Everything Is Related and It All Leads Up to My Mental Well-Being: A Qualitative Study of the Determinants of Mental Wellness Amongst Urban Indigenous Elders

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Abstract

Indigenous peoples in Canada often experience a greater burden of poor health and wellness relative to non-Indigenous Canadians due to a legacy of colonisation and racism. However, Indigenous mental wellness outcomes vary by community, and it is essential to understand how a community has been impacted by the determinants to improve mental wellness outcomes. This article shares insight from a research partnership with the Ki-Low-Na Friendship Society, an urban Indigenous community service organisation. The study used a decolonising, qualitative methodology in which urban Indigenous Elders shared their knowledge of mental wellness and experiences of services and supports. Elders described mental wellness holistically, connected to their relationships, land, language and culture. They described several determinants of wellness including identity, poverty, transportation, abuse and trauma. Elders shared experiences of culturally unsafe care and identified colonisation as root causes of poor mental wellness. They shared how some determinants affect urban Indigenous communities uniquely. This included limited transportation to cultural activities

outside urban centres, such as medicine picking, the importance of urban organisations (such as Aboriginal Friendship Centres) in developing social support networks, and the role of discrimination, racism and inequitable care as barriers to accessing services in urban centres.

Keywords: aging and older people, Indigenous Elders, mental health, qualitative methods, urban issues

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Background

Indigenous peoples in Canada (First Nations, Métis and Inuit) often experience a greater burden of poor health and wellness relative to non-Indigenous Canadians due to a legacy of colonisation and racism. Traumas resulting from colonisation and the resulting impact on mental wellness of Indigenous peoples in Canada are well established in academic literature. In a scoping review on the impact of residential school attendance on Indigenous health and well-being in a Canadian setting, [Wilk *et al.* \(2017\)](#) found that trauma associated with residential schools is amplified over time and carried across generations (i.e. intergenerational). Further, the review of forty-three studies associated residential schools with adverse mental health outcomes including mental distress, depression, substance use, stress and suicide ([Anderson, 2015](#); [Corrado and Cohen, 2003](#); [Dionne, 2008](#); [Elias *et al.*, 2012](#); [Hackett *et al.*, 2016](#); [Stout, 2010](#); [Walls and Whitbeck, 2011](#)).

These health disparities are highly correlated with inequity in the social determinants of health (SDoH), which extend beyond traditional boundaries of health care ([World Health Organization Commission on Social Determinants of Health, 2008](#)). However, conventional understandings of SDoH fail to explain social inequities experienced by Indigenous peoples in Canada as they do not account for process and experience of historical and contemporary colonisation. To address this gap, [Wien and Reading \(2009\)](#) proposed an alternative framework for social determinants of Indigenous wellness, including three levels of determinants:

- Proximal: Factors that have 'direct impact on physical, emotional, mental or spiritual health' of Indigenous peoples (p. 5). These include health behaviours, physical environment, social environment, employment, income, education and food security.
- Intermediate: Infrastructure, resources, systems and capacities that impact proximal determinants (the 'origins' of the proximal determinants) (p. 15). These include Indigenous access (physical, political and social) to health-care systems, educational systems,

environmental stewardship, cultural continuity, community infrastructure, resources and capacity.

- Distal: ‘Political, economic, and social contexts that construct both intermediate and proximal determinants’ (p. 20). These include racism, social exclusion and self-determination. Distal determinants are the social forces that shape intermediate and proximal determinants of Indigenous wellness.

Suboptimal determinants of Indigenous health and wellness have contributed to poor mental wellness outcomes in many Indigenous communities in Canada. For example, according to data from the Aboriginal Peoples Survey ([Statistics Canada, 2016](#)), off-reserve First Nations people aged fifteen and over were less likely to report their mental health as excellent or very good compared with the general population. Further, First Nations peoples were more likely to be diagnosed with an anxiety disorder, mood disorder or report suicidal thoughts at some point in their lives. Prevalence of domestic violence was also higher amongst Indigenous versus non-Indigenous peoples in Canada. For example, [Daoud et al. \(2013\)](#) found Indigenous mothers were two times more likely to experience intimate partner violence than non-Indigenous mothers, even after statistically controlling for other variables such as socio-economic status.

However, it is essential to understand that while disparities in Indigenous and non-Indigenous mental wellness exist at the population level in Canada, this is an oversimplification of the wellness of Indigenous peoples and communities. Indigenous mental wellness outcomes vary by community; [Chandler and Lalonde \(2008\)](#) found suicide rates amongst First Nations youth in British Columbia varied by band from virtually non-existent to over 800 times the national average. The authors found a strong, positive association between increased cultural continuity/self-governance and reduced rates of suicide. These findings indicate diverse experiences of colonisation and ongoing colonial processes, resulting in a range of health outcomes within and between communities ([Wien and Reading, 2009](#)). For example, a critical determinant of Indigenous health is whether individuals or communities live in community (‘on-reserve’), in rural areas or in urban centres. It is essential to address these disparities by understanding how a community has been impacted by the SDoH to improve Indigenous health through effective policy, service planning and delivery.

According to 2011 census data, over half of Indigenous peoples in Canada lived in urban settings ([Government of Canada, 2016](#)). Despite urban Indigenous peoples being the fastest growing and youngest population in Canada, Indigenous health research and statistical reporting most often depict Indigenous peoples as living in community, rural, or remote areas. The dearth of research on urban populations has resulted in an underrepresentation of urban Indigenous peoples in academic literature ([Nelson and Wilson, 2017](#); [Young, 2003](#)). Because urban-dwelling

Indigenous peoples may experience proximal, intermediate and distal determinants of health differently than in community, health policies and services need to be informed by the unique needs and experiences of urban Indigenous communities.

There is a scarcity of published literature on the mental wellness of Indigenous Elders and urban populations. In a scoping review of 223 articles on mental health of Indigenous peoples in Canada, [Nelson and Wilson \(2017\)](#) found only one article that focused on Elders' mental health, and two that focused on mental health in urban Indigenous populations. There were no articles focused on mental health or wellness of urban Indigenous Elders. The purpose of this article is to share insights gleaned from a research partnership with a local, urban-based Indigenous community service organisations, the Ki-Low-Na Friendship Society (KFS), to address the gap in knowledge regarding how urban Indigenous Elders in Kelowna, BC, are uniquely impacted by the social determinants of mental wellness.

Methods

The purpose of this study was to describe the knowledge and experiences that urban Indigenous adults shared about social determinants of mental wellness. Please note, this project uses the term mental 'wellness', as opposed to 'health' as a non-clinical term, recommended by the Community Advisory Committee (CAC) to (i) reduce stigma associated with the topic, (ii) reflect holistic well-being, and (iii) take a strengths-based approach that acknowledges wellness achieved despite the considerable barriers of racism and colonisation.

Findings presented here are part of a larger qualitative study exploring the knowledge and experiences of mental wellness amongst urban Indigenous Elders in Kelowna, BC. The overarching goal of this study was to use a decolonising methodology to provide a space in which urban Indigenous adults (aged fifty-five years and above) had opportunities to share their knowledge and experiences of mental wellness. The specific aims of the project were to explore:

- the knowledge of mental wellness from the perspectives of urban Indigenous Elders and
- mental wellness services and supports as experienced by urban Indigenous Elders.

Methodology

This project was grounded in postcolonial theory and, therefore, used a decolonising methodology. [Kurtz \(2013\)](#) describes decolonising methodology:

Because scientific research of the world's Indigenous people has been historically linked to colonization, this research aimed to decolonize ... developing ongoing respectful reciprocal relationships shaped by the urban [community's] ... ways of knowing and doing, guided by their ethics, protocols and methods throughout all aspects of the research. (p. 233)

Postcolonial theory, often used to inform social work, nursing and medicine, emphasises race as a social construct, and ways in which racism and social processes are linked to colonial practices that adversely affect health outcomes, examining social justice and ways in which power relations are created, maintained and can be changed (Browne *et al.*, 2005). Postcolonialism is a theoretical approach that strives for decolonisation through 'revealing and dismantling colonialist power in all its forms' (Ashcroft *et al.*, 2006, p. 56), including academic and research institutions. As part of a decolonising research process, postcolonialism:

- reorients the power dynamic, imploring researchers to share control over the research process with the people who have been colonised;
- establishes a reciprocal relationship of learning between researchers and participants; and
- emphasises Indigenous theory, knowledge and culturally integrative methods to avoid perpetuating the biases inherent in colonialist methodologies (Chilisa, 2011).

In keeping with a postcolonial approach, a CAC and the university research team (with experience in nursing, health promotion and Indigenous methodologies) established the study design. The CAC recommended a qualitative methodology: by having participants define the relationship between wellness and other aspects of life, this methodology reinforced the postcolonial aim of decolonising the research by invoking and privileging participants' knowledge of mental wellness.

Postcolonialism has been critiqued in the literature for implying colonialism is of the past; however, authors such as Smith (1999) argue this is not the case, contending colonialism continues to affect contemporary social, economic and political processes. The authors of this paper acknowledge the contemporary impact of colonisation on the lives of Indigenous peoples and use the term 'postcolonial' as defined by Browne *et al.* (2005) to acknowledge past and current perpetuating acts of colonisation.

Study design

Community advisory committee

In compliance with the Tri-Council Policy Statement (TCPS), Chapter 9 Research Involving the First Nations, Inuit and Métis Peoples of Canada

(Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada, 2014), the community was engaged in the study design of this project from inception. In Canada, Friendship Centres play an important role in supporting urban Indigenous peoples. Therefore, before moving ahead with the project, the research team approached the Executive Director, Edna Terbasket, on behalf of the KFS regarding participation in the project. Ms Terbasket agreed and recommended establishing a CAC. CAC members, selected by Ms Terbasket, were approached by K.S. following traditional protocol of presenting tobacco and requesting their support and guidance of the project. All three CAC members had lived experience and expertise in Indigenous wellness programme planning and delivery. Guidance from the CAC was sought at each stage of the research process from inception, guiding the study design and subsequent interpretation of data to ensure the study design was culturally integrative and results were appropriate and relevant to the community.

Inviting participants to share wisdom

The CAC suggested the minimum age of fifty-five years for people interested in joining the study. They stated that at this age Elders qualify to participate in KFS Elders programming. This age limit is also consistent with previous literature on mental health in older Indigenous adults (eSchure *et al.*, 2013). Inclusion criteria for participants included: (i) urban-living, (ii) Indigenous, and (iii) aged fifty-five years and older. Exclusion criteria included: not being able to participate in English. Key stakeholders (recommended by Ms Terbasket and the research team) were invited via email invitations to attend the preliminary sharing circle to share their knowledge and hopes for the project.

The research team recruited community members for participation in sharing circles and interviews using convenience sampling (Mays and Pope, 1995), with presentations at KFS Elder's luncheons and by posters placed in public spaces at KFS. The presentations and posters requested interested individuals contact K.S. or N.O. for further information about participation.

Protocols

As recommended by Wilson and Restoule (2010), the project followed local protocol and ceremony during data collection. Overseen by CAC members, protocol included having an Elder to open the project with a prayer before data collection and asking an Elder to pray at the beginning of each sharing circle. Each time they participated in a sharing

circle or interview participants were compensated \$25.00 for their time and expertise, provided with bus tickets, and given a traditional gift of tobacco to thank them for sharing their knowledge and honour their contribution.

Information sharing and gathering

This project used individual interviews and sharing circles to collect data. These methods were culturally appropriate according to the CAC and were well-established Indigenous research methodologies (Chilisa, 2011). Interview and sharing circle guides (approved by the CAC) were adapted from Hulko *et al.* (2010).

The CAC recommended beginning data collection with a sharing circle, facilitated by K.S. and N.O. Community members and key stakeholders were invited to define mental wellness for Indigenous Elders living in urban settings and to share their goals for the project. Following sharing circle protocol Elders spoke one at a time and, holding a talking stick, shared their stories and goals.

Following the initial sharing circle, a semi-structured interview guide was developed (Creswell, 2007). Given the legacy of oppression and silencing of Indigenous voice in research, providing opportunities for participants to expand on topics or points they felt were relevant was an important part of the postcolonial approach (Hulko *et al.*, 2010; Kurtz *et al.*, 2008). Interviews were forty-five minutes to two hours in length. Questions that guided the interviews included:

- Tell me about what mental wellness means to you.
- Do you think experiences of mental wellness might be different for urban versus on-reserve Indigenous people? How?
- Where do you go when you are concerned about mental wellness in urban areas?
 - What would make these services better for you?

A final sharing circle was held after analysis of the initial sharing circle and interview transcripts were completed. This circle, facilitated by K.S. and N.O., shared preliminary insights from the interviews and initial sharing circle. Participants were asked if the themes accurately represented their experiences, and provided feedback in an open discussion rather than following Traditional Sharing Circle protocol.

Data analysis

Interview and sharing circle transcripts were thematically analysed (Creswell, 2007). Qualitative data analysis software was used in the analysis for coding and sorting codes into themes.

Member checking

Member checking was used to establish internal validity (Mays and Pope, 1995; Morse *et al.*, 2002). Member checking is consistent with a postcolonial methodology because it ensures participant control over how they are represented in the final results (Chilisa, 2011). This project used a combination of individual and group member checking. The project team conducted individual member checking by providing participants with a summary of themes and select quotes from their interviews. The researchers provided an interpretation of the quotes, and participants were invited to meet with K.S. to discuss any concerns or issues they had with the themes, quotes or interpretation. The final sharing circle was also used to establish internal validity. Participants from the first sharing circle and interviews were invited back to the final sharing circle. In the final sharing circle, K.S. presented the themes. Participants confirmed the themes honoured their intended messages and suggested additional themes that were missing.

Ethical considerations

In compliance with the TCPS (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2014), the project team obtained a letter of support from the KFS board and drafted/signed a community research agreement with KFS representatives.

Participants provided informed consent. In some Indigenous communities, written consent is not culturally appropriate (Chilisa, 2011). As such, the project team offered participants the option to provide verbal consent. K.S. asked in the sharing circles and interviews if participants preferred their data to have names and identifiers removed, or if they preferred to be identified as the source of their knowledge and stories. Elders who wished to remain anonymous have been identified by a pseudonym. Pseudonyms are indicated with an asterisk in the results. All other participants have been identified by name.

This research project received approval from the University of Calgary and the University of British Columbia Okanagan ethics boards.

A note on writing style

In presenting the results of the data analysis, the authors adapted a literary tool put forth by Wilson (2008) in his Indigenous research methodologies textbook, *Research Is Ceremony*. Like Wilson's writing, the author's voice (presented in regular font) serves to define the idea and

connect it to the overarching theme(s). Elders' voices (presented in italic font) provide the context for ideas and themes. By presenting voices together, the text reflects the relationships that were central to developing the results, acknowledging the contribution of each to this project.

The authors also used Wilson's tool to promote an agenda of reconciliation via the text. By centring the experiences of urban Indigenous Elders in their own words, readers are offered the opportunity to practice relationality with the Elders through the stories.

Results

The preliminary sharing circle had eight participants, including six community members ($n=6$) and two community stakeholders ($n=2$). Individual interviews included nine urban Indigenous adults aged fifty-five and over ($n=9$). Seven community Elders ($n=7$) and two CAC members ($n=2$) participated in the final sharing circle. The groups were not mutually exclusive, and a total of twelve different community members participated in different components of the data collection. There were five themes identified as part of this project:

- Holistic wellness
- Determinants of mental wellness
- Poor mental wellness outcomes
- Mental wellness as a healing journey
- Services and Supports.

Due to the breadth of findings in this project, two themes, Holistic wellness and Determinants of mental wellness, will be shared. The remaining themes will be elaborated upon in future publications.

Holistic wellness

In response to the question, 'What does mental wellness mean to you?' Elders described it holistically and within the medicine wheel model of four quadrants (mental, physical, emotional and spiritual) explicitly or implicitly. They further connected mental wellness to relationships with family, friends and the land.

Well, it's [...] physical health, emotional health, spiritual health. [...] It's a whole package. [...] I think physical health has a lot to do with personal mental health, and so what you do to your body impacts you in some way. [...] The medicine wheel is the Aboriginal way of dealing with all parts of your health. I think that's all part of mental wellness [...] all part of your body and mind, your soul. Your living environment also is part of your mental wellness, part of your living. (Simon Moses, interview)

Elders spoke about the power of culture in healing and mental wellness, and the significance of the connection between language and culture. They described the significance of language in communication and the transference of cultural values (e.g. connection to the land).

In Cree, we believe that the language is the culture and the culture is the language and the two go hand-in-hand. [...] I listen to the group and what I'm hearing collectively is the longing for the language. [...] I think part of that healing journey is listening to the language. (Dorothy Goodeye, sharing circle)

Elders related mental wellness to a relationship with the land by describing how physical connection to the land (i.e. being in nature) helps balance the mental, emotional, spiritual and physical aspects of wellness.

We do need to help balance ourselves in our way of life. [...] When we stir up the emotions, you realize that sometimes you need to just go for a walk, which is the physical part. And when you're out on your walk, the physical part allows you to feel that connection of your spirituality, at least that's with me. I can find it that way. The spirituality in a lot of things that we are connected to, such as even the smallest of things, is a blessing in disguise. So, I truly believe in making that balance of mentality, physical, and emotions. (Leonard Raphael, interview)

Elders discussed the importance of family in maintaining mental wellness. The significance of extended family (including close friendships) was identified as particularly important in urban settings when Elders left their home communities, often leaving the support of their family behind. In many cases, these extended families were built through participation in community organisations such as KFS.

I've found that my family has been the most important to me. And that's my immediate family, but also my extended family, the family that I've built up in the urban community. Because when you move to the urban community from the reserve, you don't usually have family that lived there, you don't have the support of the family, the extended family of the community that you have on the reserve. So, you've got to find that and make it for yourself. (Mary*, sharing circle)

Determinants of mental wellness

Proximal determinants

Elders mentioned many experiences related to proximal determinants of health, including identity, poverty, transportation, abuse and trauma. They shared the importance of Indigenous identity in orienting ones'

self to create and maintain mental wellness. However, when discussing mental wellness, they also spoke about the importance of identity in terms of belonging to a family or community.

When I think of Indigenous wellness, in situating myself within the intergenerational piece of knowing who I am and where I come from. I need to pay attention to who I am and where I come from. (Vanessa Mitchell [service provider], sharing circle)

Due to ongoing stigma and racism surrounding Indigenous identity, one participant was unaware of her ancestry until later in life.

Now I didn't find out that I had Aboriginal blood in me until I was over 40, and I remember my dad married – it's on my dad's side- and when he married my mother he never told her. [...] My dad's generation, they [...] didn't want to admit there was Aboriginal blood in them. (Jessica, sharing circle)*

Transportation challenges were noted as limiting people from engaging in activities intended to promote mental wellness. A. Mason discussed the importance of cultural practices such as medicine picking, which served to maintain mental wellness. He said that lack of transportation options is a barrier to participation in such cultural practices as they often occur outside urban centres not serviced via public transportation.

So, a lot of that we do [...] we prepare our foods, preserve foods. I pick berries, I pick medicines, and so I'm always active [...] I think a person needs family support, you know, transportation, to be able to do all those things. (A. Mason, interview)

Trauma was discussed as a root cause of becoming mentally unwell later in life. Allan Ermoff described the physical abuse he endured as a child; however, he also shared desire to not follow in those footprints, and to provide a safe environment when he had his own family.

My Dad was really mean when he drank. But when he was onboard as a captain he was good, you know, he was a really nice man. [...] But he would always come home and my sisters [would say], 'he's drunk, better go hide.' [...] I'd find places to hide otherwise he'd beat me up. So, what that taught me was that I treat my children the way I wanted my Dad to treat me. (Allan Ermoff, sharing circle)

Intermediate determinants

Elders shared several instances in which they received care or had interactions with health-care providers that were culturally unsafe. Culturally

unsafe environments caused Elders to be fearful of health-care services and to actively avoid using them.

Our people are very scared of doctors. [...] And sometimes we don't trust the doctors. We don't trust them because we don't know what they're going to give us. And sometimes that can harm our body. [...] That's why when I was smoking and I was coughing for three days, I didn't go to the hospital because I'm scared of hospitals. [...] A lot of our people are like that. It's, sometimes it's trust, sometimes we're shy, sometimes we just - that's just the way our people are, you know. (George Pierce, interview)

Janice found the lack of Indigenous care providers resulted in experiences of discrimination for Indigenous clients. It is also a barrier to communication, as non-Indigenous care providers are often unfamiliar with the culture and root causes of poor mental wellness outcomes in Indigenous populations.

It bugged me, [counsellors] dealing with First Nations and they're white, and what the hell do they know about, about us? Except they're just arrogant and they, they'd rather get the pay [...] they're white and they don't know the culture. (Janice August, interview)

Distal determinants

Elders pointed to historical and contemporary colonisation as a root cause of poor mental wellness, including residential schools, the 'Sixties Scoop' and ongoing removal of Indigenous children into foster care. Several Elders spoke about the time they spent in residential schools, and the impact it had on their mental wellness.

I truly realized that residential school wasn't the best of things for a lot of our people, because [before] we always had the freedom of learning from our Elders, learning from our parents. All of that being taken away as we were starting to [...] grow up. I felt that being taken away from the family structure was, well, it's, it's a hurting feeling in one's heart to be torn away from the family like that. (Leonard Raphael, interview)

The trauma affecting mental wellness is not limited to individuals. As Simon Moses shares, mental wellness concerns are common across communities affected by trauma because of colonisation.

I had a very good friend I went to school with, I think he's now my life friend, he had a beautiful son. [His son] went through the alcohol stage and I heard about it, so I phoned and he was very distraught and he was actually ashamed of it. [...] I could not find the words to console him, so all I could say was - you're not the only community that's having problems with that. It's the whole Aboriginal community. (Simon Moses, interview)

Discrimination and racism were mentioned as significant barriers to mental wellness.

I mean, people say that 'oh, there's no racism here and there's no, there's not this and not that' but they don't walk in our shoes and they don't know. [...] Frequently, I confront assumptions about who I am, and discrimination for who I am. [...] Very often people assume that I have problems with substance abuse. I've been asked if I've been an alcoholic. I've been asked if I've lived on the streets. (Mary, sharing circle)*

Shirley spoke of the discrimination she and her family experienced early in her life and how this impacted her present self-worth and identity.

It finally dawned on me where that trauma came, why I feel the way I do. Because up to about now, I always feel like I'm not good enough. I'm not worthy enough. And that [foster mother], she was white, [...] always putting us down, the way we lived at the village. [...] And she always put me down or put my family down [...] just mocking the way we were. [...] That's why I never really thought highly of myself. (Shirley, interview)

Mary talked about cultural safety and the significance of developing respectful relationships between providers and patients. She also shared her frustration with white privilege being detrimental to developing respectful relationships, and the significance of hiring Indigenous health-care providers to help create a culturally safe space.

I think that I have to mention cultural safety. It's so important. It's something that should be a way of being for everyone, so that we can develop respectful relationships with no matter who it is. And I think that if you've lived with white privilege, you have no idea of what we have experienced in our life. [...] I like to go where my own people are. [...] If I know where our people are, like the Ki-Low-Na Friendship Society, I'd rather go there than to go elsewhere. (Mary, interview)*

George spoke about the meaning and impact of developing trust between service providers and patients, and the role of trust in a person's willingness to access services.

A lot of [Indigenous people] are scared to reach out for help. And I was, I was scared to reach out for help. I wouldn't go - holy man! I can't go up to you and talk to you because I didn't even know a person. I didn't know anybody. (George Pierce, interview)

Discussion

The Elders described mental wellness as part of overall holistic well-being. This description of mental wellness reflects previous definitions of

mental wellness in the literature (McCormick, 2009; Vukic *et al.*, 2011). However, what is significant in this study is that the Elders highlighted several dimensions of mental wellness unique to urban Indigenous populations. The Elders said relocation from their home communities to urban centres posed a barrier to mental wellness. There were two main reasons for this: first, they reported feeling isolated in urban communities, with less social support to draw on compared to the extensive social support networks available to many in their home communities. This is similar to findings in the literature reporting family and community involvement is essential in Indigenous care planning and healing (Kirmayer *et al.*, 2003; McCabe, 2007; McCormick, 2009) and the association between social supports and 'thriving health' amongst Indigenous peoples (Richmond *et al.*, 2007, p. 1,827). Provincial and national Indigenous health frameworks recommend interventions that promote individual, family and community healing (Health Canada, 2015; Tripartite First Nations Health Plan, 2013); however, social support was described as significantly pertinent for urban dwelling individuals as relocation often separates Elders from family, friends and their communities. When working with clients, social workers can use this knowledge to ensure opportunities for family and community participation (e.g. family counseling and/or group programming) are included as part of holistic services and supports for urban Indigenous Elders.

Second, Elders described how relocation to urban centres often limited their access to traditional activities. They talked about being unable to access traditional land-based activities that occur outside city limits (e.g. medicine picking) as they aged and became reliant on friends, family or public transportation. Lack of transportation outside the urban centre limited their access to activities that have positive influences on their mental wellness. Access, including transportation, to land-based activities is vital for mental wellness programming for urban Elders. Social workers and other health and social service providers can facilitate the incorporation of land-based healing into mental wellness and healing services and can work with Elders to understand and overcome barriers to access (e.g. transportation). Further, partnerships with urban Indigenous organisations can be leveraged by frontline social workers and at the systems level to sustainably provide support for holistic and land-based wellness and healing.

While the Elders acknowledged spirituality as a critical aspect of mental wellness, they also emphasised the vast diversity in cultural and spiritual practices of their communities and the importance of accommodating diversity in service planning and delivery. Health and social service providers such as social workers can advocate for, and implement in their own practice, service planning and delivery that recognises diversity within and between Indigenous individuals and communities (Hart-Wasekeesikaw

and Gregory, 2009; National Aboriginal Health Organization, 2006). Structurally, urban wellness and social service organisations can review and revise their policies and procedures to accommodate flexible care planning and delivery to reflect diversity amongst Indigenous service users.

While much of the existing literature focuses on inaccessible and limited supports and services in rural and remote areas, discrimination, racism and inequitable care continue to pose a considerable barrier to access in urban centres (Goodman *et al.*, 2017). Elders confirmed many urban Indigenous peoples in their community actively avoid using culturally unsafe health-care services (i.e. those that undermine cultural identity) which instill fear, fail to treat Indigenous peoples with dignity or respect, are highly discriminatory, and recreate power dynamics experienced in colonial institutions such as residential school. In addition, culturally unsafe health and social services are a symptom of broader social isolation and marginalisation, operating as both a cause of poor mental wellness and a barrier to healing mental wellness (Nelson and Wilson, 2017).

As a key stakeholder in mental wellness service planning and delivery, the call for cultural safety in social work is compelling and essential for ethical, respectful, and safe care. Because much social work practice has been historically grounded in theoretical perspectives such as anti-oppressive practice, social work is uniquely positioned to embed principles of cultural safety into practice. While anti-oppressive practices are grounded in 'notion of equality, rights and justice, and non-discrimination' (Rutman *et al.*, 2005, p.156), cultural safety acknowledges causal factors which are deeply rooted in colonial ideologies that shape systemic and individual determinants of health and wellness for Indigenous peoples in Canada.

To incorporate cultural safety into care, social work will need to address colonial roots of ineffective and harmful mental wellness and social services that have negatively impacted urban Indigenous peoples in Canada. Further, incorporation of cultural safety into social work practice will require decolonisation of health and social service practice, programmes and policies. Decolonisation requires providers and decision/policymakers to practice self-reflection to deconstruct their power and privilege and the impact of their power and privilege in creating and maintaining inequitable power dynamics, which reinforce colonial practice in health and social services. By recommending increasing the numbers of Indigenous frontline staff, and emphasising establishing trusting, reciprocal relationships with clients, the Elders in this project provided valuable insight on how to improve mainstream health and social services for urban Indigenous Elders.

Implications for global strategies

In 2015, the United Nations developed a strategy to address the social determinants that contribute to poverty and inequity on a global scale, called the Sustainable Development Goals (SDGs) ([United Nations, 2018](#)). The strategy builds on the anti-poverty targets of the Millennium Development Goals, and provides targets for health and wellness, education and poverty. The SDGs provide a framework by which social workers, and other health-care professionals, can develop policy and practice guidelines to address the SDoH, promote equity and improve health and wellness outcomes.

The results of this project echo and reinforce many of the goals and their associated targets (i.e. Goal 1: No poverty; Goal 2: Good health and well-being; Goal 4: Quality education; Goal 16: Peace, justice and strong institutions). However, this study indicates diverse experiences of colonisation amongst Indigenous Peoples in Canada. Therefore, because colonisation affects lives socially, politically and economically, the impact of poverty and inequity on Indigenous peoples is also diverse. The results of this project thereby indicate the SDGs will need to be interpreted through a decolonising, postcolonial lens, mindfully considering how these processes have impacted Indigenous communities specially and differently (e.g. urban versus in-community). Further research is required to better understand how diverse experiences and perspectives of the determinants of wellness, including poverty and inequity, can be effectively addressed through the implementation of the SDGs.

Limitations

There are a few limitations of this project. First, because participants opted into participation in the study, a sampling bias may have been introduced (e.g. because KFS offers holistic services grounded in Indigenous knowledge as alternatives to mainstream services, individuals may have been more likely than the general population to subscribe to a holistic worldview); however, the results of this qualitative study were not intended to be generalisable to the population, and internal validity was established through member checking.

Second, because K.S. is not Indigenous, her worldview may have impacted the collection and interpretation of the data (e.g. she may have missed the nuances or significance of stories shared [[Chilisa, 2011](#)]); however, the effect was mitigated via member checking, and through guidance of the CAC who reviewed the data as it was collected and reviewed.

Finally, the third limitation was the inclusion criteria of English speaking only for participants. This criterion was selected based on project

timeline and lack of interpreter resources; however, excluding participants who do not speak the dominant, colonial language runs counter to a postcolonial approach. The authors would recommend postcolonial research be cognizant of this limitation and prioritise the inclusion of Indigenous language speakers to further decolonise the research process.

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