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The mental health of Indigenous peoples in Canada: A critical review of research

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ABSTRACT

Many scholars assert that Indigenous peoples across the globe suffer a disproportionate burden of mental illness. Research indicates that colonialism and its associated processes are important determinants of Indigenous peoples' health internationally. In Canada, despite an abundance of health research documenting inequalities in morbidity and mortality rates for Indigenous peoples, relatively little research has focused on mental health. This paper provides a critical scoping review of the literature related to Indigenous mental health in Canada. We searched eleven databases and two Indigenous health-focused journals for research related to mental health, Indigenous peoples, and Canada, for the years 2006e2016. Over two hundred papers are included in the review and coded according to research theme, population group, and geography. Results demonstrate that the literature is overwhelmingly concerned with issues related to colonialism in mental health services and the prevalence and causes of mental illness among Indigenous peoples in Canada, but with several significant gaps. Mental health research related to Indigenous peoples in Canada overemphasizes suicide and problematic substance use; a more critical use of the concepts of colonialism and historical trauma is advised; and several population groups are underrepresented in research, including Métis peoples and urban or off-reserve Indigenous peoples. The findings are useful in an international context by providing a starting point for discussions, dialogue, and further study regarding mental health research for Indigenous peoples around the world.

1. Introduction

1.1. *Indigenous peoples worldwide*

The population of Indigenous peoples around the world is currently about 370 million (World Health Organization, 2007). The meaning of the term “Indigenous peoples” is generally used to refer to peoples who have roots in ancestral lands that predate colonial incursions and nation-state boundaries (Wilson and Richmond, 2009; World Health Organization, 2007). What unites Indigenous peoples worldwide is a shared experience of colonialism, although what this experience and history look like varies widely among different geographies and Indigenous groups. Indigenous peoples are referred to by different names globally. In Canada, Indigenous peoples are constitutionally defined as First Nations, Métis peoples, and Inuit, collectively referred to as “Aboriginal peoples”; in the United States Indigenous peoples are referred to as American Indian or Alaska Native peoples; in Australia the terms used are Aboriginal and Torres Strait Islanders; and in New Zealand Indigenous peoples use the name Maori (Duran, 2006; Durie, 2011; Government of Canada, 1982; Wilson and Richmond, 2009). Many of these terms ignore the names which Indigenous peoples use for themselves, and obscure the differences among Indigenous groups within nation-states. For example, in Canada, the term “First Nations peoples” includes over 600 individual e and distinct e First Nations (Royal Commission on Aboriginal Peoples, 1996). In Canada, First Nations peoples are often also grouped into categories based on place of residence: on-reserve or off-reserve. A system of reserves e small parcels of land set aside for Indigenous peoples e was developed during early settlement and since 1876 has been legislated under the Canadian *Indian Act* (Government of Canada, 1985; Hanson, 2009).

1.2. *Colonialism and health*

As a group, Indigenous populations across the globe suffer a disproportionate burden of mental and physical illness (Doyle, 2012; Kirmayer and Valaskakis, 2009; Kral et al., 2011; Marrone, 2007; Waldram et al., 2006). International literature has

linked health outcomes such as infant mortality, high rates of acute or chronic pain, and high rates of injury with social inequalities associated with determinants of health such as poverty and racism stemming from colonialism (Commission on Social Determinants of Health, 2008; Elias et al., 2012; Gracey and King, 2009; King et al., 2009). For mental health in particular, research from around the world strongly indicates that we should be cautious in drawing conclusions about the prevalence of mental illness without taking colonial processes and structures into account. Colonialism has been implicated not only as a cause of mental illness among Indigenous peoples e for example, linking residential school ex- periences with suicidal ideation or attempts (Elias et al., 2012) e but also as a structure which can construct mental illness based on its own set of norms and definitions (Duran and Duran, 1995; Durie et al., 2009; Gone, 2013, 2009; Kirmayer et al., 2000; Waldram, 2009, 2004). Historically, research into the mental health of Indigenous populations, in Canada as elsewhere, has been under- taken by settlers using colonial and non-Indigenous concepts and epistemologies (Waldram, 2009, 2004). Much scholarship indicates that a disregard for Indigenous perspectives persists in contem- porary mental health research in Canada (Fritzsche et al., 2011; Nelson, 2012; Waldram, 2004), creating the potential to misrepresent rates as well as types of mental health problems among Indigenous communities. Further, Canadian scholars warn of the embeddedness of colonialism in the health care system, a problem that creates barriers for Indigenous peoples seeking to access health care services, especially for mental health problems (Browne, 2007; Fiske and Browne, 2006; Varcoe et al., 2013).

Colonialism in Canada operates on multiple levels. These levels have been described as structural (the broad, institutionalized policies and processes that perpetuate the colonial structure), distal (effects of colonialism that are felt on a societal level such as racism and poverty), and proximal (the immediate, individual-level effects such as poor health or unemployment) (Loppie Reading and Wein, 2009). It is easy for these levels to become confused, and at times racism or poor health are effectively equated with colonialism, which causes a shift in focus away from the broader colonial structure. Focusing research on the effects of this broad structure on individuals can

cause colonialism, as a concept, to become medicalized and narrowed to an individual-level problem, as in the discussion of treatment for historical or intergenerational trauma (Maxwell, 2014). Further, in Canada, liberal discourses of multi- culturalism and inclusion can function to "culturalize" colonialism, transforming the discussion into one about efforts to include a wider variety of cultural practices in the national identity and ignoring Indigenous questions of economic and jurisdictional sovereignty (Lawrence, 2012; Thobani, 2007). Thus, while discussions of colonialism are an essential part of Indigenous mental health research, it is important that these discussions be undertaken carefully and with attention to the bigger picture of colonialism.

1.3. The present study

Mental health problems, indicated by outcomes such as suicide and emotional distress, are generally higher among Indigenous peoples in Canada, yet rates vary dramatically from community to community (Chandler and Lalonde, 1998; Kirmayer et al., 2009b). In the Canadian context, scholars remind us that existing research provides an incomplete picture of Indigenous health, excluding certain populations such as urban Indigenous peoples (Place, 2012; Wilson and Young, 2008), or neglecting key factors such as determinants of health (Greenwood et al., 2015), geography (de Leeuw et al., 2012), or colonialism (Czyzewski, 2011; Durie, 2011). Despite an abundance of health research documenting morbidity and mortality rates for Indigenous peoples (Wilson and Young, 2008; Young, 2003), Canadian scholars have yet to provide a comprehensive overview of mental health research regarding Indigenous populations. Therefore, the purpose of this paper is to provide a critical scoping review of the literature related to Indigenous mental health in Canada. In doing so, the goals of this research are to: (1) determine the scope of research on Indigenous mental health in Canada; (2) identify gaps that may exist in the topics studied in such research; and (3) determine to what extent mental health research is representative of Indigenous populations and geographies in Canada. The findings will be of relevance to both Canadian and international scholars, Indigenous communities, and policy makers in shedding light on the areas where research topics tend to cluster and considering some of the historical reasons for this. Beginning with the Canadian research context, this paper can begin a

dialogue on mental health research involving Indigenous peoples internationally.

2. Methods

This study is undertaken as a scoping review following the framework set out by Arksey and O'Malley (2005) and expanded upon by Levac et al. (2010) and Daudt et al. (2013). Accordingly, the search was conducted and literature analyzed in five stages: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data; and (5) collating, summarizing and reporting the results (Arksey and O'Malley, 2005).

The research question, designed to include the greatest breadth of scholarship on the topic, is as follows: *What published literature exists on the topic of mental health relating to Indigenous peoples in Canada, and what gaps in terms of geography, population, or research theme can be identified?*

Studies were identified through a comprehensive search of 11 databases (PsycINFO, AMED (Allied & Complementary Medicine), Embase, Medline, Science Direct, Indigenous Studies Portal, Scopus, JSTOR, CBCA Complete, Web of Science, and PubMed) and two Indigenous-specific journals (Journal of Indigenous Wellbeing/ Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health; and the International Journal of Indigenous Health/Journal of Aboriginal Health) using a combination of search terms related to Indigenous identity and mental health (see Table 1). The databases and journals were chosen in order for results to include both medical perspectives and multidisciplinary Indigenous studies perspectives, and to achieve the widest possible coverage of the literature related to Indigenous mental health in Canada. The process of choosing databases and journals was iterative, being refined based on bibliographic searches of included articles, feedback from anonymous reviewers on previous drafts of this article, and the need for depth of analysis based on research themes.

Study selection was made according to several criteria, developed throughout the search process as the authors became more familiar with the literature in the area. Articles are included which were published within the past 11 years (2006e2016; search completed in August 2016), address Canadian Indigenous populations, are published in

English or translated into English, are relevant to mental health (including community wellness and suicide prevention), and are scholarly articles published in peer- reviewed journals. Of over 3000 results, 223 articles are retained for analysis (see Fig. 1). Article titles and abstracts were initially screened for inclusion; for those whose relevance could not be determined by title and abstract alone, the full text was read to gain further information. Articles included in this review include reports from quantitative studies (n = 85); qualitative studies (n = 65); studies that draw on existing literature to advocate for a new theoretical stance, treatment, or approach to delivering care (n = 45); mixed methods studies (n = 14); and systematic, comprehensive or scoping reviews (n = 14).

Table 1
Databases and search terms used.

Database/journal searched	Search terms (related to Indigenous identity)	Search terms (related to mental health)
CBCA Complete Indigenous Studies Portal JSTOR Ovid (includes AMED (Allied & Complementary Medicine; Embase; Medline & PsycINFO) PubMed Science Direct Scopus Web of Science Journal of Indigenous Wellbeing/Pimatisiwin International Journal of Indigenous Health/Journal of Aboriginal Health	Aboriginal, Inuit, Métis, First Nations, Native, Indigenous	mental health, wellness, well-being, mental illness, holistic health, disorder, psychiatry, psychology, psych*, trauma, stress

Article analysis is based on charting, or categorizing, the data contained in each article. This process consists of reading each article in full, noting the article's major research theme, the population studied, the geographic area included in the study, methods used and the main conclusions of each article. Articles are assigned to one of five research themes, including: mental health services; social determinants of mental health; prevalence of certain mental illnesses; mental health promotion; and mental health research (see Fig. 2). These categories are treated as mutually exclusive; thus, in the case of an article addressing more than one of the research themes, the topic most directly addressed in the article's conclusion is the one to which the article is assigned. Colonialism is a theme addressed in many of the articles in some way; therefore this paper also offers an analysis of how the articles included in the review engage with the

role of colonialism in the mental health of Indigenous peoples in Canada.

3. Results

3.1. *Research themes*

Following Ning and Wilson (2012) and Wilson and Young (2008, 2003), articles are categorized according to five research themes that emerge from a reading of the articles themselves. The first theme, social determinants of mental health (81 articles, or 36 percent), includes articles whose focus is the broader social or socioeconomic conditions that could be considered to cause mental health problems, including experiences of racism or other effects stemming from colonialism. The second theme, mental health services, includes 68 articles (30 percent) whose main focus is any aspect of mental health service delivery, including the perspectives of mental health professionals. The third theme, prevalence of a specific type of mental illness, focuses on certain mental illnesses within a population (for example, depression among pregnant First Nations women), and includes 33 articles (15 percent). The fourth theme, mental health promotion (25 articles, or 11 percent), includes articles whose major focus is on ways of promoting mental health and preventing mental illness. Finally, the fifth theme, mental health research, covers articles whose focus is on the process of doing mental health research, and includes 16 articles (7 percent). A sixth and final research theme, the thread of which can be traced through many of the articles categorized under the other five themes, is the role of colonialism in mental health and mental health research involving Indigenous peoples.

3.1.1. *Social determinants of mental health*

Of the 223 articles, most articles focus on the social determinants of mental health (81 articles, or 36 percent; see Appendix A, Table 2 for a complete list). Of these, the greatest number (n = 29) look at various aspects of colonialism as a determinant of mental health, including the manifestation of colonial ideas in policy decisions including child welfare, residential schools, and general social policy; and the concept of

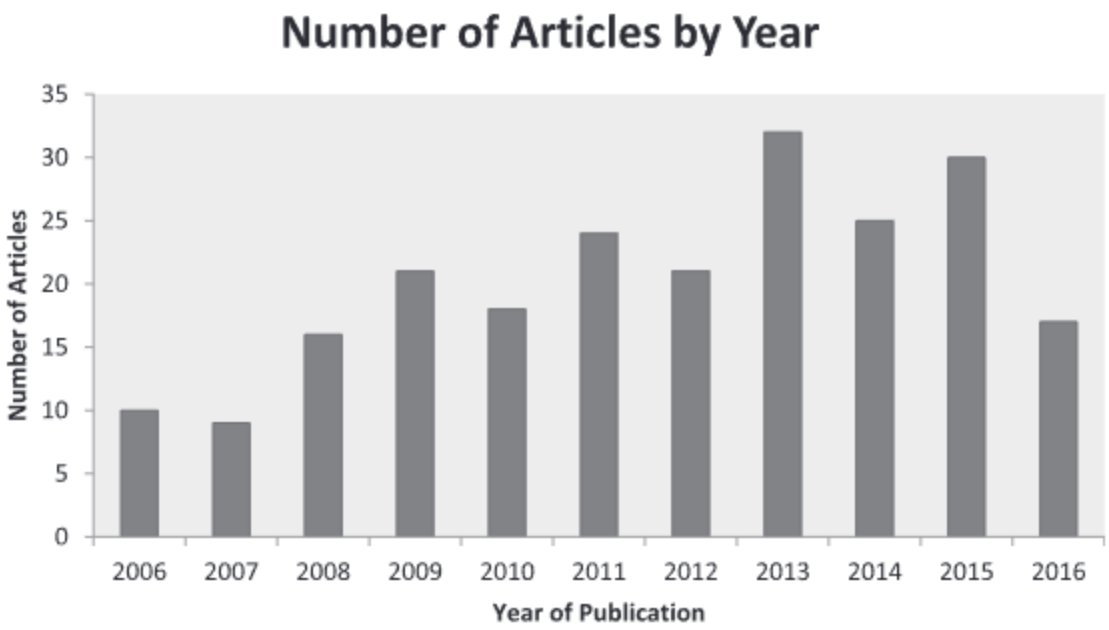

Fig. 1. Number of articles by year of publication.

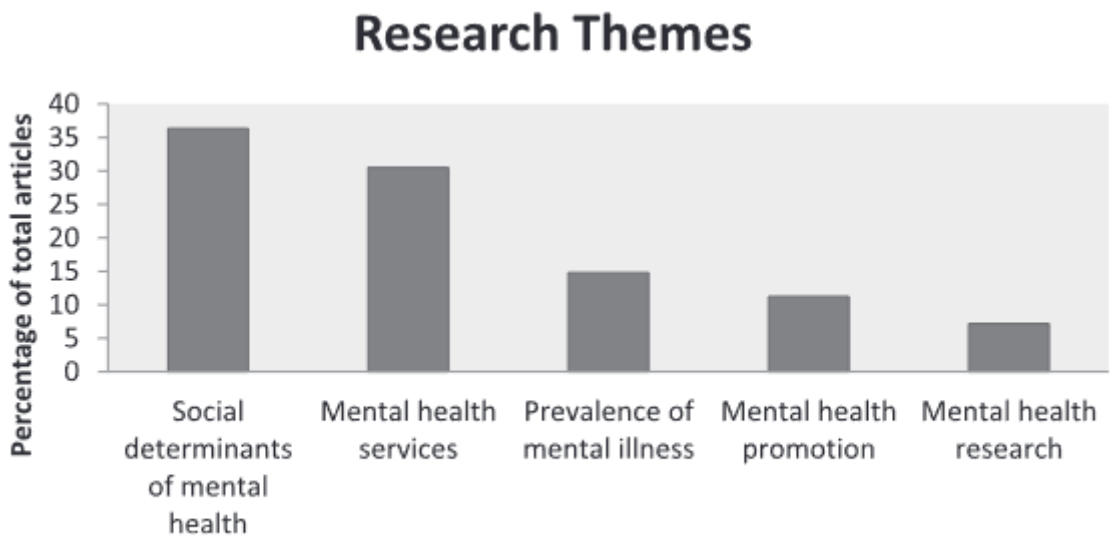

Fig. 2. Research themes.

historical or intergenerational trauma. For example, charged by the community of Whapmagoostui, in Quebec, to find out “why … women [are] experiencing more stress these days” (p. 318), Adelson (2008) de- scribes an ethnographic investigation in which women explain how colonial interventions have created a rigid patriarchal system in their community, limiting the roles and social supports available to them, thereby

causing undue burdens of stress. Elias et al. (2012) undertake a quantitative study of correlations among attendance at a residential school (or the attendance of a parent or grand- parent), trauma histories, and suicide behavior, finding that abuse histories and suicidal thoughts or attempts were present in many residential school attendees, their children and grandchildren. Residential school is frequently used as a proxy for colonialism, especially in quantitative studies. However, other studies examine the role of other structures of colonialism such as government policy or the child welfare system. For example, Mitchell and MacLeod (2014) critically analyze the negative impacts of government-led social policy on Aboriginal peoples, arguing for community psychologists to advocate on behalf of their clients in the realm of social policy; and Roos et al. (2014) examine the impact of a history in care on homeless individuals with mental illness, finding that participants with a history in care are uniquely high- risk, in that they are more likely to have experienced trauma and to be impacted by residential school and colonization.

Nine articles examine the role of interpersonal violence (including school violence, bullying, intimate partner violence, racial discrimination, and sexual abuse) on mental health (see Appendix A, Table 2). For example, The Cedar Project Partnership et al. write that, in a study of Aboriginal youth (aged 14e30) in Vancouver and Prince George, BC who use illicit drugs, “sexually abused participants were twice as likely to have ever self-harmed and to have seriously thought about suicide and attempted suicide” (2008a, p. 2191). Zahradnik et al. (2010), on the other hand, find that exposure to violence predicts a posttraumatic response e but only in children showing low levels of resilience; in other words, resilience is a mediating factor of the impact of violence.

Eight studies examine various factors impacting problematic substance use, including alcohol use and cigarette smoking (see Appendix A, Table 2). Seven studies examine other factors specificically related to suicide, including intoxication (Laliberte and Tousignant, 2009), economic factors (Lemstra et al., 2009b), individual and cultural continuity (Chandler and Proulx, 2006), and the protective effects of language and spirituality (Haggarty et al., 2008). Six articles look at the role of social support, including community belonging, in mental health. Five articles investigate the role of the land in Indigenous mental health, including the impacts of

climate change (Durkalec et al., 2015) and protective factors against these impacts (Petrasek MacDonald et al., 2015). Two studies examine social, economic, and demographic factors leading to depression; one names Aboriginal identity as a risk factor (Cushon et al., 2016), and the other asserts that parental education and sex of child are more important factors than Aboriginal cultural status (Lemstra et al., 2008). Two articles examine the protective impacts of a fatty acid contained in fish on psychological distress and depression (Lucas et al., 2010, 2009). Two articles each examine the role of mobility as a determinant of health (Berman et al., 2009; Snyder and Wilson, 2015); the impacts of body image and body size on emotional health (Fleming et al., 2006; Willows et al., 2013); the impact of having a young mother on the mental health of Indigenous children (Guevremont and Kohen, 2013, 2012); and general factors in child and youth mental health and wellness (Werk and Xinjie, 2013; Yi et al., 2015). Other articles look at the contextual factors influencing Fetal Alcohol Spectrum Disorder prevention (Badry and Felske, 2013); the impact of hand drumming on Indigenous women's mental health (Goudreau et al., 2008); education as a determinant of wellness and a tool for empowerment (Offet- Gartner, 2011); the impact of a gold mine closure on a nearby community (Rixen and Blangy, 2016); and how structural factors (related to, but not explicitly referencing colonialism) such as socio- economic class, are implicated in Indigenous peoples' mental health (Wingert, 2011).

3.1.2. *Mental health services*

The second-most populated research theme is that of mental health services (68 articles, or 30 percent; see Appendix A, Table 3). The majority of these articles (n ¼ 38) describe or evaluate existing mental health services or training programs in terms of effective- ness, funding, staffing, challenges and support, and cultural relevance. For example, Gibson and colleagues, Monthuy-Blanc and colleagues, and Volpe and colleagues (Gibson et al., 2011a, 2011b; Monthuy-Blanc et al., 2013; Volpe et al., 2014) provide assessments of telemental health technologies in remote and rural First Nations communities, and the potential of these technologies to improve access to psychiatric services in remote places. O’Neill et al. (2013a, 2013b), in two

related studies, describe the challenges and supports experienced by formal and informal mental health workers in northern and remote areas. Malone and Stanley (2013) offer a personal reflection, as mental health care providers in a rural Cree First Nation in Alberta, on the benefits and limitations of their practice, their presence in the community, and the programs which they developed while working there. Many of these articles describe success stories of innovative programs that integrate Indigenous healing and mainstream mental health services (Dell et al., 2011b; Maar and Shawande, 2010; Puchala et al., 2010); one, however, is a cautionary tale about a gatekeeper training program for suicide prevention, which did not translate well into an Indigenous context (Sareen et al., 2013).

Many other articles in this theme (n = 15; see Appendix A, Table 3) address issues of colonialism within mental health services in a general fashion, often by drawing a contrast between Western mental health services and Indigenous ways of healing, and attempting to articulate ways in which these differing approaches can be integrated in a health care setting. For example, Shepard et al. (2006) offer context and background on colonialism for counsellors working with First Nations women in Canada, and Leske et al. (2016) undertake a systematic review to compare the effectiveness of culturally unadapted, adapted, and culturally- based interventions for mental health or substance use problems. The premise of the majority of these articles is that mental health practices as they currently exist are rooted in a colonial system and therefore do not adequately take the perspectives of their Indigenous clients into account. This in turn results in culturally inappropriate services that are inadequate in responding to clients' needs. The way to improve services, as outlined in these articles, is to educate practitioners about Indigenous perspectives on health and mental health, and to incorporate these perspectives into the mental health services and programs being offered to Indigenous clients.

Four articles (see Appendix A, Table 3) outline theoretical approaches used to inform the delivery of mental health services for Indigenous peoples, including anti-oppressive approaches (Green, 2010), developmental approaches (for adolescents) (Wekerle et al., 2007), expressive therapies (Graham, 2013), and intersectional analyses (that is, taking into account people's multiple life experiences and the broad

range of factors affecting their mental health when offering mental health treatment) (Smye et al., 2011). Four articles argue for the development of an ethical framework for the delivery of mental health services, so that accountability for funding and continuity of services can be established. For example, Tait (2008) argues for a set of moral standards based on cultural safety and ethical space (Ermine, 2007), to apply to mental health and addictions services for Indigenous peoples. The remaining articles have diverse foci. Tough et al. (2007), in an article on Fetal Alcohol Spectrum Disorder prevention, find that physicians with high proportions of Aboriginal patients are more likely to ask patients about drinking patterns and substance use problems. Josewski (2012) points to the role of policy in constraining the abilities of mental health services to address issues of cultural safety. Lessard et al. (2015) examine breaks or delays in the continuum of care for adults in Nunavik seeking help with common mental health problems including anxiety and depression. This study finds that "more than half (62%) the episodes of care were interrupted before the second follow-up" (Lessard et al., 2015, n.p.). Dobson and Schmidt (2015) look at the concept of mental health from a specific cultural perspective in order to explore the relevance of mental health services to Dakelh people in northern British Columbia. Keightley et al. (2009) examine issues related to the care of Aboriginal individuals with brain injuries. Newton et al. (2012) find that, among children accessing an Emergency Department for mental health crises in Alberta, rates are highest among First Nations children; these children are also more likely to return and have the longest time to follow-up with a physician. Niccols et al. (2010) describe gender-specific as well as Aboriginal-specific barriers to treatment for substance abuse for pregnant Aboriginal women. Many of the articles in this category argue strongly for a trauma-informed (including intergenerational trauma) approach to mental health care for Indigenous peoples (e.g., Gone, 2013; Roy, 2014), and many take the structures of colonialism as the major barrier for Indigenous peoples in accessing mental health care in Canada.

3.1.3. *Prevalence of mental illness*

Thirty-three articles (15 percent) deal with the prevalence of different types of mental illness (see Appendix A, Table 4). Of these, nine focus on substance use

disorders including alcohol use, drug use, cigarette smoking, and problem gambling (which is the sole remaining entry under “addictions” in the DSM-V (Nelson et al., 2016; O'Brien, 2010)); nine articles look at rates of any mental health or substance abuse problem; five focus on depression; two on anxiety; two on suicide; and two on memory loss and dementia. Further, one article focuses on neurological conditions (Bourassa et al., 2015); one on perceived stress (Rieger and Heaman, 2016); one on complicated grief (Spiwak et al., 2012); and one on seasonal affective disorder (Tam and Gough, 2013).

3.1.4. *Mental health promotion*

Twenty-five of the 223 articles (11 percent) have mental health promotion as a major research theme (see Appendix A, Table 5). Of these, nine articles focus on wellness promotion through the strengthening of community, culture, and/or Indigenous identity. For example, Petrasek Macdonald et al. (2013) review protective factors involved in maintaining good mental health for Indigenous youth living in the north, of which the most important factor has to do with strengthening a sense of community and connectedness to Indigenous cultures. Seven articles focus on suicide prevention programs, efforts, and recommendations. Three explicitly engage with the concept of resilience; for example, Kirmayer et al. (2011) report on adapting the psychological construct of resilience for (and with) Indigenous communities, taking relational, historical, language and cultural resources, and renewing agency as factors. Two are related to prevention of alcohol use problems; for example, Ames et al. (2015) look at relationships between alcohol use, self- esteem, optimism and depression, and Rawana and Ames (2012) look at protective factors against alcohol use among Indigenous adolescents who do not drink. The remaining articles deal with diverse topics. Crooks et al. (2010) report on successes they have had with increasing school engagement among Indigenous youth. Ferrazzi and Krupa (2016) evaluate the applicability of “rehabilitation-oriented criminal court mental health initiatives” in Nunavut, the goal of which are to keep those with mental illnesses out of the criminal justice system. McHugh et al. (2014) study how young Aboriginal women conceptualize body pride, and Potvin-Boucher and Malone (2014) focus on

improving mental health literacy among Indigenous youth.

3.1.5. *Mental health research*

Sixteen articles (7 percent) focus on the processes of conducting mental health research (see Appendix A, Table 6). Seven of these describe the development or adaptation of measurement tools used in the evaluation of Indigenous mental health: Young et al. (2015a, 2015b, 2013) focus on the Aboriginal Child Health and Wellness Measure (ACHWM); Williamson et al. (2014) evaluate the various measurement tools used in assessments of Indigenous youth mental health from 1998 to 2008 in Australia, New Zealand, Canada and the United States; Snowshoe et al. (2015) develop a Cultural Connectedness Scale to evaluate cultural connectedness among Aboriginal youth; Clarke (2008) validates postpartum depression scales for First Nations and Me□tis women; and Bougie et al. (2016) validate the 10-item Kessler Psychological Distress Scale (K10) for use with Aboriginal peoples. Four articles are systematic reviews: Demarchi et al. (2012) search for and evaluate existing instruments to assess psychotic symptoms for Indigenous peoples; Harder et al. (2012) evaluate the methodological rigour of studies of Indigenous youth suicide; Kumar et al. (2012) investigate gaps in Metis-related health research; and Rountree and Smith (2016) describe community-developed well-being indicators for Indigenous peoples around the world. Stewart (2009) is concerned with the tensions involved in being an Indigenous researcher, related to perceived conflicts between academic research and Indigenous community values; and Davey et al. (2014) evaluate staff use of research in Aboriginal addictions programs serving women. Burack et al. (2007) argue for a developmental approach to researching risk among Indigenous youth; and Chachamovich et al. (2013) provide a description and evaluation of a psychological autopsy method they have used.

3.2. *Population groups included in research*

The major population groups that are the focus of the research reviewed here are identified as follows: (1) Indigenous or Aboriginal peoples in general (including Indigenous or Aboriginal women, and Indigenous or Aboriginal children and youth); (2) First Nations peoples (including First Nations women, children, and residential school

survivors); (3) Inuit (including Inuit youth and people living in the territory of Nunavik, in northern Quebec); (4) Metis peoples; (5) urban or off-reserve Indigenous populations; and (6) health care workers or traditional healers. It is important to note that the categories are not mutually exclusive. For example, if an article focuses on urban First Nations peoples, the total count includes '1' for 'urban' populations and '1' for 'First Nations.' The population groups that are the focus of each article are summarized in Fig. 3, which compares the proportion of total articles devoted to each group to that population group's share of the total Indigenous population in Canada.

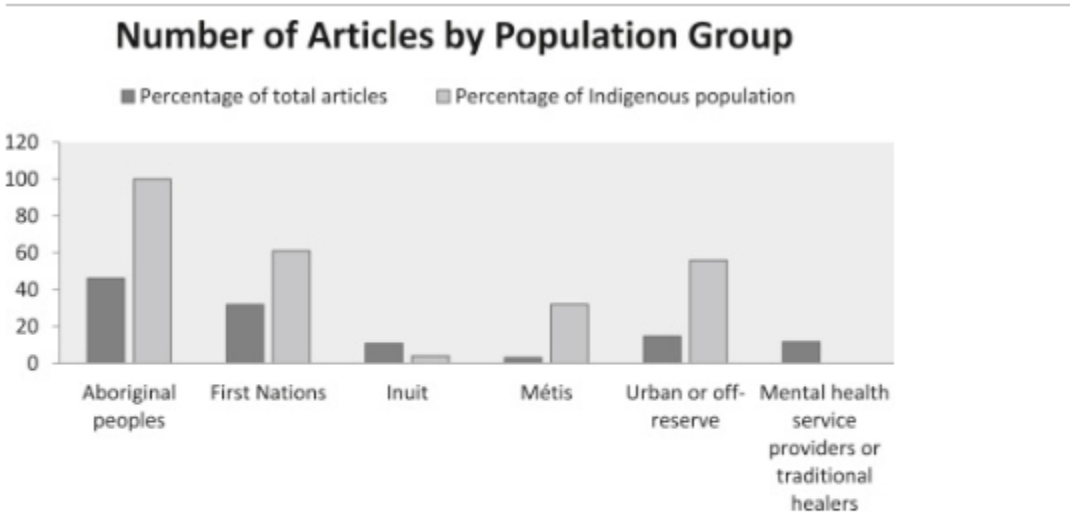

Fig. 3. Number of articles by population group (Source: Statistics Canada, 2015a).

Almost half of the articles (103, or 46 percent) only identify the study populations as "Aboriginal" or "Indigenous," making it difficult to determine whether the populations included are First Nations, Inuit, Metis, or another group (see, e.g., Alaazi et al., 2015; Bombay et al., 2014a, 2014b; Chandler and Proulx, 2006). Twenty-nine articles relate to Indigenous children and/or youth (see, e.g., Ames et al., 2015; Burack et al., 2007; Kaspar, 2013); 17 look at the mental health of Indigenous women (see, e.g., Alani, 2013; Green, 2010; Niccols et al., 2010); two focus on Indigenous men (Gross et al., 2016; Menzies, 2008); and 19 focus on urban Indigenous peoples or Indigenous peoples living off-reserve (see, e.g., Bougie et al., 2016; Gross et al.,

2016; The Cedar Project Partnership et al., 2008a,b).

Seventy-one articles (32 percent) focus specifically on First Nations peoples (see, e.g., Adelson, 2008; Elias et al., 2012; Whitbeck et al., 2014). Some distinctions are made between on- reserve and off-reserve First Nations; however, no articles make a distinction between status and non-status First Nations.

Twenty-seven articles deal with the mental health of First Nations children and/or youth (see, e.g., Chalmers and Dell, 2011; Cheadle and Whitbeck, 2011; Young et al., 2015a, 2015b). Ten articles look at First Nations women (see, e.g., Badry and Felske, 2013; Bottorff et al., 2009; Tait, 2013); one focuses on First Nations men (Janelle et al., 2009); and one focuses on First Nations Elders (Hulko et al., 2010). 23 articles specify which First Nation or cultural group they are talking about, such as Cree, Shibogama, Mi'kmaq, Dene, or Carrier-Sekani (see, e.g., Dionne and Nixon, 2014; Harder et al., 2015; Sareen et al., 2013). Only two focus on off-reserve or urban First Nations people (Firestone et al., 2015a; Guevremont and Kohen, 2013), whereas 40 specify a location on-reserve (see “Geographies,” below).

Twenty-four articles (11 percent) were retrieved in this search that include Inuit peoples (see, e.g., Auclair and Sappa, 2012; Chachamovich et al., 2015, 2013; Healey et al., 2016). Nine of these focus on the mental health of Inuit children and/or youth (see, e.g., Dell et al., 2011a; Fraser et al., 2015, 2012; Kral et al., 2014); and two focus on Inuit women (Badry and Felske, 2013; Fraser et al., 2012). No articles were found that focus on Inuit living in urban areas.

Significantly, only seven articles (three percent) focus on Metis peoples (Clarke, 2008; Crooks et al., 2010; Isaak et al., 2015; Kaspar, 2014; Kirmayer et al., 2011; Kumar et al., 2012; Ryan et al., 2015); one on First Nations and Me□tis youth (Crooks et al., 2010), one on First Nations and Metis women (Clarke, 2008), and one on Me□tis peoples off-reserve (Kaspar, 2014); making the Me□tis the most under-represented group in the research examined here. One re- view of Me□tis-focused health research in Canada notes that, although health research in general is giving more focus to Me□tis peoples, a significant gap remains with respect to mental health research (Kumar et al., 2012). This is a significant oversight, especially given that Metis peoples make up 32 percent of the Indigenous population in Canada (Statistics

Canada, 2015a).

Twenty-six of the articles (12 percent) take as their study population mental health service providers, traditional or Indigenous healers, clients of mental health services, or all three (see, e.g., Dobson and Schmidt, 2015; Josewski 2012; Maar and Shawande, 2010). Clients are generally identified as Indigenous, as are many (but not all) service providers. One study tracks changes over time in non-Indigenous service providers' concepts of their own racial identity and cultural worldview after working in predominantly Inuit communities (Wihak and Merali, 2007). The main foci of this set of research are an evaluation of the cultural relevance of the mental health services provided, or accessed, by Indigenous peoples, as well as the challenges and opportunities faced by both Indigenous and non-Indigenous service providers in a variety of contexts.

3.3. Geographies

The geographic foci of the articles, compared with the proportion of the Indigenous population living in each geographic region, are summarized in Fig. 4. In terms of geographic area of focus, 83 articles look at Canada as a whole (see, e.g., Ames et al., 2015; Currie and Wild, 2012; Czyzewski, 2011). 18 of these include data from Canada in addition to other countries, including the U.S., Australia, New Zealand, Guam, Brazil, and the entire globe (see, e.g., Bowen et al., 2014; Leske et al., 2016; Whitbeck et al., 2014, 2009, 2008, 2006a, 2006b). For example, Whitbeck et al. (2009) examine the impact of historical loss on Indigenous youth, from a common cultural group, in the northwestern United States and Central Canada. Five articles focus on Arctic Canada, Inuit Nunaat (Inuit territory including Nunavut, Nunavik, Nunatsiavut & Inuvialuit Settlement Region), or the (global) circumpolar north (Kral et al., 2009; Lehti et al., 2009; Petrasek Macdonald et al., 2013; Redvers et al., 2015; Willox et al., 2015). For example, Lehti et al. (2009) conduct a systematic review of the literature regarding mental health, suicide, and substance abuse for Indigenous youth in the Arctic. These regional foci often centre Indigenous rather than colonial geographies, by crossing nation-state boundaries in order to include entire indigenous groups or territories that transcend these borders.

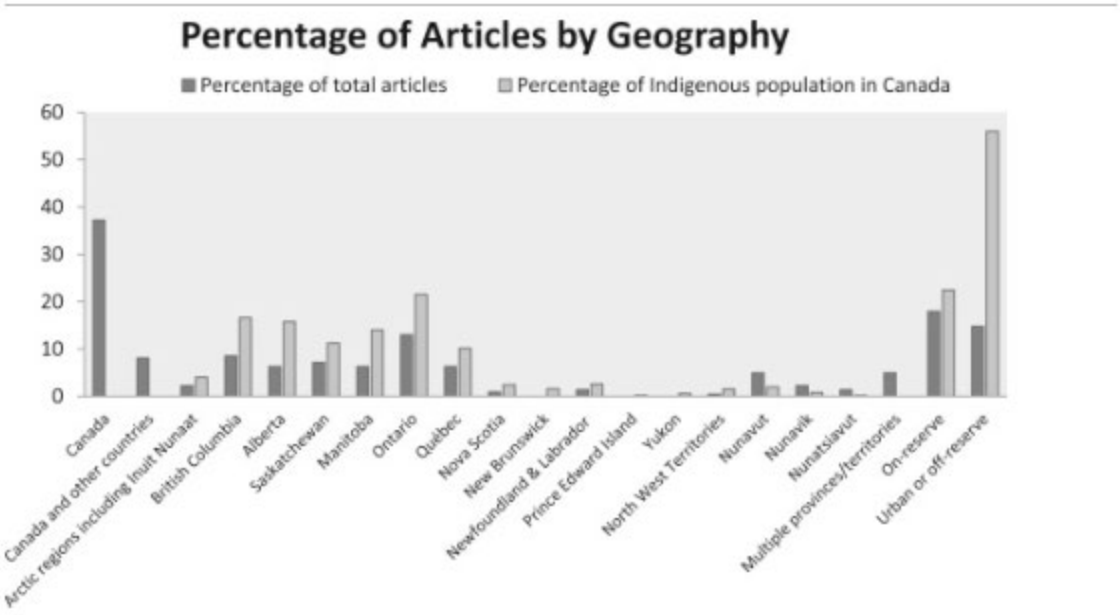

Fig.4. Percentage of articles by geography (Source: Statistics Canada, 2015a).

The majority of the provinces are slightly underrepresented with respect to the proportion of the Indigenous population in Canada living there. Nunavut, Nunavik and Nunatsiavut are slightly overrepresented in Indigenous mental health research, a fact which most likely represents their acknowledgement as Indigenous territories. The urban Indigenous population is dramatically under- represented in the research analyzed here.

Most studies focus on Ontario (n = 29; see, e.g., Finlay et al., 2010; Gibson et al., 2011a; Goudreau et al., 2008) and British Columbia (n = 19; see, e.g., Gerlach, 2008; Hughes, 2006; McCall and Lauridsen-Hoegh, 2014). 16 articles focus on Saskatchewan (see, e.g., Cushon et al., 2016; Dell et al., 2008); 14 articles focus on Alberta (see, e.g., Currie et al., 2015, 2013, 2012; Newton et al., 2012); 14 articles focus on Manitoba (see, e.g., Bone et al., 2011; Gone, 2013); and 11 on Nunavut (a northern territory, formerly part of the Northwest Territories, now under Inuit governance; see, e.g., Haggarty et al., 2008; Healey et al., 2016). Nine articles focus on Quebec (see, e.g., Gill et al., 2016; Janelle et al., 2009) and five on Nunavik (Inuit territory in northern

Quebec; see, e.g., Lessard et al., 2015; Lucas et al., 2010). Three articles focus on Nunatsiavut (northern Labrador) (Durkalec et al., 2015; Petrasek MacDonald et al., 2015; Willox et al., 2013), two on Nova Scotia (Vukic et al., 2009; Zahradnik et al., 2010), and one on the Northwest Territories (Badry and Felske, 2013).

Ten articles look at multiple provinces and/or territories within Canada (including Nova Scotia, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia, the Yukon, the Northwest Territories, and Nunavut; see, e.g., Burton et al., 2015; Kant et al., 2013). No studies were found relating to New Brunswick, Prince Edward Island, or Newfoundland.

Forty articles (18 percent) focus on on-reserve Indigenous communities (see, e.g., Belanger, 2010; Cheadle and Whitbeck, 2011; Katt et al., 2012). The Census shows that in 2011, approximately 22 percent of the total Indigenous population in Canada were living on-reserve (Statistics Canada, 2015a). Of the 223 papers reviewed here, the 18 percent that refer to the on-reserve Indigenous population corresponds closely to the proportion of Indigenous peoples living on-reserve. In contrast, only 33 of the 223 articles, or 15 percent, are focused on urban or off-reserve settings (see, e.g., Bougie et al., 2016; Bowen and Muhajarine, 2006; Snyder and Wilson, 2015), compared to 56 percent of the Indigenous population (Statistics Canada, 2015b). The latter group is dramatically underrepresented in the articles analyzed here, compared to how many Indigenous people are living in urban or off-reserve areas in Canada.

4. Discussion

The purposes of this critical review are to determine the scope and representativeness of research on Indigenous mental health in Canada, and to identify any gaps in this literature. Before discussing the key findings it is important to note that the review does not include a search of the ‘grey’ literature e that is, research reports produced by the government, non-profit agencies, or others that were not submitted to peer-reviewed journals. Including such work may increase the number of articles on the topic of Indigenous mental health, including documents such as mental health strategies that have been adopted by various organizations, health authorities, provinces or territories, which may have contributed additional information. That said, we believe that

the 223 articles reviewed here provide a solid representation of the typical research being done on Indigenous health in Canada.

The majority of mental health research reviewed in this paper addresses issues of colonialism e either in mental health services, in relation to community wellness promotion, or as a social determinant of Indigenous mental health. This includes colonial policy, child welfare systems, residential schools and the concept of historical or intergenerational trauma. It also includes studies on how to counteract a colonial focus in mental health services, and how to strengthen cultural identity and pride as a wellness pro- motion tactic. Given concerns about colonial assumptions in research, the predominant focus on colonialism in research on mental health services, mental health research, and the social determinants of health, resonates with the broader literature on colonialism and Indigenous health in Canada (Greenwood et al., 2015). While the topic of colonialism is often taken up in nuanced ways in the articles included in this analysis, it is important to note that at the same time, the term 'colonialism' is often used to refer to issues which are effects of colonialism rather than part of the colonial structure itself. For example, many articles use individual experiences in residential school as a quantitative indicator of colonialism, which can lead to a narrowed understanding of the term. As a broad and ongoing process with a long history, it can be easy to misinterpret colonialism as something that happens to individual people, rather than as a generalized structure whose intersections with capitalism, class, race, and gender are complex and not always easily identifiable. The effects of colonialism are myriad and not generalizable. Indigenous peoples have in common an experience of colonialism; however, different encounters and experiences with different aspects of the colonial structure can look very different and it is important not to overlook this diversity (Byrd, 2011; Pasternak, 2015; Wolfe, 2006). It is important, moving forward, for research on the mental health of Indigenous peoples to consider the concept of colonialism carefully, in order to ensure that the societal and structural level problems of a colonial society are not obscured by attention to the immediate mental health needs of individuals. Both can be considered simultaneously.

The cumulative effects of colonialism, through several generations, on Indigenous peoples in North America are often conceptualized as historical or

intergenerational trauma. Originating with Yellow Horse Brave Heart (2003) and Duran and Duran (Duran and Duran, 1995), the literature on historical or intergenerational trauma has proliferated in the past twenty years (Maxwell, 2014). Historical trauma is generally conceived as the effects of colonial devastation and loss (such as warfare, massacres, disease and, most commonly in Canada, Indian Residential Schools) on an individual as well as on their children, grandchildren, and future generations. The idea is that such experiences have communal effects that reach beyond an individual person, and that these effects can persist through generations (Bombay et al., 2009; Czyzewski, 2011). Intended as a way to link individual and social problems with the community-wide losses that have accompanied colonialism in Canada, some authors caution that historical trauma is becoming medicalized, referring to the process by which the problems of a community or a collective become a medical problem to be treated individually (Maxwell, 2014). The literature included in this paper reflects the history and current developments in the concept of historical trauma, including critical reviews (Kirmayer et al., 2014; Maxwell, 2014) and empirical analyses of the concept (Bombay et al., 2009; Elias et al., 2012), more of which would definitely be a positive direction for research in this area.

Much of the mental health research reviewed in this paper describes, and advocates for, the process of integrating Indigenous methods of healing into the system of mental health services. While there are challenges in doing so, many authors argue that the very process of attempting to integrate services in this way goes some distance towards challenging, and changing, the colonial attitudes that are often found embedded in mental health services (Vukic et al., 2009; Maar and Shawande, 2010a). That said, the focus of research on this type of integration leaves some gaps. Specifically, the majority of the articles included in this review draw a sharp distinction between Indigenous ways of knowing (and by extension, Indigenous methods of healing) and Western ways of knowing (and by extension, biomedical mental health services). While differences in ways of knowing are important sources of misunderstandings in health and health care, overemphasizing such binary distinctions can collapse both Indigenous and Western world-views into homogeneous generalizations of what are in fact remarkably diverse perspectives. In other words, the

effect can be to reduce differences in ontology or epistemology to differences in culture (Blaser, 2012). Many of these stereotypes have their origins in colonial ideologies, in which “an essentialized ‘Other’ is con- structed in a way that homogenizes both the West and the rest and occludes on-going colonial relations” (Blaser, 2012, p. 51). Further, focusing on individual practitioners' attitudes and behaviours, or the policies of individual health care institutions, may deflect attention from the ways in which colonialism is institutionalized and structural in broader Canadian society (Smye et al., 2011; Smye and Browne, 2002). Another problem, articulated by Leske et al. (2016) and others, is that there is only a small, methodologically weak evidence base for culturally adapted, integrated, or otherwise community-based interventions. Overall, it is important to examine more deeply which mental health practices and interventions are most beneficial for different Indigenous peoples in different con- texts, as well as to be mindful of which practices tend to be labelled “Indigenous” and which “Western,” and for what reasons.

The goal of integrating Indigenous thought and healing practices into mainstream mental health care, however, is to make the experience of accessing services more comfortable for Indigenous people, and to make health care practitioners and decision makers aware of the colonial basis of much medicalized mental health care. In this respect, the literature reviewed in this analysis intersects with the literature on cultural safety in health care (Josewski 2012; McCall and Lauridsen-Hoegh, 2014). The paradigm of cultural safety assumes that culture has an important impact on health that is related to societal imbalances of power; its goal is to achieve health equity among different populations by addressing power imbalances in health care. Culture is defined broadly as a concept that goes beyond race or ethnicity (Papps and Ramsden, 1996). Another important tenet is that the people receiving services are empowered to decide whether or not they feel culturally safe in a given encounter e it is not the providers of health care services who evaluate cultural safety (Browne et al., 2009; Papps and Ramsden, 1996). Perhaps most importantly, cultural safety requires self-reflection on the part of the health care provider with respect to his or her own cultural context and the impact of his or her culture on the provision of health care (Browne et al., 2009; Ramsden and Spoonley, 1994).

Another approach advocated by many papers reviewed here is the use of Indigenous “culture” as a healing practice (e.g., Gone, 2013). Culture proves to be a difficult concept, often left undefined even in studies which purport to measure its impact, as Harder et al. (2012) point out. Colonialism can also be minimized by discussions which frame it as a cultural problem rather than as a political, social, economic and land-based issue (Lawrence, 2012). Many of the articles reviewed here rely on a concept of culture that may reinforce multicultural ideals which, in turn, limit decolonization to the inclusion of “cultural” activities or perspectives within mental health care and preclude more substantial political, social, economic, jurisdictional and territorial decolonization. Overall, however, the message imparted by articles related to Indigenous culture-based mental health interventions is that effective services are those which are developed with the participation and input of community members and which take the history of colonialism in Canada into account. In other words, community control of mental health services, from their inception, seems to be the best predictor of their success.

In terms of prevalence of mental illnesses, the most common topics studied in articles in this review are substance use, including the comorbidity of substance use problems with mental illness, and suicide. Articles included in this study almost universally state that rates of mental health problems among Indigenous peoples in Canada are higher than those found in the general population, and most frequently relate these mental health problems to experiences of historical trauma. Historical trauma in its original formulation includes substance use and suicide as symptoms; as Yellow Horse Brave Heart writes, “the HTR [Historic Trauma Response] often includes depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions” (2003, p. 7). While the focus on historical trauma as a model to understand the effects of colonialism on Indigenous individuals and communities is important, emphasizing substance use and suicide in so much of the research on Indigenous mental health can have unintended con- sequences. Myths about Indigenous peoples such as “The Alcoholic Aboriginal” or “The Depressed Aboriginal” (Waldram, 2004) can be unintentionally perpetuated. As Maxwell (2014) points out, the discourse of historical trauma can be used to

individualize and medicalize the effects of colonialism, and divert attention from the more foundational structural issues facing Indigenous peoples in Canada. For the general Canadian population, major mental ill- nesses include depression, suicide, and substance abuse, but also extend to anxiety, schizophrenia, bipolar disorder, personality disorders, seasonal affective disorder and eating disorders (Canadian Mental Health Association, 2016; Mental Health Commission of Canada, 2012; Mood Disorders Society of Canada, 2009); illnesses which are not addressed in most research on Indigenous mental health in Canada.

Distinctions in prevalence rates between different Indigenous communities are also significant, yet underemphasized in the research reviewed in this paper. For example, although high rates of alcohol consumption are more common among First Nations women in Ontario than among non-First Nations women, rates of abstinence from alcohol are also found to be higher in the former group (MacMillan et al., 2008). A well-known study conducted in British Columbia finds that rates of youth suicide vary widely among First Nations, with high rates being concentrated in just a few communities and many communities having much lower rates than the national average (Chandler and Lalonde, 1998). Further- more, much research seems to conflate mental illness with suicide and substance abuse, whereas the latter two may be indicators of mental health problems rather than mental health problems *per se*. As Vukic et al. point out, “while several studies have investigated Aboriginal mental health and services related to suicide and sub- stance abuse, minimal research has been done specifically about mental illness” (2009, p. 432).

The emphasis on certain mental illnesses over others, in research pertaining to Indigenous peoples’ mental health, can also have implications for access to health care. Prevalent themes in research can lead to perceptions on the part of health care providers that an Indigenous person is most likely to be suffering from substance use problems or having suicidal thoughts. Scholars have documented the fact that such perceptions often lead to inaccurate diagnosis, inappropriate delays of treatment, and in some cases the complete denial of health care for Indigenous peoples (Browne, 2007; Nelson et al., 2016). Most Canadians who report experiencing a mental health problem also report feeling stigma as a barrier to seeking help or treatment for a mental health

problem (Canadian Mental Health Association, 2016; Mood Disorders Society of Canada, 2009); when this stigma is layered with racialized discrimination and experiences of colonialism, it is likely to be much more difficult for Indigenous peoples to seek help (Browne, 2009; Fiske and Browne, 2006).

It should be noted that for the purposes of this paper, mental illnesses or mental health problems generally refer to those identified in formalized health care institutions, usually according to categories laid out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V and earlier; American Psychiatric Association, 2017). Several scholars, including authors of articles reviewed here, have pointed out that the relevance of these categories for Indigenous communities is extremely limited (Duran and Duran, 1995; Gone, 2009; Kirmayer and Valaskakis, 2009; Waldram et al., 2006). A more useful direction for future research, and one taken by several of the studies examined in this paper (Healey et al., 2016; Kral et al., 2011), may be to begin with Indigenous concepts of disorder or imbalance, specific to particular cultures and communities, rather than structuring research with Indigenous peoples around Western modes of categorizing mental health problems.

In terms of population, there are significant gaps in the literature reviewed. Articles predominantly focus on Indigenous or Aboriginal peoples in general, or specifically First Nations peoples or Inuit, to the near exclusion of Metis peoples, and with only limited attention to more specific identities based in (for example) community, nation, or language. In some cases looking at specific Indigenous identities is extremely complex or in fact unwarranted, such as in studies dealing with urban populations, studies giving an overview of colonialism, or studies examining government policy or legislation. The choice of including all Indigenous peoples is often deliberate and reflects an acknowledgement of the similar colonial situation created for all Indigenous groups in Canada by the presence of the nation-state. However, it can also reflect problems related to identity politics and how data is collected and collated. Many of the studies analyzed here use quantitative data from national sources such as the Aboriginal Peoples Survey. The Aboriginal Peoples Survey is the only national survey in Canada that specifically targets the broader Indigenous population. While the Assembly of First Nations in Canada has launched a

longitudinal survey of Indigenous health, this survey only covers health issues for First Nations individuals living on-reserve (First Nations Information Governance Centre, 2016). As such, it excludes Inuit and Metis populations along with First Nations people who live off- reserve (i.e., in rural or urban settings). The Aboriginal Peoples Survey (APS), on the other hand, is limited to only off-reserve populations, but does collect data from status and non-status First Nations, Inuit and Me□tis populations. However, the APS categorizes Aboriginal peoples into three groups; First Nations, Me□tis and Inuit. These three broad categories are not sufficient for acknowledging the distinct identities within each group. Thus, this categorization is a crude measure of Aboriginal identity that creates three homogeneous categories of Aboriginal peoples, which do not actually exist. Due to the essentialized categorization of Aboriginal identity, researchers using such surveys are not able to draw finer distinctions among groups or provide data that give a more accurate picture of the prevalence of mental illnesses among different groups of Indigenous peoples in Canada.

A further complication is related to jurisdictional issues regarding the funding of health services, including mental health. The Federal government mainly assumes financial responsibility for health care for status First Nations people living on-reserve. Status First Nations people living off-reserve can access certain services such as prescription drugs and eyeglasses through the federal government's Non-Insured Health Benefits program. However, off- reserve status First Nations individuals along with non-status First Nations, Inuit, and Metis people must utilize health care services, such as hospitals, provided under provincial jurisdiction. It becomes very difficult to identify health data specific to Metis populations because of the homogenization of health services and health data at the provincial level, which perhaps contributes to the dramatic lack of research pertaining to Me□tis mental health in this review.

Women, who represent 51 and 52 per cent of the Indigenous and First Nations populations of Canada, respectively (O'Donnell and Wallace, 2011), are the focus of only 13 per cent of the articles (n = 30). Given the significantly gendered impacts of colonialism in Canada, this is an area in which more research should be focused (Browne, 2007; Lawrence, 2003). Another notable lack in terms of gendered analysis is the extremely small number of studies relating to Indigenous

men (n = 3, or just over one percent), who are overrepresented in rates of death due to injury and poisoning (including suicide), indicators of the effects of racial discrimination and colonialism (Mood Disorders Society of Canada, 2009). Indigenous or First Nations children and youth are the focus of 66 articles (30 percent), which is more comparable to the pro- portion of young people in Indigenous populations in Canada (about 48%), although still low (Statistics Canada, 2015a). Only one study focused on First Nations Elders, reflecting an almost complete exclusion of older Indigenous people (see, e.g., Wilson et al., 2010).

Inuit are actually overrepresented compared to population numbers, whereas Metis and urban Aboriginal peoples are drastically underrepresented in the research analyzed here. The same result has been found in other studies related to the overall health of Indigenous peoples (Wilson and Young, 2008; Young, 2003). Wilson and Young (2008) provide some possible explanations for these imbalances:

> The focus on Inuit populations may be explained by the fact that, in general, there has been a historical research focus on the Inuit population, especially with respect to ethnography. In addition, it may be more difficult for researchers to access urban-based populations [perhaps including many Metis] because they tend to lack a land base (from which they can be easily identified) and a central administrative organization or group that could facilitate access to such a diverse population. In contrast, the Inuit population is easily identified by its geographic location and there are clear research guidelines and licensing procedures required by the Nunavut Research Institute. (p. 185).

Again, it is possible that unevenness in research may be created by unevenness in data availability, centralized governance, and formalized research institutions and regulations. The idea that contemporary mental health research pertaining to Inuit, or other Indigenous peoples in Canada, may follow in the footsteps of its intellectual predecessors may also sound a note of caution. Meta- analyses of colonialism and the history of mental health research with Indigenous peoples suggest that the topics taken up by contemporary researchers may be more the result of a colonial intellectual history marred by assumptions of racial inferiority, rather than informed choices (Gone, 2009; Waldram, 2009, 2004).

In terms of geographical representation, a dramatic gap in the literature was found relating to urban and off-reserve populations. Only 15 per cent (n = 33) of articles were relevant to the urban- based population, in spite of the 56 percent of Indigenous peoples who live in urban areas of Canada (Aboriginal Affairs and Northern Development Canada, 2014). As other studies have found, despite the increasing proportion of Indigenous peoples living in cities, research related to urban Aboriginal peoples has not kept pace (Waldram et al., 2006; Wilson and Young, 2008). This may be explained, in part, by difficulties with data availability, as discussed above. However, it is also possible that mental health research pertaining to Indigenous peoples in Canada continues to be informed by colonial ideas, which locate Indigenous peoples in remote and rural areas and erase them from cities (Edmonds, 2010; Royal Commission on Aboriginal Peoples, 1996).

Ignoring or underrepresenting such significant Indigenous communities and groups in research, such as urban populations, women, older populations, and Me□tis peoples, can lead to over- generalizations about Indigenous peoples' experiences of mental health problems, and overlook issues unique to those populations.

5. Conclusions

The majority of mental health research reviewed in this paper, related to Indigenous peoples in Canada, deals with the topic of colonialism and the effects of colonization on Indigenous peoples' and communities' health and well-being, emphasizing the pivotal role that colonial practices and policies have played, and continue to play, in Indigenous mental health. The remedies proposed by much of the research here reviewed rely on a concept of 'culture' which may reinforce multicultural ideals that, in turn, limit decolonization to the inclusion of 'cultural' activities within the colonial nation and preclude more substantial economic, jurisdictional and territorial decolonization. However, the overall message is still one of empowering communities and exercising community control over mental health services.

The emphasis placed on substance abuse and suicide, often in relation to the concept of historical trauma, necessitates a cautionary note. The themes of suicide and

substance abuse have a long history in mental health research with regard to Indigenous peoples, and the validity of much early research on these topics has been called into question (Waldram, 2004; Kirmayer and Valaskakis, 2009). In addition, while historical or intergenerational trauma can be helpfully used as models to explain the impacts of colonization on Indigenous peoples in Canada and around the world, the concepts are also at times employed to individualize and pathologize the impacts of colonialism e which is at its heart a collective and structural force, requiring collective and structural change.

Another prominent focus among the articles reviewed here is addressing colonial attitudes in mainstream mental health services by integrating them with Indigenous ways of healing. This often creates a dichotomy between Indigenous world views and Western perspectives; one which is not only arbitrary, obscuring the diversity within each of these categories, but which may also have the effect of reinforcing stereotypical views rooted in colonialism. Further, by focusing on individual practitioners' attitudes and practices within health care, such research may again overlook possibilities of addressing the structural and institutionalized roots of colonialism in society more broadly, in order to correct the problems at their source.

This review finds that both demographically and geographically, research on the mental health of Indigenous peoples in Canada shows some significant gaps. As a result of historical identity politics and jurisdictional issues with respect to the provision of health services, both health services and health data on Indigenous peoples in Canada do not adequately address the specific mental health determinants or issues faced by different Indigenous populations in different geographical spaces (for example, on-reserve and off- reserve). In particular, Me□tis peoples and urban or off-reserve Indigenous peoples are dramatically underrepresented; this is a significant gap which needs to be addressed. More research is needed which continues to take into account the impacts of colonialism, and critically examines the history of mental health research in Canada so as to avoid following patterns rooted in colonial stereotypes. The results of this study also point to the value of conducting similar reviews in other countries, as well as the need for more comparative work between countries and in different Indigenous contexts. These findings will be

useful in an international context by providing a starting point for discussions, dialogue, and further study regarding mental health research for Indigenous peoples around the world.

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Appendix A

Table 2

Research theme: Social determinants of health.

Author(s)	Year	Colonial	Problematic violence	Interpersonal substance use	Suicide	Social support	Other L
Adelson, N.	2008	X					
Alani, T.	2013		X				
Badry, D., Felske, A.W.	2013						X
Beswick, A., Zoccole, A., Dewey, C., Rourke, S., Watson, J., Lachowsky, N.	2013				X		

Berman, H., Mulcahy, G.A., Forchuk, C., Edmunds, K.A., Haldenby, A., Lopez, R.	2009					X
Bombay, A., Matheson, K., Anisman, H.	2014a	X				
Bombay, A., Matheson, K., Anisman, H.	2010		X			
Bombay, A., Matheson, K., Anisman, H.	2009	X				
Bombay, A., Matheson, K., Anisman, H.	2011	X				
Bombay, A., Matheson, K., Anisman, H.	2014b	X				
Bone, R., Dell, C., Koskie, M., Kushniruk, M., Shorting, C.	2011				X	
Bottorff, J.L., Carey, J., Mowatt, R., Varcoe, C., Johnson, J.L., Hutchinson, P., Sullivan, D., Williams, W., Wardman, D.	2009			X		
Chachamovich, E., Kirmayer, L.J., Haggarty, J.M., Cargo, M., Mccormick, R., Turecki, G.	2015				X	
Chandler, M., Proulx, T.	2006				X	

Clarke, D.E., Colantonio, A., Rhodes, A.E.,	20				X		
Escobar, M.	08						
Crawford, A.	20	X					
	13						
Currie, C.L., Wild, T.C., Schopflocher, D., Laing,	20		X				
L.	15						
Currie, C.L., Wild, T.C., Schopflocher, D.P.,	20			X			
Laing, L., Veugelers, P.	13						
Currie, C.L., Wild, T.C., Schopflocher, D.P.,	20		X				
Laing, L., Veugelers, P.	12						
Cushon, J., Waldner, C., Scott, C., Neudorf, C.	20						X
	16						
Czyzewski, K.	20	X					
	11						
de Finney, S., Greaves, L., Janyst, P., Hemsing,	20			X			
N., Jategaonkar, N., Browne, A., Devries, K.,	13						
Johnson, J., Poole, N.							
de Leeuw, S., Greenwood, M., Cameron, E.	20	X					
	10						
DeGagne□, M.	20	X					
	07						
Devries, K.M., Free, C.J., Saewyc, E.	20		X				

	12		
Dionne, D., Nixon, G.	20	X	
	14		
Durkalec, A., Furgal, C., Skinner, M.W.,	20		X
Sheldon, T.	15		
Elias, B., Mignone, J., Hall, M., Hong, S.P., Hart,	20	X	
L., Sareen, J.	12		
Fast, E., Collin-Ve□zina, D.	20	X	
	10		

(*continued on next page*)

Table 2 (*continued*)

Author(s)	Year	Colonialism	Interpersonal violence	Problematic substance use	Suicide	Social support	Land	Other
Fleming, T.-L., Kowalski, K.C., Humbert, M.L., Fagan, K.R., Cannon, M.J., Girolami, T.M.	2006							X
Fraser, S.L., Muckle, G., Abdous, B.B., Jacobson, J.L., Jacobson, S.W.	2012			X				
Goudreau, G., Weber-Pillwax, C., Cote-Meek, S., Madill, H., Wilson, S.	2008							X
Gue□vremont, A., Kohen, D.	2013							X
Gue□vremont, A., Kohen, D.	20							X

	12					
Haggarty, J.M., Cernovsky, Z., Bedard, M.,	20				X	
Merskey, H.	08					
Haskell, L., Randall, M.	20	X				
	09					
Henry, R.	20	X				
	13					
Hutchinson, P.J., Richardson, C.G., Bottorff, J.L.	20			X		
	08					
Jaworsky, D., Benoit, A., Raboud, J., O'Brien-	2016					X
Teengs, D., Blitz, S., Rourke, S.B., Burchell,						
A.N., Loutfy, M.R., OHTN Cohort Study						
Research Team						
Kant, S., Vertinsky, I., Zheng, B., Smith, P.M.	20					X
	13					
Kaspar, V.	20	X				
	14					
Kaspar, V.	20		X			
	13					
Kirmayer, L.J., Gone, J.P., Moses, J.	20	X				
	14					
Kral, M.J., Salusky, I., Inuksuk, P., Angutimarik,	20			X		

L., Tulugardjuk, N.	14						
Laliberte□, A., Tousignant, M.	20 09			X			
Lemstra, M.E., Neudorf, C., Mackenbach, J., D'Arcy, C., Scott, C., Kershaw, T., Nannapaneni, U.	20 08						X
Lemstra, M.E., Neudorf, C., Mackenbach, J., Kershaw, T., Nannapaneni, U., Scott, C.	20 09 b				X		
Lemstra, M.E., Rogers, M., Redgate, L., Garner, M., Moraros, J.	201 1a		X				
Lucas, M., Dewailly, E., Blanchet, C., Gingras, S., Holub, B.J.	20 09						X
Lucas, M., Kirmayer, L.J., De□ry, S., Dewailly, E.	20 10						X
Martin Hill, D.	20 09	X					
Maxwell, K.	20 14	X					
McCall, J., Lauridsen-Hoegh, P.	20 14	X					
McQuaid, R.J., Bombay, A., McInnis, O.A.,	20					X	

Matheson, K., Anisman, H.	15						
Menzies, P.	20	X					
	08						
Miller, C.L., Pearce, M.E., Moniruzzaman, A.,	201		X				
Thomas, V., Christian, C.W., Wayne, C.	1a						
Mitchell, T., MacLeod, T.	20	X					
	14						
Na, L., Hample, D.	20			X			
	16						
Nutton, J., Fast, E.	20	X					
	15						
Offet-Gartner, K.	20				X		
	11						
Petrasek MacDonald, J., Cunsolo Willox, A.,	20				X		
Ford, J.D., Shiwak, I., Wood, M., IMHACC	15						
Team, The Rigolet Inuit Community Government							
Poonwassie, A.	2006	X					
Rixen, A., Blangy, S.	2016					X	Roos, L.E., Distasio, J.,
Bolton, S.L., Katz, L.Y., Afifi, T.O., Isaak, C.A., Goering, P., Bruce, L., Sareen, J.	2014	X					
Ross, A., Dion, J., Cantinotti, M., Collin-Ve□zina, D., Paquette, L.	2015	X					

Ryan, C.J., Cooke, M.J., Leatherdale, S.T., Kirkpatrick, S.I., Wilk, P.	2015		X			
Snyder, M., Wilson, K.	2015				X	
Spence, N.D., Wells, S., Graham, K., George, J.	2016		X			
Taiaiake Alfred, G.	2009	X				
Tait, C.L.	2013	X				
The Cedar Project Partnership, Pearce, M.E., Christian, W.M., Patterson, K., Norris, K., Moniruzzaman, A., Craib, K.J.P., Schechter, M.T., Spittal, P.M.	2008		X			
Waldram, J.B.	2014		X			
Werk, C., Xinjie, C.	2013					X
Whitbeck, L.B., Walls, M.L., Johnson, K.D., Morrisseau, A.D., McDougall, C.M.	2009		X			
Willows, N.D., Ridley, D., Raine, K.D., Maximova, K.	2013				X	
Willox, A.C., Harper, S.L., Ford, J.D., Edge, V.L., Landman, K., Houle, K., Blake, S., Wolfrey, C.	2013	X				
Willox, A.C., Stephenson, E., Allen, J., Bourque, F., Drossos, A., Elgaroy, S., Kral, M.J., Mauro, I., Moses, J., Pearce, T., Petrasek MacDonald, J., Wexler, L.						

2015		X			
Wingert, S.	2011				X
Xin Feng, C., Waldner, C., Cushon, J., Davy, K., Neudorf, C.	2016			X	
Yi, K.J., Landais, E., Kolahdooz, F., Sharma, S.	2015				X
Zahradnik, M., Stewart, S.H., O'Connor, R.M., Stevens, D., Ungar, M., Wekerle, C.	2010		X		

Table 3

Research theme: Mental health services.

Author(s)	Year	Program evaluation/ description	Integration Theoretical approach	Ethics Other
Alaazi, D.A., Masuda, J.R., Evans, J., Distasio, J.	2015	X		
Auclair, G., Sappa, M.	2012	X		
Baskin, C.	2007a			X
Baskin, C.	2007b			X
Belanger, Y.D.	2010	X		
Carriere, J., Richardson, C.	20	X		

	13			
Chalmers, D., Dell, C.A.	20	X		
	11			
Crowe-Salazar, N.	20	X		
	07			
Dell, D., Hopkins, C.	20	X		
	11			
Dell, C.A., Seguin, M., Hopkins, C., Tempier, R., Mehl-	20	X		
Madrona, L., Dell, D., Duncan, R., Mosier, K.	11			
	b			
Dell, C.A., Chalmers, D., Bresette, N., Swain, S., Rankin,	201	X		
D., Hopkins, C.	1a			
Dell, C.A., Chalmers, D., Dell, D., Ernie, S., MacKinnon,	20	X		
T.	08			
Dobson, C., Schmidt, G.	20			X
	15			
Gerlach, A.	20		X	
	08			
Gibson, K., Coulson, H., Miles, R., Kakekakekung, C.,	201	X		
Daniels, E., O'Donnell, S.	1a			
Gibson, K., O'Donnell, S., Coulson, H., Kakepetum-	20	X		
Schultz, T.	11			

	b				
Gone, J.P.	20		X		
	13				
Graham, J.S.	20		X		
	13				
Green, B.L.	20		X		
	10				
Gross, P.A., Efimoff, I., Patrick, L., Josweski, V., Hau, K.,	20	X			
Lambert, S., Smye, V.	16				
Hughes, M.L.	20	X			
	06				
Josewski, V.	20				X
	12				
Katt, M., Chase, C., Samokhvalov, A. V, Argento, E.,	20	X			
Rehm, J., Fischer, B.	12				
Keightley, M.L., Ratnayake, R., Minore, B., Katt, M.,	20				X
Cameron, A., White, R., Bellavance, A., Longboat-	09				
White, C., Colantonio, A.					
Kiepek, N., Hancock, L., Toppozini, D., Cromarty, H.,	20	X			
Morgan, A., Kelly, L.	12				
Lavallee, L.F., Poole, J.M.	20	X			
	10				

Leske, S., Harris, M.G., Charlson, F.J., Ferrari, A.J.,	20		X		
Baxter, A.J., Logan, J.M., Toombs, M., Whiteford, H.	16				
Lessard, L., Fournier, L., Gauthier, J., Morin, D.	20				X
	15				
Li, X., Sun, H., Marsh, D.C., Anis, A.H.	20	X			
	13				
Maar, M.A., Shawande, M.	20	X			
	10				
Maar, M.A., Erskine, B., McGregor, L., Larose, T.L.,	20	X			
Sutherland, M.E., Graham, D., Shawande, M., Gordon,	09				
T.					
Malone, J.L., Stanley, D.	20	X			
	13				
Malone, J.L.	20				X
	12				
Marsh, T.N., Coholic, D., Cote-Meek, S., Najavits, L.M.	20	X			
	15				
McCabe, G.H.	20		X		
	08				
McCabe, G.H.	20		X		
	07				
McKennitt, D.W., Currie, C.L.	20	X			

	12				
Miller, L.D., Laye-Gindhu, A., Bennett, J.L., Liu, Y., Gold,	20	X			
S., March, J.S., Olson, B.F., Waechtler, V.E.	11				
	b				
Monthuy-Blanc, J., Bouchard, S., Maiano, C., Seguin, M.	20	X			
	13				
Newton, A., Rosychuk, R.J., Dong, K., Curran, J., Slomp,	20				X
M., McGrath, P.J.	12				
Niccols, A., Dell, C.A., Clarke, S.	20				X
	10				
Nowrouzi, B., Manassis, K., Jones, E., Bobinski, T.,	20	X			
Mushquash, C.J.	15				
O’Neill, L., George, S., Sebok, S.	20	X			
	13				
	b				
O’Neill, L., George, S., Koehn, C., Shepard, B.	201	X			
	3a				
Oulanova, O., Moodley, R.	20		X		
	10				
Pauly, B.B., Gray, E., Perkin, K., Chow, C., Vallance, K.,	20	X			
Krysowaty, B., Stockwell, T.	16				
Puchala, C., Paul, S., Kennedy, C., Mehl-Madrona, L.	20	X			

	10						
Redvers, J., Bjerregaard, P., Eriksen, H., Fanian, S.,	20	X					
Healey, G., Hiratsuka, V., Jong, M., Larsen, C.V.L.,	15						
Linton, J., Pollock, N., Silviken, A., Stoor, P., Chatwood, S.							
Reeves, A., Stewart, S.L.	2014	X					
Restoule, B.M., Hopkins, C., Robinson, J., Wiebe, P.K.	2015			X			
Ritchie, S.D., Wabano, M.J., Russell, K., Enosse, L., Young, N.L.	2014	X					
Rowan, M., Poole, N., Shea, B., Gone, J.P., Mykota, D., Farag, M., Hopkins, C., Hall, L., Mushquash, C., Dell, C.	2014			X			
Roy, A.	20		X				
	14						
Sareen, J., Isaak, C.A., Bolton, S.L., Enns, M.W., Elias, B., Deane, F., Munro, G., Stein, M.B., Chateau, D., Gould, M., Katz, L.Y.	20	X					
	13						
Schiff, J.W., Moore, K.	20	X					
	06						
Shepard, B., O'Neill, L., Guenette, F.	20		X				
	06						
Smye, V., Browne, A.J., Varcoe, C., Josewski, V.	20				X		
	11						
Tait, C.L.	20					X	
	08						

Thomas, G., Lucas, P., Capler, N.R., Tupper, K.W.,	20	X			
Martin, G.	13				
Thomas, W., Bellefeuille, G.	20	X			
	06				
Tough, S., Clarke, M., Cook, J.	20				X
	07				
Volpe, T., Boydell, K.M., Pignatiello, A.	20	X			
	14				
Vukic, A., Gregory, D., Martin-Misener, R., Etowa, J.	20				
	11				
Vukic, A., Rudderham, S., Misener, R.M.	20		X		
	09				
Wekerle, C., Waechter, R.L., Leung, E., Leonard, M.	20			X	
	07				
Wesley-Esquimaux, C.C., Snowball, A.	20		X		
	10				
Wihak, C., Merali, N.	20		X		
	07				
Zinck, K., Marmion, S.	20		X		
	11				

Table 4

Research theme: Prevalence of mental illness.

Author(s)	Year	Substance use disorders	Any mental health or substance use problem	Depression	Suicide	Anxiety	Dementia	Other
Bourassa, C., Blind, M., Dietrich, D., Oleson, E.	2015			X				
Bowen, A., Muhajarine, N.	2006			X				
Bowen, A., Stewart, N., Baetz, M., Muhajarine, N.	2009			X				
Bowen, A., Bowen, R., Maslany, G., Muhajarine, N.	2008			X				
Bowen, A., Duncan, V., Peacock, S., Bowen, R., Schwartz, L., Campbell, D., Muhajarine, N.	2014			X				
Brown, G.P., Hirdes, J.P., Fries, B.E.	20		X					

	15					
Burton, P., Daley, A., Phipps, S.	20		X			
	15					
Cheadle, J.E., Whitbeck, L.B.	20	X				
	11					
Currie, C.L., Wild, T.C.	20	X				
	12					
Derkzen, D., Booth, L., Taylor, K., McConnell,	20		X			
A.	12					
Elton-Marshall, T., Leatherdale, S.T.,	20	X				
Burkhalter, R.	11					
Firestone, M., Smylie, J., Maracle, S., McKnight,	201		X			
C., Spiller, M., O'Campo, P.	5a					
Firestone, M., Tyndall, M., Fischer, B.	20	X				
	15					
	b					
Fraser, S.L., Geoffroy, D., Chachamovich, E.,	20			X		
Kirmayer, L.J.	15					
Gill, K.J., Heath, L.M., Derevensky, J., Torrie, J.	20	X				
	16					
Hulko, W., Camille, E., Antifeau, E., Arnouse,	20				X	
M., Bachynski, N., Taylor, D.	10					

Kral, M.J.	2012				X	
Lehti, V., Niemela□, S., Hoven, C., Mandell, D., Sourander, A.	2009		X			
Lemstra, M.E., Mackenbach, J., Neudorf, C., Nannapaneni, U., Kunst, A.	200X9a					
Lemstra, M.E., Rogers, M.R., Thompson, A.T., Redgate, L., Garner, M., Tempier, R.,	2011b			X		
Moraros, J.						
MacMillan, H.L., Jamieson, E., Walsh, C.A., Wong, M.Y.-Y., Faries, E.J., McCue, H., MacMillan, A.B., Offord, D.R., The Technical Advisory Committee of the Chiefs of Ontario	2008	X				
Maranzan, K.A., Stones, M.J.	2013			X		
Mushquash, C.J., Stewart, S.H., Mushquash, A.R., Comeau, M.N., McGrath, P.J.	2014	X				
Riediger, N.D., Lukianchuk, V., Lix, L.M., Elliott, L., Bruce, S.G.	2015	X				
Rieger, K.L., Heaman, M.I.	2016					X

Spiwak, R., Sareen, J., Elias, B., Martens, P.,	20				X
Munro, G., Bolton, J.	12				
Tam, B.Y., Gough, W.A.	20				X
	13				
Warren, L.A., Shi, Q., Young, T.K., Borenstein,	20			X	
A., Martiniuk, A.	15				
Whitbeck, L.B., Hartshorn, K.J.S., Crawford,	20		X		
D.M., Walls, M.J., Gentzler, K.C., Hoyt, D.R.	14				
Whitbeck, L.B., Hoyt, D., Johnson, K., Chen, X.	200		X		
	6a				
Whitbeck, L.B., Johnson, K.D, Hoyt, D.R.,	20		X		
Walls, M.L.	06				
	b				
Whitbeck, L.B., Yu, M., Johnson, K.D., Hoyt,	20		X		
D.R., Walls, M.L.	08				
Williams, R.J., Belanger, Y.D., Prusak, S.Y.	20	X			
	16				

Table 5

Research theme: Mental health promotion.

Author(s)	Year	Community, culture, identity	Suicide prevention	Resilience Alcohol prevention	Other
Ames, M.E., Rawana, J.S., Gentile, P., Morgan, A.S.	2015			X	
Crooks, C. V., Chiodo, D., Thomas, D., Hughes, R.	2010				X
Ferrazzi, P., Krupa, T.	2016				X
Finlay, J., Hardy, M., Morris, D., Nagy, A.	2010	X			
Goin, L., Mill, J.E.	2013		X		
Harder, H.G., Holyk, T., Russell, V.L., Klassen-Ross, T.	2015		X		
Healey, G., Noah, J., Mearns, C.	2016	X			
Isaak, C.A., Campeau, M., Katz, L.Y., Enns, M.W., Elias, B., Sareen, J., Swampy Cree Suicide Prevention Team	2010		X		
Isaak, C.A., Stewart, D.E., Mota, N.P., Munro, G., Katz, L.Y., Sareen, J.	2015			X	

Janelle, A., Laliberte□, A., Ottawa, U.	2009	X					
Kirmayer, L.J., Sehdev, M., Whitley, R., Dandeneau, S.F., Isaac, C.	2009a				X		
Kirmayer, L.J., Dandeneau, S., Marshall, E., Phillips, M.K., Williamson, K.J.	2011				X		
Kral, M.J., Wiebe, P.K., Nisbet, K., Dallas, C., Okalik, L., Enuaraq, N., Cinotta, J.	2009			X			
Kral, M.J., Idlout, L., Monore, J.B., Dyck, R.J., Kirmayer, L.J.	2011	X					
Marquina-M□arquez, A., Virchez, J., Ruiz-Callado, R.	2016	X					
McHugh, T.L.F., Coppola, A.M., Sabiston, C.M.	2014						X
Mota, N., Elias, B., Tefft, B., Medved, M., Munro, G., Sareen, J.	2012			X			
Petrasek Macdonald, J., Ford, J.D., Cunsolo Willox, A., Ross, N.A.	2013	X					
Potvin-Boucher, J.T., Malone, J.L.	2014						X
Rawana, J.S., Ames, M.E.	2014					X	

	12		
Taylor, D.M., Usborne, E.	20	X	
	10		
Tempier, A., Dell, C.A., Papequash, E.C.,	20	X	
Duncan, R., Tempier, R.	11		
Tousignant, M., Vitenti, L., Morin, N.	20		X
	13		
Tremblay, M., Gokiert, R., Skrypnek, B.,	20	X	
Georgis, R., Edwards, K.	13		
Wortzman, R.L.	20		X
	09		

Table 6

Research theme: Mental health research.

Author(s)	Year	Measurement tools	Systematic reviews	Other
Bougie, E., Arim, R.G., Kohen, D.E., Findlay, L.C.	2016	X		
Burack, J., Blidner, A., Flores, H., Fitch, T.	2007			X
Chachamovich, E., Haggarty, J., Cargo, M., Hicks, J., Kirmayer, L.J., Turecki, G.	2013			X
Clarke, P.J.	2008	X		
Davey, C.J., Niccols, A., Henderson, J., Dobbins, M., Sword, W., Dell, C., Wylie, T., Sauve, E.	2014			X
Demarchi, C., Bohanna, I., Baune, B.T., Clough, A.R.	2012		X	
Hall, L., Dell, C.A., Fornssler, B., Hopkins, C., Mushquash, C.	2015			
Harder, H.G., Rash, J., Holyk, T., Jovel, E., Harder, K.	2012		X	
Kumar, M.B., Wesche, S., McGuire, C.	2012		X	
Rountree, J., Smith, A.	2016		X	
Snowshoe, A., Crooks, C. V., Tremblay, P.F., Craig, W.M., Hinson, R.E.	2015	X		
Stewart, S.L.	2009			X

Williamson, A., Andersen, M., Redman, S., Dadds, M., D'Este, C., Daniels, J., Eades, S., Raphael, B.	2014	X
Young, N.L., Wabano, M.J., Burke, T.A., Ritchie, S.D., Mishibinijima, D., Corbiere, R.G.	2013	X
Young, N.L., Wabano, M.J., Ritchie, S.D., Burke, T. a, Pangowish, B., Corbiere, R.G.	2015 a	X
Young, N.L., Wabano, M.J., Usuba, K., Pangowish, B., Trottier, M., Jacko, D., Burke, T.A, Corbiere, R.G.	2015 b	X

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American Psychiatric Association, 2017. Diagnostic and Statistical Manual of Mental Disorders (DSM-5), WWW Document. American Psychiatric Association. https://www.psychiatry.org/psychiatrists/practice/dsm.

Ames, M.E., Rawana, J.S., Gentile, P., Morgan, A.S., 2015. The protective role of optimism and self-esteem on depressive symptom pathways among Canadian Aboriginal youth. J. Youth Adolesc. 44, 142e154. http://dx.doi.org/10.1007/ s10964-013-0016-4.

Arksey, H., O'Malley, L., 2005. Scoping studies: towards a methodological frame-work. Int. J. Soc. Res. Methodol. 8, 19e32. http://dx.doi.org/10.1080/ 1364557032000119616.

Auclair, G., Sappa, M., 2012. Mental health in Inuit youth from Nunavik: clinical considerations on a transcultural, interdisciplinary, community-oriented approach. J. Can. Acad. Child. Adolesc. Psychiatry 21, 124e126.

Badry, D., Felske, A.W., 2013. An examination of the social determinants of health as factors related to health, healing and prevention of foetal alcohol

spectrum disorder in a northern context - the brightening our home fires project, Northwest Territories, Canada. Int. J. Circumpolar Health 72.

Baskin, C., 2007a. Part I: conceptualizing, framing and politicizing aboriginal ethics in mental health. J. Ethics Ment. Heal 2, 1e5.

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Blaser, M., 2012. Ontology and indigeneity: on the political ontology of heteroge- neous assemblages. Cult. Geogr. 21, 49e58. http://dx.doi.org/10.1177/ 1474474012462534.

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