Knowledge Mobilization Plan

Knowledge Synthesis: COVID-19 in Mental Health and Substance Use

Instructions:
The Operating Grant: Knowledge Synthesis: COVID-19 in Mental Health and Substance Use was designed to enable the development of rapid and timely knowledge syntheses and related knowledge mobilization plans to address evidence gaps and build the evidence base as part of the mental health and substance use response to COVID-19.

As outlined in the conditions of funding, funded teams are required to submit a plain language, knowledge mobilization plan with recommendations to decision makers/knowledge users on how to mobilize the outcomes of the synthesis. Information recorded in this report may be made available to policy makers, healthcare and service providers, partners, and the general public, and may be used to facilitate additional CIHR knowledge mobilization activities, and enable linkages between research teams and partners and/or knowledge users.


Email completed report to COVID19MH-COVID19SM@cihr-irsc.gc.ca by June 22, 2020.

Synthesis Title:
Niikaniganaw (All My Relations) II – the COVID-19 Rapid Response: Indigenous approaches to synthesizing knowledge for culturally-safe and stigma free mental health care for under-served Indigenous communities in Ottawa-Gatineau

Nominated Principal Applicant (name and affiliation):
Laperrière, Hélène (School of Nursing, University of Ottawa)

Knowledge mobilization goals:
• The purpose of this project is to respond rapidly to the impacts of COVID-19 by (1) synthesizing knowledge for culturally-safe and stigma free mental health care for under-served Indigenous communities in Ottawa-Gatineau, (2) offering an innovative ‘virtual’ cultural-safety intervention model that has been collaboratively developed and assessed with a variety of groups and is ready for scale-up across Canada to a rapid response to COVID-19 issues in Indigenous communities

List all knowledge users engaged in developing the knowledge synthesis:
• Building on the relationships and success of Niikaniganaw I and II, we have assembled an experienced and enthusiastic team for Niikaniganaw II-the COVID-19 rapid response that balances experienced and newer team members; Indigenous and allied stakeholders; academic, health professional, service provider and client perspectives; local languages (English and French); and cultural realities (Algonquin, Mohawk, Ojibwe, Métis, and non-Indigenous). Collectively, our team is a microcosm of the underserved Indigenous community in
Ottawa-Gatineau, including those who live with mental health and substance use concerns. All team members have worked together on Niikaniganaw I or II.

- Our team is formally led by Dr. Hélène Laperrière (PA, UOttawa), a bilingual scholar who brings an expertise in HIV/AIDS community-based research, with a specific interest in the role of civil society and participatory evaluation.
- **Traditional Knowledge Carrier Christina Bendevis** (PKU), excels at creating a safe, non-judgemental and welcoming space for all who wish to participate in ceremony. She also brings her vision of stigma-free mental health services for Indigenous people. This leadership team is supported by,
- **five Indigenous Knowledge Carriers and Traditional Helpers** (Sharp Dopler, Ross Saunders, Francine Desjardins, Neal Shannacappo, Michele Penney), who share a commitment to harm reduction, to gender inclusivity, and to providing ceremony for those who need it most, i.e., those with the least access to ceremony such as 2SLGBTQ, those who use substances, and those who have been disconnected from their culture for a variety of reasons.
- **Mike Laframboise** brings his Indigenous living experience of HIV and intersecting stigmas including culturally unsafe health and social services.
- **Seven community partners** (AIDS Committee of Ottawa, Drug Users Action League, Ottawa Inner City Health, Le Bras, ADOO, and Public Health Agency of Canada COVID-19 Quarantine Department) Ottawa Public Health representing frontline service organizations who serve the Indigenous community, will ensure that we are grounded in local community concern and are well-positioned to ‘take up’ the knowledge we share with each other to create immediate and lasting social change.
- Researchers (**Dr. Leah Layman-Pleet, Dre. Marie-Hélène Chomienne**) from two academic departments (Psychiatry, Medicine),
- nursing professionals (**Karina Pelletier**) and trainees (**Rana Annous, Ines Zombre**) ensure that our research can continue to build capacity for culturally-safe care in Ottawa-Gatineau.

**How could knowledge users (e.g. decision makers) use the outcomes of this synthesis?**

Consistent with the Indigenous Peoples’ Health Research Centre’s (IPHRC) approach to knowledge translation (Kaplan-Myrth & Smylie, 2006), our plan integrates a multifaceted and interactive strategy to link our findings to action (Masching, Allard & Prentice, 2006). Consistent with Niikaniganaw I and 2 we will share our process and findings through a robust, integrated and end-of-grant strategy that prioritizes KTE at three levels: 1) increasing knowledge and capacity for individual health care and social service providers; 2) increasing organizational capacity for culturally safe care and stigma-free mental health services; and 3) increasing knowledge and capacity in the broader society including academic and policy-maker audiences.

We are pursuing integrated knowledge translation (iKT) by including knowledge users as key members of the research team and ensuring that those individuals actively and meaningfully participate. Specifically, community partners and students who are the intended end-users of the information and lessons learned from our project, will be active participants and learners in the project. This is precisely the promise of experiential learning opportunities, is that participants ‘learn by doing’.
At each stage of the Niikaniganaw process, participants and team members are actively collaborating to create an experience that is unique to that moment but that also carries a broader, more generalized message of inclusion, connection and cultural safety. Participants will also be learning by observing and watching the way that the Niikaniganaw team creates and emulates a stigma free and culturally safe environment for Indigenous people living with, affected by, and at increased risk of HIV. Indigenous people with lived experience are integral to this process in all team activities. This provides an unparalleled opportunity to break down barriers and misconceptions between service providers, knowledge carriers, researchers, and students.

Potential barriers to successfully mobilizing/disseminating this knowledge:
The planned activities are in real-world and real-time. We acknowledge the intensity of the activities for participants that are challenging life and work. We believe that the virtual ceremonies offered an opportunity of expressions. We engaged about 20-25 members from May to October 2020.

Knowledge dissemination plan (complete the following table*):

Based on Niikaniganaw I and II, activities for this 6-months project fall into three inter-related categories: (1) We created meetings/ceremonies (2 for the first month, once a month/5 months) in virtual Indigenous spaces, co-facilitated by researchers and Knowledge Carriers. Each of these meetings integrate ceremony and culture with qualitative and quantitative data collection, as well as opportunities to reflect on the living experience with COVID-19 pandemic situation. (2) We documented and implemented the innovative ways of providing ceremonies at-distance and online for Indigenous people and stakeholders, using qualitative research approach including a series of Indigenous graphic novel-style images. (3) Simultaneously, we did a literature review on cultural-safety, indigenous health and COVID-19 and (4) We activated new social media tools with our Niikaniganaw website platforms to outreach and interconnect the Indigenous communities as well as social and health care providers, academics, students, partners as a kind of “virtual culturally-safe care” community.

<table>
<thead>
<tr>
<th>Product/Tactic/Strategy</th>
<th>Target audience(s)</th>
<th>Partner organization(s) engaged in knowledge dissemination</th>
<th>Timing</th>
<th>Will the product be bilingual (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virtual meetings/ceremonies safe space (n=6)</td>
<td>Indigenous and allied stakeholders; academic, health professional, service</td>
<td>20-25 Indigenous and non-Indigenous stakeholders from Ottawa-Gatineau,</td>
<td>June 22nd, June 29th, July 13th, August 24th, Septembe 21st,</td>
<td>N, but we do provide French material</td>
</tr>
</tbody>
</table>
provider and client perspectives; local languages (English and French); and cultural realities (Algonquin, Mohawk, Ojibwe, Métis, and non-Indigenous). Collectively, our team is a microcosm of the underserved Indigenous community in Ottawa-Gatineau, including those who live with mental health and substance use concerns. All team members have worked together on Niikaniganaw I or II. including researchers, nursing students, health professionals, service providers, Knowledge Carriers, Helpers, and Indigenous people who are living with, affected by, or at increased risk of HIV, STBBIs or who experience intersecting issues such substance use, mental health, homelessness or incarceration.

October 19th
Working Group to meet 4 times, *between Bigger group ceremony meeting*, to engage in on-going reflexive practice and plan for next meeting (n=6)

Indigenous and allied stakeholder s; academic, health professional, service provider and client perspectives; local languages (English and French); and cultural realities (Algonquin, Mohawk, Ojibwe, Mêtis, and non-Indigenous). Collectively, our team is a microcosm of the underserved Indigenous community in Ottawa-Gatineau, including those who live with mental health and substance use concerns. All team members

Niikaniganaw team (indigenous, non-indigenous, academic, community members)

Thursday afternoon, one a month, June to November 2020

English and French
A conceptual reflexive tool for cultural safety in virtual spaces. Working Group to meet 4 times, *between Bigger group ceremony meeting*, to engage in on-going reflexive practice and plan for next meeting.

<table>
<thead>
<tr>
<th>have worked together on Niikanigana w I or II.</th>
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<tbody>
<tr>
<td>Indigenous and allied stakeholders; academic, health professional, service provider and client perspectives; local languages (English and French); and cultural realities (Algonquin, Mohawk, Ojibwe, Métis, and non-Indigenous).</td>
</tr>
<tr>
<td>Niikaniganaw team (indigenous, non-indigenous, academic, community members)</td>
</tr>
<tr>
<td>Along the research process, use of Slack to include working team discussion between indigenous and non-indigenous members</td>
</tr>
<tr>
<td>English, and a final version in French</td>
</tr>
</tbody>
</table>

**A guide to culturally safe care – Indigenous health : Niikaniganw – All my Relations (pdf).**

**And Video**
[https://www.youtube.com/watch?v=H94Z1BYAD-4&feature=youtu.be](https://www.youtube.com/watch?v=H94Z1BYAD-4&feature=youtu.be)

<table>
<thead>
<tr>
<th>Nursing students and School of Nursing, University of Ottawa. High potential for diffusion at the national and</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nadège Guillemette, Aimée Iradukunda, Mélissa L’Abbé, Sophie Regnier, Seynab Sougal, Rana Annous, Neal Shannacappo</td>
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<tr>
<td>Already available online</td>
</tr>
<tr>
<td>Expect to provide a French version</td>
</tr>
</tbody>
</table>
international level for cultural-safety approach , Christina Bendevis, (tool created by
<table>
<thead>
<tr>
<th>Title</th>
<th>Details</th>
<th>Authors</th>
<th>Date</th>
<th>Language(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous artist to create a visual record (interpretive drawings – graphic novel style) of our time together to support KTE (a special chapter for our Niikaniganaw novel)</td>
<td>Indigenous and allied stakeholder s; academic, health professional, service provider and client perspectives; local languages (English and French); and cultural realities (Algonquin, Mohawk, Ojibwe, Métis, and non-Indigenous).</td>
<td>Neal Shannacappo, Oshkabewis (Traditional Helper) and a talented Indigenous artist with deep roots in the local community</td>
<td>From June to October 2020</td>
<td>English, French and other indigenous language</td>
</tr>
<tr>
<td>A literature review on cultural safe practices, indigenous mental health, COVID-19, harm reduction, and cultural-safety online practices.</td>
<td></td>
<td>Inès Zombre, PhD candidate in Population Health</td>
<td>November 2020</td>
<td>Bilingual</td>
</tr>
<tr>
<td>Activate new social media tools with our Niikaniganaw website platforms to outreach and interconnect the Indigenous communities as well as social and health care providers, academics, students, partners as a kind of “virtual culturally-safe care” community.</td>
<td>Indigenous and allied stakeholder s; academic, health professional , service provider and client perspectives ; local languages (English and French); and cultural realities (Algonquin, Mohawk, Ojibwe, Métis, and non-Indigenous).</td>
<td>Cristina Bendevi s (Spirit of the Rainbow Lodge) and Sharp Dopler (Sharp Solutions)</td>
<td>Starting in July 2020</td>
<td>English with a potential French version</td>
</tr>
</tbody>
</table>

*add lines as required*
Report on Niikaniganaw project N-COVID-19

I’m writing from the perspective of a Drum Carrier, Pipe Carrier, and one who honours those teachings passed on by my Ojibway, Algonquin, and Mohawk Elders.

Our approach was much in line with the teachings I follow from the medicine wheel. Each meeting was ceremony with songs and teachings shared, along with pipes being lifted. These are some of the medicines we carry and share, to offer much needed healing with our intentions focused on what was needed and called for in the present moment. We never plan, rehearse or practice what we share. This comes through our Spirit, our Orenda deep within. We feel these teachings with our humanity, knowing that we are all part of Creation, that we are part of that circle of life in this cosmos – Niikaniganaw – All My Relations.

When a song is sung and drummed, we address the 4 directions and the Center. Those 4 cardinal points of that medicine wheel, the Center addressing our Orenda (our spirit within) and all of the teachings that we carry associated with them. Some call them push ups. Here in this project it was incorporated into the 5 meetings. So, when sharing these teachings, there’s always hope that someone would connect with some aspect to support their struggles, learning from each other, as people share their experience with the restrictions of COVID-19. These are challenging times and we were able to support each other through these meetings – sometimes with much emotions. This is truly ceremony and an honouring in itself.

First, we started with the Eastern Doorway, where the sun rises, where those journeys begin, as the Eagle travels and watches over us all day. Nesema (tobacco) was offered to those offering ceremony and sharing teachings. “First with tobacco” is our tradition. This medicine first came to us to teach us reciprocity, to acknowledge an exchange and offer gratitude. My daughter when taught this understood and referred to it as ‘Spiritual Currency’. When we are first born, we are closest to spirit and are nurtured and cared for by our family. To offer a parallel, we began our journey together, as a community, a family of sort, connecting with Spirit, with Ceremony. We learned from each other as we took our baby steps into the knowing of our ways of being, how our spirituality and culture affects us, and how we would like to be treated in a culturally safe way. Our focus was on “What is the effect of COVID-19 on the mental health of health and social service providers who serve these communities?”

The second meeting was addressing the Southern Doorway, where we learn to navigate as a family, guided by the wolf’s way of living – as a pack, as a community supporting each other. When we begin our meetings, some of us are able to smudge with sage. This medicine helps us ground ourselves and cleanses to enable us to be there with an open heart and clears our minds to what we are there for. Sometimes we needed to pause and do this to support someone in need, even though virtually. In the youth of our group, there was much learning, albeit through much emotions – just like the youth living through their emotional state. Traditionally it is easier for youth to receive and be guided by Elders or Grandparents. In our case we had Knowledge Carriers willing to share teachings and their personal journeys with the group. Our focus was on “How they were receiving/adapting to the standard public health messaging?”
The third meeting was addressing the Western Doorway, where our ancestors wait for us, where we imitate the bear going into their dens, doing that internalization and reflection of ourselves. The group was sensitive to what each were going through during these times of confinement, restrictions, sickness and weariness. Cedar medicine is used in many lodges, ceremonies and there’s a good cedar tea to enjoy and cleanse. This doorway in our lives is focused on the working life, much like all the service providers, teachers, learners doing what they can to provide and receive care. Our focus was on “What does culturally-safe and stigma free care look like during COVID-19, and by extension, future pandemics or remove/isolated environments?”

The fourth meeting was addressing the Northern Doorway, where our Elders sit and share their teachings of all of the knowledge they’ve accumulated, their wisdom. As a community grandmother, I willingly share the teachings I carry with community. This reflects the Bison represented in this direction, which has shown the people its generosity by sustaining them. I was taught generosity and gratitude is the way of my people – the Haudenosaunee. “Be grateful, be kind to all, and take care of Mother Earth”. These are our original instructions as two-legged. Sweetgrass shows us and reminds us to show kindness and gentleness. That medicine is honoured by braiding it. We remind ourselves that a braid woven together is strong and creates that balance we need of feeding our mind, body and spirit. Our focus was on “How can we develop capacity for culturally-safe and stigma free care in the context of COVID-19?”

The fifth and final meeting addressed our Spirit within, our Orenda – the Center. We have lit a fire - our own fires to be tended and nurtured. As we go forward, we hope to have “an innovative ‘virtual’ culturally-safety intervention model that has been collaboratively developed and assessed with a variety of groups and is ready for scale-up across Canada to a rapid response to COVID-19 issues in Indigenous communities.”

It has been an honour to collaborate with this wellness-centered community. It gives me hope that there are folks who are caring and willing to learn our ways of being. We can go forward knowing that our next generation of care-givers will carry this forward in a good way. Nia:wengowa – thank you very much!

Francine Desjardins
Kateró:roks, She is watching
Kanien'kehá:ka or "Flint Stone Place" or "People of the Flint Nation" (Mohawk)
I acknowledge that the land on which I live is the traditional unceded territory of the Algonquin Anishinaabeg People. I offer my gratitude to them for their care of and teachings about our Mother Earth and all Our Relations. May we honour those teachings.
Niikaniganaw (All My Relations) II – the COVID-19 Rapid Response: Indigenous approaches to synthesizing knowledge for culturally-safe and stigma free mental health care for under-served Indigenous communities in Ottawa-Gatineau

Statistics on rapid sharing of results strategies with relevant knowledge users
(May to October 2020)

<table>
<thead>
<tr>
<th>OPERATIONAL AND PLANNING MEETINGS DATES</th>
<th>HOURS</th>
<th>PARTICIPATION</th>
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<tbody>
<tr>
<td>1 02/06/2020</td>
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<td>2 04/06/2020</td>
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<td>3 11/06/2020</td>
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<td>4 18/06/2020 am</td>
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<tr>
<td>5 18/06/2020 pm</td>
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<tr>
<td>6 25/06/2020 am</td>
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<td>7 25/06/2020 pm</td>
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<td>8 02/07/2020</td>
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<td>9 16/07/2020</td>
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<td>10 23/07/2020</td>
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<td>11 06/08/2020</td>
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<td>13 20/08/2020</td>
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<td>14 27/08/2020</td>
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<td>15 03/09/2020</td>
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<td>16 10/09/2020</td>
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<td>17 24/09/2020</td>
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<td>18 15/10/2020</td>
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<td>19 30/10/2020</td>
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<td>20 05/11/2020</td>
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<td>21 12/11/2020</td>
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<tr>
<td>22 Additional phone and email consultations</td>
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TOTAL: 22h  TOTAL: 10
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<tr>
<th>CEREMONY AND SHARING CIRCLES</th>
<th>HOURS</th>
<th>PARTICIPATION</th>
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<tbody>
<tr>
<td>1 22/06/2020 (welcome and orientation)</td>
<td></td>
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<tr>
<td>2 29/06/2020</td>
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<td>3 13/07/2020</td>
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<td>4 24/08/2020</td>
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<td>5 21/09/2020</td>
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<td>6 19/10/2020</td>
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<tr>
<td><strong>TOTAL:</strong> 15h</td>
<td><strong>TOTAL:</strong> 32</td>
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<thead>
<tr>
<th>NURSING STUDENTS TRAINING</th>
<th>HOURS</th>
<th>PARTICIPATION</th>
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<tbody>
<tr>
<td>1 17/09/2020</td>
<td></td>
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<tr>
<td>2 24/09/2020+ Invited speaker former nursing student</td>
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<td>3 01/10/2020</td>
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<td>4 08/10/2020</td>
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<td>5 15/10/2020</td>
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<td>6 22/10/2020+ two invited Indigenous team members</td>
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<td>7 05/11/2020</td>
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<td>8 12/11/2020</td>
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<tr>
<td>9 19/11/2020+one invited Indigenous team member</td>
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<td>10 26/11/2020</td>
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<tr>
<td><strong>TOTAL:</strong> 70h</td>
<td><strong>TOTAL:</strong> 10</td>
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<thead>
<tr>
<th>Knowledge transfer: Posters and presentations</th>
<th>HOURS</th>
<th>PARTICIPATION</th>
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<tbody>
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<td>1 Public Health 2020 14-16/10/2020</td>
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<tr>
<td>2 4th year nursing students NSG 3723</td>
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<tr>
<td>3 Graduate PhD nursing students</td>
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<td></td>
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<tr>
<td>4 Nursing research Rounds 24/11/2020</td>
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<tr>
<td><strong>TOTAL:</strong> 10h</td>
<td><strong>LARGE PUBLIC</strong></td>
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<tr>
<td>ADDITIONAL PUBLICATIONS</td>
<td>AUTHOR</td>
<td></td>
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<tr>
<td>-------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Graphic Novel chapter specific to this grant</td>
<td>Neal Shanacappo (in press)</td>
<td></td>
</tr>
<tr>
<td>Educational video and pamphlet produced</td>
<td>4th year nursing students trainees</td>
<td></td>
</tr>
<tr>
<td>Community report</td>
<td>Planning team</td>
<td></td>
</tr>
<tr>
<td>Narratives of perspectives on the co-constructed project Niikaniganaw – Covid-19’s response</td>
<td>Participants (to be continued in further project Niikaniganaw II)</td>
<td></td>
</tr>
</tbody>
</table>
Niikaniganaw (All My Relations) II – the COVID-19 Rapid Response: Indigenous approaches to synthesizing knowledge for culturally-safe and stigma free mental health care for under-served Indigenous communities in Ottawa-Gatineau

MAIN RESULTS AND RECOMMENDATIONS

I- IMPACT OF COVID-10 ON SERVICE USERS

1. Interruption in services

Many facilities and services were shut and cut-down leaving underserved Indigenous populations with a lack of access to support and to basic needs (clean clothes, bathrooms, food, medical care). Participants using substances had less access to safe injection sites.

2. Staying connected to networks of support

All participants spoke about the mental health impact of the lack of social interactions and face to face ceremony. Many lacked access to technology and Internet, which further complicated their access to care and their virtual participation. Virtual mental health services were hard to access and not satisfying. Many preferred not to have the service at all than to have to do sessions virtually. Even though having ceremony online was helpful, in many cases it was not enough or even triggered to mental health suffering.

3. The feeling of being understood:

Service users thought that it was helpful to see that service providers were going through the same frustrations in accessing the services as they were, since it gave them a sense of finally being understood!

II- IMPACT OF COVID-19 ON SERVICE PROVIDERS

1. Reacting to the crisis

Many service providers acknowledged the lack of services and inadequacy of COVID-19 response to the needs. Feeling helpless and not being able to respond to the needs of their clients was hard for them. Some members of the workforce were left on their own to find ways to respond to the situation and sometimes there was a time lag in the response to the clients’ needs.

2. Need for support

Service providers were undergoing stressful situations on both the personal and professional levels. That created the need for service providers to access mental health and well-being support, which was not always readily available, and many had to put their needs on hold.

Participating in the project increased their knowledge about Indigenous ceremonies and about the impact of Indigenous ways on the mental health needs of both Indigenous and non-Indigenous populations.
III-Therapy and caregiving roles

1. Helping the helper

Participating in the project allowed service providers to express the above-mentioned needs and frustrations in a safe space which became a precious resource of ‘helping the helper’. Also, Door teachings and ceremony shared by knowledge carriers echoed with the needs of participants in the time of COVID-19. It was clearly stated that there is a need for a more comprehensive mental health approach including both the workforce and service users to respond to the Domino effect created by the COVID-19 context.

2. Blurred roles

Therapy and caregiving roles were blurred. Since many service providers expressed their own need of accessing the services, Indigenous participants stepped in to provide therapy and guidance.

3. Acting outside the box

As employees of institutions, some social service providers felt their hand tied because of COVID-19 restrictions and being subversive to the shut-down. They had to come-up with individual initiatives to get essential things done for those who don’t have access to them, such as providing clothes and essential needs. Some healthcare service providers also changed their practices to be more inclusive of Indigenous ways of knowing as a step forward towards culturally safe care.

III-Virtual community-based research

1. Adapting the ceremonies.

Many procedures had to be adapted as we go to the virtual space and discussions were focusing on the pertinence and how-to of such practices as offering virtual tobacco, passing the feather in the virtual circle, and doing virtual smudging and drumming when sharing became emotionally intense in the circle. Despite the need for such adaptation, there was a fear of misuse of these protocols and that non-Indigenous institutions could found in them an easy alternative.

2. Reaching out to the most vulnerable

Quick and urgent actions were needed to reach participants who did not have access to computers, cellphones, or Internet, as well as to support them in the process of connecting to Zoom. Also, immediate actions were undertaken by participants to respond to underserved
Indigenous service users, such as distributing clothes or planning a travelling fire and outdoor ceremony.

**IV- Recommendations and next steps**

This project has confirmed the importance of continuing to grow community and capacity for culturally safe care in Ottawa-Gatineau and to scale up to other regions. Therefore, knowledge carriers and team members should continue providing ceremonies and virtual meetings to respond to the needs, mental health, and well-being of underserved Indigenous populations and overwhelmed service providers in the time COVID-19. Nevertheless, virtual ceremony should not be a replacement to face to face ceremonies.

Based on those expressed needs and on the conviction that ceremonies can still happen despite of the restrictions, it is on us to find ways to do ceremonies while respecting the safety procedures for COVID-19. For example, we could hold the pipe instead of smoking it, and plan outdoors ceremonies so as to respect participant numbers and distance requirements.

As next steps, our team is looking at ways to provide comprehensive and culturally safe mental health care to both service users and providers. Examples of such actions are to:

- Provide a safe space for Indigenous underserved populations as well as service providers who need support
- Provide a list of protocols adapted to the COVID-19 that can be shared with the service providers

We have also welcomed four nursing students on our team as part of their community health course, which led to a rich learning experience and the production of an educational video and pamphlet about cultural safety stigma free and an ‘ALL my relations’ perspective, which are described as a cornerstone of care that the COVID-19 pandemic further reinforced as a must-be norm in service provision.

We are also looking at maximising the use social media and the project’s website as a knowledge dissemination platform, publishing the educational tools that we have produced, the reports and the narratives from participants reflecting their experience.
Niikaniganaw (All My Relations)II: the Covid-19 rapid response

Context
The intersection of several inequities such as racism, stigma, and the experience of culturally unsafe care may explain the difficult access to health care and social services for Aboriginal people living with HIV/AIDS (IIPHAs) in the Ottawa/Gatineau. To this end, the Niikaniganaw participatory intervention was developed to define the capacity to provide culturally safe and stigma-free care and social services. This cultural safety intervention for non-Indigenous organizations who serve IIPHAs was a success with the various participants (Indigenous people living with HIV/AIDS, Indigenous knowledge Carriers, healthcare and social service providers, researchers, students, and community partners). As we approached Phase II of Niikaniganaw intervention which consists to synthetize knowledge for culturally-safe and stigma free mental health care for under-served Indigenous communities, our team has confronted new preoccupations regarding Covid-19 pandemic: How is COVID-19 affecting the mental health of Indigenous community members in Ottawa-Gatineau who are living with or affected by HIV or related issues, such as substance use, mental illness, poverty, or homelessness? How are they receiving / adapting to the standard public health messaging? What is the effect of COVID-19 on the mental health of health and social service providers who serve these communities? What does culturally-safe and stigma free care in health and social services look like in the age of COVID-19, and by extension, future pandemics or remote / isolated environments? How can we develop capacity for culturally-safe and stigma free mental health care for under-served Indigenous communities in Ottawa-Gatineau in the context of COVID-19? To answer these questions, the Niikaniganaw model will be adapt to the Covid-19 context.

Purpose of this literature review
- Present how off-reserve indigenous people are adapting to covid-19 public health measures
- Demonstrate the impact of Covid-19 and the related containment measures on access to mental health services and harm reduction services for indigenous people off-reserve.
- Emphasize the importance to have cultural ceremonies or Elders program as essential service during the pandemic
- Address the need for culturally-safe care in health and social services during pandemic

Search Strategy
Evidence will be identified through the following mechanisms:
- Provincial and Territorial Covid-19 government documents
- Snowball searching in reference lists from new articles
- Health database search (CINAHL, PubMed, ScienceDirect and PsycInfo) and Google scholars search with key- concepts
Notes to reader

- All data is from Canada, unless indicated otherwise
- This evidence summary is not an exhaustive literature review, as Canadian data is still emerging on many of these topics
- Gaps to be addressed are identified in *Italic* font

A. Data extraction table

<table>
<thead>
<tr>
<th>Topic</th>
<th>Synthesis</th>
<th>References</th>
</tr>
</thead>
</table>
| Covid-19 and Social Determinants of Health | Social and economic circumstances increase risk for Covid-19 infection and severe outcomes.  
  o Several socioeconomic factors such as gender, socioeconomic position, indigeneity, homelessness and incarceration limit ability to respect public health Covid-19 measures.  
  o For an equitable Covid-19 response, it is important to incorporate socioeconomic factors or Social Determinants of Health.  
  • Structural factors in Canadian society such as racism and colonization are also important structural determinant that increase Covid-19 risk for Indigenous and black population.  
  o Canadian neighbourhoods with the highest ethnic concentration and the lowest income present a higher percentage of confirmed positive Covid-19 tests. In additional, higher rate of hospitalization has been noted in the lowest income quantile in Toronto.  
  o Indigenous people and Black population in Canada are overrepresented among Canadians with low socioeconomic status  
  • Existing structural inequities such as unsuitable housing may contribute to increase Indigenous people Covid-19 risk.  
  o In Canada, 23% of First Nations people live in insecure housing and multi-generational households may be at particular risk for Covid infection.  
### Factors Determining Health:

- Social determinant of health and their relationship with Covid-19 outcomes are relevant and important for understanding inequalities and informing an equitable response to the pandemic.

### Indigenous community response to the pandemic

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>By drawing on cultural strengths to weather the covid-19 pandemic, many Indigenous communities are finding ways to take care of each other.</td>
<td></td>
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<tr>
<td>The Six-Nations of Grand River Territory⁴</td>
<td></td>
</tr>
<tr>
<td>While Indigenous people are in a uniquely vulnerable position when it comes to COVID-19 crisis, many communities are taking the lead in fighting the pandemic.</td>
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</tr>
<tr>
<td>The Six-Nations of Grand River territory is home to the largest population of all First Nations in Canada.</td>
<td></td>
</tr>
<tr>
<td>Their Covid-19 action plan is based on a balance of Western medicinal practices as well as practices regarding the traditional heritage.</td>
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</tr>
<tr>
<td>Their emergency response informed and guided by the proud and true history of their people and the colonial system that continues to shape their outcomes.</td>
<td></td>
</tr>
<tr>
<td>Pandemic response</td>
<td></td>
</tr>
<tr>
<td>To protect Elders who are their greatest resource of knowledge, wisdom and language</td>
<td></td>
</tr>
<tr>
<td>- They limited visits at local long-term care facility and began testing of all Elders and others warriors who help them.</td>
<td></td>
</tr>
<tr>
<td>To protect most vulnerable members, the project: Protect our people was implemented to restricted the flow of traffic in and out of the territory.</td>
<td></td>
</tr>
<tr>
<td>Pandemic recovery</td>
<td></td>
</tr>
<tr>
<td>The Indian Act gas created Indigenous communities riddled with over crowded homes, food security and underfunded healthcare systems that have created higher rates of illness – both physical and mental – and prime feeding grounds for viruses like COVID-19.</td>
<td></td>
</tr>
</tbody>
</table>

Six-Nations pandemic recovery plan will be guided by values of truth, consensus, equality and respect for each other and land.

By recognizing and incorporating these values, they are contributing to the reconciliation that is relevant and necessary for full prosperity of Indigenous peoples and Canadian.

Kakisa Community

- Kakisa, the smallest community of the Northwest Territories engage to raise awareness against Covid-19.
- Community members decided to distribute door-to-door pamphlets on best hand washing practices and information on the virus, including possible symptoms.

### Mental Health of Indigenous Populations during the Covid-19 Pandemic

| Data | Prior to the Covid-19 pandemic, 16% of Indigenous people off reserve reported fair or poor mental health, compared to 53% with excellent or very good mental health.
|      | During the pandemic, 38% of Indigenous people surveyed by Statistics Canada reported fair or poor mental health, while 31% indicated very good mental health.
|      | 60% indicated that their mental health has deteriorated “somewhat worse” or “much more”, since the onset of physical isolation.
|      | 46% of Indigenous women describe most of their day as “quite a bit stressful” or “extremely stressful”.

### Socio-economic, cultural context:

- Mental health disparities among Aboriginal people are linked to several intersectional factors.

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4. Matheson and al. (2019). *Intergenerational communication regarding*
• Mental health disparities are associated with the intergenerational effects of residential schools, forced relocation of communities and removal of children from families and communities, and gaps in mental health services\(^2\).
  o Among Indigenous with a parent or grandparents who attended an residential school in Canada, higher rates of depressive symptoms, suicidal thoughts and childhood abuse are reported\(^3\).
  o Higher rates of mental health problems among Aboriginal populations are the result of childhood adversity, trauma and discrimination\(^3\).
• Certain social determinants of health, such as poverty, unemployment, housing and food security, contribute to the mental health problems experienced by Aboriginal populations\(^4\).
• Socioeconomic and health vulnerabilities to the impacts of Covid-19 among Indigenous people may exacerbate existing mental health challenges\(^5\).
  o Public health Covid-19 measures may disproportionately affected Indigenous women and girls mental health risks due to multiple caregiving burdens, risks of gender-based violence and economic vulnerabilities\(^6\).
• Given all of these intersectional factors that impact Indigenous people mental health, many research advocated to integrate Indigenous methods of healing into the system of mental health services, and the use of Indigenous “culture” as a healing practice\(^7,8\).
  o There is a distinction between Indigenous methods of healing and Western mental health services, which is an important source of misunderstanding in health and health outcomes\(^7\).
• For instance, "Biigajiiskaan: Indigenous Pathways to Mental Wellness" has been implemented. This is a culturally appropriate mental wellness service provided in collaboration with Ontario health providers to Aboriginal populations\(^9\).

This program aims to offer Indigenous health practices in tandem with Western medical care. Biigajiiskaan attempts to fill gaps in Western health services by providing clients with access to Indigenous knowledge keepers, Elders, nurses and physicians.

Indigenous people living in urban areas and off-reserve are underrepresented in mental health research. 

Public health measures to contain Covid-19, such as social distancing, family isolation and closed reserves, are more difficult for indigenous populations in urban areas, who still face historical trauma. Healthcare system off reserve face challenging (racism, discrimination and culturally unsafe care) to serve Indigenous people. Services on reserve don’t help people who living off reserve.

During the pandemic, the Congress of Aboriginal Peoples criticizes and denounces the federal government’s inadequate and discriminatory funding for off-reserve Aboriginal peoples.

Inner-city Indigenous People access to Harm Reduction Services during Covid-19 Pandemic

Data

- British Colombia: 117 suspected illicit drug toxicity deaths in April 2020. Since 2018, March and April 2020 was the first time B-C has had over 100 illicit drug toxicity deaths.
- Ontario: In March 2020, Toronto reported 345 suspected opioid overdose calls with 19 fatalities.

Social, Economic and Cultural Context

- There is a higher rates of injection drug use among Indigenous people than non-Indigenous people.


Asha. (2020). Ontario health providers collaborate to provide culturally-relevant mental wellness services to Indigenous peoples.
For many Indigenous people, drug use is a way to deal with past trauma and abuse, such as experience with the residential school and child welfare systems, legacies of colonialism and racism, and childhood traumas. For people who use substances, the Covid-19 pandemic has exacerbated risks already associated with the overdose epidemic. Limited access to certain illicit drugs due to social changes related to Covid-19 has led to higher prices and falsification.

- In B-C, heroin tested at the end of April were found to contain Fentanyl and Benzodiazepine. In additional, Manitoba indicated an increase unintentional polysubstance use.
- People are adjusting their behavior as consequences of drugs shortages. Some people who use drugs are attempting to make their own drug or switching to other substances.
- The risk of overdose death increased with the physical distancing and self-isolation measures containment measures related to the pandemic.
- Many people who use drug experience homelessness, with containment measures related to the pandemic, they have been cut off from community access points, which will increase isolation and may result in increased public drug use.
- The presence of bystanders who could intervene in the event of an overdose is limited.
- Covid-19 public health measures have posed challenges in providing direct services to people who use drugs.

<table>
<thead>
<tr>
<th>Factors Determining Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Harm reduction and treatment services should be seen as essential and resourced.</td>
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</tbody>
</table>

**Indigenous Knowledge**

1. **Mental Health Services**

**Socio-economic, cultural context:**

- The legacy of colonization (economic, social and political inequities) and Indigenous cultural genocide are the etiology of mental disparities between indigenous people and non-indigenous people.  


- Mental health services in urban settings are not adapted to serve Indigenous patients needs.  
  - Some of the reasons for the reluctance of Aboriginal people to use the health care services include: racism, the feeling of being a second-class citizen and the lack of cultural practices.  
  - There is a low rates of voluntary use of mental health services, but a high rates hospitalisation for suicide and mental health crisis in this population.  
- The legacies of colonization have left a deep epistemological chasm that cannot be easily traversed by health care providers, no matter how well intended or culturally competent.  
- The inclusion of the Elders in the treatment of Indigenous patients in Canadian health care systems has been recognized; however, they are not formally included as legitimate care providers.  
- Indigenous people living in the inner city may turn to the Elders rather than using mainstream mental health services.  
- The crucial role of Elders in the mental health of Aboriginal peoples is unanimously recognized by the First-nation, Inuit and Métis.

<table>
<thead>
<tr>
<th>Socio-economic position</th>
<th>Social cohesion</th>
</tr>
</thead>
<tbody>
<tr>
<td>The effect of poverty, racism, and other layers of discrimination and marginalisation on mental health cannot be ignored for many Indigenous people living off-reserve.</td>
<td>Elders are the community knowledge keepers and supporters of its collectives; they are essential actors the connection with the past.</td>
</tr>
<tr>
<td>- They provide Aboriginal patients with opportunities to restore cultural identity as part of their mental health treatment.</td>
<td></td>
</tr>
</tbody>
</table>

4. Goodman and al. (2017). “They treated me like crap and I know it was because I was Native”: The healthcare experiences of Aboriginal peoples living in Vancouver’s inner city. *Social Science & Medicine*.  
Involving Elders in patient care assists to improve understanding and trust between Indigenous and non-Indigenous staff and patients. Positive impact of Indigenous Elders program on the mental health of Indigenous patients in inner city:

- Place of healing after a prolonged period of seeking and desperation.
  - Many patients who take part to the Elders program are struggling to recovery from severe social adversity and disruption, that mainstream health services can’t provide help. Through the Elders program, they find the remedies they need.

- Strengthening cultural identity and belonging
  - The Elder Program helps to strengthen the sense of cultural identity and belonging of Indigenous patients by improving self-esteem and confidence.
  - Patients can share with Elders histories of colonial oppression and address the more deep-rooted problems underling their symptoms.

- Developing trust and “opening up”
  - Only after participant the Elders program that many patients are “opening up” about their spiritual or mental health struggles.

- Coping with losses
  - As Indigenous people living in the inner city, many patients have suffered multiple personal and collective losses. Through teaching, support and ceremonies, Elders provide them with the guidance they need to deal with their grief.
  - Many patients see Elders as role models of resilience.

- Engaging in ceremony and spiritual dimensions of care as a resource for hope
  - Spiritual dimensions is a part of Indigenous patients mental health concerns, that they believe health care providers can’t address.
  - The Elders enable them to feel that they are taking care of their spirit.

2. **Health care services**

**Socio-economic, cultural context:**

- Indigenous people are over half of the Northwest Territories population\(^{11}\).
- Residents in the NWT have one of the lowest life expectancies in Canada\(^{12}\).
  - Complex social, economic, geographic and colonial factors explain this disparity in life expectancy\(^{13-14}\).
- Leaders of the territorial health system are committed to working towards equity and reconciliation in health care, which requires access to traditional care for indigenous communities\(^{11}\).
- For Indigenous communities, traditional healing and traditional medicine are a set of health practices that incorporate their understanding of health and wellness\(^{1}\). Knowledge keepers are the primary sources of expertise on traditional medicine and healing\(^{11}\).
  - Currently, there is no institution-based traditional healing services offered within the NWT health system\(^{11}\).
  - Barriers to accessing traditional medicine and healers persist not only in the NWT, but in many places in Canada\(^{11}\).
  - However, some jurisdictions such as Ontario recognized the value and necessity of integrating traditional medicine into care for Indigenous patients\(^{5}\).

**Potentials barriers to accessing traditional healing in health system\(^{11}\):**

- Policies often do not consider cultural practices and therefore create structural impediments to Indigenous -centres care.
- Health funding structures in the Northwest Territories complicate the integration of traditional medicine into health care delivery.

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The stark differences in the dissemination of knowledges in Indigenous and Western health system is an obstacle for the implementation of traditional medicine practices in Western dominated setting.

- Health care providers are concerned about the possible negative interaction between traditional medicines and pharmaceutical treatments.

**Factors Determining Health:**

- Culture and traditional healing practices are a source of identity, confidence, resilience and strength for Indigenous people, and have an important role in promoting individual and community health.

**Cultural Safety during Pandemic Context:**

- With this health crisis, there are certain principles that health professionals should consider when working with indigenous peoples:
  - The results of the colonial history and current realities explain why Indigenous communities are facing increasing vulnerabilities related to poor health and economic challenges.
  - Covid-19 measures implemented in the broader Canadian community may not be easily transposable to Indigenous environments.
  - After experiencing traumatic events and exposure to several pandemics, Indigenous peoples will carry these memories and psychological scars both as lived experiences and as patterns found in intergenerational and epigenetic trauma.
  - Trauma-informed care or practical skills will be helpful in understanding that their responses may come from a triggered place.
  - During this Covid-19 pandemic, it is important to understand Indigenous people context and work with them rather than imposing western ways. In additional, it

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| Indigenous Cultural Practices during Covid-19 | The resilience of Indigenous communities during this health crisis is manifested by their proactive approach to the pandemic and the sacrifices they made:
  
  o During the lockdown, many Indigenous communities have put on hold or modified their ceremonies, funerals and rites of passage.
  
  Indigenous spiritual traditions and community connections are a symbol of survival in the face of the structural barriers and social inequalities in health that Indigenous peoples facing in normal times and during health crises.
  
  Cultural practices and social connectivity also symbolize resistance to the multiple inequalities experienced by the indigenous population.
  
  Virtual connection in times of pandemic is a powerful expression of the strength of Indigenous culture.
  
  Different cultural activities that take place during these virtual meetings provide support to the indigenous people. Moreover, they transcend borders, time and space.

Niikaniganaw has a very important meaning to the Indigenous community. In its simplest words it signifies "All My Relations". As defined by Neal Shannacappo, "It is asking for a blessing upon you that encompasses everything that has spirit in the universe from the past, present and future".
Ceremony is something very important to many Indigenous people. Indigenous people share a tradition of regularly giving thanks, through everyday acts, through rituals, and through ceremonies. A ceremony is a formal act or series of acts conducted as prescribed by custom, law, or other authority. Ceremonies can be simple or elaborate, it can be in celebration, or a solemn occasion.

**Cultural Safety VS Cultural Competence**

**Cultural Safety**
Focuses on the *relation* between the service provider which can be the Nurses or the doctors and the service user which is the client.

**The goal**: Help the health care system and its workers to incorporate and consider the patient's culture in their delivery of services.

**Cultural Competence**
Focuses on *learning* about the culture of the service user.

**The goal**: Prevent the negative effects that may result from a lack of respect for culture in the delivery of health services.

**Smudging**: Smoke is created by burning medicinal or sacred plants and the smoke is wafted over the person being smudged. It is used for purifying or cleansing the soul of negative thoughts.

**Pipe ceremony**: Participants sit together and lite the sacred tobacco or kinnikinnick within the pipe. The pipe carrier says a prayer and the pipe is then passed around. Each participant is invited to speak as well.

**Song and drums**: Singing songs and playing the drums for/with another person can provide spiritual grounding and can hold a safe, therapeutic space.

http://www.learnalberta.ca/content/aswt/symbolism_and_traditions/documents/ceremonies.pdf
A GUIDE TO CULTURALLY SAFE CARE - INDIGENOUS HEALTH

HOW CAN I PROVIDE CULTURALLY SENSITIVE CARE TO INDIGENOUS PEOPLE AS A HEALTH CARE PROFESSIONAL?

The Do's and Don'ts of patient care towards Indigenous people

**Do's**
- Listen and honour personal experiences of the healthcare system
- Incorporate traditional herbs, medicines and cultural practices in care
- Understand that some medications may interfere with cultural practice and offer alternatives
- Focus on family-centered care/communication and holistic approaches for patient care plan
- Try to find and use evidence based data aimed to improve Indigenous health
- Understand that past history will still affect Indigenous people today. It's called intergenerational trauma
- Understand that some may not feel safe to ask for medical services due to history of colonialism and systematic racism
- Understand the importance of ceremony and its beneficial impact on health

**Don'ts**
- Engage in unequal power relation between you and the patient
- Blame cultural ways for health problems
- Use racially inappropriate names, terms or comments
- Dismiss traditional herbs or medicine in Indigenous culture
- Belittle the person and their spirituality/culture
- Mock cultural ways or beliefs of a patient
- Imitate and appropriate Indigenous culture. This is called the “wannabe syndrome”
- Allocate general biases or generalization to Indigenous people

A GUIDE TO CULTURALLY SAFE CARE - INDIGENOUS HEALTH

SOME USEFUL LINKS:

- Niikaniganaw Website page: http://www.niikaniganaw.ca


Instructions:

The Operating Grant: Knowledge Synthesis: COVID-19 in Mental Health and Substance Use was designed to enable the development of rapid and timely knowledge syntheses and related knowledge mobilization plans to address evidence gaps and build the evidence base as part of the mental health and substance use response to COVID-19.

As outlined in the decision letters sent to successful applicants, this template is being provided in order to facilitate the rapid sharing of results with relevant knowledge users. Information recorded in this report may be made available to policy makers, healthcare and service providers, partners, and the general public, and will be used to populate a website and inform a variety of CIHR knowledge mobilization products. Responses should be written in plain language, respecting word limits where indicated.

Email completed report to COVID19MH-COVID19SM@cihr-irsc.gc.ca by June 22, 2020.

Synthesis Title:
Niikaniganaw (All My Relations) II – the COVID-19 Rapid Response: Indigenous approaches to synthesizing knowledge for culturally-safe and stigma free mental health care for under-served Indigenous communities in Ottawa-Gatineau

Nominated Principal Applicant (name and affiliation):
Laperrière, Hélène (School of Nursing, University of Ottawa)

Authors (names and affiliations):
Our team is formally led by Dr. Hélène Laperrière (PA, UOttawa), a bilingual scholar who brings an expertise in HIV/AIDS community-based research, with a specific interest in the role of civil society and participatory evaluation. Traditional Knowledge Carrier Christina Bendevis (PKU), excels at creating a safe, non-judgemental and welcoming space for all who wish to participate in ceremony. She also brings her vision of stigma-free mental health services for Indigenous people. This leadership team is supported by, five Indigenous Knowledge Carriers and Traditional Helpers (Sharp Dopler, Ross Saunders, Francine Desjardins, Neal Shannacappo, Michele Penney), who share a commitment to harm reduction, to gender inclusivity, and to providing ceremony for those who need it most, i.e., those with the least access to ceremony such as 2SLGBTQ, those who use substances, and those who have been disconnected from their culture for a variety of reasons. Mike Laframboise brings his Indigenous living experience of HIV and intersecting stigmas including culturally unsafe health and social services. Seven community partners (AIDS Committee of Ottawa, Drug Users Action League, Ottawa Inner City Health, Le Bras, ADOO, and Public Health Agency of Canada COVID-19 Quarantine Department) Ottawa Public Health representing frontline service organizations who serve the Indigenous community, will ensure that we are grounded in local community concern and are well-positioned to ‘take up’ the knowledge we share with each other to create immediate and lasting social change. Researchers (Dr.
Leah Layman-Pleet, Dre. Marie-Hélène Chomienne) from two academic departments (Psychiatry, Medicine), nursing professionals (Karina Pelletier) and trainees (Rana Annous, Ines Zombre) ensure that our research can continue to build capacity for culturally-safe care in Ottawa-Gatineau.

For more information, please contact:
Laperrière, H. School of Nursing, University of Ottawa (Helene.laperriere@uottawa.ca)

Target/priority population(s) in synthesis:
- Indigenous community members in Ottawa-Gatineau, who are living with or affected by HIV or related issues, such as substance use, mental illness, poverty or homelessness
- Health and Social services providers as well as graduate and post-graduates’ educators in the discipline of nursing, medicine, psychiatry

What is the issue?
With Niikaniganaw II-the COVID-19 rapid response, we face the unanticipated situation of COVID-19 pandemic. Our team inevitably confronts new preoccupations: How is COVID-19 affecting the mental health of Indigenous community members in Ottawa-Gatineau who are living with or affected by HIV or related issues, such as substance use, mental illness, poverty, or homelessness? How are they receiving / adapting to the standard public health messaging? What is the effect of COVID-19 on the mental health of health and social service providers who serve these communities? What does culturally-safe and stigma free care in health and social services look like in the age of COVID-19, and by extension, future pandemics or remote / isolated environments? How can we develop capacity for culturally-safe and stigma free mental health care for under-served Indigenous communities in Ottawa-Gatineau in the context of COVID-19?

Key messages (max 100 words):
- We are pursuing integrated indigenous knowledge translation (iKT).
- Participants ‘learn by doing’.
- Participants learn by observing and watching the way that the Niikaniganaw team creates and emulates a stigma free and culturally safe environment for Indigenous people facing challenges on their mental health, substance uses, harm reduction practices, homelessness, life with HIV/AIDS or other situations exacerbated by COVID-19.
- Indigenous people with lived experience are integral to this process in all team activities. This provides an unparalleled opportunity to break down barriers and misconceptions between service providers, knowledge carriers, researchers, and students.

How was the synthesis conducted?
Based on Niikaniganaw I and II, activities for this 6-months project fall into three inter-related categories: (1) We created meetings/ceremonies (2 for the first month, once a month/5 months) in virtual Indigenous spaces, co-facilitated by researchers and Knowledge Carriers. Each of these meetings integrate ceremony and culture with qualitative and quantitative data collection, as well as
opportunities to reflect on the living experience with COVID-19 pandemic situation. (2) We documented and implemented the innovative ways of providing ceremonies at-distance and online for Indigenous people and stakeholders, using qualitative research approach including a series of Indigenous graphic novel-style images. (3) Simultaneously, we did a literature review on cultural-safety, indigenous health and COVID-19 and (4) We activated new social media tools with our Niikaniganaw website platforms to outreach and interconnected the Indigenous communities as well as social and health care providers, academics, students, partners as a kind of “virtual culturally-safe care” community (see http://www.niikaniganaw.ca).

In total, here are the number of knowledge sharing activities with knowledge users and direct participants engaged in this process (May to October 2020):

- 21 operational and planning meetings (22 hours), 10 participants,
- 6 ceremony and sharing circles (15 hours), 32 participants
- 10 nursing students training meetings (70h), 10 participants
- Knowledge transfer activities one poster and three presentations (10h), large public (Conference of Public health 2020 (October): +- 200 participants potential)
- Other knowledge transfer activities (graphic novel, educational video and pamphlet, community report), large public (diffusion in a Nursing round webinar (+- 30 participants), virtual presentations (+- 65 participants).

What did the synthesis find? Provide a lay summary of the outcomes (max 300 words):
Building on our strong network and the experience from Niikaniganaw I and II, we adapted the Niikaniganaw model to the COVID-19 context, and offered ‘virtual’ sharing circles and ceremonies to answer these questions (one question per sharing circle virtual ceremony/from June to October 2020). To this end, we have six Indigenous Knowledge Carriers and Traditional Helpers on our team who shared their knowledge and ensured that we are grounded in culture, ceremony, and Indigenous ways of knowing. We also have seven Indigenous team members with lived or living experience of HIV, substance use, mental health concerns, street involvement, incarceration, or who are 2SLGBTQ, who share their experiences of accessing health and social services, identifying mental health and substance use issues that might be exacerbated by COVID-19 (e.g. prolonged periods of social isolation, decreased access to critical services such as counselling, chronic health conditions, anxiety and uncertainty about the future, and also stigmatization and culturally unsafe experiences with public health surveillance activities). Specifically, we offered virtual sharing circles / ceremonies for Indigenous community members and Niikaniganaw partners. These sharing circles were co-facilitated by researchers and Indigenous Knowledge Carriers. Consistent with the Niikaniganaw approach, we also evaluated the challenges and opportunities of providing virtual sharing circles and ceremonies as a way to address the needs of underserved Indigenous people in Ottawa-Gatineau, including IPHAs, people who use substances or who struggle with mental health. Those Indigenous approaches of knowledge synthesis encompasses a variety of sources, a timely mobilization of knowledge and an exchange of practical information within a number of multisectoral stakeholders in real-life during the pandemic.

What are the implications of this synthesis?
Consistent with the Indigenous Peoples’ Health Research Centre’s (IPHRC) approach to knowledge translation (Kaplan-Myrth & Smylie, 2006), our plan integrates a multifaceted and interactive strategy to link our findings to action (Masching, Allard & Prentice, 2006). The anticipated outcomes are: (1) increased awareness and understanding of Indigenous worldviews and issues related to mental health concerns associated to COVID-19 for IPHAs among team members and our expanded networks; (2) increased capacity to provide culturally-safe and stigma free mental health care for under-served Indigenous communities in Ottawa-Gatineau; (3) a stronger, larger, more educated community of stakeholders who are engaged in delivering culturally-safe and stigma free services to Indigenous people living with or affected by HIV and intersecting issues (such as substance use, mental health, and gender) in Ottawa-Gatineau; (4) an innovative ‘virtual’ cultural-safety intervention model that has been collaboratively developed and assessed with a variety of groups and is ready for scale-up across Canada to a rapid response to COVID-19 issues in Indigenous communities; (5) a visual and written document, including a series of graphic novel-style images. (see Neal Shannacappo); and (6) an up-to-date academic literature review on the issues of culturally-safe and stigma free mental health for Indigenous communities faced by COVID-19.

List up to 10 keywords specific to this synthesis to facilitate website search filters and sorting:
(e.g. depression, virtual care, autism, opioids, racism, chronic pain, sleep, etc.)

- Indigenous health
- Mental health
- Homelessness
- Virtual culturally-safe care
- Cultural-safe and stigma-free mental health
- HIV/AIDS
- Indigenous research methodologies