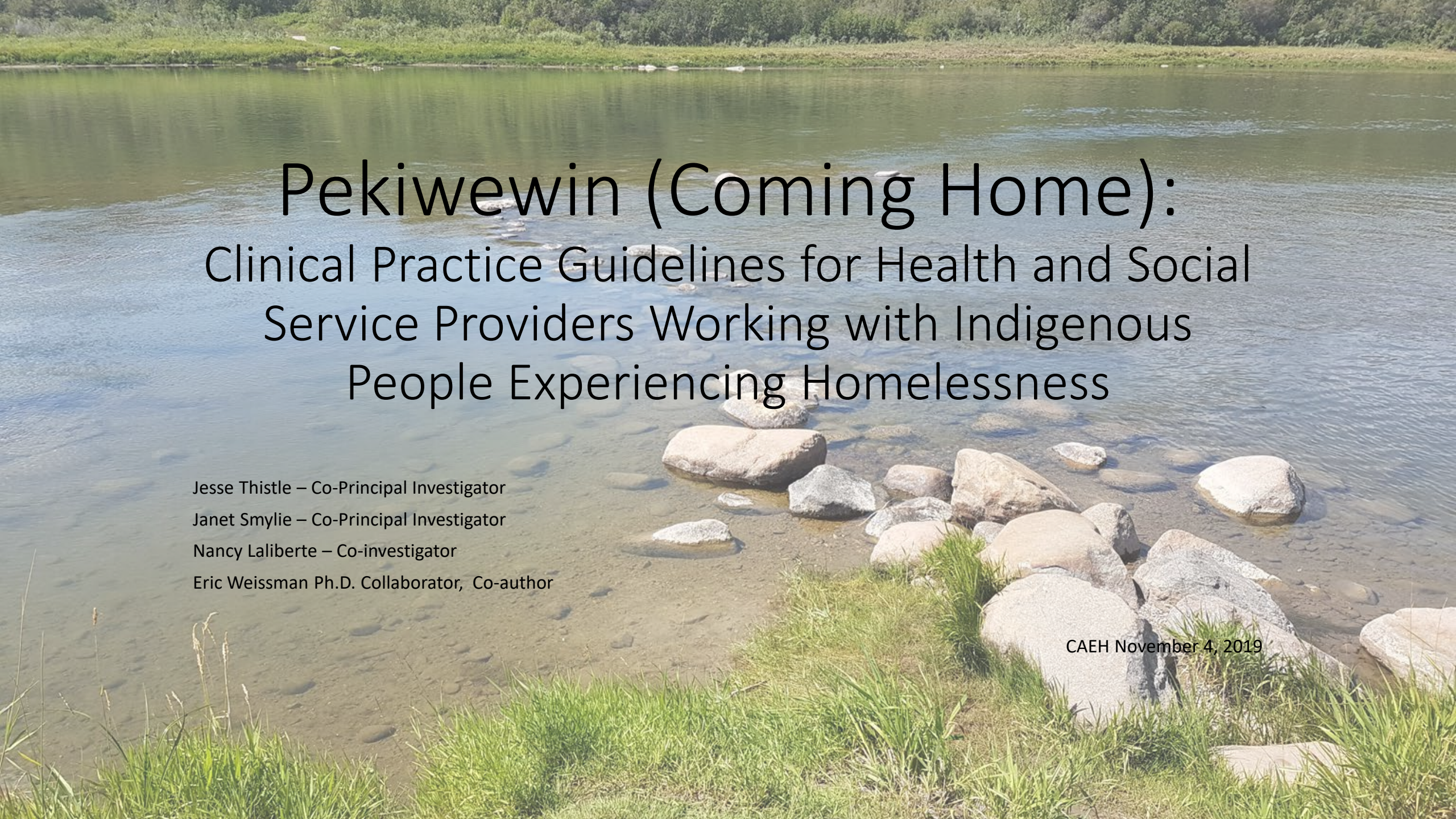


Pekiwewin (Coming Home):
Clinical Practice Guidelines for Health and Social Service Providers Working with Indigenous People Experiencing Homelessness

Jesse Thistle – Co-Principal Investigator

Janet Smylie – Co-Principal Investigator

Nancy Laliberte – Co-investigator

Eric Weissman Ph.D. Collaborator, Co-author

CAEH November 4, 2019

Background

- ICHA support the development of clinical practice guidelines for providers working with people experiencing homelessness led by Bruyére Research Institute
- Indigenous people experience homelessness differently as per the Definition of Indigenous Homelessness in Canada
- ICHA supported parallel development of guidelines for Indigenous Peoples
- Project began in 2017 when Smylie and Thistle won an Inner City Health Associate grant

Dr. Janet Smylie

ICHA | Inner City Health Associates

Background

- Homelessness is a certain type of worst-case social determinant and has been termed by Canadian palliative care physician Naheed Dosani as a “terminal diagnosis”
- Homelessness is persistent, widespread, and life-threatening, occurring disproportionately in Canada’s Indigenous population, shortening Indigenous lives of those who are chronically homeless to an average of 33 to 47 years old
- Beyond resolving problems of geographic remoteness or economic marginality to address homelessness, rebuilding relations

MD Dr. Naheed Dosani, 2017

Definition of

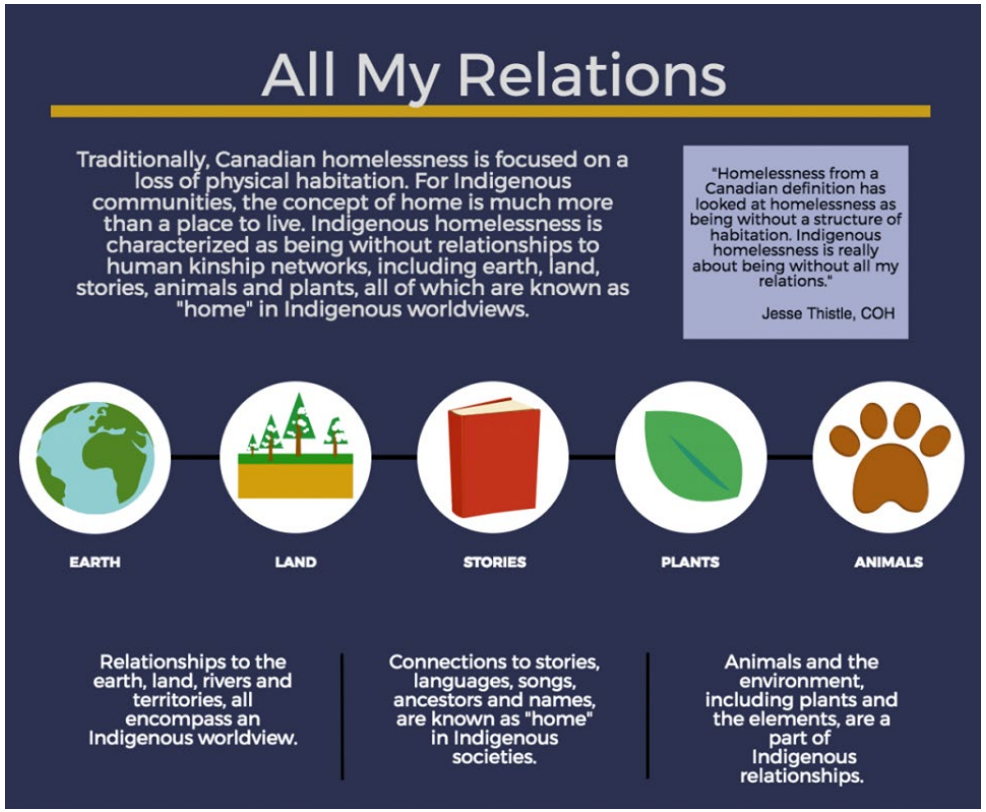
Indigenous Homelessness

in Canada

Joey Reynolds in Regina, 2017
Eagle Feather News

- Disconnections from healthy physical, social, emotional, cultural, and spiritual relationships due to processes of colonial interruption
- Individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities
- Indigenous people experiencing these kinds of homelessness cannot culturally, spiritually, emotionally or physically reconnect with their Indigeneity or lost relationships

- Loss of land and knowledge systems connected to traditional territories
- Loss of culture and purposeful linguicide through colonial projects like residential schools
- Loss of spirituality by the Christianisation and acculturalization of Indigenous populations over time
- Mental imbalance homelessness from the pressures of exclusion, poverty, and destruction of domiciles
- Destruction of land bases through environmental manipulation and destruction
- Climatic refuges homelessness due to shifts in global temperatures
- Indigenous women and children disempowered through legislation like the Indian Act or fleeing domestic violence
- The ineffectiveness of health and other institutions to serve Indigenous populations and their needs creating forms of homelessness like transience and bureaucratic “passing the buck”



Advisory & Co-investigators

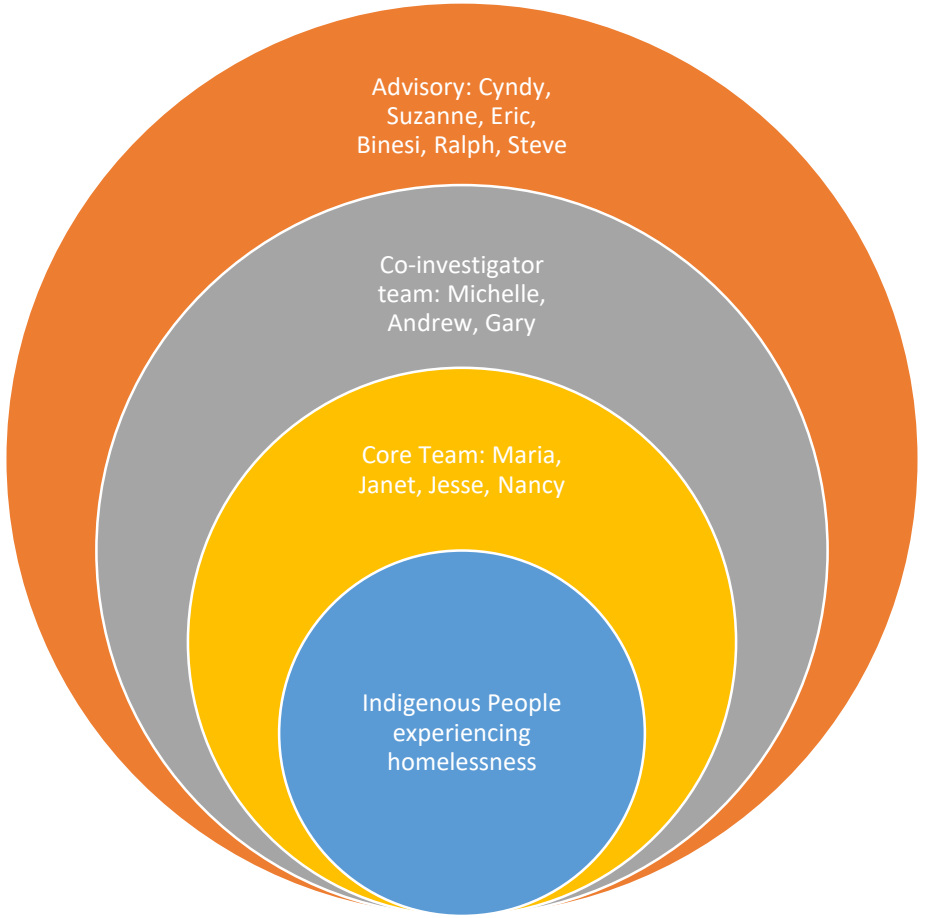
ADVISORY

- Suzanne Stewart – University of Toronto
- Cyndy Baskin – Ryerson University
- Ralph Thistle – MNO Senator & Elder
- Steve Teekins - Director of Native Men's Residence in Toronto
- Eric Weissman – University of New Brunswick
- Binesi Morrisseau - University of Michigan

CO-INVESTIGATORS

- Michelle Firestone – Centre for Urban Health Solutions, St. Michael's Hospital
- Gary Bloch – St. Michael's Hospital, Inner City Health Associates
- Andrew Bond – St. Michael's Hospital, Inner City Health Associates

Circles of Responsibility to Pekiwewin



The Academy of Lived Experience
Each member of the collaboration has lived experience of one or more of the following:

Indigeneity
Addictions
Mental health diagnoses and treatment
Experience of medical and other interventions
Homelessness
Poverty
Extensive applied research in the areas of homelessness, housing, addictions and healthcare
Medical practice
Experience working with marginalized and vulnerable people

Connecting to Lived Experiences

- " I remember when I was reaching out from a desperate bottom, and was directed to an addictions psychiatrist. He listened to my story and witnessed me - 128 pounds, slightly yellow, teeth decaying, and obviously uncomfortable in his presence. He looked at me in the eyes and as if he had had no experience whatsoever with addicts, he said: " Your problems are too vast for psychiatry." My next move was to call my sister, on a payphone- I recall how passersby looked at me, "balling my eyes out," shaking and pleading for her to pick up, hiding my face as best I could in the corner of the wet, cramped booth, hoping she could help me; I wanted her to know I loved her, and my family, but he had let me leave his office completely lost and forlorn, and I knew I was going to try and drug myself to death. I hunkered into my hovel, with my futon, climbed under the sheets and hoped for death. Fortunately, my sister found me and connected me to a physician who really knew how to talk to an addict, like me, and found me a bed in a recovery program. 24 sober years later, I still cannot shake the absolute fear and sense of disconnect I felt after that first rejection, and the hope I felt when I was connected with a provider who understood me. (Eric Weissman, 2019).
- Above 1985 MA Student: Below: 1989- on the way down)

What does Lived Experience Bring to the Table?

- More than personal anecdotes, L.E. provides thick descriptions, a term used by some ethnographers to describe rich and detailed discussion of experiences that are sometimes foreign to practitioners and lay people
- For these guidelines, L.E. is the source of our cultural intelligence, offering ideas, solutions, awareness of barriers, and culturally relevant approaches to talking to people and honouring their experience
- Medical students and teachers are very interested in in this kind of experience in order to help them interact with high acuity or complex needs patients. The following quote from a top medical student is a good example:
- Though our guidelines focus on Indigenous Peoples, they will translate well into other care scenarios

- “Hi XXXXXX. I just listened to your recent podcast interview and I was really blown away by your story. I knew a little bit about your history but there were so many things I had no idea about! I was really shocked about the way that the doctor yelled at you in his office. I know that may have been powerful for you, but it is everything we learn NOT to do in medical school. I'm going to be doing a lot of work at St. Mikes over the next four years where many of the patients are experiencing homelessness or face low SES and struggle with addiction. I was wondering if you'd be free for me to call you at some point to speak with you about what you wish physicians knew about addiction and homelessness and maybe some tips I could use when treating those patients? (October 2019)”

The total number of years of lived experience = 40-plus years

Active Years	Recovered Years
• Jesse Thistle, 10 years	• 10 years
• Eric Weissman, 18 years	• 24 years
• Binesi Morrisseau 10 years youth	• 11 years
• Ralph Thistle 3 years	• 10 years
• Steve Teekens 15-plus working in Homelessness	• NA
• Suzanne Stewart 20-plus “ ”	• NA
• Cyndy Baskin 20-plus “ ”	• NA

Partners

- Inner City Health Associates, Toronto
- St. Michael's Hospital, Toronto
- Well Living House, Toronto
- Canadian Observatory on Homelessness, York University, Toronto
- Faculty of Medicine, University of Manitoba, Winnipeg
- Klinik, Winnipeg
- RaY: Resource Assistance for Youth, Winnipeg
- End Homelessness Winnipeg, Winnipeg
- Assembly of Manitoba Chiefs, Winnipeg
- Winnipeg Plan to End Homelessness, Winnipeg
- College of Medicine, University of Saskatchewan, Saskatoon
- Northern Medical Services, University of Saskatchewan, Saskatoon
- Saskatoon Indian & Metis Friendship Centre, Saskatoon
- AIDS Saskatoon, Saskatoon
- Westside Clinic, Saskatoon
- S.H.I.P: Saskatoon Housing Initiatives Partnership, Saskatoon
- Saskatoon Poverty Reduction Partnership; Prince Albert Region: Provincial Metis Housing Corporation, Prince Albert
- Station 20 West, Saskatoon;

Methodology

- Elder leadership for project Maria Campbell
- Four seasonal pipe ceremonies to work through ceremony
  - Development of Methods Feb 2018
  - Literature review to inform steps forward
  - Post visits with health practitioners, social service practitioner and Indigenous people experiencing homelessness
  - Present findings at CAEH November 2019
  - Final in December 2019 to address final report
- Directed toward a Métis situated (Saskatoon & Winnipeg) visiting methodology to explore experiences of Indigenous and non-Indigenous health and social service practitioners and Indigenous people experiencing homelessness

Human Ecology -- Housing is Healthcare

The guidelines employed a human ecology approach

This approach is linked to the Chicago School of Sociology, (1921) – Championed by Robert Park, and Ernest Burgess, *Introduction to the Science of Sociology – heavily qualitative research employed ethnographic techniques and focused on the city as a social laboratory*

Homelessness and Hobos, as well as other social problems were key foci

Nels Anderson, a hobo himself, wrote *The Hobo* in 1923 under Burgess and Park, in which he used a type of participant observation to write about the world of hobohemia

Today, the approach is interdisciplinary: the main focus is on how natural, social, built and virtual environments impact individuals and social groups of all sizes

Today we also speak of Medical Ecology, (E.g. Le Riche and Milner, 1971) referring to the way practitioners anticipate health outcomes by *conscientiously* linking the environmental factors patients face to treatment plans and desired outcomes, and understanding health as an outcome of human interactions with different features of the environment (built, social, geographical etc.)

Lived experience is an important tool for the HE approach today for the way it translates participants' observations into qualitatively useful data for larger scale planning

Honouring Traditional Practices and Systems

- ***In order to be faithful to this systems approach, guidelines such as these recognize that there are more than one system out there, and these are only understandable through the lens of lived experience – In fact, we have found, in agreement with other work, that the systems approach most often discussed in epidemiological and public health research has ignored traditional Indigenous systems, where in fact, it is by restoring recognition of such systems in clinical guidelines that the real work will be achieved. We are grateful that the lens is shifting to see these goals realized.***

Indigenous and Western methods

- Indigenous
  - Utilizing ceremony throughout the project
  - Visiting, conversational method with Indigenous people
  - Gathering berries
  - Holistic narrative approach to analysis
  - Reporting in a way Indigenous communities can re-create their own process

- Western
  - Human Ecology
  - Semi-structured interview guide
  - More structured qualitative interview with non-Indigenous people
  - Theme approach, more reductive in nature
  - Journal publication

Participants

SASKATOON

- 5 Indigenous people with lived experience of homelessness
- 6 Medical Providers
- 7 Social Service Providers

WINNIPEG

- 4 Indigenous people with lived experience of homelessness
- 4 Medical Providers
- 6 Social Service Providers

Themes From Lit Review and Interviews

- **Relationship** - *wahkootawin* meaning “kinship”
- **Trust** - *kitapwitatin* meaning “I believe you” or *aspēyimowin* meaning “trust somebody”
- **Practitioner disconnect** - *moyadawekemow maskihkiwiyiniw* (not correct spelling of the first word) meaning “phony doctor” or “I don’t trust doctor” or “they think they know but they don’t know”
- **Kindness/Caring** - *miyotēhēwin* meaning “you have a good heart”
- **Physical Space** - *naneegana* or *pepeteque* meaning “feels at home” & “welcome to my home”
- **Trauma** – could not find Indigenous word
- **Racism** - *moniyahkaso* meaning “act like a white person”
- **Culturally relevant services** – no comparable Indigenous wording
- **Cultural Safety** – no comparable Indigenous wording

Further translation of terms will be done in mid-November at a meeting with Elder Campbell

A Uniting Idea

A return to Indigenous knowledge and Treaty Making

Four Protocols of Indigenous conduct

1) Situating oneself – best known example is land acknowledgements

2) Visiting – a formal Cree encounter practiced from pre-colonial times right through to today

3) Hospitality – pre-colonial Indigenous code of conduct enshrined in wampum and treaty law, and into 19th century numbered treaties

4) Hearing – learning and evolving from encounter feedback (Covenant Chain)

Treaty signing

Protocol 1 – Situating

1876
Treaty Six Medal

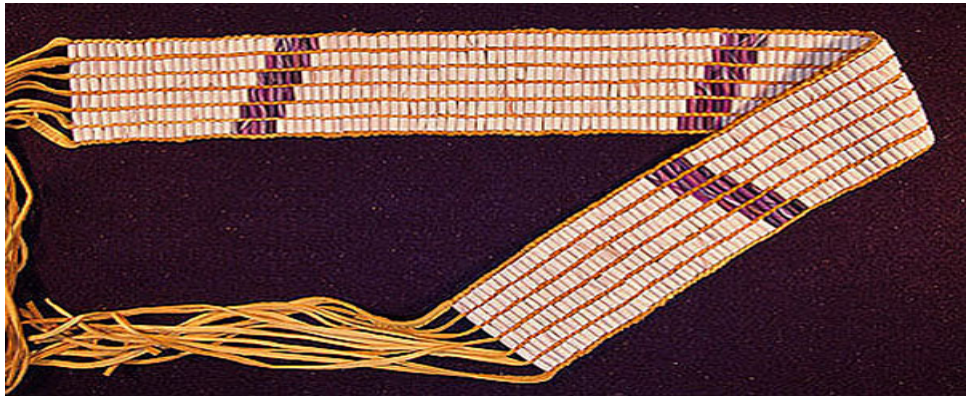
- Understanding Wahkootawin (knowing both MD and patient are but strands in the web of relations as per Indigenous worldviews. Also understanding Indigenous homelessness is a displacement from this circle of relations)
- Situating oneself as a Guest in relation to the land (knowing the Nations, History, and stipulations of Treaty 1 and 6; e.g. the medicine chest clause, federal responsibility to provide proper housing, Federal vs Provincial care stream confusion, Jordan's principal. Understanding that the medical profession has the right to practice in this land because of Crown-Indigenous treaties going back to the Royal Proclamation of 1763)
- Reaffirm Guest/Host relationship enshrined in Two Row Wampum, Hospitality Belt, Covenant Chain Wampum, Royal Proclamation, Treaty One, Treaty Six, and Manitoba Act (Indigenous law founded this country and the western provinces, medical practitioners need to revisit and learn the spirit and intent of these fundamental and still valid texts and then implement them)
- Knowing treaty rights and responsibilities thereof (As J. R. Miller has noted, understanding we are are 'Treaty People' and starting from there; same as above)
- Situating oneself as a Guest in relation to gender, race, power
- Situating a Host patient in relation to gender, race, power
- Trauma informed training for all MDs and service providers working with populations of Indigenous people, especially if they are homeless or have complex mental health/addiction issues.

Visiting Elders
In their home
In Pine Ridge, ND

Protocol 2 - Visiting

- *Keeoukaywin* should govern service provider and patient meetings to regain *milo pimatisiwin* - the good life (elevating homeless Indigenous peoples wellbeing into a higher standard of living)
- Visits between Guests and Hosts in medical settings are acts of relationship renewal primarily, thus they need time (10 minutes per-patient will not due. If absolute homelessness is a terminal diagnosis we should devote at least 30 minutes)
- Cup-of-tea visits (Where possible, medical staff go *in situ* where clients live on the streets or unsecure rooms. Outreach is the most preferred and effective way to access homeless Indigenous clients and also to build trust as well as get an understanding of client's living conditions and health impacts)
- Guests and Guest institutions must make efforts to remember homeless Host relatives (Onsite file system or community Elder to recognize and advocate for homeless Indigenous clients, even when they do not have Treaty or health card or ID)
- Guests listen to the stories of homeless Hosts in medical settings (story is how we know ourselves – community, family, personal history all must be recorded and considered when signs of hyper tension, diabetes, thyroid issues, etc. are exhibited. Stories also point to upstream causes of illnesses – water-related rashes have been misdiagnosed as bed bugs; access to clean water is cause)
- We help our relatives outside the circle travel safely between visits, even if they are elsewhere (provide bus tokens or taxi to and from visit. This could mean long-distance travel to and from home communities hundreds of kilometres away)
- Guests stay long enough to build trust in Host communities (Doctors and social service providers need to sign onto working in a community for longer than two years so they can help homeless clients. We need long-term commitment to the fabric of our communities if any measure of health or social service provision is to be created for our most marginalized)

Protocol 3 Hospitality

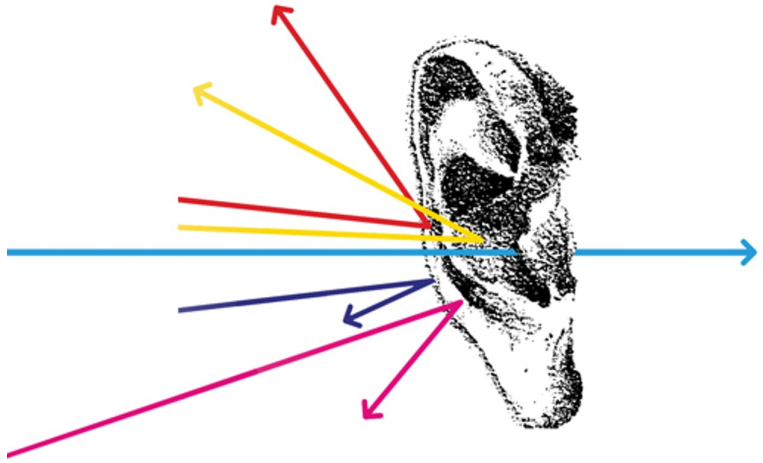


Reproduction of Hospitality Wampum

- Hospitality starts with treating patient as relative in the web of Wahkootahwin (We need to challenge the idea of medical objectivity and professionalism - respect patient as one would respect a Mom or Dad, Son or Daughter)
- Guest institution geographies need to welcome Host relatives walking outside the circle by having holistic interior design (Have culturally specific spaces: land acknowledgement plaque, space for ceremony, Elder room, Indigenous symbolism and imagery, access to social or trauma worker, spaces designed by Indigenous people for Indigenous clients – these may be the only places a homeless Indigenous client has access to these services)
- Homeless Indigenous Hosts must recognize themselves within Guest institutions and employees numbers (Indigenous frontline staff and MDs are preferred in regions with high Indigenous visitation – train and hire more Indigenous)
- Host Nations build culturally specific spaces designed for embedding homeless relatives back into circle
- Share the Mat - Guest institution geographies need to welcome Host relatives with smile and open concept/arms (Blocked off receptions areas and grumpy staff stigmatize and disconnect the already disconnected homeless Indigenous person seeking care)
- No pre-judgement around the fire (Hot-spotting or labelling a homeless Indigenous person as “drug-seeking” or “violent” does more to harm someone seeking care than help them).
- We share the same dish - Medical spaces must have food & clothing available for homeless Indigenous clients as per the Hospitality Wampum (medical sites must had clothing vouchers, socks, or food onsite for homeless clients)
- Medical spaces can never let a homeless relative go without safe and stable shelter (MDs must ascertain housing needs & refer to social service worker to begin Housing First uptake, unless client objects. Housing must be administered as a prescription for the harmful social determinant of homelessness which is known to shorten lives in half)

Protocol 4 - Hearing

- Sitting with the visit (Self-reflection on tone of encounter and also the way the person engaged and left. Where did they go? How were they traveling? Did I do enough? Was I helpful? Etc.)
- Opening your heart (listening to feed-back from patient, colleagues, social worker, or college)
- Making sure the Guest professional is walking as a relative (Holding people and institutions accountable on how they treat homeless Indigenous clients)
- Develop and use kiosk “tablet” mechanism to chart quality of patient care and, if possible, charting if they are Indigenous and homeless – method proposed by medical educators at U of M.
- Data from U of M kiosk system used to monitor, reward, or discipline MDs. If repeated violations occur than reprimanded accordingly.
- Interventions for self-reflection and feedback developed by Beth Israel Hospital in US for peer to peer interventions for residents and physicians to deal with unprofessional behaviour – begins with “a cup of coffee” intervention, training, counselling, and ends with dismissal



Next Steps

- Final pipe ceremony November 10th
- Complete final report
- Publish

QUESTIONS?

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