major traumatic event and how the internal processing of this event influences the mental health and psychological distress.
The human experience of trauma can occur in many ways and also be at various severity levels in terms of the psychological effect. Strain trauma occurs when an individual presents with symptoms of post-trauma related stress but has not experienced a high-magnitude traumatic event directly, but rather through partial traumatisation or through repeated exposure to stress over-time (Arnold & Fisch, 2011). Repeated exposure to stress over an extended period, even if it doesn’t overwhelmingly interfere with functioning, can also cause an increased vulnerability to developing a high response trauma expression, such as in Posttraumatic Stress Disorder (PTSD). This vulnerability is acquired in terms of cognitive processing, where the traumatic memories cannot be processed quickly as they are encoded into the memory during experiences of high stress. As a result, the stressful information tends to stay in the active memory and can be readily activated by triggers that activate the memories (Arnold & Fisch, 2011). In the presence of a significant psychological stressor such as trauma, the psyche undergoes an interpretive process that determines the fate of the psychic impact of stress.

Psychological trauma can be defined as a painful or overwhelming event that may happen to an individual. It can also be a process of cognitive and emotional encoding where the mind is set up in a certain way to cope with a painfully overwhelming event. The process of interpreting a traumatic event into the memory consists of four phases: traumatic induction, the peri-traumatic phase, and the acute phase of the traumatic state itself; followed by a post-traumatic period of either psychological recovery or decline based on the mechanisms and interpretation through this process. Whether a traumatic event is followed by psychological recovery or decline depends substantially on the individual meaning that is attached to the experience, combined with the process of the available resources as well as the ability for coping (Arnold & Fisch, 2011).

Trauma induction is the traumatic impact or shock of the given event: the imprinting and psychological processing of the impressions, combined with the physiological sensations associated with feeling out of control, helpless, and being caught off guard. The peri-traumatic phase of a traumatic state describes the emotional, cognitive, and physical experiences that occur at the time of the traumatic impact. During this stage, three things are likely to occur. First, there is a sense of being immersed in the traumatic stressor. Second, there is a feeling of being petrified by the suddenness and the overwhelming presence of the trauma. Third, there is a sense of internal imploding where the mere fact that one experienced the occurrence of such an event is overwhelming in itself (Arnold & Fisch, 2011).
The sense of immobilization combined with emotional flooding occurs following a traumatic event, as the traumatic stressor isn’t anticipated or predicted and cannot be processed accurately even afterwards. Phenomenologically, the victim of the traumatic induction feels fused with both the traumatic event and/or the perpetrator of the trauma. There is no sense of differentiation as the individual goes on and “becomes” the trauma. This acute phase of the traumatic state includes shock, fear, as well as tremendous feelings of loss and helplessness. The person is flooded with emotion that, since it can't be expressed, must be contained internally. There is an inability to emotionally articulate or to modulate affect (Arnold & Fisch, 2011).

When the trauma stops, the peri-traumatic phase is over and the traumatic state is set in motion. It is the reaction to the impact, the psychological consequences that remain following the trauma. It consists of the person’s attempts at making meaning of the traumatic impact. In this time period, the individual is processing what has happened during the trauma and what the person thinks about it after it is over. The traumatic state can involve distorted perceptions, vivid imagery, or the development of a fantasy caused not directly by what may have actually happened, but by the person’s mental construction of what happened. Whatever the person contributes to the traumatic experience, the attempt to make sense of the experience happens to be a crucial part of the traumatic state (Arnold & Fisch, 2011).

At a neurological level, trauma jolts the autonomic nervous system into a fight or flight arousal. The arousal is paired with the victimized passivity that sweeps over the individual, along with its ensuing hypnotic phenomena. This fundamental paradox - of arousal and inertness - produces not only the feelings of helplessness but also brings about some real changes in the cognitive processes, such as distortions of time and loss of a sense of self and volition. When there is no sense of specific agency, events are experienced as “just happening” to a person, as if the body exists independently of its occupant. The person constantly experiences feelings and ideas as detached from their own volitional activity, as if a passive bystander. Apart from disorganized thinking, the trauma victim also experiences problems with memory; concentration and judgment challenges; impaired self-awareness; as well as distorted self-reflection (Arnold & Fisch, 2011).

The post-traumatic phase brings in the verbal, explanatory, or meaning-making aspects following the trauma itself. It is the individual’s attempt to understand what happened, which may turn out to be a distortion of the actual experience. This phase is followed by recovery or by traumatic
(psychological) decline. Recovery occurs when the event is processed and integrated; it is recognized as something that the person survived and is, in the current state, about memories and feelings. In the post-traumatic decline, however, there is an inability to process or integrate the event and the individual develops a new set of emotional and behavioural characteristics in attempts to cope with life following a psychological trauma. Emotionally, incomprehensive feelings are experienced and are frequently attributed to something internal rather than to the original traumatic experience. Survivors of catastrophe struggle to master the impressions and memories of the traumatic event, as well as the ego disorganization that results from being emotionally overwhelmed can lead to psychosis or even psychological death (destruction of a human being’s potential and sense of identity), when unable to organize and integrate a sense of self post experiencing a psychological trauma (Arnold & Fisch, 2011).

Post-traumatic stress disorder (PTSD), according to the DSM-V, occurs when an individual: “(1) experiences, witnesses, or is confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and; (2) the person’s response involved intense fear, helplessness, or horror” (p. 271). Symptoms of PTSD include re-experiencing the event in intrusive memories, dreams, or flashbacks; avoidance of and numbing related to the event; physiological and psychological symptoms upon the presence of trauma-related triggers; and ongoing, persistent hyperarousal that eventually results in hypervigilance, reckless behaviour, insomnia, flashes of anger, or a sudden startle response (American Psychiatric Association, 2013; Arnold & Fisch, 2011).

Acute (type I) trauma

Some factors can also interfere with the presence of stress, thereby making one less reactive and more resistant and resilient to the detrimental effects of severe stress. The presence of social support and a supportive environment that promotes and facilitates emotional processing can facilitate a protective factor in terms of resiliency towards developing post-traumatic stress symptoms when exposed to a traumatic experience in the later stages of life. In general, when a stressor occurs, an emotional and cognitive integrative response is generated. As the degree of threat is evaluated in a cognitive manner, the appropriate emotional response tends to increase. The level of threat is then compared to the available coping resources; the resulting discrepancy between the level of threat and the available coping capacity determines the emotion and degree
of expression. When an initial cognitive appraisal creates a response of fear or anger, a re-evaluation through the cognitive process quickly recognizes a benign threat. As a result, the emotional response either reduces or subsides. When this same threat persists and the cognitive process identifies that the threat is beyond the individual’s coping ability, the emotional response intensifies and thus turns into acute psychological trauma, which is also known as type I trauma (Arnold & Fisch, 2011).

The long-term psychological characteristics of acute trauma are influenced by a variety of factors. These include whether the experience was random or malicious; perpetrated or a natural disaster, accidental or intended; the developmental stage of the person during the experience; quality of the relationship if the trauma was interpersonal; and single occurrence or repetitive (Arnold & Fisch, 2011). These factors are also shared with the individual and unique cognitive and emotional processes involved for the person that is experiencing the acute trauma. For example, these factors, combined with the vulnerabilities and perceived abilities to cope, tend to interact together in order to determine the degree of psychological distress. It is the extent of these factors that also differentiate the acute type I trauma from its more complex version, the type II trauma.

**Complex (type II) trauma**

Complex trauma occurs when the overwhelming experience (traumatic stressor) is both chronic and unpredictable, as in the case of ongoing victimization or abuse. The consequences of complex trauma are developmentally pervasive. The most damaging complex traumas are those that are perpetrated interpersonally by a known and trusted individual (Arnold & Fisch, 2011). These factors raise the complexity of the cognitive and emotional appraisal of the traumatic experience, as they often tend to challenge the major core belief structures and ways of being in the world.

Arnold and Fisch (2011) precisely describe the main difference between acute and complex trauma:

> Acute trauma in infancy or childhood can encroach on the healthy development of a child and result in a specific developmental deficit that then becomes incorporated into every succeeding stage of development. Complex trauma, however, is even more
insidious, creating deficits in multiple stages and aspects of development that build on one another. Complex trauma results from having been under total ‘totalitarian control’ for a long period of time. This could be due to being interred in a concentration camp, being isolated within a cult, or simply being a child within a controlling and oppressive family system (p.6).

Physiologically and psychologically, as a response to chronic exposure, individuals with complex trauma histories often remain in survival mode, even when they are no longer prone to the same risks of danger (Osterman & Chemtob, 1999). Research has demonstrated that adults with complex trauma histories are at considerable risk for re-traumatisation during stress across their entire lifespan since this perpetual ‘survival state’ puts them at a substantial vulnerability for triggers in response to a hypersensitive cognitive and emotional processing system (Duckworth & Follette, 2011; Widom, Czaja, & Dutton, 2008).

When victimization continues or reoccurs, survival reactions become ingrained, leaving an imprint on the individual’s physiological and personal development. Survival strategies can develop more permanently and begin to define the sense of self, ability to self-regulate and to relate well and in an intimate manner with others. These reactions then precipitate the defences and coping mechanisms to help soothe that are often secondary effects, such as with addictions, self-injury and the rate of suicide (Courtois & Ford, 2013).

Those with complex trauma histories often have diffused identity issues and are likely to feel like outsiders, different from the others and feel that they somehow can’t seem to get along with, fit in with, or get close to others even after trying. Moreover, they often feel a sense of personal contamination and that no one understands or can help them, which can influence some very negative self-concepts as well as a tendency for isolation. Yet in many cases, the individuals with these histories display a remarkable capacity for resilience and resistance and demonstrate a sense of morality and empathy for the others, a strong sense of spirituality, and perseverance that goes on to create a strong capacity and strength for survival (Courtois & Ford, 2013).

Complex trauma stressors differ from acute traumatic stressors. The criteria outlined by the Diagnostic and Statistical Manual- fifth edition (DSM-V) recognize factors in the onset of complex trauma in the instances of (1) learning of a violent or accidental death or threat of death that happened to a close relative or close friend or (2) repeated or extreme exposure to aversive
details of the event(s). These criteria include a relational component such as the traumatic impact of an actual or potential loss of a primary-attachment relationship or the vicarious impact of learning of something terrible that happened or could happen to key people or to other vulnerable persons, such as children (American Psychiatric Association, 2013; Courtois & Ford, 2013).

Complex traumatic stressors are often chronic, involve interpersonal associations and include threats to the integrity of the self, to personal development, and the ability to relate to others in healthy ways. These are also inclusive of abandonment, neglect, lack of protection, and emotional, verbal (including bullying), sexual, and physical abuse by significant attachment figures or loss of these primary attachment figures through illness, death, deployment, or displacement of some sort (Courtois & Ford, 2013).

Complex trauma, regardless of its type or developmental time of onset, is often a multiple occurrences and can escalate in severity over its duration. More specifically, one type of trauma may “layer” on the top of another - a pattern found in family abuse victims who are multiply victimized in the family by more than one member (poly- or multiple-victimization). Such victims also include those who are more vulnerable to abuse outside of the family (re-victimization) in numerous life domains such as school, work, the military, religious congregations and groups. The result of this multilayered victimization is what has been identified by Ford and Courtois (2009), Duckworth and Follette (2011), Follette, Polusny, Bechtle, and Naugle (1996), and Kira and colleagues (2010) as cumulative forms of trauma that deprive the victims from a sense of safety and hope, their connection to primary support systems and community, and their very identity and sense of self. Such compounded stressors go on to become the norm rather than the exception for any number of complex trauma survivors (Courtois & Ford, 2013).

Identity (type III) trauma

Additionally, a complex trauma may be based on and associated with the victim’s primary identity that they are born with, including such immutable characteristics as race; ethnicity; skin colour; gender; genetic and medical conditions; physical limitations; family, tribal, clan background and history; and other factors including religious and political orientation; class; economic status; and resultant power or lack thereof (Kira et al., 2011). Traumatic victimizations, based on these characteristics, can literally begin before the person’s birth and
can continue to stick with them life-long or can occur primarily in adulthood. They can result in both individual victimizations and in the persecution of entire communities or populations who share characteristics. This can lead members to be deemed as suspects, inferior, or of sufficient threat to warrant their eradication and creates a glass ceiling\(^2\) effect and barrier towards effective coping, when trauma is so deep set and rooted based on an entire group, further creating an effect of learned helplessness\(^3\). Kira and colleagues (2011) describe the violence perpetrated in the name of these types of prejudices or political and economic motives by calling them “identity trauma” or type III trauma because they are based on the intent to discredit and destroy the personal and cultural identities of the victims (Courtois & Ford, 2013). This type of trauma perpetuates the complexity of the traumatic experience since it is not only perpetual and chronic in nature, but is intended to harm the existence of a member of a target group.

Complex trauma, during adulthood and across the lifespan of an individual, can have a great emotional impact and can even break down the key prior developmental achievements at any point in the lifespan. Regardless of its origin or type, what makes the trauma complex is the overwhelming threat or harm that it poses to personal safety. The threat to identity, relationships, and overall security will also negatively impact or reverse the individual’s development. Furthermore, some distinguishable characteristics of identity can be the very target of the abuse that occurs at both the individual and systemic levels (Courtois & Ford, 2013; Kira, 2010). Other personal characteristics or group affiliations that are acquired through teaching and as part of a group culture that is not inborn or unchangeable, but nevertheless is central to the individual’s sense of self and community are also forms of vulnerability. For example, religion, political affiliations, belief systems, and practices may be used by adversaries as a target for imprisonment, forced evacuation, relocation, torture, or other forms of violence and cruelty, including genocide (Courtois & Ford, 2013).

\(^2\)Glass ceiling affect refers to the unofficially acknowledged barrier to advancement in a profession or social system, especially effecting women and persons of minority.

\(^3\)learned helplessness is the behaviour that occurs when one (animal or human) endures repeatedly painful or otherwise aversive stimuli that one is unable to escape of avoid. They begin to accept the situation, often occurring with a subsequent depression or negative view of the world.
Chu, Frey, Ganzel, and Matthews (1999) described the phenomenon of chronic disempowerment that often accompanies the ongoing victimization and entrapment that is referred in this type of identity-based (type III) trauma. The violence that terrorizes or attempts to destroy a gender, culture, religion, or generation; or one that violates the fundamental human values is disempowering because it destroys the victims’ core source of personal power, their sustaining beliefs, guiding principles, and eventually, their essential hopes.

Colonialism, torture, captivity, genocide, gendercide, and terrorism are purposefully disempowering because the victims’ sense of personal safety, identity; as well as the meaning and value of life and community get shattered in the process. Thus, complex trauma, in this sense, holds the potential to destroy not only families, communities, and cultures but also has the ability to maintain an intact individual personality, sense of self, and body. It is thus challenging for that individual to maintain hope, a sense of agency and personal safety (Courtois & Ford, 2013). Trauma occurring to a specific group, community, or population based on characteristics that are severe, ongoing and penetrates deep into the roots of identity can also have lasting effects. The trauma is often transmitted to further generations of the targeted group and is then recognized as historical or intergenerational trauma (i.e., type IV trauma).

**Historical and/or intergenerational (type IV) trauma**

Although historical trauma is often experienced by the entirety of a collective group (usually through an identity-based group trauma); it can be transmitted through individual members in familial and community systems. The most primary feature of historical trauma is that the original trauma is transferred to subsequent generations through biological, psychological, environmental, and social means. This eventually results in a cross-generational cycle of trauma (Sotero, 2006). Historical trauma transmission is described as occurring through the processes of three different phases.

The first phase entails the dominant culture perpetrating mass traumas on a population that is viewed as inferior, thus resulting in cultural, familial, societal and economic devastation for the targeted population. The second phase occurs when the original generation of the population chooses to respond to the trauma showing biological, societal and psychological symptoms. The final phase is when the initial responses to trauma are conveyed to successive generations through environmental as well as psychological factors. This includes experiences of prejudice
and discrimination as the members of an identified group (Sotero, 2006). The combination of these factors perpetuates the trauma, and as a result, the further generations are also more vulnerable to experiences of direct (type one) trauma.

Historical trauma theory is a social construct, conceived of and elaborated by people with specific interests, drawing on the resources available to them at a particular social location and at an important historical moment (Maxwell, 2014). What is distinct about historical trauma as compared with other diagnostic categories, according to Gone (2009), is that “there are no consensually acceptable diagnostic criteria for historical trauma” and “reliable and valid assessment of historical trauma has never been a pressing issue” (p.758). Further, historical trauma is described as not an empirically validated diagnostic category, but rather a highly malleable hermeneutic tool, which is employed for making meaning out of the social suffering in the present, through the reference of the past (Lambek & Antze, 1996).

Just as the impact of a stressor on individual functioning in acute trauma is influenced by a person’s past experiences as well as their current environment; the influence of a collective trauma on a person’s well-being also needs to be considered in the context of the group’s historical and contemporary stressor experiences (Bombay, Matheson, & Ainsman, 2014). In the case of complex trauma, this group vulnerability can exist in an individual’s family narrative of the experienced trauma. Furthermore, the family narrative of trauma, in comparison to the group trauma, also goes on to influence the magnitude of emotional impact at an individual level.

Evans-Campbell (2008) identified three distinguishing characteristics of historical trauma events: (1) the event was widespread among a specific group or population with many group members getting affected by it; (2) the event was perpetrated by out-group members with purposeful and often destructive intent; (3) the event generated high levels of collective distress in the victimized group. In addition, there also seem to be generally agreed upon characteristics of historical trauma responses, which comprise of the following: historical trauma events that continue to undermine the well-being of contemporary group members; responses to historically traumatic events interact with contemporary stressors to influence well-being; the risk associated with historically traumatic events can accumulate across generations.

Three primary collective examples of historical/ intergenerational trauma that illustrate this deep-seated form of complex trauma transmission are the intergenerational effects of slavery on
African -in the United States; the influences that the Holocaust had on European Jews; and the lasting effects of colonization and the residential school systems that was forced on the Indigenous people by the Christian Church and the Canadian government; similar to that forced on the Native Americans by the Christian Church and the United States Government.

The history of slavery in the United States comprises of the brutal capture of Africans by the European colonizers and their brutalizing transport to the United States. Many accounts estimate that during such transportation processes, almost half of those captured would fail to make it to the destination due to various factors such as disease, the cruel and unsanitary conditions on the ships and also from brutal death that occurred due to other means. This account of history for African people meant a complete disruption from their land, people, and customs. For example, attachments, one’s place in the world, continuity with the past, and an expectable future, were all destroyed during this experience (Graff, 2011, 2014). Furthermore, the combined fear of being captured and taken as a hostage, away from known surroundings and forced into an unknown and frightening situation became the reality of many Africans. that the sole basis for these dynamics was that one group of people identified as superior and felt the right and power to inflict such trauma on a population of other people. The impact of this group trauma is explained by Gump (2010):

There is little in slavery that is not traumatic: the loss of culture, home, kin… sense of self, the destruction of families through sale of fathers, mothers and offspring, physical abuse, or even witnessing the castration of a fellow slave. Yet subjugation was its most heinous aspect, as it sought nothing less than annihilation of that which is uniquely human, the self (p.48).

Although the abolition of slavery successfully recognized the atrocity of human ownership, domination and power of one population over another, identity-based trauma and racism did not end there for Africans in the United States. During the times of freedom from slavery came a new age of shame to which the African-Americans were continually subjected. This was followed by Jim Crow (a rigid pattern of racial segregation), lynching (hanging), disenfranchisement, an economic system- sharecropping and tenantry. All these things combined to leave very little room for ambition or hope and created unequal educational resources and enforced ignorance. Litwack (2009) described that these events were generated by a “Belief
system that defined a people not only as inferior but as less than human” (p.23). The civil rights movement struck down the legal barriers but failed to dismantle racial barriers. Litwack (2009) states that “Although this movement ended ‘violence of segregation,’ it did not, however, end the ‘violence of poverty’, which exists as perpetuated oppression” (p.109).

Intergenerational effects of these traumas that perpetrated on the African-American people are still evident in the United States today, where although the presence of African-Americans in powerful and influential positions has increased, there is a disproportionate number of African-Americans living in poverty and being over-represented in the prison system. In 2007, African-Americans represented nearly half of those incarcerated in the United States federal correctional institutions (Litwack, 2009). It can, therefore, be clearly seen that the trauma of slavery and its aftermath has been transmitted from generation to generation. Traumatic transmission, specifically, has been noted to predominantly occur through parenting styles and dysfunctional family dynamics.

History of slavery and the brutal experience of helplessness combined with repeated and chronic exposure to abuse is a severe emotional disruption that can result in complex psychological trauma. In addition to the shame and traumatic experience of being enslaved itself, Gump (2000) states:

> That to be a victim of human induced violence and trauma is the ultimate mortification. There is no shame as profound as that which destroys subjectivity, which says through word or action, what you need, what you desire, and what you feel are of complete and utter insignificance (p. 623).

Further, it is also explained that “The need to justify slaves’ economic exploitation required the destruction of their subjectivity and that destruction reverberates in the parenting practices of too many African American families” (p.626).

It has been observed that the intergenerational trauma, the feeling of helplessness and destruction of subjectivity that occurs during the chronic, prolonged and perpetrated abuse on a specific target group, get passed on through generations. This occurs through the power dynamic as well as the interpersonal relational context of parenting. The nature and the quality of trauma-specific interpersonal communications between the survivor-parent and their children have been found to
be pivotal in the emotional experiences of these children (Wiseman, Metzl, & Barber, 2006). A key aspect that is assumed to be involved in the intergenerational transmission of various traumas in the descendants of those who have directly experienced the trauma, is the quality of family communication of the traumatic experiences (Danieli, 1998). Apart from the intergenerational communication patterns between parents who have experienced various traumas and their offspring regarding slavery in African American families; the same interactions have been described to have taken place in Jewish families of holocaust survivors (Auerhahn & Laub, 1998).

Specific to the Jewish community, an intergenerational communication pattern referred to as the ‘conspiracy of silence’ has been found to have a strong prevalence in the families of holocaust survivors (Danieli, 1998). The conspiracy of silence refers to a non-verbal agreement in the family of keeping some traumatic experiences unspoken and detached from the everyday life. This silence originated not only from the parents’ need to be able to forget and adjust to the newly established social contexts, but also from their belief that it was crucial to safeguard and withhold the information about the horrors of the holocaust from reaching their children for the sake of their development (Bar-On et.al, 1998). This lack of communication between generations, however, was found in a study by Wiseman, et al. (2006), to have instilled emotions of anger and guilt by the children of the parents who were ‘silenced’. This further perpetuated the second generation of holocaust survivors who were, by nature, overprotective of their parents and more sensitive towards them as they interpreted their silence of the holocaust experiences as something that their parents needed to be protected from.

Since the act of genocide was born by fear, indifference, or collaboration in the larger communities, it is advocated that the healing of holocaust-related trauma must extend beyond the individual families and must also begin in the larger community. Clinical preoccupation with traumatic symptomology impedes awareness of the crucial role of society and culture in facilitating or impeding the passage from the holocaust world to the world as we see it today (Peskin & Auerhahn, 2001). Witnessing begins in the community and follows that the quality of holocaust transmission becomes a measure of the community’s capacity to acknowledge the reality of the holocaust and create appropriately suitable conditions for listening. A community’s resistance to holocaust awareness may be counted both as an identification with and as a post-traumatic symptom of the Nazis’ injunction against knowing and bearing witness and may be felt
as such by the survivor (Peskin & Auerhahn, 2001). This community knowledge and the resistance to the impact and horror that Nazi Germany had on the entire Jewish population can begin and amply restore resilience and healing for many Jewish communities, families and individuals who are still affected by the traumatic memories related to the holocaust.

Based on research examining the cross-generational transmission of trauma of holocaust survivors and their descendants (Doucet & Rovers, 2010; Jacobs, 2011; Neigh, Gillespie, & Nemeroff, 2009; Yehuda, Schmeidler, Wainberg, Binder-Brynes, & Duvdevani, 1998), three means of trauma transmission to subsequent generations have been identified: (a) children identifying with the sufferings of their parents, (b) children being influenced by the style of communication that caregivers use to describe the trauma, and (c) children being influenced by the various, particular parenting styles (Doucet & Rovers, 2010). Parental identification is a form of vicarious learning in which, the child identifies with the trauma and takes on the historical loss symptoms (Brown-Rice, 2013). Therefore, it is the parenting styles that go on to model the behaviour, and therefore, when trauma is experienced with the parents, much of it is passed down in the modelled behaviour demonstrated to their children.

Parenting style also can be impacted as a result of exposure to trauma by one or both the parents (Walker, 1999). First, the parents may have difficulty with the very feelings of trust and intimacy due to their experiences of having been victimized. Therefore, it may be a challenge for them to develop a healthy attachment with their children and vice-versa. Secondly, many adults who have been subjected to abuse and neglect may in turn, unintentionally enter into a cycle of violence with their own children (Cole, 2006). Subsequent generations of victimized groups may not have been able to develop healthy parenting styles and may have thus inadvertently continued a cycle of violence and abuse within their own homes.

Research (Neigh et al., 2009; Yehuda, et al., 2000) has demonstrated the relationship between a parent’s diagnosis of PTSD and abuse and neglect of their children. This research has also suggested that some children of holocaust survivors who are diagnosed with PTSD generally report more neglect and emotional abuse than demographically similar children of parents who were not diagnosed with PTSD, which only illustrates this theory in a better light. Furthermore, the adult children of holocaust survivors have a greater lifespan occurrence of PTSD, as well as
other mood and anxiety disorders than the demographically comparable individuals who reported a similar kind of exposure to trauma (Neigh et al., 2009; Yehuda et al., 1998).

It is important to note that these referred methods of trauma transmission perpetuate the existent trauma in the future generations. They also add a certain level of vulnerability for the future generations to the exposure of new traumas. This also includes some sort of sensitivity to the emotional and cognitive processing of that trauma and it may even put one at risk for psychological distress. Such exposure can also influence the degree of symptom severity of response as well as the presentation of post-traumatic stress.

The presence of historical trauma has been recognized to be a significant feature that is present and experienced in many Canadian Indigenous and Native American communities because of their lands being colonized by some dominant European cultures. As a result, the Indigenous North American population experienced multiple traumas including the loss of many lives, loss of land, loss of family and eventually, as a result, the loss of culture (Brown-Rice, 2013).

For Canadian Indigenous peoples, the legacy of forced assimilation, cultural genocide, and abuse that occurred for many generations of the first peoples has had lasting and complex effects. The historical trauma that Indigenous peoples face is defined by Yellow Horse Brave Heart (2003) as, “Cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences” (p.7).

There are six phases in the development of historical trauma for Indigenous peoples, as has been presented in Duran and Duran’s model (1995). These phases correspond with the stages of Euro-American imperialism, colonialism, and colonization and include the periods of the first contact, economic competition, invasive war period, subjugation and reservation period, boarding school period, and forced relocation and termination period. The model does not stipulate that a trauma in one phase leads to trauma in the next; however, it is the continued and/or isolated experiences of colonization in North America and the lasting consequences of such colonization that has perpetuated and descends the impacts of trauma on the Indigenous peoples.
Intergenerational trauma and Indigenous peoples

Intergenerational abuse and family violence for Indigenous peoples has been linked to numerous factors including colonization that is known to have induced significant experiences of trauma. These traumas are inclusive of, but are not limited to: systemic discrimination and racism against Indigenous peoples through government policies, treaties, and relocation and neglect; breakdown of family life due to the removal of Indigenous children from their families (i.e., residential schooling, the sixties scoop); as well as the abuses that were endured in the aforementioned systems; overcrowded and substandard housing; economic and social deprivation; alcohol and substance abuse as a primary coping mechanism; and the intergenerational cycles of violence (Statistics Canada, 2008).

More specifically, in terms of psychological and emotional functioning, research with the Indigenous communities identified a phenomenon called ‘generational grief’, which has been recognized as a continuous descent of unresolved as well as deep-seated emotions, such as grief and chronic sadness that was a result of the previous traumatic experiences (Aboriginal Healing Foundation, 2004). When the emotional trauma is ignored and there are no specific ways of support that can help one deal with it, the trauma will be passed on from one generation to the next.

Another consequence of colonization and the symptom of communal emotional distress that is common in the Indigenous communities, is the prevalence of substance abuse and addictive behaviours (Brave Heart, 2004; Chansonneuve, 2007; Kawamoto, 2001; Mussell, 2005; Spittal, et al., 2007). In fact, the majority of participants in the First Nations and Inuit Regional Health Survey (FNIGC, 2012), indicated that there was no significant reduction in alcohol and drug abuse despite all the efforts that were exerted in various mental illnesses and substance use reduction strategies in their respective communities (Svenson & LaFontaine, 1999). Furthermore, McCormick (2009) suggests that for many Indigenous people, the “Consumption of alcohol has been their attempt to deal with the state of powerlessness and hopelessness that has arisen due to the devastation of traditional cultural values” (p. 348). It is evident that there is a high degree of self-medication that occurs in Indigenous communities as a result of various aspects of current and intergenerational trauma. This has further led to other high rates of social
difficulties that were experienced in Indigenous communities such as criminal involvement and homelessness.

The essence of intergenerational trauma observed within the Indigenous communities is that lasting effects of unresolved and historically traumatic experiences. Generational or unresolved emotional grief is not only being passed from one generation to the next but are also being continuously acted out and recreated in contemporary Indigenous cultures and in communities as a whole. This grief has, therefore, continually affected families in terms of cycles and vicarious models of inadequate parenting, domestic violence, and physical/sexual abuse. Unresolved historic trauma will continue to impact the Indigenous individuals, families and communities for many generations unless we learn to address the trauma mentally, emotionally, physically and spiritually (Aboriginal Healing Foundation, 2004).

The concepts of intergenerational trauma and cumulative trauma have also provided a useful framework for healthcare practitioners who provide their services to the various Indigenous peoples (Struthers & Lowe, 2003). More specifically, the understanding and inclusion of the aspects of intergenerational trauma in the context of mental illness and distress will help improve the quality of care in mental health services for the Indigenous people. This describes a large-scale cumulative mass-experienced trauma that hasn’t been adequately explained by the DSM-V diagnostic impositions of PTSD, which identifies the mental condition through imminent, singular and episodic experiences of trauma.

Keeping with the continuum of trauma model, historical trauma, such as what has been experienced within the Canadian Indigenous communities, is recognized more comprehensively as complex trauma that is rooted in a deep identity core and passed on through the family dynamics as well as acts of neo-colonialism (systemic oppression and disproportionate health disparities). Thus, the complexity of the trauma increases in terms of assessment, diagnosis and treatment. This is primarily captured through acute and chronic exposure to acute trauma, which goes on to create limitations that impede one from clinically addressing the aspects of more complex identity-based traumas.

In order to better understand the context of Canadian Indigenous peoples and the influences of intergenerational trauma, Herman (1997) developed a theory of individual responses to psychogenic trauma. She termed this complex post-traumatic stress disorder. This theorized the
intergenerational trauma through a Western psychology, clinical and diagnostic lens, to capture some aspects of identity-based trauma. In response to this theory, a hybrid model of post-traumatic stress disorder was recognized in the literature and it is since referred to as historic trauma transmission (HTT) and stems from the impacts of colonization. This model identifies that Indigenous people not only suffer from the impacts of generational grief but that they are acting it out at both personal and cultural levels and recreating trauma as a way of life. It should be clarified, however, that not all individuals manifest overt PTSD symptoms in their lifetimes. The expression of latent symptomology can be inferred from the high prevalence of lateral violence, family breakdown and community dysfunction in many of the Indigenous communities (Ursano, McCaughey, & Fullerton, 1994). It is proposed by Herman (1997) that over time, the experience of repeated traumatic stressors become normalized and are incorporated into the cultural expression and expectations of successive generations in families as well as communities.

Although the discipline of psychology has grown to include various cultural elements and considerations for clinical theory and practice, the literature on Indigenous health and healing practices is very limited. Furthermore, it should be emphasized that psychology, as a discipline and practice, needs to recognize and be educated that the cultural belief systems are different and unique for each distinct Indigenous group and band throughout Canada. Furthermore, as with the cultural differences, psychology practitioners also need to recognize that historical trauma and experiences are also different for each Indigenous person, family and community.

There are, however, common core values that tend to run across the most Indigenous nations (Garrett, 1999) that could help influence specific mental health approaches as well as treatment programs for the Indigenous peoples. In regards to the collective colonial trauma experiences that many Indigenous peoples have shared, there are distinct mental health patterns that can be observed in the various Indigenous communities. Furthermore, it is important to conceptualize historical trauma diagnostically and incorporate it into mental health treatment models to account for the aspects of colonial trauma in the conceptualization of emotional distress, psychological functioning and the overall wellbeing.
Mental health of Indigenous peoples

Indigenous people in Canada have endured decades of devastation to their communities as a result of colonization. As indicated, some of these disparities include but are not limited to poor living environments; social exclusion; systemic racism; and effects of residential school. As a result, there are high rates of mental illness and addiction in a lot of Indigenous communities. Furthermore, addiction and mental health issues are often concurrent, where many individuals tend to use substances such as drugs and alcohol to cope with the mental health issues and experiences of trauma. These maladaptive coping strategies are also transmitted through parental modelling and family dynamics. This is especially true for many Indigenous peoples since the mental health problems are generally more complex, severe, and persistent as compared to the general population. Such complexities are generally deep-rooted in identity-based group traumas. One specific epidemic that amply demonstrates this is the overrepresentation of suicide in various Indigenous communities.

Suicide rates are exceptionally high in Indigenous communities, where Health Canada (2011) reported that in 2001-2002, the First Nations suicide rate was three times as much as that of the general population. In some communities, the rates are even more devastating where suicide among the Inuit and other northern Indigenous communities can be anywhere from six to eleven times that of the national average. Some Northern Canadian communities are known to have the highest suicide rates in the world (Government of Canada, 2006). Suicide is a significant concern among the Indigenous youth, where the rates are five to seven times higher for First Nations youth as compared to their non-Indigenous peers (Health Canada, 2006).

High rates of suicide in Indigenous communities are clear indicators that many individuals in this specific population experience significant psychological distress. Disproportional levels of expressed suicide in the Indigenous communities, when compared to the non-Indigenous Canadian population, are found to be significantly higher (Health Canada, 2006). This recognizes there are many group-specific factors here that have been contributing to the high rates of psychological distress. Firstly, high rates of suicide in Indigenous communities are commonly indicative of extreme social stress, disempowerment and/or mental health or addiction challenges. These challenges are often left unaddressed as many communities lack the appropriate services needed to address that. Furthermore, the resources that exist often lack in
terms of quality and/or are provided by the non-Indigenous peoples that are ignorant of the said issues. The problem of homelessness has also been found to increase the risk of suicide (Goldstein, Luther, & Haas, 2012; Prigerson, Desai, Liu-Mares, & Rosenheck, 2003; Rew, Taylor-Seehafer, & Fitzgerald, 2001).

Secondly, the First Nations people experience heightened mental health concerns that put them at an increased risk for homelessness and suicide such as: higher rates of major depression, with rates of diagnoses that are twice the national average (Government of Canada, 2006); experiences of poverty; unemployment; and high rates of alcohol-related problems. Furthermore, one major contributor to the increased presence in psychopathology and emotional distress is that the Indigenous peoples face a heightened exposure to daily stressors and systemic stressors (such as disadvantages in the socioeconomic status) that is disproportionate to the non-Canadian population.

Research has demonstrated that this phenomenon within the Indigenous communities where high exposure to stress and experiences of traumatic and high-stress events, negatively influences psychological functioning and increases the presentation of distress. Specifically, Kirmayer, Boothroyd, Tanner, Adelson, and Robinson (2000) found that the phenomenon of a higher number of significant life events in the past year was associated with the elevated rates of distress among the Cree in James Bay. On a similar note, the research involving Native American Elders in Michigan found that life events were related to increased risk of experiencing depression in the short-term (Chapleski, Kaczynski, Gerbi, & Lichtenberg, 2004). Evidence has also been found, which suggests that greater exposure to traumatic events among Indigenous peoples tends to have a significant impact on the psychological health of the individuals. For example, research from a study with Native Americans aged 15 to 57, living on two reservations, demonstrated relatively high lifetime rates of exposure to at least one trauma, particularly among women (Manson, Beals, Klien, & Croy, 2005).

Thirdly, the Indigenous peoples are often exposed to aspects of overt and covert racism and oppression. Exposure and experiences of racism are very distressing and are a major impairment of the psychological functioning of the Indigenous peoples. In the First Nations Regional Longitudinal Health Survey (FNRHS), two out of five First Nations participants reported having experienced racism in the past year. Participants with higher levels of education and who are
employed in non-Indigenous agencies are generally more likely to have encountered it (RHS National team, 2007). The perceived experiences of racism were also found to have a strong association with depressive symptoms among the Indigenous adults, while engagement in traditional practices was found to be associated with fewer depressive symptoms (Whitbeck, McMorris, Hoyt, Stubben, & LaFramboise, 2002).

Fourthly, the social position and economical disposition are also integral factors that contribute to the experiences and presentation of psychological distress for the Indigenous peoples. Research suggests that Indigenous people, particularly those who experience the socioeconomic disadvantage, may have a reduced access to social support, may live in communities where colonialism and poverty have undermined the traditional values in terms of social ties, and have social networks that reinforce negative health behaviours and therefore, it was recognized that social supports are also important factors in the well-being of the Indigenous peoples (RHS National Team, 2007; Richmond, 2008).

A Study conducted by Wingert (2011) examined the social factors as they relate to distress and the well-being of Indigenous peoples in Canada living off the reserve. Results found that social distribution of distress and well-being in the off-reserve Indigenous population was related to daily stressors, mastery, and social support. These findings suggest that stress is a strong contributor to the negative mental health outcomes, while psychosocial supports and resources are more important for the positive outcomes. Furthermore, the results of this study imply that higher education and income are indirectly related to distress via their effects on stress.

As the literature shows, there are many factors that clearly contribute to the overall disproportionate levels of psychological distress expressed in the Indigenous communities. Of these factors, the most prominent one is the extremely high rates of suicide that seem to be occurring in many Indigenous communities. These unique factors contribute to the high levels of psychological distress including extreme exposures to social stress and disempowerment; frequent exposures to daily stressors and negative life events, including traumas; experiences of racism and oppression; as well as the social position, such as group socioeconomic disadvantage. The accumulation of these factors influencing the psychological well-being of the entire population also needs to be taken into consideration.
One way of understanding the various trends and dynamics in terms of psychological theory and context of mental health and trauma occurring within the Indigenous populations is the influence of ‘ethnostress’, which has been identified by Hill (1992) as the “Confusion and disruption that people are experiencing inside their world” (p.1). This stress is known to have influenced the disruption of Indigenous peoples’ identities and the lasting impact on both an individual, family and an entire community. The concepts of ethnostress address the political and historical factors of colonial trauma. It has been expressed as a loss of traditional social independence and organization, spiritual practices and independent governance systems of the communities. These effects, according to Linklater (2014), have had significant group effects such as the loss of faith and belief in the traditional ways, the narrowing down of culture, isolation, internalized stereotypes and racism, as well as the adoption of maladaptive survival behaviours.

Indigenous peoples are exposed to disproportionate levels of acute stressors that further perpetuate their vulnerability to psychological distress and mental health difficulties. These are inclusive of exposure to system social stressors and disempowerment; high exposure to daily stressors and higher rates of acute traumas; experiences of racism; and socio-economical disadvantages such as poorer living conditions and experiences of poverty. Combined, group intergenerational vulnerabilities of trauma with increased factors contributing to increased distress; demonstrate the high rates of mental health concerns within the various Indigenous communities.

As a group, Canadian Indigenous peoples have had a unique and complex history regarding their psychological functioning, mental health and traumas. The experiences of colonization seem to have drastically affected the entire Indigenous communities in Canada through the generations. This disruption in culture and life for the Indigenous peoples has caused deep roots of racism, oppression and expressions of complex identity-based traumas that have been passed down throughout many generations. These expressions are passed on generationally through the aspects of parenting styles, cycles of violence, and biological sensitivities and vulnerabilities to new traumas based on the intergenerational trauma transference theory.

Furthermore, the aspects of colonization have had distinct effects on the Indigenous communities, including many health disparities. This has especially included quite high rates of mental health problems. For example, the Indigenous people were forced to abandon their own
cultures and identities, reinforcing the fact that their traditions and knowledge systems were not only inferior to the European ways but as a people were also substandard. Therefore, the psychological well-being and healing from colonialism for Indigenous communities are grounded in healing the Indigenous spirit and revitalizing the culture through traditional knowledge and community connection.

**Traditional Knowledge**

Traditional knowledge is defined as the sacred information that is an integral part of a culture and history of any given local community. Traditional knowledge evolves through many years of regular experimentation on the day-to-day life and available resources surrounded by the community and passed down through the generations. It is unique, traditional, local knowledge existing within and developed around the specific living conditions of the people that are Indigenous to a given geographical area (Ghosh & Sahoo, 2011). The specific acquired information in one community is valued in terms of both survival and identity. It refers to the integrated expression of collective values and customs that guide the interpersonal interactions of a distinct group as well as between the people and nature. This exists through the transmission of sacred knowledge to the younger generation by the Elders (International Development Research Centre, 1993).

As a social function, especially in terms of transmission, the Indigenous traditional knowledge is based on a knowledge system that is developed, preserved and refined by many generations of people through continuous interaction, observation and experimentation with their surrounding environments. This interaction between the community and the surrounding environment is a dynamic and ever-changing system; adopting new information and knowledge while also adjusting to the local situations and thereby, interacting closely with the culture, civilization as well as the spiritual practices of the communities (Pushpangadan et al., 2002).

At a global level, in terms of cultural analysis of human dynamics and groups, traditional knowledge seems to be deep-rooted in many countries around the world and in the cultures that comprise them. These knowledge systems are vital for community factors of well-being and for sustainable development, besides monitoring their cultural liveliness and values. This aspect of traditional knowledge is particularly important for concepts and practices that are concerned with health. The World Health Organization (WHO) has stated that as much as 80 percent of the
world’s population depends on traditional medicine for its primary health care and recognizes that ‘traditional knowledge is indispensable for its survival’ (Gosh & Sahoo, 2011; Jena, 2007). The inclusion of traditional knowledge of models of health practices and basic community functioning is important to the livelihood and well-being of a specific cultural group that has its own unique traditional healing knowledge, which is sacred within their generations of people.

**Canadian Indigenous traditional knowledge**

Traditional knowledge differs for every specific group, depending on various factors such as the geographic location, the environment where the people live, the available resources, spirituality, values and cultural norms. Everyone in a community or culture holds some amount of traditional knowledge because it is collective (Pauktuutit Inuit Women’s Association, 2003). In Canada, Indigenous peoples have significant diversity in terms of the traditional knowledge that they hold as a broad group. Each nation, band, tribe and community, however, has its own unique, shared collective of sacred knowledge. Such specific knowledge to one community is determined by a First Nation’s land, environment, region, culture, language and history. Furthermore, the aspect of the knowledge that is ‘traditional’ is not viewed as something that is old or ancient but is rather looked at as something that is based in custom and is thus created, preserved, and dispersed (Hansen & Van Fleet, 2003).

**First Nations traditional knowledge**

First Nations people in Canada use the term ‘traditional knowledge’ to describe the information that they have been passing on through their generations. This information, which is collectively referred to as ‘traditional knowledge’, may be rooted and more tangibly expressed through storytelling; ceremonies; traditions; ideologies; medicines; dances; arts and crafts; or a combination of all these (National Aboriginal Health Organization, 2008a).

**Inuit traditional knowledge**

In the Canadian Inuit communities, oral history plays a very important part as a vital component of the traditional knowledge. Valuable and sacred information is passed down generationally, from Elders to children about the practical knowledge of how to live off the land as well as the origins of their peoples and the ancestry as well as the ongoing cultural history. More importantly, Inuit knowledge of health, healing and wellness is current and is not necessarily
based on knowledge from the past and strives to be incorporated into the cultural presence of the community. This simultaneously ensures that younger generations continue to learn the traditional ways of thinking, embrace the cultural continuity in the value of Elders and the community. Furthermore, the well-being of Inuit people in Northern regions is more focused on identifying the importance between the human-environment relationship that incorporates hunting, fishing and collecting activities within the individual as well as the larger communities (National Aboriginal Health Organization, 2008a).

**Métis traditional knowledge**

In the Canadian Métis communities, there is a strongly placed value in the gathering of plants and the indication of which plants are good to eat and which ones possess medicinal properties. This value is also a central aspect that is present in the Métis traditional knowledge. Métis Elders regularly gather together to recognize, share, protect, affirm, use, and revitalize the Métis traditional health and healing knowledge and practices. The Elders of Métis communities stress on the awareness of historical, cultural and Indigenous language perspectives as being necessary for understanding the traditional cultural protocols. They further also encourage learning and practice in the younger generations. Métis traditional knowledge also values the incorporation of ancestral wisdom regarding health and healing, the importance of the Métis women and families to community health, as well as the importance of land and water, which are recognized to be central to the Métis health and wellness (National Aboriginal Health Organization, 2008a).

Canadian Indigenous peoples such as the First Nations, the Inuit and the Métis value their traditional knowledge pretty highly since it teaches and promotes alternative medicine practices, healthy eating, and traditional ways of using natural resources. Although all of them share their unique values, histories, and practices, they share many similar core values and traditions surrounding health and wellness. The philosophical foundation of traditional knowledge for the Canadian Indigenous people revolves around a holistic model that recognizes the intimate interconnectedness between the person, the kinds of foods they eat, their environment, health and healing, as well as the influences of their specific lifestyle choices. Therefore, a framework that encompasses traditional knowledge and perspectives of health is essential when addressing the First Nations health promotion towards improving the health and quality of life of the Indigenous peoples (National Aboriginal Health Organization, 2008a).
Traditional knowledge and healing

From a Canadian Indigenous perspective, holistic health care is an integrative approach that seeks to balance the mind, body, and spirit and align it with the interests of the community and the environment. Healthcare specialists that seek to address the health needs of Indigenous people are required to bring non-Indigenous (Western) medicine full circle to the way it was traditionally practised. The First Nations Traditional medicine emphasizes the basic spiritual principles of compassion for others and for the self. The incorporation of traditional knowledge into models of health, in one dimension, incorporates the more traditional foods into the diet, while also focusing on whole foods and eliminating or reducing the intake of processed food items. This is primarily accomplished by bringing one back to a more traditional form of diet. The belief is that the land is sacred, as is the resources in which it provides. Therefore, it is reflected in the teachings of these communities to respect the land because it is the land that provides them with nutrition through gardens, fishing, hunting, trapping and gathering (National Aboriginal Health Organization, 2008a).

Some First Nations people follow the medicine wheel as a traditional teaching regarding their health and wellbeing. The medicine wheel includes various components that recognize the physical, emotional, intellectual, and spiritual aspects of a human being. All of these areas are connected to Mother Earth and focus on balance. When one area is not working as well as it should work, the other areas are also affected. The First Nations’ knowledge stems from the Elders’ understanding of peoples’ needs using the Earth’s gifts (Fletcher, 2003). Uniquely, the First Nations’ cultures are based on their beliefs about the earth, and its flora and fauna. This knowledge is the cornerstone that helps maintain their identity and determines what is passed on to future generations. Further, the lived experiences are central to the First Nations knowledge and are a part of how the information is processed and shared. Storytelling is also a vital aspect of keeping the Native culture alive, in terms of knowledge transmission, as was vital to the cultural survival of ancestors.

Language is also recognized as a vital aspect that helps maintain the traditional knowledge. Over time, language has adapted to changes in the world; however, among many First Nations languages, there are traditional words that do not as easily translate to any other language and thus, their meanings can be learned and passed on only through their specific ceremonies,
cultures, and crafts (National Aboriginal Health Organization, 2005). Language is integrally linked to the Indigenous traditional knowledge and practices. Without the continuance of language, a people’s relationship with the land with which they live, their health and well-being, and culture and traditional practices are compromised, as the means of transferring the complexities of Indigenous knowledge is lost. Although there are many differences amongst communities in specific traditional practices, medicines, and means of knowledge transmission, the conservation of language is identified as the core component in terms of sustaining the Indigenous traditional knowledge and healing.

Indigenous traditional views of health incorporate the knowledge of healing and wellness that emphasizes the individual necessity of seeking harmony within the self, with others, and most importantly, with the environment. Furthermore, an active relationship between the physical and spirit world is strongly valued, along with the importance of seeking harmony and balance within both these worlds. More specifically, in terms of the Indigenous traditional knowledge regarding psychological distress and trauma, healing strategies focus on confronting the internal damage and wounding of the spirit that is caused by colonization in the external world. Furthermore, Duran (2006) recognizes this collective damage that has existed in the physical destruction and extermination of the Indigenous people’s culture as well as the damage this has caused to the spirit, as the “soul wound”. Further, he also emphasizes that “psychological healing and treatment processes need to include the journey of the trauma from past to present in terms of understanding the impact of the soul wound on psychological functioning” (p. 27), within a framework of traditional healing.

In terms of psychological wellness and healing from a traditional knowledge and an Indigenous perspective, Indigenous healing traditions are recognized as being important to the psychic processes of healing in the context of relationships and the four constructs: of (1) spirituality (creator, mother earth, great father); (2) community (family, tribe); (3) environment (daily life, nature, balance); and (4) self (i.e., passions, thoughts, and values). However, it must be recognized that all aspects of relationship and spirituality are identified as being the core values and are at the foundation of Indigenous healing traditions (Portman & Garrett, 2006).

The incorporation of traditional knowledge into the current dominant models of health is not only crucial but it is also integral to the overall health and wellbeing of Indigenous people at a
global level. Furthermore, since the traditional knowledge and medicines have been used by the Indigenous peoples for thousands of years and have been passed on through many generations, the knowledge and medicines become crucial to health and survival at a global level for the Indigenous peoples, as well as on an individual cultural and community scale. The World Health Organization (2013) has defined traditional medicine as:

The sum of knowledge, skills, and practices based on the theories, beliefs, and experiences; Indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness (p.15).

Traditional knowledge, in terms of traditional medicines, is shared through various ways such as exchanging the cultural and traditional information; for example, from storytelling through the sacred knowledge keepers such as Elders and Healers and passed down in sacred and traditional ways (National Aboriginal Health Organization, 2005).

In the past, many ancestors of today’s Indigenous peoples followed some distinct protocols, customary laws and social conventions that regulated their social behaviour. This also included specific protocols that informed people how to obtain objects, such as medicines, through various stories and ceremonies. With the European contact and the dominant colonial rulings that followed, many First Nations protocols were overshadowed, abolished or forgotten. Central to the consequential impacts of colonialism, traditional knowledge and medicines were viewed poorly and were considered to be substandard. As a group, as the Indigenous peoples continue healing themselves from the lasting traumas associated with colonization, the importance of the rules and protocols for the Indigenous traditional knowledge has become a concerning issue for maintaining and rebuilding the various Indigenous cultures (National Aboriginal Health Organization, 2005).

Healing and the current modes of health care, traditional medicines and practices continue to remain an important part of the lives of Inuit, Métis and the First Nations people in Canada. A report conducted for the Ontario Women’s Health Council in 2003 indicated that of 276 Indigenous women respondents, 72.1% reported consulting traditional Healers and 42% sought out the services of medicine people (Ontario Women’s Health Council, 2003). Even in an urban setting, a significant number of Indigenous peoples tend to access the traditional medicines.
According to the 2001 Aboriginal Peoples’ survey, about 34% of the Indigenous people living in urban areas had access to various traditional medicines (Statistics Canada, 2003; Statistics Canada, 2004).

For the Indigenous peoples living in Canada and around the world, the inter-relationships between the physical, mental, spiritual, and emotional aspects of being are integral to the individual and community health. This holistic view is being acknowledged and accepted by the mainstream health community at an ever-increasing rate. This view is often described in relation to the non-medical, or social determinants of health, such as education, housing, socio-economic status, and social capital. This is differentiated from the bio-medical concepts of disease and health, as is often the case in Western health. This model postulates that the medical model is not necessarily an effective system for disease prevention and public health factors for the various Indigenous populations. Culture and ethnicity are among the key determinants of health, which has now received recognition by Health Canada (National Aboriginal Health Organization, 2008a).

There is an increasing recognition of the value of the Indigenous traditional knowledge and practices and the potential contribution to increasing the health and wellness of the First Nations, Métis and Inuit peoples in Canada. There is a range of national, provincial and territorial health policies, strategies and initiatives in Canada that are supportive of this. The province of Ontario, for instance, has incorporated an Indigenous Healing and Wellness Strategy that funds four major types of initiatives, i.e. the community wellness workers, crisis interventions teams, health liaison and health outreach - as well as specialized projects such as healing lodges, treatment centres, and Indigenous health access centres (National Aboriginal Health Organization, 2008a).

From an Indigenous perspective, wellness and mental health are directly related to the balance and harmony within the individual. This can be demonstrated through care and compassion for one’s self as well as one’s community. Incorporating the Indigenous paradigms, traditional knowledge and healing methods are quite important in mental health service delivery, as many First Nations people in Canada wish to return to their old ways of lifestyle. This is important as many value the cultural teachings and healing practices (Svenson & LaFontaine, 1999). Furthermore, the Indigenous peoples’ experience of the trauma of having their traditional ways exiled from their communities has led to many of the psychological difficulties and traumas that
have historically and currently been experienced by the Canadian Indigenous peoples. Therefore, reconnection to language and culture may promote healing and well-being when included in the mainstream mental health treatment models.

Traditional knowledge for the Indigenous peoples in Canada recognizes that the health and wellness of the Indigenous peoples are acquired through the balance of the physical, mental, emotional as well as spiritual aspects of the self. Knowledge is passed down through generations and values language as the central vehicle in the transmission of the traditional and conventional ways. Furthermore, the inclusion of value in terms of interpersonal relationships as well as the relationship with the environment is also central to the traditional views of health. As the Indigenous peoples continue to heal from the lasting traumas that have been inflicted on them as a group, the revitalization and reconnection with traditional knowledge has now been recognized as an integral part of the process in the healing journey. It must be recognized, however, that despite the current efforts to restore traditional knowledge in the health of the Canadian Indigenous communities, contact with dominant health institutions that practice from a Western healthcare approach is inevitable. Furthermore, contact with Western health is essential in terms of government healthcare systems and the need for seeking modern medical interventions. Thus, the implementation of a hybrid model that recognizes traditional knowledge and healing strategies within a Western health system can be an ideal move. In terms of trauma-informed approaches, however, it is important to also recognize the ways in which these systems continue to oppress and put many of the Indigenous peoples in a vulnerable spot by making them prone to re-traumatisation.

Traditional knowledge and the Western world

Western approaches and paradigms differ from the Indigenous traditional knowledge in that the Western-based ideologies are rooted in European worldviews with more values placed on academics, science, and literature. One major difference between the Western and Indigenous paradigms is that the Western perspective does not incorporate the lived experiences in the way that the Indigenous paradigm does. The Western thought only places importance on quantitative evidence and numbers, which often views concepts in absolutes, or what is tangible and scientifically proven through the empirical evidence. Furthermore, health and illness are viewed as initiating as a function of the body and its parts. The people, their surroundings (environment)
and their relationships with others, nature and the spirit world, are often not taken into consideration (National Aboriginal Health Organization, 2005). Therefore, when the Western models of health and wellness ignore these components as valuable contributors to health and illness, the traditional Indigenous knowledge is continuously viewed as valueless and inferior to the Western dominate perspectives of health.

The dominant theories and practices of psychology such as with the Western psychiatric epidemiology and concepts of mental health, that inform diagnosis and treatment are particularly problematic when applied to the psychological treatment of the Indigenous peoples. Regarding trauma, in order to reiterate, Western psychology conceptualizes singular episodes of traumatic experiences, such as acute stress or posttraumatic stress as being caused as a reaction of one’s perspective and response to a discrete, singular and identifiable event or experience (American Psychiatric Association, 2013). This goes on to become problematic in the diagnoses and conceptualization of Indigenous mental health and trauma, as the Western European perspectives accounted for in the DSM-V are not inclusive of the group effects of trauma and complex personality-based trauma such as that of forced assimilation/acculturation, oppression and daily experiences of racism, which are commonly experienced as roots to the psychological distress experienced by many Indigenous peoples (Feagin, 2006; Sue, 2010). Furthermore, many of the Western psychotherapy frameworks that conceptualize mental health in terms of assessment, diagnosis and treatment do not account for these cultural differences and unique aspects of the Indigenous community that are influential to the mental health outcomes.

The institution of Western dominant psychology, including various aspects such as research methods, diagnostic nosology, theories, concepts, and applied interventions/ clinical practices have been recognized and experienced by many Indigenous peoples as the currents modes of continued colonization and oppression (Hill, Pace, & Robbins, 2010; Mohawk, 2004). In order to address this cultural and contextual gap in terms of the mainstream psychology representations of trauma, it is recognized that these unique aspects of group traumas must be understood in terms of both the cultural and trauma domains of psychology (Hill, Lau, & Sue, 2010; Tuck & Fine, 2007).

Mainstream psychology practices face numerous challenges in cross-cultural application because of the differences in how people experience and express symptoms of distress.
(Kirmayer, 1989; Kleinman, 1987; Van Ommeren, 2003). The differences in beliefs and practices in other cultures that vary from the Western ways of thinking and differ from the Euro-Canadian concepts of mental health and illness may also contribute to the over-pathologizing and over-diagnosing of people from other cultures, in this case, the Indigenous peoples.

In order to address this issue, understanding and learning other models and concepts, contexts and perspectives of mental illness and distress are important for bridging the gaps in these limitations and promoting practices that are culturally safe and non-harmful (Beals, Manson, Mitchell, & Spicer, 2003; Canino, Lewis-Fernandez, & Bravo, 1997; de Jong & van Ommeren, 2003; Manson, Shore, & Bloom, 1985; Waldram, 2006). Understanding the cultural differences and concepts of distress and mental health can also be incorporated into the mental health practice through revising interviews, questionnaires, and criteria so as to ensure that the relevant dimensions of the distress and illness experience are captured through the appropriate lens (Kirmayer et al., 2009).

In terms of the worldview and conceptualization, mainstream psychology can be quite inappropriate for the Indigenous peoples as it does not embrace the importance of spirituality, community and relationship in the context of the environment, including the shared experiences of others (Battiste, 2007). Therefore, in order for the mainstream psychological theories and practices to be appropriate and/or effective in the Indigenous communities, especially in terms of understanding and treating of trauma, an emphasis must be put on the social context, the spirit, relationships, and strengths of the various Indigenous communities (Hill et al., 2010).

To create and define clear models and best practices in mainstream psychology for Indigenous peoples, it is imperative that the psychological concepts include the unique aspects of both historical and contemporary colonialism; psychological theory. This can be readily achieved if research and practice continue strengthening and reinforcing Indigenous peoples and their capacity for social resolution and social action and how these aspects of governance, and control, especially in terms of the services available, effects mental health outcomes for Indigenous people (Aboriginal Healing Foundation, 2004). Furthermore, besides the mere inclusion of historical and contemporary models of intergenerational trauma in the conceptualization of mental illness and psychological distress, the positive factors and sources of resiliency must also be explored. This is important in terms of understanding how incorporating traditional
knowledge in the treatment of mental health issues and trauma can prove to be healing, especially for the deeply marginalized groups such as the Indigenous homeless people.

Traditional knowledge is overall, the cumulative, shared, and valuable information regarding the history of the people, the ways of interacting and surviving in the environment, as well as relational and spiritual ways of generally being in the world. They are specific to a cultural group and are based on a certain geographical location, its environment and the area-specific values. In general, Canadian Indigenous peoples share a collective holistic worldview that encompasses traditional knowledge that values the land as resourceful in terms of medicine as well as healing. The maintenance of health recognizes a system that honours the balance of the physical, emotional, mental and spiritual quadrants. In the past, as a result of colonization, these traditional knowledge systems were viewed as inferior and were also devalued. Furthermore, the Indigenous peoples suffered significant traumas as a result of this view where the knowledge systems were attempted to be exterminated. This was merely due to the fact that they were viewed as being substandard to the dominant superior European approach to health. Therefore, healing from these past Indigenous group traumas involves a focus on the Indigenous traditional knowledge and the importance of presence and incorporation in the current, mainstream health systems.

**Summary of Chapter 2**

Indigenous people in Canada have endured numerous traumas in the wake of colonization. Its implications, left on families and communities today, are catastrophic and can be observed through poor social determinants of health (education, employment, mental and physical health, addiction, incarceration and homelessness) as seen in many Indigenous communities, on a national scale. Homelessness, particularly, has been noted as being at a state of crisis for the Indigenous people, especially in Toronto. As such, many Indigenous people are migrating from their reserve or rural communities to urban centres in the search for better opportunities, both in economic and psychological terms. When they arrive in Toronto, however, they often find themselves falling into the patterns of isolation, addictions, or just do not utilize the specific services that are available. As a result, they ultimately find themselves in a state of homelessness, disconnected from their communities and culture.

Traditional knowledge is the collective term used to define the different practices and values that exist in every community, band and tribe of Indigenous people in Canada; however, it is not
limited to this view for it is the central aspect of identity, life and culture for the Indigenous peoples and the way of life of their ancestors. As a result of colonization and the various vehicles of the perpetuation of historical trauma (residential school, sixties scoop); many Indigenous people have been disconnected from their culture, from such previous attempts of cultural extermination. Thus, by researchers and community members have now recognised that Indigenous people must begin their healing process with the spirit and reconnect with their culture and traditional knowledge as part of the process of decolonizing.
Chapter 3
Methodology

This chapter describes the methodologies and methods that were utilized in this study and also offers a rational of the reasons that made this specific approach the most suitable one. Moreover, the sampling strategy, recruitment, sample population, data collection procedures, management, analysis and interpretation are described. Ethical considerations have also been described in this chapter, as well as the plan for dissemination of the research results is also described.

Qualitative Research

Qualitative methodologies are designed to enhance the understanding of the lived experiences from the perspective of those who were involved. It is suggested that the quantitative methods that search to find meaning in terms of cause and effect relationships between variables (i.e., surveys, models and instruments) may confine the findings to one paradigm that may lack in both depth and detail (Hoffman, Jackson, & Smith, 2005; Jackson & Smith, 2001). Qualitative methods, however, allow for the flexibility and exploration, which are not defined by the researcher assumptions and are instead led by the narratives and lived experiences of the participants (Patton, 2002). The primary goal of the qualitative research, as described by Bogdan and Bicklen (1998) is to “Better understand human behaviour and experience… grasp the processes by which people construct meaning and to describe what those meanings are” (p. 38).

Qualitative researchers stress the socially constructed nature of reality. The heart of any qualitative research is the intimate relationship that exists between the researcher and context as to what is being studied as well as the situational constraints that shape inquiry and outcome (Denzin & Lincoln, 2003). In qualitative research, the paradigm of focus is that of post-positivism (constructivism), which according to Gall, Gall, and Borg (1996) assume, “That social reality is constructed, and it is constructed differently by different individuals” (p.19). Furthermore, by the views of this paradigm, one would assume that social reality is constructed by the participants involved and is continuously constructed in the local situations over time (Gall, et al., 1996).

Since the scope of methodology inquires a specific social context regarding the unique aspects of political, social, and psychological functioning; qualitative research inevitably becomes the most
appropriate for understanding the life contexts of the Indigenous people. This is important in order to be able to understand any phenomena experienced by the Indigenous people since the Indigenous social context, aspects of psychological distress and trauma are significantly different from those of the non-Indigenous population who may be experiencing the same type of phenomenon (i.e., homelessness). Furthermore, the qualitative research methods are more appropriate with the Indigenous population as the participants are in control of the things they are sharing with the researcher, thereby making the approach of the research less intrusive. This is an important factor for research with the Indigenous peoples, as, in the past, the Indigenous communities were further victimized by many research agendas that did not include them in the process. The research results were also previously analysed and disseminated through the Western perceptions without the Indigenous input, which was often misunderstood and misrepresented by the Indigenous communities. Therefore, these previous research models were viewed as a further source of oppression for the Indigenous peoples.

Social constructivism

Social constructivism is a post-positivist framework of qualitative research that emphasizes the role of social processes and action in the construction of knowledge (Young & Collin, 2004). More specifically, the individuals seek an understanding of the world in which they live and work. As a result, they develop subjective experiences and meanings towards certain objects or things. In this way, the researchers can find complex and varied views that are derivative in multiple meanings rather than in gained knowledge through a single, narrow view.

Furthermore, the meaning of the research data has a social and historical relationship with the others (Creswell, 2003). In this sense, the researchers interact within the context of the research and position their own subjective self as a component; they are, therefore, more concerned with how the individuals perceive their world and their subjective experiences of a phenomenon (Creswell, 1994; Krathwohl, 1998). Although the natural and physical world is conducive to methodologies that search for the truth, the social and human world is distinct and is better suited to the methodologies that respect the possibility of multiple truths (Guba & Lincoln, 1990). Human beings are viewed as engaging in an ongoing process of self-construction and interpreting the world around them; from this point of view, individuals create meaning based on their culturally bound construction of reality (Crushman, 1995; Young & Collin, 2004). This idea
is congruent with the Indigenous traditional knowledge that suggests that there are multiple truths and no single reality (Steinhauer, 2002). This demonstrates how social constructivism in the realms of qualitative research is an appropriate methodology when exploring the lived experiences of Indigenous peoples and how these experiences relate to the larger social context of the overall Canadian society.

**Narrative/Indigenous inquiry**

Social constructivism forms the basis for narrative inquiry and according to Chase (2005), narrative inquiry is “Characterized as an amalgam of interdisciplinary analytic lenses, diverse disciplinary approaches and both traditional and innovative methods – all revolving around an interest in biographical particulars as narrated by the one who lives them” (p. 651). This suggests that narrative inquiry is not a static, standard set of principles that are applied to the research; but is an approach that continues to grow and evolve. This approach is centred based on the experiences of people and the approach can be as diverse as are the experiences of these people.

It has been presented by Chase (2005) that five analytic lenses are utilized in the narrative inquiry methodology; these lenses make this methodology distinctly different from the other forms of qualitative research methods. The first lens recognizes that the narrative method centres the narrator’s perspective in a retrospective manner, incorporating the narrator’s emotions, thoughts and interpretations in such a way that it gives a unique understanding of the individual’s experiences over time. The next lens described by Chase emphasizes that a narrative is constructed to address an audience with a particular purpose and identifies the individual’s experience while taking into account the social context that is involved. The final distinguishing characteristic of the narrative method, as outlined by Chase, is that the authors using narrative methods by interpreting and presenting their studies are themselves the narrators. This suggests that the narrative method involves both the participants and the researchers in the processes of meaning-making and storytelling.

This last characteristic of narrative inquiry is imperative to the research methodology of the current research. Indigenous peoples usually describe and identify themselves as storytellers and many of their traditions and beliefs are embraced and passed on through oral history (Lightening, 1992; Medicine-Eagle, 1989); as a result, given the storytelling traditions of the Indigenous
people, the narrative methodology is an appropriate choice in working with the Indigenous people. Additionally, the congruence between narrative inquiry and Indigenous epistemology suggests that narrative inquiry is both culturally sensitive and appropriate for exploring the lived experiences of the Indigenous peoples. Furthermore, Kovach (2009) explains, “Story as the methodology is decolonizing research. Stories of resistance inspire generations about the strength of the culture.” (p.103)

Storytelling is recognized as a valuable practice for Indigenous peoples that validates experiences and sustains culture in communities (Iseke, 2013). Storytelling has also been recognized as an important approach to research by Indigenous scholars (Archibald, 2008; Kovach, 2009), that enables researcher engagement with the stories and histories of families, communities and cultures (Lewis, 2006, 2011). This involvement connects the researcher in a valuable way to the traditional knowledges of the participants as it connects to the understanding of the research. As a result, the research is located in connection to the storytelling context and as such, cannot be separated or generalized from the context. However, this does not limit the value of the research, as the stories continue to be transferred to others and influence knowledge of Indigenous communities (Iseke, 2013). Therefore, Indigenous storytelling pedagogies encourage broader understandings of identity, community, culture, and relations. This is a valuable in the overall goal of this research study.

**Research Design**

This research explores the rich and unique stories of the Indigenous peoples and how each of their narratives entails of homelessness, trauma and traditional knowledge contributed to the overall themes and results. The depth and detailed focus of the research question required a qualitative methodology that emphasizes co-construction and meaning-making in context. More specifically, as previously mentioned, a narrative orientation is the most appropriate. Furthermore, in the adherence of anti-oppressive based research, community partnerships and ethical principles are integral to the study design, as this research explores the personal and systemic aspects of trauma.
Procedures

This research is part of a larger study by Dr. Suzanne Stewart, who holds a Canada Research Chair in Aboriginal homelessness and life transitions. This larger study comprised of four data sets that include: harm reduction, traditional healing and Elders, Métis traditional knowledges, and trauma. All data was conducted in collaboration with Indigenous community partner organizations.

Participants

For the scope of this research, 16 self-identified Indigenous adults were invited for individual interviews in a large urban centre; all of these individuals are currently homeless or have experienced homelessness or street-related lifestyles at some point in their lives. Gender, class, sexuality, ability or position was no bar for the participants. There were no exclusionary criteria that precluded participants from participating in the individual interviews.

Recruitment

The participants were recruited through collaboration with the community partner outreach team in a large Canadian city. The researcher joined the outreach team, along with an Indigenous Elder. The researcher accompanied regular visits to drop in sites, shelters, and common areas they regularly met with the homeless clients to provide them with outreach services. Members of the outreach team approached known Indigenous peoples and introduced the researcher as well as the purpose of the interview.

The researcher approached consenting participants, introduced herself and provided the participants with the recruitment flyer (see Appendix A) and asked if they would be interested in participating in an interview either at the current time or future date. If the participants met the inclusion criteria of being Indigenous, the researcher discussed the informed consent and the details of the overall study and the interview (see Appendix B). The participant was informed that their participation was voluntary and that they could withdraw the participation at any time. All the participants were given a $20 honorarium in the forms of gift cards at the beginning of the interview (see Appendix C).
Individual interviews

Individual interviews were conducted by the researcher with 16 self-identified Indigenous (First Nations/ Métis/ Inuit) people at risk, currently, or who have experienced homelessness at some point in time. The interviews provided an opportunity for participants to reflect on their stories and experiences of homelessness. The participants were asked the following interview questions: (1) Tell me about some of your experiences of street-involved living or homelessness? What are your key needs? (2) What is your understanding of (First Nations/Métis/Inuit) Indigenous Traditional Knowledge? How would you define it? Please provide some examples. (3) What is the intersection between (First Nations/Métis/Inuit) Indigenous traditional knowledge and mental health? (4) What supports and challenges does (First Nations/Métis/Inuit) Indigenous traditional knowledge offer in addressing the life transition needs of urban (First Nations/Métis/Inuit) Indigenous homeless peoples? Please speak to the dimensions of mental health and trauma. (5) What changes would you like to see in the urban (First Nations/Métis/Inuit) Indigenous peoples with respect to traditional knowledge and mental health services and trauma supports?

The format of the chosen questions, speaks to the overarching research question in a way that minimizes the possibility of the psychological harm. For instance, the experiences of trauma were inquired through querying the current supports available for trauma; the participants were not asked directly about their experiences of trauma. This was further prompted in a way that complimented the first question that asked directly about their experiences of homelessness. The initial narrative provided by the participants allowed the research additional opportunity to query further on the specific experiences of trauma, if the participant chose to include them in their story and how it related to the experienced homelessness. The subsequent questions addressed the personal accounts and understanding of traditional knowledge and the influence on mental health. Furthermore, the participants were given the opportunities to address their own reflections on how the concepts of trauma, traditional knowledge and homelessness interact in terms of the systemic change.

Data Management

Each interview was conducted on a digital recorder and each of the participants was provided with a non-identifiable code. Audio recordings were transferred onto a password protected flash drive that was stored in a locked cabinet at a research office at the University of Toronto. Audio
files were stored separately from the signed consent forms in a cabinet. Each interview was transcribed by the volunteers and research assistants that were supervised by the researcher and Dr. Suzanne Stewart. The transcripts were again coded with non-identifiable labels and were saved as password-protected files on a secure flash drive that was stored in a locked cabinet at the University of Toronto. Following the data analysis, the audio recordings were destroyed.

**Analysis**

Individual interviews were recorded, transcribed and coded using a modified form of the procedures developed by Dr. Suzanne Stewart for her dissertation research (Stewart, 2007) and refined in her subsequent research (Stewart 2008, 2009, 2010, 2011; Stewart & Reeves, 2011; Reeves & Stewart, 2014). Analysis and meaning-making from the individual interviews were conducted within an Indigenous inquiry framework. Interpretative meaning-making involves a subjective accounting of social phenomena as a way of providing insights or clarifying an event and in nature is an inductive way of knowing. Analysis, in this context, involves reducing a whole to the sum of its parts to explain a phenomenon. The qualitative analysis primarily requires groupings of data with the purpose to show the various patterns that build a theory (Kovach, 2009), which, in this research, was referred to as meta-themes.

Kirby, Greaves, and Reid (2006), suggest that within social science research, there is an “Analytical ladder that moves in a linear manner and includes epistemological issues, theoretical issues, contemporary issues, social issues, and lived experiences” (p. 219). The inductive qualitative research utilizes this conceptual framework to organize, understand, and record the obtained data. Analysis, in terms of meaning-making, also includes clarity in terms of who the research will benefit while recognizing the implications of the findings. This also includes the said beneficiaries and the responsibility of the construction of knowledge that has been generated from the research (Potts & Brown, 2005). The process of interpreting and meaning-making within the Indigenous inquiry is less linear than what would be seen in non-Indigenous models of the qualitative data analysis. Working with the story as a means of making meaning requires that the research is presented in its contextualized form. This can be obtained through the thematic coding through the individual research stories presented in the participants’ voices. Therefore, the truths of the stories are held within the storyteller’s life context (Kovach, 2009).
The analysis process began with a verbatim transcription of the audio-recorded interview with each of the participants. The purpose of having verbatim transcripts was to transform the oral interview into a written document that preserves all the natural elements, such as pauses, laughter and crying, considering all meaning delivered from the participants’ story. The second step in the analysis process was inclusive of chunking each transcript into thematic statements by going through the entire document and formatting the interview into a thematic statement that would give meaning to and understand the information provided in the interview. The third step includes the researcher identifying a code to represent the content of each part of the interview. These descriptive codes are used to identify and encrypt in summary what the participant is saying in a more general and cohesive manner. The fourth step involves the interpretation of each descriptive code. This step is where the meaning can be derived from the descriptive codes and summarizes the experiences of each participant in a rather comprehensive way.

As a part of the fifth step, the salient themes that were identified for each participant were placed into a story map in order to integrate the themes of the narrative into a meaningful whole (Stewart, 2008). Each of these story maps consisted of a chart that displayed the major emerging themes on a timeline of the past, present and future. On the basis of the preliminary analysis and the overarching the research question, the participant narratives were further organized by self; traditional healing; homelessness; mental health and trauma; and social service experience. Table 1 demonstrates the presentation of each participant story map.

Table 1

<table>
<thead>
<tr>
<th>Example outline of story map for this project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Story map (P.000)</td>
</tr>
</tbody>
</table>

Past Experiences

Present Experiences

Future Intentions
The final stage consisted of the process of identifying the overarching meta-themes across the participants that were determined as the themes from each individual interview. They were combined in order to identify any overarching between the participant themes. These themes are what contribute to the overall goals of the research as the across participant stories relate to the research question and aptly inform the overall goal of this dissertation. The across participant analysis was completed using a constant comparison analysis so as to derive the overall meta-themes from the individual interviews. The complete analysis process has been described below.

The constant comparison analysis framework was developed by Glaser and Strauss as a framework for qualitative data analysis (Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss, 1987). There are three main stages that compose the entire analysis process using a constant comparison framework (Onwuegbuzie, Dickson, Leech, & Zoaran, 2009; Strauss & Corbin, 1998).

The first stage involved data chunking into smaller units (open coding). For each individual interview, the researcher read the transcript and gave a code to each individual chunk of the narrative. During the second stage, which involved axial coding, the individual codes were categorized into a theme. The individual themes from each participant were then grouped together, which then produced the overarching categories between each individual participant’s narratives. The last stage involved selective coding, where the categories were then identified by the key results (meta-themes) and were further broken down into smaller themes within each of the overarching categories. The themes were analysed again by the researcher assistants to ensure the inter-rater reliability. Below is an example of the coding process of one of the narratives in the given research.

Table 2

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Content</th>
<th>Code</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: So, my first question for you is if you can tell me some of your experiences of street-involved living or homelessness?</td>
<td>It is difficult living on the street for many years. sleep in the shelter or on benches</td>
<td>shelter streets sleep</td>
<td>Housing Streetlife</td>
</tr>
</tbody>
</table>
either that we used to just come inside or XXX would just let us in, and sleep on the benches.

I: So for how many years would you think?

Below is the overall summary of the data analysis process, including within the participants and across participants data analysis using content analysis and a constant comparison model and framework.

Table 3

*Summary of Data Analysis Process*

<table>
<thead>
<tr>
<th>Step</th>
<th>Analysis description</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Verbatim interview transcription</td>
</tr>
<tr>
<td>Two</td>
<td>Chunking transcript into thematic statements</td>
</tr>
<tr>
<td>Three</td>
<td>Assigning descriptive code to each statement</td>
</tr>
<tr>
<td>Four</td>
<td>Create story map for each individual narrative</td>
</tr>
<tr>
<td>Five</td>
<td>Identify core themes within each participant’s story</td>
</tr>
<tr>
<td>Six</td>
<td>Identify across-participant overarching meta-themes</td>
</tr>
</tbody>
</table>

**Ethical considerations**

The ethical approval for this dissertation was sought from the University of Toronto Social Sciences, Humanities and Education Research Ethics Board in the December of 2014 as a part of Dr. Suzanne Stewart’s Canada Research Chair on Aboriginal homelessness and life transitions. It was approved by the ethics board in the January of 2015.

In the past, those who conducted research within the Indigenous communities had little knowledge of the Indigenous traditions and history without involving the community in the process. This only makes it understandable why the First Nations communities are suspicious of
the researchers (Cochran et al., 2008; Hudson & Taylor-Henley, 2001; Marshall & Stewart, 2004; Menzies, 2001). In the past, research was usually conducted in ways that excluded the people it aimed at understanding. In general, an outside researcher would initiate a research project while the community and its members were simply the subjects of the research. The communities were seldom consulted with, and had very little, if any, control over the research process. The OCAP (Ownership, Control, Access and Possession) principles were therefore created to ensure that ethical research was being conducted with the Indigenous communities in ways that promoted the safety of the Indigenous communities (First Nations Center, 2007).

In order to ensure the promotion of the OCAP principles in the results of this project, the community partner was involved in all stages of this project right from the development of the research questions and design, data collection, analysis, all the way to the dissemination of the results. Following a collaborative project that was conducted in 2012 regarding harm-reduction approaches to Indigenous homelessness (Stewart & Teekens, 2013), an Indigenous community organization showed an interest in deepening the understanding of the impact of traditional knowledge in supporting the mental health needs of the urban Indigenous homeless. This doctoral dissertation specifically addressed the needs of the urban Indigenous homeless regarding the intersections of traditional knowledge, mental health and trauma. The results of this project belong to the community partner organization. They will be used to help strengthen the facilities, care and support for the homeless population.

To ensure appropriate ethical practices, this research also follows the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, Chapter Nine- Research Involving the First Nations, Inuit and Metis Peoples of Canada (TCPS, 2014). As indicated, this study is grounded in reciprocity that is centred in relationship building with the community partner.

**Social location of researcher**

The researcher was born into a middle-class Caucasian family with Western European ancestry from a small farming village in South-Western Ontario. Although she grew up neighbouring a First Nations reserve, she was very limited in knowledge regarding Indigenous social issues and the historical context. She first became aware of Indigenous social and health issues as a research assistant at the Addictions Research Centre of Correctional Services Canada when she worked
with the Aboriginal liaison officer who educated her on some of the social and health detriments of many Indigenous communities in Canada.

Since having the privilege to work under the supervision and mentorship of Dr. Suzanne Stewart, she has continued to learn about social and health issues within Canadian Indigenous communities, as well as healing and resiliency. She has also become highly involved professionally and personally in the local urban Indigenous community and has developed relationships with community partners, Elders and community members. The researcher’s own learning experiences have influenced her own identity as a Canadian, causing her to recognize her own privilege both personally and as a researcher and clinician. She will continue to reflect on her own position within these cross-cultural relationships, to ensure ethical and successful research that benefits both knowledge and community/participant needs.

Dissemination

The purpose of this doctoral dissertation is to inform the mental health professionals, educations and other care providers who work with the Indigenous community to meet their mental health needs and who support the Indigenous homeless people. More specifically, the goal of this research is to identify how traditional knowledge intersects with the healing approaches of intergenerational trauma and homelessness. In keeping with the Indigenous ethical principles, this research will belong to the Indigenous community of the participants and will be used to inform programming and policy for service providers who interact with the Indigenous homeless peoples. With the appropriate permissions, these results will be disseminated to academic and professional communities in order to inform the policies regarding best-suited practices for Indigenous health.

Regarding the academic dissemination, Kovach (2009) explains that for Indigenous researchers, there are three primary parameters that must be met prior to engaging in the transfer of knowledge with the audience: (1) findings from the Indigenous research must make sense to the general Indigenous community, (2) schema for arriving at the findings must be clearly articulated to the non-Indigenous academy, and (3) both the means for arriving at the findings and the findings themselves must resonate with the other Indigenous researchers who are in the best positions to conduct an evaluation of the research.
Specifically, for the Indigenous community, the results will help inform the agencies on specific mental health needs and considerations for care when providing the services for Indigenous homeless needs and issues. This research will also focus on the traditional knowledge as one of the strengths that can help promote the mental health and well-being. For the academic community, the results will be published in scholarly journals such as Canadian Journal of Community Mental Health; Society and Mental Health; Mental Health & Prevention; Journal of Psychology and Psychotherapy and presented at scholarly gatherings such as American Psychological Association Annual Convention, Canadian Psychological Association Annual Convention, etc. The Indigenous researchers will receive results by publication in Indigenous academic journals such as the Journal of Indigenous Research; The International Indigenous Policy Journal; the International Journal of Indigenous health.

The knowledge that surfaces from this study will first be used by the community partner organization, in the understanding of the individuals in which they serve to help promote the improvement of these services to address their current needs (i.e., funding support). The results of this study will also be contributing to the literature in terms of the influence that traditional knowledge has on the mental health outcomes for severely marginalized individuals such as the Indigenous homeless people who may have experienced complex traumas. Furthermore, this knowledge will also promote strength-based practices that highlight the mental health influences of cultural connection and how it can be implemented into the theory and practice of contemporary psychology as a process of decolonization and as an anti-oppressive mental health strategy. More specifically, the results of this research will address the calls to action in regard to health, as part of the Truth and Reconciliation commission of Canada (2015) in the Canadian responsibility in reconciling the harms caused to Indigenous communities from the effects of the Indian Act and the Residential School System:

18) We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the treaties.
19) We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20) In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Metis, Inuit, and off-reserve Aboriginal peoples.

21) We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22) We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23) We call upon all levels of government to:
   i. Increase the number of Aboriginal professionals working in the health-care field.
   ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
   iii. Provide cultural competency training for all health-care professionals.

24) We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require
skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism (p. 329-330).

The results of this research will be disseminated in a way that will support and contribute to the overall goals of the Truth and Reconciliation Commission of Canadian calls to action regarding health outcomes for Indigenous peoples. This will specifically include health outcomes related to Indigenous homelessness and influences of trauma resulting from issues related to colonizing, more specifically the impacts lasting from the residential school system. The results will also reflect influences of Indigenous traditional knowledges on overall health outcomes.

As a group, the Canadian Indigenous peoples have always been victimized in terms of deep-rooted, historical traumas that have had lasting effects on the current psychological functioning of Indigenous peoples. One major implication of these chronic and complex factors of trauma is the poor determinants of health that are experienced by many in Indigenous communities. Currently, in many large urban areas, and throughout Canada, homelessness is in a state of crisis within all Indigenous communities.

Since many roots of cultural trauma that involve the bleak social picture that is relative to the cycle of homelessness for Indigenous peoples, traditional knowledge is believed to interact in this process as a protective factor or mechanism of healing for mental health difficulties experienced by the Indigenous homeless people. Therefore, the primary goal of this dissertation is to inform the psychological perspectives and practices of trauma for Indigenous peoples who are currently experiencing or have experienced homelessness.

**Summary of Chapter Three**

Chapter Three presents the methodology that was used in this study. Theoretical approaches to qualitative research that were used in this study, such as social constructivism and Indigenous narrative inquiry were also described. The research design was outlined as per the Indigenous ethical standards; including recruitment, participants, cultural considerations as well as the appropriate data storage. The analysis process was also described in great detail. The following two chapters present the findings from within the participant narratives and the across participant results, which were described in the current chapter.
Chapter 4
Within-Participant Results

Chapter Four presents within the participant results including a summary of each of the participant’s narrative. The analysis is presented through the means of an individual story map and how the narrative corresponds to time as a function of the research question (i.e., how individual experience relates to traditional knowledge, homelessness, mental health and trauma). These summaries include a character sketch for each participant, including aspects of their stories as well as their overall experience shared in the interview. For each participant, the core message is presented as the predominant theme in meaning-making of the narrative. This is further described by the various themes that have emerged throughout the individual narrative. The core message and themes are presented and described using descriptive quotes. Other dominant ideas within the data of the participant’s story have been included within the individual story maps. The representation of the participants is in the same order in which they were interviewed.

Participant 145

Narrative summary

P.145 was a 35-year-old woman who was currently living in an apartment; however, she was about to lose her home as a result of failure to pay the rent. P.145 identified myriad early traumatic experiences. She explained that she first became homeless when she left her home in a small town in Canada and moved to a large Canadian city in order to escape an abusive relationship. She indicated that upon moving to a large Canadian city, she experienced a significant loss (the homicide of a loved one) and thus began to have mental health issues. She subsequently became homeless for approximately five years. P.145 shared that she used to be a teacher prior to going through this experience and was unable to continue teaching, given her mental health issues.

Since her arrival in a large Canadian city, P.145 has attended numerous healing circles that are offered by the Indigenous community. She noted that being in the presence of an Elder makes her feel calm and healed. She also noted that it was helpful to be connected with other Indigenous peers with like experiences, as there are an underlying understanding and support.
She noted that talking circles facilitated by an Elder are important in terms of the Indigenous connection in an environment free of judgment and full of empathy.

Table 4

*The World of Participant 145 from Individual Interview*

<table>
<thead>
<tr>
<th>P.145</th>
<th>Self</th>
<th>Tradition al Healing</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was a teacher</td>
<td>Indigenous people are family to each other</td>
<td>Homeless for 5 years; living on the streets and in shelters</td>
<td>After death of her ex, illness contributing to the drastic change in life course</td>
<td>Being connected to Indigenous services has helped overcome life transitions</td>
<td></td>
</tr>
<tr>
<td>Moved away from her home</td>
<td>Lives by the seven grandfather teachings learned as a child</td>
<td>Difficulty and frequent contact with police</td>
<td>Domestic abuse and violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother to two boys</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of friends and family</td>
<td></td>
<td>Homeless because escaped violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiences of oppression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Present Experiences** | | | | | |
| Respect for everything around you | Indigenous Knowledge attributes to self | Hardship in steady housing | Peer Connections | Living to support workers and facilities |
| Stigma of mental illness and physical capability | Circle helps with mental health | Financial instability | Support, inclusion, awareness of upholding knowledge | Comfort with shelter workers |
| Elder support/ guidance | Witnessing violence on the streets | | Women’s group | A lot of workers and agencies willing to help |
| Part of Indigenous community | Sense of community among Indigenous homeless | | Not feeling safe in housing | Employment services and job finding |
Core messages and themes

The core message derived from P.145’s narrative was that relationships can have a healing effect. For participant 145, she felt that the support from her peers on the street played a major part in healing her mental health issues and provided her considerable support in her battle with trauma. What is healing about these relationships is having the understanding and empathy of other Indigenous homeless peoples with shared histories who have the ability to relate to the colonial and intergenerational trauma, racism and discrimination. For example, she stated: “Honour and respect, you treat your friend with respect right, and if anything, you honour them too; because we have lost a lot of Native people.” Further, she stated:

[Talking] actually helps, because you’re releasing things and everyone is going to experience your pain too, you know. Everybody listens, it’s actually good to be around a
circle of friends, you know what I mean and being able to tell your feelings without feeling ashamed… We help each other out, because we need the circle and that helps, because most of us do have mental health issues.

Relationships with Elders and other Indigenous community members were cited as being key factors in the process of healing from mental health and trauma challenges in that they provided cultural resources such as ceremony and traditional teaching, which helped her to get in touch with her cultural identity as an Indigenous woman. She stated:

“[Elder] comes down here every Wednesday, we do our smudging and everything like that, everyone has a chance to speak and we just tell all in our heart… The Elders help you out because they have been through that life, and they’re probably either recovering addicts or stuff like that. They are just trying to spread the word, saying what you’re doing right now, it will affect you in the long run. It’s helpful and supportive.”

She also recognized the symbiotic relationship with the Elders’ support within the community and the importance of their presence for preserving the cultural values and for the general survival of the community. She stated:

“That’s our Elders, they help us out, and we help them out. When they are in need, we’ll help them. You know it’s like a few of them are in walkers, some of them are in wheelchairs, but you know what I mean, help them out and they’ll help you out.”

Having a strong relationship with the service workers was also recognized as an important aspect of healing and getting support when one is dealing with mental health issues, trauma and homelessness. For instance, she stated:

“They [homeless with mental health issues] need a good follow-up worker to advocate for them… My worker comes here once a week and she chills with me for hours. I have known her for quite a few years now. Then I ended up having her as my follow-up worker after care. So yeah, they help out a lot.”

The themes were identified as trauma, lack of safety and stigma. P.145 described her experiences of trauma, the lack of safety that she continually feels as an Indigenous woman living on the
streets, and the experiences of mental health stigma as being the key factors in her overall experiences of homelessness.

**Trauma**

The experience of trauma was recognized as a strong indicator of homelessness and mental health issues, as many Indigenous homeless people have experienced and endured trauma to some or the other extent. P.145 noted that it was her trauma history that connected her with many of her homeless peers. She explained these aspects of trauma, relationships and healing in the following words:

I went through a lot, way too much. That’s how come all the older people like talking with me because I went through so much. They can relate to that because they even never experienced that in a lifetime for themselves, and they are like 50-60 years old.

The challenges that P.145 experienced due to the trauma history were also described, as was described how the relationships and connections with other Indigenous peoples can be helpful towards healing. She stated, “I just kind of broke down, all the shit I have been through. I just kind of, that’s how come I like coming here for the circle and stuff you know.”

**Lack of safety**

The concerns of safety and wellbeing were recognized as a negative factor in the experiences of the homelessness lifestyle. P.145 recognized the high risk of re-traumatisation and unsafe conditions for an Indigenous homeless woman. For instance, she described some of the experiences she had in the shelter system:

Having fucking crack dealers coming to my door, and it’s just like, ‘she don’t live here, she lives down the hall,’ you know what I mean, she moved out of this place; this is stressful.

P.145 further described the risk and lack of safety that she experiences on a regular basis when living on the streets. For example, she noted: “Living on the street, I almost got raped and stuff like that, it’s bad.” The theme of safety recognized the high level of stressors that exist for someone experiencing street-involved living, especially for Indigenous women.
Stigma

Another general theme for P.145 was the feeling of stigma as it is experienced by many homeless individuals, particularly those with mental health issues. She indicated that stigma and discrimination was a primary concern in many of the services that she encounters from time to time. For example, she stated:

When they see me come in there [ODSP office], they are just all different toward me; because what, just because I have some mental health issues… Just because you are a recipient, and they just treat people with mental health issues really bad, wrongly.

Table 5

<table>
<thead>
<tr>
<th>Core message</th>
<th>Relationship is Heating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trauma</td>
</tr>
<tr>
<td></td>
<td>Lack of Safety</td>
</tr>
<tr>
<td></td>
<td>Stigma</td>
</tr>
</tbody>
</table>

Participant 146

Narrative summary

P.146 is a 45-year old man who has been living on the streets for an approximate period of 15 years. He moved to a large Canadian city at the age 15 and was educated in a Catholic school. He summarized his overall experiences of homelessness as being pleasant, but at the same time, also challenging. He identified as being an alcoholic for many years and admitted to having used alcohol as a coping strategy for many of the stressors and traumas that he experienced, both before and during his state of homelessness. He shared that he had only recently lost his mother and had been having difficulty coping with that fact; however, he further identified himself as a survivor.

P.146 shared that he did not grow up learning the Indigenous ways and has learned a lot about traditional knowledge and Indigenous culture from his homeless peers who were also Indigenous. He indicated that he currently practices an Indigenous way of life and respects all the things and people. He noted that he is grateful for the life that he is enjoying.
P.146 described racism as being a large barrier to seeking the supports that he needs. For instance, during the interview, he became tearful at one point when he was discussing racism and stated that he was even surprised that a White woman was speaking to him, let alone asking him what he needs. He noted that housing is the first concern in terms of recovery and that there is a need for more supports that serve the Indigenous homeless people to deal with their issues of substance abuse as well as suicide response and prevention. Furthermore, he recognized hope, connections and mutual respect with his community as being the primary contributing factors in his strength and resiliency.

Table 6

The World of P.146 from individual interview

<table>
<thead>
<tr>
<th>P.146</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td>Experiences of criminal activity for survival</td>
<td>Indigenous identity</td>
<td>Many years of homelessness (10-15 years)</td>
<td>Years spent in criminal justice system (i.e., prison)</td>
<td>Shelters are expensive and have long waiting lists</td>
</tr>
<tr>
<td></td>
<td>Educated in Catholic school</td>
<td>Experiences of racism</td>
<td>Living on the streets as a choice</td>
<td>Multiple losses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family disconnect and regret</td>
<td></td>
<td>Would rather live on the streets than in the shelters</td>
<td>History of violence</td>
<td></td>
</tr>
<tr>
<td><strong>Present Experiences</strong></td>
<td>Self-respect</td>
<td>Respect for everything and everyone around you</td>
<td>Connections with homeless peers</td>
<td>Indigenous medicine as healing and spirituality</td>
<td>Poor living conditions in shelters. Would rather be outside</td>
</tr>
<tr>
<td></td>
<td>Identifies as a survivor</td>
<td>Living on the land like ancestors</td>
<td>Being hungry and cold are biggest challenges</td>
<td>Alcohol used as maladaptive coping with trauma</td>
<td></td>
</tr>
</tbody>
</table>
Core messages and themes

The core message derived from P.146’s narrative was that he was attempting to cope with the myriad challenges and stressors that had contributed to his state of homelessness, as well as those that exist as a factor of homelessness. He indicated that homelessness can be challenging, however, coping with the environment is crucial for survival. The themes identified in P.146’s narrative regarding homelessness were his experiences of racism, engagement in spirituality and the experiences of loss.

Coping

Being able to cope with some of the environmental aspects of homelessness was also identified as a major stressor. He noted that this is especially true given the state of some of the shelters, particularly in the large Canadian city where he was. He noted that he would rather choose to cope with the harsh factors of the external environment (i.e., weather and lack of shelter/safety) than being confined to the poor living conditions and difficult environments that are generally experienced in a shelter. For example, he stated:

[Being homeless is being] hungry and cold… Some places you go to, it sucks more than being homeless. Not even the shelter; I never go to shelters, hell with that, that’s worse
than hell. I’d rather be outside because you are free. I am not stuck in some of those bug infested, mouldy places and stuff like that. Some of the places you rent, it’s worse than hell. I’d rather sleep in fresh air and freeze to death.

P.146 discussed the inner strength and resiliency that he had been able to gather about him in his personal journey of coping with trauma, loss and the experiences of homelessness. He recognized that his perspective has helped him survive and cope during some of his most difficult times. He stated:

Yeah, I’m a survivor, where I sleep, I sleep… Where my head goes, my head falls. I sleep and I don’t care what anyone thinks… Honestly, I don’t care. I’m still a survivor, forty-five years old, and I don’t care… because I know I could survive out there.

P.146 also discussed some of the negative aspects of being able to cope with homelessness and finding different ways to survive. He mentioned criminal activity and violence as being the mechanisms that are necessary for survival when living on the streets. For example, he stated:

I’d rather sleep on the street, but I heard they’re going to cut us off. Well then, I’ll decide to go back to being a criminal, and I hate doing time. Shit happens in this life. Criminal activity, I don’t like it. I don’t even like violence. I learned the hard way of hell… I am too old for that shit. I hate running. I’d rather walk free and proud.

He also mentioned the values and personal perspective of life that influenced his experiences of homelessness and helped him cope with some of the challenges. He noted that this could greatly influence his ability to survive the hostile homeless environments, as well as the influences of outlook, perspective and attitude on overall health and well-being. For instance, he stated:

Basically, anyone who’s walking on this earth, depending on your mind and your concept of life… Here happy go lucky or just pure angry, angriness causes disease, heart attack and shit. Me, my glass is half full, I laugh, sure I cry, but some sorrow, but not suicidal or anything like that.
Racism

Experiences of racism were identified as being a significant factor in the domain homelessness and mental health of the Indigenous people. Racism was acknowledged as being an aspect of P.146’s identity; it was a strong component of his current mental health, and it appeared to be well-embedded in his past experiences. He shared his personal plight with racism. For instance, he stated:

If you don’t have respect for man, got no respect for yourself. That’s why people kill themselves. I am a very deep man, I respect. You are making me tear up. It is called dignity and humanity and the Charter of Rights and such. I read that sucker, it is the government trying to put me down. They are doing the wrong thing, they are taking you down, because of your colour, the skin, is who we are. I am doing nothing, I just walking down the road.

He further demonstrated racism as being a major hindrance in his attempts at connecting with the service providers and building trust in them. He recognized that a person’s previous experiences of oppression and racism can create barriers toward trusting those who are providing services, especially the non-Indigenous peoples. For example, he stated:

People are racist and biased. That’s the biggest challenge because the colour of the skin and the way you look. I am surprised a White woman is talking to me because they look at me and they loathe me… They think I am a damn ass criminal… They always look down to you, I am here man, I am fucking human. That’s what it is, racism.

He also asserted that racism was embedded in his experiences and identity from a young age. He noted that racism is experienced by the young people in the Indigenous communities well before they have even begun to understand what it means; therefore, it can have a large impact, particularly in a healthy emotional development. For instance, he stated: “The day I was born, every damned day I was called a damn Indian. So what, I was born poor, we are all poor, we weren’t born rich. We were just kids. Racism is the bottom line.”
Spirituality

Spirituality was a theme that recurred in terms of mental health, resiliency and hope in the narrative of P.146. Having a sense of connection to culture was recognized as being a strong aspect of identity and a positive influence toward health and wellness. For example, P.146 discussed how the aspects of his spiritual self, helped him to cope with some of the hardship of being homelessness. This was further recognized as strength and sense that fostered resiliency. For example, he stated:

Spiritual, heart-warming and such. It gives me inspiration of life. Look at the sun, the moon, the stars… but they [society] are polluting our world. Don’t talk to Indigenous about that. They are killing our mother earth.

Spirituality was also recognized as being a healing factor. Engagement in cultural practice and spirituality was demonstrated as being healing and beneficial towards tending to emotional wounds and traumas. He noted that it was particularly helpful to be engaged with the other Indigenous peoples who have shared experiences. He noted the strength that lied in talking and sharing with the community. For example, P.146 stated:

Every Wednesday there is spiritual closure, how to let your emotions go. They smudge… you cleanse yourself because you talk, let your emotions go such as, you talk it out to someone.

He also recognized spirituality, engagement in cultural practice and connection with traditional knowledge as being healing by stating:

I think Aboriginal will be the best medicine for any man, woman or child on this earth, even an animal… It’s more spiritual… You know why? Because you got to believe in something. The other one is just written. They believe in the creator and such; but it is in the heart, not reading. It comes into you, like inner spirits.”

Loss

Experiences of loss and grief were identified and were thematic in the narrative of P.146. Addictions and loss were recognized as being closely connected, where addictions were often used as a coping mechanism for dealing with the current and past losses. For instance, he stated:
“My hands are dirty bloody, that from falling. I drink a lot, to kill the pain. My mother died this month.”

He also recognized experiences of loss within the homeless community, and the prevalence of death amongst peers, which was a direct result of the homeless lifestyle. He stated:

I have lost a whole bunch of friends… about 60-70 people give or take. All my good friends, men and women; even kids. Fire, accidents, I am going through hell in a handbasket but I am still here and I am optimistic if the glass is half full, it is full, so let’s put more whiskey in there.

A sense of cultural loss and grief was also recognized as being a factor in emotional difficulty, especially from the loss that occurred early in life. He recognized that as an adult, cultural engagement as an adult, for example, learning his language as being a positive coping mechanism that helped him deal with the loss and encouraged growth as well as cultural reconnection. He stated:

I may not know much about Indigenous from my own people like I told you, I am Roman damn Catholic. So I learned the White man way… My mother did not teach me my language.

Table 7

<table>
<thead>
<tr>
<th>Participant 146 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core message</td>
</tr>
<tr>
<td>Finding ways to cope</td>
</tr>
<tr>
<td>Themes</td>
</tr>
<tr>
<td>Racism</td>
</tr>
<tr>
<td>Spirituality</td>
</tr>
<tr>
<td>Loss</td>
</tr>
</tbody>
</table>

Participant 147

Narrative summary

P.147 moved to a large Canadian city at age 18 from a Northern Canadian community in order to find and create a better life for himself. He shared that in his growing up age, there was a lot of alcoholism and violence in the home and that he spent a lot of time in the criminal justice system as a youth. He indicated that he has had a lot of issues with substance abuse, which influenced
his street-involved lifestyle and experiences. He noted that the addictions often precede the basic need attainment, making the basic survival difficult. This was recognized as a major hindrance in his attempts towards achieving housing. He further noted that he continued using substances while living in a large Canadian city; however, it has improved since becoming connected with his culture. For example, connecting to his culture and community helps him to stay engaged with programmings such as Indigenous-based rehabilitation programs and Alcoholics Anonymous.

P.147 described his difficult transition from the reserve life to an urban centre. He noted that the reserves operate as if they are lawless; this kind of lifestyle differs from a large city, in the frequent contact that Indigenous homeless have with the police and the corresponding racism. Regarding mental health and trauma, he was recently diagnosed with Posttraumatic Stress Disorder and recognized that coping with PTSD symptoms can be difficult while trying to survive on the streets. For instance, dealing with constant hyperarousal, paranoia and intense emotional/physical stimulation can trigger risky responses. He shared his difficulty in accessing Indigenous services, as he previously worked within the agencies. He also noted that this was a humbling experience as it was helping him to appreciate the work he had done in the past. He noted that it gives him hope to change to be able to help others in the future.

Table 8
*The World of Participant 147 from individual interview*

<table>
<thead>
<tr>
<th>P.147</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
</table>

**Past Experiences**
- Previous employment with the community
- Moved from Northern
- Grew up hunting on the land
- Living on the land- being part of the environment
- Many years homelessness due to substance use
- Substance use over housing
- Dependence on substances impacted basic need attainment

- Has been on social assistance for three years
The core message derived from P.147’s narrative was oppression of the Indigenous people. He indicated that homelessness was a factor in the oppression that was experienced through a community to [large city] In and out of jail as a youth

<table>
<thead>
<tr>
<th>Present Experiences</th>
<th>Lack of transferable skills in finding employment</th>
<th>Connection to culture as healing</th>
<th>Adjusting from reserve life to city policy is difficult (interactions with police)</th>
<th>Adjusting to city environment as stressor</th>
<th>Systemic racism experiences in many social services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Currently working for Native organization</td>
<td>Cultural practices as deterrent to substance use</td>
<td>Always have guard up/defensiveness for survival. Makes it hard to connect with others</td>
<td>Brother a current strong support</td>
<td>Shelter system feels like being in jail</td>
</tr>
<tr>
<td></td>
<td>Recent PTSD diagnosis</td>
<td>Attending pow-wows; drumming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cultural traits making one more vulnerable to mental health issues</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future Intentions</th>
<th>Continue to be a strong advocate for Indigenous community</th>
<th>Continue to learn more about self and culture</th>
<th>Would like to remain in housing and stay off the streets.</th>
<th>Activism and learning about culture as healing</th>
<th>Authority figures and police need to be trained on Indigenous issues/health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provides a strong sense of purpose</td>
<td>Native Rehabilitatio n program</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Core messages and themes**

The core message derived from P.147’s narrative was oppression of the Indigenous people. He indicated that homelessness was a factor in the oppression that was experienced through a
societal failure. This exists for many Indigenous people, in that they encounter a glass ceiling effect in terms of their capability to survive and thrive in a society that limits and marginalizes them. The themes identified in P.147’s narrative include systemic racism, community connections, and culture as healing.

**Oppression of Indigenous peoples**

Oppression and marginalization was the overarching message that seemed to be embedded in P.147’s narrative, regarding Indigenous homelessness. He noted that systemic factors, such as the lack of opportunities in communities make it difficult for one to thrive. He further noted that systemic issues and the oppression of Indigenous peoples are a couple of factors that are passed on through the generations. This oppression was noted to be prevalent in many reserve communities, creating a vicious cycle of poverty, trauma and lack of opportunities. For example, he stated:

> I’ve been on disability for about three years. Some of it has been a trap in a way because you kind of have access to addiction through the assistance. Somewhere in between I just didn’t function proper and look after myself properly… I think it was a lot of unresolved, not being able to let go. I had three families that fell apart because of drugs and alcohol use. Then I came from a Northern community in a Canadian province and it’s not much employment… and growing up, you grow up with alcoholism. You grow up with violence. I left there purposely to find- trying to stay out of jails and institutions because I did time when I was a youth and young adult.

**Systemic racism**

The aspects of racism as a function of systemic oppression and colonialism were thematic in the narrative of P.147, as he identified a significant aspect of ongoing barriers to systemic racism throughout the institutions limiting Indigenous people. These prevent the Indigenous peoples from being able to thrive, especially when they grow up with the models of maladaptive coping and influences of poor determinants of health, which can be said to be a lasting effect of colonialism. For example, P.147 highlighted the influence of colonial oppression and systemic racism that exists in the criminal justice system. He stated: “Well I’m currently going through a
court process where um I’ve always been overcharged; 10 times more than a normal person I think.”

P.147 also described the effects of intergenerational trauma and the challenges that occur for many Indigenous people who continually have negative experiences of a system that continues to oppress them. This is particularly the case with their experiences of trauma and homelessness. For instance, P.147 acknowledged his negative experiences with authority figures. He recognized this as a factor of systemic racism and how it has contributed to the ongoing trauma triggers related to his current experiences of homelessness. For example, he stated:

We have different cultural traits maybe, so I’ve got all these charges- I’ve always had like authority figures you know that got me like this- in this state because of my young life. Just being in this type of environment with men only- in a men’s shelter- it kind of reminds you of jail you know because you see the different characters. You got to put up with them because I need somewhere to stay. It’s for my own mental health that I choose to stay here right now.

Community connections

Community involvement was recognized as an important aspect of decolonizing homelessness for the Indigenous peoples. P.147 highlighted the importance of community involvement and bringing about policy changes in the Indigenous communities and the greater society at large in order to encourage the Indigenous peoples to begin and further their healing from the traumatic memories of colonial oppression, which could be achieved by building community as the strength. He stated:

I went and I started educating myself about the politics and the plight of our people and why they are the way they are by going to rallies. Activism and learning about the social way that other people manage and function under what happened to them in the municipality or like in the city. Then different rules apply to different types of land.

Culture as healing

Colonial trauma was recognized as a major mental health factor by P.147. He said that the Indigenous peoples experienced extenuating traumas through the years of systemic oppression.
To revive and heal from these and such injustices, the Indigenous peoples need to come together and engage in conversations and exchange of information as a community. He noted that engagement in culture is healing in moving forward toward a change in promoting a societal system that embraces and encourages autonomy and connection in the Indigenous community. Furthermore, the communities’ cultural engagement is, in itself, a part of the decolonization and healing process. For instance, he shared:

You know, that’s culture- part of our way of living, living with the environment. Interacting and going camping and all those things that I was comfortable doing and relocating to the city. I didn’t know what to do. Kind of shocks you, you know. Then picking up the same old habits too and doing the same old revolving door- being institutionalized you know- becoming the third one being locked up the first year. Then I got immersed into the culture; I took up powwows and the big drum. That took me to different places that I never would have went if I didn’t.

Further, he also shared the importance of community connection and cultural engagement. He noted that this occurred through the spiritual strength and togetherness as a form of healing from systemic oppression and promoting a sense of cultural continuity and engagement. He stated:

You know maybe because I never give up- I believe in prayer you know so maybe somebody out there- my family, loved ones; they are always into that. Two nights a week now I am back into drumming- that’s something that helped me turn my life around, so it’s almost like a full circle you know. I am getting there.

Table 9

**Participant 147 Results**

<table>
<thead>
<tr>
<th>Core message</th>
<th>Oppression of Indigenous Peoples</th>
<th>Systemic racism</th>
<th>Community connections</th>
<th>Culture as healing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Themes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participant 148

Narrative summary

P.148 was a 30-year-old man and had been living on the streets since the age of 15. He mentioned that he is Indigenous on his mother’s side; however, he was not raised in the presence of other Indigenous peoples. He shared that he was informed of his Indigenous heritage later in his life and had had difficulties obtaining a status. Nevertheless, he began learning his Indigenous culture from other Indigenous homeless peers. He shared his early experiences of loss and trauma with subsequent mental illness as a factor in his journey towards becoming homeless. For example, he has experienced anger and mental health issues due to these losses and engaged in criminal activity and substance use as a means to cope and survive. He noted that he had been in and out of the criminal justice system for most of his youth.

P.148 shared his experiences of the shelter conditions and indicated that he generally chose to sleep outside. He noted, however, that he was vulnerable in terms of his personal safety when he was sleeping outside. For example, he shared that many homeless people who sleep on the streets were at risk for being robbed, especially when they had no fixed address to be able to deposit their money into a bank account. P.148 also described a street ethic in regards to safety and recognized the importance of community for protection and support.

Regarding services, P.148 noted a sense of internal motivation required for bringing about a change, despite accessibility or availability of the various services and supports. He noted that this applied to traditional knowledge and that Indigenous peoples should have the intrinsic motivation to want to connect with their culture, people, and worldview to be truly engaged and feel a sense of purpose within their Indigenous identities.

Table 10

The World of P.148 from individual interview

<table>
<thead>
<tr>
<th>P.148</th>
<th>Self</th>
<th>Traditional Healing</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Past Experiences</strong></th>
<th><strong>Present Experiences</strong></th>
<th><strong>Future Intentions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumultuous relationships with family members</td>
<td>Learning to trust and respect others</td>
<td>Respect and traditional knowledge gives hope</td>
</tr>
<tr>
<td>Experiences of incarceration and feeling “institutionalized”</td>
<td>Loyalty and respect as being core values learned from culture</td>
<td>Needs a job, but finding difficulty in attaining employment</td>
</tr>
<tr>
<td>Served in the Armed Forces</td>
<td>Streets ethics involved in survival</td>
<td>Hope in receiving supports</td>
</tr>
<tr>
<td></td>
<td>Violence as survival during homelessness Learn to adjust to environment-survival</td>
<td>Thankful for his health</td>
</tr>
<tr>
<td></td>
<td>Early experiences of loss and trauma</td>
<td>Patience and confidence for supports.</td>
</tr>
<tr>
<td></td>
<td>Mental health issues and criminal behaviour as a youth</td>
<td>Employment and housing come together</td>
</tr>
<tr>
<td></td>
<td>Hyperarousal and anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experiences of racism and discrimination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Violence and vulnerability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spirituality as strength</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symptoms of PTSD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty obtaining his status because of government policies-previous lack of resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficult to receive social assistance without an address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experiences of racial profiling from police</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housing comes with motivation</td>
<td></td>
</tr>
</tbody>
</table>
Core messages and themes

The core message that was derived from the conversation with P.148 was that regarding survival. He shared that survival was his primary concern and was at the centre of his experience of homeless. He noted that this was a primary concern in that there were considerable aspects of physical, emotional and spiritual survival. The themes were respect and determination.

Survival

P.148 recognized survival as the core message in terms of safety from both the environmental conditions; emotional survival and resiliency through interpersonal stressors such as violence, as well as while coping with the mental health and trauma; and cultural survival that was immersed in the experiences of the Indigenous homeless peoples. Spiritual survival referenced the unique aspects of colonization and overcoming racism and systemic oppression that the Indigenous homeless face. This included reconnecting with culture as strength in the process of empowerment and healing. For example, regarding the physical aspects of survival and the street ethics that exist amongst the homeless, P.148 stated:

You have to get beaten up a lot and then beat people up; but then after everything smoothens out, it’s just everything, just becomes like smooth, natural, calm... but like anxiety quick solutions and everything is fixed. Now it just comes naturally. It will fall into place you always need patience. But then they get to that, you have to get your ass kicked. Don’t rip people off, don’t lie, don’t cheat, don’t steal, just be real with people you know.

He further described the challenges faced while maintaining physical safety while living on the streets by stating:

You never know, maybe people might- from your high school ten years ago. Oh, that guy, oh you sleep in there? And some people don’t wake up. It is not a joke, people sleep and cover their head when they sleep, sleep in a group, you find like squads. People stick together, nobody is going to steal from each other, but they come and go.”

He further described the emotional and mental components of survival; while describing it, he mentioned that many homeless are facing significant mental health concerns such as emotional
difficulties coping with the previous and current traumas. He noted that survival can become challenging when the aspects of maladaptive coping, such as addictions take primary president over the basic needs. For instance, he stated:

I was on the street since I was 15 years old. I just turned 30… my first offense was 53 armed robberies… you know, 18 months but that was during the time a lot of my family was killed… The drugs are nothing, it’s just the drugs balance, you know what I mean, anybody can do whatever they want. But you got to eat and take a shower.

Respect

A salient theme that emerged from P.148’s narrative was that revolving around the idea of respect. He recognized respect as being a value that had been ingrained from being around other Indigenous peoples. He noted that respect was that aspect of Indigenous culture that he most strongly identified with. The theme of respect continued to emerge when he spoke of his other homeless peers, his culture, as well as his challenges with the authority figures. For example, when speaking about the overall experiences of homelessness, including his homeless peers, he stated: “Perseverance, loyalty and trust. I don’t consider anybody homeless, because even when you live outside you still live somewhere; you live outside, so nobody is really homeless.”

He also identified the lack of respect for Indigenous people, particularly the homeless by many authority figures, such as the police. He further described the oppression that occurs for Indigenous homeless people. For instance, he noted that when one has multiple identities of a marginalized group identity, this can become especially challenging while experiencing homelessness. He stated:

I am Muslim too… Native Muslim… and that, racial profiling, even the police, not like racial profile or status profile, you don’t have a fixed address and then they’re profiling you if you don’t have a tax, payroll, job, they profile you by the skin colour, they profile you.”

Determination

Another theme that emerged from P.148’s narrative was that of determination and resiliency. He indicated that this was a strong aspect of what he was as a person and incorporated a significant
influence on spirituality. He recognized that having such an attitude towards life was quite crucial if one wished to survive some of the physical, emotional and spiritual hardships of being a homeless Indigenous person. For example, he shared:

I had a job… but it didn’t work out; but I can’t complain, I am still alive; I am still healthy. A lot of people they have a disease, it’s not their fault. But I am fortunate enough, with the scars and stuff; that I am clean, my blood is clean.

He also demonstrated his determination and resiliency by stating:

Patience… it makes you more confident and makes you stronger. Perseverance, just don’t give up. It could be hailing outside, a big snow storm and you really need like a glass of water and everything is closed… but once you are about to give up on yourself, the last step you take, there is a fountain right there. It is always like that.

Table 11

<table>
<thead>
<tr>
<th>Participant 148 Results</th>
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</thead>
<tbody>
<tr>
<td>Core message</td>
</tr>
<tr>
<td>Themes</td>
</tr>
</tbody>
</table>

Participant 149

Narrative summary

P.149 was a 43-year-old, two-spirited woman who had been living on the streets for five years, had then become sober and was now living in her own apartment. She indicated that she first became homeless at the age of 17. When recalling her experiences of homelessness, she shared that sometimes they were enjoyable while at other times, they were very hard. For example, she was involved in sex-trade as a means of survival. She shared that she would use substances consistently for days and would then go on finding places to sleep (under cars, under trees, or in parking garages). This participant acknowledged substance abuse as being a key factor in her journey toward becoming and sustaining homelessness.
P.149 acknowledged having had heavy exposure to substance use as a child and noted the prevalence of substance use and the related exposures within the Indigenous community. She also noted that significant substance use was common among the homeless community as well. For instance, she shared that while she had friends around using drugs, she once overdosed on heroin and noted that when she had woken up, people were still in her home drinking and did not help her. She noted that she felt alone, afraid and isolated amongst her peers and it was then that she decided to make a change.

This participant also spoke of systemic oppression and the factors that were responsible for the high rates of Indigenous homeless people. She indicated that due to the intergenerational traumas, many Indigenous youths grow up learning about unhealthy coping mechanisms (i.e., alcohol, drugs and violence) instead of being exposed to their traditional knowledge, practices and ways of life. She expressed her Indigenous pride and voiced that it gave her a sense of meaning in the world. She recognized the power and strength that Indigenous healing circles have for mental health and trauma needs for Indigenous people, as it connects them with each other in a profound way.

P.149 also acknowledged the ongoing challenges that Indigenous people experience due to the problems of racism and oppression. For example, there is a need for better training for police on Indigenous peoples’ history and needs. She noted that Indigenous people continue experiencing discriminating treatment by the police, especially if they are homeless.

Table 12

*The World of Participant 149 from individual interviews*

<table>
<thead>
<tr>
<th>P.149</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Past Experiences</td>
<td>Employment/education</td>
<td>Building relationship</td>
<td>Substance abuse causes homelessness</td>
<td>Alcohol/substance abuse as factor in becoming homeless</td>
<td>Finding shelter important for survival</td>
</tr>
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<td>------------------</td>
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</tr>
<tr>
<td></td>
<td>Self-respect</td>
<td>Traditional knowledge and practices core to identity and belonging.</td>
<td>Ending unhealthy relationships</td>
<td>Recovery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-protection</td>
<td>Provides a sense of purpose in life</td>
<td>Lack of peer support</td>
<td>quiting</td>
<td>Having access to basic need attainment (hygiene, food)</td>
</tr>
<tr>
<td></td>
<td>Self-revelation</td>
<td>Traditions are necessity for Indigenous people</td>
<td>Survival</td>
<td>Systemic/Intergenerational substance issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sex-trade involvement</td>
<td>Learning to respect the land, Elders, and youth</td>
<td>Family impact</td>
<td>Heroin abuse, danger</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cycle of homelessness</td>
<td>Being around other drug users and feeling alone; isolated</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Systematic oppression as factor in homelessness</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Experiences</th>
<th>Challenges overcome</th>
<th>Indigenous vs. non-Indigenous worldviews</th>
<th>No longer homeless</th>
<th>Healing circles and community connection as important to healing from trauma</th>
<th>Police discrimination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Two-spirited</td>
<td>Traditional knowledge for coping</td>
<td>Recovery</td>
<td>------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indigenous pride</td>
<td>Community/street connection remains</td>
<td>------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
</tbody>
</table>

| Future Intentions | Those without the traditional knowledge | Education is necessary for employment, avoiding | Respecting traditional | Mental health workers need | |

|                     |                      |                        |                        |                        |                      |
Core message and themes

Cultural identity recurred as the core message throughout P.149’s narrative. She discussed her Indigenous pride and what it meant for her to be a Native. She noted this as being a strength and the most integral and primary aspect of who she is. The themes are colonial oppression, culture as healing and addiction.

Cultural identity

Her identification as an Indigenous person and her connection with the Indigenous culture was recognized as the overall core message of P.149’s narrative. She indicated that cultural identity was central in her past experiences, how she interacts with others around her, particularly within a homelessness context; as well as in healing and connecting with the others in her community. For example, she acknowledged her Indigenous identity as being her strength; however, she noted that oppression and stereotypes of Indigenous peoples create systemic barriers in terms of being able to thrive in a Canadian societal context. She stated:

[Traditional knowledge] showed me, I guess it taught me, there is more to being Native than just saying you’re Native. It is learning to respect the land, to respect your Elders, to respect the young ones, to show other people that you know, just because we are Native does not mean that we don’t know what is going on in this world. We have a lot of knowledge and we share it with our art… and I mean that is some of the stuff people don’t know; they think, wow those Natives’ can paint like they normally drink in the park but they can paint.

She further described the importance of cultural identity by stating:

To be Native? In this country? I was born in this country. To be an Aboriginal, I wouldn’t want to be anything else. I am, at least I can walk around and say this is our country.
Where other people just say, we were just visitors, we just came here, but you know, something, you make a country too. That’s what makes us a wonderful people; because we can accept you, just as long as you can accept us.

Colonial oppression

Systemic racism and aspects of colonial oppression also surfaced as a theme and aspect of cultural identity for P.149. She shared how oppression is particularly the case for Indigenous homeless that are in regular contact with authority figures, where stereotypes and discrimination often plague their experiences of contact with the police officers. She noted that there is often an ignorance regarding the colonial history. For example, she stated:

“They have got to teach these police a little more knowledge about how to approach Aboriginal people when they are drinking or where we are. To respect us, a little bit more. Please don’t come up to us just to say you are a bunch of drunks in the park, can you take this somewhere else. Well no, we were born here, this is our fucking land… We don’t discriminate. I came down the street the other day and the cop said, P.149 where is your beer? I said, still in the beer store… So, when they come in the park they see us drinking in the park, I mean it’s not a new thing. They say, can you take it to someplace else, where do you like me to take it, to your place? Can I come to your house and drink in the back yard? Some of us don’t have a back yard. This is our backyard; they don’t understand that, what do you want us to do? Sit on the back corner? If we sit in the park at least we aren’t bothering people.”

This demonstrated the challenges that many Indigenous peoples face because of aspects of oppression combined with the influences of colonialism including the loss of land and culture, which is a major factor that contributes to Indigenous homelessness initially. She further commented on the ignorance that exists within the systemic vehicles such as mental health and criminal justice systems, which often perpetuate and propel oppression of the Indigenous people. She stated: “They have to have more knowledge, I mean the police and the mental health workers, they have to open up their eyes instead of just opening up a book and say, oh they are Native people, that is where they came from, oh this is what they know, oh this is what they have learned.”
I mean, we are having a gathering, I mean, we don’t have, we can’t go to a centre and start drinking there because we respect our Native people that don’t drink. If you drink, you shouldn’t be going to the Native resources. That is why I don’t, I respect my people when they say, P.149, please don’t come in when you are drunk or have been drinking. I am an honourable woman. I’ll drink in the park, but I will not go drink where those people are trying to stay sober.

**Culture as healing**

Connection with the Indigenous culture was also recognized as a theme in the narrative of P.149 in healing from colonial trauma. She shared the interconnectedness of Indigenous traditional knowledge with others in the community. For instance, she stated:

> You got to go to one of our circles, you got to go hang around us. Learn these things and then, you will have a better understanding about what we know. I mean it is in the heart, I mean like everything comes from the heart, from the four directions. I mean like, if you look at this hawk… I get a lot from him, I get a lot of knowledge because if you look at him, he’s got to survive too. He picks up a bird, he picks up a squirrel, he takes it home right up there and feeds his family; that is exactly what we do. It does not matter if you go out and look for a job, and then you come home and you got to feed your family. Same thing like the hawk. He is teaching us.

P.149 further recognized that engagement in cultural practices and learning traditional knowledge as well as passing the obtained knowledge to the younger generations is what sustains Indigenous people and heals them from the past and ongoing colonial traumas. For example, she stated:

> If we don’t have traditional ways, something has to pull us back in, to make us feel like we are Natives. If we don’t learn our traditional values and what our other people had learned; like to follow on and show the younger ones, this is what we are supposed to be learning. Not learning how to be homeless, not learning how to drink. No, we are supposed to learn about trees, birds, animals. You know… drinking is not a Native thing. We have traditional values and we got to respect them. We got like, our values are not the same that the White man, because they want to destroy our land, we want to save it, we are trying to save our fish, we have to fish and we have to hunt up north to survive.
Addiction

Influences of addiction were recognized as a contributing and ongoing factor in the experiences of homelessness. She also noted how addiction also seems to be intersecting with her cultural identity as an Indigenous person. For example, she stated, “Drugs and alcohol, that’s it. It is big with us. You can’t push it away sometimes, it is in our blood. Sometimes it’s just the way we are.” She further described how her challenges with addiction perpetuated her inclination towards homelessness; however, it was that very addiction which led her to make a change. For instance, she shared:

Doing heroin, I thought I had died. I had people at my house smoking crack, still drinking while I was out for three hours and then I woke up; they are still sitting there, didn’t bother to see if I was dead or alive. I got mad, and said well that’s it; I threw all fucking paraphernalia outside and smashed up all the crack, got rid of all the needles and said that’s it. I had enough. You people don’t give a fuck if I lived or died. They just kept going on, not even to see if I was… I said I did heroin, and there you still are, drinking my beer. I could have been dead and they didn’t give a shit. So I said, well I don’t give a fuck either, get the hell out and don’t fucking come back, and that was the end of this party. So that is how I kind of straightened my life out.

Table 13

Participant 149 Results

<table>
<thead>
<tr>
<th>Core message</th>
<th>Cultural Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td>Colonial oppression</td>
</tr>
</tbody>
</table>

Participant 150

Narrative summary

P.150 is a 47-year-old, two-spirited man who moved to a large Canadian city from a different part of Canada. He shared that his experiences of homelessness have been lived with intermittent periods of employment; however, substance use and mental health issues have interfered with his ability to sustain continuous employment and housing.
He was adopted by a non-Indigenous family and grew up without having much idea about his background and thus disconnected from his culture. He noted that when he was young and served in the Navy, he met other Indigenous people and was introduced to their traditional knowledge and culture. He indicated that he has lived in poverty and has suffered from substance abuse issues for many years and that his husband died in 2002, which was quite a traumatic experience for him. He shared that he had been using substances as a means of coping. This participant noted that when he became involved with traditional knowledge (i.e., medicines, smudging and sweat lodging); he began to heal from his past traumas. He noted that it was his cultural engagement that saved him.

P.150 acknowledged the strong relationship between mental health and traditional knowledge/medicines and noted that many of his Indigenous peers did not make that connection and thus died from mental health issues. He shared that this was due to the fact that they were unable to heal from their historic pains. He noted that many issues due to colonialism persist for Indigenous peoples, especially within the homeless community. For instance, the issue of missing and murdered Indigenous women. He noted the need and importance for cultural components and influences into mental health models that prioritize the Indigenous healing methods.

Table 14
_The World of P.150 from individual interview_

<table>
<thead>
<tr>
<th>P.150</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Experiences</td>
<td>Experiences of loss</td>
<td>Was disconnected from culture as a child.</td>
<td>In and out of employment</td>
<td>Substance abuse</td>
<td>No supports from government</td>
</tr>
<tr>
<td></td>
<td>Was adopted by a White family- received a good education</td>
<td>Did not know he was Native Community involvement and support</td>
<td>Many friends have died to live on the streets</td>
<td>Husband died in 2002</td>
<td>Isolation and lack of support</td>
</tr>
<tr>
<td></td>
<td>Isolated through mental</td>
<td>Became involved in</td>
<td>Homeless peers have their own traumas and</td>
<td>Previous suicide attempts</td>
<td>Inadequate living conditions</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Heavy alcohol use</td>
<td>and abuse in</td>
</tr>
</tbody>
</table>
Core messages and themes

The impact of colonization was the core message throughout P.150’s narrative. The themes are culture as a healing factor and community supports.

Impacts of colonization

The core message for P.150 was the impacts and influences of colonialism. He noted that the aspects of colonization have had a strong impact on his experiences; including the current experiences with the mental health practices (i.e., diagnostic and Western medicine), as well as his early deprivation of culture due to the aspects of the 60’s Scoop. For example, he noted that he had been adopted by a non-Indigenous family and was raised without any Indigenous cultural
influences at all. He noted that as an adult he was introduced to other Indigenous people, where he then began engaging in cultural practices:

My family were European, non-Native. I was the only Native in the family. I was in sea cadets and was going to join the Navy and I don’t think it would have happened. It was a dream. I always go by the Natives, so one night I am in my uniform, I open the door and I walk in and they just started—‘Who are you?’ Laughing. But previous to that, I was outside shovelling the driveway, and all these Natives went by, and I looked at them, they stopped and looked at me, and I said, ‘you look just like me.’ So I went to the Native centre and that’s when I was introduced to Native culture.

Culture as healing

The Indigenous approaches to mental health, combined with traditional knowledge and engagement in cultural practices were together recognized as a prominent theme in the healing journey of P.150. He noted that being engaged with the other Indigenous peoples and practising traditional ways had helped with many of the emotional and mental challenges that he had experienced. This included the spiritual as well as the cultural loss he has endured. For instance, he shared the healing aspects of the presence of Elders, however, noted the challenges that exist when one is on psychotropic medications for psychiatric issues. He noted that psychology practices from a Eurocentric perspective of treatment can prove to be more harmful rather than helpful in a spiritual sense. He discussed this conflict by stating:

The Elders come in, and they talk to these people and within a few months, these people are ok, you know. They still have to be sedated though. It helps because there is so much out here, so much negativity out here, it’s like a big tidal wave. That’s what my sponsor said, as soon as he got off the plane, he could feel it in the air and he had to centre himself or it would swallow him up.

Further, he discussed the positive impacts that cultural engagement has had on his healing process by sharing the influence that it has had on his emotional well-being. For example, he stated:
Native magic has always, I was 13 when I became an apprentice and I won’t call myself a master, but I’ve had good days, I have bad days; but the medicine was always there to tap into and that’s all the worlds. You can just tap into that and assume universal power.

Community supports

Indigeneity connections and the strength of community were identified to collectively exist as the central theme in the narrative of P.150. He recognized many crises that keep occurring within the overall Indigenous community, including the influences of colonization that are required to be addressed by the strength and togetherness of the greater Indigenous community. For example, P.150 expressed a heightened concern for the missing and murdered Indigenous women and noted that the community now needs to come together in order to protect each other. He stated:

Aboriginal males are needed here in [large Canadian city] because they’re strong, they’re able and through medicine or magic you can alter reality if you have enough magic to push this all. But Native females have been disappearing for the past few years now, but I don’t know where they went and they produce our children so that’s a major challenge. There’s now police watching and we are watching and the Elders are watching. If anybody goes missing, we are to call the police right away if they are gone over 48 hours.

Community supports were also recognized as strong healing factors in terms of mental health and trauma experienced amongst the Indigenous community. For example, P.150 described the strength and healing qualities that community supports can have for overcoming the mental health difficulties. This was inclusive of the general wellness that community support could bring for the Indigenous peoples. He recognized how these supports were also important for healing in terms of learning and reconnecting with the traditional knowledge. He stated:

The few Natives are from my original group, I am one of them and there is a few more. There is about 10 of us left from about 300. We were young men once, who were doing ceremony, I was there’ they taught me how to dance, they taught me how to pray, they taught me what to say when I am praying, to be humble, to be true… Only a humble man can stand before God. Now say thank you; and there is a song, it means thank you for the
life I’ve lived, thank you for the experiences, the good times and the bad, when I go I want that song sung in my prayers.”

Table 15

**Participant 150 Results**

<table>
<thead>
<tr>
<th>Core message</th>
<th>Impacts of colonization</th>
</tr>
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</table>

**Participant 151**

**Narrative summary**

P. 151 shared that he was raised by his Catholic aunt and was exposed to the Indigenous culture while growing up. He indicated that getting influenced by the environment around him, he first started drinking at age of 11. He noted that drinking had always been around him, and it became his coping mechanism to deal with emotional difficulties. He moved to a large Canadian city approximately seven years ago from a Northern community to escape a situation of domestic abuse and subsequently began using drugs. He explained that when he moved to a large Canadian city, he initially stayed at an Indigenous homeless shelter and has since been living on the streets. He shared that he currently was still using alcohol and drugs to cope with the psychological difficulties of his past and present.

P. 151 highlighted the gap in the current resources and supports for homeless people. For instance, many of his peers have ongoing mental health and substance abuse issues that still remain unaddressed. Furthermore, he noted that many of the current counselling models do not incorporate an Indigenous paradigm, as a result of which, the traumas remain unresolved. He further noted that although there are many types of supports available in the city; many people still have difficulty accessing them.

Table 16

*The World of P. 151 from individual interview*
<table>
<thead>
<tr>
<th>P.151</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td>Indigenous identity</td>
<td>Drug/alcohol use led to homelessness</td>
<td>Moved to escape dysfunctional relationship and domestic situation</td>
<td>Correlation between traditional knowledge and religion (Catholic)</td>
<td>Experiences of trauma</td>
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<td>Dysfunctional Relationship/violence</td>
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<td>Substance use experience as a youth</td>
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<td>Experiences of assimilation and racism</td>
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<td>Started drinking at age 11</td>
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<td>Transmission of Traditional knowledge from Elders</td>
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<td>Culture connection from youth</td>
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<td>Raised with traditional teachings</td>
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<td>Elders, Pow Wows, circles</td>
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<td>Survival skills/living traditional way</td>
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<tr>
<td><strong>Present Experiences</strong></td>
<td>Indigenous identity</td>
<td>Integrity of self</td>
<td>Following your beliefs</td>
<td>Criminal activity to buy drugs</td>
<td>Environment: shelter and streets</td>
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<td>Uses more than one shelter</td>
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<td>Survival</td>
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<td>Having respect for the land</td>
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<td>Connection with Elders</td>
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<td>Blending religious and spiritual practices</td>
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<td>Teachings as life guidance</td>
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<td>Environment: shelter and streets</td>
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<td>Uses more than one shelter</td>
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<td>Survival</td>
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<tr>
<td><strong>Future Intentions</strong></td>
<td>Personal development</td>
<td>Self-identity</td>
<td>Spirituality</td>
<td>Harm reduction protocols for ceremonies</td>
<td>Future Connections More Resources needed</td>
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<td>Traditional Knowledge of guidance and support</td>
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<td>Traditional Knowledge infused treatment models</td>
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<td>Need for better services that address early influences of trauma</td>
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<td>Traditional Knowledge infused treatment models</td>
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</tbody>
</table>
Core messages and themes

The overall core message that could be derived from P.151’s interview was cultural identity. The themes are maladaptive coping, culture as healing, and interconnectedness for services.

Cultural identity

Cultural identity was the primary message throughout P.151’s narrative. More specifically, he spoke of a cultural conflict in the self between Indigenous identity and the identity related to existing in a society dominated by the non-Indigenous practices and worldviews. He recognized that his Indigenous identity was very important to him, especially in terms of healing; however, he spoke of the challenges that it brought, especially regarding the pedagogical clash that existed within a Canadian context. For instance, he stated:

I guess you are taught whatever you want to believe right? A lot of people use to look for God and stuff, but we were taught our Native way of life also. You have to accept, you know, the Catholic system; but I was raised, my auntie was raised Catholic, so I was kind of raised Catholic… I guess it’s important to exercise both, because we are living in a society… I look at it like a package, you know what I mean, in guidance in life is good enough and take it your own way, thinking of nature, whatever, God was teaching respect for the land.

Maladaptive coping

Issues with addiction were a recurrent theme throughout P.151’s narrative, especially when it came to his experiences of homelessness. What was especially noteworthy in his narrative was the thematic presence of addictions as the primary mechanisms to cope with traumas, abuse, social isolation and mental health issues. He provided a more intimate example by stating:
I was drinking also, I guess, I was drinking looking for something better because I wasn’t really getting off on drinking a lot of the times. Started using them [ pills ], just wanted to be high all the time you know, feel better… I drink I use [ pills ], it kind of takes your mind at ease; you know, makes you function, deal with life.

Culture as healing

Engagement in cultural practice and having a connection with the Indigenous community was identified as being a central component of healing from the various aspects of mental health and homelessness. For example, P.151 discussed the mental health benefits of relating to Elders for guidance and support; he asserted that this kind of relativity helped to both reconnect with Indigeneity, and to promote a healthy path in life. He stated:

I know what mental health is when people have issues with mental health, and you got to learn what to follow, you know what I mean, just guide them, I guess, guidance in life… guide you through the Native way of life.

He exemplified the importance of cultural connection and traditional knowledge and teaching in the mental health and healing journey of the Indigenous peoples and having that support and guidance to do so. He went on to say:

You got to do whatever you want to believe… you know, those teachings. You could use those teachings for guidance… and you found a silver lining, maybe that helped them. Like everybody, they can get better. They just need some guidance.

The interconnectedness of services

A need for better services that are inclusive of Indigenous paradigms and traditional teachings was identified. P.151 recognized the need for services that can promote health and wellness in culturally appropriate ways. This was noted to be quite crucial in terms of housing needs for the Indigenous homeless peoples, as well as for mental health and trauma needs experienced by the Indigenous community. For instance, P.151 spoke of the need for inclusive services that are interconnected with the Indigenous models of care. He stated:

There is always going to be more programs, teach people, teaching people that those accesses are out there… community teaching you know… so more programs you know,
resources; women need women counsellors, work with computers, do resume… because there are resources out there, but then if you are out there teaching the Native people and there are resources, then they can do things. Learn you know, be out there to help, give more education and try to do better for themselves.

Table 17

\[ \text{Participant 151 Results} \]

<table>
<thead>
<tr>
<th>Core message</th>
<th>Cultural identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td>Maladaptive coping</td>
</tr>
</tbody>
</table>

**Participant 152**

**Narrative summary**

P.152 is a 29-year-old man who was raised in an environment with observable domestic violence as well as sexual abuse. He experienced abuse himself and noted that from an early age, he had seen a strong influence of substance abuse used as a coping mechanism to deal with the emotional stressors. He noted that he began using substances to be able to cope with distress/memories of trauma at the age of eighteen and that substance abuse was the central component in his experiences of becoming homeless.

P.152 discussed how overall, addictions become major hindrances in functioning and overcoming the state of homelessness. For example, the lack of security and safety from being homeless increases distress and therefore sustains substance use. Furthermore, he also shared that he had had a recent period of sobriety and housing and indicated that a strain in terms of relationship and the lack of healthy coping skills can lead to a relapse of homelessness and substance abuse. He identified that substance use also stands a major barrier to accessing and achieving stable housing due to various policies that enforce sobriety within the shelter system.

P.152 recognized an inverted connection between traditional knowledge and mental health, addictions as well as trauma recovery. For example, being connected to ceremony and medicines can be healing for the soul and clears out any existent negativity; however, when one is using,
they stay away from medicines and traditional practices out of respect for the protocol and also due to the effects of intoxication.

He further shared his experience of depression when he had become disengaged from his culture, and noted that in conditions as these and such, substance abuse often increases. He shared his perspective on the changes in care and noted the need for better trauma supports that are specifically tailored to the unique histories and needs of the Indigenous homeless. For example, there are myriad difficulties, especially when addiction is a factor. He recognized that the current treatment models do not fully address the cultural gap. This includes difficulty in accessing traditional medicines and healing practices when using. He also recognized the need for more group supports for the Indigenous peoples who are currently using that enable engagement in the ceremony.

Table 18

*The World of P.152 from Individual Interview*

<table>
<thead>
<tr>
<th>P.152</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Experiences</td>
<td>Exposure to substance use in childhood</td>
<td>Became involved in sweats and ceremony in jail</td>
<td>Relationship conflicts leading to homelessness</td>
<td>Trauma and domestic violence</td>
<td>Accessing Indigenous agencies</td>
</tr>
<tr>
<td></td>
<td>Early experiences of trauma</td>
<td>Used to be involved in ceremony until drug use</td>
<td></td>
<td>Began using substances as coping at age 18.</td>
<td>Previous substance treatment</td>
</tr>
<tr>
<td></td>
<td>Experiencing and witnessing sexual abuse</td>
<td>Respect of medicines and cultural practice</td>
<td></td>
<td>History of depression</td>
<td>High level of distress in previous treatment</td>
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<td></td>
<td>Previously employed</td>
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<tr>
<td></td>
<td>Diagnosis of Bipolar Disorder</td>
<td>Smudging as healing</td>
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</tbody>
</table>
Core message and themes

The core message observed in the narrative of P.152 was cultural dissonance. He noted that there was a clash between mental health and traditional knowledge and indicated that when one is not engaged within their Indigeneity, they are more likely to experience mental health issues; this is particularly true in the case of addictions. He also noted that when one is engaged in cultural practices and contact with the community, particularly with Elders, one has a better-adapted sense of self, wellbeing as well as emotional connectedness. He noted that the gap exists regarding cultural protocols and it is this very gap that prevents one from engaging in the ceremony when using substances. He described cultural dissonance throughout the primary
themes in his narrative, which was maladaptive coping, and culture as healing and harm reduction.

**Cultural dissonance**

While discussing cultural dissonance in the sense of mental health and addiction, P.152 spoke of the challenges faced while heading towards healing when one is engulfed in addiction, even if one has the intent and motivation to get engaged in ceremony and traditional knowledge; especially in terms of connection to Indigenous culture and moving towards healing. For example, he stated: “I don’t want to go to sweats when I am using. It is not right… it’s like, you’ve got to be clean for 4 days, at least.”

He further explained the aspects of cultural dissonance and addictions in that, he used to be engaged in many cultural practices in the past and noted that this engagement promoted wellness in his life; however, he recognized that addictions became a maladaptive form of coping that had then disconnected him from his cultural and spiritual engagement. For example, he shared:

I used to do it a lot [engage in ceremony] … As soon as I started doing drugs, I just didn’t care… Just cared about getting high, getting drunk. It’s kind of tough… because like sometimes, some of the places you don’t want to go around because you know, like there is medicines and some powerful stuff around. You can’t be going around that when you are using heightened drugs you know.

**Maladaptive coping**

Addictions, as a form of coping with emotional and spiritual pain, were also acknowledged in the narrative of P.152. He recognized that addictions had kept him away from his Indigenous identity, however, it was the only way he was able to cope with the emotional pain that he had endured while growing up in an environment of violence and drug abuse; and how this intergenerational trauma, as well as intergenerational maladaptive coping, was transmitted. For example, he shared:

My experience is drinking, taking drugs… just not being able to deal with my [problems]; building it up and then trying to deal with it in different ways, drinking and drugging…Addictions, addictions is a challenge… like the addiction part, just being
homeless. Some of the stuff you see, when you’re using it, like violence. Like when you use it… everything is worse than the way you think it is.

**Culture as healing**

Engagement in cultural practices and being around medicines and other Indigenous peoples was identified as a recurring theme in the narrative of P.152. He noted that the phenomena of cultural connection and traditional knowledge had helped him in his own healing journey by processing some of his past traumas and helping him deal with mental health issues. He noted that cultural engagement can have a powerful effect on emotions. For example, he stated: “Knowing about the culture, like sweats, healing ceremonies, smudging and cleansing. [It helps you] self-heal from all those bad, negative feelings.”

He further described the importance of cultural connections in the process of healing, especially from various emotional pains. For example, he stated: “I think it’s helpful… getting in touch with your culture. It is definitely a part of its healing. Like just a lot of the aspects of it helps you out, like sweats.” He also recognized the positive influences that cultural engagement and traditional knowledge could have on one’s mental and emotional wellbeing. For example, he stated: “When I smudge in the morning, I feel happy you know, I feel good… and when I do sweats, I feel good inside. I feel a weight has been lifted off my shoulders.”

**Harm reduction**

Regarding the overall core message of cultural dissonance, one of the main themes observed regarding traditional knowledge and mental health, particularly addictions was the need for harm-reduction services specific for the Indigenous peoples. For example, as previously stated, he noted how being disconnected from culture had had a negative impact on his mental health and wellbeing; however, when one is using substances, they cannot engage in cultural practices and ceremony. Thus, many people refrain from engaging their culture, as addictions often take the primary need. For instance, he stated:

Challenges? Stay sober long enough to build strength when you go and do the sweat. Obviously, you are not going to get high one day and then go to do the program and stay, you know. So, I feel more depressed because they usually share up because you are there, and you are using drugs and drinking.”
He identified the need for harm-reduction models of treatment for Indigenous peoples, especially for the homeless that are more inclusive of wellness as the primary goal that focuses on cultural engagement. This would include an emphasis on the emotional, mental and spiritual health as the primary concern, including traditional medicines in the healing process, regardless of addictions. For instance, he shared: “Mentally [traditional knowledge], it helps you… like it clears out all the negative stuff you hold in, it cleanses your body. It’s just good all around. Even smudging, pain; I used to do that, I don’t anymore.”

Table 19

*Participant 152 Results*

<table>
<thead>
<tr>
<th>Core message</th>
<th>Cultural dissonance</th>
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<tbody>
<tr>
<td>Themes</td>
<td>Maladaptive coping</td>
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**Participant 153**

**Narrative summary**

P.153 indicated that at the time of the interview, she already owned an apartment in which she was living. She shared that she generally spends time with her peers living on the streets and then returns home. She noted that addiction, particularly, alcoholism, had played a major part in her experience of homelessness; however, she also shared that she has now been sober for 42 years now. She indicated that her sobriety had been a significant aspect in her process of achieving stable housing.

P.153 recognized unresolved traumas and mental health issues, especially maladaptive coping such as addictions, as a key factor in the initiation and maintenance of homelessness. She shared, for example, that individuals can become more successful if they receive ongoing support in terms of managing finances and learning basic life skills. She also noted that having the Indigenous homeless people involved with traditional practices, such as skilful crafts and art could work as a good outlet for mental health/ trauma issues and be a deterrent for substance use engagement. She indicated that this was especially important for the youth who were at high risks for homelessness.
Table 20

*The World of P.153 from individual interview*

<table>
<thead>
<tr>
<th>P.153</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
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<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
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<tr>
<td>Impacts of colonization; influences of Christianity</td>
<td>Tensions of Christianity and Native spirituality</td>
<td>Experiences of homelessness; hard in the cold</td>
<td>Previous suicide attempt; supporting suicidal peers</td>
<td>Supportive housing</td>
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<tr>
<td>Previous alcoholism</td>
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<tr>
<td><strong>Present Experiences</strong></td>
<td>Currently housed</td>
<td>Involvement with traditional crafts and art as healing; teaching others (i.e., dream catchers) Talking circles helpful. Being amongst Elders and other Indigenous peers</td>
<td>Occasional street living; being with peers Basic needs not met; food; hygiene; shelter and safety</td>
<td>Emotional impact of financial situation Prevalence of mental illness and addiction amongst homeless community Successful employment when overcome addictions (drinking and smoking)</td>
<td>Financial challenges; loss of government assistance Basic need attainment important; comes with housing Indigenous supports help promote employment and housing</td>
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<tr>
<td>Sober for 42 years</td>
<td>Not financially independent</td>
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<tr>
<td><strong>Future Intentions</strong></td>
<td>Financially independent</td>
<td>Inspiring the younger generation of Indigenous people to connect to culture as</td>
<td>Employment eliminates homelessness Fears of becoming homeless again Concern for job loss</td>
<td>Addiction support There is a need for more supports for homeless who are experiencing job loss</td>
<td>Improving addition programs Increased community support for homeless</td>
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Core messages and themes

The core message for P.153 is recovery. The themes are maladaptive coping, cultural connection and survival.

Recovery

The core message for P.153 was recovery. She noted her own experiences and indicated that she was currently housed: “I have my own apartment, I’ve had my apartment for a long time.” She indicated that addictions had been significant components of her previous experiences of homelessness; however, she indicated that sobriety was part of her recovery process. For example, she noted: “I used to drink… but I quit 42 years now… I was a binge drinker.” She recognized that continued sobriety is an important aspect of ongoing recovery and healing. She recognized the importance of community involvement and support for peers, as well as how crucial it was that she would become a mentor to people who were still on their healing journey. For example, she described:

“My friend, she got herself out of it, she got a job now. She quit five years ago, the addiction with drinking and smoking. She got a job working as an assistant. Helping out people and taking people to the hospital… but sometimes she thinks she can go back [addictions]. It will be easy for her to go back, but she doesn’t want to lose her job and the things she built up for herself. She is trying to get other people to see that happen. She doesn’t want to preach to them or bug them about it. She wants the people to see how good she looks and that she’s got a steady job… she is supposed to be speaking to the youth soon, about street problems and alcohol and drugs.”

Maladaptive coping

In terms of the barriers toward recovery, P.153 recognized factors such as addictions and unhealthy coping of emotional challenges, mental health concerns and traumas; for instance,
addictions remain the most challenging obstacle towards recovery, including housing, employment, as well as seeking and receiving psychological treatment and rehabilitation in regards with substance use. For example, she stated: “Well they get depressed and stuff like that and they drink a lot, just to kill the pain I guess… that is the mental illness that they have, is a drinking problem.”

Cultural connection

In regards to recovery, P.153 recognized how important and healing talking circles can be in terms of connecting with other Indigenous peoples who currently are or who have been homeless, as many have encountered similar difficulties. She noted that sharing experiences and listening was a powerful aspect of healing and recovery from mental health, addictions, trauma and homelessness. For instance, she spoke of the strength that can be drawn from connecting with Indigenous peers. She stated:

We have circle here… like we talk to your creator, nobody speaks when this person speaks, and then you speak after, they don’t like what they talk about sometimes you fall right in there, lines that they talk about and then you just get help that way… and a lot of them is hurt from losing their family you know, people dying and like depressed that way. So they sit there and give it to the Lord to help them and to get that out to clear their mental health.

Survival

Having the basic need attainment was recognized as being one of the most crucial barriers toward recovery from homelessness and in helping an individual’s overall survival. P.153 highlighted these challenges and noted the importance of the basic need attainment when one is homeless. For example, she stated:

People need housing, they need blankets, toiletries for them to use too when they are out here. Sometimes, the restaurants aren’t opened 24 hours. Some of them are open until three o’clock. People have to have those paper and stuff to go to the washroom. It’s cold out there.
Participant 153 Results

Core message  
Recovery

Themes  
Maladaptive coping  
Cultural connection  
Survival

Participant 154

Narrative summary

P.154 recognized that he had only recently become homeless in the last five years. He indicated that he had been living a “double life” and had found the transient lifestyle of living on the street better suited his needs. For instance, he pays rent at three different places and always has a place to go; however, it is this transiency that is the most suitable for his current life circumstances. In that way, living on the streets and moving from place to place without a fixed address is the most comfortable for him.

P.154 recognized that he had a strong influence amongst the Indigenous communities and had created quite a reputation for himself. He shared that he was raised in a traditional way and indicated the importance of being involved in various traditional practices. For example, when he first began living on the streets, he became disconnected from his culture and noted the loneliness and distress that the disconnection caused. He indicated that he reconnected 17 years later when he achieved sobriety and is now in touch with the drum. He noted that he shares his experiences with others and has found that this connection is healing not only for him but also for the others.

Table 22

*The World of P.154 from individual interview*

<table>
<thead>
<tr>
<th>P.154</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past Experiences</td>
<td>Moving often, Mobility Moving between</td>
<td>Traditional upbringing Family support in</td>
<td>Cyclical barriers Inherited barriers Education and employment barriers</td>
<td>Disruptive/destructive behaviour, alcohol abuse</td>
<td></td>
</tr>
<tr>
<td>Present Experiences</td>
<td>Comfortable being mobile</td>
<td>Belonging to traditional community</td>
<td>Freedom of choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<td>-----------------------------------</td>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Two identities/ways of life</td>
<td>Empowered and respected in community</td>
<td>Recently homeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Traditional drummer</td>
<td>Elders’ supporting role</td>
<td>Transient lifestyle of homelessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community support, encouragement to recover from mistakes</td>
<td>makes one disconnected from culture</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future Intentions</th>
<th>Balance is key to staying on the healthy path</th>
<th>Desire to return to tradition and community</th>
<th>Balance for health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not all imbalances can be corrected</td>
</tr>
</tbody>
</table>

|                     |                                              |                                           | Need more service locations |
|                     |                                              |                                           | More employment supports/ resources |

- Defence mechanisms for avoiding problems
- Self-avoidance as coping; addictions
- Experiences of trauma strongly related to homelessness and addictions

- Lacking Services
- Welcoming/engagement needed
- Employment is priority
- Communal support
Core messages and themes

The core message that emerged through the narrative of P.154 was a connection. The themes were a holistic balance for wellness, culture as healing, and community involvement/s supports.

Connection

The overarching message seen throughout P.154’s narrative was connections. Firstly, P.154 recognized the power of connection between peers in terms of survival, empowerment and perseverance. He noted a symbiotic relationship between the connections, where the supporter and the person in need collaboratively help each other in terms of healing, recovery and resilience. For instance, he shared his connection with other homeless individuals and how it had helped him in his own healing. He stated:

I sit there as I said, I just try to help them. Wherever I am at, the way I look at it, I see their difficulties, their transitions, the ups and downs. When I am there, I try to calm them, a couple of my friends there, when they are with me, always say, when they are broken up they are straight with me, they go along with me. But when I am not around, everything crumbles around them. With me with everything is straight for them.

Secondly, he described the connections within an Indigenous paradigm and the connections that exist regarding the traditional knowledge and healing. He recognized the transference of knowledge and supports within the Indigenous communities, as well as continuing the connections of maintaining balance within the mental, physical, emotional and spiritual aspects of the self, others as well as the larger community. For example, he shared this larger sense of connection within Indigeneity:

The way I see it, the foundations [traditional knowledge] being put back together, it does not break. If we watch over each other, we don’t turn our backs, we’ve got friendships. If there is one problem there we all share together [Indigenous peoples]. It doesn’t break, putting in the mental, it’s how we look at it.

Holistic balance for wellness

A specific theme that seemed to emerge throughout P.154’s narrative was that of holistic balance. He noted how the balance of the spiritual, mental, physical and emotional was an
important connection with identity in terms of the overall wellness. For instance, he believed that treating the spirit was an important aspect of wellness and noted the importance of recognizing and finding a balance for intergenerational traumas and wounds; well beyond the current difficulties so to achieve balance and wellness. He said:

For the ones I see on the street, again it comes back to their background, their own upbringing, the things they’re seeing and what they are doing. It doesn’t just start with us, it starts with their past and history, it falls on whatever happens in their past and in their childhood… the mental part, is embedded in them, they will always repeat it, the same thing over. I see a bunch of them on the streets, I try to help them.

Balancing mental health issues was also identified as an important factor in connecting with emotions, spirit, and physical limitations for connecting one with a full sense of identity. This was especially true in terms of achieving wellness within an Indigenous paradigm as well as healing approach. He spoke to the inclusion and the emphasis on the spiritual aspect of the self, as to achieve holism in terms of a mental health and wellness perspective. For example, P.154 further stated:

Look at the mental part, I have to trick my own self; therefore, what I’m doing is horrible for my health, once in a while I will go see my Uncle. He told me this, he told me to change my ways and he took me back to who I am, my traditional side. It takes time; you got to have that time, to make time, that’s why I totally look at it in a total way different from other people.

The balance of Indigeneity and cultural identity with the other aspects of the self, such as emotional turmoil and difficulties with substance abuse, were also recognized as important elements in the holistic approach to wellness and holism. In that sense, many Indigenous peoples experiencing homelessness struggle with the balance of cultural practices and traditional knowledge as well as addictions. For example, P.154 stated: “We have to be strong, I try to help them balance it. Some people I see falling off and can’t come back through. Some people will fall away, just off balance and come back through.”
Culture as healing

Connection to culture was recognized as an important aspect of the overall healing and wellness. P.154 recognized his own connection with the Indigenous culture and practice and how it was important for his healing journey. He noted the connection that he felt with others in the Indigenous community as a part of the overall healing experience. He shared that he can sense how it affects his mental, emotional and spiritual wellness, especially during times when he is disconnected from his Indigenous identity and spirituality. For instance, he stated:

My nations, I am a traditional dancer and also a drummer, that tradition I hold tight and strong to it… I always got to hold my ground, people see me coming, they are like… we got to work with him, or if they go against me it’s going to be difficult for them… On my traditional side, I miss it, because I am out here. When I go back into it, I am a totally different person, that’s why I say I live a double life.

Disconnection and estrangement from culture were identified as a significant barrier to recovery and in the overall healing journey for the Indigenous homeless peoples. This is especially true for the aspects of addictions and mental health that factor into the circumstances of homelessness. P.154 particularly identified the aspects of cultural protocols and sobriety while dealing with aspects of addiction, which stood a barrier in his attempts to achieve overall healing. He illustrated this by stating:

The barriers are if I am following drinking, one of my Elders told me when I was sober, if you fall back get up don’t let the guilt or anything bother you. Just get up and do it again, keep going. Don’t feel none of that guilt. Just keep going, that the way I look at it. I don’t stop.

Community involvement/supports

P.154 recognised reconnection with the community and Indigenous peers as a primary aspect of traditional knowledge, which was also important for his own wellbeing. For example, he stated:

I am well known in different communities and I help them out as much as I can, as much as they are helping me. Also, I built on my reputation and that knowledge that I have, outreach as well. That means I got both.
He recognized that having community connections was quite important for his own positive experiences of homelessness. He noted that even at times where he was without a home, he never felt homeless in a sense, where he knew he always had the support from his community and a place where he could stay. He shared: “In my upbringing with the tribe, I always had those places to go... Like I said, I just pick a spot.”

Community connection and supports were identified in P.154’s narrative as being symbiotic in nature in that, having a sense of a community could give a sense of purpose and strength to an Indigenous person. He described that by feeling connected to a part of the community, one can feel motivated to support others; such a phenomenon promotes wellness, connection and builds on the resiliency of many Indigenous communities in their process of healing from the ill-effects of colonialism. For example, P.154 demonstrated this community connectedness and resiliency by stating:

The connection is with the community and I feel the connection is what gives you the strength and I feel good about it or with this kind of life. They all look up to me, they know I am down with everybody, they know that I live two lives. When I live out on the streets, help people out dutifully, on a personal note. Or I just turn around and go back traditional.

Table 23

**Participant 154 Results**

<table>
<thead>
<tr>
<th>Core message</th>
<th>Connection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td>Themes</td>
</tr>
<tr>
<td></td>
<td>Holistic balance for wellness</td>
</tr>
<tr>
<td></td>
<td>Culture as healing</td>
</tr>
<tr>
<td></td>
<td>Community involvement/ supports</td>
</tr>
</tbody>
</table>

**Participant 155**

**Narrative summary**

P.155 was a woman currently experiencing homelessness. She seemed to be guarded during the interview process; however, she noted that substance abuse issues played a major role in her experiences of homelessness. While discussing traditional knowledge, she recognized that her
connection to culture was what taught her many of the values that she currently lives by, such as respect, relationships and love. She noted that in terms of resources, there is a lack of supports available for the Indigenous homeless women who are experiencing mental health issues, trauma and addictions. For instance, she noted that cultural engagements in supports would be healing and helpful if she had access to them.

Table 24

*The World of P.155 from individual interview*

<table>
<thead>
<tr>
<th>P.155</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Healing</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td>Lived in many places</td>
<td>Early influences of culture</td>
<td>Prevalence of substance/alcohol addiction</td>
<td>Disruptive/destructive behaviour, alcohol abuse</td>
<td>Need for more and better shelters</td>
</tr>
<tr>
<td></td>
<td>Self-avoidance</td>
<td>emphasized values</td>
<td>Environment as threat for survival</td>
<td>Defence mechanisms for avoiding problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involvement in youth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Present Experiences</strong></td>
<td>Alcoholic, drug addict</td>
<td>Foundational teachings of good relationships</td>
<td>Better shelters needed</td>
<td>Loneliness</td>
<td>Lack of shelter, more and better services needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Education can provide access to teachings</td>
<td>Basic needs require additional provisions</td>
<td>Substance abuse is a barrier to Indigenous strategies</td>
<td>Need better resources for obtaining medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discrimination is a barrier to Aboriginal strategies</td>
<td>Access to medication is necessity</td>
<td>Healing through talking circles, collection of diverse experiences</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lack of shelter</td>
<td>Talking circles are effective for healing</td>
<td></td>
</tr>
<tr>
<td><strong>Future Intentions</strong></td>
<td>Connecting with Indigenous community</td>
<td>Escaping the urban environment</td>
<td>Traditional knowledge provides understanding and respect to benefit mental health</td>
<td>Need more service locations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indigenous Community support</td>
<td></td>
<td>Need more outreach programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Need expanded services/</td>
<td></td>
</tr>
</tbody>
</table>
Core messages and themes

The core message for P.155 was cultural connection and healing. This was the overall message for P.155, which can be attributed to her tendency to stay quite guarded throughout the interview. She did not elaborate on her experiences either and thus, there were no additional themes.

Cultural connection and healing

P.155 identified traditional knowledge as being an important aspect of her overall experiences of homelessness, and asserted that it had been central to her own identity and healing journey. For example, she described the presence of traditional knowledge and mental health in her own life by stating: “[Traditional knowledge is] caring, respect, love, good things, respect, a lot of things; ceremonies, like sweat lodge, sharing circles and pow wows… it is understanding and respect.”

Connecting with other Indigenous peoples with shared experiences was also identified as being an important aspect of healing for P.155. For example, she shared that: “[Talking circles are helpful] because you take other peoples’ experiences and add them up to yours and see which their solution is possible. Traditional knowledge can help in healing from aspects of mental health issues within the homelessness community by connecting with other Indigenous peoples, and to alleviate prevalent and prominent emotional difficulties such as loneliness. For instance, she shared: “[Cultural connection can positively influence mental health by] getting out of the city and going somewhere with other Natives.”

Table 25

<table>
<thead>
<tr>
<th>Participant 155 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core message</td>
</tr>
</tbody>
</table>
Participant 156

Narrative summary

P.156 was a 30-year-old man. He indicated that he was pushed into a life characterized by homelessness around the age of 19 and has been living on the streets ever since. He mentioned alcoholism as one of the major factors involved in his experiences of homelessness. He had utilized youth services until he was 25 years old and had then begun utilizing adult services. He shared that his biggest obstacle in terms of achieving housing and transitioning out of the phase of homelessness the challenges he faces with alcoholism. He noted that alcohol is a further barrier in terms of his cultural connection. For example, he indicated that he enjoys participating in the ceremony when he is sober; however, his addictions keep him from being able to do so most of the times.

P.156 shared that he was not exposed to a lot of traditional knowledge and practices while growing up since his home community was heavily influenced by Christian beliefs. He noted that a connection with the Elders and the land (i.e., hunting) has helped him catalyse his healing process since he can access such connections whenever he wishes. He noted that he grew up hunting and being on the land, but did not learn about smudging, sweats and other traditional Indigenous practices until he moved to a large Canadian city. He specifically discussed the concepts of mental health, sobriety and traditional knowledge, and how they seem to intersect. For example, he shared that when one relates to cultural practices and traditional knowledge, they are usually sober, which influences one’s mental health in a positive way; however, when one is using, they often find themselves in an emotionally more negative place.

Table 26

*The World of P.156 from individual interview*

<table>
<thead>
<tr>
<th>P.156</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Experiences</td>
<td>On and off the streets since age 19</td>
<td>Traditional knowledge not part of upbringing</td>
<td>Alcoholism strong part of homeless experiences</td>
<td>Went to hospital programming, he felt weird</td>
<td>Utilized youth services</td>
</tr>
</tbody>
</table>
Core message and themes

The core message for P.156 was cultural dissonance. Colonialism and traditional knowledge were recognized as the disharmonious factors and the resulting impacts of intergenerational...
trauma and maladaptive coping, as in the case of addictions issues amongst the Indigenous homeless peoples. The themes include impacts of colonialism, harm-reduction, as well as culture and healing.

**Cultural dissonance**

The gap in cultural connection in terms of cultural participation and engagement in the ceremony, combined with barriers of maladaptive coping (i.e., substance abuse) was recognized as a primary factor in the sense of the cultural disconnection that was described by P.156. For instance, he discussed the challenges of wanting to connect and engage in the ceremony; however, in times when his addictions were prominent, it often interfered with his ability to engage in the ceremony. He stated: “So it’s good when I’m sober [engaging in ceremony], it’s hard when you are drinking because you are not supposed to. You are not really welcomed around for using and stuff like that.”

He also recognized a sense of cultural dissonance to feeling disjointed and disconnected within the community regarding a clash of urban Indigenous traditional knowledge and community engagement as compared to rural and reserve traditional knowledge and practices. He noted that this can impact the cultural engagement in terms of feeling isolated and disconnected from the teachings that he has received from his home community. For example, he stated: “A lot of teachings in the city… they don’t even know about on the reserves.”

**Impacts of colonialism**

Influences of colonialism and cultural disengagement were also seen as thematic in the narrative of P.156 regarding his early experiences of cultural identity. He indicated that although there were some traditional practices in his home community, many of the traditional teachings were already lost due to the influences of Christianity. For example, he stated: “There was always hunting and stuff [on his home reserve], but my family is Pentecostal… There was [traditional] people on the reserve, but there is more Christianity than there is traditional spirituality.”

He also described his current experiences stemming from the impact of colonization, especially in terms of the mental health systems and colonial (Western/Eurocentric) approaches to psychology. For example, he shared an experience where he was attending an outpatient program
at a mental health hospital and noted that the approach had felt disconnected and inappropriate. For example, he shared:

I have been there [hospital substance rehabilitation program]; I just didn’t like the way they had the psychiatrist sitting there, jotting down everything in a circle. It felt weird… just makes me feel weird that I was in a circle with a psychiatrist jotting down notes.

Harm-reduction

The issues of substance abuse were recognized as significant barriers in achieving housing and were a barrier also in terms of cultural engagement and participation in the ceremony. Access to shelters was also identified as a significant barrier with substance abuse, and thus was also identified the need for a harm-reduction approach to shelters and care, especially for the Indigenous homeless people. For example, P.156 stated: “Alcoholism being the first need. Housing is another problem. Need a lot of help from drop-ins, places like this, shelters. If when I have a place sometimes, I am still on the streets due to alcoholism.”

He further recognized the need for a harm-reduction approach to Indigenous homelessness and recognized some of the current service workers who took this approach and how helpful it actually is. For example, he stated: “I guess my health worker helps me work with my addiction, because I am not always sober… Some programs work around it, reschedule or help me even when I am drinking.”

He recognized some of the current Indigenous harm-reduction approaches that have been helpful in terms of cultural engagement, traditional knowledge and addictions. For example, he shared that although he is unable to engage in certain ceremonies due to his substance use, the Elders would speak with him and listen to him non-judgmentally, which he finds to not only be helpful but also healing. He stated: “When they do bring the Elders around, the Elders will talk to you later [after the ceremony] … it’s helpful... just not feeling judged.”

Culture and healing

Cultural engagement and participation in ceremony were recognized as being significantly healing for P.156. He noted how relating to the members of the Indigenous community, particularly, Elders, was also a protective factor in regard to sobriety, substance use and healing.
For example, he stated: “[Talking with an Elder] It helps keep me sober, helps to still talk to someone, using it when they bring them around… with spirituality and mental health most of the time.”

Although he discussed cultural engagement, he noted a disparity in a disconnection from the traditional knowledge from his home community and how it can be difficult in finding those connections in a diverse city. For example, he stated: “I just talk to them [Elders], I don’t really work with them. I don’t have any clan or anything out there.”

Table 27

Participant 156 Results

<table>
<thead>
<tr>
<th>Core message</th>
<th>Cultural dissonance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td>Impacts of colonialism</td>
</tr>
</tbody>
</table>

Participant 157

Narrative summary

P.157 indicated that she had been living on the streets for fifteen years. She noted that addictions have been a strong contributor to her street-involved lifestyle. She shared that living on the streets can be very challenging in that some very basic needs such as hygiene and food are hard to attain. She noted that environmental stressors, such as the weather conditions make it difficult and challenging for one to survive. She noted, however, that she prefers living on the streets to shelters, as the conditions there are unsanitary (i.e., bed bugs) and can be quite unsafe for women. For instance, she often feels threatened by potential sexual assault.

P.157 shared that she currently smudges and participates in ceremonies, such as sweats. She noted that she feels that there are culturally appropriate health services available for the Indigenous people living in large Canadian urban centres. For example, she indicated that being involved in culturally-based services gives her the space to smudge and pray, which has influence her mental health in a positive manner. She further shared that having access to talking circles that involve an Elder has been particularly helpful to her in terms of healing from the past trauma experiences. She described that being surrounded by others and having an Elder present
is grounding, especially with the company of other Indigenous peoples who may have experienced similar situations in the past. She noted that this connection makes her feel understood and supported and has given her the platform and strength to effectively cope with her own current mental health concerns (i.e., recurrent depression).

Table 28

The World of P.157 from individual interview

<table>
<thead>
<tr>
<th>P.157</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td>Has been living on the streets for 15 years</td>
<td>Has had difficulty finding places to shower/keeping warm</td>
<td>Difficulty getting into a house due to long waiting lists</td>
<td>Living on the streets can be better than staying in a shelter</td>
<td>Has been on a housing waiting list for 2 years</td>
</tr>
<tr>
<td><strong>Present Experiences</strong></td>
<td>Healing continues even after leaving ceremonies Has a strong influence on the self</td>
<td>Participates in ceremony, smudging-able to access things through the Aboriginal Centre Smudging helps by connecting to the Creator and asking for help</td>
<td>Feels like living on the street is comfortable - it has ups and downs Street living fits the needs of addiction lifestyle Difficult transition to living inside once used to live outside Feels comfort in living on the street due to being surrounded by others</td>
<td>Reported having major Depression Has addictions Having connection with the workers at the shelter helps with addiction and mental health issues The best healing experience</td>
<td>Shelters are mostly accessed on cold nights Has been working with a caseworker There is accessibility to a lot of services Able to access them for 7 years Difficulty getting into a shelter</td>
</tr>
</tbody>
</table>
Being connected spiritually to the culture is very important, emotionally, and personally.

is hearing others say nice things and smudging

house due to long waiting lists

Future Intentions

Would like to find an apartment

Wouldn’t make any changes to the traditional supports as current traditional supports are helpful

Would like to continue accesses traditional supports and services

Core message and themes

The core message was cultural connection and support. P.157 described connections and relationships to be central to her overall experiences of homelessness, traditional knowledge and mental health/trauma.

Connection with culture

Involvement in the Indigenous community and attending ceremonies was identified as being a strong source of strength in P.157’s identity. Furthermore, she acknowledged this engagement and participation within the Indigenous community as an important factor in her mental health needs and overall wellness. For instance, she shared: “Ceremonies, smudging; I go to the Aboriginal Centre. Smudging helps a lot… since my Creator, and I ask for help all the time. It helps me, I love smudging. I feel special.”

Community supports

Connection with other Indigenous people and having the support of the community was also identified as a positive factor regarding mental health as well as strength and resources for the Indigenous peoples who are experiencing homelessness. P.157 recognized the empowerment of being connected to a community, especially when one is isolated because of homelessness. For
example, she stated that she feels “comfort is staying around people… you know. Surrounding… connecting… it is a great time, dancing, steps, sounds, everything.”

She recognized the connection and supports that she feels through the workers at the Indigenous services that she utilizes. She commented on the sense of community that she feels through engagement in specific Indigenous services, as well as through the connection and rapport that she builds with the workers and other service users whom she encounters. For instance, she stated: “It’s really great out there, in every way… they are really good, they care in the way that works for you since you are Aboriginal.”

Table 29

<table>
<thead>
<tr>
<th>Participant 157 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core message</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Themes</th>
<th>Connection with culture</th>
<th>Community supports</th>
</tr>
</thead>
</table>

**Participant 158**

**Narrative Summary**

P.158 was a 54-year-old man. He mentioned that he first became homeless at the age of 17. He indicated that he had been living on and off the streets ever since; however, he currently is housed in his own apartment. He noted that he regularly smudges, attends ceremonies and participates in talking circles that are organized by the Indigenous services downtown. He shared that having access to these resources was especially helpful and important to him. For example, he shared his experience of having attended a colonial camp and disclosing that he previously had significant difficulties with alcohol, which he used as a way of coping and that he had come to the Indigenous shelter for getting some sleep.

Further, he also shared that the workers helped him get sober and even helped him access his own apartment. He also noted that he feels supported by the agencies and trusts them. For instance, he said that they always help him get access to the basic needs, such as clothing, food and access to transportation. He also shared that he feels a connection with the other Indigenous people that use the services, as they generally have shared experiences.
### Table 30

The World of P.158 from individual interview

<table>
<thead>
<tr>
<th>P.158</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td>Used to live on the streets</td>
<td></td>
<td>Became homeless and came downtown at age 17</td>
<td>Indigenous service helped obtain housing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Was living on the streets for about 2 years on the sidewalk</td>
<td></td>
<td></td>
<td>Drunk in shelter-sleep on the floor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Went to training to survive the residential school</td>
<td></td>
<td></td>
<td>Staff provided money and food</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Was married but wife deceased</td>
<td></td>
<td></td>
<td>Services from church for 15 years</td>
<td></td>
</tr>
<tr>
<td><strong>Present Experiences</strong></td>
<td>Happy at his new place</td>
<td>Enjoys cooking traditional foods such as Bannock</td>
<td>Is not currently living on the streets or in a shelter</td>
<td>Is a chronic alcoholic</td>
<td>Having access to bus tokens, food and money is helpful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participates in smudges, talking circles</td>
<td></td>
<td>Remembering to not be prejudiced and hurt or judge people based on culture, instead support each other</td>
<td>They offer food, showers, clothing, laundry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Looking at the four colours (red, yellow, white and black) to look at the world in terms of race</td>
<td></td>
<td>Receives a lot of support from people at the shelter</td>
<td>They open at 5 am so people can take a shower and get food</td>
</tr>
</tbody>
</table>
Core message and themes

Indigenous identity was the core message for P.158. This was inclusive of aspects of culture, services and the self. The themes observed with P. 158 were trust in the community as well as trust in the support workers and culture as healing.

Indigenous identity

Influences of colonialism and survival as an Indigenous person were recognized to form the core message throughout P.158’s narrative. He noted that his experiences as an Indigenous person significantly affected his self-identity, his interactions and connections with others, as well as the way he connects with his culture as an aspect of healing from the colonial wounds and the subsequent maladaptive coping strategies, such as substance abuse. For example, he stated: “I never had been in residential school and I suffered, since the school. I went to training school to survive the school. I went to training school from the residential school. That’s different.”

Trust

Interactions and connections with others particularly trust was also recognized as a theme in the narrative of P.158. He recognized that his previous experiences have negatively affected trust, especially in terms of security in relationships and mistrust of non-Indigenous peoples and service providers. He also noted that he has had positive experiences that allowed him to trust the current people he works with and receives services from in the Indigenous community. For instance, he shared a positive and trusting relationship with some of the Indigenous shelter workers by stating:

I support these people here [workers]. I was coming here drunk, so they let me sleep on the floor and all I need is a blanket to give me cover… when I was down they help me walk, you know. I am a chronic alcoholic but I manage to make it down here.
Culture as healing

Engagement in cultural practices and ceremonies was identified as a positive healing experience and positive factor in wellness and the overall well-being of mental and emotional health. For example, he shared: “I smudge and participate in circles and we got the four winds… which is my favourite thing to do.” He further commented on the positive healing effects of cultural engagement, particularly in connecting and sharing his experiences with other Indigenous homeless peoples by stating: “I do like circles, I go to the [talking] circles… support each other while stick with each other.”

Table 31
Participant 158 Results

<table>
<thead>
<tr>
<th>Core message</th>
<th>Indigenous identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td>Trust</td>
</tr>
</tbody>
</table>

Participant 159

Narrative summary

P.159 identified himself being an alcoholic since the age of five. He noted that he had also used drugs in the past, but has come clean of the drugs since 1997. He described that many of the homeless people that he has met have had a variety of addiction issues and must utilize many of the shelters and services throughout the city; however, they get kicked out or are denied shelter due to intoxication and must restore to living on the streets. He shared that addictions are especially burdensome when one needs to and wants to access Elders, due to sobriety and cultural protocols. He shared that there are various levels of mental health and addiction needs for the homeless individuals and that accessing appropriate services can thus become a challenge.

P.159 also discussed the street ethics that exist amongst others when one becomes homeless. He indicated that there are rules that need to be followed to survive in a type of “sub-culture” that exists amongst the homeless, particularly in a large city. He also noted a camaraderie amongst the homeless peoples, especially amongst the Indigenous homeless; where they look out and
support one another, but chooses not to engage with many of the Indigenous services due to the “politics” and the racism that exists even within the Indigenous community.

P.159 acknowledged the strength in being Indigenous, in that, Indigenous are “adaptable people.” For instance, in the Indigenous mix, there is a lot of understanding and non-judgmental attitudes towards others; spiritually, emotionally, mentally and physically. He shared his perspective that the service providers need to be better educated so that they can understand multiculturalism, especially when working with the Indigenous community. He further shared his concerns for bringing about a change in the shelter system; as there are still many sexual assaults that occur in these establishments, thereby putting vulnerable people, such as Indigenous women, at risk.

P.159 shared his view that respect and relationships are at the heart of Indigenous traditional knowledge. For example, when applied to mental health, it can be seen that traditional knowledge is about accepting everyone at the same level, regardless of their education, race, background, mental illness, or homelessness. He noted that addictions are often used as an avoidance of feeling certain emotions; where traditional knowledge can be used to connect someone with one part of the self to be able to access the emotions. In that regard, it is necessary to have better connectivity with and availability/access to Elders. Subsequently, there is a need for multi-level services to help people at each phase of mental health trajectory. He also noted a multidimensional trauma and that Indigenous homeless can be experiencing physical, emotional, mental as well as spiritual traumas. This need to be addressed in the psychological treatment models of helping people cope with their forms of distress.

Table 32
*The World of P.159 from individual interview*

<table>
<thead>
<tr>
<th>P.159</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Experiences</td>
<td>Discriminated by people in community and people in social services</td>
<td>Indigenous culture is about adapting to different</td>
<td>Experiences of homelessness changes daily</td>
<td>Struggles with Alcoholism There are different forms of trauma:</td>
<td>Has been kicked out of shelters/host</td>
</tr>
</tbody>
</table>
due to alcoholism
Quit drugs in 1997 due to program
Drinking from the age of 5

situations and being understanding of each person

physical, psychological, emotional
Mental trauma is more difficult to process

due to

It’s comforting to know that others are out there and can be used as a support
If we want something positive- must work for it
Important to be understanding that people are at different levels of their journey, therefore should be free of judgment

There are rules and guidelines such as protect one another in life, especially the vulnerable
Experiences of

Living conditions are difficult when homeless, especially in terms of accessing basic needs

The lifestyle of being homeless is unpredictable and can be very stressful

It is difficult to maintain a steady, healthy diet

There are ethics and rules that some groups of homeless people

Many keep an eye on the women and children, as there are some people that may intend harm

It is difficult getting new people to

Elders are being overworked and are using

The existing programs are difficult for the homeless to be able to access

Services and quality of services fluctuate based on location

Racism within the community from the Elders, counsellors and instructors

Counsellors can be intimidating to some of the people

It is difficult to match housing needs, such as medication

Present Experiences

Life is more difficult to process

Emotional distress that is one of the largest barriers towards healing

Outreach Elders are available but are not always understanding when it comes to addictions

Some people who live on the street have more severe mental illness

More substance abuse concentration in the downtown area

Addiction is more likely when one has experienced multiple traumas in life

The existing programs are difficult for the homeless to be able to access

Services and quality of services fluctuate based on location

Racism within the community from the Elders, counsellors and instructors

Counsellors can be intimidating to some of the people

It is difficult to match housing needs, such as medication
Core message and themes

The core message for P.159 is having respect towards others, towards the land and acceptance. The overall message includes the intersections of homelessness, traditional knowledge and mental health as to the value of respect for both survival as a homeless person, as well as
survival as an Indigenous man. The themes noted in his narrative were: harm reduction, culture as healing, racism, and concurrent disorders.

**Respect and acceptance**

The main message that encompassed P.159’s narrative was having respect for the self, for the others in the Indigenous community and for the land. He noted that within the homeless community, particularly for the Indigenous homeless peoples, there is an overarching ethical value or respecting one another and the land as a means of survival. He noted that this overarching “street ethic” is a part of a rule system that helps guide each other and also provides safety. For instance, he spoke of the communal aspects of the Indigenous homeless community and the importance of respect by stating:

> A lot of Natives prefer to smoke so they will go down by the ravine and they know the rules… There are a few new ones… they don’t respect those rules, you know and it’s not our people, its different cultures… we have a hard time with them trying to get them to understand, this is the rules… like make sure the park is clean, there is no needled, or you know crap by the floor and especially by the kiddy playground. We also watch for the women and kids there, because there had been a few people with undesirable attitudes show up. So we basically, we are trying to protect the area.

He also noted the importance of respecting the self when it comes to mental health and survival while experiencing homelessness. He further indicated that what lies beyond the domain of self-respect, is having respect for other peers within the community and being able to protect the vulnerable people, especially in when it comes to the street culture. For example, he stated: “If you don’t respect yourself you know things don’t work too well… but we helped out people that are handicapped or whatever, you know. Everybody is handicapped in some sort.”

He further noted that respect and acceptance is an indivisible component of Indigenous worldview and traditional knowledge. He demonstrated this by stating: “The thing is, you know when you use traditional teaching and stuff, you have to be accepting of everybody and everywhere.”
Harm-Reduction

Addictions and the interaction with cultural engagement were also identified as potential barriers, particularly in terms of mental health and housing. For instance, P.159 recognized the challenges of seeking shelter and supports when using. He stated: “The addiction thing is the reason why we get kicked out of here sometimes.” He also described the barriers in regards to services that meet a harm-reduction approach, especially when one is making attempts to recover. For instance, he stated:

You can’t put a drug addict into a drug house. You can’t put an alcoholic into a booze camp. You know a lot of times that’s what happens…. They find it is convenient to get somebody in, it’s a numbers thing. You know people out here, we are not numbers, we are people. You know but for them, the idea of housing someone is a pattern, their pattern or whatever and they may not be doing anybody any justice.

Culture as healing

Being engaged in cultural practices and ceremony, as well as having a strong connection with the community was also recognized as an important factor in healing from the emotional, mental and spiritual wounds, especially traumas. P.159 explained how being connected with the other Indigenous peoples is particularly helpful in terms of respecting and accepting one another through a lens of shared experiences and togetherness. He also noted the presence of camaraderie that can be seen while protecting and looking out for other Indigenous peoples, particularly those who are vulnerable. For example, he stated:

[Traditional knowledge is practiced every day] by talking to people, sharing moment with people. Sharing time… because some people are sick, you come out here and you know they are vulnerable. So you try and show them or teach the best way that makes it easy; basically that is a very, very generalized rule is you got to respect yourself and you got to respect everything else around you.

He also described the relationship between traditional knowledge and mental and emotional well-being. He recognized that the best way to help someone who had endured spiritual loss and trauma were to accept them, no matter where they were in their healing journey; he stated that respecting them was equally important in terms of helping them. For example, he shared:
There are 137 different emotions that we are aware of and most times, you know, traditional teachings are applied with compassion, acceptance. So you can’t walk in the situation of somebody with mental illness and spiritual loss because they don’t even understand what they are going through.

He further described the importance of acceptance in terms of respect, especially from a traditional knowledge approach to mental health and healing by stating: “Those spiritual teachings help a lot, because that is one of the big stones, accepting human beings, accept other people at different stages.”

Racism

The experiences of racism and an overall disrespect for Indigenous people from the non-Indigenous peoples, as well as within the Indigenous community were found to be thematic in the narrative of P.159. He noted that racism is particularly prevalent within the various social service agencies, both Indigenous and non-Indigenous. For instance, he stated:

I think that some of the instructors, or counsellors… I hate to say it, like there is a lot of racism in our community, even from our Elders… the fact is like that fight has been fought and it’s old, you know. It is not like we are hearing people be raiding other cultures and other people. You know it is because they got anger issues or something.”

He also recognized the need for a generalized acceptance of multiculturalism in the homeless community as well as in the various available services. He also spoke of a generalized acceptance of the difference in thought, behaviour, emotions and personalities as a function of multiculturalism. For instance, he stated:

When you are multicultural you have to understand that there are different beliefs and also different personalities and they generalize everything. So it kind of puts a stigma on it… and I don’t know, maybe they need to get people skills, you know it’s really important.

Concurrent disorders

Through the experiences shared by P.159, the presence of co-occurring mental illnesses and addictions issues was found to be prevalent in the Indigenous homeless community. For
example, he shared the issues of the combination of mental illness and addictions in terms of accessing and obtaining the required help. He stated:

So when the guys get kicked out of [the shelter because of substance use], they need somebody to be able to speak to them on their level… because people are on different levels, some have mental illness, people with extremes like bipolar, schizophrenia and a lot of other psychological problems…. We go from the mental ailment to the physical ailment, you know to emotional distress and whatever. Right, so and a lot of problems for people out here is the emotional distress.”

Table 33

<table>
<thead>
<tr>
<th>Participant 159 Results</th>
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</thead>
<tbody>
<tr>
<td><strong>Core message</strong></td>
</tr>
<tr>
<td>Respect and acceptance</td>
</tr>
<tr>
<td><strong>Themes</strong></td>
</tr>
<tr>
<td>Harm reduction</td>
</tr>
<tr>
<td>Culture as healing</td>
</tr>
<tr>
<td>Racism</td>
</tr>
<tr>
<td>Concurrent Disorders</td>
</tr>
</tbody>
</table>

Participant 160

Narrative summary

P.160 was a 32-year-old male. He shared that a White family had adopted him, as a result of which he grew up without the influence of Indigenous traditional knowledge. He noted that his mother was an alcoholic and wanted him to have a better life. He shared that his adopted family brought him to visit his home community when he was ten years old; however, in his opinion, back then he was too young to really absorb what it meant to be there. As a youth, he had quite some difficulty with the law and was sentenced to community service and was then returned to his home community. He began to learn about his culture from an Elder and from engaging in ceremonies.

P.160 shared that he first moved to a large Canadian city in 2007 at the age of 23 and was completely alone; he first went to live on the streets in 2009. He acknowledged the stigma that comes into existence from a societal level regarding homelessness without understanding or experiencing it, and identified a layered level of stigma and marginalization as an Indigenous homeless person. He shared that he was happy living on the streets and had made great friends that formed a sense of community. He noted that it was the influence of substance use that put
some limitations on the camaraderie. He identified the physical effects that the lifestyle of addiction and homelessness can have, for instance, the stressors involved in basic need attainment when addiction is the primary need. He noted the emotional difficulties that he experienced when he lost his homeless peers and shared that he lost his partner to an overdose.

P.160 shared his perspective that youth was a crucial time to intervene when one initiates homelessness or substance use/abuse. For example, when one has become used to a certain coping mechanism or living a certain lifestyle, it gets hardened with age and it becomes difficult to change the habits later. He recognized that one must want to make a change; therefore, services should be adapted to an individual level.

Table 34

*The World of P.160 from individual interview*

<table>
<thead>
<tr>
<th>P.160</th>
<th>Self</th>
<th>Traditional Knowledge</th>
<th>Homelessness</th>
<th>Mental Health &amp; Trauma</th>
<th>Social Service Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td>Was adopted by a White family</td>
<td>Introduced to culture (Elder/ceremony) through the criminal justice system</td>
<td>Stigma of homelessness</td>
<td>Used alcohol/drugs to cope</td>
<td>Outreach and Indigenous shelter helped a lot</td>
</tr>
<tr>
<td></td>
<td>Positive experience in family upbringing</td>
<td>Open dialogue in adopted family about cultural knowledge</td>
<td>Panhandling is part of the lifestyle</td>
<td>Cycle of addiction and hopelessness are major deterring factors against accessing services</td>
<td>Utilized other services to obtain housing</td>
</tr>
<tr>
<td></td>
<td>Birth mother was alcoholic</td>
<td>Learned about culture through experiences and helping Elders with ceremony and sweats</td>
<td>Addiction and violence are a downside to homelessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Girlfriend died in 2011</td>
<td>Overcoming grief made him stronger</td>
<td>When first homeless, addictions are primary concern</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Present Experiences</strong></td>
<td>Has a personable personality</td>
<td>Reconnecting with Aboriginal background can</td>
<td>Homeless peers can help each other in hard moments of</td>
<td>Struggles with alcoholism</td>
<td>Services with tokens, health, and</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Feels guilty asking for help
give a sense of happiness
alcoholism/drug use
drink less than before
overall support are appreciated

Tries to enjoy life as it is
Alcohol and drug use are barriers to access Aboriginal ceremony and healing strategies, such as smudging
Stress is caused by interactions with police
Change has to come from self
There are some people in the circle of care that are not supportive

Isolation, even when surrounded by peers
Homelessness lifestyle can become comfortable for some people
Support can have strong influence on mental health
Some services are driven by economic interests and not homeless needs

Aging effects of substance use and street lifestyle
Depression; avoidance not effective coping strategy
Indigenous services provide supports and resources

Use of money for food and substance use in a large portion of the homelessness lifestyle

Outreach is positive for accessing supports

Future Intentions
Wants a 9-5 job
Important to intervene when people first get on the streets, time and response to change are strongly correlated
Homeless people need to come together

Services need to be geared to what the homeless really want, otherwise, no one will use it
Services should be tailored to
Core message and themes

Identity was the core message that emerged from the narrative of P.160. He recognized that identity was embedding in multiple aspects of his experiences, including homelessness; this identity was as an Indigenous person as well as the self in survival and coping, including relationships and loss of others. The themes noted were discrimination and stigma, survival, loss and coping and cultural engagement.

Identity

The core message throughout P.160’s narrative was the various aspects of identity and the self within a community, an environment, society and a culture. First and foremost, he recognized the importance of support and the sense of self within a group. He noted that being on the streets provided him with a sense of belonging, especially following the isolation that he had experienced from moving to Toronto. For instance, he stated:

The benefit is you get good friends out of it too, and really close friends, like I’ve got family here now… The streets kind of help me get in touch with people that experienced what I experienced and gone through what I went through.

Second, he recognized a sense of identity gap in that he was raised by a non-Indigenous family and was, therefore, missing aspects of his identity in that he had never really been able to connect with his Indigenous culture and background. He noted that although he felt disconnected from his culture growing up in a White family, he felt that his upbringing was a part of his identity, which he valued. For instance, he shared:
I haven’t really been big into my background, I lived a lot more than I did, I was adopted by a White family, so I grew up in a White house… I was raised by a really good family, I completed up to grade twelve, I was raised to respect my Elders, anybody that is older than me, and my one rule that was taught to me is if you want respect you have to give it. And my family, I am proud to say that I am a secure man, because my family raised me to be the men that you see in front of you.

**Discrimination and stigma**

As an Indigenous homeless person, P.160 also recognized identity as a theme, regarding the negative experiences of stigma, discrimination and racism. He noted that the Indigenous homeless is a much-marginalized group, and therefore many of their experiences were comprised of aspects of racism and discrimination. For example, he shared, “A lot of people like to judge the homeless, without knowing or experiencing it, and that’s one thing society has a problem with, is they judge before they have the experience, or give the chance to experience.”

He also talked about the aspects of marginalization and racism that occur for Indigenous homeless peoples by stating: “The judgments, and just the way society looks at you, and especially being Aboriginal too.” He further recognized the stigma regarding addictions issues when one is homeless and the judgment that then occurs from the greater public and society. For instance, he shared:

That’s what they do because I am an alcoholic but I am not a drunk, and I was walking down the street, and a lot of people, not just Whites or anything, it just society itself, they look at me like I should be drunk or I should be on the corner panning or something.

He also noted the challenges faced in terms of survival, especially when one is experiencing addiction issues and the aspects of stigma and discrimination that the people are likely to face when attempting to survive on the streets. He stated:

You got to look for your next drink and everything and that’s a lot harder because society doesn’t really want to hand you money, because they know where it is going they know you are going to drink with it or do whatever drug with it or everything. That’s makes it a lot harder because the person is just trying to survive.
Survival

Having the basic needs met while enduring the experiences of homelessness was also recognized as central to the experiences of P.160. He noted, specifically, that having peer support was integral to his survival and perseverance, such as in mental health when experiencing homelessness. For example, he stated:

But as long you meet the right people, and hung out with the right people, you won’t have the problems, but I mean, you will have problems if you go looking for them, or you know you start stuff or whatever.

He especially noted that having peer connections had helped him both emotionally and mentally:

It gives me experience hearing the stories and everything, and that’s what I like hanging out with older people just because their experiences are helping me for the future, and it guides me in the right direction as well.

He also discussed the challenges of survival and addiction and the effects that chronic substance use can have on one’s body and mind. He mentioned that addiction not only creates health issues but also brings about lifestyle challenges. He noted that intervention needs to occur early in homelessness and when one is most vulnerable to substance abuse in order to promote survival and recovery. For example, he shared:

When I was 20, I could drink like a champion, you know, get up the next day and do it again, but now I get a hangover and everything, and I recover for three or four days. And especially doing that out on the streets, with the planning and everything you got to look that’s the job, how am I going to get my next drink, I am shaking, I got the DTs, and everything, and that’s your job.

Loss and coping

Loss and grief was also a recurring theme in the narrative of P.160 and also in his overall aspect of identity as an Indigenous homeless person. He shared that a part of his homelessness experiences was ridden with the loss and death of loved ones and friends, particularly due to the harsh environment and lifestyle that encompasses homelessness. He noted that this loss and grief
further influence one’s mental and emotional health in a negative manner. For example, he shared:

My girlfriend died of her life style, she was in the drinking industry, rub, while she did pretty much any drug, and everything. And when I got with her, I told her I am not here to change you. I am here to support you through whatever you need. And I think that’s what people need on the streets.

He further shared his experiences of loss by saying:

A lot of people, a lot of my friends, passed away. And it is from the life style, and that’s the life style that will kill you. It’s the drugs and alcohol and the homelessness and everything. And if you want that change, you physically and mentally got to want it… I really got tired of going to the memorials and everything you know, so I just started being support for everybody else.

Cultural engagement

Cultural identity and engagement in cultural practices and being part of the Indigenous community were also recognized as an important theme in the narrative of P.160. He also identified that disconnection from the culture and not being exposed to traditional knowledge at an earlier stage in was regretful for him and it was something that he found to be missing in his life. He also shared his story of cultural disconnect. For example, he shared:

My parents told me, that if any time I want to learn about my background and anything, what do you want to know, just ask. And that was when they took me out, out north somewhere… I can’t, [ok] and told me all I was young at that time, I was about ten years old, they took me there, they want me to learn?? But like I said I was too young, I didn’t really know that- that it means so much to me, but now, now that I look back at that time, I wish I could go now.

He also noted that reconnecting with his culture as an adult had had a very positive influence on his mental health and wellbeing, and as such with his identity. He noted that he became engaged with his culture and began learning about the traditional knowledge through contact with the criminal justice system. He shared:
I got arrested and in trouble and get me in community service. I went to this Elder at sweat lodges... Now first, I was... ok with community service, so I just wanted to lay down all the time, and make the notice, so they told me, get up and start doing some work, I said all right, I started chopping some wood, I was the fire keeper. That’s how I started learning more about my culture and my parents were supporting me. And it was one of the best experiences that I had in my life. Ah, if I could go to more sweat lodges I would.

Table 35

*Participant 160 Results*

<table>
<thead>
<tr>
<th>Core message</th>
<th>Identity</th>
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<td>Themes</td>
<td>Discrimination and stigma</td>
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**Summary of Chapter Four**

Chapter Four presented the participants’ analyses and results for the sixteen participants who shared their narratives representing their experiences of homelessness, traditional knowledge and the influence of mental health and trauma. This was inclusive of a summary of all the participants’ narratives combined with the overall message and underlying themes that were present in each participant’s narrative. Their story was then presented on the basis of the core themes that related to the research question on the intersections of homelessness, traditional knowledge and mental health/trauma. These core themes were presented in terms of time as in past experiences, present experiences and the future intentions. Descriptive examples of each participant’s themes were also incorporated in the within-participant results.

Chapter Five will now present the overall themes that are emerging from the individual narratives of all the participants. This is inclusive of a summary of the common themes that were presented to the participants. The analysis in chapter five including a summary of the common themes is presented in the across-participant results. As such, overall the meta-themes were analysed in function time, as presented in the within participants’ results via individual story maps. The following chapter explains the overall meta-themes of the intersections of traditional
knowledge, mental health and trauma as well as the overall experiences of homelessness for various Indigenous peoples.
Chapter 5
Across-Participant Results

Chapter five consists of the results of analysis of the across participants’ experiences of the intersections of homelessness, traditional knowledge as well as mental health/trauma. This chapter will also discuss the analysis process of the data and its importance to the overall concepts and data presentation in qualitative research. As indicated in the methodology section, this research was a part of a larger project by Dr. Suzanne Stewart’s Canada Research Chair in Aboriginal homelessness and life transitions. Therefore, the analysis followed a specialized process that has been adapted and constructed by Dr. Stewart for her doctoral research (Stewart, 2007).

The results presented in this chapter are organized according to their theme and relate to the research question, “What are the intersections of trauma, mental health and traditional knowledge for urban Indigenous homeless people?” These are the across participant results that summarize the overall experiences of the participants’ that had been presented in chapter four, within the participant results. The across participants’ results chapter has been divided into three sections, which reflect the three overarching meta-themes that emerged from analysis across the sixteen interviews with the self-identified Indigenous people who were currently homeless or had been so in the recent times.

The three most important meta-themes that emerged from the participant data are recognized as being fundamental to the unique experience of homelessness as an Indigenous person. These three meta-themes are Psychological Factors, Cultural Identity and External Factors (See Figure 1). These overarching meta-themes represent the factors that influence homelessness in different ways. None of these meta-themes was mutually exclusive, but nonetheless, all the meta-themes were present throughout the stories of all the participants’ experiences. Furthermore, the participant results indicated that there were important time frames in the experiences of homelessness, in which these factors were quite critical in terms of their influence on the narrative. For example, the themes identified were observed to be critical in the outcome of the experience, as it appeared to be intersecting with the function of time in regards to the experience of homelessness. These three critical time points in the homelessness experience were identified
as timing as a risk for homelessness, the experience and maintenance phase of homelessness, and transition to housing/ recovering from the state of homelessness.

Figure 2
*Overarching meta-themes as a function of time*

Although the themes varied in terms of homelessness, it must be noted that the time frames outlined here are interchangeable and can be cyclical in nature. Therefore, what is notable is that one does not progress through these stages linearly, but can cycle through them, at any given point; for example, one can cycle back and forth through the stages of homelessness and transitioning to housing, via waitlists, eviction, etc.). The results of the qualitative thematic analysis across the participant interviews were specifically the participants’ experiences of homelessness and the intersections with traditional knowledge and trauma support for the Indigenous peoples. Figure 1 demonstrates how each meta-theme was represented in the participants’ overall portrayal of homelessness in the context of traditional knowledge and trauma/ mental health.
Each meta-theme was recognized as an influential factor to the homelessness experience and emerged as a common aspect of the intersections of homelessness, traditional knowledge and mental health/trauma amongst the participants’ narratives. Each meta-theme will be presented below in more detail as it relates to the research question as well as in the experiences of the participants. They are also presented with the specific themes that were identified in the participants’ narratives and how they relate to time in terms of homelessness.

**Psychological Factors**

The participants recognized that psychological factors had a strong influence on their overall experiences of being homeless. Aspects of trauma, mental health issues and addictions were recognized as the primary psychological factors that reinforced the risks of homelessness and were thought to be concurrent with or emerged during the direct experience(s) of homelessness. Furthermore, it was recognized that dealing with these issues, especially through a cultural lens, was imperative in the recovery process and required stabilization in some way before one could successfully recover and or transition out of the state of homelessness.

**Table 36**

*Thematic psychological factors of Indigenous homelessness*

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<thead>
<tr>
<th></th>
<th>Risk for Homelessness</th>
<th>Homelessness</th>
<th>Housing/Recovery</th>
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<tbody>
<tr>
<td><strong>Trauma</strong></td>
<td>Early experiences of trauma</td>
<td>Ongoing traumas during homelessness</td>
<td>Healing from trauma with appropriate supports</td>
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<tr>
<td><strong>Mental Health</strong></td>
<td>Mental health issues as vulnerability</td>
<td>Mental health concerns from being homeless/coping with homelessness</td>
<td>Overcoming mental health issues and holistic care; resiliency</td>
</tr>
<tr>
<td><strong>Addictions</strong></td>
<td>Addiction as vulnerability to homelessness</td>
<td>Concurrent addiction issues maintaining homelessness</td>
<td>General and cultural barriers and supports to cycle of addiction/recovery</td>
</tr>
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*Experience/ cycle of homelessness*

Psychological factors are transient in that, they are not crystallized but are ever-changing. Therefore, they are recognized as the major contributors in the cycle of homelessness and need to
be stabilized and concurrently treated during the change process in order to promote recovery. Although the psychological factors are separated into three separate themes as they relate to trauma, traditional knowledge and homelessness, it is important to recognize that these three factors often occur together, and therefore, the experiences differ individually; however, the following table explains each theme in relation to time and homelessness regarding the psychological factors that are involved. The three themes that underpin the meta-theme of Psychological Factors are as follows: trauma, mental health and addictions. Table 34 presents the themes and how they intersect with homelessness at three points in time, when an individual is at risk for homelessness when he or she is homeless, and when they’re in housing or recovering from homelessness. These themes will not be discussed within this temporal organization.

**Experiences of trauma**

Trauma was present and was a predominant theme in most of the participants’ stories. This was especially reflected in the early experiences of trauma in childhood and adolescence or as an adult as being a factor as a potential precursor to the phenomenon of homelessness. The early influences of trauma either directly or in an intergenerational sense were identified as a type of vulnerability and a predisposing factor towards homelessness as well as towards experiencing further traumas later in life, especially during periods of homelessness.

Trauma was recognized as an ongoing reality of homelessness, and thus, it can be experienced as a direct single trauma, or can even be recurrent. The ongoing stress of homelessness and the environment that ensues were also identified factors that could trigger re-traumatization. The results suggest that trauma can be seen as a predominant factor in the homeless experiences of Indigenous peoples. This can be attributed to the surmounting accounts of trauma present within the Indigenous community and part of the historical context of Indigenous people in Canada. This was further recognized as a primary need that must be addressed in the healing process of Indigenous peoples in their process towards overcoming the state of homelessness.

The early experiences of trauma faced in life were recognized as a theme than tended towards emotional vulnerability and therefore, were recognized as a contributing factor in the development of psychological distress through dysfunction in the family dynamics. The participants discussed how intergenerational trauma often transmits through the family environment and exposes individuals to the unhealthy coping mechanism as well as attachments.
For example, P.147 stated, “Growing up, you grow up with alcoholism; you grow up with violence. I left there purposely.” Another participant stated:

A lot of [Indigenous] people seen a lot of abuse, they just you know, go to drinking, seeing a lot of violence, I don’t know. A lot of people told me they seen a lot of violence happening at a young age (P.151).

Another participant described the home environment as a source of complex and perpetual trauma; this assertion was followed by a description of how the chaotic home lives often become risk factors for the upcoming experiences of homelessness. For example, P.152 stated:

Yeah, a lot of alcohol and drugs. Growing up in a home with alcohol and drugs and parties all the time and violence, and a lot of sexual abuse. I had seen a lot of sexual abuse. It has a lot to do with who I am (P.152).

Experiences of early trauma were further recognized as being a void in terms of healthy emotional development and psychological growth. P.152 further explained:

It was tough, a lot of skeletons in my closet and stuff. It was tough, it was all emotional because I have been so blocked for a long time, like all my feelings, everything I was holding in, was blocked, a mental block. When I sobered up I started realizing how much problems I had. I got to look at my life (P.152).

Family dynamics and dysfunctional attachments were also identified as distinct aspects of trauma. Often times, the participants said that the family dynamics played the role of catalysts in the progression of trauma and they even created a sense of environmental vulnerability. One participant explained:

I don’t even have a mother. Like I call my mother, but it’s like talking to a friend or something, like you know, ‘hey how you doing you little bitch’, and I’m like ‘fuck you, you old cunt.’ That’s my relationship with my mom. She even tried to shoot me with a twenty-two [shotgun] and it skinned a part of my head here, just missed me. I ran out of the house before she could reload. I was only 13 then (P.145).
The family dynamics and environmental stressors were recognized as being risk factors towards the psychological difficulties and experiences of the homelessness. When applied to the experiences of the Indigenous peoples, the aspects of intergenerational traumas and colonialism were recognized to be influential in the experiences. The participants recognized influences of trauma generationally in the way it factored into experiences of homelessness. P.151 described how the family environment can foster vulnerability towards patterns that can put someone at risk for homelessness and stated, “Well I don’t know, it [vulnerabilities to homelessness] just depends on the way the family lived their life, right?”

Trauma was also recognized as being a primary predisposing factor that contributed directly to an acute state of homelessness. Although intergenerational as well as early experiences of trauma create a strong emotional vulnerability towards other unhealthy trajectories; acute trauma was recognized as a factor that could put one at imminent risk for homelessness. P.145 described how the violent circumstances and trauma contributed to the onset of his first experience of homelessness:

I came to [a large Canadian city], because I was homeless for a bit, because I moved from [small Canadian town] to here. I had to leave the guy I was with because he was very abusive so I left, left all my belongings and everything. Just came with a free backpack on my back.

The homeless lifestyle also brings an added aspect of repeated exposure to trauma. When one is chronically deprived of the basic needs and safety; they are at a chronic level of emotional arousal and, therefore, show much more vulnerability towards having their trust and safety threatened. This can put one at the exceptional risk of experiencing ongoing/new traumas while being homeless. P.150 explained, “There is so much around that one subject [trauma] alone, I’ve bled, I have been cut, I’ve been shot, I’ve been knifed… I have had friends executed in front of me, you just go with it.” These chronic traumas were recognized as being a part of the reality of living on the streets. P.150 further stated how the pre-existing mental health concerns, coping with drugs and alcohol and the ongoing traumas perpetuate through homelessness was a predominant concern among the homeless people. For instance, he stated: “Well when you are out there … there’s a lot going on, people getting shot, and people overdosing. One day your friend is there, and the next day he is gone.”
Another participant described the ongoing exposure to traumas as a reality that people experience when living on the streets, and that the street peoples’ trauma can strongly influence their aggressive and erratic behaviours:

I’ve seen how people react. Even off the booze people just, you can see their face go blank and then something clicks on in their head and then next thing you know you are defending yourself from this person and just ten minutes ago, you guys were laughing. That’s what blackouts are; something in their brain clicks, and I have gone through enough of it, I’ve been beat up countless times, my street father has almost killed me twice (P.160).

The risk factors for both experiencing trauma and being triggered were recognized as being significant issues in the shelter system. Physical safety was identified as a serious concern, especially for people who had histories of trauma, where it was felt that shelter staff did not always address these concerns:

They [the shelter staff], never tried to fix the situations and there were, you know, a few sexual assaults and stuff that happened [in the shelters], not from staff or whatever but you know, they just ended up that way. So, they never did nothing for that (P.159).

P.145 also recognized the personal physical safety and trauma as an issue in her experiences of homelessness. For example, she stated: “Living on the streets, I almost got raped and stuff like that, that’s bad. I always sleep at [shelter name] now because they got cameras so it’s videoed. Everything is videoed, so I feel safe there.”

Coping with trauma was said to be a significant barrier in the recovery from homelessness as well as from the other mental health challenges. Some of the symptoms of psychological trauma were recognized as being challenging when faced with high-stressed environments, such as with living on the streets. This was recognized as a painful process and was a major contributor to the ongoing cycles of homelessness. One participant stated:

I just got recently diagnosed with Post Traumatic Stress Disorder (PTSD). That’s kind of got me on survivor mode all the time- like sometimes maybe my paranoia acts up or my anger you know- turns into like hatred you know it just comes like [snap] sensitive
trigger. Like if you were to have senses like [pew pew pew]. So, uh I’m more reactionary; irrational; so being like that and then... you know, being challenged like that- when you’re suffering from things you don’t know about- you know posttraumatic stress (P.147).

Experiences of trauma were recognized as being significant contributing factors in the maintenance as well as the continuation of the cycle of homelessness. The participants described the different ways in which one can be (a) supported from trauma; (b) support other members of the homeless community who dealing with trauma and (c) what can the services providers do to help and heal a homeless Indigenous person from the immediate, chronic and intergenerational trauma(s). The participants also voiced their own experiences of coping with traumas that they have endured in their life, pre- homelessness, as well as during their experiences of homelessness.

Avoidance was recognized as being a common coping mechanism for the individuals who have experienced trauma, especially while dealing with acute stress in volatile situations such as homelessness. Dealing with emotional issues can be overwhelming and distressing and can therefore serve as a major barrier in engagement and motivation towards psychological treatment. One of the participants described the painful process of emotional wounds of trauma when engaging in psychological treatment. The healing journey that helps one recover from trauma is a complicated process, and to some, it can seem easier to avoid, rather than processing emotionally. The participant stated:

What was difficult was bringing it [trauma] up and talking about it, writing it down, facing it. Digging up stuff from my past; stuff that I didn’t really think about when I was out on the street, not sober, hard drunk. I mean you know, I didn’t think about none of it, then when I started sobering up, then I started thinking about that, yeah, that explains why I am the way I am (P.152).

Another participant commented on the use of avoidance as a coping mechanism and also as a means of survival when having to go through the stressful experiences of homelessness. The suppression of trauma through avoidance, thus creates more emotional difficulties. It was recognized that if psychological trauma and pain are not dealt with in an adequate manner, the
pain can be easily triggered and can then lead to other emotional challenges, especially in times of high stress and in unhealthy or chaotic environments:

If you don’t talk [address the trauma], you just suppress it, and its always going to be there, anything can trigger it and you get right to that feeling of when it first happened. It will always come back right away because it just happened again. But it shouldn’t be happening, maybe you should deal with it, and talk about and get it out maybe that feeling just goes away, you know, doesn’t surface anymore. If it does surface, it’s like, oh I’m done with that already, I deal with it, and it goes away again. Right? But a lot of those other people they don’t deal with it, they just suppress it (P.160).

Another participant further discussed the difficulties that are maintained through the processes of avoidance of dealing with psychological traumas. This participant also described the difficulties that arise while supporting homeless peers while at the same time, everyone is managing their own emotional pain at a separate, individual level:

Emotionally, not really, it [talking] hasn’t helped, because I am the type of person that pushes everything down, which isn’t good to push everything down. The reason that I push everything is because, I am the type of person to be strong for everyone else, because I know everyone else takes things harder than I do- and part of that is because of my upbringing and everything… The emotional part is hard, because I am trying to keep it down, but it won’t stay down and yes, it comes up (P.160).

The different aspects of trauma were also described in the complexity that these experiences can have on the self, how one interacts in the world and their interpersonal relationships with others. One participant discussed how the system has failed many victims of trauma by focusing on the problems and/or the consequences that psychological trauma can have on a person’s life. This participant discussed the lack of focus on the resiliency that many trauma survivors have, especially since many have endured multiple ongoing as well as intergenerational traumas:

Well again you know, there are different forms of trauma. Physical, psychological, emotional, basically mental; they [mental health providers] haven’t progressed too much in the last few years anyways. You can show up with a physical trauma and they will send your ass down to the hospital. You show up with an
emotional trauma they will send you down to the crack farm. You show up with a mental trauma or with a physical trauma, which is a substance abuse and they will put you inside somewhere. We as a society are quite comfortable with negativity in our lives. One of the things we forget is in order to have positive things; you got to work for them (P.159).

Peer supports was also recognized as an important factor that could help one heal from trauma, as peers have shared experiences and can understand what that emotional process feels like, even if they can’t put it in words or talk about it in their emotional healing journey. Having a safe space to talk about these experiences was recognized as an important aspect of the healing process and is not always accessible when one is living on the streets. One participant stated: “[Trauma survivors] need support. They need to learn how to build up their strength, you know, to fly, you can’t do it then [when homeless], I can’t even- I have my issues too” (P.148).

Homeless individuals need to have a safe space in an environment that is inclusive of people that can support them while allowing them to feel understood and heard. This is especially true for the Indigenous homeless community that can understand and support each other in a safe environment. One participant further commented on the ways in which this could be achieved by stating:

Maybe focus groups or something [for trauma survivors], like connecting people that had been through the same stuff and find [talking circles] coping ways to deal with it all; that pain and shit, you know. Sometimes it is good to do this with more people that had been through the same stuff (P.152).

Another participant said, “That is how come we hold the circles and everything. Yah, that is the reason why, that is our support, it is being with each other” (P.145). Yet another participant discussed healing from trauma and suggested some recommendations for trauma therapy. This addressed the gap that was mentioned earlier about the difficulties with managing emotional traumas in high-stressed environments, such as while living on the streets. Many individuals resort to unhealthy coping mechanisms in order to avoid painful emotions; such tendencies eventually lead to addiction. Therefore, it was proposed that treatment should include emotional processing in healthy ways that help someone express and regulate their emotions, especially when triggered:
More of the understanding of your feelings, like the emotion, you got to understand emotions, you know, that there are hundreds of them, they’re all good, you know. They may all not be good at that time you know, emotions, and if you understand emotions and then you get down to align everything of the emotions and then you know, yeah. To guide people into their emotions and to show what their emotions are, don’t be afraid of them, because a lot of things you know you’ll hear people talk, especially if you are a guy, being emotional, you know, you’re looked at (P. 160).

Mental health

The participants recognized how mental health issues are a predominant factor in the homeless community. Personal accounts of mental health issues were recognized as risk factors in the process that leads to homelessness. It was also recognized that mental health issues can be a significant concurrent factor, where homeless people often have pre-existing mental health issues. It was also recognized that the participants experienced emotional difficulties as a result of the stress and effects of being homeless. The participants also recognized that homeless people are amongst the most emotionally vulnerable people, and thus, acute mental health stabilization should be the first priority in terms of healing and recovery. Furthermore, mental health issues were recognized as negative prognostic indicators in transitioning from the state of homelessness into housing.

Regarding the pre-existing mental health issues as a risk factor to homelessness, one participant discussed how grief and trauma had contributed to homelessness and ultimately, how the mental health issues had maintained homelessness:

Well when I got here, I found out that my eldest son’s father was murdered and dismembered… that’s how I finally lost it… I was a substitute teacher… but I got blacklisted because I have mental health issues now because of that (P.145).

Emotional effects from the experiences of homelessness influence mental health as well as the psychological well-being. Many participants recognized grief and loss as a primary theme in the psychological effects of homelessness. P.146 discussed the consequences of maladaptive coping from emotional pain: “My hands are dirty bloody, that from falling. Drink a lot… to kill the pain. Besides, my mother died this month. Ah! She was my best friend” (P.146). This participant
further spoke about the losses that he experienced during her times of homelessness and the emotional effects of deaths of peers in the homeless community. He also recognized the aspects of resiliency that exist:

It [deaths] was about sixty-seventy people, give or take. [They were] all my good friends; men, women, and even kids. Fire, accidents- I am going through hell in a handbasket. But I am still here and I am optimistic. If the glass is half full, it is full, so let’s put more whisky in there. (P. 146)

The emotional loss that is experienced within the homeless community was also recognized. Many peers are suffering and enduring significant levels of emotional pain. The lifestyle of homelessness puts one under a lot of emotional and physical distress. Many individuals who experience homelessness generally end up experiencing significant losses of their peers:

A lot of them [homeless] are hurt from losing their family you know, people dying, and depressed that way. So, they sit there and give it to the lord to help them, and to get that out to clear their mental health (P.153).

Although the theme of grief and loss was prevalent throughout the interviews, the participants spoke of their coping with such distress, both adaptive and maladaptive. P.160 chose to discuss a personal experience of homelessness and loss:

The first nine months [after wife’s death], I didn’t have a care when she passed away, I didn’t care about the world. I drank myself into blackouts, I did any prescription pill; I smoked as much weed as I could. It was all about numbing myself. My friends were really worried about me, but that’s where my mental stability, emotional side and physical side came in, and is where my upbringing took over. I just ran through my head like it was hard to think for the first three months, because you know, she was my best friend and it was hard. That was where my upbringing came in and just really kicked me in the butt and said you know, don’t fall too deep into this, because you know where it is going to go, I mean with suicide. I did not have a care, whether I died or not. I just did not have a care; I knew I wasn’t going to jump in front of a car or jump off a building. I did not have the energy for that. It was going to be my addiction that killed me (P.160).
P.160 further commented on the challenges of homelessness and the consequences of that kind of lifestyle. It was recognized that if one wishes to recover from the state of homelessness, both the emotional and physical needs must be addressed concurrently. Furthermore, there is a significant loss that occurs with the peers and relationships throughout during the process of homelessness:

A lot of people, a lot of my friends passed away. It’s from the lifestyle, and that’s the lifestyle that will kill you. It’s the drugs and alcohol and the homelessness and everything. If you want to change, you physically and mentally got to want it. It’s not just mental, its physical as well. So, it gets hard but, I really got tired of going to the memorials and everything you know, so I just started being a support for everybody else (P.160).

P.152 recognized the emotional struggles of the past experiences and traumas that maintain and exacerbate the ongoing mental health challenges, especially if not addressed: [The] “problem is I think too much, I think too much about the past… Just everything, I think about all the people I have hurt.” P.152 further stated:

[What’s hard about living on the streets] “it’s just like everything, I get stressed out by it. I feel depressed a little bit. I got a kid too; she’s like sixteen months old. So, I am like struggling on my addictions, and trying, you know to do my shit on top… it’s hard [being homeless], it's stressful, you know it’s not having anywhere that you know, to call home, or anywhere to go, sometimes at night, when it gets late. It just gets hard after a while, mentally (P.152).

P.153 discussed the ongoing acute emotional challenges and crises within the homeless community:

It’s cold out there, one time I stayed with my friend because she wanted to kill herself. We were doing drugs at the time. So, I stayed with her, it was minus twenty-six with the wind chill. I did not want her to do something to herself, so that’s why I stayed with her (P.153).
Another participant discussed the cumulative distress that occurs in homelessness in relation to the constant struggles in maintaining/acquiring the basic safety and other requirements:

A lot of times, you feel you are doing ok during the day, like everything is fine, but then some of your friends have places and then they are going home, and then part of you is just left alone. You are left alone to deal with everything yourself. You understand you put yourself in that position and you have to get yourself out… Then your other friends come out, and then maybe you say let’s go get some alcohol or something. Then that leads into something totally different, and then you end up- you lose a day you know, a day where you are drinking with a friend. When meanwhile you could be focusing on getting your life back together (P.160).

Another participant spoke of the common experience of homelessness and the influences that psychological stress and strain had on them. In their own words, “Maybe, I see a lot of people that live with the same illness, I live in the same environment. People gone, I guess I use drugs and alcohol just to, makes me happy and… I don’t know what is” (P.151). P.154 also discussed the how mental health influenced the experience of homelessness:

The mental part is like you hear that guy yelling around, that is a problem. He’s got mental health problems. We could not get him into the mind, because of how they are. For me, again, it comes back to the choice. If I want to be like that, the mental part is tied to that choice and choosing it, that is what I mean. It is easy for me to do it but for them… because whatever happened to that individual before, something caused them to have that breakdown. That’s why they choose, because if they choose to act crazy, it just keeps the other people away. So, they are avoiding (P.154).

Another participant commented how the aspect of loneliness was a common and predominant experience in the state of homelessness:

Yeah, that’s… being homeless even though you are with people, you can feel all alone. It’s a feeling that you can’t get rid of it, especially being homeless out on the streets. Depression is a big part of it too, because you look at it, oh that person got a job, a home and everything. I wish I had that, I want that, you know. You just start thinking all that stuff, goes around and around in your mind and the next thing you know is that person
starts drinking and a lot of alcohol does not make it any better, or give you any job. So, I am just, homeless and on the Aboriginal side of it, it is great what they do and everything, but I think they really need to focus on how to get everybody off the streets (P.160).

P.146 commented on the mental health issues and the co-occurrence of addictions and how they co-exist in a way that further exacerbates the mental health issues: [Regarding mental health issues on the streets]. Its, “dope, alcoholism, suicide. I don’t know [what to do to help this issue], it is really hard to say, it happens every god damn year” (P.146).

P.159 commented on the mental health issues in general amongst the homeless and how untreated mental health issues can impact the interpersonal experiences and some of the discrimination that occurs in terms of mental illness:

One of the hard things is having people out here, where they talk down to everybody right; because people are on different levels, some have mental illness, people with extremes like bi-polar, schizophrenia and a lot of other psychological problems (P.159).

This participant further recognized the diverse mental health needs that vary amongst the homeless individuals in terms of where they are at in their healing journey: “Well, mental health comes at many different levels. I mean right from the get-go; straight from schizophrenic to bi-polar to suicidal, the thing is how you deal with that moment depends where you catch them” (P.159).

Multilevel mental health needs and concurrent addictions issues were also recognized as prevalent factors that exist within the homeless community. P.151 stated:

I don’t know, I find a lot of my friends have ADD, they suffer from the problem of mental health, I am not quite sure, anxiety or something like that, you know what I mean, we all got that, same problems (P.151).

P.160 recognized the importance of supporting those suffering from mental illness and also recognized the struggles that the peers with have emotional challenges have to go through:

My understanding of mental health, could vary from bipolarism to schizophrenia to you know, a wide range of things. My girlfriend was bipolar, it is like a rollercoaster, with a
bipolar person, one minute they could be happy and next minute they are swinging at you, and I deal with that, but, you can’t change them, you got to support them (P.160).

Another participant described the emotional challenges of being in a peer group together that is emotionally vulnerable along with many different mental health challenges:

Well usually out here what is happening is that when you have a lot of problems, and situations, if you got an addictive nature, you use that addictive nature to blank out certain emotions right? A lot of time people just get together but we think that we are just getting together to have fun, by the time we are done drinking a little earlier, you know the guys going through problems enough. Are you going to take an open book, and let them do or go through what they are going through (P.159).

Participants also discussed the different ways that they use to cope with mental health issues and the ways that they could be better supported in terms of the healing process. One participant stated that she could best be supported by: “Talking. What’s helpful about that? It’s healing. Just talk to them [the homeless] about their shit instead of holding it in and building up. It eats you up inside, it’s more hard on you, your body, the stress every day” (P.152).

P.145 further discussed the benefits of having talking circles available for the Indigenous homeless people who have had experiences of trauma:

It [talking circles] help a lot, as we get to speak our mind, and not be judged or anything… it helps because we are able to speak our minds, and basically, we all hug each other and you know shake our hands (P.145).

P.146 described how perspective and emotional resiliency can help cope with the stressors of homelessness:

Basically, anyone who’s walking on this earth, depending on your mind and your concept of life. Here happy go lucky or just pure angry, angriness causes disease, heart attack and shit. Me, my glass is full, I laugh. Sure, I do cry, feel some sorrow, but not suicidal or anything like that. I just keep thinking ahead, the past is the past that’s behind you (P.146).
Listening and talking were also indicated as the strongest mechanisms for overcoming mental health issues and getting healed from homelessness. P.153 stated:

We have a circle here [Indigenous Shelter] every Wednesday, an hour for an hour and then after that, we have a breakfast; like we talk to our Creator, nobody speaks when this person speaks, and then you speak after and they don’t like what they talk about, sometimes you fall right in there, lines that they talk about, and then you just get help that way (P.153).

Another participant discussed some of the barriers that thwarted conversations with care providers versus talking with peers:

When you’re talking with somebody who was educated or has some level of education, expect some level of conversation to be different, but when you are talking with somebody that is on the street, find out what level they are at. Then you got to deal with it on that level and it is a hard thing to do, because you got to be a person to person to go there and understand somebody with mental illness, right. You got to accept the fact that yeah, he got some problems, ok, what’s the best way to help him. You know a lot of times they just need somebody to listen to them. It is not very much what is behind traditional teachings it is how you accept the person that is there at different levels (P.159).

P.145 described how being connected and talking about mental health in a circle could prove to be helpful as a result of the level of understanding that exists amongst the group members:

Well it does help [the sharing circles] because you know, everyone’s going through a bad time. Just like my friend, he lost his mother, and stuff like that, you know what I mean? We help each other out, because we need that circle, and it’s just, like you know, that helps, because most of us do have mental health issues. Just like me, I wasn’t like this before (P.145).

The positive qualities that individuals possess in terms of thriving and surviving during episodes of homelessness also had a thematic nature in terms of mental health. The participants
demonstrated significant resiliency in factoring wellness despite the challenges and stressors that occurred during their periods of homelessness. P.146 stated:

I would be sleeping away, having my nightmares, though I have a lot of nightmares. I love them, when I wake up, I am still here and good dreams, they happen. You got to make people happy in life, sure it’s supposed to be inspirational and such- not to look back, but to look to the future and to think about good things every day (P.146).

Another participant demonstrated the emotional resiliency that can be seen in homeless individuals:

I don’t recommend it [homelessness]. If I had a home, whatever everybody else thinks is normal, to me this is just life. I had a job in place in the winter, but it didn’t work out. I can’t complain; I’m still alive, I am still healthy. A lot of people they have a disease, it’s not their fault. But I am fortunate enough, with the scars and stuff, that I am clean, my blood is clean (P.148).

This participant further commented on the personal attributes that facilitated survival during their times of homelessness and how it factors into resiliency as well as survival:

Patience, it makes you more confident and makes you stronger. Perseverance, just don’t give up. It could be hailing outside, a big snowstorm and you really need a glass of water and everything is closed. But once you are about to give up on yourself, the last step you take, there is a fountain right there. It is always like that (P.148).

Another participant discussed how resiliency can grow over time as a factor of lived experiences, such as with habituation:

The experiences, I am glad I went through, not really glad, but to a point where I know how to handle it and help other people through it. That’s what I said; I am stronger mentally and physically and emotionally now. Not only with the upbringing, but going through that death of my girlfriend. I mean I have friends that passed away over the last four years since her (P.160).

This participant further stated:
Every year it goes by it’s a bit easier, it takes a little chunk of hardness out of it, but, it is like a big rock and keeps getting smaller and smaller. As I thought about it, I am not going to live in depression, I am not going to live sad, there is no point because I know she [bereaved] doesn’t want me to, she wants me to move on and I know, where I am right now in my life, I know she is happy for me. Because I really, really kicked myself in the butt, I moved on, I had to, I really couldn’t stay in the place I was in (P.160).

Another participant recognized the survival and resiliency that could exist amongst the homeless by indicating that there always exists a certain level of fear:

You didn’t want to meet your maker when you are only like thirty. I mean, you’re still good, like I still have twenty more years. I still live a happy life that could have been the end of me. God knows that dying in a place like that, you don’t want to be. I wouldn’t want my mom getting a phone call saying [participant] died in a place full of junkies and addicts (P.149).

Another participant chose to describe the realities of survival and homelessness that came from their first-hand experiences:

Most people don’t make it past fifty to fifty-five. I am forty-seven now; somehow, I survived all of it, I don’t know how. Someone up there likes me. I tried to commit suicide at least five times already and they found me each time (P.150).

The participants also recognized the influence that traditional knowledge has on healing from the mental health challenges associated with being homeless. P.148 stated: “If they seek [traditional] knowledge then they’ll learn it, but they have to want to seek it. If they don’t come for it, then they will never learn. They will never and they will be lost forever.”

P.154 recognized how traditional knowledge and values form the central aspect of the overall wellness, especially in an emotional sense for the Indigenous people:

We use our culture and knowledge as traditional people to turn the way we look at things. I am there helping them. How do we get from this place to the future? It’s always a struggle, we just hope differently. I use reverse psychology, it always has to do with that, to connect the foundation. If the foundations aren’t there it doesn’t work… In my life,
there has always been balance. We have to be strong, I try to help them balance it. Some people I see falling off and can’t come back through. Some people will fall away, just off balance and come back through (P.154).

Another participant stated how the roots of Indigeneity can be traced in resiliency and the ability to be adaptive:

Our culture is a culture of adaptation, you know we can adapt to different situations, you know, they have to understand people. Where they are on different levels and understand how if you don’t understand and you are judgmental, basically what you are doing is messing with somebody’s head (P.159).

P.145 highlighted the importance of including traditional knowledge into the general mental health practice when it was concerned with the Indigenous homeless peoples:

Well we have circles here [shelter name] to help out with the mental health. The Elder comes here- but he hasn’t been around- he’s been getting ill, he’s getting older, so he comes down every Wednesday, do our smudging, and everything like that, everyone has a chance to speak and we just tell all in our hearts. That’s basically what it is, and then we sit down and have breakfast after (P.145).

While talking about the inclusion of spirituality in the conceptualization of understanding psychological difficulties as well as in the treatment and various approaches to mental health, P.160 stated:

When our souls come into our body, into all of us, what I’m trying to say is that I have been told, that these souls, it is not their first time here. Or even in this universe, there are different planets way out there. They are more like an advanced soul, so like they are coming here, and they are trying to get out what they are going through. Like all of those negative thoughts, all those things in their head that they are hearing. It just other stuff in different dimensions… ok, so they come here to live on, because God doesn’t help itself (P.160).

This participant went on to describe the spiritual aspects of getting healed from trauma and stated:
There is some [trauma]… but a lot is mostly in their mind… and they can’t let it go. I was
telling some, I have a spiritual soul, and talk with them, until I finally get out of them, or
they are willing to let it out finally, and then I can help them in that aspect, to deal with it
more (P.160).

While discussing accessing the appropriate services and some of the existing barriers that tend to
restrict recovery, the participants provided feedback. In their feedback, one of the participants
said:

When people get kicked out of [services/shelters/residential programs], there is nobody
out there to advocate for them and to be on their side and talk, they have to. So, they get
kicked out, and they are out here with the rest of us, you know, so I think they need to
find a better way to deal with people and their illnesses, and addictions and stuff (p.159).

The participants also identified other barriers that occurred while accessing treatment:

Sometimes I can’t find a detox when I need it. The season before I had to be medically
cleared just to go to the detox. I had to wait in a room to get clearance letter other than
before I just used to be able to call them and go in (P.156).

P.152 offered feedback for the ways that healthcare workers can better support the Indigenous
homeless with their mental health issues and trauma by asserting that the counsellors should
“Provide more feedback [during counselling sessions]- it felt like she [counsellor] just sat there
while I told her everything. We need more positive feedback and constructive criticism…
sometimes that’s good to hear” (P.152). Another participant, while discussing the mental health
and counsellors’ support, stated:

Yeah, they have to have more knowledge I mean the police, I mean the mental health
workers, they have to open up their eyes and instead of… just opening up a book and say
‘oh they are Native people, this is where they came from, oh, this is what they know, oh
this what they have learned’ (P.149).

Discussing the mental health services, it was suggested that the workers are required to be more
concise in terms of the level of quality of support as well as the follow-up:
They just need a good follow up worker and everything to advocate for them. So you know- I have mine it’s with [shelter name] and she comes once a week to see me and she just chills- but I have known her for a long time and ended up having her as a follow-up worker. They help out a lot and you know, with mental health issues, you need that (P.145).

The stigma regarding both mental health and homelessness was said to be a barrier that kept the Indigenous people from getting an access to appropriate mental health support. One participant, while giving an example of her state, said:

Well it [support] is very, very important, because you know, cause if you had mental health issues, if you are alone, nobody is going to believe you. You know what I mean? It’s just, it’s horrible. I even had one of the workers here call up for my boyfriend’s ODSP and she [ODSP service worker] thought she [counsellor] was one of the recipients and she is like ‘no, I am a worker here.’ She had it on speaker phone and the lady said, ‘oh I am sorry, I can hook you right up right now.’ I was just like what the hell is this (P.145).

There was another participant who backed this assertion by saying:

Even in my office, when they see me come in there, they are just all different towards me, because what, just because I have mental health issues and stuff like that. Just because you are a recipient [of ODSP] and they just treat people with mental health issues really bad, wrongly (P.145).

While discussing the services, another participant highlighted the ways that the current services disconnect the Indigenous peoples and create a further barrier between receiving treatment and the actual process of recovery. He said that he had “Been to [psychiatric hospital] before, withdraw, I did a day of the Aboriginal program too. I been there I just didn’t like the way, they had a psychiatrist sitting there, jotting down everything in a circle. It felt weird” (P.156).

Addiction

Alcohol and substance abuse was identified as a significant psychological factor that influenced the participants’ experiences of homelessness. There were six categories that indicated how
addiction issues were related to the psychological factors of homelessness, trauma as well as traditional healing. These included the cycle of addictions and homelessness, the presence of addiction in the homeless community, the lifestyle that addiction induces in the experiences of homelessness, comorbidity of addictions with other mental health problems, addictions and culture, as well as healing from addictions.

Overall, substance use, abuse and addiction were identified as the major factors that interplayed with all the meta themes in terms of the experience of homelessness for Indigenous peoples. This was especially true for mental health in trauma. The participants identified substance use as means of coping with their past traumas and/or were parts of their childhood experiences; where they had significant exposure to substance abuse and addictions in their environment. Addictions were also recognized as a means of coping with the current emotional distress; however, they were known to create other psychological difficulties as well; this was especially true when co-occurring with the phenomenon of homelessness. Furthermore, addiction was recognized as a barrier that thwarted the propagation of traditional knowledge and healing, as the participants identified less engagement in cultural practices and ceremonies if they were using.

Direct experiences of homelessness included drug addiction, which was recognized as a major influence on the cycle of homelessness, helping it thrive. One participant explained how drug addiction consumes a person’s life by becoming their main priority, and thus often leaving the basic survival needs unattained. It was recognized that at times, some of the basic needs take second priority to addiction, thereby creating many health and psychological challenges for the individual. This peculiar phenomenon can be clearly seen in the following statement given by the participant:

Not knowing where you’re going to stay is right up there with us in the morning you are kind of like- you got to figure out how to fix yourself up you know, when you become dependent on alcohol and drugs and that’s where most of your basic needs money goes to if uh you’re on the assistance [ODSP] (P.147).

P.147 also explained, “Since my last employment with the community, I’ve experienced a lot of homelessness and that’s in regard to substance use and abuse. Alcohol abuse and basically not looking after my needs.”
Another participant described the challenges they faced due to substance abuse and addiction while living on the streets; it was described as a factor of the environment. The participant clarified that this was a part of their lifestyle, however, it brought many challenges in terms of having basic safety and meeting the basic needs of survival. For instance, it was stated:

Oh, I was there on the street for a bit… five years, and I went to [program] and quit drinking and I am back on my feet now. Sometimes [living on the streets] was enjoyable and sometimes it was hard. When I was young I was working out there, so I mean, during the three days I guess I was high, I didn’t really care but when you get tired you have to find a place to sleep. I slept in cars, outside sometimes under trees, and one of the worst I would have to go underneath parking garages and crawl into a car and sleep there; but that’s what you did to survive (P.149).

Addiction was also recognized as being a perpetual cycle through the current system and an ongoing factor in the cycle of homelessness. The resources that are given (i.e., ODSP) are used in the primary need attainment (i.e., to finance addictions) and thus, many individuals continue to go without housing since they lack the funds for other basic needs, For instance, P.147 stated:

I’ve only been on disability for about three years, some of it has kind of been like a trap in a way because I kind of have access to my addictions through my own assistance- and um somewhere in between I just didn’t function as a proper- I didn’t look after myself (P.147).

Addiction was also recognized to be a strong contributing factor that increased the risk of homelessness, as well as a concurrent issue for many other contributing risk factors that could make someone vulnerable in terms of becoming homeless (i.e., criminal activity). One participant highlighted this fact by saying:

I got into crime, and then crime and drug dealing and all kind of other stuff. Hurting people, just cause, you know, for drugs. Then I’d go extract money like for drug dealers and stupid stuff. I have wasted a lot of time on drugs, never had my own place after all this time. I’m twenty-nine, I have treatment booked in and it’s time to get my life back under control. It’s hard to kick the addictions and stuff and being homeless too, on top of that is murder (P.152).
Another participant also shared similar experiences of drug addiction that were an integral factor in their experience of homelessness: “A lot of alcoholism and drug addiction” (P.155), when asked about his experience of street-involved living.

Exposure to substance use and addictions in youth was also recognized to be a strong risk and a major contributing factor towards experiencing and maintaining the state of homelessness. The participants shared early influences as well as the ongoing issues of addiction. For example: “I am still on the streets due to alcoholism. Yeah. Have been on and off the streets since I was nineteen” (P.156). Another participant said, [on being homeless] “That will be 15 years staying here and there, sleeping on the streets. The place [streets] allows me to continue with my addiction” (P.157).

Addictions, in terms of the maintenance of homelessness, were recognized as major phenomena due to the barriers to accessing and utilizing housing/shelter services, as many require sobriety in order to utilize the shelter services. For example, P.159 stated:

> It [situation of homelessness] drastically changes from day to day, one of the things is a lot of people that I find that come out here have addiction problems and usually what happens is they come out of [various shelters] and they come to the park and basically trying to follow them through the night. But like I said, the addiction thing is reason why we get kicked out of here [shelter name] sometimes (P.159).

The participants acknowledged that the lifestyle of addictions (i.e., transience) compliments the state of homelessness and therefore, these two social ills, at often times, occur together. It was recognized that homeless peers were seen as supports because they can understand the circumstances and even have shared experiences; however, they also enable the addiction behaviour and become associates in the maintenance of addiction. Some of the peer dynamics can further cause unhealthy coping and interpersonal difficulties. Such a connection between shared experiences was especially true for the Indigenous homeless community. It was recognized that the connection of peers can not only reinforce the racist responses from the community, but it can also reinforce stereotypes and the phenomenon of judgement. One of the participants explained it adequately by stating:
The street kind of helps me get in touch with people that experienced what I experienced and gone through what I went through. The downfall of it is the alcohol and drugs, and the blackouts and the fighting and the judgments and just the way society looks at you and especially being Aboriginal too (P.160).

This participant further also discussed the stigma that occurs with concurrent addictions and homelessness, especially for the Indigenous people. This participant discussed how the Indigenous people feel judged every day and how the social evils such as stigma, oppression and racism are significant contributors to the experience of Indigenous homeless peoples:

I am an alcoholic, but I am not a drunk and I was just walking down the street, and a lot of people, not just Whites or anything, it’s just society itself, they look at me like I should be drunk or I should be on the corner panning or something. Yes I have done it before, I’ll admit that, but it wasn’t in me, I did not want, I did not want to be there the rest of my life. I was only twenty-three when I first came here, I am thirty-two now and it’s like I said, it’s an experience. I really enjoy it to a certain point though, but I can say, I would rather have a nine to five job; because being homeless is a lot harder job than a nine-five. Because then you got to worry about how am I getting my next drink, you got to wake up whenever the cops come bother you or anything- that’s stressful (P.160).

Beyond the various aspects of stigma that occur as a part of being an Indigenous homeless person, the participants described how the issues related to addiction create further challenges in homelessness that make the issues of safety and basic survival an ongoing challenge.

Experiencing addiction as an Indigenous person was also described as an effect of colonialism and intergenerational trauma, since the participants, as Indigenous people, described being vulnerable to the issues of addiction. This was also recognized as a significant contributing factor that could lead to homelessness. One of the participants stated:

Drugs and alcohol that’s it… it’s a big thing with us [Indigenous people], you can’t push it away sometimes, it is in our blood. Sometimes it is just the way we are. [When I first became homeless] that was twenty-five years ago. I was just a young pup… sixteen, seventeen, eighteen. I was doing heroin; I thought I had died. I had people at my house smoking crack, still drinking while I was out, for three hours and then I woke up, they are
still sitting there, didn’t bother to see if I was dead or alive, so I just got mad and said well that’s it. I threw everything outside and smashed all the crack, got rid of the needles and said that’s it. I had enough… So that is how I kind of straightened out my life (P.149).

Another participant described how an early exposure to drugs and alcohol in the home and in the communities, can lead to unhealthy coping mechanisms such as addictions during youth. Although such an early exposure was a common and recurring theme in the individuals, one of the participants shared:

I’ve always been an addict, always; you know made you happy, happy to be drunk, have fun all the time. I started drinking at age eleven or twelve… Just growing up with older people- just started, brought into it at an early age, drinking and doing some drugs, smoking (P.151).

Another participant acknowledged an early exposure to alcohol as being a significant factor that had led to his difficulties and experiences with homelessness; as well as his ongoing addictions. For instance: “My problem is that I am an alcoholic. I have been drinking since I was five years old. You know, I try and just stay alive I guess” (P.159).

The participants also recognized that for many individuals, addictions are the primary concerns and challenges in terms of lifestyle and need attainment. For instance, it can be seen that addiction catalyses one’s attainment of the state of homelessness. One participant said:

I am still on the streets due to alcoholism… [biggest barrier] for me is alcoholism, I drink a lot. I tend to stay in my place if I have it. I can lose it if I don’t follow up (P.156).

Another participant indicated that if it were not for addictions, he would have had some place to stay; but being on the streets was a function of drug use and was a complementary factor to the phenomenon of homelessness. The participant stated:

I slept in the park last night, so it had been a rough night. I could have stayed at my friend’s place in the east end but I just didn’t feel like going back there, plus I was doing drugs, so just stayed around. Got woken up by the cops this morning, getting kicked out of the place for a while (P.152).
It was recognised that addictions also have significant negative effects on interpersonal relationships. This was a result of conflict as well as the companionship in having addiction associates; as well as how relationships can become very co-dependent and established when it comes to substance use. P.160 explained that addiction had played a key role in his romantic relationship, as it could bring about significant emotional outcomes. For example, he said:

We spent every day together, you know, we were both addicts, we inject together. She wasn’t a big pothead or anything, she smoked the odd drug here and there… it was hard to see her do all that damage and everything to her body (P.160).

This participant further described addiction not only leads to significant emotional and interpersonal effects but also brings about significant physical implications:

There are better ways of living life, instead of all that drugs and alcohol and… me personally, I had done everything, except for needles and everything but like I said, it gets tiring after a while. Like I don’t drink like I used to anymore, and as you get older too your body doesn’t recover. When I was 20, I could drink like a champion, you know, get up the next day and do it again, but now I get a hangover and everything and I recover for three or four days. Especially doing that out on the streets with the panning and everything, you got to look that’s the job, how am I going to get my next drink, I am shaking, I got withdrawals, and everything and that’s your job (P.160).

When viewed in relation to the nature of homelessness and the bonding that occurs with the peers who are also experiencing similar drug use experiences, it can be seen that addiction brings about significant challenges. While talking about kicking the habit, one of the participants said: “It takes a lot of work. It’s not like I can just say oh yeah, I’m going to be clean. Yeah, especially as there are people you are destroying yourself with too, right” (P.152). The involvement of homeless peers that form a sense of community for group protection was also indicated as a positive factor in the domain of addiction, peers and homelessness. Participant 159 stated:

Yeah you see a lot of us up here, we drink, yeah, but a lot of guys downtown, they’ll go to the other stuff, that is rubbing alcohol, mouthwash, you know and the ones that are close-up here, we watch out for each other (P.159).
Another participant described how homelessness and life on the streets can also put someone at risk for developing addictions or using harder substances due to the culture as well as the peers in the homeless community. Exposure could create more significant problems even if substance use was a part of one’s life prior to their experience of homelessness. The participant stated:

Say if one person does have to be there at the time, and they don’t have to be doing anything heavy, the people down there are introducing it to them, because they know they just want to smoke a joint. Instead of giving them weed, they’ll give them like cocaine or crack or something. So that’s the first stage in getting hooked on something else and that’s purposely done, because they need them as customers first, that really bothers me (P.160).

The dangers of addiction and living on the street were also recognized as a significant aspect of homelessness, especially in the context of drug use and addictions. The lifestyle and circumstances of having limited resources while subsequently having addictions, can lead to various concerns. For example, one participant stated:

Yes, there is a higher risk [for addiction] downtown. Then you have to go left field on heavy drugs and stuff and those people usually try to see if you have something that they sell or for instance they might try to set you up and it’s easier to do down there where they have friends. They appear to be a friend, but they are not friends, you know, just waiting for you to go down that alley and that you got to watch for- a lot of curves. Yeah just don’t follow somebody somewhere, right. You got to make sure you are somewhere safe (P.160).

This participant further described how addictions and homelessness can also lead to rather difficult interpersonal relationships. Some peers can turn out to be harmful thereby creating further challenges, especially in the context of drug use on the streets. One participant described how he tried to dodge and avoid these interactions:

I had been in [large Canadian city] since ’07, what it comes down to, if you really want to do something, it is up to you to choose to do it or not. I like to smoke weed, I choose to sit alone and stay by myself. I feel safe in that way. That’s why I don’t have relationships, and it’s why you know, I don’t hang around a lot of people (P.160).
The emotional and psychological effects of addictions co-occurring with homelessness were recognized as a significant factor in the ongoing struggle of homelessness and how the psychological effects could further boost one’s state of homelessness. They can become significant barriers in terms of healing and recovering from the state of homelessness. One participant recognized the difficulties and challenges with addiction and stated: “The only person that hurts me is myself. If I fall down or whatever - I am an alcoholic, just sometimes. I won’t hurt nothing” (P.146). Another participant described how addictions and homelessness can occur concurrently as a result of other emotional difficulties and go on to become a source of escape from situational as well as emotional distress. The participant stated:

About seven years ago [became homeless] I guess. I started using drugs; I was in [city] and started using pills. I moved to [large Canadian city] because of a domestic situation I was trying to get away from. It was a lot of… girlfriend causing a lot of trouble, just trying to get away from all that (P.151).

Trauma and emotional difficulties were identified as being prevalent among people who were experiencing homelessness; this was especially true in the case for Indigenous homeless peoples. One participant described that addictions became a coping mechanism to manage the psychological distress during periods of homelessness:

Well my experience [of living on the streets] is drinking, taking drugs… just not being able to deal with my issues. Building it up and then trying to deal with it in different ways, drinking and drugs. It started when I was eighteen (P.152).

Addictions were also recognized as being a significant barrier that could keep an individual from receiving treatment and accessing services. This can put one further from finding housing and hinder their process of recovery from the experience of homelessness. It could be observed that there was also a strong sense of ambivalence toward change when addiction was a part of the experience: For example, P.152 also stated:

There’s part of me that wants to go to treatment, and there’s part of me that doesn’t, the addictions side- it’s hard. Yeah, I’ve gotten myself in deeper with the drugs. Yeah, well lately, I have been starting to get back into it, every time I get kicked out, I end up doing that, mistreated, whatever, I end up just using it, yeah, going on big binges. All I think
about is my daughter and it hurts more, because I am using it. When she’s there, she’s there and I kind of lack, what do you call it, my own priorities, things that shouldn’t be priorities, kind of put them before her (P.152).

This participant then stated that addictions cause further challenges in terms of values and significantly influence one’s life, even if they are contemplating a change:

Ya, I see her [daughter] and when I don’t see her, it’s like I just go off and drinking, drugging and partying and just lose myself. I miss her, I am trying to get my life back on track, it’s hard though. Addictions, addictions are a challenge (P.152).

Another participant described the concurrent effects of mental health and addictions, specifically in the context of homelessness. For instance, it was stated:

I used to drink too but I quit forty-two years now, in June will be forty-two years. I was a binge drinker, when I drink, I drink for a month or a couple of weeks then I stop. Yes, that is the mental illness that they have is a drinking problem (P.153).

This participant recognized that addiction, in itself, is a challenge. The phenomenon of addiction can be very challenging and can prove to be a dynamic factor in the cycle of homelessness.

It has been observed that mental health issues and addictions often occur together, especially in the context of homelessness. One participant even stated: “Ah pretty self-explanatory, here in [large Canadian city] I live in poverty, and there’s a lot of drinking going on, there’s a lot of drugging going on. I came from [large Canadian city] - my husband just died- that was back in 2002” (P.150). Another participant described how addictions often act as coping mechanism when one has limited resources. This becomes complicated when one cannot even sustain the addictions due to the limited financial resources. Another factor that was recognized was the stigma and judgment of sustaining addictions (i.e., panning for money):

You got to look for your next drink and everything and that’s a lot harder because society doesn’t really want to hand you money. They know where it is going, they know you are going to drink with it or do whatever drug with it. That makes it a lot harder because the person is just trying to survive, you know what I mean, this person is coming down, they are really hurting, and if you can actually help that person. I know you are going to do
this, with this money, that’s fine, just fix yourself up, at the same time try to make sure to get some food in you. That’s the one thing with the homeless, is people don’t eat. They just drug at it, drug, drug, drug, or drink, drink, drink, and no food, and that’s why a lot of people overdose or end up in the hospital with alcohol poisoning- and a lot of my friends have seizures off of it (P.160).

As mentioned previously, the participants described that as Indigenous peoples, there also are other impacts of mental health and physical health when it comes to the ills of homelessness and addictions. There is a strong intersection with cultural identity, where addictions make individuals distant from cultural engagement, which can be a negative prognostic factor in healing, recovery from homelessness and the overall community engagement. For instance, one participant stated:

If we are having a gathering, I mean, we can’t go to a Centre and start drinking there because we respect our Native people that don’t drink. If you drink, you shouldn’t be going to the Native resources. That is why I don’t. I respect my people when they say, please don’t come in when you are drunk or have been drinking. I am an honourable woman, I’ll drink in the park, but I will not go drink where those people are trying to stay sober (P.149).

P.152 described how addictions do not necessarily mean that one is not engaged with their culture; it rather means that out of respect, they are avoiding attending the ceremonies or being connected with cultural events, places or people because of certain protocols. For example, he stated: “Sometimes, some of the places you don’t want to go around, because you know like there’s medicines, and some powerful stuff around, you know, you can’t be going around that when you are using heightened drugs or you know.”

The cultural barriers of addiction in attending sweats are laden with protocols such as one must abstain from using mind-altering substances for at least 4 days prior to attending a ceremony, as the mind and spirit need to be clear. This can become challenging for many Indigenous people who are addicted to substance use, as withdrawal symptoms or even the drug habits can prevent such people from being able to achieve sobriety long enough to attend ceremonies. The participant stated:
I don’t want to go to sweat when I’m using, it’s not right. Addiction [is hard] you know, like you don’t want to go to a sweat when you’re using, it’s like you’ve got to be clean for four days at least (P.152).

This participant further indicated how addiction has had a negative impact on his cultural engagement in that he became less interested in the cultural practices, prioritizing the addictions: “I used to do it [participate in traditional ceremony] a lot, [then] drugs, soon as I started doing drugs, I just didn’t care, that’s how it is. Just cared about getting high, getting drunk. It’s kind of tough” (P.152).

Regarding the cultural engagement, traditional knowledge, mental health and addictions; ceremony was identified as a positive indicator for recovery, especially in terms of addictions. One participant described how his engagement in cultural activities, such as smudging helped him with psychological wellness during the periods of sobriety. For example, the participant stated:

I use circles once in a while, when I am sober, I smudge. Part of this stuff [traditional knowledge] is being sober and so that helps your mental health right there. It’s like a form of counselling too (P.156).

Spirituality was identified as both a positive and a negative factor in regards with an involvement in substance abuse. Spirituality is a strong value for the individuals. This can be positive in that, when one is engaged in traditional ceremony, they would tend to abstain from drugs and alcohol in order to stay connected with their spirituality. However, this can also be a deterrent, in that if one is actively using, they will avoid the aspects of their spirituality since the cultural protocol demands abstinence:

Everyone has their own different aspects and respect for the religion. That’s the way I look at it you know, I don’t do anything, of course my culture, if I drink or done any drugs or anything. I have to be at least three, almost a week sober before I start doing something, because by then I know I sweat it out or you know, just ride it out. That is what all the eating and drinking water, maybe flushes it out. I would like, you know, smudge every day, but because I drink, I got to be careful. I mean I might forget, for a day, one time, but most of the time, like I said, I don’t drink too much like I use to,
because it gets tired. I am unable to start using the medicines that is more spiritual and
everything (P.160).

Respect towards cultural engagement and spirituality in addicted individuals was also recognized
as being a personal value. Although there exists community support and access to spirituality, it
finally boils down to the individual to abstain and maintain sobriety in order to make that
personal choice of engaging in ceremony. For example, P.160 further stated:

I had a supportive community that said, ‘would you like to smudge’ and whatever else,
just people asked me. But with the respect of my culture, I said no because I drank or
smoked the night before. I do believe in that, you got to be clean to deal with the
medicines (P.160).

A close relationship between sobriety and culture was also recognized. For example, a
participant stated; “It’s good when I am sober, it’s hard when you are drinking, because you are
not supposed to. You are not really welcomed around for using it and stuff like that” (P.156). To
look at it broadly, addictions were recognized as significant contributors to the overall mental
health and experiences of homelessness and spiritual engagement for Indigenous people.
Therefore, aspects of addiction influenced spiritual disconnection, mental health decomposition
and the state of homelessness, whereas sobriety influenced cultural engagement, psychological
well-being and healing.

Healing from addictions was also recognized to be a difficult process, but it was still an
important aspect of recovery in breaking the cycle of homelessness. This was especially true in
terms of cultural engagement for addressing the mental health concerns and reconnecting to
culture as a means of healing from the intergenerational trauma for Indigenous peoples: One
participant discussed the different values that strongly reinforced recovery:

Yes, I am definitely going to treatment on May six. I wasn’t going to go, and just go
party it up, but just going to go and change my mind. It’s the least I can do for my
daughter, my daughter needs me- need to kick the addiction and drinking… yes [been to
treatment before]. I did twelve months in the treatment centre before (P.152).
P.152 further described the process of seeking treatment and the challenges that come as an integral part of interpersonal relationships and addictions. Emotional difficulties were recognized as triggers for relapse. The participant stated:

I broke up with my girlfriend so I just like kind of went off; Besides, I’ve got to quit it and just kind of get it together… I just been going off the drinking and drugs. I don’t know about what the treatment does. Next week, and after, I might have to go to detox for a couple of days. I’m not too happy about it, I have never been to detox before (P.152).

The workers and services helping the addicted individuals in their recovery and to overcome addictions and making accommodations were recognized as positive support systems. For example, P.156 stated: “My health worker helps me work with my addiction, because I’m not always sober. Some programs work around it, reschedule or help me even when I’m drinking.”

The participants also provided feedback regarding service delivery that matches where someone is at, in terms of addiction and recovery. This was recognized as including the strengths that currently exist in terms of the current services, as well as the gaps that could be improved in treating the addictions and mental health for the Indigenous homeless individuals. One participant said:

Services between ages are different. You got to look at how far they are into their addictions and work on what illnesses they have, maybe, because you can’t just go to this twenty-year-old and this fifty-year-old and say ok, we are both going to help you with the same stuff; because they are not going to be on the same drug or the same… it’s the different degrees of addiction (P.160).

The stage and degree of addiction and homelessness were also identified as being an important factor that required consideration in the psychological treatment of the Indigenous people. P.151 stated:

I don’t know, I was drinking also I guess, I was drinking, looking for something better, because I wasn’t really getting off on drinking, a lot of times. I started using them, just wanted to be high all the time you know, feel better (P.151).
Another participant described how the intersections of complex mental health challenges can create further barriers to the treatment process. It was described that addictions and mental health often tend to overlap and that there is a cultural piece that influences the wellbeing as well as emotional challenges:

Anxiety and the need for drug use—alcohol use and so my doctor started treating me for insomnia— but the anxiety attacks— you know I’d be hungover and of course if you want to stay a mellow person, dramatic person you know — but there is a scale there— like somebody else who got into using a lot and someone who is not a user; they function at different levels on the scale; different styles. So that’s what I mean…maybe someone’s nature you know. Sometimes we have different cultural traits (P.147).

When combined together, the themes represent the overarching issue of addictions and its presence within the homeless community, and furthermore, how addiction can factor into risk and longevity of one’s homeless experience. Individuals’ experiences with addiction were recognized as dynamic, in that they may have occurred early in the individuals’ lives through aspects of intergenerational trauma and exposure through the community and family; as well as later in life.

Addiction was also recognized as a significant aspect that could help individuals cope with both their previous and ongoing psychological difficulties, including trauma and further as a way of coping with the experience of homelessness. Homelessness was also recognized as a state in which the environment was highly stressful, in which many of the peers and interpersonal relationships encourage and enable maladaptive addiction and substance-abuse behaviours. In turn, these relationships were often the only supports available to them, and the substances then became the limited resources that could help them cope with the emotional pain.

The issues of addiction can become a major barrier in an individual’s path of recovery and healing, where addictions need to be addressed first before one can successfully transition out of the state of homelessness. It was recognized that addiction is a strong negative factor and a significant barrier that can hinder cultural engagement as well as one’s connection with the traditional knowledge. Furthermore, sobriety was recognized as a catalyst in the process of bringing about a positive change and positive engagement in terms of respecting the cultural protocol and engaging in the healing process for Indigenous peoples.
Cultural Identity

Cultural Identity was recognized as a significant factor in the lives and experiences of Indigenous peoples who have had experiences of street-involved lifestyles. This meta-theme of Cultural Identity was further broken down into three main themes, which were as follows: values, cultural connection, and cultural oppression. These factors were recognized on the basis of how they influenced the identity of an Indigenous homeless person. Cultural identity can have a significant impact on the overall experience of homelessness, and it was also recognized to have a strong influence on the process of mental health recovery for an individual. This was also significant in escaping the cycle of homelessness and the way it intersects with the connection and engagement in traditional knowledge.

Broadly, cultural identity was recognized as the central meta-theme and the core factor in the overall experiences of homelessness, especially as an Indigenous person. Furthermore, this meta-theme of cultural identity can be recognized as being fluid as compared to the other two meta-themes, as identity had an affluent connection to both the psychological factors as well as the external factors that are associated with Indigenous homelessness, trauma and traditional knowledge. The three themes that underpin the meta-theme of cultural identity are traditional values, cultural connection and cultural oppression. Table 35 presents the themes and shows their intersection with the phenomenon of homelessness at three points in time, when at risk for homelessness, when homeless, and when in housing/recovery from homelessness. These themes will not be discussed within this temporal organization.

Table 37

*Thematic cultural identity factors of Indigenous homelessness*

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<th>Risk of homelessness</th>
<th>Homelessness</th>
<th>Housing/Recovery</th>
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<tbody>
<tr>
<td><strong>Traditional Values</strong></td>
<td>Values that come from culture/family and early experiences shape view of self, others and the world</td>
<td>Relationships and respect valued on the streets</td>
<td>Relationships and respect for resiliency and survival</td>
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<tr>
<td><strong>Cultural Connection</strong></td>
<td>Association between separation from cultural identity when</td>
<td>Elders/ cultural supports of Indigenous</td>
<td>Connection to traditional knowledge and</td>
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experiencing homelessness  homeless (i.e., talking circles); essential source of support  Indigenous culture identified as component of mental health and homelessness recovery

| Cultural Oppression | Systemic racism and oppression of Indigenous peoples identified as central factor in the cycle of Indigenous homelessness | Additional marginalization and stigma/racism as an Indigenous homeless person | Ignorance and lack of knowledge by services remains ongoing barrier to mental health care and recovery |

### Traditional values

The participants described traditional values as the central aspects of what it meant for them to be an Indigenous person. This was in reference to how one viewed themselves as Indigenous, how they interact with each other interpersonally, as well as their connection with their community. This had reference to how they view others, how they feel about their Indigenous connections as well as how they act. There are three main categories that can fit into the theme of Indigenous identity and values. These three categories are as follows: relationships, support from family, friends and community, as well as respect. Traditional values were also recognized to be at the core of cultural identity. This aspect of values was related to identity as a homeless person, identity as an Indigenous person, and furthers the intersection of identity as an Indigenous homeless person.

The relationships were recognized as being an important aspect of cultural identity. More specifically, the participants identified that the interpersonal relationships were important to identity and as a factor of who they really were. The participants spoke about their peer groups and the ways that these interactions affect the sense of self, especially identity. Relationship values were recognized to be at the core of Indigenous identity and more specifically, being connected with family, looking out for one another and respecting each other at whichever stages of the healing journey, whether that was in relation to mental health, trauma, addictions or the state of homelessness.
The relationship dynamics such as mentorship and role models was recognized as being an important element of identity and the personal as well as traditional values. This was particularly true in terms of homelessness. One participant stated:

I went through a lot, way too much. That’s how come all the older people like talking with me, because I went through so much. They can relate to that, because they even never experienced that in a lifetime for themselves, and they are like fifty-sixty years old (P.145).

This participant recognized how experiences can connect them with others and help build relationships. Life experiences are one example of how others can connect, especially in seeking support and guidance, through both life challenges and in sharing the successes. Another participant stated, “You got to learn what to follow, you know what I mean- people need to guide them I guess, guidance in life you know, it is a way to find guidance. Guide you through, Native ways of life” (P.151). Having traditional mentorship was also recognized to be a valuable factor in terms of understanding one’s own identity as an Indigenous person. Connecting to culture through relationship was also recognized to be a strong aspect of identity development.

Relationships and caring for one another in terms of peer supports in both the Indigenous and homeless community were determined as being central to spirituality and were at the core of traditional knowledge and what it means to be an Indigenous person. This was viewed as an intricate aspect of the Indigenous identity. One participant discussed the importance of having the space to talk openly about the experiences and share these with others as a way of connection. P.149 stated:

What you got to do, you got to go to one of our circles, you got to learn these things, then you will have a better understanding about what we know. I mean it is in the heart, I mean like everything comes from the heart from the four directions, like if you look at this hawk, have you seen him around here? I get a lot from him I get a lot of knowledge because well if you look at him, he’s got to survive too. He picks up a bird, he picks up a squirrel, he takes it home right up there, and he feeds his family, that is exactly what we go to do. We got like I mean, it does not matter you go out, and look for a job and then you come home you got to feed your family (P.149).
This participant also spoke of the aspects of responsibility and sacrifice that one has to make at times for the people they love and for the relationships that are important. The metaphor described by the participant recognized the value of protection that comes from the community and looking out for one another, especially those who are vulnerable.

Traditional knowledge was acknowledged as being a great way to connect with people and was believed to underline the importance of meaningful relationships. One of the participants stated: “You get it [traditional knowledge] every day, it is not a hard thing. It’s not something that you need to complicate but you get it actually by talking to people, sharing moments with people, sharing time” (P.159). Another participant stated: “It’s actually good [for mental health] to be around a circle of friends you know what I mean. Then being able to tell your feelings without being ashamed” (P.145). The participants described talking and sharing to be an important aspect of wellbeing and also asserted that having connections with others and learning through their experiences is a way of understanding traditional knowledge, it is about learning through others’ stories while also being connected to them in a rather meaningful way.

Acceptance from others without feeling judged was recognized as a strong value and a vital part of interpersonal relationships. These values, in terms of relationship, were viewed as being significant in maintaining relationships both with those on the streets and also as a component and value ascribed from the traditional knowledge in respect as a member of the Indigenous community. For instance, P.159 stated:

I talk with a lot of people, you know, so I think that is a matter of just you know, learning how to talk to people, not down to people, because it is trying to make yourself look good and doesn’t matter. You know, because usually you end up sticking your foot in your mouth then you don’t look too smart (P.159).

This participant was describing the importance of the authenticity that can be seen while with people. Listening to their story as it is, and being with them in the experience, rather than displacing judgment, trying to problem solve, or challenging with your own experience.

Authenticity and genuineness were also to be crucial factors in relationships, especially as a peer within a vulnerable community, such as in homelessness. The value of acceptance within peer relationships was also identified. The participant stated:
I mean I get along with a lot of people; I don’t have a problem with people because I just accept them, whatever, whoever, wherever they are in life. So not being judgmental is probably one of the biggest emotions that you can have out here [on the streets]. So, I have some pretty acceptable views, it works for me (P.159).

The power of relationships in terms of mental wellness and having those available supports was also recognized in the context of homelessness. For instance, P.154 stated:

All my friends are here. For instance, they just mention rehab, I still look up to him. He used to be bigger than me, the way I see it, the foundations being put back together, it does not break. If we watch over each other, we don’t turn backs, we’ve got friendships. If there is one problem there we all share altogether. It just doesn’t break, putting it in the mental, it’s all how we look at it (P.154).

This participant was recognizing how relationships and connections involve supporting the person at every stage of their lives and being there for them through the success or difficulty that they are experiencing at that time and being there as a support. The aspect of shared success and burden was recognized as a function of community support. Listening and just physically and emotionally being there for someone was also identified as a way that the peer supports help each other and relationally support each other in a community setting. The participant stated:

I sit there, as I said, I just try to help them. Wherever I am at, the way I look at it, I am good at it. I see their difficulties, their transitions, and the ups and downs. When I am there, I try to calm them, a couple of my friends there, when they are with me, always say, when they are broken up they are straight with me, they go along with me. But when I am not around, everything crumbles around them. With me everything is straight for them (P.154).

There are a strong camaraderie and support network that exists amongst the peers on the streets. It was described how a lot of individuals look out for each other and protect each other, thereby forming a sense of community. One of the participants stated:

Yes, we all support each other, either which way it don’t matter. If you need a smoke, ok you’ll have a smoke. You want a beer, ok you can have a beer. You
need this, I can give you clothes and stuff like that, and we all share here. Like I even bring my friend clothes, you know, it’s just random stuff, random stuff for everyone (P.145).

Further, while talking about the traditional values and the importance of relationships, P.145 commented on the sense of support in the community in the following words: “We [Indigenous people] are all considered family. We call each other either cousin, big love, quite a few things; sister or brother, it’s just totally awesome. We are all connected and supportive” (P.145).

Connection and relationship were also described as the aspects of a larger community, whether that is of the Indigenous community or of the homeless community. The participants recognized the value in belonging as an important factor in their cultural identity. One participant stated:

Like I say, everywhere I go, everybody knows I can go to help, everybody can be falling apart, as soon as I get there, they are all walking beside me, all together. My nations, I am a traditional dancer and also a drummer, that tradition I hold tight and strong to it. My name I came into it, [animal] standing strong. I always got to hold my ground, people see me coming, they are like ok there’s [animal], we got to work with him, or if they go against me it’s going to be difficult for them, but the way I look at it, I can’t do that (P.154).

This participant recognized that being connected with the culture also connected him with the other people and in sharing his traditional knowledge with others through ceremony and dancing he could form relationships with them. Further, P.154 made a comment on this connection with the community and the strength that comes from relationships with other Indigenous people, and especially with the other Indigenous people who are experiencing homelessness:

The connection is with the community, and I feel the connection is what gives you the strength and I feel good about it, or with this kind of life. They all look up to me, they know I am down with everybody, they know that I live two lives. When I live on the streets, help people out, dutifully, on a personal note. Or I just turn around and go back traditional (P.154).
Traditional knowledge and the larger community were also described as being important aspects of identity and holding values in a relationship. One of the participants noted:

Being spiritual is more of a social thing. Being social with everybody, in the community and around. When you come here you know a lot of people use, you know your neighbour maybe a person at the store, and you may just say hi to the person at the store, but that’s still a friendly face that you see all the time- that’s social (P.160).

The value of community connection as an Indigenous person and the relationship that one has with the greater community was discussed as being an important as well as a strong value. It was recognized that being a member of the community gives a sense of purpose and belonging. The participants also shared a personal sense of strength as feeling supported by a community was also shared; one participant said:

When you live up North [in an Indigenous community], you live all together. Even when you go to sleep you lay down and you will wake up and you will be like three or four people sleeping beside you, you know, everyone is like together. And here everyone is all divided and everybody’s got their own separate rooms. I understand that- everybody wants their privacy right, everybody is into their little box, and everybody just wants to be left alone. Whereas somebody come down here, and you are not used to it (P.160).

This participant also recognized how leaving an Indigenous community and migrating to a large Canadian city, can separate individuals from those values of community support, leaving one feeling isolated.

Respect was defined as an important aspect of the traditional values. The participants defined respect for others, the land and the community. Being respectful was indicated as an important aspect of identity as an Indigenous person, and was also considered to be important for survival amongst the peers in the homeless community. Respect was recognized as being essential for receiving respect and giving respect to others. This was important in order to develop trust and supportive relationships.
One participant recognized the importance on honouring and respecting others as a traditional value and strong aspect of Indigenous identity. This participant stated:

[Traditional knowledge is about] honour and respect, it’s a treat your friends with respect right, and if anything, you honour them too. At the same time because we lost a lot of people, lot of Native people we lost. They found my one friend inside her place, she was already dead for three days. Then her husband, when he found out he lost it, and just ended up started just drinking and drinking, not eating just drinking and then he died too. Then my friend John who was dying of HIV/AIDS, that’s pretty bad news, his legs were just horrible. There are just so many things, but we all honour and respect everybody (P.145).

Another participant recognized the importance of respect in terms of identity and traditional values as an Indigenous person and stated: “It [traditional knowledge] is understanding. It’s about understanding and respect” (P.155). Respecting all people, especially those battling mental health issues, was recognized as a strong and desirable value by the participants. This was identified as being especially important in the street environment as well as in interacting with others in that particular community. Having an understanding of all people in regard to the struggles that they are going through was considered to be important in terms of being free of judgment. P.159 recognized extending support to one another and looking out for one another as a form of respect, especially for vulnerable peers. For instance, this participant stated:

Some people are sick, you come out here and you know they are vulnerable. So you try and show them or teach the best way that makes it easy, basically, that is a very, very generalized rule, is you got to respect yourself and you got to respect everything else around you; because if you don’t respect yourself you know that, things don’t work too well… A lot of knowledge, knowing what to do, you know, how to do things (P.159).

The participants also recognized respect for each other as an important function of surviving street life. It was recognized that there is a certain degree of street ethics that should be maintained and followed while surviving being homeless. In this regard, respecting other people was recognized as an important ethical response. One participant explained: “You don’t have to
get your ass kicked. Just don’t rip people off, don’t lie, don’t cheat, don’t steal, just be real with people you know” (P.148).

The participants also discussed respect for the environment while living on the streets. This was in relation to honouring and respecting the land as an Indigenous person, as well as being respectful to others who tend to share that environment, such as in the context of living on the streets; this included being mindful of those who are not homeless but still utilize the public space. For example, P.145 stated:

There were three of us sleeping there, but there were quite a few other people there, nah probably about eleven of us out there. Yes, and mostly [Indigenous tribe] too. They wake us up in the morning and all, but we treat everything with respect. We clean up our mess and everything so its’ just like, you know, our cardboard (P.145).

Traditional knowledge was inclusive of respect, as verified through the narratives of participants; this was recognized as a strong value as well as a vibrant force in the overall identity of the Indigenous peoples. One participant recognized this and said [traditional knowledge] “It’s about respect and honour, yes. There are actually seven teachings, humility, honour, respect. Honour and respect are the most important. It’s you treat your friends with respect right, and if anything, you honour them too” (P.145). Respect was also recognized as an intimate form of valuing the community members where everyone treats everyone like family. For example, P.146 stated:

I call everyone my brother and sister. That is respect. You have got to have respect for people. [traditional knowledge] is humanity of course. It is truth. If you don’t have respect for man, got no respect for yourself. That is why people kill themselves. I am a very deep man, I respect. It is called dignity. They [society] have no respect for themselves. I respect everybody, especially the children and the Elders. They are the future of Canada. That’s my belief, in society and such. If you respect someone, they will respect you (P.146).

Loyalty to others and to the community was also recognized as being an important aspect of the street ethics that are involved in interpersonal relationships and survival during a period of
homelessness, and also in general. This was indicated as being an essential aspect of traditional knowledge and a part of their identity as an Indigenous person. The participant actually said:

Best thing I can say [about traditional knowledge] is, it is loyalty and respect… you can give up in a second. Like one little thing, you know, you can lose all your respect just like that. It will take a lifetime, you may never get it (P.148).

P.148 further outlined the nature of respect and explained how it can affect what happens to you in terms of the way you treat others and interact with any community. The participant stated [traditional knowledge], “Basically it comes naturally, it is karma and respect. I may had made some mistakes sometimes but, you got to have respect for everything- appreciation.”

The participants identified respect as a value that was, like a legacy, passed down through the family dynamics and teachings, separate as well as together with the teachings that come from the Indigenous knowledge. One participant stated:

I was raised by a really good family, I completed up to grade twelve. I was raised to respect my Elders, anybody that is older than me, and my one rule that was taught to me is if you want respect you have to give it. And my family, I am proud to say that I am a secure man, because my family raised me to be the man that you see in front of you. Everybody tells me that I have a lot of education behind me. Everything that I have learned to this day, I am grateful and thankful for my family that adopted me (P.160).

This participant was referring to being raised as an Indigenous person by a non-Indigenous family. The participant discussed that he was given the values he has had through his family, which was an important part of his identity and it went beyond the domain of race.

**Cultural connection**

The cultural connection was also identified as a fundamental value in terms of Indigenous identity as well as homelessness. This included both cultural disconnect as well as connection to the traditional knowledge. The participants discussed connecting to Elders, being involved with their culture as well as the influences that traditional knowledge and identity has on the various aspects of mental health, healing and supports.
The support of the Elders was identified as a strong source of connection to the Indigenous culture in terms of strengthening identity. This was further recognized as quite a significant aspect of the healing and the recovery process. Having access to these supports while on the streets was recognized as a strong source of support and was said to be a valuable component of the healing process. One participant discussed the various Indigenous services that were available on one particular street and mentioned, “Elders are there that you can talk to and everything” (P.145).

Having an access to Elders was recognized as a strong cultural and personal support and it was also said to be a good way of getting guidance. For instance, P.145 further stated:

Well the Elders help you out because they have been through that life and they’re probably either being recovered addicts or stuff like that. They are just trying to spread the word out saying you know, what you’re doing right now, it will affect you in the long run; you know what I mean? It’s helpful and supportive. They know how to speak to you to make sense and you feel really cared for by them. That’s how our Elders help us out and then we help them out. When they are in need we’ll help them out. You know, it’s like a few of them are in walkers, some of them are in wheelchairs. They help us out, we’ll help them out (P.154).

This participant described the support that is found and valued when one has an access to the Elders while living on the streets, but also described the aspect of community and taking care of the Elders, as the Elders are one of their own. Another participant said:

If I am following drinking, one of my Elders told me when I was sober, if you fall get back up, don’t let the guilt or anything bother you. Just get up and do it again, keep going. Don’t feel none of that guilt. Just keep going, that’s the way I look at it. I don’t stop (P.154).

Having a connection with the Elders as a youth as well as an adult living on the streets was also recognized to possess positive strength in terms of being exposed to or introduced to the Indigenous traditional knowledge and teachings. The latter was especially true if one had been disconnected from this part of their identity, or had grown up in environments without any exposure. One participant stated: “Aboriginal knowledge is what Elders teach you… circles…
teaching how to smudge when you are young, go to powwows, do sweats and stuff like that” (P.151). Another participant discussed how talking to that the Elders as a healing effect since they provide guidance in a non-judgmental way and a safe place. For example, P.156 stated:

When they do bring the Elders around, the Elder will talk to you later [even when using]… It’s helpful because you’re just not feeling judged. It helps to keep me sober, helps to still talk to someone, using it when they bring them around… it helps with spirituality and mental health most of the time (P.156).

Having access to the Elders was identified as a major component of the healing process and was also said to be a strong factor in the process of recovery; however, the resources were recognized as limited and it was indicated that having more Elders around would be more helpful. This was especially true for those individuals who live on the streets and are still in the habit of using and therefore cannot get an access to the Elders in other ways. For instance, one participant stated:

I think that if there were more [Indigenous supports], better options for people to get in touch with Elders, unfortunately, there is a section of Elders that come through the city and they are basically in it for whatever reasons, so I think that they have to generalize the teachings so people can accept them, a little bit more easily. Then you put rules and regulations and traditions together, then it’s hard for people to understand what is considered and continue with that learning phase (P.159).

The Elders were also viewed as positive role models and in general, people whom the individuals could look up to. This kind of support is very important in terms of building hope and as a sense of purpose, especially in the terms of one’s identity. Many participants spoke of feeling lost and alone. Connecting with Elders was also recognized as an important indicator and motivator that pushed these individuals towards change. One of the participants stated how connecting to an Elder promoted their recovery in these words:

It gives me experience, hearing the stories and everything, and that’s what I like, hanging out with older people just because their experiences are helping me for the future, and it guides me in the right direction as well. Because if I really didn’t and went and hung out with the younger people and everything, I would
still be out there and I’d probably be into the heroin and everything and what not. But I have seen what it does, I’ve seen how people react (P.160).

The Elders were also identified as being helpful in that they talked to the individuals personally without any judgements or preconceived notions; they could, therefore, see every individual as a unique person and meet them where they are at and in seeing who they are. For example, one of the participants shared:

When I go up North, I talk to some of the Elders and stuff like that. Each person is a certain individual, so when you meet one of the Elders, they’ll pick up on who or what type of individual you are, if you are an artist, or if you are like kind of like a diplomat, you know like a healer, story talker, or just someone who tells history. So, each individual has a certain attribute to which the Elders pick up on, in a way they’ll say this is you, this is your gift. They pinpoint and say, this is what this person really does, then you see it, it resonates with you. And you are like yea, you totally feel it. And that what you know, the Elders come in handy for, they can guide you person to person, this should be your path. If you know you really feel truly… that’s what I get from the Elders and stuff like that (P.160).

Being with the Elders and learning from them was recognized as an important aspect of healing in terms of reconnecting with the traditional knowledge and/or being exposed to it for the first time. This was recognized to be an important and valued source of support, especially in terms of healing from the various aspects of colonialism. For instance, P.160 further stated:

You could sit down with an Elder for hours until, you understand. They’ll talk, talk, talk and talk, then spirituality seems to be- when I was younger I got into Christianity… and I noticed that everything was fear based… so I started speaking with some of the Elders and they explained to me that you know, that power is something the human mind has created for, out of fear (P.160).

Being aware of the traditional knowledge and incorporating the various angles of it in one’s everyday life was said to be significant in terms of identity for the Indigenous homeless. It was recognized as a source of purpose and was said to foster pride and meaning in the lives of the participants. One participant stated:
Traditional knowledge is more basically about Elders and kids and the pow-wows and being together. Like where I am from we have the largest traditional pow-wow in [place]. Last year it was over 4,000 people and it’s all by the lake (P.145).

An individual’s connection to their culture was also identified as a central component of healing and maintaining wellbeing. P.145 further discussed the importance of traditional knowledge being included in the recovery programs and stated:

Well we have the circle here to help with mental health. [Elder] comes down here every Wednesday we do our smudging and everything like that, everyone has a chance to speak and we just tell all in our heart (P.145).

The participants also discussed how being Indigenous is more than a profile identity, extending into the domain of spiritual identity that comes from a desire to connect with the traditional knowledge and the way of life from ancestors and to pass that along to the next generation. The participants discussed the significance of this in the development of their identity as Indigenous people. For example, P.148 stated, “If they seek [traditional] knowledge then they’ll learn it, but they have to want it to seek it. If they don’t come for it, then they will never learn. They will never and will be lost forever.”

The connection to traditional knowledge and its importance in terms of identity as well as in the development of a personal sense of belonging was also discussed. Furthermore, the conversations with the participants also indicated that colonization has taken the Indigenous people farther away from learning the traditional ways and instead, had incorporated maladaptive behaviours like drug and alcohol abuse in their children. One participant stated:

If we don’t have our traditional ways- something has to pull us back in, to make us feel like we are Natives. If we don’t learn our traditional values and what our other people had learned- like follow on and show the younger ones, this is what we were supposed to be learning. Not learning how to be homeless, not learning how to drink. No, we are supposed to learn about trees, birds, animals, you know. Drinking is not a Native thing. We have traditional values and we got to respect them (P.149).
Connecting to traditional knowledge was recognized as a central aspect of healing from emotional pain; it also holds a significant position in the general well-being in that it can help ground and centre a person and strengthen their identity, which is in itself, healing P.150 stated:

Indigenous traditional knowledge has been really strong for me. I go to sweat lodges when I am not sedated. It centres you, it just centres your whole being, the sweat lodges, I have that much more power, when you are ill, to fight for a few more days. I won’t go down without a fight, I won’t. I refuse to just lay down and die (P.150).

The participants also recognized the positive effects that incorporating traditional knowledge into mental health care helped to ground the individuals and promoted healing. One participant said:

It’s only in the past few years our Native medicine and magic has been introduced to mental health and people can’t believe the impact it has had in just only a few years. The Elders come in and they talk to these people and within a few months these people are ok, you know (P.150).

This participant further discussed how the introduction of traditional knowledge into mental health care and in the treatment of mental illness is beneficial. For instance, the participant stated:

I was diagnosed with schizoaffective mood disorder in 2003 in [large Canadian city] and then shortly after, Native medicine was introduced into mental health in the province; and so, it did, and it has helped me out a lot since I was thirteen, I have always used it (P.150).

Further, P.150 also discussed how being connected to traditional knowledge from an early age can be a protective factor in that, a connection with one’s ancestors and the Indigenous worldviews can have a positive effect on one’s mental health and resiliency. For example:

When I was much younger, I was able to connect and I think that’s what saved me, I was surprised when I made that connection, when so many others hadn’t. And there’s kids that missed the boat and they rejected them [ancestors] because they didn’t make that connection, and they died early (P.150).
The importance of being connected to traditional knowledge and medicines was said to have a positive influence on the participants’ mental health. In the very words of one participant, “Smudging feels very good I guess. They did it back in the old days, you know what I mean, to survive. After hunting and stuff, they did it, had powwows and feasts, traditions” (P.151). Another participant discussed how being connected to traditional values played a vital role in helping the individuals maintain their wellbeing and emotional resiliency, “Sweats are helpful, it is definitely, getting in touch with your culture is definitely a part of its healing. Like just a lot of the aspects of it helps you out” (P.152).

P.152 also recognized the importance of connection to traditional knowledge and its influence on the healing and recovery of one’s mental health. For instance, the participant stated:

Traditional knowledge- mentally, it helps. Like it clears out, you know all the negative stuff you hold in, it cleanses your body. It’s just good all around, even smudging, pain. It’s good, use to do that, don’t do that anymore (P.152).

The participant further stated, “When I smudge in the morning, I feel more, I feel happy, you know, I feel good. And when I do sweats, I feel good inside. I feel a weight has been lifted off my shoulders” (P.152). The participant also said, “I don’t know like, knowing about the culture like, sweats, healing ceremonies, smudging, and cleansing. Self-healing from all those bad, negative feelings” (P.152). Another participant stated, “Yeah [attending ceremonies] it is a great time. Dancing, steps, sounds, everything. It is helpful [for mental health] it stays with me. I follow-up, I do the same thing, to follow up. It makes you to continue the way” (P.157).

P.146 discussed how one’s involvement in cultural talking circles and groups has had numerous benefits and has also had an improved well-being:

Every Wednesday there’s a spiritual closure, how to let your emotions go, they smudge and then Fridays they have it over at the health centre. You cleanse yourself because you talk, let your emotions go as such, you talk it out. You talk to someone. Like my brother right there. We all are talking men around here, got to talk it out. Just don’t keep it bottled up. Got to talk man, woman or jail, even the kids learn (P.146).
Another participant discussed how connecting with culture and being involved in the talking circles was an important aspect of the healing process because the people there not only understand the circumstances but also have shared experiences. Talking circles tend to create a safe space for healing. The participant said:

I used to excel in math and science and stuff like that. And I just kind of broke down, all the shit I’ve been through. I just kind of, that’s how come I like coming here for the circle, [because other people have been through stuff too] and sometimes we may argue, but it’s like family though, you know what I mean (P.145).

Being connected as a group and a community was recognized to be very important in relation to both maintaining a strong sense of identity as well as in the process of recovery and well-being. This was quite evident in the statement of one of the participants:

I think Aboriginal will be the basic best medicine for any man or woman or child on this earth, even animal. It is more spiritual - because you got to believe in something, believe in something. The other one is just written. They believe in the creator and such, it is in the heart, not reading. It comes into you. Like inner spirits. I believe in the source. I remember when I was in a storm lost, I found my way home, because I believe (P.146).

Another participant described the importance of connection with traditional knowledge and the overall belonging in the sense of community and how group healing is an important factor that can help an Indigenous person heal from trauma. P.157 said:

Smudging helps me a lot. Well since my creator, and I ask for help all the time. It helps. I love smudging. I feel special. I attend circle and traditional group. The most important things are someone saying something nice you know. Smudging. Everything all around that place. I found it really special for me (P.157).

Another participant discussed how traditional knowledge has been incorporated into the general health approaches but identified that connection with mental health supports were lacking. The participant said:

I smudge and participate in circles and we got four winds, which is my favourite
thing, but there is no connection [to mental health], there is only health. I just get up and travel. So I can hear it— because I got a lot of support (P.158).

Yet another participant highlighted how influential Indigenous culture and traditional knowledge were on an individual’s psychological as well as overall wellbeing. P.150 stated:

I am an apprentice of men of magic. And I think that’s what kept me going all this time, smudging, praying the sweat lodges… I think it actually saved me, my ancestry. And if you look hard enough you’ll find it in the community, and you go to these Elders and they just glow. You go to the Grandmothers and the Grandfathers and they are just ‘come here’, laughter they saved me I don’t know how many times (P.150).

Another participant shared a personal story of cultural identity, community connection and the journey of connecting with the Indigenous tradition and spirituality. He discussed how relating to others in the community provided him with the exposure to the political concerns as well as traditional knowledge, that he had been disconnected from in his youth. This participant also discussed how this knowledge helped him to understand some of the aspects of his upbringing and the differences between the non-reserve and the reserve culture. For example, the participant stated:

My older brother, he volunteered with uh some other friends of his- it was like a cultural awakening you know- back in the 60’s and 70’s. So, my brother was a part of that and uh he really enjoyed it and he asked me- come try this out you know and I went and I got into educating myself about the politics, the plight of our people and why they are the way they are and I started going to rallies. Activism, and learning about the social way the other people manage and function under what happens to them in the municipality or like in the city. You know, a provincial jurisdiction- a federal jurisdiction- one kind of like you’re blinded and the other one is kind of like you know- I just think they are a different set of rules out there together right. It’s another sort of adjustment because back home we come from like lawless almost and to here where the police will grab you, you know (P.147).
Another of the participants also shared how he was inadvertently exposed to traditional knowledge by being connected to an Elder through the means of community service. He explained that this experience allowed him the opportunity to learn and practice the traditional ways and also led him to want to know more. P.160 shared:

I went to this Elder at a sweat lodge I went back in 1998, in community service. Now first, I was just you know, with community service, so I just wanted to lay down all the time, so they told me, get up and start doing some work, I said all right, I started chopping some wood, and I was the fire keeper. That’s how I started learning more about my culture and my parents were supporting me. It was one of the best experiences of my life. If I could go to more sweat lodges I would. I mean, not here in the city, because it is not really, you know, it’s not going out in the woods, but the point is… I want to learn more (P.160).

The participants did indicate that street-involved living prevented their connections with the traditional ways and was a divide in terms of removing or separating someone from their culture. For instance, one participant stated:

The old habits kept keeping up with me until I became involved with culture. Back home we do hunting- you know, that’s culture. Part of our way of living- living one with the environment. Interacting and going camping and all those things that I was comfortable doing (P.147).

Another participant shared his personal experience of how connecting to the Indigenous tradition was important and how it was also quite normal and common to feel disconnected to that part of the self when living on the streets:

When they’d seen me [family], when I fell apart, or looked at me when they had seen me on the streets at my worst, they’d seen my transition piece by piece and then I got back right into it. Look at the mental part, I have to trick my own self, therefore, what I’m doing is horrible for my health, once in a while I will go see my Uncle. He told me this, he told me change my ways and he took me back to who I am, my traditional side. It takes time, to make time. You got to have that time, to make time. That’s why I totally look at it in a totally different way from
other people (P.154).

P.154 further described how homelessness can drive an individual away from getting engaged in the traditional knowledge and ceremonies and the conflict in identity as a result of disengagement:

On my traditional side, I miss it, because I am out here. When I go back into it I am a totally different person, that’s why I say I live a double life. I want to get back into the traditional cycle of where I live. Where I am from. I love the feeling of it, I know where I belong. I fell away two and a half years ago from myself, it got brought back to me after seventeen years, finally came back and I had the most upstanding respect from the Native community. Ok he’s back, he’s not drinking anymore, when I started drumming again two years ago, I was with all the drummers, they were all happy to see me, you haven’t been around in seventeen years and you can still do it… I am proud of it, where I am from, and all the trails (P.154).

The participants also discussed the ways which traditional knowledge influence the way that mental health is viewed within the community and in general, further beyond the aspects of healing. The participants spoke of what mental health means to an Indigenous person. One participant spoke of the traditional knowledge and mental health and the meaning that it has, not only in the traditional language but also in terms of its meaning. The participant also spoke of the values of the community and protecting those people in the community who are affected by mental health and are therefore in a vulnerable state. P.159 stated:

Well there are hundred and thirty-seven different words [in traditional language], which attach to emotions and life is a word you are supposed to be, we have some rules and some guidelines and the major ones that I believe in, the major ones that I try to follow. People our age, our warrior age and getting up there, so the fact is that we are put here to protect the women, the children, the elderly, the handicapped, you know, and everybody that can’t provide or fend for themselves. We have all these emotions that are attached to it, it is very basic, it is very simplistic, you know, it’s very simple; but people need to complicate things (P.159).
P.159 further discussed the meaning of mental health and emotions in a traditional way and discussed dynamic emotions in the Indigenous languages and knowledge:

There are a hundred and thirty-seven different emotions that we are aware of. And most times, you know, traditional teachings are applied with compassion, acceptance. So, you can’t walk in the situation of somebody with mental illness and spiritual loss because they don’t even understand what they are going through (P.159).

P.159 spoke more specifically about mental health in terms of the healing process and how to best help someone who has mental health needs. The participant recognized the need for more supports that are readily available for various people who are experiencing an array of psychological symptoms, with a list of resources, as many people often fail to understand what is it that they are feeling or how to cope with it. For example, P.159 stated:

There are a lot of people in different stages out there so you got to learn how to adapt to each situation. You know, see where they are and what is the best way to help them. We go from the mental ailment to the physical ailment, you know to emotional distress and whatever. Right so, and that’s a lot of problems for people out there, the emotional distress. I think if they got on to some kind of website, you know; because every culture for every creed that there is in Aboriginal have different teachings. Making it easier to obtain would probably in my idea is to put something on the internet- like notes of enthusiasm. A lot of times there is not a lot of gratitude out there (P.159).

The participants also discussed how traditional knowledge and following Indigenous spirituality and way of life can help promote a positive sense of morale that influences identity as well as the overall wellbeing. For instance, P.160 stated:

It [traditional knowledge] gives you a clear view of life, so you are traditional and that won’t help you enter society, but, yeah it will. Because it will give you a better understanding of human beings as individuals and everybody is different and that when they are being mean to you or whatever they mean to you got to look to why and stuff
like that. But you’ll never know why, unless you sit down with them, why would you turn on me that day or why maybe you were just having a bad morning (P.160).

P.160 also discussed the phenomenon of not judging others in an Indigenous perspective and applying this approach to mental health. The participant also recognized the spiritual aspects of the self and interpersonal relationships in the way of understanding others objectively rather than personally. This participant recognized that understanding others through the spirit of the self and being there authentically was at the core of empathy, with the self and others. For instance, the participant stated:

I can’t do anything bad to anybody, because I feel it. You are supposed to battle too, right, being spiritual you are supposed to battle with yourself, because you always have thoughts, you know, that type of mind, where did that come from? It’s totally what I am not about; never take revenge on someone. Like it’s about themselves, it’s not just I look at the spirituality, and just kind of always sort of look into the person, what triggered that, why are they mad at me? And it turns out, they are not really mad at me, they are mad at themselves you know and because of my spirituality, mental health is almost like a gift (P.160).

Another participant described traditional knowledge as the lifestyle and values that the Indigenous people practice as a way of life. This participant also recognized that although there is a common way of being, there are many differences in regards to traditional knowledge based on their geographic location, band, community and family that intersects with traditional values and how they are acted out on at an individual level. The participant also reflected a cross identity that many Indigenous people are likely to experience through the aspects of colonization as well as religion. The participant said:

Aboriginal traditional knowledge would be related to the knowledge that Aboriginal people practice- I know a lot of Natives do, they have Cree Natives, they have religious families brought up, their families set back, so they did too. Like I go to church myself on Sunday- I try to tell them what the Lord in other Nations, I know that, but they don’t want to hear it. What am I supposed to say? You are not supposed to argue, they are brought up the religious way (P.153).
The participants also discussed the importance of having an Indigenous identity and cultural influence into social services as well as public service. This was identified as an important factor in terms of recovery and change, especially in the aspect of an Indigenous homeless person. One of the participants stated: “It is really great out there, in every way. They [service providers] are really good. They care in the way that works for you- since you are Aboriginal” (P.157). Another participant highlighted the importance of Indigenous-specific services by saying:

So [Indigenous Shelter] is a really good place, I tell everybody about it. It is like a second home to me. And there is [Indigenous health services] right next door, for you know, the addictions and everything. There is Outreach even they can help you get a place and everything. I mean, that’s where it comes back down to a few, if you want to help you have to go and ask for it and go look for it (P.160).

P.145 also specific services for Indigenous people that are available in [large Canadian city] and how they are specialized in terms of needs. The participant recognized the value of having traditional resources such as the Elders available for these services. For instance:

Yes, plus the other services just right in between you know. Because [Indigenous women’s shelter] is here, then you got [Indigenous employment services] over here and [Indigenous health services] and there are Elders there that can talk to you and everything (P.145).

Another participant discussed the importance of incorporating traditional knowledge into mental health supports and indicated how these services need to adapt their approach for the Indigenous peoples, especially for those who are experiencing complex issues:

Well just to be treated with a little bit more respect [in terms of change] you know what I mean, for people. Like here they know who has mental health issues and they help us out and that’s how come we have smudging and stuff like that (P.145).

P.160 discussed the value of having an Indigenous shelter to go to. This participant also asserted that although there are various other non-Indigenous people who stay there as well, there is an overall sense of support that can be felt from the staff, in the shoes of an Indigenous person utilizing those services:
I really like it [Indigenous homeless shelter] because of the Aboriginal, and in a way, there’s a lot of White people and other races there. So, they are like, it’s like they are divided, where the Aboriginal people, almost like being treated better, but I didn’t see that right. But in the staff, they might be treating, a little bit more just because you are Aboriginal. But by the same token, I see other Aboriginals that are not being allowed in, and they are being asked to leave, in the end, it’s sad you know; It’s tough dealing with all this right (P.160).

Further, this participant discussed the importance of having Indigenous specific shelters and services that are adapted to cultural needs; he shared his own story to explain this:

When I first came to the city I went directly to [homeless shelter] at [street] and [street] and I stayed there. That was more for refugees and so I had never been in a shelter before. So, I was nervous I did not know where to go. So, I went directly into there. And what I noticed was that they didn’t really care too much about the people on the street, you fill the bed, you obey the rules that was it. The one day I had found a job, and then I was working the midnight shift, and the counsellor said to me, he goes, ‘how come you are at this shelter?’ There’s Native shelters in this city. I had just come into this city and I was not aware of anything. So, I said, ‘where are they?’ and he told me where [Indigenous shelter] was (P.160).

P.160 also discussed some of the existing barriers and challenges in the present services that tend to create hindrances in delivering quality service to the Indigenous people who utilize these services looking for culturally appropriate care, in that they are often running at an organizational level by the non-Indigenous people. For instance, P.160 stated:

I would like to see, from what I get, so ok you have these organizations that are Aboriginals, but they are run by the White people. So, they’re kind of dictating what these people are doing at the, you say, the Native tribe or something like, they are the ones that are really dictating what’s going on there. Which I would like to see stopped, because I see them when I go in there, and then they are just acting, I don’t want to say it to them but now you are just being like their doing (P.160).
Cultural oppression

It was highlighted that when coupled, oppression and racism also seemed to be significant aspects of identity for the Indigenous people, especially for those Indigenous people who are in a state of homelessness. More specifically, this theme spoke about the experiences of stigma, racism and discrimination that was felt by the Indigenous people and the extended elements of marginalization that they felt as Indigenous homeless. Furthermore, ignorance was also highlighted as a major barrier as well as an aspect of oppression that exists within the current Canadian context, especially in the mental health and social services.

All the participants discussed experiences of racism in their life as an Indigenous person. This was identified as a core theme in identity and feelings of ostracism. Some aspects of racism were identified through a systemic, societal as well as a personal level. For example, one participant highlighted societal racism by stating:

The people [Canadians] are racist and biased. That’s the biggest challenges because the colour of the skin and the way you look. I experience it always, that’s why I turn my back and walk away and sometimes I have to fight. I’ve felt that every damn day. I’m surprised a White woman is talking to me- because they look at me, they loathe me. You know the word- they think I’m a criminal. They always look down to you, I am here man, I am human. Jesus Christ, that’s what it is- racism (P.146).

This participant further shared his experiences of racism and how it has been an integral part of his life since birth; he also spoke of how being born in an Indigenous family has impacted his life and how it is true for the entire Indigenous community as a whole. For example, P.146 stated:

I grew up all my life feeling it [racism]. It hurts me, ma’am. We are all people, we all bleed red. It’s a kick in my ass. I loathe people for that. Especially those poor children; they shouldn’t have to experience that. Read them the Charter of Rights, this and that and they experience it every day. The day I was born, every damn day, I was called a damn Indian. So, what, I was born dirt poor, we are all poor man, we weren’t born rich, we were just kids (P.146).
P.148 also spoke of experiences of racism and commented on the multiple layers of this social ill, which are reflective especially when an individual holds more than one marginalized identity. For instance, this participant stated:

I am Muslim too, I am a Native Muslim, smoking actually taught me knowledge and wisdom for the last five years. That makes me question my mother- I got status. Based on that I am a Muslim too, and that, a racial profiling, even the police, not like racial profile, or status profile, you don’t have a fixed address and then you’re profiling you if you don’t have tax, payroll, a job, they profile you by the skin colour (P.148).

The participants also described how the Canadian context and system works in a racist manner and oppresses the Indigenous peoples in many ways, thereby having a significant impact on identity. One participant described how the system acted as a barrier that impacted the Indigenous peoples’ learning of traditional knowledge and being exposed to Indigenous culture due to the various ongoing effects of colonization. The participant said:

I didn’t learn that much [traditional knowledge] when I was young. My mother sent me to the Catholic school, I learned among my friends, and my White brothers, Black brothers, this and that I learned the knowledge among them. I was a little man when I first came here [to the shelter]… I may not know much about Indigenous [knowledge] from my own people, like I told you, I am Roman damn Catholic. So, I learned the White man way (P.146).

Another participant shared his own life experience to describe this challenge of systemic oppression due to colonization: “Well, I’m currently going through a court process where um- I’ve always been overcharged- ten times more than a normal person I think.” (P.147) Systemic oppression was also identified by the stereotypes that exist amongst the general public towards the Indigenous community as a whole, not to mention the Indigenous homeless, and that strongly affects the experiences of how they experience racism. For instance, P.149 stated:

They, [general public] just think like, wow they can paint, you know, like they normally drink in the park but they can paint. There are a lot of people that just don’t know. Like you can do a lot more than that, have music. Right now, I say
there is a lot of Native people going to University (P.149).

One participant described the daily experiences of stereotyping that many urban Indigenous people have to go through. The participant described how the general public often makes assumption about you on the basis of your appearance and race alone, knowing nothing else about you as a person. This participant stated:

It’s what they [society] want to expect to see. You could be a nine to five Aboriginal working seven days a week. All that they do is judge just one based on a thousand. You can’t do that, because you know what, those ten people that you saw, always drinking, all drunk, you can’t judge the gentleman walking down the street to work every day, you know, doing a nine to five- because that’s not fair and that’s what I notice in the city (P.160).

This was also shared in regard to the reality of what racism is like in the general public. The participant described the experiences of overt and covert racism and distinguished the difference from how it can be felt directly from the behaviours as well as interactions with the public, but also from non-verbal cues that people can give and which radiate racism and validate an internal sense of racism. This participant shared:

Ok, so like you are watching TV everything seems all happy, enjoying there is no racism and stuff like that. But the very minute you get off the bus downtown, you would notice how people are looking at you different for some reason, you pick up on it right away and you are like, what’s up with you? Then it happens again and again and no one’s actually saying anything, but they are just looking down at you, for some reason (P.160).

This participant also asserted how systemic oppression and racism was being rooted in the family and described the intergenerational effects that colonization has had in terms of family history as well as the personal identity. The participant described how this had led their family to lose the Indigenous culture and traditional knowledge and how it affected personal identity development. For example, P.160 stated:

Traditional knowledge is defined as being suppressed and close to being wiped
out with the schoolings and stuff they try to wipe it out a long time ago. Even my side of the clan, my mother—she was not put into a home when she was young, she was put into a school. My grandparents both died of tuberculosis. So, my mom was with fifteen hundred children and her twin died of tuberculosis as well. Then they split up the whole family, and sent them all over the country and to this date we only know five of the fifteen that were sent all over the place. They tried to wipe it [traditional knowledge] out back in the early 1900s and tried to integrate us by making us into the White culture, and you know to forget about everything else, right. So, they did pretty good on that, like so I would say around 30% is trying to come back ok so we are— it’s coming back. The grandparents now have the knowledge and then we’ll have the middle-aged people where some of them almost wiped out and then you got the children now that are interested. And they are the ones who want to learn, they want to bring it back (P.160).

Systemic racism was also identified as being covert in that many people who work with the Indigenous peoples as professional helpers are ignorant of the specific contexts of trauma within the Indigenous communities. Lacking awareness about the Indigenous traditional knowledge is a form of systemic oppression. The participants recognized a lack of education on the Indigenous histories and the social context of mental health. This ignorance further divides the Indigenous people and oppresses them by disregarding the impacts of colonization on the health and wellbeing of the Indigenous people today. It was acknowledged that racism also exists among the Indigenous peoples themselves. P.159 stated: “I think that some of the instructors or counsellors you know - I hate to say it, like there is a lot of racism in our community, even from our Elders and stuff like that, you know”.

This participant further indicated the effects of ignorance as well as covert and overt racism by describing his interactions with the diversion of power and the feeling of helplessness that generally follows. For instance, P.159 stated:

A lot of times what happens when the counsellors are there, given that position, they are trying to be intimidating, you know. In 2001, I went after the Executive Director of [large national corporation], because there were a lot of racism right, they promoted it and one thing that I know is that they accept funding from [charity]. In order
to obtain the fund, you got to be multicultural. When you are multicultural you have to understand that there are different beliefs and also different personalities and they generalize everything. So, it kind of puts a stigma on it right and I don’t know, maybe they need to get people skills, you know- it’s important (P.159).

Overall, cultural identity was recognized as a central aspect of peoples’ experiences of Indigenous homelessness. Traditional knowledge was recognized as a major component that encompassed this identity but was also recognized as being void in many cases as a result of the layers of colonization. Further, the participants recognized the negative impacts of Indigenous cultural identity in terms of the existing stereotypes and racism. These factors had a fundamental involvement in the current marginalization of the Indigenous people.

External Factors

There were other factors that were recognized to have a central position in the overall experiences of Indigenous people; further, it was also described how this influenced their transition into the state of homelessness. This was in relation to the homeless experience itself, the factors that influenced the ability to change in regards to healing from mental health and trauma, as well as in the ability to escape the cycle of homelessness. Lifestyle, including the acts of survival and attaining the basic needs, was recognized as a major aspect in the procession of the cycle of homelessness. There were also specific social determinants that were recognized as specific factors in the overall risks, experiences and recovery from mental health and homelessness. These included age, poverty and antisocial behaviours. Finally, social services and supports were recognized to play a significant role in the homeless experiences of Indigenous peoples. The three themes that underpin the meta-theme of External Factors are environment, social determinants and services and supports. Table 36 presents the themes and shows how they intersect with homelessness at three points in time, when at risk for homelessness, when homeless, and when in housing/ recovery from the state of homelessness. These themes will not be discussed within this temporal organization.

Table 38

| Thematic External factors of Indigenous homelessness | Risk of Homelessness | Homeless | Housing/Recovery |
The participants acknowledged that there is a certain environment that comes with being homeless apart from just the natural aspect of living outside without being protected from the elements. The participants identified a certain transient lifestyle approach and culture that comes as a part of being homeless. Furthermore, they identified the various social determinants that can put one at risk of homelessness, perpetuate the cycle of homelessness and further promote the change and escape from the cycle. Social services were also identified to serve a central role in this process.

The participants described a certain “culture of homelessness” and recognized a subsequent lifestyle. One participant stated: “[Homelessness] is perseverance, loyalty and trust and I don’t consider anybody homeless, because even when you live outside you still live somewhere, you live outside, so nobody is really homeless” (P.148). This participant further described some other aspects of the homeless lifestyle, indicating: “When you’re homeless, you have to get beaten up a lot and then beat people up. But then after, everything smoothens out and it’s natural- calm” (P.148).

P.148 further described a sense of street ethics that exists as a function of survival and homelessness that is in a way implied in the homeless community. This ethical system creates a
sense of value and respect that not only facilitates survival but also facilitates camaraderie and trust. The participant stated:

Don’t complain and just be honest. Don’t lie, steal, cheat, you don’t need to rob. Just be real with people, instead of please, thank you, spare change for food; if you really don’t have nothing. I don’t have shit right now, I sleep outside- and give them the message of the conditions of the shelters. They are infested with bugs and disease. I chose to sleep outside (P.148).

Transient lifestyle was also described as a component of homelessness, which can be recognized as a risk factor for falling into and maintaining the cycle of homelessness. One of the participants indicated how this lifestyle provided a positive quality and said:

I have various addresses. I pay for two places- I live in [city], I live here, I live at my cousin’s place. To me it’s not really difficult. I can’t stay in one spot for too long, that is why I pay for three different places. To me it’s easy. In my upbringing with the tribe, I have always had those places to go. Even if I wanted to go home, I have different parks, I have forty-seven properties. Like I said, I just pick a spot (P.154).

Another participant described how the transient lifestyle, especially factoring in the culture of substance use and addictions, can further the cycle of homelessness; but the participant also asserted how it reinforced the sense of transparency and freedom. This participant said:

Like actually the first time I slept outside- like usually, I sleep at my friend’s place. Last night was just one of those nights you know. I was here. You can go back and sleep or stay and do drugs all night. Today I feel a bit down- feeling like shit. I have to figure what I am going to do for the rest of the week. Whether I am going to get a place or I kind of want to go and do some shopping (P.152).

Some participants even described the homeless lifestyle as a choice that is adaptable to their needs, lifestyle, and personal context of where they are in their own personal journeys. This choice gives one a sense of personal control, especially if they’re coming from chaotic or volatile environments. One participant described:
Homelessness- for me it only started a couple years ago, I did have a life and to me I have been living a double life. I had a place for almost five years, I still have the address, but I just won’t go home. I just split” (P. 154).

P.157 described how the personal choice of living on the land, and being outside can bring about an experience that one can become accustomed to. It was also recognized that the transition to living inside again can also be a challenge in itself. The participant stated:

Learning to live inside again- it’s hard. Some of us, we don’t like to be inside because I had been inside… So, when you’re inside you want to be outside, because it is not the same. Once you like to be outside you don’t like to be inside. If you get an apartment it is hard… because there are a lot of us that have apartments and we lose them because we are out here (P.157).

Another participant described the aspects of what it means to live a transient lifestyle. The participant described that when in a state of homelessness, there is more than just a lack of permanent housing facilities. P.151 stated:

Well, I am in the shelter now but sometimes I sleep outside in the summertime when it’s warm. I don’t really have time to well look for an apartment… because I am always trying to do something, trying to get out of this… I don’t really- you know what I mean, I don’t really care if I have a place or not because I don’t live too comfortably anyways, just day to day or whatever (P.151).

P.160 discussed the aspects of the homeless lifestyle which were positive and which made the participants comfortable; however, they agreed that there also are aspects of homelessness that are challenging and undesirable, even for those who are more amenable to living outside:

In my experience, I was happy, I was comfortable, something I wasn’t comfortable about, like the whole planning and asking for money and everything. I wasn’t comfortable about that, but I mean I know that it is part of the homelessness thing and everything, at the same time, there’s benefits to it and there are downfalls to it (P.160).
P.157 recognized that homelessness can be a variable experience for some people, in that at times, living on the streets can be more comfortable, but at other times, it can also be a stressful and difficult lifestyle choice:

You mean living on the streets. It is ok and then it’s not ok. But then I learned to live this way- I live because a lot of people on the street say that this position is more comfortable. But it’s hard. It is hard to find a place, to always find a shower, you know (P.157).

One of the participants also described the benefits of the homelessness lifestyle by recognizing peer dynamics and supports that are cultivated amongst the people of a shared experience, in this case, homelessness. The participant described a sense of community and belonging as an aspect of the homelessness culture by stating:

The benefit is you get good friends out of it [homelessness] and really close friends, I’ve got family here now, whereas I moved to [large Canadian city] in 2007 and I had nothing, I had nobody here and nothing (P.160).

This participant further indicated, that although homelessness is stressful, having the right people surrounding and supporting you while you’re at it can make the experience much better. The participant further explained how people can influence the experience regarding the quality of the experience:

I’d rather have a nine to five job than be homeless. It all depends on the situation the person’s in and problems that they are going through. As long as you meet the right people and hang out with the right people, you won’t have the problems, but I mean, you will have problems if you go looking for them, or you know you start stuff or whatever.

P.154 recognized the transient lifestyle that comes along with homelessness as well as the role that the homeless community provides in an individual’s personal sense of belonging:

My experiences have been kind of up and down. I am not always in the same spot too long but always moving around. To me, it is not difficult, because I used to work and I am well known in different communities and I help them out as much as I can, as much as they are helping me. When I am on the streets, as you see, I joke. It’s not to cover up
any pains or anything like that. I just do it. Doesn’t matter where I am- I’m always doing the same thing (P.154).

The phenomena of survival and safety were recognized as a major aspect of the homelessness culture and the realities of what it actually means to be homeless. P.148 indicated that some of the resources, such as shelters, are not necessarily always the better alternatives. The participant indicated that the environment and living conditions of many shelters can be worse than sleeping on the streets:

The shelter doesn’t mean anything. People think that they got to run to a bed and what is that? It is just a bed and then they get maybe bed bugs from that bed. Just be wise and then be wise where you sleep. You know like uh, don’t give up and find a place (P.148).

This participant also described the negative experiences of the homeless culture in terms of the safety concerns that are consequential of sleeping on the street when one is not staying in a shelter:

Don’t let anybody know where you sleep… because someone could be like- oh that guy, oh you sleep in there? And some people don’t wake up. It is not a joke, people sleep and cover their head when they sleep, sleep in a group. You find like squads. People stick together, nobody is going to steal from each other- but they come and go (P.148).

P.160 also discussed the process of acquiring safety while living on the streets:

A lot of times you kind of stake out an area for a while. Like you go near the railway tracks and find somewhere that is kind of secluded and no one could actually, there is no path that anyone could walk in, and then you kind of make that your area. Then you could hear as people come trying to get through right. So then you know if something is true, you know could just be a racket. Yes, so you just do make sure you are in a safe area (P.160).

P.160 further explained the importance of ensuring safety, especially in the context of drug use. This participant indicated that there are times when living on streets becomes more dangerous,
such as when the homeless people receive social assistance. Since they do not have a fixed address, they often carry the money they receive on their person:

You’ll lose alertness if you are high. A lot of guys don’t have bank accounts, and they’ve got their ODSP cheque and they’ll have like $600 in their pocket and these guys it’s like every month they’re looking for you, because this one has just passed out, they come sit and drink and wait a little bit and they just go into your pocket. Then we wake up and he’s thinking oh yeah, everything is fine, everything is just cool, I’ll get some more booze or something. He has no money and he’s trying to remember what happened. A lot of the times, they don’t know what happened to them… Now they are screwed for a month, right so when they finally get out of it or slow down then even if they slip up once, they got to wait another month. So that’s thirty days where they say oh ok, and they just bide their time, and it’s even worse because they start borrowing money off friends and stuff. And when they finally get another cheque, they are going to pay it all back, so then that’s another month that they got to stay somewhere else again. So it’s just a continuous thing (P.160).

Another participant explained some of the survival risks and challenges in terms of the safety concerns while living on the streets. This participant discussed the hardships of living on the street when having to face the physical elements and the stress that can be involved with the basic survival needs. The participant stated:

Street living? It’s basically a lot of fighting, people getting picked up for no reason, cold at night. God, if there was one I would be like just bring me home, you know. It’s like horrible then, living in a park, it’s frigid you know, you got to find shelter when it starts to rain and everything like that. Or you got to carry around a tarp, so it’s like I did that for a few years. Staying here, staying over at [shelter], everything. Sometimes it’s just, I go over to the park just down the street, stayed there, stay underneath a bridge, down underneath the Expressway. Everywhere, it’s not good (P.145).

Another participant spoke about the constant safety concerns that individuals had in their overall experiences of being homeless: “You see a lot of things, being homeless, you meet a lot of
people. Some survive, some don’t. I just buried my best friend like three weeks ago” (P.150). Another participant discussed some more safety issues that were specific to the Indigenous homeless women, especially in the backdrop of the current Canadian crisis of the missing and murdered Indigenous women. This participant stated:

There is the challenge of losing some of the women that have gone missing and it’s a big concern. We don’t know where they went, they just disappear, some are taken and brought to homes near [small Canadian city], perhaps. Some just go back home, others are found dead. In a big city like [large Canadian city], it’s hard to tell where everybody is. We try not to leave no stone unturned (P.150).

P.146 recognized the amount of resiliency that many Indigenous homeless people have in their strength and stamina for survival. The participant stated: “Grow up or die, and I got to live. It’s a hard life, but we get through. I might be a little guy, but I am strong, strong and I get through it. Strong and willing”. This participant further illustrated the resiliency and will for survival, especially while dealing with the everyday stress and challenges of obtaining the most simple safety and survival needs. For instance, P.146 stated:

Yea, I am a survivor, where I sleep, I sleep. I am not too saddled, or nothing like that. Where my head goes, my head falls. I sleep and I don’t care what anyone thinks. Some people care. Honestly, I don’t care. I’m still a survivor, forty-five years old and I don’t care. I care because I know I could survive out there (P.146).

Although resiliency was recognized as a prominent characteristic that existed in many of the homeless participants, P.159 asserted that the most prominent characteristic was the negative experiences and emotional pain that stems from the homeless experience. The participants discussed the challenge of survival as well as emotional stability when one’s basic needs are not always met:

There is a lot of people down low. A lot of people are mostly distraught, you know, a lot of times and the fatigue does a lot because once you are not getting a proper diet and proper sleep, you know your level of comprehension your thinking pattern goes a little distorted (P.159).
The attainment of basic needs was also identified as a significant struggle in the lifestyle of a homeless person and was a daily stressor that many individuals in this context were likely to experience. P.160 indicated:

Like getting you know, a clean shower and toothpaste and stuff like that- could change your whole day right there that could be the challenge to at least look clean, if someone offers you a job or something good could happen, at least you look presentable (P.160).

Overall, in a thematic sense, there was a certain lifestyle, culture and ethical conduct that was predominant in the homelessness experience. A sense of safety was acknowledged through peer supports and dynamics; however, there was also the recognition of fear and uncertainty when it came to the attainment of the basic needs and personal safety when in isolation. Furthermore, there was a sense of lifestyle, in that living on the streets gave one a sense of flexibility and mobility. This transience was paradoxical in that it was viewed as adaptable for some, whereas it was emotionally disabling for some others.

**Social Determinants**

The participants also discussed various social factors that contributed to one’s overall experience of homelessness. These included the aspects of age that intersected in terms of the level of risk that was experienced in the state of homelessness; maintaining the cycle of homelessness; and influencing the likelihood for transitioning from homelessness into homes. Unemployment, level of education and an involvement with the criminal justice system were recognized as contributing factors to the experiences of homelessness.

Regarding employment and education, the participants discussed the major barriers in how these vocational institutions and social systems’ influences can have a negative effect the cycle of homelessness, setting up the marginalized peoples for failure. In regards to this, one participant stated:

Employment comes with housing. I don’t see employment happening without housing- because I tried it. It was good for a while- but it catches up with you. You come out of the forest, good morning, good morning and it’s in your
appearance, you know what I mean, like it catches up with you, where you are, and then you quit it (P.148).

P.150 also highlighted the difficulties of employment that can be faced when one is homeless, especially when there may be an involvement of the mental health issues. Maintaining employment was identified a significant struggle when one has to face psychological difficulties. When this is brought in combination with living on the streets, it can become quite overwhelming:

I came here in 2002 and between that time and now, I have been working on and off, mainly off but I have been keeping busy, so I don’t go stir crazy and it’s been interesting, I have been here on and off in poverty, still on ODSP, still sedated and my injection is due today (P.150).

Another participant discussed the importance of education in terms of survival in the society and an asset in the ability to thrive. The participant also acknowledged that education actually works like an asset for one by helping them get a job. The participant stated:

Education [is an important need]. I went to school. I learned, I mean I was brought up to go to school. You know the knowledge. Maybe I go reading, I love learning. I mean if you can’t pick up a book and read it, you might as well kiss your cookies goodbye, because if you don’t have any knowledge of what’s going on out there, how are you supposed to get a job, how are you supposed to fill out a resume and without this education I got, I will be nothing (P.149).

P.145 also discussed how an access to the educational programs and employment opportunities through services in the state of homelessness or at risk can also help in the transition process: “[Indigenous] Resource Centre. I go there too. They all know me over there, and it’s just like they offer like courses, schooling- everything”. On the contrary, another participant recognized the need to have more resources for people living on the streets in terms of training for employable skills, education, as well as job searching resources. The participant recognized the need for specific resources for Indigenous people who are in a transitional stage:

Community teaching you know- but other things you could do. So more
programs, you know, resources, women would need women counsellors, work with computer, do resume, you know. There are resources out there but then if you are out there teaching the Native people- and there are resources then they could do things. Learn, you know be out there to help, more education, try to do better for themselves (P.151).

P.160 stated that the Indigenous people who are street-involved could also connect with the culture by learning the traditional crafts. These skills that incorporate traditional knowledge can encourage marketable skills, which also engage them in an activity that provides a sense of mastery as well as pleasure:

Teaching how to make dreamcatchers, or whatever that people do. Odd little jobs, you know learn to be involved. Once the people start just sitting there, doing nothing just thinking, more they are addicted, to make themselves more depressed or whatever. That is why they want to try and make some more jobs in here to do something to make craftwork (P.160).

Financial Instability and experiences of poverty were also recognized to be significant risk factors that are likely to contribute to the transition into homelessness as well as perpetuating the cycle in maintaining homelessness. Participant 145 described the difficulties of financial strain and the struggles of escaping homelessness by stating:

I was on the street for I don’t know how many years, it wasn’t nice. Two, three four, almost 5 years. I am actually housed now but I am going to lose that apartment at the end of the month. I wasn’t even there for a year. Now I got to go (P.145).

P.152 described the realities of poverty, finances and priorities when there are other issues that become the contributing factors to homelessness, such as additions. This is especially true in major urban centres, where the costs of living are high and out of proportion to social support; combined with the accessibility and access to substances in a large city. The participant stated:

I am getting my basic needs today, but I don’t know what is going to happen. I got to just go get my cheque for my room somewhere and it’s going to cost me
like $450 to get a room, and I only get $600. I don’t know if they’ll give me the rent portion, next week- because if I don’t go and get the room today, I am just going to spend all the money on drinking and drugs. I want to get my own, as I said, I was thinking of, just getting going to get the room I want, I’ll probably get a rent portion back so I paid for the room. Then again, I just want you to know, addictions and tell me otherwise, it’s hard (P.152).

Another participant described the challenges of poverty, social assistance, and the challenges faced while attaining the basic needs for the sake of health and wellness. This is especially an added factor for health and wellness. Nutrition and medications are expensive and are often neglected when one is in a state of poverty. Furthermore, housing and transportation costs make it even more challenging to maintain financial stability. When combined, these factors substantially influence the dynamics of systemic failure and poverty that perpetuates the cycle of homelessness:

They used to give them [homeless] money for the transportation, and how would you call the other one, for diet, like they give the insurer, whatever for the medication too and they give them diet money, it used to be $280 a month, but they cut it off. Just like me when I was on ODSP, I was getting $1600, so they took $600 off because they said I was getting too much, so I told them you guys are the ones giving me the money for my needs. And some new guys turned around and want to know why I was getting that much. It felt bad, they said they were cutting everybody off (P.153).

P.153 further commented on the difficulty of managing finances and transitioning out of the state of homelessness. This individual recognized that this can be a difficult skill to acquire when one has been living in crisis, especially in terms of both basic survival and addictions. This participant also recognized the need for support:

It would be better for when they [homeless] get the money from them [social services] to pay the rent and then give them the rest of the money they have to buy food and give them the rest of the money to play with it or whatever they want to do with it. That’s best you know. It would be good for them to do it that way, so they would not be homeless, so their home will be paid. So they take out automatically from the cheque to pay the housing, and they can take them to go
shopping to get clothes, or whatever they need, shoes and food and then the rest they can just keep it, just put it away (P.153).

P.153 described a personal experience that indicated how support can be beneficial: “Some of the staff, they take them [homeless] shopping because they know that when they give them the money, they won’t buy what they are telling them to buy, they will go buy the drugs or the alcohol”.

The age of the individual at the onset of homelessness was also recognized as a major contributing factor in the trajectory of the time spent being homeless. Age was said to be related to both the positive and negative prognostic indicators of change and transitioning from the state of homelessness to housing. The experiences of quasi-homelessness beginning in the youth (i.e., being kicked out of the home, couch surfing, staying with friends, due to unstable family environments, juvenile detention, etc.) were recognized as the risk factors towards chronic homelessness and living on the streets as an adult. Many of the participants recalled their early experiences of homelessness beginning in youth. P.147 stated:

Growing up- you grow up with alcoholism. You grow up with violence. I left there purposely to find- trying to stay out of jails and institutions because I did time when I was a youth and a young adult. I went in when I was thirteen to eighteen- pretty much locked up between those ages and then I came to [large Canadian city]. I relocated at the invitation of my brothers, that maybe I would stay out (P.147).

Another participant recognized their early exposure to drugs and alcohol: “I started drinking when I was eleven years old” (P.151). This was also recognized as a significant risk factor for early age at the onset of homelessness. P.148 also described an early onset of homelessness and the experience of chronic homelessness: “I was on the street since I was fifteen years old, I just turned thirty”. P.149 stated: “I have been homeless since I was seventeen”.

P.156 also described being of a young age at the first experience of homelessness. It was recognized that youth-onset homelessness is a critical intervention time in having a successful transition and preventing chronic homelessness. This participant recognized that at a young age, being engaged with supports and services can be valuable: “I’ve been on and off the streets since
I was nineteen and now I’m thirty. When I was younger I was using a lot of youth programs, drop-ins and shelters” (P.156).

Age was also recognized as a significant factor in the change process, where P.160 suggested an inverted correlation between the age and time of homelessness in the likelihood of change. The participant described that a younger age and time of homelessness experienced was more amenable to having a shorter time span of homelessness. It was also recognized that homelessness for a long time was a negative prognostic indicator for transitioning out of homelessness. The participant stated:

> It is up to the homeless person, everyone has a choice. Sometimes the person who, like say a twenty-year-old goes on the streets, he’s still young. He hasn’t really gotten into his addiction, whereas a forty to fifty-year-old is a lot deeper into the addiction. It is harder for him you know, to decide whether I should go eat or go bruise it out (P.160).

This participant further commented on the relationship between age and unhealthy behaviours that contribute towards the maintenance of homelessness and go on to become a primary sense of coping, such as with addiction; maintain the cycle of homelessness, in both chronic homelessness and multiple experiences of homelessness:

> A lot of people on the streets are forty or over and they are deeper into their addictions and they are happy with their lives that way; which is sad to see, because I see a lot them, because I walk around [large Canadian city] a lot, and it is just sad to see, because only if the services were a lot more back then, maybe they could have helped out a lot more. But can’t really say that the past didn’t work, you got to live in the now and I understand why this is happening, why you doing this and I salute this because maybe in the future you will be saving those other people that are going to be fresh to the streets. You know, maybe you’ll save a couple of hundred lives, in the future (P.160).

Involvement in criminal activity was also recognized as a contributing factor to the onset and maintenance of homelessness. The participants discussed various periods of criminal activity or
contact with the criminal justice system, and whether those were actual charges, prison time, or ongoing difficulties with the police. P.148 stated:

What brought me to homelessness? Prison. I was on the street since I was fifteen years old, I just turned thirty and my first offence was fifty-three armed robberies, firearm charges, it was my first offence. You know, eighteen months but that was during the time a lot of my family was killed, my sister. The drugs are nothing, it’s just the drug balance, you know what I mean, anybody can do whatever they want- but you got to eat, and take a shower. Basic needs are nothing, like the welfare systems- I don’t have a fixed address. Where you know- where to go (P.148).

P.148 further identified the risk factor of prison and homelessness in that it mirrors similar lifestyle and similar qualities of living. He described that transitioning from prison often comes with other risk factors such as a lack of stable housing, poverty and limited supports. The participant said:

Because you are already adapted to one environment and it is natural for you, and it is easier, it is comfortable. So someone gives you a big house of gold or amethyst. You wouldn’t feel right, you’d be uncomfortable. Maybe it’s being institutionalized, but just on principle, you know what I mean, respect (P.148).

P.152 also described the relationship between antisocial behaviour and the risks of homelessness. The participant stated:

I came on the streets when I got into crime, and then crime and drug dealing and all kind of other stuff. Hurting people, just because you know, like for drugs. Then I’d go extract the money like for drug dealers and stupid stuff (P.152).

Another participant recognized that this is an ongoing risk and can be a significant challenge when one is homeless and not in prison. In this aspect, it is an ongoing challenge with the police. P.160 indicated:

Personally, I hate cops, because they killed one of my brothers on the streets, but I am not going to say all cops are bad because I have met cops that are nice, cops that are rude, cops that are ignorant. But that’s where it comes back to you, if you
want respect, you give it and that is where a lot of homeless people don’t realize or they are too far in their ignorance. Like a fifty-year-old he would be more ignorant than a twenty-year-old because he is not so hard into the drugs. Whereas the fifty-year-old he is probably done with that cop over the last fifteen years, you know (P.160).

Overall, there was a thematic acknowledgement that the factors ascertain and increase the risk of homelessness. These factors are inclusive of early experiences of quasi-homelessness and the first onset of homelessness; poverty; limited education and unemployment; as well as antisocial behaviours and periods of incarceration.

**Services and supports**

The participants discussed their experiences of the current services that exist in their experiences of homelessness; they also discussed the services that helped them to transition into housing, employment and helped them recover from their mental health, trauma and addiction. P.160 recognized the challenge of accessing these services and the first step in making the change. The participant stated:

> I got off the streets from [housing specific service] and took me four days to get a place from them. And it is really hard for me to really ask for help, because I know I can do it myself. But I took a big step and I was like ok, let’s go to [housing service] and I did, I got a worker and within a week I had a place, and you know what, a lot of people I understand are used to that life, and want to stay on the streets. Which is just totally fine, if you are used to it, then that’s fine. It’s like a person who is used to having a home, they’d prefer that. I just figured that if you are happy, enjoy your life the way you want to live it (P.160).

Another participant discussed the positive experiences with services in finding housing while transitioning from the state of homelessness. The participant asserted that the services help in an overall improvement to the quality of life and provide resources to meet all the other basic needs and help promote the change as well as transition. The participant said:

> They help me with the housing and the staff helped me out here. They give
me money if I need money, and food if I need food. I am going to say, when I was
down they help me walk. You know, I am a chronic alcoholic, but I manage to
make it down here (P.158).

P.158 further indicated that services also helped with other needs beyond that of their basic
survival. Many services recognize the spiritual needs of individuals, which is an important
component in the process of recovery:

We got [pastor] upstairs. I don’t know if you know- if you go upstairs, gives you food,
other charities and clothing and everything. They open at five o’clock in the morning,
they just let us into the shower, to the laundry, to the breakfast. They support the
homeless people that sleep outside. I am not a homeless, but I do sleep outside (P.158).

Although many of the services exist in order to support and provide the people with the
necessities, P.159 recognized that there are many barriers or issues that exist within the system
and in the current services that they access:

There is a lot of sick crap going on over there [at one of the shelters]. They never
did nothing for the kids. They never tried to fix the situations, and they were you
know, a few sexual assaults and stuff that happened, you know, not from staff or
whatever but you know, they just ended up that way. They never did nothing
for that, in our traditions they have a healing circle, and I don’t see too much of
that going on, I mean [Indigenous shelter] now they have their sweats and stuff, that’s
good (P.159).

Another participant shared negative experiences with services saying: “Yeah, and sometimes I
refuse shelters because it’s better to be outside you know, bugs and stuff like that. Otherwise, it’s
ok, except for the cold nights” (P.157). Another participant recognized that the basic needs are
trying to be accommodated with services; however, there is still a challenge and barrier to the
quality of these services. This participant said:

People they need housing, they need blankets and toiletries for them to use.
When they are out here, sometimes, the restaurants are not opened twenty-four hours.
Some of them are open until three o’clock. People need to have that paper and stuff to
go to the washroom (P.153).

This participant recognized that although there are current services that support some of these needs, there still are some added challenges that exist. The participants recognized that they are given food items for between the times that they cannot access the times for food or for the times they need food beyond the hours in which it is available. Many of the items that they are given are inappropriate for their circumstances, such as canned foods, for they may not have the required utensils to open the containers, or must eat the food cold. For instance, P.153 stated:

Every Saturday they have a church group there that feeds the homeless. They give them dinner, they give sandwiches and three kinds of soups, they have two kinds of chili and different groups of people coming from different churches to help the homeless. They give out canned food too - some people have to eat it cold, you know, open the can (P.153).

Another participant stated, “Some of the shelters are ok, for you know if you need a shower it is great. To have a place to eat that was even greater” (P.149). The participants recognized that housing is the main service that needs to be addressed in terms of assisting the homeless and in transitioning them out of the state of homelessness. P.147 described, “Housing is the main need because just trying to survive on the streets is pretty tough.” P.146 indicated that the quality of living conditions in many of the city shelters is worse than sleeping on the streets. The participant also believed that there was a sense of entrapment while living in the shelter system or even in the housing system. For instance:

When you’re hungry and cold and what else, basically just being homeless. Because some places, you go to, it sucks more than being homeless. Not even shelters, I never go to shelters, hell with that, that’s worse than hell. I rather be outside, because you are free. I am not stuck in some of those bug infested, mouldy places and stuff like that. Because some of the places you rent, it’s worse than hell. That’s what I rather sleep in the fresh air and freeze to death (P.146).

P.148 further validated this experience and said: “I’d rather sleep outside than in those shelters”. Another participant asserted: “Nobody deserves to live in squalor you know, with cockroaches and bed bugs, the kitchens aren’t clean and everything” (P.160).
Regarding the attainment of the basic needs, one participant said:

It’s difficult trying to acquire blankets and stuff from the Good Will. We have to wait until after they close because people make donations and you go through it, trying to find out if there is some kind of thing you can cover yourself with. And proper diet out here is crazy… The problem with that is that you have to deal with the diet that comes from the second harvest truck, whatever they have on it (P.159).

Housing services were looked at as a barrier in that they currently weren’t meeting the individuals’ needs to where they are in their healing journey and not hosting the appropriate environment for encouraging the change. P.159 further stated:

Well, the thing is I know there is not a lot of man time, you know that the housing coordinators can come up with to go and inspect these places. You can’t put a drug addict into a drug house. You can’t put an alcoholic into a booze camp. You know a lot of times that’s what happened. A lot of times, you know, they find it is convenient to get somebody in. it’s a numbers thing. You know, people out here, we are not numbers, we are people. You know but for them, the idea of housing someone it’s a pattern, their pattern or whatever, and they may not be doing anybody any justice. You know, they are putting somebody in a house or situation (P.159).

Accessing services was also identified to be a difficult barrier, and so was the readiness of the participants to receive the services. It was recognized that the individuals can become accustomed to the homeless lifestyle. It can become a pattern of familiarity, especially when one has been living that way for quite some time. Like any behavioural change, it can seem daunting to some individuals to bring about any change. It can be the fear of the unknown, the fear of failure, or the idea of acquiescence in making the change. In these regards, one participant stated:

[Housing is] your own personal battle, to go and find it or not. That is what a lot of people battle with, is themselves. Whether they go find the services or whether they do not go find the services, or whatever they want to or not. Pretty much, a lot of the homeless look for the easy way. And that’s just sit on the street, panhandle, go drink, or pass out somewhere. And the next morning get up and do it all over again. Next thing
you know it’s five years later and they’re dead. And within that five years, they could have had a place, and they could have got a job or volunteer, got back on their feet you know (P.160).

P.159 also identified the challenges faced while trying to have an access to the services. The participant indicated the dynamic needs that every homeless person has, not only in a physical sense but also in the psychological sense since every individual’s needs for their psychological wellbeing can be different with variable emotional and spiritual needs. For instance:

The programs that they set up, are basically impossible for people on the street to get to. A lot of times they are all on different levels, of hygiene, of mental health. So, there is a lot of different areas that people need to be aware of, just because somebody is on the street, doesn’t mean that he is in a bad position. It could just be temporary or whatever (P.159).

P.160 stated that there are many services out there that can help the people get off the street and help them with the basic needs; however, the participant recognized that there was a sense of abandonment in many of these services, where once an individual is housed, they are on their own. The participant stated that the services help with:

Clothing, with tokens, with rides. They take people if they need to go to the hospital, pretty much anything you need, they are willing to help you with. And [program] too but they are more get you off the streets and put you in a house. They come check on you once in a while because that’s what they did with me, they just put me in a rooming house, and that was it (P.160).

This participant further discussed, however, that if an individual wants the help, they have to initiate the process by asking for it and when they do, the resources are available to help them. This participant recognized an important aspect regarding where the individual is at in their readiness for the change:

If you get the ball rolling they will go ahead and help you keep it rolling. It all comes down to whether the person wants it or not. It is up to the person to make the change, and change is possible- it’s up to you. Because if I did not want to
change, I would still be on the streets. I’d still be down in the market doing drugs, and whatever else. Your body gets tired after a while and a lot of people don’t realize it, they don’t listen to their bodies. Your body can easily tell you that it is tired and needs a break or anything. Everybody always wonders why I am not downtown anymore. My body needs a break. That’s where it comes down, if you keep the ball rolling, the services will help you keep that ball rolling until you reach your goal. Services are there, it is up to the person whether they want it or not (P.160).

Further, P.160 said:

Just you know, just say you are out having a beer on the street, or something that the person wants, to get a place or a job or anything. That is where someone like me would be ok, here is the number, call the number, see if they have a bed, and then see a counsellor. If you get the ball rolling they will go ahead and help you keep it rolling (P.160).

The participants also provided suggestions for improving the current level of care and housing services. One participant recognized the need for a facility that can reach out to a multitude of care services:

Well, they should actually have like some sort of big building, housing sort of thing. Then they got their transitional housing too. So when people get on their feet, then they can move out. You got to be in a shelter first before they can help you out, so it just like jump through hoops and hurdles all the time and stack them on. That’s how come it’s like you got to have a worker so that they help you out. If you have a drop in like this, they’ll help you out, but only to a certain extent. And that’s how come like I’m with [Indigenous shelter] right? They are always on the ball and everything you know (P.145).

Waitlists were also said to be major barriers in the process of acquiring housing. The participants also recognized that there are many systemic issues such as long waitlists that can keep them on the streets and therefore keep them from change and be housed. One participant stated: “Housing- they gouge the prices, and the places are not even nice and they put the price up.
There are 67,000 people ahead of me, I will be dead before that- it’s a long list” (P.146). Another participant said: “So many of us need housing, I am on a waiting list and the waiting list is so long. I have been waiting for like two years now” (P.157).

Furthermore, the participants recognized the need for a continuum of shelters that could meet the range of needs that people have in the transitioning process of obtaining suitable housing. One participant said, “I just wasn’t to be able to go to my own treatments, and get into my home this time, no half way stuff there” (P.152). Another participant highlighted another fact, “Better shelters in more important and closer to where I hang out, there are more places to eat that are closer, transportation” (P.155). Yet another participant, while highlighting the multitude of needs, asserted, “Alcoholism is the first need, housing is another problem. Need a lot of help from drop-ins, places like [Indigenous shelter], shelters” (P.156).

The participants also recognized the various societal and systemic barriers that perpetuate the crisis of homelessness. P.160 explained:

Stop investing in condos. You know what if they did not invest in so many condominiums, maybe they could invest in housing, you know or build apartments, or housing buildings, where you can get some of these homeless people off the streets and everything (P.160).

Another participant discussed the aspects of ongoing colonialism that perpetuate the cycle of homelessness and create a specific kind of system that makes it difficult for one to escape the state of homelessness. Furthermore, this participant also discussed that despite the services that help homeless individuals with their basic needs, such as food, there is a gap in servicing the underlying problems of trauma and addictions:

This is government housing, and the government doesn’t know what’s going on. If they ever found out they would shut them down so fast. If people do show up, we are given these beautiful meals, and of course, we are sedated, so we don’t know what’s going on. And I don’t know, most of us are sick and they crack and they are all just added to that, so a lot of people OD [overdose] (P.150).
Regarding the Indigenous-specific services, the participants also commented on their current experiences with services and provided suggestions for a better level of service. One participant stated, “Service providers [at the Indigenous shelter] they helped to be strong to get away from that [addictions] and that’s the helped to like get appointments to go to these places to get better” (P.153). Another participant indicated, “We need more outreach and more places to go” (P.155). Another participant discussed the importance of having culture-based services for Indigenous homeless people in meeting their specific needs:

I just feel more comfortable at Indigenous services- because it is my spirituality. I am comfortable- but I feel comfortable at any other drop-in too. Does not have to be Aboriginal based- and they work together too, they don’t judge each other (P.156).

Another participant said: “There doesn’t need to be changes here [Indigenous shelter]. We have support- When I want to go home, they give me a bus token, when I’m hungry, food” (P.158).

The participants highlighted the existing barriers in services and provided their suggestions for what could make the system better accommodate their needs. While speaking about this, one participant stated, “We need more education and housing services. All kinds of education, school, this and that, they teach you” (P.146). Another participant said:

I mean, I am fifty-six right now, I have kind of like you know, I have some knowledge, and how to get around now, I mean I can use the supports that we have in the city, and it is a good thing that I wasn’t born somewhere in the suburbs. Because those people there, they have nothing (P.149).

P.160 recognized the challenge of accessing services in terms of availability and location of the services. The participant recognized that many services are located in the downtown area of the city, which can make it a tad difficult for other people who are in other areas of the city. The participant also recognized the challenge faced in survival and attainment of basic needs in that not getting a specific service at a given time, or not being aware of where and when they are provided. This can be especially challenging for an individual that is new to the city:

There is a lot of help out there for us. It’s just more of this area, south of [street name],
there is not as much right. So, there is some but it’s only some specific times and
days. You might be, have to be between one and two, you got to make sure you are in
that area, at the time of if you forget you know, you wouldn’t make it in time, so
you may go without food or you may go without some needs (P.160).

P.159 recognized the need for integrative services that help connect the people to one another,
especially in the homeless community. The participant recognized that there can be a sense of
segregation, which can result in the individuals feeling more isolated:

Well, I am looking for something to set up, or somebody to set something up, so
some of the people out here- that they know somebody out there cares. They
know that there is a place that they can go when they get help, or if they need
somebody to talk to, or if they need to listen to somebody talk or whatever.
Hopefully, something comes up like that, because out here you know, as a culture,
we don’t do a lot of post talking to other cultures, we don’t learn how that person
is or what that person is about, a lot of times it’s the Elders out there and they have
racism in their minds. And there is no place for it. So getting somebody to
understand you know, and accept people at different levels, wherever, whatever
level they are at, you know it’s probably about it (P.159).

Service support and change were also recognized as an important in combination with
motivation and the readiness to change:

When it comes down to it, homeless people really have to want it. If you want to
go find the place, or you want to find the services, you have to look for it, not all
of them are going to come to you. There are places you could be, in other places
you can get, that are for rent or anything, it is whether you want it or not (P.160).

There were also a lot of barriers recognized in terms of accessing mental health services in terms
of support for the Indigenous homeless. One participant highlighted, “It’s really hard for
someone on the streets to go out and find a counsellor- someone to talk to” (P.151). Another
participant said: “What kind of changes are needed? More support groups” (P.152). The
participants also recognized the need for change in terms of mental health services. For instance,
P.148 stated, “Some people that have addictions, they feel scared to go talk to someone
[counsellor] sometimes, you know because of what people might think about them.”

Furthermore, another participant recognized the problem, “There is a big gap between mental health and homelessness that a lot of people fall through. The grid was never updated since 1997-99” (P.150).

P.159 recognized that there are services and supports that are preferred by the individuals. This participant stated the connection with outreach and utilizing them as a support since there is a specific kind of understanding: “I deal with outreach because it is easier for me to put the finger to them and they know the situation because they experience it every day.”

P.159 also recognized the challenges in the system in terms of fully helping one to get off the street and making the change when there is no active follow up or continuing supports. This participant recognized that even if one is housed, there are still issues such as medication compliance, maintaining services, etc. that can easily remit:

You know how do you house somebody like that. You know, if they are choosing to opt off their medication, if they have to take medication, how do you explain that to them. To make it acceptable for them to say ok, if I do this, I will take care of myself I will be alright. You know, so there is a lot of things out there that people don’t understand, you know, a lot of times people that are out on the street, they can be epileptic. So how do you teach people they need to be on their meds, or they have to cool it down. To understand what people have, right, where they are in their life or whatever, where they are in getting involved in the programs (P.159).

It was also recognized that the counselling services are in need of more peer support. One of the participants indicated that the services need to be inclusive: “Guidance, having someone else to look up to, you know, teach you” (P.151). Regarding trauma specifically, it was recognized that in order to improve the services, the mental health care providers need to be available:

Talk to people on the streets and having somebody to talk to, somebody to ask for help. Like access to somebody to talk with, counsellors. It is lying to yourself [addictions] because you are not really giving your hundred percent you know. You got to do whatever you want to believe, you want to follow those teachings. You could use those teachings for guidance, you know, may be those are just a
guidance, you found a silver lining, you know what I mean, maybe that helped them. Like everybody, they can get better. It is just like you know, guidance, you got those people (P.151).

Summary of Chapter Five

In chapter five overall, the participants recognized that there were specific factors that were involved in the intersection of traditional knowledge, mental health and homelessness for the Canadian Indigenous people, especially in the context of a large city. The participants recognized that there are influences of psychological factors that contribute to the risk of homelessness, maintaining the homelessness lifestyle and keeping one in a state of homelessness, as well as in recovery from the mental health and trauma and in creating change to acquire housing. The participants also recognized cultural identity as a central component in the experiences of Indigenous homelessness. External factors such as lifestyle, determinants of health and the environment were also identified as factors that contributed to the overall experiences of homelessness.

Psychological factors were recognized to have a certain level of significance in the phenomenon of homelessness, especially for the Indigenous peoples. The participants recognized that the influence of early life traumas, as well as the aspect of colonialism and intergenerational transmissions of trauma was significant in terms of the experiences leading up to homelessness, as well as in emotional development, thereby putting one at risk and vulnerability for the factors associated with homelessness (i.e., mental illness; maladaptive coping). For instance, addictions and mental health concerns were a primary cause of the experiences that participants shared in their journeys leading them to homelessness and were also recognized as notable factors that maintain one’s homelessness.

Cultural Identity was also recognized as a prominent component in the experiences of Indigenous homelessness, traditional knowledge and mental health. The participants identified that the connection to their culture was an important aspect of who they were, especially in terms of mental health and healing. Cultural Identity was also embedded in the narratives of the participants through the aspects of traditional knowledge such as relationships and respect. The participants recognized that these values helped guide their interactions with others in the homeless community, their environment, as well as themselves. They asserted that they had a
strong respect for their traditional teachings as well as for the importance of being connected with Elders and other Indigenous peoples. It was noted throughout the narratives that being connected with the community and having those supports was imperative so as to have a sense of personal and cultural survival.

Some external factors were also recognized as being a core component in the experiences of homelessness for Indigenous peoples, especially regarding their traditional knowledge and mental health/trauma. The participants discussed various factors that influenced their experiences of homelessness; including the social determinants of health that featured some issues contributing to the aspects of homelessness as well as that of maintained homelessness. This included criminal behaviour and being involved in the criminal justice system as well as the ongoing criminality in order to maintain aspects of homelessness. Environmental factors such as lifestyle, street ethics and safety during the state of homelessness were also recognized as a major factor in the experiences of homelessness for the Indigenous peoples. The participants described the importance of having supports amongst their homeless peers and how this was helpful to them in terms of physical safety as well as emotional support and camaraderie for having a sense of street community.

Age was identified to be a significant factor in terms of the trajectory of homelessness, and the participants indicated that this was a strong factor in terms of treatment, where one would have a chance of better success if treatment was initiated at an early part of their homelessness and/or addictions. They recognized that their lifestyle can become more difficult to change once an individual becomes used to it, rather than when they are first experiencing homelessness. The aspects of employment and education were also identified as being important factors regarding journeying into and out of homelessness, especially for the Indigenous peoples.
Chapter 6
Discussion

Organization of Discussion Chapter

The purpose of this study was to explore the intersections of traditional knowledge, mental health/trauma and experiences of homelessness for the self-identified Indigenous adults. In order to explore this research question, the interviews were conducted with 16 Indigenous adults aged 16-65, who were currently experiencing or had recently experienced homelessness. The detailed findings were presented in the results chapters, identifying the core message that was delivered in each participant’s narrative over time, as it has been presented in the within-participants results chapter. The combined overall meta-themes that emerged across the participants’ narratives were described in the between participants results chapter. The overarching meta-themes (psychological factors, cultural identity and external factors) will be presented again as the structure for this discussion chapter.

The results that emerged from the participants’ experiences were able to identify the specific factors that influence the homelessness experience and its trajectory. These are inclusive of psychological factors, the cultural identity of the individual (static and fluid factors), as well as the external factors that influence the experience of homelessness. These overarching meta-themes were recognized as the primary factors that were present in relation to the research question of, what are the intersections of trauma, mental health and traditional knowledge for urban Indigenous homeless people? This chapter will discuss each of these factors as it relates to homelessness from the perspective of Indigenous peoples, specifically in relation to traditional knowledge and the influence of mental health and trauma. These factors are presented again below (figure 2).
Given the details that were presented, these factors are thus applied to the key aspects of the participants’ experiences of living on the streets, which include their previous experiences, present experiences as well as their future intentions. These psychological and external factors point to several aspects of mental health needs for healing in an Indigenous way and are the primary factors in the state of homelessness. These factors are fundamental in the process of transitioning out of homelessness and in moving towards a state of positive healing; however, the external environmental factors often interfere in the experiences of homelessness, thereby keeping one from heading towards positive healing, which calls for the need to acknowledge them.

Table 39

*Presentation of discussion chapter*

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**Psychological Factors**

The participants in this study acknowledged the various aspects of psychological factors that influenced their experiences of the intersections of homelessness, Indigenous traditional knowledge, as well as the mental health and trauma needs. The participants identified the various aspects of intergenerational trauma to be central components into the risk and onset of homelessness. This was coupled with maladaptive coping strategies for dealing with these traumas (i.e., addictions) and thus, it often put the participants at an imminent risk of homelessness and was also the main factor in the maintenance cycle of homelessness.

The participants also recognized a need for the integration of Western and Indigenous methods for approaches in psychology, especially in meeting the unique trauma and mental health needs of the Indigenous peoples. Furthermore, the participants noted that addictions are quite prevalent amongst the Indigenous homeless community. Culturally sensitive models towards addictions and the concurrent mental health needs were also recognized as factors that needed to be addressed in terms of the individuals’ experiences of homelessness.
Figure 3

*Psychological factors in the homelessness trajectory*

Figure 3 describes the psychological factors as they pertained to the overall experiences of homelessness. The participants recognized that colonization and intergenerational trauma influenced their personal, early experiences of trauma through trauma transmission, as well as in learning maladaptive coping strategies through their family upbringings, such as in addictions. Furthermore, the experiences of trauma and addictions were identified to be significant risk factors for the phenomenon of homelessness and part of the experience of being homeless. This was also a factor that relapsed back into homelessness as a function of inappropriate service delivery for the Indigenous peoples, or from the experiences of new traumas. The participants noted that being engaged in their culture had a healing effect and combined with the other community support, including mental health services that include the Indigenous approaches was the most effective way to exit the state of homelessness and promote healing.
Intergenerational trauma and homelessness

The experiences of trauma, particularly early in life, were recognized as a common theme in the narratives of the participants and were also noted as a primary factor that led to their homelessness. These experiences were noted to be perpetuated by either the stressors of the homeless environment or from new traumas that come from the ensuing chaos. As such, many participants experienced complex traumas, and therefore often remained in the survival mode even in neutral, non-threatening environments (Courtis & Ford, 2013). According to trauma literature, such individuals are at considerable risk for re-traumatisation during times of stress across their lifespan. It is recognized that perpetual activation of trauma places one at a highly emotionally vulnerable position (Duckworth & Follette, 2011; Widom et al., 2008). This emotional vulnerability was illustrated in the results of this research as the participants recognized histories of trauma and the ongoing emotional vulnerability that existed while they were living on the streets.

What was especially of note in the results was the perseverance and instinct of survival seen in the participants in spite of the adversities in homelessness; however, self-perseverance and aspects of identity were acknowledged as areas of difficulty for many of the participants. This was aligned with the trauma literature that suggests that the individuals with complex trauma histories often have diffused identity and do not feel like they have any sense of belonging. Despite this, independence and determination often posit them with remarkable capacities in terms of resilience and resistance as they are often able to withhold an exceptional level of morality as well as spirituality (Courtis & Ford, 2013). Overall, the complex traumas (pre-existing and current) were described throughout the results two-fold. One regarding the experiences of trauma in being homeless itself, and the second regarding the intersection of trauma experienced as an Indigenous person.

Trauma and homelessness

Some aspects of trauma were a unique factor in the participants’ experiences, particularly around the safety issues and violence that occurs when one is living on the streets. Most of the literature on mental health and homelessness described some individual factors, such as trauma, to be a risk for homelessness (Breakey, et al., 1989; Wood, Valdez, Hayashi, & Shen, 1990); however, Goodman, Saxe, and Harvey (1991) argued that homelessness is itself a factor that can play a
significant role in the development of an emotional disorder. Therefore, the experiences of homelessness can put one at risk for psychological issues, regardless of the predisposition of trauma or pre-existing mental health concerns. As a result, it was proposed by Goodman et al. (1991) that the psychologists can play an important role in addressing and preventing the psychological consequences of homelessness, regardless of the presence or absence of previous mental health difficulties.

Psychological trauma refers to the set of responses that are made to extraordinary, emotionally overwhelming and personally uncontrollable life events (Figley, 1985; Van der Kolk, 1987). A wide range of symptoms or psychological conditions have been included under the rubric of psychological trauma, many of which involve the rupture of interpersonal trust and the loss of the sense of personal control (Goodman et al., 1991). This was especially true in the participants’ experiences in terms of the impacts of interpersonal relationships amongst the homeless community. It must further be understood that trauma remains embedded throughout the narratives of the participants’ experiences - if not directly, it indirectly establishes a connection with the other homeless peers and interpersonal contacts. Therefore, trauma is a rather large factor in the overall experiences of homelessness.

Trauma theory and research, thus, can provide a useful lens to conceptualize and understand the experiences of homelessness, especially in the context of psychological comprehension and treatment. First, the event(s) leading up to one being homeless and the initial experiences of first becoming homeless (i.e., losing one’s home, neighbours, routines, accustomed social roles, and possibly even family members) may itself be phenomenal in producing the symptoms of psychological trauma. The transition period, where one goes from being housed to being homeless can last for days, weeks, months, or for even longer durations. Furthermore, some people can experience this more than once and can have multiple experiences of homelessness or partial homelessness.

Research has shown that many people living on the street or in shelters have already lived with friends or relatives (i.e., couch surfing) and may have experienced previous episodes of homelessness (Shinn, Knickman, & Weitzman, 1989; Sosin, Piliavin, & Westerfelt, 1991). As such, the loss of a stable shelter, whether sudden or gradual, may result in the symptoms of acute psychological trauma. Second, among those who are not psychologically traumatized as a result
of becoming homeless, the ongoing condition of homelessness (i.e., shelters; lack of safety) can bring up a multitude of stressors (Goodman et al., 1991).

Third, if one does not experience psychological trauma from the experiences of becoming homeless or from living in a shelter, homelessness may exacerbate the symptoms of psychological trauma among people who have had histories of past victimization and/or emotional vulnerabilities. For instance, these people are particularly vulnerable to the phenomenon of homelessness. As a result, homelessness can also become a viable barrier to recovery. In such cases, it is often the pre-existing trauma that requires being addressed first, which can often be inaccessible in the event where one is concurrently dealing with the daily stressors of being homeless, including the safety and needs attainment.

Psychological trauma can be explained as a variety of symptoms and conditions that are commonly found among people who have undergone extraordinary stress, as is with homelessness. These symptoms have been primarily grouped to form the diagnostic criteria and clinical picture of posttraumatic stress disorder (PTSD). This diagnosis via the Diagnostic and Statistical Manual, fifth edition (DSM-V) captures the group of symptoms that are commonly found among the victims of an acute traumatic event, including the persistent re-experiencing of the event through intrusive memories, dreams, or dissociative states; a numbing of general responsiveness manifested by a restricted range of affect or a markedly diminished interest in significant activities; as well as recurring symptoms of increased arousal such as irritability, angry outbursts, hypervigilance, and sleep disturbances (American Psychiatric Association, 2013). Some other symptoms are often present but are not recognized in the DSM-V, including substance abuse, self-mutilation, intolerance of intimacy, a general sense of helplessness, and a sense of isolation and existential separateness from others (Figley, 1985; Harvey, 1996). This is especially true for individuals who experienced homelessness, as their methods of coping can often be maladaptive and complex.

A key feature of psychological trauma, especially amongst the homeless is the experience of social disaffiliation. Bowlby (1969, 1973) described the human need for intimate and long-lasting attachments as a hardwired biological need that results from a long-term evolutionary development. According to this theory, the feelings of safety and connection are essential for the healthy development of people to attain the emotional security necessary in order to develop self-
reliance, autonomy, and self-esteem. Furthermore, in adulthood, developing relationships with others can continue providing a fundamental sense of existential meaning and self-worth (Goodman et al., 1991).

The core of psychological trauma is the perceived severance of secure affiliative bonds, which damages the psychological sense of trust, safety and security. Van der Kolk (1987) suggested that trauma occurs when one loses their sense of having a safe place to retreat within or outside oneself in order to deal with frightening emotions or experiences. Further, Janoff-Bulan and Frieze (1983) suggested that from a social cognition perspective, trauma victims no longer perceive themselves as safe and secure in a benign environment since they have already experienced a malevolent world. When this is applied to the experiences of homelessness, isolation can form an emotional vulnerability.

Experiences of homelessness, like other traumas, can produce a psychological sense of isolation or distrust and also lead to the actual disturbance of social bonds. When an individual becomes homeless, they are automatically stripped of their social roles. In many cases, the homeless can no longer fulfil their obligations as workers, neighbours, friends, or caregivers (Kozol, 1988) due to the lack of a stable shelter. The established patterns of relating to others, which are developed over a lifetime, are then interrupted. Homeless people can lose faith in their own ability to care for themselves and in the willingness for others to help them, and are likely to develop a sense of mistrust (Goodman et al., 1991). Results from the participants’ narratives in this study, however, recognized that the homeless community and the peers they interact with can form a sense of social cohesion and support, and these peers may be the kind that has been injured or impacted by the various aspects of trauma. Furthermore, these relationships were noted to be bonding factors for the resilience and survival of the people experiencing homelessness. It was, however, also a maintenance factor for homelessness and a barrier to recovery, especially in the context of addictions.

Helplessness is a major contributor to psychological trauma. Seilgman (1975) presented learned helplessness as a theory to understand the diminished sense of efficacy and self-worth among the survivors of trauma (Figley & McCubbin, 1983; Walker, 1978). People are said to experience learned helplessness, a phenomenon that is often accompanied by profound depression, when they lose the belief that their own actions can be capable of influencing the course of their lives.
Learned helplessness most likely occurs when people hold themselves personally responsible for their situations, perceive their situations as long-term, or believe that the situations are caused by global rather than specific factors (Garber & Seligman, 1980).

As such, many of the behaviours, circumstances, and cognitive patterns associated with learned helplessness are recognized as a common consequence of homelessness. For instance, becoming homeless frequently renders people unable to control their daily lives (Goodman et al., 1991). Homeless people, whether they live on the streets, in cars, in shelters, government housing, or in other temporary accommodations, experience daily assaults on their sense of personal control. They are often dependent on others for help, particularly the social service providers, in order to fulfil their most basic needs, such as eating, sleeping, personal hygiene, guarding their personal belongings and caring for children (Goodman et al., 1991). This can further prove to be traumatic if one previously has had negative experiences with the social services, or the greater social system in general.

Research has demonstrated the existence of high rates of depression amongst the homeless; which is likely a result of learned helplessness. This is consistent with the theory that becoming homeless and living in a shelter can exacerbate a person’s sense of helplessness as well as hopelessness, thus furthering the risk of developing depression (Breakey et al., 1989; Goodman et al., 1991). The learned helplessness theory suggests that the absence of control in the lives of the homeless can eventually engender a generalized passivity. The ongoing experience of helplessness may lead to an apparent unwillingness on the part of some people in order to fight and strive for survival or to utilize the services that are available to them. Some may come to view their daily difficulties with apparent indifference as if they do not expect to move into better circumstances; whereas others may become overly dependent on the social service or mental health professionals (Flannery, 1987).

Learned helplessness and the motivation to ‘dive or survive’, was particularly observed in the experiences of the homeless peoples that participated in this research. Many participants identified a sense of helplessness while maintaining their homelessness and mental health issues, particularly in the case of addictions. Learned helplessness was also identified in the narratives regarding the sense of control being lost in the lives of many of these people, such as the systemic barriers in recovering from homelessness (i.e., waitlists, lack of supports) that
perpetuate learned helplessness and emotional difficulties in the context of homelessness, and decreased hope for change amongst the participants.

Goodman and colleagues (1991) suggest that a significant proportion of homeless people have had histories of trauma. Some people may demonstrate a clear diagnosis of PTSD, while others with histories of alcohol and substance abuse may have done so to cope with/avoid such memories, and yet others may suffer from social disaffiliation and learned helplessness. Thus, even when becoming homeless or living under the extraordinary stress, one does not always produce the symptoms of psychological trauma (Goodman et al., 1991).

Trauma was recognized to be a significant factor in the context that led to homeless as well as in the experiences of the episodes of homelessness itself within the narratives of this research. Particularly, the results demonstrated that many of the homeless individuals have not addressed their traumas and thus, continue to live in a cycle of maladaptive coping (substance abuse, unhealthy relationships, self-harm, etc.). These coping strategies often indirectly or directly contribute to the maintenance of the cycle of homelessness. What was particularly notable in both the literature and the results of this study was that for the Indigenous homeless, complex traumas and issues of colonialism have deepened the severity of trauma(s), as well as the social context of learned helplessness and the presence of maladaptive coping.

Complex traumas and Indigenous homelessness

Historical/intergenerational trauma is understood as the transmission of a trauma experienced collectively by a group, which is then passed on to other family members and community systems (Sotero, 2006). This is usually achieved through the aspects of biological, psychological, environmental and social means (i.e., emotional vulnerabilities, substance abuse, domestic violence/physical, emotional, sexual abuse and parenting). The concepts of Intergenerational trauma have particularly been acknowledged as factoring into the social disparity amongst numerous Canadian Indigenous communities as a result of the spiritual and cultural genocide of the Indigenous peoples, which was one of the ramifications of colonization (Yellow Horse Brave Heart & DeBruyn, 1998).

Historical trauma theory suggests a connection between historically unresolved grief and intergenerational transmission of trauma among the Indigenous peoples. Historical unresolved
grief accompanies trauma and “May be considered impaired, delayed, fixated, and/or disenfranchised” (Yellow Horse Brave Heart, 2003, p.7).

Taking into account the cumulative effect of these traumatic experiences, the intergenerational transmission of trauma and the associated pain, grief, anger, behaviours or responses are often considered to be destructive in nature (e.g., alcoholism, drug abuse, suicide, domestic violence); as they often serve an anesthetizing purpose (Duran, Duran, Yellow Horse Brave Heart, & Yellow Horse-Davis, 1998). Yellow Horse Brave Heart (2003) categorizes these and other such behavioural social problems (e.g., child abuse, family violence, accidental deaths, depression, and anxiety) under the umbrella termed as historical trauma response (HTR). For instance, Mohawk (2004) describes the consequences of colonization in the following words:

Being colonized- has had an impact. When an individual loses his or her memory, they cannot recognize other people, they become seriously disoriented, and they don’t know right from wrong. Sometimes they hurt themselves. Something similar happens when a people become colonized. They can’t remember who they are because they are a people without a common history. It’s not that they don’t have a history, it’s just that they don’t know what it is and it’s not shared among them. Colonization is the spiritual collapse of a nation…Colonization is the greatest health risk to Indigenous peoples as individuals and communities. It produces anomie- the absence of values and sense of group purpose and identity- that underlies the deadly automobile accidents triggered by alcohol abuse. It creates the conditions of inappropriate diet which leads to the epidemic of degenerative diseases, and the moral anarchy that leads to child abuse and spousal abuse (p. 6-7).

Duran et al., (1998) have termed these colonial traumas as a soul wound; one that has always been present as part of Indigenous knowledge and experiences, and has been passed on from generation to generation since Columbus’s so-called discovery of the New World.

This study was also recognized grief and loss as a theme in the results of the experiences of Indigenous peoples. For instance, many participants discussed the emotional challenges of losing their peers to the aspects of addiction and other consequences of the homeless lifestyle (i.e., violence).
The participants also discussed a concept of spiritual and cultural grief and loss. This was acknowledged as being a component of colonialism in that, many were adopted by non-Indigenous families; and were, therefore, not raised in a traditional way where they could have an access to their own people, knowledge and communities. This was recognized in this research, in that many of the participants had a spiritual and cultural loss from situations such as: migrating to a large Canadian city for better opportunities; in order to escape violence; and/or simply out of leaving the reserve communities as a result of personal choice. The participants shared that once they arrived at the city, there was often a sense of spiritual or communal loss that seemed to come with an isolation from their community. This was especially true when one was not connected with other Indigenous peoples or Indigenous services in the large city.

Integration of Western and Indigenous approaches to trauma and healing

As stated previously in the literature review, for many of the Indigenous communities, the tools of Western psychology such as research methods, diagnostic nosology, theories, concepts and applied interventions have simply served as the modern forces of colonialism, thus leading to further oppression, marginalization and colonization of the remaining sites of resistance (Mohawk, 2004). Furthermore, these tools have also historically over-pathologized the Indigenous people and have failed to address their unique needs, which continues to marginalize them in the context of public health. One of the main themes that were recognized within the psychological factors from the participants in this research was a disconnect in the mental health approaches that failed to meet the requirements of the Indigenous peoples. This dysfunction in these approaches failed to acknowledge the Indigenous histories of trauma and was inclusive of the therapeutic process of decolonizing and healing, thereby perpetuating marginalization and systemic trauma.

Colonial psychology: The need for change

One way to address the cultural and contextual void within the field of trauma is through the various methods of decolonization and reparation from an Indigenous perspective (Tuck & Fine, 2007). This would require a transformation to occur within the Western psychology as a discipline. This transformation would involve the acknowledgement of the sites of struggle that exist within the areas of cultural psychology and trauma psychology, both separately and
together, as well as within the other related fields. Reclaiming the intellectual landscape within these important areas to reject the dominance of cognitive imperialism (Battiste, 2000), and to include a critical examination of the cultural politics (Gone, 2008). This would also require a reassertion of Indigenous epistemologies, ontologies, and technologies across the broad range of contexts in the greater representation of psychology.

Battiste (2007) recognizes that the Western schools of thought in psychology lack what is of paramount importance within the Indigenous communities and contexts: the relationship with a certain place and the immediate ecological environment, including one’s shared experiences with others, and the engagement with the spiritual world through “dreams, visions, and signs interpreted with the guidance of Healers or Elders” (p. 116). For instance, she explains:

Indigenous knowledge represents a complex and dynamic capacity of knowing, a knowledge that results from knowing one’s ecological environment, the skills and knowledge derived from that place, knowledge of the animals and plants and their patterns within that space, and the vital skills and talents necessary to survive and sustain themselves within the environment. It is a knowledge that requires constant vigour to observe carefully, to offer those in story and interactions, and to maintain appropriate relationships with all things and peoples (p.116).

The transformation of trauma psychology and cultural psychology must, therefore, be inclusive of the integration of place and relationships, beyond the rhetorical acknowledgement. The implication, of course, is that effective integration of trauma psychology and cultural psychology within the Indigenous contexts that include the necessities and self-determination of the Indigenous communities and Nations (Hill et al., 2010). This proposes a sense of autonomy and continuity in the psychological approaches and treatments of the Indigenous people. These approaches are thus informed and adapted by the members of the community that establish culture and spirituality at the root of healing, and therefore, encompass decolonization at the heart of healing.

The Western perspective of trauma psychology often deals with the concepts such as a singular episode of acute stress or posttraumatic stress from the perspective of a discretely identifiable incident (American Psychiatric Association, 2013). The traditional trauma psychology fails to understand or sympathize with the experiences of forced assimilation/acculturation, current
oppression, and how the daily indignities visited on people of colour symbolize strong memories of historical and continuing injustices (Feagin, 2006; Sue, 2010).

In dominant psychology, posttraumatic presentations are said to be influenced by a variety of individual and environmental variables. It is important to recognize, however, that the people from different cultures or subcultures often experience trauma and express posttraumatic symptoms differently than in the mainstream North American society (Friedman & Jaranson, 1994; Kohrt & Hruschka, 2010; Marsella, Friedman, Gerrity, & Scurfield, 1996). There is a current shift in recognizing the cultural difference in psychological presentations and the beginning of inclusion and awareness of multicultural differences in posttraumatic stress responses that are not all captured by the diagnosis of PTSD (Briere, Scott, & Jones, 2015). For instance, the DSM-V now includes Appendix three (cultural concepts) which lists several cultural-specific syndromes that involve potentially trauma-related dissociation, somatisation and anxiety responses (American Psychiatric Association, 2013). The DSM-V now specifically allows the coding of culture-bound stress disorders as ‘Other Specified Trauma and Stressor-Related Disorder (American Psychiatric Association, 2013; Briere et al., 2015).

Various aspects of racism and discrimination were also recognized in the results of this research as being a central factor in the mental health and trauma experiences of Indigenous peoples, especially during their experiences of homelessness. This included both the events that preceded the initial episode of homelessness and those occurring within the experiences of homelessness. The literature suggests that race-related stressors are more powerful predictors of psychological distress among the people of colour than ordinary stressful life events. This is because (a) they are constant reminders of racism; (b) they occur continuously rather than being time-limited, and (c) they are present in nearly all the aspects of the life for a person of colour. This is inclusive of but is not limited to: education, employment, healthcare, social interactions, etc. (Sue et al., 2007; Utsey, Giesbrecht, Hook, & Stanard, 2008).

As such, the cultural context has been recently added to the DSM-V (American Psychiatric Association, 2013) and with that, it has been getting more attention more recently in the literature. Further, this is recognized as an important component in the guidelines of psychology training. For instance, Weine and colleagues (2002) contend:
A deep appreciation of the culture, its historical roots, and the way it has shaped Indigenous concepts of mental health and healing requires an ongoing commitment to learning. The process of familiarizing oneself with the Indigenous society and culture needs to evolve throughout the period of training and may take several forms. The informal ongoing contact with individuals, families, and communities in their everyday lives is an important element in this learning process (p. 159).

Further, Kirmayer et al. (2009) stated, “The ways that individuals adapt to trauma reflect their personalities and psychological resilience and resources, but also depend on the social, cultural, and political contexts in which they find themselves” (p. 15). Attention to trauma and the effects among health professionals often focus on a narrow range of psychological experiences of the victims and neglect the broader contexts. Systemic trauma refers to the contextual features of environments and institutions that give rise to trauma; maintain it and impact the posttraumatic responses. This maintains systemic racism and the continued marginalization of the Indigenous peoples.

The aspects of systemic trauma and the barriers that exist and keep the Indigenous peoples from exiting their state of homelessness were recognized in the results of this study as a continued failure in the system, and as such, an existing, post-modern form of colonialism (i.e., the glass ceiling effect). Therefore, for the Indigenous peoples, they are often unable to heal from the past traumas of colonialism and thus also cannot thrive within a Canadian social context. As such, the systemic trauma framework is informed by ecological models that emphasize the contributions of families, schools, communities, and cultures to psychological functioning and healing from the said traumas (Casey & Linndhorst, 2009; Reilly & Gravdal, 2012).

An understanding of systemic trauma in the conceptual framework of trauma psychology provides opportunities for addressing some outcomes that are beyond the posttraumatic stress disorder (PTSD) as it is currently defined by the DSM-V (American Psychiatric Association, 2013). The research demonstrates that the consequences of systemic trauma extend far beyond

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4 Glass ceiling effect refers to the unofficially acknowledged barrier to advancement in a profession or social system, especially effecting women and persons of minority.
the PTSD symptoms to include depression, other anxiety symptoms, substance use, physical health problems, alexithymia\textsuperscript{5}, dissociation, and difficulties in terms of emotion regulation (Freyd, Klest, & Allard, 2005; Grant, Cannistraci, Hollon, Gore, & Shelton, 2011; O’Brien & Sher, 2013; Subica, Claypoole, & Wylie, 2012).

Although the DSM-V has been executing strategies to bridge this gap, it seems to be failing in bridging the Western and Indigenous pedagogies in the approaches to Indigenous trauma care and healing. Further, to address this, there is need to have more inclusive models and approaches that can incorporate Indigenous healing traditions and traditional knowledge into the mainstream understanding, conceptualization and treatments models of mental health and trauma care for the Indigenous peoples, particularly amongst the homeless.

**Indigenous approaches to Western psychology**

Historically, many researchers have oppressed and further, harmed Indigenous peoples in their ploys to study various mental health aspects, where they acted as examiners rather than collaborators in the process. Currently, efforts are being taken to include Indigenous peoples into the research processes, as with the OCAP principles\textsuperscript{6} (First Nations Centre, 2007) and the inclusion of ethical regulations for research involving Indigenous peoples in the 2014 Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2). However, there is a need to get the Indigenous community more involved in mental health treatment approaches for the Indigenous peoples. This would comprise a hybrid model\textsuperscript{7} that encompasses the Indigenous approaches to mental health, wellbeing and healing into the existing North American DSM-V and dominant evidence-based treatment models that are currently being used in mainstream psychology.

As the Indigenous approaches are being infused into mainstream psychology, there is a growing need to emphasise the continued relationship building and trust between the mental health

\textsuperscript{5}Alexithymia is the inability to identify and describe emotions in the self.

\textsuperscript{6}OCAP principles include: Ownership, Control, Access and Possession and refers to the relationship of Indigenous peoples to their cultural knowledge, data and information.

\textsuperscript{7}A hybrid is the combination of two elements.
practitioners as well as the Indigenous Healers (McViker, 2010). The best practices toward addressing Indigenous trauma issues have been viewed as integrative models that embrace a hybrid model of Western psychology and Indigenous traditional knowledge and medicines concurrently. Furthermore, McViker (2010), acknowledges that these “culturally-derived tandem approaches” (p. 40) may foster a more inclusive understanding of wellbeing that collaboratively includes both the worldviews in a simultaneous manner.

The Indigenous approaches to wellbeing are different from the perspectives of Western ideologies in that, wellbeing in most of the Indigenous communities incorporates the intersection of humanity as well as the spirit. Furthermore, the spirit is also acknowledged as a component of the self, in that, wellness is often composed of interacting parts of the emotional, physical, mental and spiritual self and the subsequent balance in wellbeing.

**Hybrid model of psychology**

As indicated, the core component in Indigenizing psychological approaches to mental health and trauma healing is inclusive of the understanding of a healthy balance of the emotional, physical, spiritual as well as mental self; apart from the Western models that focus more on the concept of illness. The results of this research indicate that the participants found many mainstream evidence-based mental health approaches that further oppressed them; and that many care providers are uneducated regarding their worldviews, practices and histories of the Indigenous peoples. They also recognized that the current models fail to address their unique needs as Indigenous peoples, particularly in the spiritual aspect of the self and how this interacts with the mental health issues.

The participants in this research also recognized that talking circles were primarily helpful in terms of healing from trauma, as they were generally inclusive of Elders who were able to connect spirituality with the mental and emotional challenges that they were experiencing. Furthermore, the results indicated that talking circles were especially healing for the Indigenous homeless, as they focused on the community and the support from other Indigenous peoples, as well as culture and traditional knowledge as grounding and healing. Talking circles also provided a safe space for peer support, connectedness and relationship building, which was also noted to inadvertently soothe the other mental health needs such as companionship and support.
This model presents a hybrid model that combines the Indigenous healing into the mainstream trauma frameworks, based on evidence-based treatment models. This model includes needs that were recognized as important aspects of healing from trauma for the Indigenous homeless participants in this study, combined with the literature based on combined influences of dominant DSM-V diagnoses and evidence-based treatment models (Beck, 2011; Courtois & Ford, 2013; Herman, 1997; Wright, Basco, & Thase, 2006). Indigenous identity rests at the core of this model and is inclusive of the balance of the physical, emotional and spiritual elements that are involved in conceptualizing wellness. The grey dotted circle represents the harmonious balance of these elements. The sun figure highlights the importance of focusing on the spiritual element of the self while addressing trauma for Indigenous peoples. The participants in the study recognized this as a core need, especially since many of the current models fail to do so.

The outer circle represents the dominant mainstream treatment models for approaching trauma care. This is inclusive of a clinical approach that incorporates the assessment and DSM-V diagnosis. Following the assessment and/or subsequent diagnosis (if any), the therapist would then create a case conceptualization as a formulation in order to understand the individual’s symptoms and presentation, given the framework they were using and thus implement the
treatment on the basis of this conceptualization. It is important to note, however, that trauma-informed treatment would always begin with the development of a strong therapeutic relationship and creating safety between the client and the therapist (Herman, 1997).

From an Indigenous approach, as pertained in the model presented in Figure 4, the conceptualization for the Indigenous person would include historical traumas and influences of colonialism. Thus, as it has been indicated in the literature, the mental health provider would be required to have an understanding and education on the various aspects of colonial history for the Indigenous peoples. The model also emphasizes the current stressors and traumas of the homeless experiences as impacting the emotional, spiritual, mental and physical aspects of the self within the conceptualization. Here, the spiritual aspect has been focused upon, as this is the aspect that the participants recognize to be absent from the current mainstream models of psychological treatment.

Regarding treatment, the model presented in Figure 4 demonstrates the key component of focusing on the relationship and building trust between the mental health provider as well as the individual. This is especially important for the Indigenous homeless people as many of them are suspicious and reluctant to engage with the service providers, due to their experiences of stigma from these services. As such, given the isolation of many homeless individuals, safety and relationship building is the most important function of the hybrid model to treatment that bridges both influences from a mainstream trauma-informed care with Indigenous healing.

This treatment would be combined with the community resources through collaboration with the Elders and Healers. This would include participation in talking circles, which are facilitated by Elders as well as engagement in ceremonies such as smudge, sweats, fasts, etc. Lastly, the individual would then focus on accessing the services and resources that could help with housing, attainment of the basic needs, employment; concurrently with continued engagement in the Indigenous community.

As indicated previously, the participants in this study recognized a significant need for an Indigenous approach to mental health; especially in terms of conceptualization and understanding of trauma and mental health issues of the Indigenous peoples. For instance, Ocampo (2010), describes that psychology must mention the historical, intergenerational and racist incident-based trauma systems as factors in the trauma sequelae of Indigenous people and
incorporate more advocacy and policy informed practices that are inclusive of research and practice that addresses healing from historical trauma by the integration of Indigenous informed leadership and practice.

This would also be inclusive of an Indigenous lens for evidence-based practices that are currently dominant in the practice and discipline of psychology; such as with Cognitive Behavioural Therapy (Ocampo, 2010). The first aspect of decolonizing the current evidence-based treatment models is through addressing the cultural mistrust that many of the Indigenous peoples feel towards government and the service providers, especially those in the healthcare system. The second factor in bridging more culturally sensitive practices into already established best-practices evidence-based treatments is empowerment. Including more Indigenous peoples in the mental health care system as leaders, clinicians, researcher and policymakers will help to empower the Indigenous people in finding trust in these services, all the while knowing that there is an influence of Indigeneity within the system (Ocampo, 2010). Finally, Ocampo (2010) suggests that psychologists need to influence and change the current policies that preserve Indigeneity and promote balance and wellbeing within the Indigenous communities (Ocampo, 2010). This needs to be done with more community partnerships and involvement with the community recourses, especially for the services within city centres, as a way to prevent the ongoing mental health issues due to the ongoing colonialism.

The process of collaboration, consultation and connection with the Elders was also recognized by the participants in this study as an imperative importance for the mental health and well-being of the Indigenous peoples. As such, the participants noted a need for a greater presence of Elders and Healers within the mental health frameworks and services that exist for the Indigenous mental health issues. Generativity has been acknowledged by Lewis, Woods, Zuniga, and David (2010) as a strength in Indigenous communities and a high value of a culture that holds the importance of leading and caring for the next generation; whilst giving the Elders a sense of purpose. For instance, giving the Elders a role in their community and being involved in the decision making as well as in teaching the younger generation is a key aspect of successful ageing (Lewis, 2009).

The inclusion of Elders into the mental health approaches and treatment models is a form of resilience-based approach (Saylor, Graves, & Cochran, 2006). Elders are recognized as being
key figures in the Indigenous communities and often the keepers and teachers of traditional knowledge. Furthermore, they are often viewed by the community members as role models and resilient people themselves who have endured and overcome significant aspects of colonialism, historical trauma as well as oppression. They are viewed as having some of the struggles that many of the other people in the community have (i.e., addictions, mental health difficulties, and homelessness) and have regained wellbeing, and as such care and support the younger generation (Lewis et al., 2010).

Resilience-based approaches to mental health also include traditional knowledge and the inclusion of culturally valued skills, such as gathering, beading, drumming, dancing, carving, sewing and hunting. These practices are celebrated and encouraged; with lesser emphasis on the Western-based indications of success (i.e., education). The inclusion of such culturally-based skills is also identified as being a protective factor for youth in terms of behavioural health concerns and practices in adolescence and early adulthood such as substance use, criminal involvement and unprotected sex (Lewis et al., 2010).

Regarding the Indigenous approaches to mental health, the Elders primarily use herbal medicines and circles (Lewis, 2009), and can be a valuable asset and collaborative strategy for integrating Western as well as traditional Indigenous healing practices for the approaches to mental health and trauma (Lewis et al., 2010). Many participants in this study recognized the importance of having the Elders present in terms of mental health and treatment approaches, primarily in the talking circles. One of the challenges that continue to exist, however, as mentioned in the narratives of many participants, is the need to have more Elders that can approach care with a harm-reduction perspective, as this remains one of the significant barriers towards improving mental health, and combating addiction and homelessness cycle and the connection/disconnection with traditional knowledge and practices.

The participants in this research specifically discussed the benefits of having culturally informed mental health care for dealing with trauma and homelessness. They noted that having an access to Elders and engaging in talking circles were significant strengths and had a positive influence on addressing their own spiritual, mental, emotional and physical needs, with a significant emphasis on the spiritual.
Circle healing

From an Indigenous perspective, the circle is a healing entity and has quite a significant purpose in terms of traditional knowledge for the Indigenous peoples. For instance, the circle contains a valuable purpose for viewing, naming and exploring effective practices in terms of restoring wellbeing after many generations of trauma transmission. McViker (2010) describes that,

> Each part of the circumference of a circle is a point of information connected with the centre, a central viewpoint… Useful for the organization of the whole in a visible, physical community or circle, this metaphorical centre also serves as a pivotal point for turning inward to understand psychological and spiritual unseen reality. Passed down from many empowering Indigenous sacred languages are terms which describe the human centre: This profound, universal essence is translated as sacred space, heart, zero points, self, no-self, the void, source, within direction and more. Deeply held across American Indian cultures is the belief that all living beings possess a centre essence, which is in connection with the center essence of each human” (p. 41-42).

Incorporating the approach of talking circles into mental health and trauma healing is quite an important task. As the participants in this study recognized, talking circles prove to be a valuable form of healing as they include a focus on the cultural connection as well as the spirit. Such mental health and trauma practices that focus on the Indigenous approaches to healing the soul wound, caused by generations of cultural alienation and genocide are a form of decolonizing psychology and healing for the Indigenous communities (Duran, 2006; McVicker, 2010). This intergenerational soul wound can be understood if one tries to understand the continued impacts of colonialism that have descended in the Indigenous communities through familial, kinship and community networks into mental health problems such as addictions, anxiety, depression and violence.

Duran (2006) has proposed that this intergenerational soul wound that has endured on the Indigenous peoples is the root of these problems and therefore, the spiritual component of the self must be held as a central form of healing within a hybrid model of psychology. By focusing on this aspect of the self (i.e., the injured soul), the healing can go on to focus on another aspect of identity that focuses on the spirit. Furthermore, issues such as alcoholism, drug addiction, anger, depression and suicide can be viewed as an invasive spirit in the Indigenous traditional
knowledge. According to McVicker (2010) and Duran (2006), it is the integration of the Western approaches to psychology, with the influences of Elders and traditional Healers to address the spiritual component of these issues, that the Indigenous peoples are able to heal from traumas and mental health issues and overpower the negative spirit thus, bringing back balance to the self.

Incorporating the spiritual aspect of the self-happens to be an important component in the Indigenous approaches to psychology. It is recognition of the spiritual component that connects the Indigenous person to their being and thus feeling understood as well as valued within the context of psychotherapy. For instance, including the spirit into the conceptualization of trauma and other mental health issues is an important aspect of understanding the individual difficulties from an Indigenous perspective that includes and welcomes the presence of spirit, rather than viewing this through a Western lens and associating the aspects of the spirit as a psychiatric symptom. For instance, Duran and Duran (1995) present a hybrid model that focuses on the post-colonial approaches to psychology that melds the Western and Indigenous approaches. They recognize the use of language to directly address the spirits that are likely to upset the harmony and wellbeing (McViker, 2010).

In the recent years, there have been many attempts to advocate for and acknowledge the mental health needs of Indigenous peoples, whilst promoting wellbeing in psychological practices that are sensitive to the Indigenous worldviews, healing practices, and research methods. These methods have failed, however, in acknowledging the actual Indigenous beliefs and approaches to health that have existed for generations (Okozi, Zainab Nael, & Cruza-Guet, 2010). These include the Indigenous beliefs of wellness that tend to encompass the holistic properties in the balance of physical, mental-emotional as well as the spiritual elements (Patel, 1995). Traditional knowledge and Indigenous practices work on restoring the natural balance of the elements of soul, mind and body through ceremonies and medicines that are practised and prescribed by the Indigenous Elders and Healers. It can, therefore, be said that the process of resolving mental illnesses revolves around storytelling, teaching, sharing circles, sweat lodges and vision quests (Okozi et al., 2010; Poonwassi & Charter, 2005).

Another hybrid model combining Indigenous healing perspectives to the Western treatment programs was noted in the literature, for addressing issues of trauma and addictions. This model
recognized the incorporation of issues of self-identified intergenerational trauma with substance use disorders among the Indigenous peoples. This framework utilized the concept of “Two-Eyed Seeing” (Marshall & Bartlett, 2009); a philosophical, theoretical, and/or methodological approach that recognizes the need for both the Western and the Indigenous ways of knowing in research, knowledge translation, and program development (Marsh, Coholic, Cote-Meek, & Najavits, 2015).

This approach postulates that due to the complexities of symptoms that accompany the historical, intergenerational trauma and substance use disorders paired with the chaotic, poor social conditions that these clients endure, many clinicians and treatment agencies experience challenges in terms of attracting, retaining, and supporting the patients for the treatment (Evans-Campbell, 2008; Jiwa, Kelly, & Pierre-Hanson, 2008; Lavallee, 2009; Marsh, 2010).

Therefore, more research needs to be conducted on the treatment of intergenerational trauma and substance use disorders so that the challenges that both disorders can be adequately addressed in the treatment modalities. In addition to gaining a better understanding of the issues around the treatment of intergenerational trauma and substance use disorders, there is a continued need to consider the treatment and healing programs that have focused on Indigenous peoples and are able to blend the Western knowledge and Indigenous healing practices to better reach and affect the ones who are in need (Marsh et al, 2015). Figure 5 presents this hybrid model of intergenerational trauma and addictions issues based on the Indigenous pedagogies.
Two-Eyed Seeing Blended Approach to Delivering Seeking Safety Conceptualized in the Medicine Wheel


Historically, mental health and treatment models have never addressed the spiritual component as an element in wellness in the health needs of the Indigenous peoples. As such, many current psychology models fail to address the Indigenous perspectives of mental health and the conceptualization of their own difficulties. What the participants acknowledged in this study, was that discrimination and racism by healthcare workers is often the result when these models are not recognized or made available to the mainstream mental health providers. What was predominantly noted by the participants was the need for more culturally sensitive and needs-based approaches for various aspects of trauma, such as addictions and mental health needs that would focus on the spirit and encourage the cultural connection as the primary goal in the healing journey. These results were also factored into the hybrid model presented in Figure 4.

Figure 5
Culturally sensitive mental health and addictions needs

The participants in this study spoke immensely of addictions’ issues that are present in the experiences of the Indigenous homeless. The participants acknowledged a relationship with the cultural connection, mental health and addiction. Primarily, the participants discussed a need for harm reduction services. They indicated that many of their experiences included the current addiction treatment models that are based on the Western pedagogies and therefore, are not inclusive of the needs of the Indigenous peoples. Furthermore, the participants recognized a pressing challenge with cultural engagement due to their issues of addiction, as sobriety for healing ceremony is often an asset, where the Indigenous peoples are then further alienated from their culture.

In general, the current addictions treatment models tend to follow a disease model with a focus on abstinence and sobriety as the main treatment outcome (i.e., 12 steps program; Alcoholics Anonymous) (Wilkes, 2013). Gori (1996) states that this is not completely accurate, in that there are no biological markers that factor into addiction, but they are rather socially embedded. As such, viewing addiction as a societal factor is more inclusive of factors such as the over-representation of the Indigenous peoples with substance abuse issues (Wilkes, 2013). Further, many participants in this study discussed addictions as being a primary coping mechanism for dealing with the various aspects of trauma, isolation and lasting effects of colonization; a coping strategy that many identified as being intergenerational and modelled by their family and kin influences. The participants recognized that harm-reduction models were important for cultural inclusion and healing from the pains in which they were using the substances to cope with.

Indigenous harm-reduction approaches

Addiction was recognized as a predominant theme in the overall narratives of the Indigenous homelessness in this study. There are studies that confirm this finding in that the homeless Indigenous peoples often have high rates of substance abuse, more so than any other homeless racial group (Kahn et al., 1992; Kasprow & Rosenheck, 1998; Westerfelt & Yellow Bird, 1999). The participants recognized how addiction pertained to aspects of mental health and traditional knowledge, in that there was an inverse relationship between cultural engagement and substance use.
The harm-reduction approach to substance abuse treatment suggests that substance use occurs on a continuum from abstinence to abuse and that a successful reduction in the quantity and/or frequency of use should lead to the reduction of negative consequences associated with substance abuse. This will then increase the likelihood of engaging individuals that are unable to embrace abstinence as a goal (Carey, 1996; Gliksman, Rylett, & Douglas, 2007; Wilkes, 2013). Despite the criticism that harm-reduction approaches undermine the health goals of an abstinence approach (Futterman, Lorente, & Silverman, 2005), it has been proved that harm-reduction holds abstinence as the overall end-goal. Harm-reduction fundamentally utilizes the individual needs of being the primary factor as they collaboratively work on moving towards a state of sobriety. This model concurrently addresses mortality prevention and additional social and health disparities while working towards the goal of sobriety (Wilkes, 2013).

It has been proven that harm-reduction models are very effective in the treatment of addiction, as well as with complex concurrent disorders (Drake & Mueser, 2000; Mancini, Hardiman, & Eversman, 2008). This has been especially noteworthy in the mental health treatment needs of the Indigenous people. For instance, the Canadian Aboriginal Healing Foundation (CAHF) (2007) suggests that treatment of addictions and/or the concurrent mental health issues should embrace treatment models that value assessment that integrates and identifies the complex needs of the Indigenous people, including addressing physical withdrawal symptoms, relapse prevention strategies, ongoing mental health supports and trauma recovery. It was noted that this plan should also include other factors of health, such as parenting and child care, criminal justice support/ advocacy, housing (emergency, transitional and permanent) and social or disability assistance (Wilkes, 2013). These aspects of treatment were recognized by the CAHF (2007) as important factors whose incorporation can help the treatments become successful with Indigenous peoples.

In order to address some of the addictions issues, particularly, alcoholism, which exists in many Indigenous communities, some communities have adopted alcohol management policies as a harm reduction approach to community safety and wellbeing. For instance, some communities have adopted the use of green spaces in order to manage alcohol consumption in public areas (Gliksman et al., 2007). The primary goal of this harm-reduction policy is to control the availability of alcohol, moderate alcohol consumption, encourage safe drinking practices and

Policy and addictions issues were identified by the participants in this research as a major barrier, especially in terms of policing. The participants noted that they often had issues with the law enforcement when it came to drinking in the state of homelessness, as they often had nowhere to go besides parks and other public places. The participants noted the need for more education and community collaboration from the police. Education on Indigenous health was especially noted, as the participants often felt discriminated against by the police officers and further felt ostracized from the community.

Gliksman and colleagues (2007) recognize that community education is an important aspect of developing harm-reduction approaches. For a successful implementation of the Indigenous communities, such approaches require community participation throughout the decision-making process. With the collaborative support from some key community figures, the responsibility and regulations would eventually become that of the community rather than the police. Regarding the concerns that participants who have been addressed in this research, such implementations would be helpful in terms of a harm-reduction and alcohol-controlled space governed by the Indigenous community; however, this would be more difficult to manage in a multi-diverse and urban area.

Alcohol management policies also have the potential to influence some other needs that were acknowledged by the participants in this research (i.e., poor basic health; isolation; violence), where Narbonne-Fortin and colleagues (1997) describe that such policies could reduce incidents of intoxication in the communities; decrease alcohol consumption by the community members; reduce the amount of interpersonal conflicts due to alcohol; reduce incidents of accidents, injuries and violence; and increase the participation in the community by creating better community engagement as well as image; improved physical and social environments; family harmony; reduced liability risk associated with community events; and less stress on the criminal justice and corrections systems. Research has demonstrated successful alcohol management policies with smaller Indigenous communities (Chiu, Maness, Douglas, & Rylett, 2000; Narbonne-Fortin, Rylett, Manitowabi, Douglas, & Gliksman, 2001).
Traditional knowledge and healing

Sharing circles can be an important method that is familiar and comforting for many of the Indigenous peoples in Canada, who have used it as a traditional way of healing (Restoule, 2005). It is also suggested that having the presence of an Elder is important in the sharing circles and an important part of the healing practice. This contributes to seeking safety, as the Indigenous peoples have long recognized the role of the Elders to be an integral part of the healing process. The Elders’ skills, knowledge, and ability to help the individuals restore balance in their lives have earned them significant roles in the Indigenous communities (Restoule, 2005).

The Elder’s role in the sharing circle is to focus on the positive identity of each and every one in the circle and to help develop the connection to the spiritual world through their teachings (Marsh et al., 2015). For instance, the seeking of the safety-manualized program also provides informative topics that aim to educate the individuals about the cognitive-behavioural, interpersonal, and case management needs of persons with substance abuse as well as PTSD (Najavitis, 2002). To adhere to the cultural sensitivity, the material could be conveyed verbally. Indigenous facilitators are encouraged to use language that respects their cultural values and beliefs. The use of smudging and drumming and singing is also encouraged to be incorporated into the domain of safety seeking. As such, in the Indigenous culture, smudging is a sacred act that happens to be a part of many rituals (Najavitis, 2002).

Traditional medicines such as sweet grass, sage, cedar, and tobacco encompass the four sacred plants. Burning these is an act of deep spirituality in Indigenous practices. The cleansing smoke from smudging is generally used to purify people and places and it calms the central nervous system. A feather is often used to spread the smoke around, but the hand can be used as well. Drums, on the other hand, represent the heartbeat of the nation and the pulse of the universe. Drums are viewed as sacred objects and are often used in healing ceremonies (Cajete, 2000; Hart, 2010; Parker, Jamous, Marek, & Camach, 1991; Waldram, 1997b). All songs are seen as honour songs, as their names imply, and are sung to honour the Creator, the Ancestors, and the particular individuals. These songs can have a profound healing effect (Menzies, Bodnar, & Harper, 2010).

Making regular sweat ceremonies available to all the participants can be a powerful way to bring forth the Indigenous traditional healing and the seeking safety topics. For instance, sweat lodge
ceremonies involve the heating of a sweat lodge to help repair the damages done to the spirits of people, their minds, and their bodies. In order to warm the lodge, rocks are heated up in a fire outside the lodge, then they are brought into the centre of the lodge with a shovel and placed into a pit dug into the ground. The sweat lodge participants sit in a circle at a safe distance from the pit. Sweat ceremonies are led by properly trained and authorized traditional spiritual leaders (Benton-Banai, 2010; Cajete, 2000; Hart, 2010; Waldram, 1997b). As such, a sweat lodge is a place of spiritual refuge for mental and physical healing. It is a place to receive answers and guidance by asking spiritual entities, totem helpers, the Creator, and Mother Earth for the required wisdom and power (Hart, 2010; Hill, 2009; Jiwa et al., 2008).

Furthermore, the seven Grandfather teachings teach one about human conduct towards others and are inclusive of the concepts of wisdom, love, honesty, respect, bravery, humility, and truth (Benton-Banai, 2010; Nabigon, 2006). Sacred items or bundles are considered to be a very precious possession, and they represent a person’s spiritual life and may be placed in the centre of the circle (Benton-Banai, 2010; Goforth, 2007; Waldrum, Herring, & Young, 2006). A sacred bundle can consist of one or more items. It can be the little tobacco or medicine pouch that someone wears around their neck, or it can be items such as a sacred pipe or rattle that the spirits have given to a person to carry for the people (Menzies, 2014; Nabigon, 2006).

The seeking safety program is a good example of a culturally-based addictions program. It acknowledges the presence of sacred bundles and how substances can control and interfere with recovery. This can be connected to the traditional teaching about carrying your sacred bundle to help you climb the recovery mountain (Hart, 2010; Menzies et al., 2010; Najavitis, 2007). Sacred pipes can be used during both private and group ceremonies. An offered prayer is believed to be carried to the Creator through the smoke of the pipe. The pipe ceremony and the seeking safety are inclusive of topics of compassion and self-care practices that encourage sacred items in the sharing circle in order to help guide and connect them to their culture and traditions, while also integrating the seeking safety topics (Lavallee, 2009; Menzies, 2014; (Najavits, 2007).

Seeking safety also used grounding and centreing techniques in order to help the trauma survivors connect with their bodies and the elements around them (Najavits, 2007). The facilitator can guide the participants through an exercise that encourages them to focus on the different body parts, rooting their feet to the ground or feeling the contours of the chair and
connecting to the breath. These could be practised along with spirituality and traditional teachings in all the sharing circles. For instance, a sacred song with drumming and the burning of sweetgrass could be used during the grounding session. The burning of the sweet grass represents kindness and stillness. Lastly, holding a traditional feast at the onset of the sharing circle and at the end of the program would be another traditional practice that is honoured by most of the Indigenous peoples. A traditional feast symbolizes and celebrates the various gifts from Mother Earth. This is a way of recognizing the spirits and the Creator and giving them the thanks. It also symbolizes renewing the earth through prayers, chants, and dances (Kovach, 2010; Najavitis, 2007; Menzies, 2014).

Overall, the psychological factors were recognized as the ones that have a significant presence within the experiences of the participants on the intersections of homelessness, traditional knowledge’s, as well as mental health and trauma. In this discussions chapter, the needs recognized by the participants in this study were supported by the existing literature. Furthermore, one of the biggest outcomes from the overarching meta-theme of psychological factors in the scope of this dissertation is the need for more Indigenous inclusive trauma frameworks and approaches toward mental health, trauma as well as the issues of addictions. This section presented various models of hybrid approaches, as well as the Indigenous healing methods, and also presented a model of trauma care based on the experiences of the participants in this study.

**Cultural Identity**

Cultural Identity was another significant meta-theme throughout the narratives of the participants in this study. For instance, many of the participants recognized the influences of colonialism as having an effect on their identity including self-esteem as well as how they interacted with the others and with the world. The participants discussed how the influences of colonialism affected their identity in terms of culture. The participants noted the lasting effects of the residential school system; as well as the 60’s scoop, being taken from their Indigenous homes and adopted into White families. Stigma, discrimination and racism were also recognized as significant factors that affected the identity and well-being of the participants who had participated in this study. Having a negative view of the self, both as an Indigenous person and as a homeless person was significantly connected with emotional distress and low self-esteem. Finally, cultural
identity was also recognized as promoting a sense of self-worth. Cultural participation provided the participants with a sense of purpose and was seen as a positive indicator in terms of building relationships, living by the Indigenous values and morality, as well as increasing positive self-esteem and emotional wellbeing. These aspects of identity derived from the cultural value were also noted as motivators for seeking housing and treatment.

The concepts of cultural identity were recognized as being both static\(^8\) and fluid\(^9\) in terms of how they influenced the self-concept and overall experiences of homelessness. More specifically, in terms of identity as an Indigenous person, the participants recognized the lasting impacts of internalized racism as being a core part of their identities. Further, the participants discussed the traditional values that had been instilled from an early age as being an integral part of stable identity. They noted that these values gave them pride and strength, which then factored into resiliency as an Indigenous person.

The cultural connection was also regarded as a fluid factor in that cultural connection and disconnection can influence addiction, mental health issues and disparity; as well as strength, respect, resiliency and hope. The participants noted that identifying themselves as a traditional people depended on the context of their life journeys. Regarding their identity as a homeless person, the participants recognized that stigma had a static effect that influenced the self-esteem and self-concept. Factors of hopelessness and low self-worth were also identified as fluid and changing factors depending on the experience of homelessness (i.e., if one was currently house, vs. just lost housing; relapsed, etc.). The participants noted that these aspects of identity intersected and often overlapped; and noted that identity influenced all the stages of homelessness, including the risk for becoming homeless, direct experiences of homelessness, and exiting homelessness.

\(^8\)Static factors are those that are unchanging.

\(^9\)Fluid factors are those that can change dependent on situation or context.
Figure 6

*Concepts of cultural identity for Indigenous homelessness*

This model depicts the influences of cultural identity on the experiences of homelessness that were described by the participants in this study. The participants discussed an overlap in terms of their identity regarding the self as both an Indigenous and a homeless person. All the remaining factors (dotted circles), were recognized as being variables of their experiences that affected their sense of self-concept and self-esteem. As such, the dotted blue circles represent the static factors that are deep-rooted from the chronic experience, schemas, and influences of colonialism. The dotted green circles represent the factors that are more fluid and are likely to change depending on the context and the life journey of the individual.

The Indigenous self was noted to be influenced by the aspects of racism that had been internalized. This was especially true for the participants who did not grow up with their traditional families and were instead raised in White homes. The participants noted a sense of indifference, as they differed from their families and lacked a sense of belonging. They also noted having experiences of racism from other people either within or outside of their family dynamics.

Traditional values also had a strong static impression on the Indigenous identities of the participants in this study. They recognized that the traditional teachings and being exposed to the
culture within their community during their youth instilled a strong value system that influenced a positive view of themselves (spiritually, emotionally, mentally and physically); with others (interpersonally with respect, love and support); as well as with the world (respects for the land and all living things). The participants recognized how the cultural connection was fluid in terms of how it affected the self-concept. It was noted that when one is homeless, or deeply stuck in addictions, they often become distanced and separated from their cultural identity. This was recognized as being a negative factor on their self-esteem. On the contrary, being connected and engaged in cultural practices and ceremonies gave the participants a sense of purpose as well as an increased self-worth.

Regarding homeless identity, stigma was acknowledged as being a hardened aspect of identity that produced feelings of shame and worthlessness for the participants in this study. Furthermore, stigma was identified as a significant deterrent towards the initiation of change, where once it had been engrained into identity, many of the participants noted a loss of motivation or even hope towards thinking that any part of their life could be different. As such, this produced a sense of hopelessness, especially when a participant had just lost housing, and reverted back to a state of homelessness. The participants also noted, however, that self-worth and hope could often be implanted, by receiving good supports and relationships with the service workers who helped them in terms of motivation and seeking housing supports, increasing self-esteem and hope.

These influences of cultural identity were a combination of the experiences and represented the core themes that underplayed the meta-theme of identity within the narratives of the participants in this study. It is important to note, however, that this depiction of identity for the Indigenous homeless people is not a generalized concept and will not befit all the individual stories. Many of these factors, however, were consistent with the existing literature and research.

**Effects of colonization on identity**

The legacy of colonization on the identities of the Indigenous peoples was recognized as a prominent theme in the narratives of the participants in this study. This was specially recognized in the sense of the self and the influences of embracing Indigeneity in a country that has historically oppressed and continues to oppress them. For instance, overt experiences of racism, discrimination and marginalization were expressed throughout the narratives. The effects of exposure to such experiences were described by the participants as internalized racism and
ostracism that effects one’s self-esteem, relationships and motivation towards interacting in a society and system that continues to treat them in a poor and unjust manner.

The effects of colonization can be detrimental in the development of Indigenous people, long after the overt factors of oppression have dissipated (Hill et al., 2010). For instance, research involving Puerto Rican Indigenous youth found that their experiences of oppression contained themes that were related to the “lack” of identity or the devaluation of self- and national identity relative to those having historical or current power over Puerto Rico, such as the United States of America (Varas-Diaz & Serrano-Garcia, 2003).

In regards with colonization and the impacts on cultural identity, Hill and colleagues (2010) note that complex interplay can be seen during the identity formation of the Indigenous people; this phenomenon is a result of the colonizing experience. They suggest that this affects the colonizer as well as the colonized. For instance, their research suggests that identity formation for the participants in their study were affected by the historical effects of colonization and oppression in two ways. Firstly, the racialization of the people and communities (i.e., the identification of racial phenotypes and relative privileging of racial groups) forcefully shaped and manipulated the identity formation of the people. Secondly, they note that the individual reaction to racialized and discriminatory realities also crucial plays a crucial role in the process of identity formation (Hill et al., 2010).

Prolonged experiences of prejudice were also recognized by Borovoy (1966), as being debilitating in the development of the self and socially for Indigenous people, thereby making them ill-equipped for the growing demand for a “skilled and punctual labour force” (p.214). For example, Borovoy (1966) notes how this further contributes to the increasing isolation and marginalization of the Indigenous people from the mainstream society:

> Having been denuded of their own way of life and having been isolated from ours, the [Indigenous people] found themselves increasingly with nowhere to turn and nowhere to go. The result has been growing sense of despair. Despair, in turn, has fathered unemployment, alcohol and welfare cheques- the components of poverty. With each generation of our galloping technology, the gulf between them and us has grown wider and deeper (p.214).
The literature recognizes the impacts that colonization has had on the identity development of the Indigenous people due to the ongoing influences of racism and oppression. These experiences were also related in terms of development, in that the internalization of racism often ends up affecting numerous things such as work habit, motivation and self-esteem. This was also noted in the experiences of the participants in this study, where many identified racism and oppression as major barriers in terms of employment and education that continued factoring into their experiences of mental health and homelessness.

**Indigenous identity and homelessness**

As a result of over five hundred years of colonization and oppression, it is no wonder that Indigenous people continue experiencing higher rates of unemployment, incarceration, family violence, poverty, poor education, suicide and mental health issues than any other cultural group in Canada (Native Council of Canada, 1990). As a result of these factors, it has been suggested that Indigenous people experience higher risk associated with homelessness; the rates of these risks are disproportionate when compared to the rest of the population (Beavis, Klos, Carter, & Douchant, 1997). The elevated risk for homelessness indicates that many Indigenous peoples’ experiences are associated with rather high-risk factors for homelessness, including the following factors: low socioeconomic status; poverty; inadequate, unaffordable, substandard housing; racism and discrimination; substance abuse; poor mental health and physical health; family violence; and experiences of physical, emotional and sexual abuse. As such, it has been suggested that Indigenous homelessness is an endemic in the urban and rural settings, both on and off reserves (Beavis et al., 1997, p.15).

Klos (1997) recognized that the risk factors associated with homelessness were more commonplace in and more intensely experienced by the Indigenous community due to a long history of colonization and marginalization. She further identified the distinctive risk factors for Indigenous people that included ‘third world’ housing conditions on reserves, rural-urban migration and cultural dislocation (Klos, 1997, p.51). This suggests that many Indigenous people are inherently exposed to conditions that can put them at risk for homelessness, and are then exacerbated when they migrate to large urban centres. Such situations pave way for cultural identity dissociation, when one is separated from their cultural community and faces overt racism and discrimination in larger cities. This was true in the cases of many participants in this study,
where many left the reserve communities to migrate to a large city in the search for better opportunities and/or life circumstance.

For example, Indigenous homelessness in Toronto is currently in a state of crisis and has worsened in recent years. The 1998 Toronto Mayor’s Action Task Force on Homelessness (Golden, 1998) identified three distinct homeless groups within Toronto’s Indigenous community. The first group was identified as the chronically homeless, which included the substance abusers and those with mental health or emotional disabilities, particularly those who had not been able to improve by treatment or support and people living in isolation from others. The second group was identified as the youth, including those who were adopted, young people who have a high level of interaction with the criminal justice system, post-secondary attendees who were living in the city without adequate shelter or food, and the street gang members. The last group was identified as mothers and families, including those who had migrated to the city recently, and those who were sole support mothers (Obonsawin-Irwin Consulting, 1998).

The participants in this study were mainly corresponding to the first group of homelessness. It was recognized that many participants first entered the state of homelessness in their youth; however, the majority of participants recognized facing chronic homelessness and concurrently admitted to having addictions and/or mental health issues. Many of the participants also discussed the lifestyle challenges of chronic homelessness on their health and wellbeing; however, many also noted having a sense of apathy regarding change and low motivation for exiting the state of homelessness, as their experiences were more chronic in nature.

High rates of Indigenous homelessness have always been associated with colonization, and thus, it is no wonder that they have had lasting effects on the identity development of the Indigenous people. In terms of identity, it was recognized that Indigenous people have unique experiences. It is noted that identity is rooted in colonization and assimilation policies, which have created a dependent mentality within the Indigenous communities and left them with negative internal perceptions about themselves as well as their communities (Obonsawin-Irwin Consulting Inc., 1998). Homelessness is often caused by marginalization, discrimination and racism. It was also identified that a disproportionate number of Canada’s homeless people are Indigenous, and further that a disproportionate number of the homeless who are facing deaths, are also Indigenous (Toronto Disaster Relief Committee, 1999).
Social policies have historically impacted multiple generations of Indigenous peoples. The separation of families and communities, through various aspects of colonization, has created a cultural and spiritual homeless state for many Indigenous peoples. This has left a legacy of traumatized individuals who may be too unstable to function in the mainstream society and have been left to be dependent on the social institutions. Therefore, many Indigenous peoples are unable to address their individual needs. This was significantly illustrated in the results of this research, where all the participants discussed a lack of need attainment. This was regarding the basic needs of states of homelessness, as well as the cultural needs that are absent in many of the services and agencies within a large city.

Menzies (2005) identifies that the Western methods of mental health practice must include or recognize the values of traditional methods of healing, as a way to strengthen the Indigenous communities and homes that are in distress and help to rebuild the “Indigenous home” within the city of Toronto; and therefore, the work towards cultural need attainment. Phillips (1999) further recognizes that the services fail to meet the basic and cultural needs of the Indigenous peoples by stating:

There is no doubt that many treatment options presented for our peoples have been totally culturally inadequate… Cultural appropriateness for our peoples in the helping professions means going right back to our own beliefs about medicine, sickness, worldview, and re-discovering our own healing ways and beliefs (p.20).

Menzies (2005) recognized that the homeless Indigenous men are in a state of crisis for decades. His research identified a few personal risk factors for homelessness, which were inclusive of poverty, low education, family violence, poor mental health, substance misuse, and the inability to sustain housing; these factors have contributed to their chronic or episodic homelessness. The participants in Menzies’ (2005) study identified a series of unique historical factors as the determinants of their current marginal existence. They also identified a series of unique historical systemic factors as the determinants for their current marginalization. For instance, they recognized that the aspects of colonization have had an influence on disconnection to family, community, culture and self. Without this connection, Indigenous men are more than just without homes, but are also “Spiritually and culturally homeless”.

All of the aforementioned things were well depicted in the narratives of the participants in the current study. In this study, the participants discussed a sense of cultural and spiritual homelessness, in that they felt disconnected from their Indigeneity, either through the various aspects of colonization (child welfare system) or through migration to a large Canadian city, where they were disconnected from their communities, traditional knowledge and their lands. Many of the participants discussed how this impacted their identity and further also impacted their aspects of self, regarding feeling isolated and ostracized, even within the Indigenous community of that city. This was recognized to be a barrier towards cultural connection, as the Indigenous community in any city is quite diverse. Many of the participants discussed reluctance in accessing the Indigenous-specific services within a large city, as they noted a sense of cultural disconnect and dissonance in terms of being separated from their original home and culture.

It is also suggested in the literature that the trauma experienced on separation from one’s family, community, and culture, as a legacy effect from colonization, has affected the ability of many Indigenous peoples and has kept them from achieving the balance in their physical, mental, emotional and spiritual well-being. When experienced by more than one generation, personal trauma can become institutionalized within a family. When multiple families within a community experience similar life events, combined with the communities that are left without the resources, they are, at often times, unable to effectively address the resultant social consequences (Gagne, 1998; Menzies, 2005).

The effects of colonization and the subsequent marginalization of Indigenous people was recognized as a primary risk factor for homelessness that is inherently present for the Indigenous peoples. Furthermore, the impacts of marginalization were identified to be influential on identity, thus putting many Indigenous peoples at a disadvantage when it comes to the development of the necessary survival skills in the mainstream Canadian economy. Finally, the impacts of cultural homelessness were recognized as an effect of migration to larger cities, in the attempts to break this glass ceiling for the Indigenous peoples; the cumulative effect of these things puts one in a state of isolation, emotional distress and further, at risk for homelessness.

Identity and the child welfare system

Many of the participants in this study noted being raised in non-Indigenous homes as a result of the child welfare system. Many noted positive experiences; however, they also indicated a strong
disconnect in terms of identity development. These included factors such as growing up without influences of their Indigenous values, combined with the physical difference; experiencing racism growing up in non-Indigenous environments; and growing up with awareness of Indigenous identity, but having no sources of connection with the traditional knowledge, culture and influences of community.

The recent child welfare studies describe the long-term effects that can influence identity development if Indigenous children are removed from their birth families and are placed in non-Indigenous homes (Couchi & Nabigon, 1994; Frideres, 1998; Locust, 1999). For many Indigenous peoples, the connection between spiritual, emotional, physical and mental well-being is disrupted by the process of family removal. Brant (1990) attributes three factors within the Canadian Indigenous context. Of these, the first includes the Canadian society as a whole, being a significant contributor to mental illness among the Indigenous peoples. The second factor includes poverty, powerlessness and anomie, where the Indigenous people have the feeling of disconnection from their cultural community (Brant, 1993). The third factor is linked to the legacy of Residential Schools, which created confusion and conflict for the children by taking them from their homes and not providing them an alternative space where these children could form positive identities (Menzies, 2005).

In terms of the effects of colonization, family displacement by the Canadian child welfare system, and the influences on identity; Locust (1999) used the term “split feathers” to describe the long-term psychological problems that were developed by the Indigenous children adopted or placed in foster care outside of their culture and communities. The main factors in this process were that the Indigenous children, following removal from their families, homes and communities, were forced to assume the values of another culture. This forced assimilation began differing from their own cultural belief system rapidly; and thus, the children were left in a cultural vacuum, relating neither to the mainstream culture nor to their own community. The lasting effects on development were noted by Warry (1998), who stated that as these Indigenous children matured, they became apples; racially red, or Indigenous on the outside, but culturally White on the inside.

As a result, research has demonstrated that as the Indigenous youth enter the phase of adulthood, former Residential School students and Indigenous children who were part of the child welfare
system often tend to have higher rates of symptoms of anxiety disorders, alcohol and substance abuse issues, depression, suicide, and low self-esteem as compared to the general population (Beisner & Attneave, 1982; Gagne, 1998; Hodgson, 1990; Mussell, Nicholls, & Adler, 1991). This was recognized specifically by the participants in this study as being a function of maladaptive identity development, and the experiences of cultural dissonance in terms of finding their place in this world in their Indigenous communities, as well as in the mainstream Canadian society.

As a result of the influences of cultural dissonance, the participants in this study recognized that systemic barriers and racism further put them at a disadvantage in terms of successful integration and survival within a societal Canadian context. According to Rogers, Bobich, and Heppell (2016), systemic barriers and stigma can further impede access to care for the disadvantaged Indigenous youth and families. For instance, it was noted that the intergenerational transmission of parental trauma can negatively impact families who may have limited awareness of the transmission, which can resultantly increase the risk and presence of mental health symptoms within the Indigenous families. Furthermore, stigma can also be a strong factor in parents and caregivers; and therefore, many Indigenous families are reluctant to seek psychological treatment lest it impacts their level of engagement if they do enter therapy (Rogers et al., 2016). As such, the experiences of stigma were strongly identified by the participants who had been a part of the child welfare system. These experiences further affected the identity and self-esteem when combined with the added marginalization and stigma experiences as a homeless person.

**Homelessness and stigma**

The participants in this study accounted various aspects of experienced stigma while enduring their states of homelessness. They noted the assumptions that people make (i.e., drug addiction) and the discriminatory interactions with the social service workers. Many homeless people face significant stigma and resulting barriers, which were both external and internal in nature. This has been recognized as factoring into declining mental health and in accessing care. The external forms of public stigma include overt reactions that the general public has towards overt homelessness as well as mental illness. The results indicate the ongoing discrimination and social distancing of the homeless, especially those with concurrent mental health issues. Self-stigma refers to the internalization of negative stereotypes towards oneself and the resulting
demoralization (Corrigan & Watson, 2002). This is especially true in terms of aspects of identity development and self-esteem for the homeless individuals.

The interaction between public stigma, the responses that one receives from others in the environment, and the negative view of oneself that stems from self-stigma can reduce the likelihood of referrals for mental health treatment, the willingness to follow through on recommendations, and the level of engagement in treatment (Corrigan & Watson, 2002). Furthermore, multiple and non-stigmatizing opportunities to enter treatment can maximize the likelihood for someone to be able to receive effective trauma-focused treatment in order to change the discourse from the impacts of homelessness. Therefore, stigma has a significant influence on identity and the self-concept of individuals who experience or have experienced homelessness; factors that often get ignored in therapy, when one chooses to engage.

Public stigma, when associated with homelessness and mental illness, can extend beyond the general public to trained mental health professionals, contributes to a significant lack of available treatment resources, housing and employment discrimination, and social distancing utilized by the homeless individuals (Corrigan & Watson, 2002). The public stigma towards homeless adults has been linked to discrimination and social distancing (Link & Phelan, 2001). Stigma and service engagement, especially in terms of accessing mental health services, was recognized by the participants as major barriers and contributing factors in their continued cycle of homelessness. Many participants even acknowledged the need for change in terms of educating the service providers and the general public on homelessness, particularly for Indigenous peoples, as a way to minimize this phenomenon.

Kennedy, Bybee, and Greeson (2014) offer a conceptualization of how public stigma can impact the mental health and identity development for the youth. It is suggested that exposure to an abusive family context can pave way for feelings of worthlessness and shame, which may be confirmed or increased by the experiences of discrimination due to stigma. Moreover, the stress of stigmatization may serve as a reminder of the experiences of rejection or abuse by family members. In addition to the negative impacts of public stigma, self-stigma can also have a significant effect on engagement in mental health care. Self-stigma stands a barrier to seeking information about mental health (Lannin, Vogel, Brenner, Abraham, & Heath, 2016), increases the risk of sexual problems and dating violence following sexual abuse, and finally, also impacts
the ability to engage in constructive processing of sexual abuse in treatment (Simon, Fiering, & Clelland, 2014).

The Indigenous homeless peoples encounter numerous factors that interfere with a healthy identity development, both in a cultural and social context. The participants’ narratives were supported by the existing literature in that exposure to racism and discrimination and have lasting negative effects on a healthy development of identity; moreover, they also consequently interfere with one’s ability to thrive socially. Furthermore, this disquisition of identity and social status has been echoed in this study as including a multileveled marginalization for Indigenous homeless, as the effects of stigma and homelessness themselves also have a social consequence as a function of identity as well as systemic oppression.

**Cultural identity and wellbeing**

The connection to culture and traditional knowledge was noted by the participants in this study to have positive effects on one’s identity and wellbeing. The participants noted that being exposed to traditional knowledge and community early on had a positive influence in terms of developing a morality and a value system that formed a part of their identity, greater moral system and world-view. Furthermore, for those individuals who were not raised with the influences of their Indigenous traditional knowledge and culture; being connected to the culture later in life, was healing and promoted a healthy sense of self and wellness. The connection of Indigeneity, identity and cultural engagement was presented earlier in Figure 6.

Beyond the positive or negative content of self-concept, the clarity of specific identity and self-beliefs is also believed to be a contributing factor to the psychological adjustment (Campbell, Assanand, & Di Paula, 2003). This includes personal and individual self-beliefs, combined with the values and morals set from a particular group of origin that an individual can identify with. Many theorists suggest that identity clarity, the extent to which the beliefs about the self are clearly and confidently defined, is an important contributor to an individual’s psychological well-being (Erikson, 1968; Marcia, 1980). This relationship has been empirically supported (Baumgardner, 1990; Campbell, 1990; Stinson, Wood, & Doxey, 2008), and the consistent finding is that those who have a clear sense of their identities tend to have higher self-esteem and greater psychological well-being. Taylor (1997, 2002) proposes a theory arguing about the importance of collective or cultural identity clarity. He hypothesizes that individuals without a
clear collective identity might find it difficult to develop a clear personal identity, a deficit that translates to poor psychological well-being (Ursborne & Taylor, 2010).

Cultural Identity holds a strong position in terms of wellbeing and is the central aspect of the self-concept. There are many elements that combine together to make up one’s identity, whether it is gender, age, ability, religion, sexual orientation, occupation, socioeconomic status, race or culture, or any other group-based identity. Collective identity is an essential aspect of social engagement, and can be defined as that part of an individual’s self-concept that is derived from his or her knowledge of membership in a social group (or groups), along with the value and emotional significance attached to the said membership (Tajfel & Turner, 1979).

The traits, ideological positions, shared behaviour, experiences, and history those are associated with an individual’s group(s) that they connect with, are internalized by the individual to compose an important component of his or her self-concept (Ashmore, Deaux, & McLaughlin-Volpe, 2004; Ursborne & Taylor, 2010). While presenting a comprehensive framework for research exploring collective identity, Ashmore and colleagues (2004) suggested that the certainty or the clarity of an individual’s collective identity may be affected by the norms that pervade the given individual’s social environment.

![Diagram](image-url)

**Figure 7**

*Figure 7: Schematic representation of theoretical association among collective identity, clarity, self-esteem and wellbeing (Ursborne & Taylor, 2010)*

The figure identifies the process that one may endure in regard to their personal identity and how this is clarified by a general sense of collective identity. Furthermore, these personal experiences that have factored from a collective sense of identity are what influence one’s self-esteem and wellbeing. In conjecture with collective identity for Indigenous peoples, Taylor (1997, 2002)
argues that without a clear cultural identity, there is no clear frame of reference available; and therefore, there is no comparative mechanism using which an individual can construct a coherent and cohesive sense of personal identity. The consequences of such result in an inability to experience or develop a positive self-esteem and well-being.

As an example of the effects of disrupted collective identity development on the self-identity clarity and the subsequent self-esteem, the Indigenous peoples in North America saw the complete annihilation of the traditional behavioural norms and values of their culture through colonization (Frideres, 1998). Concurrently, Indigenous people have collective experiences of forced assimilation, where the new norms and values of the European colonial culture were imposed on them in a rapid, unclear and often violent fashion (Chandler & Lalonde, 1998; Taylor, 2002). Thus, many Indigenous people have been left struggling with a conflicting set of principles, a feeling of normlessness, of being left out; a feeling with which they must construct a clearly defined personal identity (Taylor, 1997, 2002). This often leaves them without a clear sense of themselves in connection with their own idea of the character, their sense of self to others, and without group belonging.

This was a factor that many of the participants identified in terms of their identity and how they interacted with others, in that disfranchised identity influenced their own sense of self. However, they also noted that finding and adopting a sense of cohesion in a group culture, whether with other Indigenous peoples or with homeless peers, had a positive effect on their identity and well-being. This idea of cultural dissonance and positive influence of mental health and wellbeing by connection to a sense of community and connection was validated in the literature as a positive source of healing.

For instance, in a series of five studies conducted by Goodwill and McCormick (2012), it was found that the extent to which the beliefs about an individual’s cultural group were clearly and confidently recognized as being positively related to a clear and confident recognition and view of the personal self and to positive self-esteem. This was further a marker of psychological well-being and emotional functioning. These researchers noted that Indigenous peoples have recently begun focussing on reclaiming their culture through attempts to revitalize their language, relearn the traditional practices, and redefine who they are in the real world. As such, the Indigenous communities that have continued to engage in practices that highlight cultural continuity (i.e.,
self-government; cultural facilities). These communities were subsequently found to have lower suicide rates as compared to the communities that were not engaging in these practices (Chandler & Lalonde, 1998; Goodwill & McCormick, 2012). Thus, the influences of cultural continuity for the Indigenous communities can be recognized as part of the collective identity, described above. Further, these impacts on the self-identity of Indigenous peoples can also be described as a function of the social identity theory.

The concepts of social identity theory (Lewin, 1948; Tajfel & Turner, 1979) propose that as a member of a specific group, individuals will subsequently go on to form a sense of belonging and it is this sense of belonging that will then contribute to a positive self-concept and also encourage the development of positive self-esteem. McCormick (1996, 1997) reported that acquiring support from others will then create a healthy expression of the self that is anchored in traditional knowledge and cultural, in this case, the Indigenous pedagogy. For instance, regarding the Indigenous community, this can be supported through the circle work based on the Indigenous values, traditional knowledge as well as the medicine wheel teachings (Brendro, Brokenleg, & Van Bockern, 1990; Hart, 2002). Furthermore, by connecting with these Indigenous means of healing, one’s attachment needs can be met and the concurrent group identity reference can be satisfied (McCormick & Gerlitz, 2008). As such, interconnectedness is essential to an Indigenous worldview (McCormick & France, 1995), and therefore, the relationships are held in high value.

This was recognized to have a thematic nature in the narratives of the participants in this study, where in terms of identity, many of the participants noted relationships and respect to have a central value to their own sense of identity and self-concept. Therefore, as with the social identity theory, it is the influence of cultural participation and knowledge acquisition as a result of community identity that held such values in high regard. Furthermore, the participants also discussed the difficulties faced in the process of identity development that negatively affected their self-esteem. This was congruent with the literature that acknowledged that Indigenous peoples’ identity problems can result from imposed language and culture dominance and the denigration of the Indigenous cultures (Anderson, 2000; Berry, 1990, 1999). As such, the participants discussed a cultural dissonance in terms of their own identity and self-concept through colonial influences of language disparity, and influences of traditional knowledge inherited from their own families as well as communities.
Furthermore, social identity theory (Lewin, 1948; Tajfel & Turner, 1979) predicts the likelihood that identification with two distinct cultures can turn out to be problematic for identity formation because of the conflicts in attitudes, values, and behaviours. Systemic and familial pressures factor into decision making between multiple identities and bicultural integration was reported to be an ongoing effort for the Indigenous people who identify with multiple races (Lawrence, 2004). Social identity theory (Tajfel & Turner, 1979) supports the finding that socially subordinated peoples with stolen and suppressed histories generally struggle to find new ways of self-identifying (Anderson, 2000; Berry, 1999; Lawrence, 2004). This was especially congruent with the participants in this study who identified an identity dissonance in terms of developing a proper self-concept when they could neither fit with the Indigenous community, as such with those connected with the child welfare system. These individuals neither felt connected with their Indigenous identity nor did they feel any solid connection with the mainstream Canadian society.

The results of a study conducted by Goodwill and McCormick (2012) further suggest that personal identity is quite an important aspect of the Indigenous identity development and restoration. More specifically, the results concluded that the individual, family, cultural, and community context of the participants were important in order to understand the personal as well as cultural identities. Restoule (2000) has further argued that the personal and cultural domains of identity are linked and therefore, the Indigenous histories and context should be included while understanding the aspects of identity. The statements of many of participants in the current research also aligned with those in the results of the aforementioned studies by Goodwill and McCormick (2012) as well as Restoule (2000), in that they identified feelings of disenfranchisement from the environmental aspects of the Canadian society, where they have experienced displacement in the aspects of both land and cultural identities. This kind of displacement in a general social sense, as well as the literal environmental sense, plays a pivotal role in their experiences of cultural urban homelessness.

**External Factors**

The external factors were identified as being a significant component of experiences of homelessness by the participants in this study. It was identified that certain environmental factors affected the discourse that was likely to put one at risk for homelessness, influence the
homelessness experience and also influence the aspects of being able to overcome and recover from the experiences of homelessness. This was especially the case regarding the intersection that environmental factors had on homelessness, traditional knowledge and cultural identity, as well as on mental health and trauma. The main external factors recognized by the participants were environmental social determinants of health; cultural safety; and multi-level needs for mental health as well as addictions.

The external influences on the experiences of homelessness have been depicted in Figure 8 based on the results stemming from this study. Reiterated here is the time continuum of homelessness that was discussed in the across participants results. The participants in this study recognized the various social determinants of health that impacted all the three phases of their experiences of homelessness. As each of these factors differed in the individual experiences, this is encapsulated in the diagram with a dotted line across between the social health factors and the homelessness trajectory. However, there were some indicators that were acknowledged by the participants and

Figure 8
External factors of Indigenous homelessness

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confirmed by the literature as being empirically supported predictors of the Indigenous homelessness, maintenance and recovery, which will be discussed in more detail below.

Social determinants and environmental factors of homelessness and trauma

Social influences can have a significant impact on the environment. This is especially true in regards to homelessness in the context of Indigenous peoples and health. The participants in this research, for instance, noted the various aspects of their environment as a part of the contributors to their experience in the onset and maintenance of homelessness. The participants further noted a need for services that address these factors and thereby, bridge the disparity between homelessness and healthy social function. The participants also noted aspects of age, education/employment, family violence and parenting, safety, housing, and Canadian policy as all factors in the health and social disparities contributing to the state of homelessness. As such, there are also environmental factors regarding the culture that intersect with the experiences of homelessness, mental health and trauma.

Apart from the cultural differences that influence the psychological presentation of peoples from a non-Western background, trauma literature recognizes that people with social disparity are also more likely than others to be victimized and experience more acute needs in terms of trauma exposures (Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Carter, 2007). The experiences of trauma were recognized to be common among those with lower socioeconomic status in addition to child abuse, neglect and exposure to domestic violence (Bergner, Delgado, & Graybill, 1994; Finkelhor, Ormrod, Turner, & Hambry, 2005; Kyriacou et al., 1999; Sedlak & Broadhurst, 1996). A study by Gamst et al. (2006) recognized that many Individuals who had experienced homelessness had dysfunctional family histories and indicated that 25% of the Indigenous adults reported that prior abuse was a contributing factor to their homelessness, as compared to the 16% of the total sample. This was also demonstrated in the narratives of the participants in this study, where many noted family dysfunctions as being a part of their experience and a factor in the trajectory of homelessness.

Parenting

Parenting methods were identified as an environmental factor that contributed to the risks of
homelessness. The influences of parenting in the narratives of participants also contributed to the intersections of Indigeneity and mental health. As previously indicated, many of the participants had early experiences in the child welfare system, and thus, either experienced dysfunctional home environments prior to contact with child welfare, or experienced challenges as an Indigenous child being parented from White parents.

According to Whitbeck and colleagues (2012), when a child is removed from their home for a long or indefinite time, they do not have the opportunity for knowledge transmission such as family values, parenting knowledge and important information regarding community function. This has been noted to be a crucial factor in the formation of homelessness; in that many times, the individuals who are in this position are not given the proper educational opportunities to learn independence, survival, community engagement and or social functioning between the generations (Payukotayno, 1988; van de Sande, 1995).

Furthermore, in terms of the impacts of parenting on homelessness and trauma, Grant (1996) suggested that without the appropriate parenting models, many of the Indigenous parents lacked the knowledge required to raise children on their own and instead, the children are then introduced into the dysfunctional models of behaviour (Brant, 1990; van de Sande, 1995). As such, many of the Indigenous children grow up in homes that are influenced in a multigenerational manner (i.e., raised by Aunts, Uncles, Grandparents, etc.). Many of these relatives, if not the children themselves, were often influenced by the overt aspects of colonialism, such as the Residential School system.

The legacy of the Residential Schools and the effects on the home is inclusive of parenting models-based on punishment, abuse, coercion and control (Hudson & McKenzie, 1981; Proulx & Perrault, 2000). The devastating trauma that is transferred through parenting methods was also described by Napier (2000), who concluded: “The bonds between many hundreds of Aboriginal children and their families and nations were bent and broken, with disastrous results” (p.3). Such intergenerational transmission of trauma, low social functioning and poor coping methods in the Indigenous families through dysfunctional parenting was also described by Hodgson (1990) who summarized the cumulative effect across the generations:

If you subject one generation to that kind of parenting and they become adults and have
children, those children become subject to that treatment and then you subject a third generation to a Residential School system the same as the first two generations. You have a whole society affected by isolation, sadness, anger, hopelessness and pain (p. 17).

Phillips (1999) also described the behavioural transmission of trauma through interpersonal relationships and parenting; he summarized the intergenerational impact of trauma in the following words:

If we do not deal with our trauma, we inadvertently hand it down to the next generation. We often take our pain and hurt on those we love the most- which is ourselves, and those closest to us- our family and friends. So, intergenerational trauma is trauma that is passed down behaviourally to the next generation: if we’re angry and act angry all the time to others, our kids will think that’s normal and do the same. If we ignore each other and deprive each other of love and affection in our relationships, our kids see and feel that deprivation of love and might think it’s normal (p.6).

As such, many of the participants described poor parenting and poor examples of coping in their family environments, which were passed on through the generations. This was recognized as a new-age sense of colonialism and another poor environmental risk factor into the development of maladaptive coping, as with substance abuse, tumultuous interpersonal relationships, as well as inadequate parenting models themselves and was identified hard factors in their experiences of homelessness onset.

**Safety**

In terms of environmental influences of homelessness, the factors of safety and survival were a significant aspect of the participants’ experiences. The literature notes (Briere & Scott, 2015) that social marginalization is recognized as something that many people with traumatic histories have experienced, which has, as a result, reduced their access to the appropriate mental health services. This is especially true for the Indigenous homeless who often feel unsafe while utilizing mental health care, as uneducated providers are often re-triggering for aspects of colonial trauma.

Combined with the discrimination that is often experienced by Indigenous people, homelessness itself ensues a relatively dangerous living environment in which many are forced to live in a hostile environment; this is inclusive of those who lack a physical shelter (i.e., on the streets;
outside) and vulnerability of living without protection (i.e., risk for physical assault, violence, robbery, sexual assault (Briere & Scott, 2015). This was a significant theme observed in the narrative of the Indigenous homeless people in this research. Many participants discussed the issues of lack of safety and how the threat of basic survival was a continuous stressor, as well as the economic factor in terms of being robbed and falling further into the cycle of not being able to find housing.

**Economic disadvantage and unemployment**

Another factor that plays a key role as one of the social determinants of homelessness and trauma is the economic disparity, which is encountered by many Indigenous peoples. This was verified in the participants’ experiences of homelessness in this study. For instance, many of the participants discussed the lack of opportunity and poverty that exists amongst many Indigenous communities and the economic isolation that results from remote reserves and communities. When the participants found themselves in a state of homelessness, it was hard for them to sustain and maintain employment, which pushed them deeper into the cycle of homelessness. Furthermore, many also demonstrated that the various periods of unemployment contributed to homelessness initially or recurrently.

As per the economic disparity that exists for Indigenous peoples, a 2003 report by the U.S. Commission on Civil Rights (USCCR), indicated that Indigenous people: “‘Rank at or near the bottom of nearly every social, health, and economic indicator’” and that the “‘socioeconomic condition of the [Indigenous] population in the United States reveals a dire need for increased national attention’” (p.8). These statistics are identical to the statistics collected on Canadian Indigenous people. For instance, according to Statistics Canada, the 2011 National Household Survey demonstrated that only 62.5% of Canadian Indigenous people aged 25 to 64, were employed as compared to the 75.8% employed non-Indigenous Canadians. It was further recognized that although Indigenous people were less likely to be employed as compared to their non-Indigenous counterparts, the Indigenous people age twenty-five to sixty-four were less likely to have a high school diploma, postsecondary certificate, diploma or degree, in comparison to their non-Indigenous Canadian counterparts (Statistics Canada, 2013). As such, the statistics from the survey noted a 5% gap between the employment rates of Indigenous people (76.2%) and those of the non-Indigenous population (81.1%) for the individuals with a high school
diploma and a postsecondary certificate, diploma or degree. This data recognizes the economic disparity and disadvantage that the Indigenous peoples experience, regardless of their education.

According to the statistics in the United States, on some reservations/reserves, the unemployment disparity is much greater than what is experienced in Canada. For instance, estimates of unemployment on Pine Ridge Reservation in South Dakota range between 83 and 85% (Schwartz, 2006). Given these dire statistics of economic disadvantage among the Indigenous people; coping with such inequality and economic disadvantage demands the Indigenous individuals and families to be constantly mobile, moving on and off reservations and reserves in search of newer opportunities (Larriviere & Kroncke, 2004). This combination of economic disadvantage and mobility can make them very vulnerable to homelessness, keeping them one lost job or one paycheque away from homelessness (Whitbeck, Crawford, & Sittner Hartshorn, 2012). Mobility and the search for opportunity was also a thematic finding in the narratives of this research. The participants also discussed mobility in terms of survival and the homeless lifestyle to be a couple of important factors in the cycle of homelessness.

Substandard housing

Many participants in this study discussed how they would rather stay on the streets than in the shelter system, as these environments are often not only unsanitary but also unsafe. This was recognized as a concern since safe and affordable housing is the most pressing necessity for the homeless people. Many participants further recognized that housing is the first requirement that should be met in order to help an individual transition out of the state of acute or chronic homelessness. It must be noted, however, that as the number of the homeless people increases, it is also important to identify and address the associated mental health issues, particularly trauma. The distinct socio-economic conditions of the Indigenous peoples make their housing needs even acuter when they’re homeless. A 1996 report by the Royal Commission on Aboriginal Peoples on the status of off-reserve housing summarized the cause of this situation:

> Without taking anything away from past accomplishments, the fact remains that governments, at all levels, have never come close to meeting Aboriginal housing needs, partly because the backlog was so great but mostly because scarce resources were allocated oblivious to the disproportionate Native requirement and the refusal of successive federal governments to accept their responsibility to give Aboriginal off-
reserve housing a priority claim on limited funds. There has been more than a shortage of fiscal resources. There has been a shortage of political will, complicated by federal/provincial jurisdictional squabbles. (p.19)

According to Menzies (2005), the Indigenous peoples in Canada have always been in a state of crisis when it comes to being adequately housed. The continuous lack of funding has led to the cancellation of many housing programs that aim at housing Indigenous people, especially in the urban settings. This has been an addition to the already desolate living conditions that many Indigenous people have experienced while living on reserves. This cycle of poor housing conditions on reserves, combined with lack of affordable housing in urban centres, continues in terms of impoverished living conditions for many of the Indigenous peoples.

Although the participants in this study did not speak to the substandard living conditions in their home communities, they did describe the conditions of the current shelter system and government-funded housing in the city. There was a strong voice in the narratives that spoke of the substandard and often unsanitary living conditions of many of the shelter within a large Canadian city, which was influenced many Indigenous peoples’ “choice” to live on the streets.

Migration and mobility

Apart from migration and mobility for Indigenous people due to the economic climate and disadvantages, it was observed that is also affected by the concerns pertaining to loss of culture, tradition, family connections, and homesickness for Indigenous peoples (Joffer & Wagner, 1996). For instance, living on a reservation/reserve represents a unique social context in that it often provides a few economic opportunities to many Indigenous peoples who have not been historically removed from their original lands, or have not been completely removed from their home territories, reservations/reserves (Whitbeck et al., 2012).

In a social context, reservations can be viewed by the Indigenous communities as the reminders of the lasting effects of colonization, which further segregate and separate them from the mainstream Canadian society, including economic, policy and even law. For instance, Whitbeck and colleagues (2012), state that some reserves can act as reminders to the Indigenous peoples, reminding them of the ethnic cleansing, broken promises, continual encroachment on tribal lands, and economic disadvantage, that has happened to their people as a result of the policies
and infringements of European colonial settlers. Whitback et al. (2012) further state, however, that the reservations can be a refuge for the Indigenous people, taking them away from the discrimination that occurs from mainstream Canadian society; moreover, such reserves can provide them with a sense of haven where they can embrace their Indigenous lifestyle.

As such, on these lands, they can embrace sacred places, be in the presence of extended kin, and remain the repository of cultural knowledge. For instance, in Joffer and Wagner’s (1996) study of return migration among the Indigenous people in South Dakota, 41% said that they left their reservation for economic reasons, yet only 16% gave ‘‘job’’ and 4.9% ‘‘cost of living’’ as a reason for returning. More than half of the people interviewed (56.8%) gave social environment, family, and cultural aspects as the reasons for returning. The participants in the study also voiced their goals for returning to their home communities, despite the availability of the services in Toronto, as many noted the disbarred economic opportunity.

As such, the literature further suggests that Indigenous people are migrating to the neighbouring urban centres so as to flee the economic and housing issues that are often faced in their Indigenous communities. The government policies in perpetuating impoverished conditions within the Indigenous communities were believed to have a direct contribution towards the urban and rural homelessness for Indigenous peoples. For example: “Homelessness is systemic from the policies of the past and the consequences of those policies” (Robinson-Superior Chiefs et al., April 2001; In Menzies, 2005).

**Canadian policy**

The policy factors were also recognized by the participants as significant factors that contributed to their experiences of homelessness. For instance, the Canadian policy has significantly impacted the lives of the Indigenous peoples through colonization, the Indian Act, the Residential School system and child welfare (the sixties scoop). The devastating effects of these systemic dispositions have continued to leave the Indigenous communities, families and individuals in a chronic state of political, social as well as economic disadvantage. Menzies (2005) highlights that the ongoing segregation and disempowerment from the Canadian government has deprived many Indigenous communities of the adequate resources and skills that are required for developing and fostering healthy communities.
This is specifically demonstrated through the poor psychological coping that occurs within the Indigenous communities. This is highlighted by the high rates of suicide among Indigenous peoples, which are at 142.2 per 100,000 as compared to the 30.7 per 100,000 in the total Canadian population; is the suicide rate of the Indigenous people is clearly three times higher than the rate of the general population, and can be six to eleven times higher in some Indigenous communities (Brant, 1993; Health Canada, 2006). However, some communities have even demonstrated zero suicide rates.

Cultural continuity has been recognized as a factor that explains this phenomenon of discrepancy in the suicide rates. Cultural continuity is the ongoing reclamation of their own communities in their efforts to recuperate and reclaims their traditional knowledge and values as an explicit effort for the Indigenous peoples that will help them build on a collective identity and social cohesion in their own communities (Kirmayer, Simpson, & Cargo, 2003). Cultural continuity is based on a sense of resisting from the current forms of oppression and historical effects of assimilation that have divided the Indigenous peoples from their culture, traditional values and language; and gives the communities a sense of governance in terms of their own policies and practices apart from the dominant mainstream society. As such, the Canadian policy applies to urban Indigenous communities as well.

An urban survey (HEDAC, 2001) identified that the historical government policies were the root cause of homelessness for the Indigenous people in the city:

The initial root of the problem stems from colonialism when governments expropriated land and displaced Aboriginal communities to reserves: often more than once (i.e., Davis Inlet). Entire communities became homeless as a result of these actions. The impact has had a multi-generational effect and many individuals today continue to wander without a home (p. 11).

In accordance to the literature, the participants in this study noted that in order to address the impacts of the government policy on the phenomenon of continued oppression of Indigenous peoples in terms of homelessness, mental health and cultural connection, more intersection is needed regarding the policy on services that provide culturally appropriate care that focuses on Indigeneity as a source of strength and resiliency. As such, the literature asks an important question in that if cultural incongruity is the key factor for reducing the high rates of
homelessness for Indigenous people, then why are other visible minority groups, including newcomers and refugees from non-European countries, not affected by homelessness to the same degree? (Menzies, 2005) The Canadian social policy was instrumental in creating institutions that eradicated the value systems that existed for thousands of years and replacing them with doctrines that continue to disrupt life for the Indigenous peoples. For instance, Menzies 2005 states:

There is increasing evidence that more than 140 years of social strategies aimed at the assimilation, segregation and integration of generations of Aboriginal children into the mainstream, Euro-centric culture have resulted in personal, familial and community trauma. The net result is that many Aboriginal peoples have been left without the necessary personal and community resources to achieve harmony and balance in their daily lives (p. 9).

The participants in this study recognized the various environmental barriers that influenced their ability to function in a society that continues oppressing them. One major theme that they addressed in terms of the environmental factor interfering with the experiences of homelessness and mental health for the Indigenous peoples was the social determinants of health. These included but were not limited to the various aspects of parenting, safety, unemployment, migration, inadequate housing, and Canadian policies. In order to better address such barriers that keep the Indigenous people from thriving and overcoming homelessness and mental health difficulties, the participants noted that having more culturally-informed services and more Indigenous people in leadership positions would help address this gap.

Culturally informed services

Although external environmental factors such as the social determinants of health were identified to be significant contributors to either of the risk factors that were responsible for driving the participant into the state of homelessness in the first place or recurring homelessness, the participants recognized specific services for the Indigenous peoples that could adequately address some of their needs. The participants even discussed that the availability of these services helped them connect with the workers and build relationships, and thus, felt more supported. Many of the participants even discussed that this support is what helped them exit the state of homelessness and acquire housing. As such, culturally informed services with trained
professions were recognized as a key strength in terms of resources and in success in overcoming homelessness, mental health difficulties as well as healing from trauma.

Although these supports are available, the majority of participants recognized that many of the services are not culturally appropriate, creating very unsafe spaces, as many of the services providers are non-Indigenous and uneducated on Indigenous histories, health and issues. Furthermore, care is usually provided on the basis of the Western protocols, which can prove to be more harmful to the Indigenous peoples, especially those who have already experienced trauma.

There is research demonstrating that the Indigenous peoples’ experiences within the Canadian health care system are generally negative, since they have been shaped by a century of internal colonialism that has effectively marginalized the Indigenous people from the dominant system of care (Adelson, 2005; Browne & Fiske, 2001; Kurtz, Nyberg, Van Den Tillart, Millys & The Okanagan Urban Aboriginal Health Research Collective, 2008; Levin & Herbert, 2004; Prodan-Bhalla, 2001; Webster, 2005).

A study by Wilkes (2013) examined the current mental health practices in Canada for the Indigenous people. Her results demonstrated that the Canadian mental health practitioners working with Indigenous people are more likely to be White, work in urban settings and see their clients in private practice. The concerning thing about these results is the fact that although many mental health care providers are educated on various Indigenous issues, there were still a few Indigenous peoples in these positions, which is alarming. Indigenous presence within these positions is important especially for issues such supervision and the quality of care. Furthermore, non-Indigenous peoples in these positions need to take it on themselves to own their position in the therapeutic alliance and to properly educate themselves on various Indigenous issues, including consultation with the Indigenous community members and collaboration with the Elders and Healers, which many fail to do.

One such strategy for integrating more Indigenous and community-oriented approaches has been proposed by May (1992); the strategy states that including more strategies that influence the community such as with education and having role models present. The focus should be kept on comprehensive, community-based prevention efforts that embrace the diversity that exists amongst the Indigenous communities, and gives each community the autonomy, cohesion and
specificity that is required for addressing the addictions needs for a specific community that is also inclusive of their own colonial history (Hunnisett & Sault, 1990; LeMaster & Connell, 1994; May & Moran, 1995; Ross & Ross, 1992). This proposed strategy was mirrored in the narrative of the participants in this study who identified the need to have more Indigenous community members in leadership roles. Having the community members in such positions will not only provide healthy role modelling and effective culturally informed care; but will also set examples for the policymakers to take step towards decolonization.

**Cultural safety**

In terms of culturally informed services, the participants in this study recognized that many of the available services, especially for mental health and healing, are provided by the non-Indigenous peoples who are uninformed about the Indigenous issues, histories, and worldviews. The outcome is that these spaces are no longer culturally safe and can, therefore, on the contrary, become reasons for trauma and oppression. Cultural safety was a theme regarding the barriers that kept Indigenous people from seeking more trauma and mental health supports and thus thwarted their healing journeys.

The concept of cultural safety is based on the framework that recognizes the power differences among various ethnocultural groups (NAHO, 2008b). The cultural safety theory draws attention to the “socio-political” reality of the individual accessing services, particularly in terms of the political status and historical experiences of the group with which one is dealing (Ramsden, 1992, 2002). As such, with the Indigenous peoples, given their experiences of oppression by the government, health, education systems, it is not surprising that many Indigenous peoples are reluctant to access services from the mainstream modes of care. The National Aboriginal Health Organization (NAHO) (2008b) defines cultural safety as an environment where “The health provider/educator/professional, whether Indigenous or not, can communicate competently with a patient in that patient’s social, political, linguistic, economic, and spiritual realm (p.4); conversely, culturally unsafe practice is any actions that diminish, demean, or disempower the cultural identity and well-being of an individual” (p.4).

Cultural safety goes further beyond the related concepts of cultural sensitivity, cultural competence, and cultural awareness and includes an analysis of power imbalances, institutional discrimination, colonization, and colonial relationships as they apply to the domain of healthcare
(NAHO, 2008b). Cultural safety necessarily involves localized education, action, and assessment and requires the “safe” service to be defined and evaluated by those who are the recipients of the service (Wepa, 2004). At the same time, it can be argued that an anti-colonial theoretical lens (Gilmartin & Berg, 2007) is necessary to evaluate the efficacy of cultural safety in practice. Thus, it can be safely stated that cultural safety starts with education. Furthermore, active action needs to be taken for the services to develop culturally safe places for care, and make it a priority to addressing Indigenous issues in an appropriate way that focuses on the strength and resiliency of the Indigenous communities; with the perspective of decolonization.

Research (Hole et al., 2015) indicated that the Indigenous community members’ perspectives about both culturally safe and culturally unsafe experiences in a community hospital are the outcomes of interconnecting identification and oppression. In terms of positive and negative experiences of the healthcare practices, the positive experiences noted a focus on human interaction; however, it was noted that the negative and culturally unsafe practices that focused on historical realities and legalities, were structured, and that personal interaction was aloof. This research further suggests that the interconnecting processes between both culturally safe and unsafe experiences is the outcome of structural violence and colonial practices that disregard the Indigenous values and beliefs (Kurtz et al., 2008). Such practices continue to oppress Indigenous people, thereby creating barriers toward accessing and utilizing health care as these systems continue to operate through political, economic, and social structures that are oppressive and dominated in the Western mainstream models of care.

**Multi-level needs approach mental health and addictions**

Individuals experiencing homelessness often have co-occurring mental health and addiction needs that differ in level of severity, longevity and risk. The participants in this study recognized that this was the primary aspect of their experiences, where many of the participants described a need for multi-level services that address the needs of the people in terms of severity. This was particularly voiced regarding the harm-reduction services, especially in terms of cultural protocols and healing.
Multilevel needs approach for service and support intervention

This model demonstrates the multilevel needs approach to care as proposed by the participants in this study. It recognizes that as the severity level of addictions and mental health issues goes up with the persistence of homelessness, so does the level of the need. The participants also recognize that as homelessness persists, in combination with chronic addictions and mental health issues, the likelihood of change and willingness to exit homelessness diminishes. The participants noted that the critical time for intervention and highest likelihood of being housed and sustaining recovery from addictions or mental health needs is when the addictions and mental health issues are acute, and/or the individual is first entering the state of homelessness. The participants also discussed a critical need for harm reduction models of care as a best practice for addressing some of these needs.

Harm-reduction in Indigenous communities

Some Indigenous communities have begun advocating for harm reduction models that can better support the healing journeys of their people; these communities have also developed and endorsed integrated harm-reduction models that focus on supporting health promotion/education, prevention, treatment and relapse prevention strategies (Glikman et al., 2007). Further, these models have sought the vision to address and focus on other concurrent issues, risk factors and variables of negative health outcomes, such as unemployment and poverty. It is noted that many
of these approaches, however, focus on the individual, rather than on the group as a whole. These models focus on the multilevel needs that the individuals have, especially in terms of homelessness, mental health and addiction. However, there remains a gap in terms of efficacy for addressing the other concurrent factors in understanding addictions, such as in the dire social determinants of health and impacts of colonialism that the Indigenous peoples experience.

Harm-reduction models that focus on reducing drinking in the communities, have proposed a model that not only works in terms of preventing addictions through abstinence, but also helps the people work through the other issues (i.e., mental health and trauma); what is noteworthy here, is the fact that these models also reduce the amount of alcohol in a controlled space, with the end goals of eventual sobriety (Erickson, 1994, 1995; May 1992; May & Moran, 1995; May & Smith, 1988; Whitehead & Hayes, 1998). As such, the goal of these harm-reduction approaches is to connect the individuals with their culture and spirituality as the primary need, while also effectively reducing the level of substance use, rather than enforcing total abstinence and sobriety for the sake of cultural engagement.

For instance, one harm-reduction approach that was not effective was the aspects of a “damp community” (Gliksman et al., 2007). This included community policy that permit the consumption of alcohol only in private spaces such as homes; however, this was also shown to have reduced the social life and interaction in the communities. It was noted that feasts and powwows were still part of the community life with attempts to involve the community in healthy lifestyle activities; many who drank chose not to engage in these events, and as result, then got engaged in binge drinking in uncontrolled environments (Gliksman et al., 2007).

As an alternative to the “damp community” harm reduction approach, Gliksman and colleagues (2007) proposed an alternative model that includes a multi systems-level harm reduction approach. For instance, the model included (1) risk and protective factors are lodged in all aspects of the community (i.e., school, families, individuals and the community); (2) community efforts affect the entire local environment (i.e., norms, values and policies); (3) promotion of widespread communication and knowledge of the risks and protective factors; (4) promoting the development of bonds to the community and its systems (i.e., families, schools) among the community members; (5) the necessary involvement of a wide spectrum of individuals, groups, and organizations within the community creates a “broad base of support for behaviour change”;
and (6) the involvement and support of community leaders are likely to promote more long-term changes.

This model includes aspects of cultural safety in that it is focusing on both the personal as human experiences, rather than specific models that follow specific guidelines and protocols. Further, it also brings in a valuable component of community engagement and support that both bring in an aspect of cultural safety, while also recognizing the focus on community healing from aspects of colonialism and intergenerational trauma. Although this model fits well with what the participants in this study identified as a central need for better service delivery; many harm-reduction models in Toronto that include an Indigenous approach still require sobriety and traditional cultural protocols. Although many noted that even just speaking with an Elder within these services is helpful when they are unable to engage in the ceremony, this still stands a barrier to their own healing journey. Furthermore, apart from the appropriate addictions approaches, the participants also recognized other social barriers toward accessing the appropriate trauma-based care.

**Summary of Chapter Six**

This discussion chapter reviewed the findings of this study in relation to the three meta-themes of psychological factors, cultural identity and external factors and how they pertained to the intersections of homelessness, Indigenous traditional knowledge, as well as mental health and trauma. Specifically, this chapter explored the current models of care for psychological trauma and mental health needs, for Indigenous peoples experiencing homelessness. This included a primary need for a better quality of care in services that embrace the culturally appropriate models and include Indigenous approaches to trauma, mental health and addiction. The primary concern in the narratives from individuals in this study was a need to have more Indigenous community members in leadership and supervisory roles so as to ensure the appropriate care by the non-Indigenous peoples.

The participants also noted a primary aspect of cultural identity as being a component in their healing journey, where connection/disconnection was a primary factor in their spiritual journey as well as in their mental health and healing journey. The participants recognized the importance of being connected with traditional knowledge and culture as a way of Indigenous identity development, or identity repair as a factor of colonialism. Identity was recognized as a central
aspect in terms of grounding in the experiences of homelessness, traditional knowledge and mental health. Identity was recognized as being both static in their experiences in terms of traditional values, even during their states of homelessness; as well as fluid, in that the connection to a culture often ebbed and flawed due to other issues such as addictions. External factors were also discussed in terms of influence on becoming homeless, maintaining homelessness, as well as the barriers and strengths for helping one exiting homelessness and achieving maintenance of housing, as well as supports for mental health and addictions recovery and trauma healing. The participants noted environments that foster poor social determinants of health such as dysfunctional family dynamics, lack of safety and threat to survival; unemployment; substandard housing; and Canadian systemic policies that create extensive barriers for being able to exit the state of homelessness.

This discussion also included the need for adopting more culturally-informed services that practice cultural safety; moreover, multilevel needs approach were identified as a positive and effective mechanism for helping someone overcome the trajectory of homelessness as an Indigenous person. The following chapter will offer the implication for mental health service workers and will also provide the concluding remarks of this study.
Chapter 7
Conclusion

This chapter presents the concluding comments. Included is a summary of the dissertation; the limitations of the study; the implications of this research for mental health training, counsellor education, the mental health service programming; policy; further directions for research, researcher reflections; as well as a general conclusion and the final remarks.

Overview of the Study

Indigenous people in Canada have been the occupants of their territories for thousands of years through their own practices, spiritual knowledge and by living off the land that they occupy. The colonization of the European settlers not only introduced a variety of diseases and supremacist ideologies but also forcibly removed and separated the Indigenous people from their lands, their beliefs and their practices. It is recognized that colonial impacts such as the deep-rooted trauma experienced by generations of Indigenous people in Canada, combined with the government system, continue the oppression of the Indigenous communities.

Indigenous people have endured various accounts of systemic trauma that is perpetuated by a system that continues to fail them. As Indigenous people have continued to experience racism, oppression and marginalization, it is not surprising to see that there is a social crisis in terms of poor social determinants of health among the Canadian Indigenous people. More specifically, examples of such social crisis are the high rates of mental health issues, trauma and homelessness that are reported in Indigenous communities. Although the media has paid a lot of attention to certain aspects of systemic trauma, including the Truth and Reconciliation Commission (TRC); the movement around the missing and murdered Indigenous women; recent compensation packages from the Trudeau Government for Indigenous child welfare survivors; and a focus on the overall Indigenous health and wellbeing with traditional inclusion in the criminal justice system, hospital settings and mental health framework. There is still an absence of Indigenous voices and leadership in these policies, where many governing forces continue to silence the Indigenous voices and are limited by “white tape” as well as the prevalent dominant social structures.
This research project was a component of a Canada Research Chair on Aboriginal homelessness and life transitions that was held by Dr. Suzanne Stewart at the University of Toronto. The proposal for this dissertation study developed from the results of an earlier project that was conducted by Dr. Stewart and the community partner that explored the harm-reduction needs for Indigenous homeless. The results of that project illustrated the various aspects of culture and trauma that were embedded in the narratives of those participants. Thus, this study was conducted in partnership with an Indigenous community organization, which was involved in the development of this project including the research design, recruitment and data collection, as well as in the analysis. The research question used to guide this dissertation was as follows: what are the intersections of trauma, mental health and traditional knowledge for urban Indigenous homeless people?

This research used a qualitative methodology grounded in social constructivism, utilizing the narrative inquiry to interview sixteen self-identified Indigenous men and women aged between sixteen and sixty-four, who were currently at risk of or had previously experienced homelessness. The participants were approached by the outreach team and completed an individual interview with the researcher in order to conceptualize and understand the intersections of homelessness; traditional knowledge; and mental health, including the experiences of trauma. A narrative analysis of the interviews utilizing individual story maps yielded the within-participant results. A constant comparative framework was used for the analysis of the across participant results. Both the results were consistent and provided the study with internal validity. The narratives were also analysed by Dr. Stewart and her research assistants, which helped to generate consistency in themes, and thus gave the study an inter-rater reliability.

The results produced core concepts of psychological factors, cultural identity, and external factors influencing the overall experiences of Indigenous homelessness and in the intersections with traditional knowledge and mental health, specifically trauma. The results were presented using three major time points in which, these factors contributed into the various experiences of homelessness such as the risk for homelessness; acute homelessness and the maintenance of homelessness; and the recovery from homelessness and transitioning to housing. These overarching concepts provided the voices of the Indigenous community members in a large Canadian city experiencing homelessness and highlighted their specific needs regarding services,
mental health and culture; which had been previously limited in the literature. These results can be used to better address the needs of the Indigenous homeless individuals; especially, regarding mental health service modules and training, future research, and policy development within services.

Summary of major findings from this study

This study sought to understand the dynamic intersections of homelessness, traditional knowledge and mental health for the Indigenous peoples in a large Canadian city. The literature review demonstrated a gap in the research regarding the specific mental health and trauma needs of the Indigenous peoples who are experiencing homelessness. As mentioned, this study aimed at addressing this gap in the literature and reporting on the specific mental health and trauma needs regarding Indigenous knowledge and the influences on the homelessness trajectory.

The results indicated significant psychological factors that influenced the course of homelessness. These included the past experiences of trauma or pre-existing mental health concerns, putting one at risk for experiencing homelessness. The results also noted that homelessness often perpetuated these concerns when one was exposed to new, acute traumas. Such exposure to newer traumas in homelessness also exacerbated the previous symptoms given the high-stress environment as well as the often-concurrent substance use. The results of this project further indicated a need for more education and training of mental health service providers in cultural safety and appropriate Indigenous protocols so as to address specific needs. It was also recognized that mental health services are mainly delivered through the Western models of care and are therefore inappropriate in both the conceptualization and treatment of Indigenous peoples. It was noted that these models did not have the ability to address specific issues, such as intergenerational trauma and spirituality in the healing and recovery process. The participants noted a need for integration in terms of cultural practices and harm-reduction.

Cultural identity was also noted as being a significant factor in terms of the intersections of traditional knowledge, mental health and homelessness. It was recognized that the connection to traditional knowledge and culture as a child strongly influenced individual identity development, including the Indigenous values. It was noted that this promoted a sense of strength and resiliency, as well as having a positive influence on self-esteem and self-concept. This cultural identity and engagement also influenced well-being in terms of physical, mental emotional and
spiritual elements of the self. More specifically, the connection to the culture at any stage of healing was recognized as an important process in decolonizing and repairing the aspects of the self and the larger Indigenous community. In contrast, racism and oppression were recognized as significant aspects that had negative effects on identity, resulting in internalized racism and low self-esteem. Furthermore, this was also recognized as a significant barrier to accessing or utilizing the services. This was significant in that it recognized a key barrier regarding identity, discrimination and reduced the access to and utilization of services by the Indigenous peoples who needed them.

External factors were also a key variable in the homelessness trajectory and in the direct experiences of the Indigenous homelessness people in a large Canadian city. Poor social determinants of health were recognized as significant contributors and were said to be co-occurring risk factors. Therefore, an aspect of the overall experiences leading up to homelessness and maintaining a prolonged cycle of homelessness was outlined. These included factors, were namely family dynamics, unemployment, substandard housing and policies. Safety and security were also highlighted as a factor in the direct experience of homelessness, where physical safety and survival needs became imminent. Many of the participants described how they exposed themselves to personal danger while experiencing homelessness. Cultural safety was also recognized as a significant factor, where many participants felt culturally unsafe in the shelter systems; assisted housing; programs and services; as well as in mental health and trauma services. It was recognized that more cultural safety was necessary for terms of educating and training the police, health providers and service agents on Indigenous issues and needs. Finally, a multilevel service approach based on needs, risk and severity were also noted in terms of policy.

In many ways, the findings of this study relate to the psychological literature presented. Firstly, this research complements the existing research noting the social determinants of health that interplay with higher rates of homelessness and social disparity amongst the Indigenous peoples (i.e., Munn-Rivard, 2014; Kirmayer, Brass, & Tait, 2000; Richardson, Driedger, Pizzi, & Moghadas, 2012). This study also reflects similar studies and validates the previous qualitative research that acknowledges the ongoing aspects of colonialism and the effects that intergenerational trauma has had on Canadian Indigenous peoples’ health and social outcomes (Bombay, Matheson, & Anisman, 2014; Goforth, 2014; Menzies, 2005). This study furthered the rigour of psychological knowledge and literature regarding Indigenous mental health and
homelessness in that it provides the specific needs of Indigenous peoples regarding factors of systemic issues, culture and emotional wellbeing as well as functioning, from the perspectives of those of interest.

The contributions from this study are of value for clinical psychology and include a description of the integration of Indigenous healing in the practice of mainstream Western psychology (hybrid model) and contributed the approaches for counsellors, service providers as well as administrators. This study also contributes to the existing literature that promotes a hybrid approach to mental health and trauma practices with the Indigenous peoples. This study provides valuable information in terms of policy and provides beneficial models in terms of quality of care for advancing the social, political and overall wellness of health for the Indigenous communities, especially in service in large urban areas.

Limitations of this Study

There were some limitations to this study, which must be noted and addressed. The individuals who participated in the study self-identified as Indigenous. In terms of the scope of this study, specific demographic information was not obtained due to the qualitative nature. In hindsight, this information could have helped enrich the data. Although many indicators were recognized in the narratives without prompting (such as current age, an age when first homeless, number of years homeless, cultural background, etc.), having this consistent information would have certainly strengthened the results of this study to a considerable extent. The diversity needs amongst Indigenous homeless in one particular urban setting was recognized; however, it would have been much helpful to see the diversity amongst the sampled participants in this study. This was also true for factors such as age, the age of first homelessness, number of times homeless, number of years homeless, etc.).

The sample size is always a concern in terms of rigour and validity in a qualitative research. Although 16 is an adequate sample size for a qualitative study (Guba & Lincoln, 1989), many of the participants were not included as a result of the limitations on the availability of the researcher in locations with the outreach team. For instance, the outreach team had potential candidates for the study; however, some were not at the locations when the researcher was present. As such, purposive sampling was used in this research in collaboration with the Indigenous community. As mentioned, the researcher accompanied the outreach team of the
community partner organization, the participants were selected by the outreach services that were known by the participants.

Purposive sampling\textsuperscript{10} aims at answering the research question in a meaningful way by careful selection of the individuals who meet specific criteria regarding a population of interest; in this study, the Indigenous homeless. This form of sampling, however, does have some limitations. Researcher bias becomes a higher possibility in that the participants are selected by researcher judgment. As mentioned, in order to reduce such bias in this study, the participants were selected by the community partner organization. Furthermore, although this methodology is significant to the overall goal, quality and appropriateness of the research context, a generalization of results is also a limitation of this research methodology.

**Subjective bias**

As mentioned, research bias is a common critique of qualitative research, this is especially true for the use of purposive sampling (LaBoskey & Lyons, 2002). Qualitative research is generally grounded in subjectivity, which is seen as one of the strengths in qualitative research, as the interpretations of the data are often a part of the analysis process. The researchers, however, must be aware of the bias that can influence the results and put appropriate protocols in place to address this concern and limit the bias in the analysis of other’s narratives and perspectives. Regarding bias, Schwandt (1997) identifies four types of biases that can occur in qualitative research: “Bias resulting from over-reliance on accessible or key informants; selective attention to dramatic events or statements; biasing effects of the presence of the inquirer in the site of investigation; bias from the effects of the respondent and the site on the inquirer” (p. 9).

In this study, the bias regarding to the over-reliance on key informants is of note, as in the nature of purposive sampling, the participants were selected based on their “fit” based on the judgment of the outreach team who were aware of both the criteria of the study, as well as some details of the individuals invited to participate. This was beneficial in terms of the level of depth and detail for answering the research question; however, poses questions of integrated bias.

\textsuperscript{10} Purposive sampling relies on judgment of researcher in selecting participants of interest in the study of a certain phenomenon.
It is also recognized in the literature that regardless of the protocols that may be set in place, bias cannot be eliminated or placed aside in any of the research methods (Denzin & Lincoln, 2000; Taylor & Bogden, 1984). Bias is, nonetheless, a part of the human experience. Thus, it would be unjust to state that bias is controlled in any study, as all people interact with some level of bias, simply because they’re humans in their own experience (Gadamer, 1994).

In this study, bias is involved in the general interaction between the researcher and the participant. This has also been recognized in the literature as being a central part of qualitative research, where the relationship between the researcher and the participant is co-constructed (Peavy, 1998). Although interview questions were pre-selected and ethically approved, subjective bias was embedded simply in the relationship between the researcher and the participant (i.e., non-verbal cues, open-ended questioning, etc.). Reeves (2013) describes this relationship in research as the central aspect of constructivist inquiry within a narrative approach and is said to be the core component of the analysis and interpretation of the results. She further notes that as a result, the findings are collaborative between both the participant and the researcher, and thus some amount of subjectivity is required. Further, the relationship was important to note in this study regarding research bias as the researcher is a non-Indigenous person interpreting the experiences of systemic trauma with a vulnerable and marginalized population.

Subjectivity in the interpretation of metaphors

As indicated, a narrative approach was utilized in this study, since the Indigenous people identify themselves as being rooted in oral transmissions of knowledge and use storytelling as a method (Medicine-Eagle, 1989). As such, the use of metaphor was strongly used in the descriptive narratives of the participants in this study. Researcher subjectivity and bias becomes a factor in the interpretation of the meaning within the context of the metaphor. For instance, Nonaka (1996) notes inter-subjectivity with metaphor interpretation; however, there is a strong tool for allowing the researcher to view the experience, and for the participant to think and communicate. Furthermore, Lakoff (1993) notes, “The locus of metaphor is not in language at all, but in the way, we conceptualize one mental domain in terms of another” (p. 203).

Despite the inherent bias and subjectivity in the interpretation and analytical process of metaphor use in qualitative research, Miles and Huberman (1984) suggest that enriching qualitative data
results requires the researcher to think metaphorically during the process of analysis. This was particularly of value in terms of the scope and context of this study; in that, the use of metaphor not only described the rich experiences of the participants but also incorporated the various aspects of traditional knowledge embedded in the narratives.

**Reliability and validity**

Although qualitative research is becoming a widely accepted standard for psychological and health-based research (Davidson, 2003), it is still critiqued in terms of scientific rigour and the quality of induction (Creswell, 2007). Induction is the analytic process in which the findings are created in research. This includes generating themes and/or confirming these themes through saturation of data. As such, this study attempted to increase the internal reliability through the process of induction through comparison of within-participant and across-participant results. As such, similar themes were noted in each analysis, thereby providing internal consistency and were able to infer the general conclusions of the research question regarding the intersections of homelessness, traditional knowledge and mental health. Furthermore, the sample of sixteen participants led to a saturation of the results, which also improved the reliability and validity.

Induction in qualitative research, however, does have some limitations. The process of induction has the potential to lead the researcher to false conclusions (Davidson, 2003) as it does not assume the scientific standard and confidence that can be gathered through quantitative methods such as with probability, and thus proposes limitations in drawing conclusions in confirming hypotheses or theories (Bonk, 2008; Rudnick, 2014). What induction in qualitative research does provide, however, is the quality of information regarding a specific phenomenon through the vast knowledge of those who have had shared experiences. The richness of such research can provide more accuracy in regards to informing policy and practice for servicing a specific population (Rudnick, 2014). A limitation to this, however, is identified by Popper (1959) in that replications of such research can become a challenge, especially regarding the inter-rater reliability in qualitative research methods. To address the reliability concerns, an analysis of the data was also conferred through a comparative analysis by the research team, which increased the inter-rater reliability.
Generalization

Scientific research primarily involves inference from data that can be applied with confidence to a broader population of interest. Generalizability, however, has noted more controversy in qualitative research methods (Creswell, 2005). The results of qualitative research are essential to the growth in literature and in adding depth and detail to the knowledge regarding a specific population or concepts. As such, the qualitative results provide information in the context and further in a greater social phenomenon. As such there are some limitations that extend beyond the aforementioned ones in terms of the generalization of qualitative research results. For instance, in reference to Indigenous research specifically, McCormick (1996) notes the challenges of generalization of data within and amongst the Indigenous communities, as there are so many variables between Indigenous groups, nations, communities and families. This was especially of note in the limitations of generalization in this study, as the Indigenous community in one particular Canadian city is heterogeneous, which makes it difficult to generalize.

In keeping with Indigenous research ethics and within an Indigenous paradigm, community collaboration is important to generalization and advancement in research benefiting the greater Indigenous community in that direct input of the Indigenous peoples is important in terms of research design that ensures the authentic results that are in line with the local community protocols (Piquemal, 2001). As such, apart from the community collaboration from service providers who work within an Indigenous diverse urban community, an Elder known in the local urban Indigenous community was also consulted with; the Elder was also made available for all the participants who participated in this study.

Defining traditional knowledge

Another limitation regarding the generalization of this study includes the difficulty faced in defining traditional knowledge. In a general sense, traditional knowledge can be quite difficult to define, as each culture includes a different set of values knowledge and paradigm that is known to them as being their specific knowledge system toward life (Lee, 1995). Furthermore, Indigenous traditional knowledge is a distinctive value system regarding environments that have been passed down through the generations over thousands of years (Alfred, 1999). Thus, every Indigenous culture, nation, community and family can have their own sets of traditional knowledge systems and what it means for them. It is important to note in the context of this
research scope, as mentioned, that the diversity of the Indigenous community of the city is very heterogeneous, as many Indigenous peoples have migrated to the city from all over Canada. Therefore, traditional knowledge and value systems would have been very different for each participant.

Lastly, the mainstream conception of Indigenous knowledge is also viewed as a limitation since it is rooted in colonial constructs and takes from the original meaning. For instance, Robins and Dewar (2011) note:

> The term traditional- is also a British colonial concept and disliked by many Indigenous groups and is a term that many scholars have introduced to Indigenous people in English. Most Indigenous healing practitioners around the world would have referenced a complex set of medical practices and beliefs simply as medicine (p. 2).

Furthermore, there are often errors in labelling the Indigenous traditional healing from a mainstream Western lens in the realms of research, as there are often conceptualizations that traditional knowledge needs to fit within a paradigm of science and religion. Robbins and Dewar (2011) further posit the challenges with this, in that many mainstream institutions that have developed out of these paradigms have explored and attempted to understand the traditional healings through the lenses of a Western paradigm (i.e., university departments, governmental departments, etc.).

Overall, despite the limitations of this study, the lumpsum strengths and contributions to the advancements in psychological research and in the benefit of the Indigenous community were found to be significant. This was especially true for the needs and value of the Indigenous homeless community in this particular large city. It must be particularly noted here, as was earlier, that qualitative research has value in promoting improved service delivery and in strengthening the policy advancements (Rudnick, 2014). As such, the results of this research hold many implications for policy development, education and training, as well as for overall understanding the experience of the Indigenous homeless peoples in this particular urban centre.
Implications

The results of this study concluded with the various aspects in regard to the current gaps within the system that pose as barriers toward access and thus, contribute to the maintenance of health disparity for the Indigenous homeless. Results also indicate identity and psychological factors that can be incorporated into the conceptualization of mental health and trauma issues for Indigenous homeless, as well as a bridge in results of the current racism and continued oppression that was noted to have significant effects in terms of self-esteem for the participants in this study. As such, there are significant implications for education and practice for the current psychological models and healthcare practice.

Public health and housing policy

The results of this research recognized the various barriers in terms of public health policy that influenced the experiences of homelessness for the Indigenous peoples. In this context, the incorporation of traditional knowledge and healing methods in mainstream public health sectors must be particularly noted. One of the main challenges in community health is in protecting the vulnerable populations. The results of this study further point to the failure of the system in protecting and supporting the vulnerable peoples, such as the Indigenous homeless. Specifically, public health policies are required to address the social health factors that contribute to and perpetuate Indigenous homelessness.

In 2012, a public health workshop was held in order to address specific challenges in public health response, and utilization for Indigenous peoples (Richardson, Driedger, Pizzi, Wu, & Moghadas, 2012). This strategy also focused on the social determinants of health and strategies for addressing the gap in the utilization of services by Indigenous peoples, despite the high health disparities observed in many Indigenous communities. The results of this study complemented the concerns that were in that workshop, noting the importance of incorporating Indigenous health strategies and approaches into the domain of healthcare.

Inequities in access to healthcare and service utilization among the Canadian Indigenous people has also been regarded as a significant issue in the literature regarding public health concerns for the Indigenous peoples (Peiris, Brown, & Cass, 2008; Richardson et al., 2012). These studies recognize the extent as well as the disparity of particular health variables and trends amongst the
Indigenous communities; however, they fail to inform policy in regards to aspects of change to address the said health issues. As such, this research contributes to the advancement of public health policy as it notes, specifically, the positive outcomes of incorporating Indigenous approaches to the domain of health care.

In terms of the environmental factors that were addressed and recognized in the health trajectories of the experiences of Indigenous homeless, this fit with the concepts of psychosocial stress. This is believed to be a common phenomenon seen in many vulnerable populations, and it highlights the significant systemic and social barriers that exist for the vulnerable populations in accessing and seeking health care. Paradies (2006) connects this social issue with the adverse health outcomes that have been observed in the Indigenous communities. This concept can further be applied to the public health policy for Indigenous peoples experiencing homelessness, in that power dynamics, discrimination and dominant models of mainstream healthcare rooted in Eurocentric frameworks. These models continue to oppress and marginalize the vulnerable populations such as Indigenous homeless, as it creates a further divide in accessing the health services for those who need them (Cass et al., 2002). Furthermore, there have been other relevant factors that have contributed to the barriers to accessing health care; some of these factors are communication dynamics and sharing of health information, language and literacy. More specifically, it has been documented that in health care for the Indigenous people, the power dynamic directly affects its communication (Peiris, Brown, & Cass, 2008).

In order to better understand the gap in health inequities amongst the Indigenous and non-Indigenous populations, the United Nations’ Human Development Index has been applied to Canada so as to understand these differences in the quality of life and wellbeing between the Indigenous and non-Indigenous populations (Carino, 2009). Overall, Canada has consistently ranked within the top five nations in the world; however, many Indigenous communities in the nation are still living in third world conditions (Richardson et al., 2012). As noted in the results section of this research, systemic barriers and government policies are a significant aspect of the experiences of Indigenous homeless peoples.

The results of this study also recognized the need for a structured housing policy that focuses on the multilevel needs of the individuals experiencing mental health and addictions issues at varying levels of severity. The housing needs were also recognized as being important, as many
of the individuals have migrated to the city from reserve communities, many who were living in homes in substandard conditions.

The Mental Health Commission of Canada (MHCC) has recommended the development of a national strategy relating to mental health services and housing (Munn-Rivard, 2014). It proposes that the strategy is accompanied by a national assessment of the current need for, and supply of, high-quality housing with related supports for the individuals who suffer from mental health problems (Munn-Rivard, 2014). As such, this strategy is in line with what the results indicated from this study. Additionally, this research could help inform this policy in regards to the model of care indicated for risk factors and time to intervene for the appropriate housing and mental health services.

**Mental health services, policy and training programs**

The participants in this study also recognized the need for including the mental health and historical contexts of health for Indigenous peoples in mental health training programs. The participants noted significant experiences of racism and oppression that were believed to have had a negative effect on self-esteem. Such experiences have been further noted in the literature and have also been associated with the underuse of services by Indigenous people (Duran, 1990; Stewart, 2007b). Furthermore, as indicated, many mental health providers are not properly educated or informed about the Indigenous issues, nor are they educated in colonial history. As mentioned earlier, many providers are also non-Indigenous (Wilkes, 2013). Other research (Juntunen & Morin, 2004), also noted the early termination of therapy by Indigenous peoples, when the therapists are not properly informed, educated, or are practising from a primarily Western model of mental health. As such, the results of this research provided the aspects of identity that are important to the therapeutic understanding of Indigenous homeless people. The participants also discussed the need for a holistic Indigenous approach to mental health strategies with the Indigenous people and speculated that it should be introduced during the training.

The need of Indigenous pedagogies and understanding of mental health infused into interventions in order to improve Indigenous mental health has also been significantly noted in the literature. A blended approach has been acknowledged in being more suitable to the mental health and addictions needs of Indigenous people; however, it has also been acknowledged by Indigenous scholars as an essential aspect of healing for the Indigenous communities, families
and individuals to heal from the colonial phenomena (Kirmayer et al., 2000). Furthermore, research in other countries with colonial histories, such as New Zealand, Australia and the United States has demonstrated similar patterns of mental health issues among the Indigenous populations (Capp, Deane, & Lambert, 2001; Strickland, Walsh, & Cooper, 2006; Gone, 2007).

It can, therefore, be safely said that training needs to focus on the integration of the Indigenous approaches to mental health, into the scope of the mainstream psychological and therapeutic frameworks. What this study also suggests is that training specializes on the factors on mental health and the known social determinants of health, as well as on the pre-existing mental health issues that are a significant risk factor into homelessness. Furthermore, in practices, these issues need to be prioritized. Thus, individuals who are at the imminent risk of homelessness, or are in the initial state of homelessness, need to be prioritized, as this study demonstrated that this is the best time to intervene and promote change.

The results of this study also identified the key importance of having traditional Healers and Elders as an integral component of counselling and psychological approaches for addressing the issues of addictions and trauma. This was consistent with the scholars who have suggested that collaboration with traditional helpers is integral to improving mental health care for the Indigenous peoples (Gone, 2004; LaFramboise, Trimble, & Mohatt, 1990; Poonwassie & Charter, 2005; Wyrostok & Paulson, 2000). As the participants in this study recognized a high importance in community collaboration and having the presence as a traditional person, training should also focus on the appropriate and respectful interactions with Indigenous Healers and Elders (i.e., presenting with tobacco); moreover, it should also encourage healthy and open relationships between the clinician and the traditional healer or Elder in terms of collaborative conceptualization and care. A study by Oulanova & Moodley (2010) showed that the counsellors who incorporated Indigenous healing and approaches to mental health did not seem to encounter difficulties in consulting with and referring their clients to traditional helpers. They suggested that this was a result of the healthy integration of both Indigenous and Western approaches that were not seen as binary or opposing, but rather as integrative. As was mentioned in the discussion chapter, integrative models that focus on a blend of both Indigenous holistic approaches and Western psychological frameworks should be the standard of care when working with the Indigenous peoples.
The integration of Indigenous approaches to mental health includes re-connection to culture and establishing a sense of community, as indicated in the results of this research. Stewart (2007b) notes the Indigenous models of helping and healing that could be incorporated into the therapy process include: medicine wheel teachings (holistic view of four quadrants: north- healthy body, south- inner spirits, east- healthy minds, west- inner peace); storytelling; advice from Elders; interconnectedness with the family and the community; healing circles (round robin, usually started by an Elder; and ceremony (sweet grass use, vision quest, sweat lodge, drumming, sun dance, and more). As such, an integrative model would also encompass a holistic approach to understanding the individual in terms of their identity, psychological symptoms and social functioning. For instance, Stewart (2008) indicates that,

An Indigenous counselling relationship, practising from a holistic approach means including more than only the ‘mental’ as the focus of counselling. Counsellors should include all four aspects of the self to address whatever problem or issues in order to address health and healing from a holistic approach (p. 16).

As previously noted, discrimination and stigma continues to be a significant barrier in terms of access and continued attendance in the utilization of mental health services of the Indigenous peoples. The participants in this study addressed this issue, with the added layer of the stigma that comes with the state of homelessness. As such, the counsellor training should further involve the processes of personal bias, position in the therapy relationship, as well as their own background and education and how it interacts with that of the Indigenous person whom they are helping. It is suggested that this process should begin by the student counsellors acknowledging, exploring and clarifying their own values, worldviews, and beliefs that are related to their own culture and that of those who are different to them (Arthur & Collins, 2005). Stewart (2007b) further notes that this can be incorporated into counsellor education through cultural self-awareness exercises (Arthur & Collins, 2005; Johannes & Erwin, 2004); journaling exercises; interacting with others from one’s own culture as well as other cultures (individual and group field trips); and actively seeking knowledge and learning about diverse cultures.

The Ontario Federation of Indian Friendship Centres (2013) has published an Aboriginal Mental Health Strategy. This strategy works as an excellent framework and tool to guide the mental health education and training for mental health service providers working with Indigenous
peoples in working toward a blended integrative approach. There is a focus on the history of Indigenous peoples in Canada, a cultural framework for mental health as well as the key concepts of Indigenous mental health. It also highlights their specific needs such as social determinants of health and aspects of colonization and Residential School. And the subsequent mental health challenges observed in Indigenous communities as a result. The strategy also focuses on policy as well as the goals for the community in terms of Indigenous mental health strategies. As such, given the needs recognized by the participants in this study specifically, this strategy can be utilized in the services throughout urban areas in order to better assume the health needs for the Indigenous homeless peoples residing in cities.

The study especially noted that access to service was a major barrier toward trauma healing and recovery. As such, the agencies need to be aware and informed of the services available to Indigenous peoples, in order to help support and promote the utilization of the appropriate services that can be available for them. For instance, there are mental health policies set in place for mental health by Health Canada, available through the First Nations and Inuit Health Branch (FNIB), which funds community-based mental health and addiction services for short-term clinical crisis, as well as for the Residential School survivors (Crisis Counselling benefits; National Native Drug and Alcohol Abuse Program; Health Canada, 2016). However, there has been some critique in the literature (Maar et al., 2009) suggesting that the range and quality of these programs are inadequate to address the complexity of the mental health and trauma needs of the Indigenous peoples.

Overall, in terms of mental health policy and services implication, the results of this study recognized a high need for better education and training of service workers and counsellors who work with the Indigenous people, especially those who are at risk or are currently homeless. Two main factors in appropriate care following training would include cultural competent service provision, as well as cultural safety within the health care dynamic.

**Cultural safety**

As mentioned earlier, racism and stigma were identified to be parts of a significant barrier towards the participants in this study in terms of access to mental health services. As such, cultural safety was recognized as a significant factor in the recovery and healing journey for the participants in their experiences of exiting homelessness. Therefore, it is recognized that the
influences of cultural safety within the services should be significantly factored into the standard of care and practice.

The literature describes cultural safety as an important framework for the development of training programs and institutional changes with the intent to improve the quality and appropriateness of mental health care (Aboriginal Nurses Association of Canada, 2009; Smye, Josewski, & Kendall, 2010). The necessity to include cultural safety into all health practice recognizes the structural inequalities and power imbalances that make clinical encounters unsafe for the Indigenous people (Brascoupe & Waters, 2009; Papps & Ramsden, 1996; Walker, Cromarty, Kelly, & St. Pierre-Hansen, 2009).

To extend what was recognized regarding the Aboriginal Mental Health Strategy (2013), The college of Physicians and Surgeons developed a core curriculum and clinical interviewing training program for the development and practice of cultural safety (The Indigenous Physicians Association of Canada, 2009). Training is inclusive of reading, discussion, role playing and interaction with trainers from Indigenous communities to provide: basic understanding of the links between historical and current government practices and policies toward First Nations, Metis and Inuit people and the social determinants of health, access to health services and intergenerational health outcomes; reflection on trainees’ own cultural values as well as emotional responses to the history, identities and contemporary events involving First Nations, Inuit and Metis people (Kirmayer et al., 2011).

**Cultural competence**

Cultural competence involves attitudes, knowledge and skills that enable a mental health professional to provide competent, equitable, and effective care to meet the diverse needs of all the patients (Qureshi, Collazos, Ramos, & Casas, 2008). As indicated above, this was recognized as a significant need in terms of health promotion and addressing the current barrier as well as the needs of Indigenous homeless individuals with issues of both mental health and addictions. This requires additional training in the health care systems that address the basic cultural issues including the clinician’s own identity and relationship with patients from diverse backgrounds; communication skills and familiarity with how to work with interpreters and culture brokers; conceptual models of how cultural context and background influence developmental processes, psychopathology, help-seeking, coping; and adaptation to illness, treatment response, healing
recovery and wellbeing, as well as the moral and ethical issues (Fung, Anderman, Zaretsky, & Lo, 2008; Kirmayer, Rousseau, Jarvis, & Guzder, 2008).

Kirmayer and colleagues (2011) propose a cultural competence model that recognizes didactic teaching, mentorship, and supervised experience in specific clinical and community settings in order to address each of these domains. At a minimum, this would be inclusive of:

1. The opportunity to explore and reflect on one’s own cultural background and identity as a resource and a source of bias, and to address the interpersonal and institutional dynamics of racism, power disparities, social exclusion and acculturative stress as they impact the domain of mental health and clinical work.

2. Basic knowledge of current research and conceptual models in cultural psychiatry, medical anthropology and cross-cultural psychology, which is relevant and ample for understanding the social and cultural influences of psychopathology as well as cultural influences on the mechanisms of psychopathology as well as the cultural variations in symptom expression, help-seeking, treatment adherence as well as response.

3. Training in working with the medical interpreters and cultural brokers as well as immigrant settlement workers, community workers, counsellors, helpers and Healers (Blake, 2003).

4. Familiarity with the values, perspectives, and experiences of the local communities pertinent to psychiatric care, including ethnocultural groups, immigrants, and refugees across all age groups and life cycle stages (child, youth, adult and Elder).

5. Experience collecting social and cultural information through individual and family interviewing and assessment in preparing cultural formulations as outlined in the DSM-V.

6. Experience negotiating treatment with individuals, families and wider community networks relevant to care for patients coming from diverse backgrounds.

Community-based groups, institutions and organizations are an important source of knowledge and resources. They can offer support, guidance and information on the needs, illness models and histories of the local group exposure to risk factors. Developing and working relationships with community-based organizations is an important skill for working in a diverse work setting.
Taken together from the results of this study, combined with the existing literature regarding the standard care of practice in the mental health service delivery for Indigenous peoples, it is highlighted that training and education regarding counsellors, to ensure appropriate cultural safety and competence when working with complex mental health needs to be exhibited among the Indigenous homeless community.

Directions for Future Research

Although the scope of this research study focused on the overall health disparities involved in the intersections of traditional knowledge, mental health and homelessness; many strengths were also identified in terms of resilience and community connection in the overall experiences of the participants in this study. As such, the future research should include strength-based models of care and examine the experiences of the Indigenous peoples who thrive in the face of adversity. This would be especially important regarding the further research for the outcomes of Indigenous peoples who were able to recover from addictions or other mental health issues, as well as exiting the state of homelessness.

Furthermore, the models of resilience require systematic rethinking in order to address the processes and dimensions that may be distinctive or especially important for specific groups such unique cultures, histories, social and geographical settings, and the definitions of health and wellbeing (Burack, Blinder, Flores, & Fitch, 2007; Fleming & Ledogar, 2008). Thus, the future research on resilience for Indigenous people would need to develop appropriate models that are consistent with both an Indigenous approach to research; as well as include a more Indigenous definition of what resilience means for the Indigenous community, since the term ‘resilience’ tends to be framed in as an individual and Westernized characteristic (Kirmayer, Sedhev, & Whitley, 2009).

As such, for the Canadian Indigenous peoples, ideas of what is termed ‘resilience’ are grounded in the cultural values that have endured despite colonization and cultural genocide; these ideas have formed a sense of renewal and reconnection of the Indigenous identities. These are inclusive of culturally distinctive concepts of the person, the importance of collective history, the richness of Indigenous languages and traditions, as well as the importance of individual and collective agency and activism (Kirmayer et al., 2011). Therefore, in terms of Indigenous identity and resilience, Kirmayer (2007) recognizes the aspects of Indigenous personhood rooted
in the identity; such as in a person’s connection to the land and environment and spirits. Future research would then be required to address the aspects of collective resilience in Indigenous communities (i.e., efforts to revitalize the language, culture, and spirituality) and one’s individual identity, as resources for individual and collective healing.

The future research should also focus on the outcomes of success in the integrative models on psychological well-being and reports of emotional distress for Indigenous peoples. Apart from a small number of cases that report the incorporation of healing rituals into conventional counselling interventions (Heilbron & Guttman, 2000; Wilbur, Wilbur, Garrett, & Yuhas, 2001); as well as a few papers proposing integration of ceremonies into individual therapy (Garrett & Garrett, 2002; Robbins, 2001) and group therapy (Garrett & Crutcheld, 1997; Garrett, Garrett, & Brotherton, 2001; Walkingstick, Garrett, & Osborne, 1995), the general conceptualization of traditional healing integration in counselling and psychotherapy is lacking. Thus, the future research should look at (a) quality of care and (b) program evaluation for mental health practitioners who do utilize an integrative, Indigenous, hybrid and or holistic model of care. These should be examined for the experiences of those using the services, as well as an evaluation should be made to determine the counsellor education, cultural safety and competence.

Additionally, the future research should also examine the outcomes of the interactions of traditional Healers and Elders and counsellors, social workers, and psychotherapists/psychologists. This is imperative to the integration of models of care in conjunction with hybrid models that utilize both Western and Indigenous paradigms. Tillson (2002) notes that many Elders are still very cautious about bringing traditional teachings into the open and building professional relationships with the non-Indigenous people who are working within the community. Currently, there continues to be a gap in the research between community practice of traditional healing and the few cases that are available for review in the traditional healing literature. In order to close this gap in the literature and within the services, Martin-Hill (2009b) notes that it is important that researchers and service providers develop and nurture meaningful long-term relationships with the Indigenous communities and Healers.
Overall, the future research needs to continue to build on the strengths of Indigenous peoples and focus on the collaboration of researchers and service providers with Indigenous communities so as to promote well-being, recovery and healing for Indigenous homeless.

**Researcher Reflections**

This study has affected the researcher in many ways and has been significant to both professional development as a researcher, clinician, and as a person. This research has also influenced the researcher personally in the relationships encountered on both professionally and personally. This project has given opportunity for the researcher to reflect on the ways that she sees herself in relation to Indigenous peoples, especially being aware of personal and colonial history, white privilege, and the value system of Canadian colonial law and how it influences peoples both interpersonally and intrapersonally.

When the researcher first began her academic journey as an undergraduate student, she was exposed to the disproportionate health problems within Indigenous communities, especially through the high rates of addiction and over-representation in the Canadian Justice System. It was then that the researcher began to learn about various Indigenous issues and Canadian politics such as the Residential School system and the Indian Act. Having been born and raised in Canada, the researcher was appalled by the fact that her secondary school education ignored these issues and facts of history; and which therefore brought to light her own ignorance. Thus began the researcher’s journey in supporting Indigenous community members as an advocate for mental health and social issues.

As a graduate student, the researcher has been both privileged and fortunate to work under the supervision of Dr. Suzanne Stewart, who is a world leader in Indigenous health promotion, Indigenous homelessness, and mental health. Under Dr. Stewart’s guidance, the researcher has been active within the Indigenous communities, and it was where the researcher worked on the initial harm-reduction and homelessness project in 2011, that the researcher became aware of the importance and strength of community-based research. It has been through this mentorship that the researcher has been able to have the first-hand experience the benefits and strength of hybrid models of care, as they have been modelled by Dr. Stewart throughout the researcher’s clinical doctoral training.
As such, the experience of conducting this research, which promises to be beneficial for the advancement of the psychological literature, as well as for the policy models that inform clinical practice with Indigenous peoples, has been extraordinarily rewarding for the researcher. As such, the collaboration with the community partner, and having the results of this project used to inform their services, as well as for program and policy development, has been an important component of this research. Furthermore, this project has also continued the researcher’s efforts and learning in conducting and practising culturally safe and ethically appropriate research with the collaboration of the Indigenous community agencies and members. This study continues to inspire the researcher’s passion for working with vulnerable populations such as the Indigenous homeless, and further a path regarding Indigenous healing and mental health services and in continuing a role as an advocate and supporter. As such, the researcher will continue to grow and learn from involvement, connection, and work with the Indigenous communities in strengthening the field of Indigenous psychology, and also in the researcher’s own personal growth as a helper.

**Conclusion**

The main objective of this project sought to explore the intersections of homelessness, traditional knowledge and mental health, specifically trauma, for the Indigenous peoples living in a large Canadian city. The research question guiding this study was: *what are the intersections of trauma, mental health and traditional knowledge for urban Indigenous homeless people?* A qualitative research design was used, which utilized the narrative inquiry in order to gather the stories of the sixteen individual participants who were self-identified Indigenous peoples currently, or had previously experienced homelessness. This study was conducted through a partnership with an Indigenous community agency, which was involved in all aspects of the study including design, data collection, analysis and dissemination.

This study revealed the psychological factors, cultural identity and external factors as being integral in the overall experiences of homelessness. Furthermore, these factors were recognized as being important in terms of traditional knowledge and Indigenous cultural connection, as well as in the presence of mental health and wellness, especially in terms of trauma. The results of this study help identify a need for integrative mental health services that focus on the Indigenous culture as a strength in the promotion of healing and recovery.
Furthermore, the results have many implications for the improvement of the current models of mental health care that embrace the Indigenous approaches to mental health and trauma supports. These results also provide rich data in terms of the actual lived experiences of marginalized people that have been silenced in many ways and are thus, a powerful model for future research. As such, the results presented in this study complement and support existing research in the literature, recognizing the importance of cultural connection and the utilization of the Indigenous approaches and paradigms in the mental health and trauma service field, in order for them to regain a sense of autonomy in their own health, and to begin healing from the continued and long-lasting effects of colonization.
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Are you an educator, employment or mental health counsellor or social service worker who has worked with Aboriginal homeless peoples? Or you a self-identified Indigenous person who has accessed homeless services in a large Canadian city?

I am from the Yellowknife Dene Nation and am currently an Associate Professor in Counselling Psychology at OISE – University of Toronto. I am interested in exploring the supports and challenges of Aboriginal (First Nations, Metis, and Inuit) traditional knowledge in addressing the life transition needs of homeless Aboriginal peoples.

To participate in this project you must:
1) Have worked or currently work as an educator, employment, mental health, or traditional counsellor or social service worker and have knowledge of the needs of urban Aboriginal homeless peoples. OR
2) Be a self-identified Indigenous person who has accessed homeless service. If you might be interested, please contact me by phone or email.

Mahsi – Miigwetch -- Thank you very much!

In Spirit,

Suzanne L. Stewart
Appendix B

Participant Consent Form

Aboriginal homelessness and life transitions

Individual Interview

You are being invited to participate in a study entitled *Aboriginal Homelessness and Life Transitions*. The research team for this project is led by Dr Suzanne L. Stewart, a faculty member at the Ontario Institute for Studies in Education at the University of Toronto. Other team members include Ms. Tera Beaulieu, PhD candidate, Ms Nicole Elliott, PhD student, and Ms Mikaela Gabriel, MA student at the OISE and research assistants (RAs) for this project, and other OISE RAs, community-based research assistants, and Community Partners. If you have any questions or concerns about the project, you may contact Dr Stewart at (416) 978-0723 or suzanne.stewart@utoronto.ca or the three graduate research assistants, Teresa Beaulieu at t.beaulieu@utoronto.ca; Nicole Elliott nic.elliott@utoronto.ca or Mikaela Gabriel at (416) 978-0688.

This research is being funded by the Social Sciences and Humanities Research Council of Canada.

Results from our previous research that examined Aboriginal people’s experiences of the supports, challenges, and barriers they have faced or are facing in lifestyles or episodes of homelessness. Results from that study showed that urban Aboriginal homeless peoples have a number of life needs related to education, employment and mental health, that are being unmet. The purpose of this research is to explore how Aboriginal traditional knowledge may be used to address the needs of Aboriginal homeless peoples. The research questioned being investigated is: “What are the supports and challenges of Aboriginal traditional knowledge in addressing the life transition needs (education, employment and mental health) of urban Aboriginal (First Nations, Metis and Inuit) homeless populations?” Research of this type is important because the results will help improve educational, career and mental health services for supporting homeless Aboriginal peoples.

You are being invited to participate because you are either an educator, employment or mental health counsellor and have knowledge of working with the urban Aboriginal homeless population or you are a self-identified Indigenous person who is a recipient of such services and have indicated interest in sharing your perspectives on the supports and challenges of Aboriginal traditional knowledge in addressing the life transition needs of the Aboriginal homeless. If you agree to voluntarily participate in this research, your participation will consist of one audio-taped interview with one of the above researchers (about 60 minutes). The focus of the interview will be on your perspectives of Aboriginal traditional knowledge in addressing the life transition needs of the Aboriginal homeless.

We do not anticipate that involvement in this research would involve any substantial inconvenience for you other than the time to travel to and participate in the interview.
It is not anticipated that participants will experience any more than medium risks or discomforts beyond those present in daily engagements, for service providers within the workplace, or for service recipients within engagement in usual services in which they regularly engage, however medium risks for all participants may include emotional discomfort/distress or embarrassment and will be addressed by the interviewers who will check in with participants regarding emotional or psychological discomfort throughout the interview or if they notice a participant’s discomfort or distress; at which point the interviewer will stop the interview and provide immediate crisis support to the participant if the participant consents verbally to this, as all researchers conducting interviews are MA or PHD students in counselling/clinical psychology. If participants are not interested in immediate support from interviewers then they will be referred for immediate support service from a list of counselling/mental health support resources. All participants will also be provided with a list of counselling/mental health support resources for immediate counselling services in case they experience any psychological or emotional distress or discomfort after the interview.

There is a medium potential for social risk and legal risks as the interviews are both intended to be anonymous and confidential from co-workers, supervisors, social service agency staff, and other users of social services/agencies, yet others associated with providing or receiving homeless services may see some participants engaging with the researchers. The legal risks are also medium risk, as topics within the research interview questions might be associated with criminality—e.g., relating to drug use—and hence might be associated with external pressure on the researcher to disclose data (for example, under subpoena).

The potential benefits of your participation in this research include contributing to the knowledge and development of promising practices in working with urban Aboriginal homeless peoples. Your participation will provide new information on the supports and challenges associated with the use of Aboriginal traditional knowledge in addressing life transition needs (education, employment, mental health).

As a way to compensate you for your participation, you will be given a $20.00 gift certificate at the time of the interview. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to be a participant in this study, this form of compensation to you must not be coercive. If you would not otherwise choose to participate if the compensation was not offered, then you should decline. Should you withdraw from the study at any time the honorarium is yours to keep.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time, or refuse to answer certain questions without any consequences or any explanation. This withdrawal will not affect you in your workplace in any way and will remain confidential. In the event that you withdraw from this study, your taped interview will be erased and the transcript and all field notes or data associated with you will be destroyed. In the event that you withdraw from the study part way through you will be asked if you want the data you have contributed to be part of the analysis. If you agree your data will remain in the study, if not your taped interview will be erased and the transcript and all field notes or data associated with you will be destroyed.

To preserve your confidentiality, your name will not appear on any of the data, as a code will be assigned to replace your name on the interview audio tapes, on the interview transcripts, and in all notes. There will be no key to link codes with the interview data. Signed consent letters
(which contain identifiable information) will also be stored separately from any data and be
destroyed within 14 days of the first interview, once we have scheduled the second interview.
Your confidentiality will be protected by storing interview audiotapes and the transcribed data in
a locked filing cabinet with all data password protected and encrypted. Only the research team
will have access to the data. The audio-tapes from your interview will be destroyed at the same
time as the consent letters, within 14 days after the first interview. The transcribed data, and any
notes taken during the interview will be destroyed after five years.

Research findings will be communicated to participants, local community members and
interested professionals through interactive workshops. The results of the study will be published
in peer-reviewed journals, in various scholarly publications, and will be presented at professional
and/or scholarly conferences. Summary results will also be posted on an Internet website. In
addition to being able to contact the researcher and/or research assistant as above, you may
verify the ethical approval of this study, or raise any concerns you might have, by contacting the
Ethics Review Office, 416-946-3273 or ethics.review@utoronto.ca.

Your signature below indicates that you understand the above conditions of participation in this
study and that you have had the opportunity to have your questions answered by the researchers.

_________________________    __________
Participant Signature          Date

Participant Name (please print) ________________________________
Appendix C

Honorarium receipt

I have received an honorarium for participation in this research ____________
(participant initials).

My signature below indicates I received $20.00 gift certificate from ____________ for
participating in this interview.

_________________________ _________________________
Participant Signature Date

A COPY OF THIS CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL BE