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Indigenous Youth Leading the Path to Improved Mental Health Systems

BRIDGING THE GAP

Groundwork Report

An institutional ethnography of Indigenous youth mental health systems in the Greater Toronto Area (GTA)

Prepared by the Finding our Power Together Research Lab

CENTRE FOR GRIEF & HEALING
Bereaved Families of Ontario - Halton / Peel

FINDING OUR POWER TOGETHER

Distress Centres of Greater Toronto

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Bridging the Gap: Indigenous Youth Leading the Path to Improved Mental Health Systems

An Institutional Ethnography of Indigenous Youth Mental Health Systems in the Greater Toronto Area. Groundwork Report

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EXECUTIVE SUMMARY

This report details findings from the groundwork phase of a 5-year study, *Bridging the Gap: Indigenous Youth Leading the Path to Improved Mental Health Systems*, which employs an Indigenous Institutional Ethnography (IE) approach to explore how Indigenous youth in the Greater Toronto Area (GTA) navigate the mental health system. It reveals how institutional structures, rather than individual behaviours, shape experiences of care, often leading to harm rather than healing. The research involved 20 Indigenous youth (aged 14–29) and utilized diverse data sources, ensuring Indigenous knowledge and governance were central to all stages.

PURPOSE AND METHODOLOGY

- **Participants**: 20 youth (14–29 years), including indigenous youth and key informants, diverse in gender, sexuality, Nation, and cultural identity.
- **Data Sources**: Youth interviews, story maps, questionnaires, key informant interviews, service landscape analysis, literature review.
- **Approach**: Indigenous Institutional Ethnography—centering Indigenous knowledge, storytelling, and governance in all research stages.

CONTEXT: STRUCTURAL AND HISTORICAL FORCES

The mental health crisis faced by Indigenous youth in the GTA must be understood through:

- **Intergenerational trauma** (e.g., residential schools, the Sixties Scoop)
- **Urban displacement**, racism, and fragmented services
- **Systemic underfunding** of Indigenous-led initiatives
- **Disproportionate rates** of suicide, psychological distress, and service exclusion

YOUTH EXPERIENCE IN THE SYSTEM

- **Fragmentation**: Youth must navigate disconnected services, retell trauma repeatedly, and face long waits and unclear pathways.
- **Crisis-Centered Access**: Crisis is often the only reliable entry point into care, reinforcing reactive models.
- **Retraumatization**: Institutional procedures (intake, assessment, rotation of staff) replicate trauma rather than resolve it.
- **Misrecognition**: Indigenous cultural identity is often erased or marginalized in clinical settings.

GAPS AND CHALLENGES

- **Difficult and inadequate service pathways.**
- **Biomedical dominance** erases Indigenous understandings of wellness.
- **Racism and discrimination** are routine in care settings.
- **Private therapy costs and jurisdictional confusion** create systemic inaccessibility.
- **Standardized tools** fail to capture Indigenous realities or trauma contexts.

STRENGTHS & PROMISING PRACTICES

- **Indigenous-led services**: Holistic, culturally safe, and community-grounded.
- **Land-based and ceremonial healing**: Central to wellness, not peripheral.
- **Cultural-clinical integration**: Combining therapy with traditional practices improves outcomes.
- **Culturally competent practitioners**: Especially Indigenous and racialized providers build trust and continuity.
- **Flexible access points**: Virtual therapy, academic accommodations, and peer networks reduce barriers.

YOUTH VISIONS FOR SYSTEMS INNOVATION

- **Indigenous-led governance** across all levels of service.
- **Integrated cultural and clinical care**, grounded in land, ceremony, and relational healing.
- **Free, accessible, low-barrier services** with no cost or crisis-based thresholds.
- **Continuity of care** with consistent case workers to reduce retraumatization.
- **Specialized spaces** for Two-Spirit, queer, and mixed-identity youth.
- **Mandatory cultural safety training** for all staff.
- **Community based support networks**.
- **Peer support and youth leadership** embedded in service design.

INSTITUTIONAL ETHNOGRAPHY ANALYSIS

This study finds that current systems operate on logics of control, surveillance, and standardization, which:

- Prioritize documentation over relationship
- Define care through compliance with biomedical norms
- Exclude Indigenous knowledge as “non-clinical”
- Require youth to adapt to systems, rather than vice versa

Indigenous youth are not system avoidant—they are system navigators. In practice, youth construct informal, relational systems of care when formal institutions fail them.

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This report is the product of many hands and hearts. It reflects a collective effort to improve mental health systems for Indigenous youth, and we remain accountable to the communities who entrusted us with their stories.

CONTEXT AND BACKGROUND

Indigenous youth in the Greater Toronto Area (GTA) are at the centre of one of the most pressing mental health crises in Canada. While the GTA is home to one of the largest urban Indigenous populations in Ontario (City of Toronto, n.d), the systems meant to support Indigenous youth well-being remain fragmented, under-resourced, and often culturally unsafe (Kourgiantakis et al., 2023). The mental health challenges confronting Indigenous youth in the GTA must be understood within the broader national landscape of health disparities that are both persistent and systemic.

National data consistently demonstrates that Indigenous youth experience significantly higher rates of psychological distress, suicidality, and substance use compared to their non-Indigenous peers (Public Health Ontario, 2019; Statistics Canada, 2021). Suicide is the leading cause of death for First Nations youth aged 15 to 24, with rates five to six times higher than the Canadian average, and as much as eleven times higher for Inuit youth (Suicide Information & Education Centre, 2023).

The mental health landscape for youth in Ontario presents a concerning trend, with a clear and significant increase in mental health conditions as children age. For instance, a recent study found that the prevalence of a diagnosed mental health condition was 9.8% for all children and youth aged 1-17, but this rate increased to 15.0% for youth aged 12-17, compared to only 9.6% for those aged 5-11 (Public Health Ontario, 2024).

These figures establish a baseline of concern for youth mental health in the province, yet they fall short of capturing the profound crisis facing Indigenous youth.

The demographics of the Indigenous population in Canada highlight a significant youth cohort, with Indigenous people, on average, being 8.8 years younger than the non-Indigenous population in 2016 (Statistics Canada, 2018). Additionally, Indigenous youth (ages 15 to 24) constitute a larger proportion of the overall Indigenous population (16.9%) than their counterparts in the non-Indigenous population (12%). While Indigenous youth represent 3.7% of all youth in Ontario, their proportion is much higher in other parts of the country. The burden on Indigenous youth is of a completely different order of magnitude, characterized by severe and disproportionate outcomes. Suicide and self-inflicted injury are not just a concern but are the leading cause of death among First Nations youth aged 15-24, a stark contrast to the general youth population where accidental death is the primary cause (Giroux et al., 2018). This data points to a crisis that extends beyond individual pathology and is deeply rooted in systemic issues. The fact that a significant proportion of Indigenous students report a diagnosis of depression (14.1%) and anxiety (15.9%) in a single year, and are more likely to have these diagnoses than their non-Indigenous peers, underscores the scale of this disparity (Wo et al., 2020).

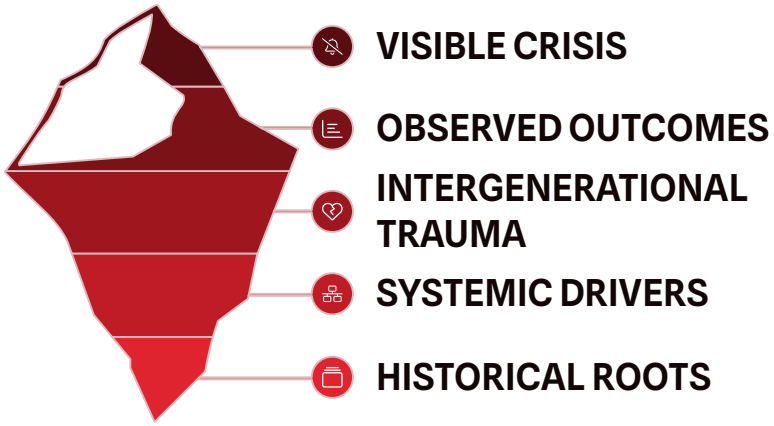
Furthermore, the intersection of multiple marginalized identities amplifies risks for Indigenous youth. Research suggests that Indigenous young people who identify as Two-Spirit, lesbian, gay, bisexual, transgender, queer, or other sexual and gender minority identities (2SLGBTQ+) face compounding layers of systemic oppression, including racism, colonialism, homophobia, and transphobia (Wilson, 1996; Bauer & Scheim, 2015). Survey data from the Trevor Project (2023), which examined suicide risk among LGBTQ+ youth in the United States, indicate that over half of Indigenous 2SLGBTQ+ respondents (54%) reported seriously considering suicide in the past year, and nearly one quarter (23%) reported a suicide attempt. These rates are significantly higher than those reported by the broader LGBTQ+ youth population in the same survey, at 41% and 14%, respectively. While this study is U.S.-based, it highlights concerning disparities that align with Canadian research documenting elevated rates of suicidality among Indigenous and 2SLGBTQ+ youth (Clark et al., 2018; Robinson, 2020). Collectively, these findings implicate mental health systems in reproducing harm when they fail to account for the intersecting structural and historical conditions shaping Indigenous 2SLGBTQ+ lives.

Intergenerational Trauma and Need for Mental Health Support

A discussion of mental health services for Indigenous youth is incomplete without first situating their experiences within the broader historical and systemic context. Research demonstrates that the current state of Indigenous mental health is a direct consequence of both historical and ongoing government policies, including the Indian Residential School System and the Sixties Scoop (Wilk et al., 2017; McQuaid et al., 2022; Statistics Canada, 2025). Historical scholarship reveals that European settlement in what is now Canada was accompanied by devastating population loss due to infectious disease, warfare, and the systematic suppression of Indigenous cultures and identities (Daschuk, 2013; Milloy, 1999). This process, described by the Truth and Reconciliation Commission of Canada (TRC, 2015) as cultural genocide, was codified in law and policy through the reserve system, the Indian Act, and the prohibition of traditional spiritual and cultural practices.

A central instrument of forced assimilation was the Indian Residential School System, which operated from the late 19th century until the late 20th century. More than 150,000 First Nations, Inuit, and Métis children were forcibly removed from their families, separated from their languages and communities, and subjected to an institutional regime that actively denigrated their heritage (TRC, 2015). These schools were consistently underfunded, marked by overcrowding, poor sanitation, and inadequate health care. Survivors have documented widespread experiences of neglect, physical punishment, psychological mistreatment, and sexual abuse (TRC, 2015; Milloy, 1999). The intergenerational impacts of these institutions continue to shape Indigenous youth mental health today, not as isolated individual experiences but as systemic and historically produced outcomes.

The devastating effects of these historical injustices are not confined to the past; they persist through what is widely described as intergenerational trauma.



The large-scale removal of children from their families and communities disrupted the transmission of cultural traditions, values, and parenting practices, producing a profound intergenerational loss (TRC, 2015). Psychologist Eduardo Duran (2006) conceptualizes this trauma as "stored in the blood memory," arguing that it alters the neurophysiology of the nervous system. Individuals may become locked in states of hypervigilance or "fight, flight, and freeze," which compromise their ability to form secure attachments and healthy relationships.

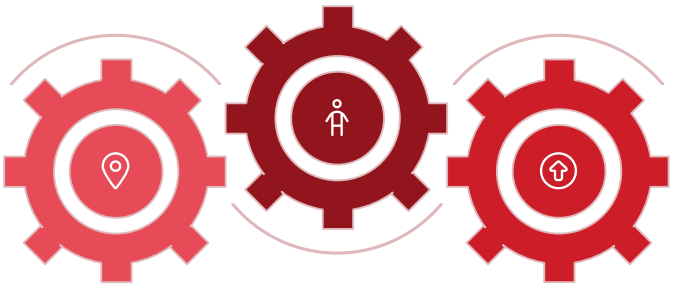
Empirical studies reinforce these accounts. Research indicates that Indigenous adults with a parent or grandparent who attended a residential school report significantly higher rates of depressive symptoms, suicidal ideation and attempts, and substance use compared to those without such family histories (Bombay et al., 2014; TRC, 2015). These individuals also demonstrate heightened sensitivity to everyday stressors such as discrimination, suggesting that the impacts of colonial policies are not only historical but continue to shape present-day mental health outcomes. Intergenerational trauma, therefore, functions as both a legacy of residential schools and a contemporary determinant of Indigenous well-being.

Defining the Distinct GTA Context

The Greater Toronto Area (GTA) provides a unique context in which to examine Indigenous youth mental health. It is home to one of the largest urban Indigenous populations in Canada, with Toronto itself housing the largest Indigenous population in Ontario and the fourth largest in the country (City of Toronto, 2016; Statistics Canada, 2022). According to the 2021 Census, 44,635 Indigenous people resided in the Toronto Census Metropolitan Area (CMA), a slight decrease from the 46,315 reported in 2016. While the City of Toronto experienced a minor population decline, surrounding municipalities within the GTA have seen growth, reflecting patterns of mobility across urban and suburban spaces (Statistics Canada, 2022). The Indigenous population in the GTA is also notably younger than the non-Indigenous population, with an average age of 36.1 years compared to 40.5 years. Children aged 14 and under represent 18.4% of the Indigenous population, compared with 15.7% among non-Indigenous residents (Statistics Canada, 2022).

YOUTH DEMOGRAPHIC LAYER

Addressing the specific challenges and opportunities for youth.



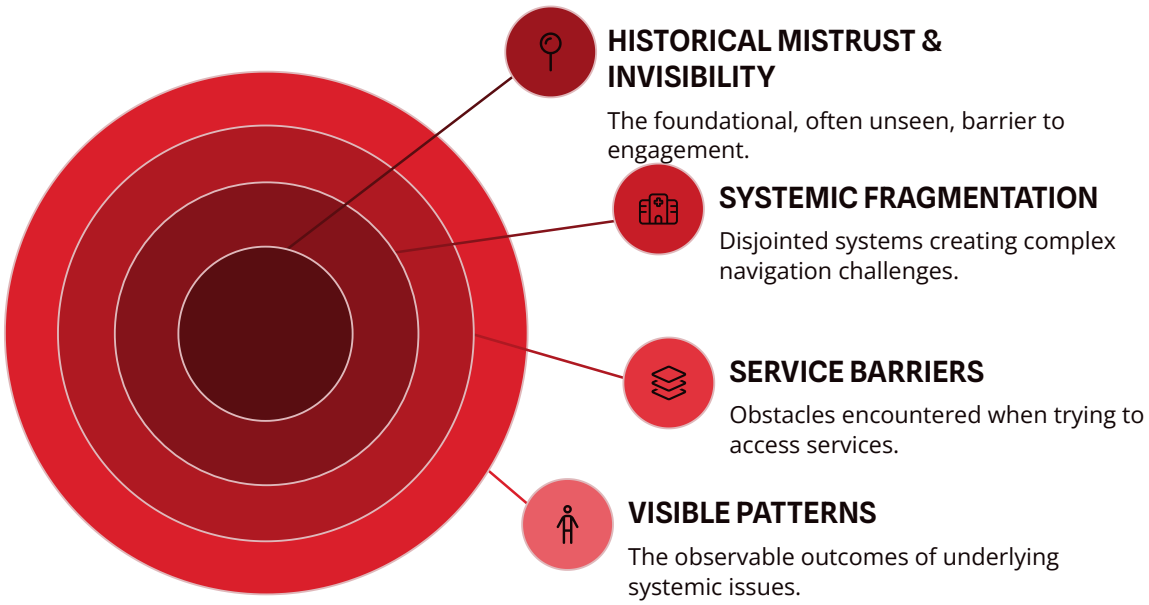
URBAN INDIGENOUS CORE

Central focus on the urban Indigenous community's needs.

REGIONAL MOBILITY & GROWTH

Supporting movement and expansion within the region.

This demographic profile intersects with structural and service-level challenges. Indigenous youth in the GTA live in a metropolitan environment marked by mobility across municipal boundaries, jurisdictional fragmentation, and diverse health and social care systems. Research indicates that these dynamics require youth to navigate multiple and sometimes conflicting frameworks of care (Allan & Smylie, 2015). Access to culturally relevant and Indigenous-led services in the GTA remains limited, unevenly distributed across the region, and chronically underfunded (Ontario Health, 2023). Together, these conditions illustrate how the GTA functions as both a central hub for Indigenous peoples and a site where systemic barriers to mental health equity are acutely experienced.



A fundamental challenge in assessing the scale of the Indigenous population in the GTA is the consistent undercounting that occurs in official surveys. Community-controlled research has revealed that the actual population is significantly higher than what the census reports. The *Our Health Counts Toronto* study estimated the 2016 Indigenous population at approximately 69,000, nearly 50% higher than the national census figure for the same year (Rotondi et al., 2017). More recent estimates from 2021 place the population at 88,397, suggesting that official census counts may under-represent the Indigenous population in Toronto by as much as two to four times (Lavoie et al., 2021). Research points to several reasons for this undercount. The census relies on fixed residential addresses, which fails to capture Indigenous peoples experiencing housing insecurity or frequent mobility across urban and suburban boundaries (Rotondi et al., 2017). There is also a historical reluctance to participate in government surveys due to mistrust of state institutions (Smylie et al., 2016). In addition, the 2021 Census was conducted during the COVID-19 pandemic, which further disrupted data collection in Indigenous communities (Statistics Canada, 2022). Together, these factors contribute to the invisibility of a large portion of the Indigenous population in official statistics.

Compounding Social Determinants of Health

Indigenous youth often migrate to urban centres such as the GTA in pursuit of education, employment, and opportunities for greater prosperity. Research reveals, however, that the transition to city life frequently introduces new and distinct stressors rather than resolving existing challenges (Environics Institute, 2010; Peters & Andersen, 2013). The urban environment can function as a "challenging market," where systemic racism, stigma, and gaps in educational preparation place Indigenous youth at a disadvantage in accessing stable employment and adequate housing. These barriers increase vulnerability to economic insecurity and housing instability, which in turn negatively affect mental health and well-being.

Studies further suggest that urban migration can produce a sense of dislocation and alienation from culture and community, particularly when youth are disconnected from Indigenous networks or cultural supports in the city (Environics Institute, 2010). This dislocation is compounded when youth experience homelessness, which is disproportionately high among Indigenous populations in Canadian cities (Belanger et al., 2013). Together, these findings indicate that while urban migration is often motivated by aspirations for advancement, structural inequities within the urban environment create new risks and perpetuate cycles of exclusion for Indigenous youth.

Systemic discrimination functions as a chronic stressor that undermines the well-being of urban Indigenous communities and directly contributes to poor mental health outcomes. Discrimination manifests across multiple systems. In justice and policing, the Ontario Human Rights Commission (2018) documented that Indigenous peoples in Ontario experience disproportionate surveillance, targeted questioning, and over-charging, practices that erode trust and heighten stress.

In the child welfare system, the same report found that Indigenous children make up 25.5% of those in foster care despite constituting only 3.4% of the child population in Ontario, a disparity linked to culturally biased risk assessment practices that often misinterpret Indigenous family structures and socioeconomic realities.

Health care is a particularly significant domain where systemic racism directly shapes health outcomes. Allan and Smylie (2015) and Nelson and Wilson (2018) found that Indigenous peoples living in urban centres report higher levels of discrimination from health care providers than their rural counterparts, which contributes to low levels of trust and reduced service utilization even in situations of acute need. Paradies et al. (2015) reported that experiences of racism in health care are associated with up to a five-fold increase in psychological distress, underscoring how encounters with discrimination intensify existing inequities and deter future help-seeking.

These findings highlight a paradox unique to the urban context. While the GTA contains a higher density of health and social services than many remote communities, systemic racism, the absence of culturally safe care, and the legacies of colonial harm render these services effectively inaccessible for many Indigenous youth.

The Greater Toronto Area (GTA) serves as a microcosm of the national Indigenous mental health crisis. It demonstrates how the enduring legacy of intergenerational trauma, compounded by the distinct stressors of urban life and the pervasive absence of culturally safe services, contributes to a complex and ongoing crisis (Allan & Smylie, 2015; Wilk et al., 2017). At the same time, research reveals that within this challenging context there are significant sources of resilience. Indigenous communities in the GTA have established self-determined, culture-based organizations that provide innovative and effective models of care, actively supporting healing and community strength (Peters & Andersen, 2013; Nelson & Wilson, 2018).

Scholars and commissions have emphasized that reconciliation requires more than acknowledgement of past harms; it requires a restructuring of policies and funding models to support Indigenous-led initiatives and governance (TRC, 2015; Greenwood et al., 2015). Without such systemic change, the inequities that urban Indigenous youth face will continue to reproduce harm. A future where Indigenous youth in the GTA not only survive but thrive depends on sustained investment in, and recognition of, Indigenous self-determination and culture-based solutions.

OUR APPROACH

Bridging the Gap: Indigenous Youth Leading the Path to Improved Mental Health Systems is a community-led research project developed in partnership between Finding Our Power Together, the Centre for Grief and Healing, and Distress Centres of Toronto, and guided throughout by an Indigenous Community Advisory Committee (ICAC) made up of Indigenous youth, Elders, knowledge Keepers, and community members. The project was designed to document how Indigenous youth experience the mental health system in the Greater Toronto Area (GTA) and to examine how institutional structures, policies, and practices shape those experiences. Rather than focusing only on individual challenges, our approach looks closely at the structures, policies, and practices that shape youth experiences. We use a method called Institutional Ethnography (IE). In simple terms, this means we are not studying people as problems. Rather, we are studying how institutions are set up, and how their rules, policies, and routines impact Indigenous youth when they seek care. By starting from the actual experiences of youth and then mapping how those experiences connect to wider systems, IE helps us uncover barriers and opportunities for change

For *Bridging the Gap*, we adapted IE into what we call Indigenous Institutional Ethnography. This approach integrates Indigenous knowledge, storytelling, and governance directly into the design, data collection, and analysis of the study. This approach required that youth voices be treated not as anecdotes, but as central data that reveal how institutions are organized. It required that analysis be guided by Indigenous governance and knowledge systems, ensuring that the findings speak to community realities as well as institutional structures.

PROJECT PURPOSE

Our project looks at how Indigenous youth in the Greater Toronto Area (GTA) use mental health services. We set out to understand their experiences and identify avenues for system innovation.

Research Objectives

Our main goals were to understand the mental health services for Indigenous youth:

- To map and describe the current landscape of mental health and wellness services available to Indigenous youth in the GTA.
- To document and analyze the experiences of Indigenous youth in navigating the GTA mental health system.
- To assess the strengths and limitations of the current system.
- To articulate visions and pathways for systems innovation.

Research Questions

To reach our goals, we focused on these key questions:

- What does the mental health system look like for Indigenous youth in the GTA?
- What strengths and gaps exist in the current system of mental health and wellness supports for Indigenous youth?
- In what ways can the mental health system be transformed to better support Indigenous youth wellbeing?

METHODS

This report synthesizes and analyzes data from the following sources:

INDIGENOUS YOUTH INTERVIEWS AND STORY MAPPING:

Qualitative, semi-structured interviews with 20 participants (ages 14-29) in the GTA explored their mental health system experiences. Collaborative story mapping visualized their journeys through services.

QUESTIONNAIRES AND SERVICE USE DATA:

Youth completed quantitative questionnaires on service access and satisfaction. This data identified patterns and contextualized individual narratives within broader trends.

LANDSCAPE ANALYSIS:

A system-level overview of GTA mental health supports compiled a database of 247 entries (184 community orgs, 35 postsecondary, 28 online). This highlighted systemic gaps in culturally safe care.

SYSTEMATIC LITERATURE REVIEW:

A systematic review of 42 sources situated local findings within Indigenous youth mental health literature, highlighting inequitable access and structural barriers, particularly in urban settings.

KEY INFORMANT INTERVIEWS

Key informant interviews were conducted with service providers and community leaders to document institutional perspectives on mental health service delivery in the GTA.

All forms of data were analyzed through collaborative analysis circles with the Indigenous Community Advisory Committee (ICAC). The ICAC, composed of Indigenous youth, professionals, and community members, met at several points throughout the project to review emerging findings. These facilitated sessions involved collective interpretation of interview transcripts, story maps, questionnaire data, and contextual materials. This process ensured that analysis was not conducted solely by researchers, but was shaped by Indigenous governance and grounded in community knowledge systems.

PARTICIPANTS

The data set includes stories and insights from a diverse group of Indigenous young people (n=20), who live in or around the Greater Toronto Area. Most participants are between 17 and 25 years old, though their experiences with mental health challenges often began in early childhood. They are navigating school, work, identity, and healing, often while facing complex barriers in the mental health system.

Participants come from many Nations, including the Anishinaabe, Mi'kmaq, Mohawk, Cree, Dakota, and Inuit. Some were raised on-reserve or in northern communities, while others grew up in urban settings. Many maintain strong ties to their home communities and cultural traditions. Mixed identities are also common: many youth identify as Afro-Indigenous or have other cultural roots (like South Asian, Caribbean, or European), which often brings unique challenges and forms of discrimination. Family backgrounds vary: some youth were raised by parents or grandparents, while others were involved with child welfare systems. Experiences of intergenerational trauma (from residential schools or the Sixties Scoop) were frequently mentioned as shaping both family life and mental health.

Gender diversity is strongly reflected in the group. While many identify as women, others are non-binary, transgender, or Two-Spirit. Two-Spirit youth in particular shared the importance of being supported in culturally meaningful ways. Participants also represent a range of sexual orientations, including queer, bisexual, pansexual, and heterosexual. Many are students or recent graduates, attending colleges and universities across Ontario and beyond. Mental health challenges often impacted their ability to stay in school, and many relied on accommodations or Indigenous student supports. Financial barriers were also common—especially for therapy, medication, and transit. Some participants had contact with police or emergency services during crises, though most have no justice system involvement. Housing situations range from living with family to student housing, with some having experienced homelessness.

Overall, this group reflects the strength, diversity, and resilience of Indigenous youth in the city. Despite the challenges they face, they continue to seek healing, support each other, and call for services that are safe, culturally grounded, and truly responsive to their realities.

WHAT WE LEARNED

This section presents the findings of the Bridging the Gap study, synthesizing evidence from Indigenous youth interviews, Key Informant interviews, questionnaires, a landscape analysis of services, and a systematic literature review. Together, these data sources provide a multi-layered picture of how Indigenous youth in the Greater Toronto Area (GTA) experience the mental health system.

Across the research, a consistent pattern emerges: while the GTA offers a wide range of mainstream services, these are often perceived by Indigenous youth as culturally unsafe, procedurally fragmented, and difficult to access. Indigenous-led services, by contrast, are deeply valued for their cultural grounding but remain limited in number, unevenly distributed, and chronically underfunded. The result is a fundamental disjuncture between what the system offers and what Indigenous youth need to sustain mental wellness.

The following sections detail these findings, organized around the central research questions: what the system looks like for Indigenous youth, what strengths and gaps exist, and what visions and pathways youth and communities articulate for a more effective and culturally grounded system of care.

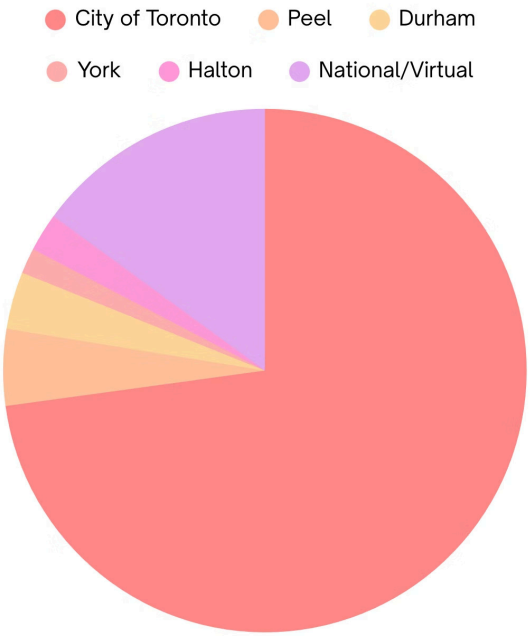
UNDERSTANDING THE SYSTEM

The mental health system available to Indigenous youth in the Greater Toronto Area (GTA) is not a single, coherent network but a fragmented collection of mainstream clinical services, community organizations, postsecondary supports, and Indigenous-led programs. Institutional ethnography directs us to examine not only what services exist, but how they are organized and experienced in practice. From this perspective, the system appears abundant on paper yet unevenly distributed, culturally misaligned, and difficult for youth to navigate.

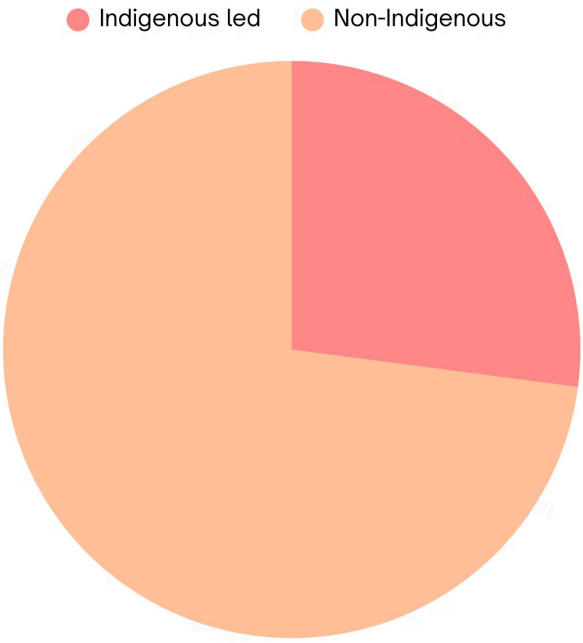
SERVICE LANDSCAPE

The mental health system for Indigenous youth in the Greater Toronto Area (GTA) consists of a wide range of services, including mainstream clinical providers, community-based organizations, postsecondary supports, and Indigenous-led programs. These services are not coordinated into a single system but instead operate as distinct and often siloed parts.

The landscape analysis documented 184 organizations across the GTA providing mental health or wellness-related supports. The majority of these services (83%) are located in Toronto. In contrast, Peel hosts 12 organizations (7%), Durham 9 (5%), Halton 6 (3%), and York 4 (2%). This distribution shows a concentration of services in the city core, with fewer options in surrounding regions.



Of the 184 organizations, 29 (16%) were Indigenous-led, and a further 39 (21%) offered Indigenous-specific programming. The remainder were mainstream services without explicit Indigenous components. Community organizations represented the largest portion of entries (51, or 28%), followed by community health centres (18, or 10%), hospitals (16, or 9%), and Indigenous community organizations (12, or 7%).



Postsecondary institutions were also included in the analysis. Of the 35 institutions surveyed, 22 (63%) did not provide Indigenous-specific mental health supports, while 13 (37%) reported some level of Indigenous programming or staffing. 28 virtual and remote services were documented. Of these, most were classified as crisis supports, with fewer providing ongoing therapy or resource navigation.

NAVIGATING THE SYSTEM IS CHALLENGING FOR YOUTH

While the structural analysis reveals a fragmented system, the youth interviews highlight how this fragmentation is experienced in real time. Indigenous youth described the process of seeking mental health support as confusing, unpredictable, and emotionally exhausting. Rather than accessing care through a straightforward or centralized entry point, youth often encountered multiple disconnected services, inconsistent pathways, and contradictory eligibility requirements. These included varying intake forms, referral requirements, and shifting criteria for program access across different organizations and sectors.

Many youth were left to navigate this system on their own. Those without strong family or community support often lacked the knowledge needed to move through bureaucratic processes.

This experience was echoed across several interviews, where youth reported learning about available supports primarily through word of mouth, not through formal referrals or institutional guidance. The lack of a coordinated care model meant that even when youth were connected to services, they were often forced to repeat their stories, rebuild relationships, and start over each time they accessed a new provider.

THE SYSTEM RELIES ON INFORMAL AND COMMUNITY-BASED NETWORKS

In the absence of coordinated institutional support, youth frequently relied on informal or community-based networks to access culturally relevant care. This informal infrastructure included peers, family, and Indigenous community organizations. For youth with strong cultural or familial ties, this system functioned as a valuable alternative, helping them find trusted care outside of mainstream institutions. However, for youth who were disconnected from community, this informal system remained largely invisible.

The significance of this pseudo-system highlights an unequal distribution of access, shaped not only by geography but by social connectedness. One participant described the contrast clearly:

> *"One of the barriers is just not actually knowing where to go or feeling scared of walking into a hospital or building. I'm very grateful that I don't have those fears. I know how to navigate a system. My mom, from a very young age, was teaching me how to fill out forms."*

The advantage of system literacy, taught through family or community, functioned as a form of privilege that enabled navigation of otherwise inaccessible services.

THE SYSTEM REQUIRED YOUTH TO TELL THEIR STORY OVER AND OVER AGAIN

A recurring theme across youth interviews was the emotional burden of retelling their stories. Many youth reported having to recount their trauma histories to multiple service providers, often within a short time frame and with little follow-up or continuity. One youth in care noted:

> *"I've had four or five different workers, and I have to explain my whole life story to them over and over and over again."*

This process was described as retraumatizing and disempowering. Rather than being met with continuity or understanding, youth felt that their experiences were reduced to files, intake notes, or risk categories.

This repetition was not experienced as therapeutic but instead as administrative—a requirement to gain access, not to foster healing. For some, this practice undermined trust in providers and reinforced the sense that institutions were more concerned with documentation than with care. The data suggests that these experiences reflect not only a lack of trauma-informed practice but also systemic design flaws that fail to prioritize relational, consistent, or youth-centered care models.

THE SYSTEM IS LARGELY BIOMEDICAL

Youth accounts also underscored the cultural limitations of mainstream mental health services.

Many participants reported being asked (explicitly or implicitly) to set aside their cultural identity in order to receive care. This erasure took the form of providers ignoring references to ceremony, land-based healing, or kinship networks, or assuming that these aspects of identity were irrelevant to treatment planning.

The underlying cause of this disconnect lies in the dominance of the biomedical model within institutional settings. Clinical norms often define what counts as legitimate treatment, leaving little room for Indigenous frameworks of wellness. While some services do attempt to integrate cultural practices, these efforts remain the exception rather than the norm. Youth frequently emphasized that meaningful cultural safety requires more than a land acknowledgment or token representation. It requires providers who recognize Indigenous knowledge systems as valid and central, not secondary.

Notably, the role of the practitioner was seen as critical in shaping cultural safety. Youth reported feeling more understood and validated by Indigenous or racialized staff members, and more often misunderstood or disregarded by non-Indigenous providers. This confirms findings from the broader literature, which suggests that culturally concordant care is strongly correlated with better mental health outcomes among Indigenous populations (Allan & Smylie, 2015; Gone et al., 2019).

THE SYSTEM PERPETUATES EXPERIENCES OF DISCRIMINATION AND SYSTEMIC HARM

In addition to structural confusion and cultural misrecognition, many youth described direct experiences of discrimination within the mental health system. These included racism, ageism, and ableism. One youth shared:

> "*I think when I was younger, people just think you don't know what you're talking about, so they try to make decisions for you.*"

Others spoke about being physically restrained during crises rather than being engaged with through conversation or de-escalation. These practices were described not just as isolated incidents but as part of a broader pattern of exclusion. The use of force in clinical settings was seen as emblematic of a system that prioritizes control over care. One youth commented:

> *"I think there's too much force sometimes [...] rather than talking to someone, they'll just tie you down to a bed."*

These experiences contribute to a broader mistrust in the system, especially among those who have already experienced intergenerational trauma related to institutional violence.

THE SYSTEM POSITIONS CRISIS AS THE DEFAULT ENTRY POINT

For many Indigenous youth, crisis is the only moment when the system becomes responsive. Several participants noted that being in acute distress—suicidal, dissociating, or in psychological crisis—was often the only way they could access services quickly.

This reliance on crisis pathways reinforces reactive rather than preventive models of care. It also places youth at greater risk, as services may only become available once a situation has escalated beyond what is manageable through community or family support. Youth in our study are acutely aware of this system function:

> *"If you're trying to get a therapist or a counsellor or someone to talk to, it's gonna take forever [...] But if you're going into a hospital because you know you wanted to [harm] yourself, you're going to get admitted"*

The use of Indigenous-specific crisis lines, such as the Hope for Wellness Help Line, was seen as a rare example of accessible, culturally aligned support. One youth described it as a lifeline:

> *"I've had full trauma flashbacks on that hotline. Even like–I've been suicidal [...] on that hotline. They have seen me through a lot ."*

However, these supports are not always integrated into the broader system, leaving youth to rely on them in isolation rather than as part of coordinated care.

The experiences shared by Indigenous youth in this study reflect more than individual dissatisfaction or poor encounters—they mirror the broader structural design of the system itself. A fragmented landscape of services, underrepresentation of Indigenous leadership, lack of coordination, and limited cultural safety converge to create a system that is experienced as confusing, unsafe, and often alienating.

STRENGTHS AND PROMISING PRACTICES

While much of the mental health system in the Greater Toronto Area presents challenges for Indigenous youth, several promising practices stand out for their ability to create culturally grounded, effective, and youth-centered care. These practices are not only service models but reflect a broader movement toward Indigenous self-determination in mental health. The following section draws on interview data, organizational profiles, and peer-reviewed literature to highlight key areas of strength within the existing system.

INDIGENOUS-LED MODELS OF CARE TAKE A WHOLISTIC APPROACH

Indigenous-led organizations were frequently described by youth as life-changing. These services provided cultural safety, respect, and a sense of belonging. Youth emphasized that Indigenous-led spaces made them feel understood. They appreciated being supported in ways that aligned with their experiences and worldviews. One participant stated:

> *"They help with not just mental health. They help with your physical health, which can support your mental health."*

These organizations often use a wholistic model of care. This means they recognize the interconnection of emotional, physical, spiritual, and mental well-being. For many Indigenous youth, this approach reflects their cultural teachings and offers a more complete form of care. As one youth explained:

> *"Having really a holistic side to someone's mental health journey [...] that part really lacks in typical mental health institutions."*

Although these spaces offer vital support, participants also noted some limitations.

While Indigenous-led organizations provide strong cultural and community grounding, they do not always offer formal clinical mental health services such as counselling or therapy. For some youth, this meant they had to choose between accessing culturally grounded spaces or seeking clinical treatment elsewhere. However, when both cultural and clinical services were available together, youth reported stronger outcomes and deeper healing.

These findings align with the broader research literature. Studies show that Indigenous-led care models support healing by reconnecting youth with community, culture, and identity (Gone, 2013; Kirmayer et al., 2014). Indigenous governance of care services also supports self-determination and promotes safer, more responsive environments for youth.

ACCESS TO LAND AND CEREMONY IMPROVES HEALING OUTCOMES

A key feature of Indigenous-led services that were supportive to youth, was those that integrated land-based, ceremonial, and traditional Indigenous healing modalities. Youth explained that being on the land and engaging in outdoor activities are natural forms of coping that they turned to even before entering services.

> *"Like some of the stuff she told me to help cope, like, 'go for a walk, go for a run, be outside, try grounding exercises, have you tried meditation?' And these were all things that I was already doing before I had even decided to meet with my social worker… Here in my community, I'm always outside at the bush. I'm always going outside with my family, we go for quad rides, we're always fishing, we're always out and about, you know. So I kind of already knew stuff that helped me."*

Others described the deep personal cost of being disconnected from the land, due to mental health challenges and urban realities.

> *"I did not go outside at all for the first two weeks. And as someone that is very connected to nature and very connected to the land, that was really hard."*

Ceremony was described with equal urgency and importance. Youth spoke about sweat lodges, women's groups, sunrise and full moon ceremonies, smudging, and drumming as practices that provided grounding and healing. As one participant shared,

> "*I've done women's groups, I've done lodges, I've done sunrise, I've done full moon ceremony. So that's what they kind of gave me access to which was just a traditional way of being, and that really helped me ground myself."*

For many, ongoing participation in ceremony was not just helpful but life-sustaining:

> *"I continue to participate in ceremony. I smudge as much as I can. I'm part of a drumming group as well as a First Nations garden that we garden […] I continue—what I've continued is my ceremony. That's who I am, that's where I feel the most safe and the most comfortable."*

The data demonstrates that participants see nature, land, and ceremony not as supplementary "cultural activities" but as fundamental, non-negotiable elements of effective mental health healing that must be central to any truly responsive system for Indigenous youth.

CULTURAL AND CLINICAL INTEGRATION IMPROVES TREATMENT

Youth described integrated care models as especially effective. These are approaches that combine traditional Indigenous healing practices with clinical mental health services. Rather than placing these two systems in conflict, integration allows for a fuller understanding of well-being.

It creates space for youth to receive counselling while also participating in ceremonies, using traditional medicines, and connecting with spiritual practices.

One youth shared their experience of returning to ceremony after other forms of therapy had not worked. They said:

> *"I accessed a counsellor—a medicine person who took me into sweat and to ceremony [...] I turned to spirituality to guide me to a journey of hopefully healing."*

Another participant reflected on therapy that was rooted in Indigenous perspectives. They explained:

> *"The Indigenous lens really, really makes a difference because some things aren't seen as so westernized [...] They don't smudge before and after and stuff. But it's just been really helpful for me."*

These experiences show that youth benefit when they are not asked to choose between culture and care. When providers offer both, youth feel more seen, more supported, and more connected to their healing journey. Research supports these findings, noting that Indigenous cultural frameworks are essential to mental health outcomes, particularly in the context of intergenerational trauma (Gone, 2013; Allan & Smylie, 2015).

Integrated care is not simply a combination of practices. It is a meaningful shift toward a system that recognizes Indigenous knowledge as legitimate, effective, and necessary.

CULTURALLY COMPETENT PRACTITIONERS BUILD TRUST

Beyond organizational structure, individual practitioners played an important role in youth experiences. Many participants spoke positively about Indigenous counsellors or practitioners with lived experience. These providers were described as more understanding, more open to cultural practices, and more willing to meet youth where they were at.

One youth shared their experience with Indigenous-informed therapy. They explained:

> *"I've been in therapy [...] through an Indigenous lens [...] The Indigenous lens really, really makes a difference."*

This difference was not only about the methods used but also about the ability to speak freely and feel respected in the therapeutic relationship. These findings are consistent with research that shows culturally competent care increases engagement and improves outcomes (Allan & Smylie, 2015). Youth are more likely to stay in care and benefit from services when they feel their identity and experience are understood.

Culturally competent care does not happen by accident. It requires ongoing education, training, and reflection on the part of practitioners. It also involves a shift away from one-size-fits-all approaches to care, toward models that are responsive to the specific histories, values, and realities of Indigenous youth.

FLEXIBLE SERVICES REDUCE ACCESS BARRIERS

Some participants reported that online therapy created new opportunities for care. For youth who faced barriers such as travel, stigma, or safety concerns, virtual therapy offered a more accessible alternative. Being able to access care from home allowed some youth to feel more comfortable and in control of their healing process.

Although the landscape analysis identified limitations in how virtual services are categorized and tracked, youth interviews suggest that online care is a meaningful strength when available. It allowed for more flexibility, helped reduce feelings of anxiety about attending in-person appointments, and expanded access to services that might not have been otherwise available.

This finding echoes existing literature, which supports virtual mental health care as an important strategy for reaching underserved populations, particularly when services are tailored to cultural contexts (Lavoie et al., 2010).

ACADEMIC ACCOMMODATIONS SUPPORT SUCCESS AND STABILITY

Participants also identified academic accommodations as an important source of support. These accommodations included extensions on assignments, flexible class schedules, and trauma-informed approaches by instructors or advisors. Youth explained that these supports were critical to their ability to stay in school while managing their mental health.

Although not every youth received these accommodations, those who did reported that they made a significant difference. They were able to remain enrolled, avoid academic penalties, and take care of their health without falling behind. These positive experiences suggest that educational institutions play a crucial role in mental wellness, especially when they understand the impacts of trauma and provide flexible support.

This theme is supported by the Truth and Reconciliation Commission of Canada (2015), which calls on postsecondary institutions to improve supports for Indigenous students, including mental health and wellness services that reflect Indigenous knowledge and experiences.

PEER AND COMMUNITY SUPPORT FOSTERS BELONGING

Finally, youth identified peer-led and community-based supports as essential to their mental health. They described how informal peer networks, Indigenous youth groups, and community gatherings helped reduce isolation and foster a sense of belonging. These spaces often became entry points into more formal services or sources of emotional strength during difficult times.

One participant shared how important peer connections were in finding services. They said:

> *"They've played a big part in me being able to know about the resources that are available."*

Another youth described how community kept them grounded. They explained:

> *"Being able to have that kinship and that support, that is why I'm still here today."*

These accounts show that peer support and community connection are not secondary to mental health. They are central. Research confirms that Indigenous youth who feel connected to their community and cultural identity are more likely to show resilience and experience positive outcomes (Wexler et al., 2015). Community spaces provide emotional support, cultural affirmation, and practical pathways to care. They also give youth opportunities to lead, share knowledge, and support one another. This approach counters the isolation and stigma that can occur in more clinical settings.

BARRIERS AND GAPS

While some Indigenous youth in the Greater Toronto Area (GTA) are able to access culturally safe and supportive services, the broader mental health system remains deeply fragmented, under-resourced, and structurally misaligned with their needs. Interviews with youth, analysis of service infrastructure, and a review of supporting literature reveal a system that too often reproduces harm rather than healing. This section outlines the key barriers that prevent Indigenous youth from receiving timely, culturally appropriate, and equitable mental health care.

CULTURAL INCOMPATIBILITY

Many Indigenous youth described mainstream mental health services as colonial, clinical, and culturally unsafe. Participants reported that service providers often dismissed or failed to understand Indigenous ways of knowing, healing, and relating to trauma. Rather than integrating traditional practices or perspectives, institutions frequently imposed Western clinical models that felt rigid and dehumanizing.

One youth expressed their frustration with this dynamic, stating:

> "*Even if you actually do want to go and you want to get the support [...] there is racism in the mental health system. There's racism in the hospitals.'*"

A participant recounted their experience seeking support during alcohol withdrawal:

> *"I had my big mukluks on, and I was like, 'Hey, like, I quit drinking, but I'm really sick.' And they're like, 'Oh no, obviously you're still drinking.' [...] And then I'm kind of like, oh maybe this is why [they thought that]."*

These experiences illustrate the ongoing impacts of structural racism and stereotyping in care environments. Afro-Indigenous and mixed-heritage youth spoke specifically to the intersectional racism they faced. One participant reflected:

> *"I'm Black and Native, so I feel like that's the most picked-on races in the world."*

When services disregard Indigenous cultural practices or treat identity as a barrier, they create environments where youth feel disrespected and misrecognized. This lack of cultural competency reduces engagement, can be traumatic, and reinforces mistrust.

LACK OF SAFE AND CULTURALLY APPROPRIATE CRISIS CARE PATHWAYS

For Indigenous youth in the GTA, crisis is often the point where the mental health system becomes most accessible, yet it is also where the system proves most harmful. Participants described seeking help in emergencies only to find themselves locked out, dismissed, or redirected to bureaucratic processes that did not respond to their immediate needs.

One youth recounted:

> *"I was really upset, because [...] I'm like, there trying to ask for help. I'm locked out of everywhere. Nobody's giving me any helpful information"*

When youth did reach hospital-based crisis care, their experiences reflected environments organized around control rather than healing. Practices such as seclusion and restraint were common, with one participant noting that instead of being comforted they were restrained.

> *"if I would have had a staff [...] come say, 'what's really going on?' [...] none of that would have happened. I wouldn't have ended up in a seclusion room. I wouldn't have got thrown in there by security and tied onto a bed there."*

Hospitals were also described as culturally barren, with no prayer or smudging spaces, signalling that Indigenous spiritual practices had no place in these settings. The involvement of police as first responders further heightened risk, as youth experiencing panic or distress were met with criminalization rather than support:

> *"I was having a panic attack and they just completely dismissed me"*

These experiences show that crisis care is not simply inadequate, but structurally misaligned with Indigenous youth needs. The system relies on coercion, containment, and biomedical frameworks at the very moment when trust, compassion, and cultural grounding are most required. As a result, crisis pathways function as barriers that alienate youth, deter future help-seeking, and in some cases, create additional trauma rather than healing.

OVERUSE AND MISUSE OF MEDICATION WITHOUT INFORMED CONSENT

Youth described concerns with how medication is introduced and prescribed within the mental health system. Many felt that clinicians focused too quickly on pharmaceutical interventions without understanding their stories or cultural context. While some acknowledged the role of medication in managing symptoms, others felt harmed by its overuse or by a lack of informed consent.

One youth described the long-term impact of being medicated without appropriate follow-up:

> *"They did not give me the right medication [...] It robbed me of my childhood. I wasn't able to express emotions. I was described as a zombie by people looking from the outside."*

This experience was compounded by a sense that their voice and self-knowledge were ignored:

> *"It was hard again, with people not really listening to what I had to say."*

These experiences raise concerns about the lack of wholistic care planning. When medication is offered without access to therapy, cultural healing, or ongoing support, it can lead to disconnection and deep emotional consequences.

WAITLISTS, DELAYS, AND LACK OF FOLLOW-UP

Accessing timely support was a major barrier across youth accounts. Participants reported wait times of six months to two years for specialized services. This included delays in accessing Indigenous counsellors or culturally aligned care. One participant described the urgency of their situation and the inadequacy of the response:

> *"It took a wait list to get a counsellor that was an Indigenous counsellor [...] I think a couple months of a wait. So, that's pretty brutal with especially a lot of the situations I've been in– a lot of dangerous situations."*

Delays in care were not only frustrating but potentially dangerous. Another youth described what happened after being discharged from inpatient care:

> *"You just held me there for like, almost two weeks, and now you're just sending me back out into the world [...] More follow-up would be good, more resources [...] it was like a band aid basically."*

These gaps in follow-up and transitions between services left youth feeling abandoned and unsupported. For many, the system only responded when they were in crisis, then offered no pathway to ongoing care.

COST BARRIERS AND FINANCIAL INACCESSIBILITY

Private therapy costs were a significant barrier for many youth. Several participants reported that therapy ranged from $130 to $200 per session, making it financially out of reach. While some were able to access therapy through school, or through other funding sources, others described challenges related to insurance, upfront payment, and affordability.

One youth shared,

> *“Recently, I've only been able to afford therapy through going to school because it's included in tuition. My therapist–with this economy now–is way too hard [to afford].”*

Another stated:

> *“I have to pay the whole price and then put in the insurance claim [...] I haven't even had room on my credit card to put up my credit card for the day.”*

These financial hurdles prevent consistent care and force youth to navigate complex reimbursement systems. For those without access to coverage, care may be entirely inaccessible.

FRAGMENTATION ACROSS SERVICES AND JURISDICTIONAL GAPS

The GTA mental health system lacks coordination between services. Youth described disjointed experiences, with poor communication across agencies, unclear referrals, and inconsistent relationships with providers.

As one youth expressed:

> *"And I was really upset, because [...] everybody seems to be preaching, 'Oh, if you need help, ask. Oh, our doors are always open and, you know, come and ask for help.' And I'm like, there trying to ask for help. I'm locked out of everywhere. Nobody's giving me any helpful information."*

This fragmentation is not just a result of poor design. It is also a function of broader jurisdictional ambiguity. Mental health services for Indigenous peoples fall between federal and provincial responsibilities, resulting in inconsistent funding and unclear accountability. Project-based funding models, rather than sustained core funding, further weaken service stability.

These systemic issues lead to high staff turnover, short-lived programs, and gaps in continuity. They also limit the formation of trusting relationships, which are foundational to Indigenous models of healing (Hart, 2002).

BUREAUCRATIC TOOLS THAT FAIL TO CAPTURE INDIGENOUS REALITIES

Standardized assessment tools, such as “plans of care,” were described as inadequate and alienating. Youth expressed that these tools were overly clinical, focused on symptoms rather than context, and failed to reflect their lived experiences.

This approach can result in misdiagnosis or dismissal of underlying trauma. The rigidity of standardized tools, combined with a lack of cultural interpretation, increases the risk that youth will disengage or be misunderstood.

STIGMA, FEAR, AND MISTRUST

Many youth described the social stigma attached to mental health care. While some noted growing openness among younger generations, stigma remained a barrier in families and communities. Youth worried about being labeled, losing privacy, or being pathologized in ways that would follow them throughout life.

One participant reflected:

> *"The fear of being labeled—the fear of coming off, "crazy" and then not being able to ever integrate back into my life. So, that was one of my fears, just because of the stigma about Indigenous people with mental health and addictions [...] the fear that if I disclosed my full journey, that someone who doesn't understand is just going to be quick to say this person needs to be locked away."*

These fears are not unfounded. They reflect real patterns of surveillance, coercion, and lack of consent that have been documented in the experiences of Indigenous peoples in health and social service systems (Allan & Smylie, 2015).

The barriers outlined in this section reveal a system that is not only fragmented and underfunded, but structurally incompatible with the realities and needs of Indigenous youth. Cultural disconnection, racism, cost, waitlists, and institutional rigidity form a web of challenges that make timely and effective care nearly impossible for many.

Youth are not disengaged from services because they do not care about their mental health. They are disengaged because the system, as it currently exists, fails to make space for who they are, how they heal, and what they need to thrive.

FUTURE VISIONS

We asked young people what a ideal system would look like, if designed with them in mind. They articulated detailed visions for what a safe, effective, and culturally grounded mental health system could look like. These visions are grounded in lived experience of what has failed, as well as in deep knowledge of what kinds of supports actually promote healing. Youth perspectives consistently called for a fundamental transformation of the system from a colonial, fragmented model toward one that is Indigenous-led, wholistic, community-based, and accessible to all. This section details some of those visions for the future of mental health services in the GTA.

A SYSTEM THAT IS INDIGENOUS-LED

A central theme in youth visions of an improved system is the call for Indigenous-led services that operate from a wholistic worldview. This was described not only as a matter of governance, but as a matter of safety and effectiveness. Participants envisioned spaces where Indigenous philosophies shape the structure of care, where ceremony and community are central, and where clinical services can coexist with land-based and cultural practices.

> *"If I had the opportunity to design a better system, it would be to have, ideally, a hospital for mental health and addiction through an Indigenous lens [...] creating a team of [professionals] through Indigenous philosophy that would be outside of the city, in a place where you're in nature, where they're not only teaching you life skills, but helping you look at mental health and addiction through an Indigenous lens. Whether that is gardening, drumming, and sweat, or doing things like CBT therapy, where it's just a safer environment."*

Rather than treating Indigenous healing as an add-on to biomedical care, youth imagine systems where both knowledge traditions stand side by side, working together. Importantly, the inclusion of non-Indigenous professionals was also described as beneficial, provided they are committed to working within Indigenous philosophies and respecting Indigenous leadership.

These perspectives suggest that Indigenous youth do not want fragmented services where they must choose between cultural and clinical supports. Instead, they are calling for integrated systems where culture is foundational to care, not optional. This vision directly addresses one of the clearest gaps identified in earlier findings: the absence of culturally safe crisis pathways and the erasure of Indigenous knowledge in mainstream care. By grounding mental health services in Indigenous leadership and holistic practice, youth see a way to transform environments that are currently unsafe and alienating into ones that are healing and affirming.

A SYSTEM THAT CENTERS LAND-BASED AND CEREMONIAL APPROACHES

Indigenous youth envision mental health systems where land and ceremony are not optional, but foundational. They described healing as inseparable from time on the land, connection to nature, and the regular practice of ceremony. These elements were understood not as cultural "extras," but as essential to safety, grounding, and identity in ways that Western therapy alone cannot provide.

Youth explained that being on the land and engaging in outdoor activities are natural forms of coping that they turned to even before entering services.

> *"Like some of the stuff she told me to help cope, like, 'go for a walk, go for a run, be outside, try grounding exercises, have you tried meditation?' And these were all things that I was already doing before I had even decided to meet with my social worker… Here in my community, I'm always outside at the bush. I'm always going outside with my family, we go for quad rides, we're always fishing, we're always out and about, you know. So I kind of already knew stuff that helped me."*

Participants also emphasized the need for accessible community spaces where ceremony, spirituality, and culture are integrated into daily practice. Suggestions included prayer and smudging rooms in hospitals, community fires with Elders available to youth, and regular access to ceremony. As one youth explained,

> *"'Hey, if we have a backyard here, why don't we get a fire pit and have a fire open once or twice a week, with an Elder there […] cultivating more safe spaces, Indigenous specific spaces, having more access to ceremony"*

Another participant emphasized that what is currently missing from mainstream care is exactly this spiritual connection:

> *"Connecting spiritually. I think that part really lacks in typical mental health institutions. […] I think adding that is really important."*

Together, these accounts describe an ideal system where time on the land, spiritual connection, and ceremony are treated as core components of healing. Youth do not want land-based or ceremonial supports to exist on the margins of clinical services; they want them embedded into the very structure of care. In their vision, a truly responsive system is one where fire, prayer, ceremony, and time on the land stand alongside counseling and therapy, forming an integrated whole that speaks to every dimension of Indigenous wellness.

A SYSTEM WITH MULTIPLE AND INCLUSIVE OPTIONS FOR DIVERSE NEEDS

Alongside calls for Indigenous-led and holistic approaches, youth emphasized that an ideal mental health system must reflect the diversity of Indigenous communities. Participants explained that a "one-size-fits-all" model is not adequate. Instead, they envisioned a network of supports that includes specialized spaces for different Indigenous identities, genders, sexualities, and cultural contexts.

> *"I would hire a bunch of Indigenous therapists, in general, social workers, people of the field. I would also bring in healers and Elders, so the supports can be unlimited almost. I would have a bunch of different buildings and centres that Indigenous youth can go to, and Indigenous people in general, all ages can go to for support. I would have a bunch of different networks so there would be different supports. So for like Two Spirit people, for queer Indigenous people, for Métis, and for like, a bunch of different [...] communities within the Indigenous communities. And I would have nights where you can come in, make food, have just a very nice community space."*

This vision underscores two key insights. First, Indigenous youth recognize that their communities are not homogenous. Supports must reflect diversity across urban, rural, and reserve contexts, as well as across Métis, First Nations, and Inuit experiences. Second, youth highlighted the need for specialized spaces for Two-Spirit, queer, and other marginalized subgroups, where identity is not only respected but affirmed through community belonging.

Youth also noted that inclusivity must extend beyond service options to the design of spaces themselves. Environments that feel welcoming, relational, and community-oriented (such as those with opportunities to share food, gather socially, or connect across generations) were described as critical for wellness.

For some youth, transformation means the creation of entirely new, Indigenous-designed systems. For others, it means ensuring that existing services embed Indigenous staff and perspectives, so that youth do not have to choose between accessing clinical care and finding cultural safety.

> *"I think it would look like creating a really safe space [...] I think ideally there wouldn't be racism in hospitals [...] and it wouldn't be so colonial, and there wouldn't be those kind of issues. I wish that it could be more accessible, that people were not turned away when they actually need the support. I wish that instead of people kind of being forced– you need to see this person or that person– it's like, if you're working with an Indigenous youth, find a way to help them see an Elder, or see a healer, or see someone in their community that they feel safe [...] Just having, definitely, more options."*

Taken together, these perspectives demonstrate that inclusivity is not only about adding cultural programming onto existing models. It requires a system designed to recognize and serve the full diversity of Indigenous youth identities.

A SYSTEM THAT IS ACCESSIBLE, LOW-BARRIER, AND FREE FOR ALL

Participants emphasized that mental health care should be accessible to all Indigenous youth, regardless of income, geography, or personal circumstance. Cost was consistently identified as a structural barrier in the current system.

> *"I would say cost is definitely one of the bigger issues. So lower the cost, because mental health, mental health help should be free [...] Because it's really important, especially to Indigenous people."*

This vision of free care reflects both a practical need and a matter of equity. Indigenous youth experience disproportionate barriers to employment, housing, and health care access, many of which are linked to the intergenerational impacts of colonialism. Expecting them to self-fund therapy through private services reinforces these inequities. For participants, free or publicly funded care is not an optional benefit but a necessary foundation for a just system.

Beyond cost, accessibility was also linked to how services are organized and delivered. Several participants described being discouraged by system barriers, which left them feeling abandoned or demotivated in their healing journey.

As one youth noted,

> *"I feel like perhaps being demotivated due to the inaccessibility sometimes definitely had a factor with it. You know, maybe had it been easier, I would have been able to be more motivated back then to get more help."*

Others spoke about the need for continuity in care. Repeating one's story to multiple staff members across disconnected services was described as retraumatizing and exhausting. Participants envisioned a model where one consistent worker or case manager could coordinate services and provide ongoing support. As one youth explained,

> *"So it would be a good idea if, through services, you have one primary case worker who's kind of [...] you have a map, right? And it's all up to me to put on the map what needs to go on there. So it would be good to have somebody who kind of stays on top of us for that [...] Because if I had to do it all on my own, and if I had to keep track of all these appointments, I couldn't do it."*

These accounts point to a systemic gap: the current system assumes that youth can navigate multiple disconnected services on their own, and that they can pay for private care if public options are unavailable. In contrast, youth envision a system where care is free at the point of access, organized to minimize barriers, and consistent enough to build trust. Accessible, low-barrier, and free care was described as an essential pillar of an ideal system. Without it, Indigenous youth are left to manage fragmented and costly services that many cannot afford or sustain.

A SYSTEM WITH COMPETENT AND CULTURALLY SAFE STAFF

Youth consistently emphasized that the people who provide care are as important as the services themselves. An ideal mental health system, in their view, would be staffed by practitioners who are not only formally qualified but also culturally competent, experienced in Indigenous contexts, and, where possible, informed by lived experience. This vision speaks directly to one of the most significant gaps identified earlier: the disconnect between youth and staff who lack cultural awareness or who treat Indigenous identity as irrelevant to care.

Participants identified two major staffing priorities. The first was the importance of advanced qualifications combined with direct experience in Indigenous communities. One youth explained,

> *"More staff who are qualified and have the experience of either living and/or working on reserve and with Indigenous youth [...] I had asked for somebody with a Masters at least, and also somebody who has experience working in Indigenous communities or working with Indigenous people."*

This perspective highlights that credentials alone are not enough. Without direct knowledge of Indigenous life contexts staff risk misinterpreting youth experiences or applying clinical frameworks that do not resonate.

The second priority was training and cultural sensitivity. Youth called for all staff, regardless of background, to be educated in Indigenous histories, intergenerational trauma, and cultural safety. As one participant argued,

> *"I feel like the people working there should be trained, you know—someone that has lived experience with mental health [...] I think even care providers that are servicing Indigenous youth should definitely have cultural sensitivity training. Understand all Indigenous youth are affected by residential school and the 60s scoop. Understand that intergenerational trauma [...] so that you can have that in the back of your mind when you're supporting those youth, right?"*

Another youth framed this expectation as a matter of policy rather than choice:

> *"It should just be mandatory that you are knowledgeable in an Indigenous lens to mental health. I think that should just be a baseline. Like, it's standard to have your first aid—it's standard to know that. Changing that immediately I think would change the narrative of people saying, 'oh, well, I didn't know.' Because I really think that excuse is old and tired. It's 2025, there are so many resources."*

These perspectives point to a system-level gap in workforce preparedness. In the current system, Indigenous cultural knowledge is treated as optional, resulting in inconsistent and often unsafe care. Youth envision a future where cultural competence is not an afterthought but a baseline requirement for all providers.

Participants expressed frustration with providers who, despite advanced degrees, were "not authentic and real" and unable to connect in meaningful ways. As one youth explained, working with non-Indigenous staff who lacked lived experience often felt alienating:

> "A lot of these people in these institutions come from a very academic place and cannot relate to somebody at all. Like, [I'm] not going to sit and talk to someone who's non-Indigenous—who will never understand what I've been through—and then tell them 'you need to do this.'"

At the same time, youth also highlighted a tension in the current workforce. They want Indigenous practitioners who bring cultural safety and lived experience, but they also called for advanced qualifications, such as graduate-level training. In the existing system, these qualities don't always align. Indigenous youth are often forced to choose between culturally safe support without formal credentials, or credentialed professionals without cultural understanding. This reveals a structural gap in the pipeline: too few Indigenous people are supported to complete advanced training in psychology, social work, or psychiatry, and Indigenous knowledge holders such as Elders or healers are not consistently recognized as equal to Western credentialing. For youth, an ideal system would resolve this gap by both expanding access for Indigenous practitioners to advanced education and elevating Indigenous knowledge as legitimate expertise alongside academic training. Youth want to be supported by staff who are both professionally qualified and culturally grounded

A SYSTEM THAT IS CONSISTENT AND EASY TO NAVIGATE

Youth emphasized that an ideal mental health system must be consistent, reliable, and continuous. For many, the most painful experiences with the current system came from constantly being passed between workers, retelling traumatic stories, or waiting so long for a referral that their circumstances had completely changed by the time services became available. In contrast, their vision for the future centered on stable relationships, seamless coordination, and timely care that recognizes the importance of developmental milestones in their lives.

A key feature of this vision is the presence of consistent workers or therapists. As one participant explained, she had asked at the outset to be assigned a worker who would stay with her, because she did not want to keep repeating her story to new staff:

> *"I want to make sure that I'm going to have a consistent worker because [...] I felt like I had told so many people what had happened and I was just getting passed around and having to repeat the same, shitty story in detail, over and over again before I had even done any type of therapy."*

Another youth described the exhausting cycle of having "four or five different workers" and the burden of starting over each time. These experiences show that consistency is not only a matter of convenience, but a precondition for trust and healing.

Youth also envisioned systems where information moves more smoothly, so that care does not reset every time a worker changes. One participant described the relief she felt when a new worker acknowledged the notes in her file and told her she did not have to rehash everything again:

> *"That was a huge relief for me, and that just —like it made me trust her a lot faster than my experience with the previous social worker."*

This highlights how continuity of information, not just personnel, reduces re-traumatization and supports trust.

Another central element of the youth vision was coordinated case management. Participants wanted one primary case worker to help them map their supports, maintain motivation, and follow up with reminders. Another added that ideally, a single case manager should keep track of all the different services, so youth are not forced to search for supports alone.

Youth also described the need for smoother transitions between services and geographies. Moving between regions often meant losing a therapist or being taken off a waitlist entirely, as one participant recalled after returning to Toronto:

> *"I didn't have a therapist anymore, and I wasn't on the waitlist for one anymore because I wasn't within region."*

In their vision, systems would ensure continuity across regions and services, with youth maintaining access to supports without starting over.

A SYSTEM THAT INTEGRATES MENTAL HEALTH WITH SOCIAL DETERMINANTS OF HEALTH

Youth envisioned mental health systems that are not siloed, but directly linked to the social supports that shape everyday life. In their view, mental health cannot be separated from housing, income, education, work, family, culture, or community. An ideal system therefore integrates these domains into a coherent structure of care.

At the foundation, housing and economic stability are treated as core mental health interventions. This means that accessing care is tied to supports such as short-term rent subsidies, access to Employment Insurance during recovery, transportation assistance, and food security. One youth explained the need for policies that make it easier to get on EI or have a rent subsidy for those two months so that treatment does not threaten basic survival. In this model, financial security is recognized as inseparable from recovery.

Education and employment must also positioned as hubs of support. Schools and universities provide not only academic accommodations but direct access to counseling, cultural workers, and peer mentors. Workplaces can embed counselors and Elders, making care accessible within the flow of daily life. As one youth noted, being able to see a counselor and Elder at work was "fantastic because not a lot of people have that opportunity."

Health carecould also be coordinated wholistically. Youth want systems where physical and mental health are addressed together, with hospitals, community health centers, and Indigenous-led organizations sharing responsibility. Rather than sending youth through disconnected services, integration would ensure continuity across all aspects of care. As one participant explained, support should:

> *"Look at them as a whole, everything you take into account instead of just one aspect."*

Family and kinship were seen as central to healing. Youth envision systems that intentionally include family-based supports, protected home environments, and opportunities to reconnect with siblings or parents during treatment. Community connections also play a role. Regular cultural programming, feasts, and social gatherings could be built into care, reducing isolation and strengthening belonging.

Another key factor to this integrative model, is the support of youth as they age out of youth specific services.

In this vision, mental health services act as the hub that connects housing, income, education, health care, family, and culture. By weaving these elements together, services could create wraparound systems that support safety, stability, and belonging—conditions youth see as essential for healing.

A SYSTEM WHERE YOUTH LEAD THEIR OWN CARE

Youth envision an ideal mental health system that is youth-centered in practice, not just in name. This means services are designed specifically for young people, not simply adapted from adult models; that youth are recognized as capable of leading, informing, and consenting to their own care; and that transitions, including aging out of services and into adulthood, are intentionally planned and supported.

Participants emphasized that services must reflect youth realities and developmental needs. Too often, they described being placed in adult-oriented spaces or receiving interventions that did not match the complexity of their experiences. One young person recalled being turned away because there was no youth ward available, and told they would have to wait for a bed in another city:

> *"They're like, 'Oh, you're adolescent [...] we don't have an adolescent ward here. We can't admit you'"*

Another described being placed alongside older, more disruptive youth as a young person as traumatizing. In contrast, being in a youth-specific space was seen as protective:

> *"It was a youth ward. I was like sixteen. So, I think that's why it was a bit better"*

These reflections highlight that age-appropriate services are not optional but fundamental to safety and effectiveness.

Youth also called for genuine choice and consent in their care. They described the ability to refuse, negotiate, and decide as essential to healing. One participant explained,

> *"Then I made the decision to go on medications [...] but that decision was totally up to me. My doctor didn't have any hand in it."*

In consideration of diagnosis, youth have differing opinions about the role it plays in their lives, but consistently share that they want to be a meaningful part of the process

> *"I want the real name because I want to be able to deal with it and accept it [...] I don't want a sugar coat."*

Others pointed to times when their consent was ignored, including being medicated as children despite protest:

> *"I remember screaming 'I don't consent' [...] but they just kept triggering me [...] and force me to take the pill."*

Youth-centered systems, in their view, must go beyond surface-level consultation to ensure true autonomy and respect for self-determination.

Transitions and aging out of services are a major point of vulnerability that must be addressed. Youth stressed that mental health challenges do not end at arbitrary age cut-offs, yet services often do.

> *"It was a cut off. At the time, the cut off was 23 [...] If you were over 23, you couldn't use the services."*

Another noted losing access to parental insurance at 25 despite ongoing need. Others described a lack of discharge planning, with one saying,

> *"They just gave me meds and were like 'take care'"*

These examples demonstrate that abrupt service cut-offs create dangerous gaps in care and leave young people unsupported during critical life stages. An ideal system would integrate transition planning into all services, ensuring continuity and scaffolding support into adulthood.

Taken together, these findings highlight that youth are not passive recipients of care but active experts in their own lives. They envision systems that respect their decision-making, provide developmentally appropriate services, and recognize transitions as part of care planning. A youth-centered mental health system is therefore one that builds trust by embedding choice, creates safety through dedicated youth spaces, and sustains support across the life course rather than ending it at arbitrary points.

A SYSTEM THAT IS WELL RESOURCED

Youth envision an ideal mental health system where organizations and practitioners are adequately funded and supported to deliver stable, high-quality care. From their perspective, the problem is not only a lack of services but the fragility of those that do exist. Many described how Indigenous-led and community-based programs operate with limited resources, leaving them vulnerable to cuts, short-term grants, and staff turnover.

> *"It's a constant struggle and a constant fight with the government [...] there's little to no funding for Indigenous groups and or places."*

The consequences of this underfunding are felt directly by youth through instability and inconsistency in care. Participants noted that staff turnover was common, with many workers leaving due to low pay and unsustainable workloads. They also described how they were often given entry-level staff or students because these providers were free or low-cost, even though they wanted access to more experienced clinicians.

> *"Not enough people, not enough staff. The employee turnover rate was very high because a lot of people use it as a stepping stone [...] they're not being paid nearly enough for what they have to deal with, and the amount of work and people and intake they have to do and the things they have to see."*

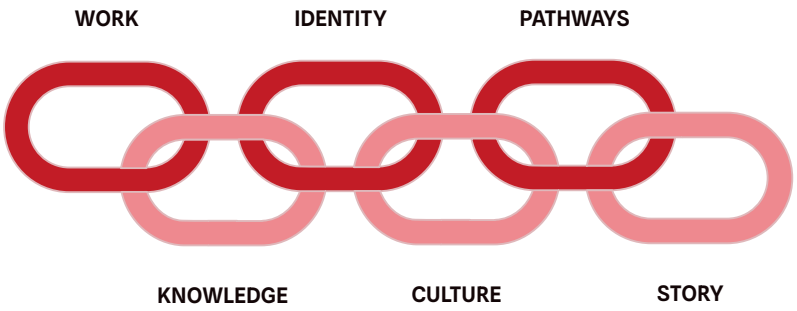
These accounts highlight how inadequate funding not only disrupts relationships but also restricts access to the quality of care that youth are seeking.

In their vision for an ideal system, youth imagine organizations that are stable, well-staffed, and properly resourced to create safe and consistent spaces for healing. This means long-term, sustainable funding that supports fair wages, reduces turnover, and ensures access to highly qualified practitioners, not just entry-level providers. It also means investment in organizational infrastructure so that programs can grow without constantly fighting for survival.

For youth, well-resourced organizations are not just a technical requirement—they are the foundation of a system capable of providing the steady, culturally grounded, and youth-centered support they both need and deserve.

This study shows that Indigenous youth in the GTA experience the mental health system as fragmented, crisis-driven, and often not designed with their needs in mind. They identified strengths in Indigenous-led and culturally competent services, supportive practitioners, and community or school-based programs, but also highlighted barriers such as traumatic hospitalizations, frequent worker turnover, re-traumatizing intake processes, and the lack of youth-specific or age-appropriate care. Beyond clinical services, youth emphasized that housing, income, education, transportation, and social supports directly shape mental health yet remain poorly integrated into care. At the same time, they articulated clear and sophisticated visions for an ideal system: one that is stable and well-resourced, culturally grounded, youth-centered, and integrative of land-based practices, community supports, and social determinants of health. Above all, youth envision a system that recognizes them as capable decision-makers and partners in shaping their care, ensuring continuity, choice, and respect across the full course of their lives.

AN INSTITUTIONAL ETHNOGRAPHY APPROACH TO ANALYZING THE SYSTEM



This section explores what Indigenous youth experiences can teach us about how the mental health system works in the Greater Toronto Area. We listened to youth perspectives to understand how their daily lives are shaped by the bigger rules and policies of the mental health system. Instead of seeing youth as the problem, this approach helps us understand how the system itself sometimes creates challenges and difficulties in their lives.

Our understanding was built through a team effort. We gathered information from youth interviews, story maps, questionnaires, and conversations with important community leaders. We looked for common themes and patterns in what they shared. These findings were then discussed in meetings with the Indigenous Community Advisory Committee (ICAC), who helped us understand the information in a way that respects Indigenous ways of knowing, governance, and community experiences. This process helped us look beyond individual stories to get a fuller picture of how mental health care is set up for Indigenous youth.

The topics we discuss next highlight the main differences between what youth experience and how the system is set up, using an institutional ethnography approach. Overall, these findings show that Indigenous youth often carry an unfair share of the effort and challenges within the mental health system—sometimes doing the work that the institutions should be handling. At the same time, their stories also reveal ideas for care that is more connected, rooted in their culture, and truly helpful. The following sections will go into more detail on these important topics.

IDENTITY

> *"When I first found out about my diagnosis, I was like, this is just me [...] I was just excited to be able to put a name to it, to give language to it, and I can help myself further from this."*

Identity emerges as actively produced and resisted within service encounters. Cultural identity, disability identity, and diagnostic categories are mediated by institutional texts and practitioner practices. Youth describe cultural identity being erased or affirmed depending on the practitioner's positioning, disability identity functioning as both a bureaucratic gateway and a site of resistance, and diagnostic categories being engaged strategically rather than passively accepted. Practitioner identity (whether Indigenous, racialized, or non-Indigenous) consistently shapes whether youth feel recognized or misrecognized.

CULTURAL IDENTITY AND RECOGNITION

For many participants, cultural identity was central to their mental health and sense of belonging. Youth described their identities in rich and complex ways. Yet these realities often had little space within institutional texts such as intake forms or assessment protocols. The administrative structures of care, built on standardized categories, reduced Indigenous identity to a checkbox rather than recognizing it as integral to wellness. When recognition did occur, it was usually tied to the presence of Indigenous practitioners or community-based programs. Youth emphasized the difference it made when care providers were culturally aware or spoke from lived Indigenous experience. This reflects broader research showing that cultural safety depends not only on individual sensitivity but on systemic embedding of Indigenous worldviews within care (Browne et al., 2016; Allan & Smylie, 2015). From an IE perspective, the analysis demonstrates that recognition of cultural identity is not incidental: it depends on how institutional structures authorize or marginalize Indigenous presence.

DIAGNOSTIC CATEGORIES AND NEGOTIATED IDENTITIES

Youth also spoke about how diagnostic labels shaped their self-understanding and access to care. For some, receiving a diagnosis provided language and validation, helping them make sense of their experience and opening doors to supports. Others described diagnosis as stigmatizing, used against them by providers, or associated with coercive practices such as being held in hospital against their will. Several participants emphasized that they engaged strategically with diagnoses; accepting them when they facilitated access but resisting or downplaying them when they threatened dignity or autonomy. This illustrates a key insight: diagnostic categories are not neutral descriptors but institutional texts that regulate access and coordinate professional responses. They function as gateways, producing both recognition and exclusion. The youth's strategic use of these categories highlights their active role in negotiating institutional structures, a finding echoed in studies showing that Indigenous clients often navigate diagnoses in ways that protect themselves against institutional harm (Hartmann et al., 2019).

PRACTITIONER IDENTITY AND RELATIONAL RECOGNITION

Another recurring theme was the role of practitioner identity in shaping whether youth felt seen or misrecognized. Indigenous practitioners were often described as creating meaningful relationships that acknowledged colonial histories and integrated ceremony or cultural teachings. By contrast, non-Indigenous practitioners who lacked cultural knowledge left youth feeling dismissed, stereotyped, or forced into Western frameworks of care. This was particularly acute for Afro-Indigenous participants, who reported experiencing racism and misdiagnosis rooted in stereotypes. From an IE lens, these encounters are not simply about individual prejudice but about institutional structures that define which professional identities are authorized as legitimate. Training programs, hiring practices, and professional standards all determine whether Indigenous youth encounter recognition or erasure in daily service interactions. The reliance on non-Indigenous staff, combined with limited Indigenous-specific positions, produces systemic conditions where recognition becomes the exception rather than the norm.

CULTURE

> *"I just don't feel the system respects Indigenous knowledge, values, and also healing practices, because most of the time it just feels like those parts of us are left at the door and the system just was on medication or talk therapy. But what about the ceremony? What about the land, the kinship, or even storytelling? Because [...] until they are treated with the same respect, the system just won't really serve us."*

Indigenous youth describe culture as something they are often asked to leave at the door of mental health services. Institutional culture, rooted in biomedical norms, defines what counts as treatment, while Indigenous traditions like ceremony, land, and kinship are considered but often seperate from institutional treatments. Youth frequently supplement institutional care with community-based services to sustain their wellness. Where Indigenous and clinical models are integrated care becomes more culturally safe and responsive.

CULTURE AS ADMINISTRATIVE CATEGORY

In our research, culture frequently appears as an institutional sorting mechanism. Youth were asked to identify their Indigenous status in order to be routed to specialized programs or to bypass lengthy wait times. This illustrates how culture operates as an “access key” within bureaucratic systems rather than as a lived relation. Allan and Smylie (2015) and Browne et al. (2016) describe similar processes, where Indigenous identity is administratively mobilized to manage equity concerns but is detached from its actual social and cultural meaning.

From an IE perspective, this reveals a ruling relation: institutions rely on categorical identities to coordinate services, transforming Indigenous culture into a bureaucratic instrument rather than respecting it as a way of life.

THE WORK OF CULTURAL NAVIGATION

Because institutions do not automatically embed cultural safety, youth must actively perform the work of bringing culture into their care. They asked for practitioners with specific training, sought out Elders, and educated service providers about what cultural competence should entail. This is consistent with Smith's (2005) observation that institutions externalize their coordination onto those who use them. Rather than being supported, youth became responsible for identifying gaps, correcting stereotypes, and advocating for the inclusion of ceremony or cultural practice. In this sense, "cultural safety" is not produced by the system itself but by the unpaid labour of those navigating it.

DISJUNCTURES BETWEEN LIVED CULTURE AND INSTITUTIONAL OFFERINGS

The starkest finding lies in the disjuncture between how youth live culture and how institutions define it. For youth, culture meant land-based practices, ceremonies, and kinship relations; for institutions, it often appeared as discrete programming—workshops, events, or designated staff positions. This gap mirrors what Browne et al. (2016) describe as the reduction of Indigenous knowledge to "add-on" cultural programming.

IE highlights this as a structural disjuncture: the ruling relations of the mental health system define "culture" in schedulable and professionalized terms, leaving youth to reconcile these narrow offerings with the broader realities of their lived worlds.

KNOWLEDGE

> *"There are lots of services. I think though they're kind of like, hush hush–like, it's secretive. It's like, you have to know someone to know the spot, which I don't think it should be like that."*

In institutional ethnography, knowledge is understood not just as information, but as a ruling relation—a system of texts, categories, and professional discourses that organizes everyday life. In the mental health system, knowledge determines who gains access, whose voices are legitimized, and who is excluded. From the standpoint of Indigenous youth, the data shows that navigating services requires both acquiring institutional knowledge and resisting its authority, while also producing counter-knowledge through family, peers, and community networks. In this way, knowledge becomes a fault line between institutional order and lived experience.

SYSTEM LITERACY AS GATEKEEPING

Youth accounts reveal how access to services is structured by system literacy: knowing which programs exist, which questions to ask, and which forms to fill out. Those with parents in health care or strong community networks were able to mobilize this knowledge as a resource, while others were "locked out" despite active help-seeking.

This aligns with Smith's (2005) observation that institutions externalize coordination work, requiring people to know and activate bureaucratic procedures themselves. In this sense, system literacy functions as a form of privilege: it reduces wait times, opens specialized programs, and creates two-tiered access. Rather than services being universally available, they are organized so that those who already hold institutional knowledge can advance, while those without it face exclusion.

INSTITUTIONAL IGNORANCE AND THE WORK OF EDUCATION

At the same time, institutions themselves demonstrate persistent knowledge gaps—about Indigenous trauma, community contexts, and cultural safety. Trauma is often treated as individual pathology, erasing its embeddedness in kinship and community relations. Even programs branded as "Indigenous" were described as staffed by workers lacking genuine cultural competence, reflecting what Browne et al. (2016) identify as the superficial "add-on" model of cultural programming. In response, youth found themselves in the position of educators: explaining their cultural practices, clarifying what cultural competence entails, or even informing staff about their own programs. This is not empowerment but unpaid labour. Institutions rely on youth to bridge knowledge gaps, thereby shifting the responsibility for system improvement onto those already marginalized.

SAFETY

> "*I think at the end of the day–right now in certain aspects–it's not the safest system for Indigenous youth. Indigenous youth are turned away, they're discriminated against, and if they don't feel safe accessing those kind of spaces, then that's kind of useless.*"

Safety is not a neutral concept but a social relation: it is produced through institutional texts, professional practices, and everyday interactions. In our study, Indigenous youth described safety as something they actively sought, created, and defended, often in contexts where institutions defined safety in ways that conflicted with their lived realities. For youth, safety meant protection from racism, poverty, violence, and stigma, as well as access to supportive communities. For institutions, safety was often equated with surveillance, coercion, or control. This contradiction produced deep disjunctures between what youth need and what services provide.

SAFETY IN EVERYDAY LIFE

Youth experiences highlighted that experiences of safety and insecurity extended well beyond the walls of service settings. Many linked their mental health struggles to unsafe housing, economic precarity, or exposure to community violence. One participant reflected on living in low-income areas where abuse and addiction were pervasive, noting that these conditions themselves became sources of distress. This resonates with broader research showing that the social determinants of health (such as stable housing, income, and freedom from violence) are foundational to Indigenous wellness (Reading & Wien, 2009).

Yet these broader conditions rarely figure into institutional definitions of "safety," which remain narrowly focused on individual behavior within clinical settings. From an IE standpoint, this disconnect reveals how institutional texts abstract safety from the broader realities of Indigenous life, placing responsibility on individuals rather than addressing structural inequities.

INSTITUTIONAL SAFETY AS CONTROL

In contrast, institutional encounters often define safety in terms of risk management and control. Youth described being met first by guards and security staff rather than nurses or counselors, being held against their will, or physically restrained with injections. In these cases, safety was operationalized through coercive measures that positioned youth as potential threats rather than people in need of care. For example, one youth recalled being told they could not leave a hospital because of their diagnosis, an encounter that illustrates how diagnostic texts authorize restrictions on autonomy. This reflects a wider pattern identified in critical mental health scholarship: institutional logics of safety frequently prioritize liability and containment over relational care (Burstow, 2015). From an IE lens, these practices show how texts and professional discourses organize everyday interactions, transforming fear and vulnerability into grounds for coercion.

NEGOTIATING SAFETY

Despite these challenges, youth described finding safety through relationships—with family members, supportive practitioners, Elders, or in Indigenous community spaces. Several participants emphasized the contrast between unsafe institutional environments and the sense of security they felt in stable family households or community settings. Where Indigenous practitioners were present, youth reported feeling more at ease, suggesting that cultural understanding and relational accountability function as protective factors. These accounts echo Indigenous health research which argues that safety is relational, emerging from respect, trust, and recognition rather than surveillance or restraint (Ponic & Frisby, 2010). From an IE perspective, these examples demonstrate that youth are not passive recipients of institutional definitions of safety; they actively negotiate and construct safety in ways that counter institutional logics.

STORY

> *"I've had four or five different workers, and I have to explain my whole life story to them over and over and over again.*

Story is both a cultural practice and an institutional demand. Indigenous youth describe being asked to retell their stories again and again through intakes, assessments, and case files, often reliving trauma without much benefit. Institutions then reduce complex lives to standardized records, shaping youth as cases of risk or disorder. At the same time, institutions tell their own story that often contradicts youth accounts of exclusion, danger, and unmet needs. While youth use story as a way to connect, heal, and assert meaning, institutions use story to categorize, manage, and legitimate their experience. Institutional activity also impacts and shapes youth experiences. Youth stories are often not understood or believed, but are a requirement of the system. Story then becomes a site where power and experience are in constant negotiation.

THE INDIGENOUS YOUTH STORY

For participants, storytelling is a cultural practice rooted in ceremony, kinship, and land. It locates distress within histories and relationships and is used to restore safety and meaning. Inside services, that practice is converted into repeated disclosures formatted for legibility: trauma retold across intakes, assessments, and transitions, often without benefit or relief. Youth in our study described this repetition as exhausting and sometimes harmful; several noted that details important to them were minimized or omitted once documented. The youth story also sits within Canada's wider colonial story; experiences of racism, displacement, poverty, and surveillance are not incidental details but structural conditions that shape the narrative and its reception. When these contexts are stripped out in documentation, the institutional text re-authors the person while erasing the relationship to colonial harm.

THE INSTITUTION'S STORY

In practice, youth stories are first converted into texts such as intake forms, assessment fields, diagnoses, risk scores, and progress notes. Once written, these texts travel across programs and time, and they begin to speak with institutional authority (Smith, 2005; Riessman, 2008). The same entries that open or close pathways also become countable data for dashboards, audits, and annual reports, including measures like throughput, wait times, compliance, and recorded risk events. In this way, a youth's narrated life becomes a case record, and the case record becomes part of the institution's story about what it does and how well it performs (Walter & Andersen, 2013). Content that does not fit standardized templates, including racism experienced in care, land and kin based healing, and community context, often falls away or is placed in optional fields. The result is a corporate narrative of coordination and quality that can contradict youth accounts of exclusion or harm (Browne et al., 2016). From an Indigenous IE perspective, this sequence functions as a ruling relation that privileges professional authorship and institutional legibility while shifting the work and risk of storytelling onto youth.

THE IMPACT OF THE INSTITUTION ON THE CLIENT STORY

The institutional story does not just represent youth; it acts on them. Once recorded, diagnoses, risk scores, “non-compliance,” or referral decisions shape the next steps—who is eligible, how quickly they are seen, whether coercive measures are triggered—and these steps become part of the textual record and the youth’s pathway. Treatments and referrals prescribed in response to the file then loop back as further evidence, reinforcing the institutional narrative. The result is a disjuncture: youth use story to connect and heal; institutions use story to categorize, manage, and legitimate practice. Youth bear the work of repeated retelling to populate files, the risk of being re-authored in ways that constrain future care, and the consequences when organizational self-stories of “access” and “safety” contradict their own reports of exclusion or harm. In IE terms, this is the power of ruling relations: standardized texts coordinate people at a distance, and narrative authority organizes both access and outcome (Smith, 2005).

PATHWAYS

> *"If you're trying to get a therapist or a counsellor or someone to talk to, it's gonna take forever [...] But if you're going into a hospital because you know you wanted to [harm] yourself, you're going to get admitted."*

Indigenous youth describe mental health pathways as fragmented routes shaped by referrals, intake procedures, and waitlists that rarely align with their needs. Formal entry points are tightly controlled by bureaucratic rules, often requiring the “right” diagnosis or referral source, while crisis becomes the fastest pathway to care. Alongside these institutional routes, youth rely on a pseudosystem of family, peers, and Indigenous community organizations to find support and fill the gaps left by clinical services. Rather than a continuum, pathways are negotiated networks where youth stitch together formal and community-based supports to create access where institutions fall short.

GATEKEPT ACCESS ORGANIZED BY TEXTS

The pathway begins at the door, but the door is textual. Referral criteria, intake templates, eligibility rules, diagnostic codes, and waitlist protocols decide who may enter, on what terms, and how long they will wait. In practice the file moves before the person. Youth must do the coordination work of finding the right referrer, supplying forms that fit categories, and repeating their histories so records align across sites. Disjuncture appears immediately: need is present, but entry is contingent on meeting textual requirements such as the right diagnosis, the right age band, the right postal code, or the right coverage.

Those without system literacy or strong advocates face delays or exclusion, a pattern widely documented for Indigenous peoples in health systems (Allan & Smylie, 2015; Browne et al., 2016). From an Indigenous IE perspective, ruling relations sort youth at the threshold while the labor of activation is displaced onto them (Smith, 2005).

HANDOFFS, FRAGMENTATION, AND CRISIS AS ACCELERATOR

Once inside, progression is organized by handoff texts such as consult notes, risk tools, care plans, and booking systems. Services are distributed across public, private, clinical, and community settings that do not reliably connect. Youth stitch care together by arranging appointments, carrying records, and translating between biomedical and Indigenous practices. Disjuncture is most visible in the tempo of care. Early and preventive supports are thin, while crisis fits triage algorithms and activates rapid response. In effect the system moves fastest when deterioration is documented. Crisis protocols can stabilize briefly, but they rarely build continuity with culturally grounded supports, reinforcing a loop back to the front of the line. The pathway is thus most coherent at the point of control rather than at the point of relationship and prevention (Browne et al., 2016; Smith, 2005).

DISCHARGE, AGING OUT, AND RE-ENTRY

Exit is coordinated by discharge summaries, transition policies, and age cutoffs. These texts close episodes and often sever connections, especially when youth cross regions, move between child and adult services, or lose eligibility with age. Follow up is frequently advisory rather than coordinated, and the burden of reactivation returns to youth. Disjuncture here is structural. The official pathway ends when the episode is closed, but the person's needs continue. Without portable, consented summaries and accountable warm handoffs, youth re-enter at new doors, re-tell their histories, and rebuild supports from scratch. For Indigenous youth, this also means re-establishing access to ceremony, Elders, and land-based practices that were not integrated into the formal plan. In IE terms, exit texts organize closure for the institution rather than continuity for the person, producing predictable cycles of re-entry that are experienced as system failure rather than follow through (Smith, 2005; Allan & Smylie, 2015).

THE PSEUDOSYSTEM

Because formal pathways are text-driven, fragmented, and slow, youth assemble a pseudosystem that actually makes care possible: family and peers as knowledge brokers, Elders and ceremony for safety and healing, school and workplace supports for navigation, and Indigenous community organizations for continuity. This network stitches together services that do not connect themselves, carries information the record does not, and provides timely, relational help when eligibility rules and waitlists stall. In Indigenous institutional ethnography terms, the pseudosystem is institutional repair performed off the payroll: coordination, advocacy, and follow-up are externalized onto youth and communities to overcome disjunctures produced by ruling relations.

WORK

> *"I feel like the lack of follow up and resources was like, 'Well, what do I do now? Like, you know, I'm left to pick up all the pieces by myself."*

In Institutional Ethnography, "work" refers to the activities people must carry out in order to make institutions function in their lives. This includes not only formal employment but also everyday tasks that require time, effort, and coordination; things like filling out forms, waiting for appointments, explaining one's history, or navigating procedures. In our data, Indigenous youth described doing precisely this kind of work in their interactions with the mental health system. Access to care required them to learn hidden rules, manage their own records, retell traumatic experiences, coordinate services across multiple providers, and advocate persistently for themselves and their families. Rather than being supported by the system, youth were compelled to take on the very organizational tasks that institutions are designed to perform.

NAVIGATING AND COORDINATING CARE

Institutional Ethnography directs attention to the everyday "work" people must do to activate institutional processes. In our data, Indigenous youth consistently described the hidden labour of navigating fragmented services and coordinating their own care. Access depended on learning how to move through bureaucratic procedures, what forms or eligibility criteria mattered, and where to seek entry.

Youth who lacked prior exposure or strong advocates were left "locked out of everywhere," reflecting an institutional disjuncture between the promise of accessible services and the lived reality of exclusion. This burden extended to coordination. Participants described tracking their own appointments, ensuring providers were updated, and reconstructing their histories with each new intake. While institutions framed these processes as routine, youth experienced them as overwhelming, particularly in moments of crisis. Several participants explained that they layered services across mainstream clinical settings and Indigenous community programs to build the kind of holistic care they needed. For example, combining psychotherapy from a hospital with cultural ceremony at an Indigenous agency required them to manage multiple referral processes and reconcile conflicting approaches to wellness. Existing scholarship shows this is not unique: research on Indigenous patient navigation emphasizes that fragmented systems often compel clients to act as their own case managers (Jacklin & Kinoshameg, 2008; Maar et al., 2017). From an IE standpoint, the key insight is that navigation and coordination are institutional tasks offloaded onto youth, who must act as brokers between disconnected systems.

EMOTIONAL AND PERSONAL COSTS

Alongside coordination, youth described the emotional labour of disclosure and the material costs of sustaining access. Many participants emphasized the toll of repeatedly narrating their trauma to new workers.

This practice, driven by intake protocols and poor information sharing, was not experienced as therapeutic but as compulsory labour. Institutional texts (forms, assessments, case notes) did not travel effectively across agencies, forcing youth to carry the record themselves. This aligns with Dorothy Smith's (2005) observation that institutional processes rely on people to act as carriers of textual coordination, even when this re-traumatizes them.

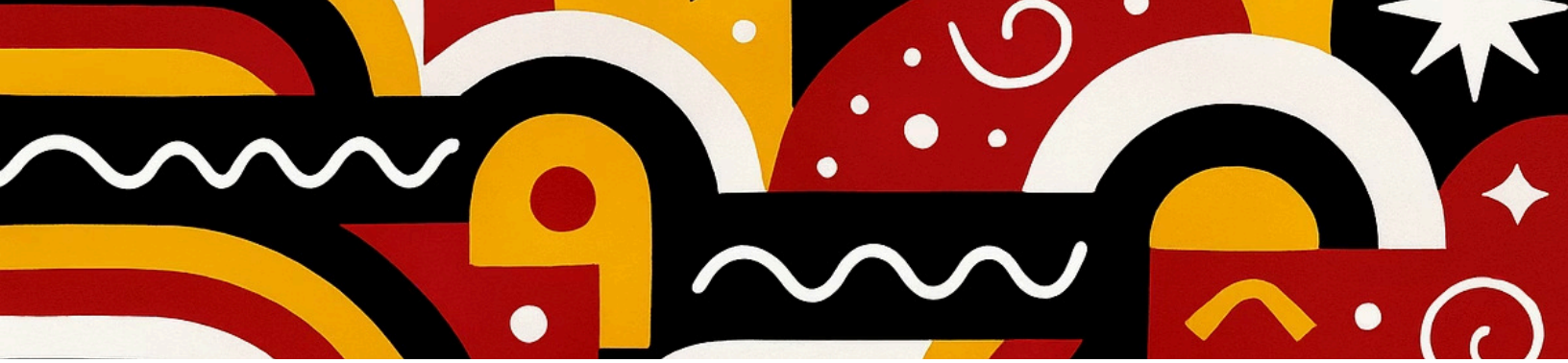
Access also demanded substantial time and energy. The attributes tables revealed that a single appointment could consume over three hours in travel alone. Youth spoke of spending hours on forms, waiting for callbacks, or commuting across the city, all of which displaced time from school, work, or ceremony. These costs were not incidental: they reflect how service geographies, funding structures, and scheduling practices externalize institutional inefficiencies onto clients. Literature on health equity similarly shows that time costs disproportionately shape Indigenous peoples' access, with long waits and travel contributing to disengagement (Allan & Smylie, 2015; Browne et al., 2016). From an IE perspective, the key point is that these burdens are structurally produced. When youth describe disengaging because of exhaustion, this is not individual failure but a predictable outcome of institutional design.

ADVOCACY AND SYSTEM REPAIR

A third form of labour evident in the data was advocacy. Families frequently acted as advocates, negotiating with providers, appealing for services, and ensuring continuity.

This advocacy was essential, yet unevenly distributed: youth without strong family networks often had to navigate alone. At the same time, youth themselves described the work of self-advocacy, persistently asking for help, following up on unreturned calls, and pushing against service delays. Service discourses often frame this as empowerment or self-responsibility, but IE reveals it as evidence of systemic failure. The system's responsiveness is contingent on how forcefully youth push themselves into it.

Several participants also spoke of turning their experiences into long-term advocacy, pursuing careers in law, health care, or community leadership to change the structures that harmed them. While this demonstrates remarkable resilience, it also illustrates the degree to which institutional responsibilities have been displaced onto Indigenous youth themselves. Scholars of Indigenous health equity note similar dynamics: systemic gaps often compel Indigenous communities to create their own services, taking on responsibilities that should belong to mainstream systems (Nelson & Wilson, 2018; Greenwood et al., 2015). In this sense, youth are not only coordinating their own care but engaging in system repair, a striking example of institutional labour being relocated onto those most marginalized.



YOUTH EXPERIENCES, INSTITUTIONAL PRACTICES, AND IMPLICATIONS

IDENTITY

Institutional Practices: Institutions impose fixed categories. Practitioner bias affects recognition.

Youth Experience: Youth shape/resist identities; diagnosis can affirm or be strategic. Practitioner identity mediates recognition.

Implications: Identity is co-constructed. Practitioner identity gates access. Institutional categories are tools and constraints.

CULTURE

Institutional Practices: Biomedical model dominates; culture is sidelined or deemed irrelevant.

Youth Experience: Youth find cultural elements excluded and seek cultural continuity externally.

Implications: Systemic erasure harms care. Integrate Indigenous and biomedical practices for safety.

KNOWLEDGE

Institutional Practices: System literacy assumed; access information poorly communicated. Professionals lack Indigenous knowledge.

Youth Experience: Access needs insider knowledge; unguided youth are excluded and create counter-knowledge.

Implications: Knowledge gates access, reproducing inequity. Youth become informal knowledge brokers.

SAFETY

Institutional Practices: Institutional "safety" is risk management: surveillance, coercion, crisis response.

Youth Experience: Youth feel unsafe due to racism/trauma; find safety in community, not institutions.

Implications: Safety is constructed. Institutional mechanisms can harm. Cultural/relational safety is overlooked.

PATHWAYS

Institutional Practices: Access is bureaucratically constrained. Crisis is prioritized. Waitlists are long.

Youth Experience: Youth navigate fragmented, crisis-driven care. Formal pathways are slow; informal networks fill gaps.

Implications: Institutional design favors crisis. Youth create parallel systems. Pathways are negotiated, not linear.

WORK

Institutional Practices: Institutions fail to coordinate care or provide clear pathways. Responsibility is displaced onto users.

Youth Experience: Youth perform emotional, logistical, and advocacy labor to secure care, compensating for system failures.

Implications: System offloads duties onto vulnerable youth. Institutional inefficiency causes structural burnout.

SUMMARY OF KEY FINDINGS: BRIDGING THE GAP

Our comprehensive analysis of Indigenous youth experiences within the Greater Toronto Area's mental health system reveals critical insights into existing challenges, promising practices, and a clear vision for transformative change. The findings underscore that while the system is theoretically dense with services, it often fails to meet the unique needs of Indigenous youth due to deeply embedded systemic issues.

CONTEXT OF DISPARITY

- Indigenous youth in the GTA face alarming rates of distress and suicidality, exacerbated by intergenerational trauma, urban displacement, racism, and systemic neglect.
- Despite numerous services, the system is fragmented, underfunded, and often culturally incompatible with Indigenous worldviews.

YOUTH EXPERIENCES

- Youth consistently describe the mental health system as confusing, alienating, and unsafe.
- They encounter prolonged wait times, retraumatization from repeatedly recounting their stories, racism, inadequate crisis support, and pressure to conform to Western biomedical models that disregard their cultural identities.

SYSTEM STRENGTHS & PROMISING PRACTICES

- Key strengths include Indigenous-led organizations offering wholistic, relational, and culturally grounded care.
- Integrated clinical and ceremonial models, culturally competent practitioners, land-based healing, and community support are vital for youth wellness.
- Virtual care, academic accommodations, and peer support also provide crucial access points.

PERSISTENT SYSTEM GAPS

- Significant gaps persist, including cultural incompatibility, a reactive "crisis-as-entry" approach, retraumatization through service fragmentation, over-reliance on medication without informed consent, and widespread inaccessibility due to cost, waitlists, and bureaucracy.
- Stigma and surveillance further erode trust.

SUMMARY OF KEY FINDINGS: BRIDGING THE GAP

INSTITUTIONAL ANALYSIS

An Institutional Ethnography perspective reveals these challenges as systemic design flaws, not individual failures. Institutional logics prioritize surveillance, control, and risk management over genuine relationship and cultural respect, actively reproducing colonial relationships and burdening youth with the system's own inefficiencies.

YOUTH'S VISION FOR THE FUTURE

Youth envision a system where Indigenous-led, land-based, and ceremonial models are central, supported by culturally safe staff. They call for free, accessible, low-barrier care, inclusive options for diverse identities (2SLGBTQ+, urban, mixed-heritage), consistent support workers, and integrated clinical and cultural services that validate Indigenous knowledge.

The overwhelming evidence suggests that Indigenous youth are not rejecting mental health care itself, but rather systems that implicitly or explicitly reject them. The current fragmented and colonial architecture of services is fundamentally incompatible with Indigenous youth realities. Instead of being passive recipients, youth actively navigate, create knowledge, and even rebuild informal support structures where institutions fail.

For genuine transformation to occur, institutions must critically re-evaluate their operational frameworks. This demands a relinquishing of control-centered logics in favor of relationship-centered care, significant funding and embedding of Indigenous governance and knowledge systems, mandatory training for all staff in cultural safety, and a steadfast commitment to ensuring continuity, affordability, and accessibility at every level of service provision. The path forward requires a fundamental shift in how mental health systems interact with and serve Indigenous youth.

RECOMMENDATIONS FOR SYSTEMS INNOVATION

Based on our comprehensive findings and direct input from Indigenous youth, we propose a strategic framework for systems innovation. These recommendations are designed to bridge critical gaps, dismantle systemic barriers, and foster a mental health system that genuinely serves the unique needs and cultural realities of Indigenous youth in the Greater Toronto Area.

1. ESTABLISH INDIGENOUS-LED MENTAL HEALTH SYSTEMS

Fund and expand Indigenous-governed mental health institutions with full clinical and cultural capacity to realign governance and legitimize Indigenous epistemologies.

2. MANDATE CULTURAL COMPETENCY AND TRAUMA-INFORMED TRAINING

Require cultural safety, trauma-informed care, and anti-oppression training for all mental health staff, including administrators, to minimize institutional harm.

3. ELIMINATE COST BARRIERS AND EXPAND PUBLIC FUNDING

Ensure all mental health services for Indigenous youth are free at the point of access, with sustained public funding for Indigenous-led organizations.

4. INTEGRATE CEREMONY, LAND-BASED HEALING, AND SPIRITUAL CARE

Institutionalize Indigenous healing practices (Elders, land-based programs, ceremony) as core clinical equivalents within mental health systems.

5. CREATE COORDINATED CARE MODELS WITH CONSISTENT PRACTITIONERS

Implement case management models with a single consistent provider or navigator to follow youth through multiple services, reducing retraumatization.

6. EMBED INDIGENOUS KNOWLEDGE AS INSTITUTIONAL KNOWLEDGE

Co-develop assessment tools, care plans, and policy frameworks with Indigenous youth, Elders, and Knowledge Keepers.

RECOMMENDATIONS FOR SYSTEMS INNOVATION

7. EXPAND INCLUSIVE, IDENTITY-AFFIRMING SERVICES

Develop specialized programs and spaces for Two-Spirit, queer, and racialized Indigenous youth within all levels of care.

8. RESTRUCTURE CRISIS RESPONSE PATHWAYS

Shift to prevention-oriented care with 24/7 culturally safe mobile teams, eliminating police involvement in mental health emergencies.

9. BUILD URBAN INDIGENOUS WELLNESS INFRASTRUCTURE

Fund permanent Indigenous wellness hubs across GTA sub-regions (Peel, Durham, Halton, York) offering integrated supports.

10. RECOGNIZE PEER AND COMMUNITY SUPPORT AS FORMAL INFRASTRUCTURE

Fund, train, and integrate Indigenous peer supporters and community connectors as formal parts of care teams, validating mutual support models.

These recommendations collectively aim to fundamentally reorient the mental health system, moving it from a framework of institutional control and biomedical dominance to one centered on Indigenous self-determination, cultural connection, and relational trust. This transformation is not merely aspirational but structurally essential for aligning systems with Indigenous youth realities and rights.

CONCLUSION

This report documents how Indigenous youth in the Greater Toronto Area experience the current mental health system and reveals the systemic structures that organize those experiences. Through an Institutional Ethnography approach, it becomes evident that the challenges youth face are not isolated incidents but structural features of a system that is not designed with Indigenous youth in mind.

Despite the presence of services, youth encounter a system that is reactive, bureaucratically rigid, and heavily reliant on biomedical norms. Care is most accessible during crisis, while preventive and culturally grounded supports remain difficult to access, underfunded, or entirely absent. Indigenous youth must often perform the work of coordination, advocacy, and emotional labor themselves, compensating for institutional gaps.

At the same time, youth demonstrate agency, insight, and leadership in articulating what effective and safe care looks like. They value culturally competent practitioners, integrated models of care that include ceremony and land-based practices, peer support networks, and consistent relationships with service providers. Indigenous-led services that embed these values are consistently identified as safer, more effective, and more responsive.

The findings indicate that meaningful transformation will require structural change. This includes a shift in governance, funding, and service design to prioritize Indigenous leadership and knowledge systems. Without such changes, the existing system will continue to reproduce harm and exclusion. Indigenous youth are not disengaged from care: they are navigating and rebuilding systems in spite of institutional failure. Future policy and service innovation must be guided directly by their knowledge, leadership, and lived realities.

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