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# “I would just like to see more acknowledgement, respect and services for the people who are in between, just Métis people”: recommendations by Métis women to improve access to health and social services in Victoria, Canada

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## Abstract

This paper reports on recommendations made by Métis women, two-spirit, and gender diverse people for improving access to health and social services in Victoria, British Columbia. Expanding on research conducted in Toronto, Ontario, this study applied a conversational interview method to further explore and understand experiences of self-identifying Métis women, two-spirit, and gender diverse people ( $n = 24$ ) who access health and social services in Victoria. Participants provided wholistic and practical recommendations for improving access to health and social services, including (1) warm and inviting service spaces, (2) Métis-specific cultural safety training, (3) Indigenous specific clinic, (4) wholistic or integrative service delivery, and (5) non-judgemental service providers. This research demonstrates that Métis women, two-spirit and gender diverse community members hold practical solutions for improving access to health and social services for the larger Métis community.

## Keywords

access, Canada, health services, Métis, urban

## Introduction

Métis Peoples account for over a third of the Indigenous population in Canada (Statistics Canada, 2017). Nested within 17th-century fur trade relationships, Métis Peoples' identity blossomed into a distinct cultural and social orientation that continues to thrive today (Macdougall, 2017). While the origins of their ancestors were mixed, Métis scholar Brenda MacDougall (2017) reminds us that Métis people are not, as subsequent generations formed communities with distinct languages and traditions, separate from that of their First Nations and European relatives. Since the emergence of Métis communities in Canada, the settler government has implemented assimilative and racist colonial policies to make way for incoming settlers and *development* (Fiola, 2012; Iseke, 2010; Thistle, 2019). These political efforts have had detrimental impacts on Métis Peoples' identity and life ways, including connection to land, governance, and kinship systems. As a result, Métis Peoples experience severe disparities in health determinants and outcomes compared to the non-Indigenous Canadian population (Smylie, 2009, Smylie et al., 2008).

Available literature highlights major gaps in access to culturally safe health and social services for the 90,000 Métis Peoples residing in British Columbia; where they feel comfortable, safe, and are able to be openly Métis (Auger, 2019; Wesche, 2013). Nestled within the unceded Coast Salish Territory of the Lekwungen and WSÁNEĆ nations, Victoria is home to over 6,500 self-identifying Métis people, whose families have thrived and contributed to the urban landscape for over two centuries (Goulet & Goulet, 2018). While Métis account for 38% of the Indigenous population in the Greater Victoria area (Statistics Canada, 2017), no literature exists to our

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knowledge on Métis Peoples experiences with accessing health and social services in Victoria.

To address the Métis health service gap, this paper will describe the ways that we, as researchers, have engaged with self-identified Métis women, two-spirit, and gender diverse people who live in or receive health and social services in Victoria, British Columbia. This paper provides recommendations for improving health and social service access for the Métis community in Victoria. Expanding on research conducted in Ontario, this paper is a call to action for policy makers and service providers to work towards closing a culturally safe service gap for Métis Peoples living across Canada (Monchalín et al., 2019).

## Methods

This research expands on multiple years of exploring Métis Peoples' experiences with health and social services in urban settings. It continues to be Indigenous-led and community-driven at all stages. It was initially nested in a project entitled Our Health Counts Toronto (OHC), a longitudinal cohort study co-led by the Well Living House (WLH) and Seventh Generation Midwives Toronto (SGMT) in 2015 and 2016 (Monchalín, 2019). Upon learning from OHC that Métis people in Toronto needed health care services but did not receive them, Author 1 conducted an in-depth, follow-up study in 2018 and 2019 for their doctoral research project with WLH and SGMT (Monchalín, 2019). This doctoral research involved conversations with 11 self-identified Métis women living in and/ or accessing health and social services in Toronto. Métis women in Toronto provided wholistic and practical recommendations for improving access to health and social services, including (1) Métis presence, (2) wholistic interior design, (3) Métis specific or informed service space, (4) welcoming reception/front desk, and (5) culturally informed service providers. The use of the term *wholistic* will be used throughout this paper to reflect wholeness (Baskin, 2016). When we use the term *holistic* in this paper, we are referring to the coding method by Saldaña (2015).

Following this doctoral research, Author 1 was hired at a university in Victoria and had conversations with Author 2—a member of the Métis community in Victoria—about a similar lack of health service access for Métis in both cities. Building on the Toronto research, Author 1 and Author 2 wanted to determine if Métis women in Victoria had similar or different experiences and recommendations, with the goal of improving health service access on the island. Author 1 and Author 2, along with Author 5, received an Insight Development Grant from the Social Sciences and Humanities Research Council to further explore and understand access to health and social services for Métis people in Victoria. Ethics approval was obtained from the University of Victoria. Prior to contacting participants, consent and guidance was received by a local and prominent Métis Elder living in Victoria who informed the project goals, recruitment plan, and interview guide.

## Recruitment

To increase project interest and for community members to see themselves reflected within recruitment materials, we contacted a local Métis artist in Victoria to feature their artwork on the recruitment poster. The artist provided the research team with multiple image options, and they chose the artwork that the Métis Elder believed best reflected the local Métis community. The recruitment poster was then shared on the Facebook group titled, *Métis Nation of Greater Victoria* (n.d.). The poster informed potential participants to contact Author 4 for more information to participate. Author 4 screened each potential participant either through email or by phone to ensure that they met study criteria. Criteria included that the participants self-identify as Métis; were 19 years old or older; self-identify as a woman, two-spirit, and/ or gender diverse; and lived in and/ or accessed health and social services in Victoria within the last 12 months. If the participant met all criteria, a date and time to meet over Zoom was arranged. The recruitment goal for this study was reached within one week of first sharing the poster.

## One-on-one conversations

Author 3 and Author 4, who are Métis research assistants on the project, conducted interviews with each participant over Zoom, applying a conversational interview method (Absolon, 2011). This conversational method facilitated the emergence of each participant's story in a style and form that reflected their knowledge and experience and avoided the externally imposed structuring of a more formal interview guide. Gathering the stories through a conversational method fostered both relational connection and flexibility, and is aligned with Métis ways of gathering and sharing knowledge through storytelling and informal kitchen-table conversations (Flaminio et al., 2020; Gaudet, 2019).

The research team was initially provided with funding to hold conversations with 15 participants. However, due to COVID-19 public health measures, social distancing requirements, and having conversations held over Zoom, the team was able to conduct additional conversations. As the interviewers did not have to physically travel to meet with participants, we were able to allocate funds to cover the costs of interviewing more participants. For example, while we initially budgeted for \$50 honorariums; travel savings allowed us to increase participant honorariums to \$95 honorarium, paid through e-transfer.

The interview guide was adapted from Author 1's doctoral research; Author 2 and the Métis Elder on the project, in addition to the recent pandemic, updated and informed the interview guide to better reflect Victoria Métis community contexts. Ten open-ended questions guided the conversations that centred around the following themes: (1) Métis identity, (2) experiences with health and social services, (3) racism and discrimination, (4) COVID-19, and (5) recommendations for improving access to health and social services. This article focuses on the theme of recommendations for improving access to health and social services in Victoria.

## Making meaning and returning to community

Following participant consent, all the conversations were electronically recorded over Zoom and transcribed verbatim and identifying information was removed. Following Métis scholar Catherine Richardson's (2016) teaching about how stories are medicine, Author 2 and Author 4 worked together to assign each participant with a local plant medicine name in the Michif language. Participants were asked for their consent to include direct quotes in the analysis and all, but one gave consent. While each participant approved their assigned plant medicine name, those who consented were also given the option of using a name of their choosing that would accompany each of their quotes.

Interviewers wore headphones and conducted interviews in private to ensure the confidentiality of conversations. A total of 24 Métis women, two-spirit, and/or gender diverse participants were interviewed during the winter of 2021; conversations were approximately 1-hr in length. Before the coding process began, Authors 1, 2, 3 and 4 reviewed the transcripts to identify major themes. Once these authors came to consensus about the individual themes, Author 4 mailed the transcripts to participants for verification and/or corrections. To ensure rigour and validity, participants were asked if the identified themes appropriately reflected their experience. All participant verifications, corrections or deletions were fully integrated into the transcripts. Participants received a thank you note designed by local Victoria Métis artist Lynette La Fontaine, along with a COVID-19 appropriate face mask. We gifted participants face masks from two designers: one by Métis artist Lynette La Fontaine and the other by Anishinaabe artist Lesley Hampton.

Once all of the transcripts and themes were returned and updated, a holistic coding method (Saldaña, 2015) was applied by Authors 1, 2, 3, and 4 using NVivo software (QSR International, 2018) to interpret the larger themes and to assist with meaning-making of the conversations. Following this, a final thematic analysis (Braun & Clarke, 2006) was undertaken by the first four authors.

## Results

Five cross-cutting recommendation groupings emerged from the analysis and were woven together with many overlapping themes. The five recommendations to improve health service access in Victoria are: (1) warm and inviting service spaces, (2) Métis specific Cultural Safety Training, (3) Indigenous specific clinic, (4) wholistic or integrative service delivery, and (5) non-judgemental service providers.

### *Recommendation #1: warm and inviting service spaces*

Seventeen participants spoke to the importance of health and social services in Victoria being warm and inviting so that they are more comfortable and accessible for the Métis community. This included having relaxing music, warm and neutral wall colours, calm lighting, windows and

natural lighting, plants, comfortable chairs, and accessible for those who are hearing impaired and/or physically disabled. For example, one participant shared:

Plants and windows. I don't understand why so many spaces have a lack of windows. We know light's important, especially sun. And even the temperature in a room is so important and I find that some of these spaces are extremely cold and you're sitting there for so long. I look at people who are a bit older and there's not a blanket, and I guess that's probably for germs or bacteria, but it would be nice that there was some sort of regular sanitation system in place with blankets. I would love to see a space where . . . for those who . . . have difficulty walking or sitting, and accessibility needs, and I found this myself in instances, and especially supporting my family . . . the chairs aren't made for people . . . they're not wheelchair accessible spaces. The doors aren't designed with wheelchair accommodations in mind, or walkers, or canes. And it's a healthcare space. So, I would love to see those changes made, you know, they're not made for people who are blind or have trouble hearing. Like, there're so many gaps in the way that these service spaces are even created and it . . . it would be so nice to see those accommodations taken into consideration. (li pchi boom)

The incorporation of local Indigenous artwork in health and social services spaces in Victoria was also highlighted by eleven participants as making a service space feel warm and inviting. Participants spoke to the importance of supporting local Indigenous artists, and that the artwork does not need to be Métis specific. For example, one participant shared: "I don't necessarily need to see sashes on the wall, or my Métis flag portrayed on the wall to feel comfortable or anything like that" (sasperal). Participants cared more about supporting local Indigenous artists on Vancouver Island.

Furthermore, participants shared how, when they see Indigenous artwork in a service space, it makes them feel more comfortable, welcomed, and gives the impression the service provider holds an appreciation for Indigenous cultures. For example, two participants shared:

You don't need medical training to say that art puts me at ease . . . It makes me feel respected, that you're representing the land that you're on by having Indigenous art and supporting the local economy. It's huge. (enn rooz faroosh)

I think that those kind of things . . . make a lot of difference . . . things like artwork and as much as it seems like a small thing, it kind of makes a queue in my brain of like oh, okay, this place . . . has some appreciation for Indigenous culture, I think is something that tends to . . . I mean that may not always be the case, maybe they just like the artwork, but I tend to think that when I go into a place with lots of Indigenous artwork and Indigenous presence and stuff and diverse presence. It's that people have an appreciation there for Indigenous people. (lii tii'd mashkek)

While the incorporation of Indigenous artwork may make the service space more warm and inviting, one participant highlighted how "you can't put artwork up on the wall and then have people who behave badly, and still

make it a friendly place. That's just not possible" (lii groo zel). The following recommendations speak to how health and social services in Victoria must go beyond incorporating physical elements in a space for the service to be culturally safe and accessible.

### **Recommendation #2: Métis specific cultural safety training**

Twelve participants spoke to the importance of health service providers and staff taking cultural safety training: "If health care providers, practitioners, had more of that cultural knowledge and cultural safety training, that would be really helpful" (enn rooz faroosh). Participants specifically highlighted the need for cultural safety training to educate service providers about Métis Peoples' unique experiences, rather than the pan-Indigenous approach to cultural safety training that is currently offered. For example, one participant shared that services "don't understand what it is to be Métis" (lii groo zel) and that services are First Nations focused:

I don't get any kind of culturally responsive service at all. In fact, I feel like it's a tremendous void here in British Columbia. People don't understand what it is to be Métis. Whenever they speak about Indigenous or Aboriginal, they're really talking about First Nations, they're not talking about Métis, they're not talking about Inuit, they're not talking about non-status in any way. They don't have any understanding of the complexity of that. (lii groo zel)

Another participant spoke to how service providers need training to "be able to work with diverse populations of people" (li pchi boom) and not respond negatively to disclosure of Métis identity:

It's just if they're not Indigenous themselves, having the cultural sensitivity to have a conversation and see what the concerns are and then connecting me to the appropriate services that I'm looking for, whatever that may be. I think that's really important. I don't need them to react to my identity, but I need them to be respectful and understanding and not make a face when they hear it . . . and say some comment . . . which I find the most common reaction is a face and then them wanting to engage with, like, "that can't be true" or it's a lot of questions . . . and . . . assumptions, misconception and it's a lack of education, and that's where I think training is really essential to healthcare providers, to be able to work with diverse populations of people. (li pchi boom)

While cultural safety training is important, this participant continued sharing how there needs to be accountability following the cultural safety trainings. They offered suggestions, such as feedback opportunities like an anonymous drop-box:

There's no accountability built into the training itself. And to me, a good program always has accountability built into it. So that's something that needs to be created from the design, you know? Like, where people have to continually be checked up on. Or there's a feedback system where patients have an

anonymous drop-box where they can make comments and then the staff is actually held accountable for causing harm. And they're removed or there's disciplinary action to their actions. (li pchi boom)

### **Recommendation #3: Indigenous or Métis specific clinic**

Participants spoke to the need for an Indigenous and/or a Métis specific clinic in Victoria. This was inclusive of having a service space with Indigenous service providers so that they would not have to explain their identity as it would get "side tripped to conversations about blood quantum and things like that" (en nipinet). This was also explained as a service space that served other Indigenous people, as participants spoke to how it would make them feel more comfortable seeing other Indigenous people in the waiting room when accessing services. Four participants spoke to the need for a Métis specific clinic to serve the unique needs of Métis People. For example, one participant shared: "I would just like to see more acknowledgement, respect and services for the people who are in between, just Métis people." (la gratelle).

Eleven participants spoke to the need for an Indigenous specific clinic that was inclusive of not only Métis, but other Indigenous groups that lived on the island. One participant noted that, given the high number of Indigenous people on Vancouver Island, there is no reason for there not to be an Indigenous specific clinic:

It would just be in the best interests of Vancouver Island to have an Indigenous walk-in medical clinic or something like that. There's so many Indigenous people on this island, there's no reason why there shouldn't be a small clinic or a larger clinic that is literally just medicine wheeled out and just really inviting for Indigenous people and really just have that feeling of culture and safety and acknowledgement. (la haarroozh)

At the same time, seven participants emphasized that an Indigenous specific clinic needed to be clear about who is, and who is not eligible to access the services. This was because current experiences with Indigenous services are typically only accessible to those with First Nations status. For example, one participant spoke to the need for "more clear lines" (aen nipinet) on which Métis people are eligible to access:

There's a lot of attention right now on Indigenous approaches and being culturally safe but it's so pan-Aboriginal that it's not specific. So having things that are more specifically related to Métis people. Because even when I thought about going through [a service in Victoria] to get the psychologist, I was like well . . . can I even access that because I'm not First Nations, I don't have status, am I still eligible for that? So maybe more clear lines on what we can and can't access if we feel like it's more directed to like First Nations people versus Métis or everyone. . . . But definitely some more Métis specific resources and more training and education about Métis people versus the pan-Aboriginal approach to make people feel like they don't have to explain themselves. (aen nipinet)

#### **Recommendation #4: wholistic or integrative service delivery**

Eight participants shared the need for the delivery of wholistic or integrative health and social services in Victoria. This meant that services should approach health and wellness not as separate elements, but rather as a whole, recognizing the connection of physical, emotional, spiritual, and mental. It means that services are integrated, and that service providers approach health through a wholistic lens. For example, one participant shared how they want a service provider who will acknowledge that everything is connected:

I need a doctor who's going to treat me like an adult, who's going to treat me like I understand my ecosystem. Who is going to treat it as an ecosystem and not treat it as a bunch of disparate parts and send them all out for like, "I'll swap one part out for the other," like they're not interconnected? . . . the interconnectedness, for me feels very Aboriginal, right? . . . Like of course it's all connected. The western medicine model doesn't really work for me, right? So, my spiritual, my mental, my physical, all of that is connected and yet that's not how I'm treated in the western medical system. (lii groo zel)

Building on the above quote, another participant spoke to wholistic health through the medicine wheel, which is inclusive of the mental, spiritual, physical, and emotional:

In an ideal world, something that I like to use a lot is the medicine wheel as a teaching tool and as a counseling tool, because I think it just so accurately depicts our whole being. And so that would be . . . a way that I would hope a health care provider would approach anybody, is to inquire and to genuinely care about all aspects of who we are and ask those questions about what are we doing to nurture our mental and physical and spiritual and emotional selves . . . what are the pillars in our lives that do hold us up and lift us up and keep us healthy and then to work from there. (li pisaanlii)

To provide wholistic services, four participants shared the importance of an integrative health care system. An integrative health care system to participants meant that service providers communicate and collaborate with one another. For example, two participants shared:

I think of integrative health care, like clinics where there's medical doctors and naturopaths and traditional medicine carriers that I just imagine . . . walking into a clinic where I know there's a collaborative approach where the medical doctors and the naturopaths and the Chinese doctors and the psychiatrists all know what each other are doing and all have an integrative approach to health care for the people that are accessing it. That's my dream. (li said)

I think integrated health care services . . . who actually speak to each other, would be a dream. Like if you could have a naturopath, a dentist, a doctor, a counselor who are all a part of the same team and would have monthly meetings and talk about that specific patient and come up with integrated care plans. Because often the health care providers are saying things that are so contradictory and you have to do the work of synthesizing what they're all saying and figuring out how to

make them work with each other. And so that's my personal dream. (zayon faroosh)

#### **Recommendation #5: non-judgemental service providers**

Participants provided recommendations about which traits a health service provider should possess. The two most common traits recommended by 20 participants were service providers who were non-judgemental and who listen. Participants wanted to be believed and not have their experiences minimized. They also preferred service providers who are transparent and reassuring; those who make eye contact, are trauma informed and ask for consent. For example, two participants shared how they want to feel listened to:

Somebody who can just really listen and isn't judgmental and isn't acting like they know more than you. That's kind of, you know, just someone who is good at holding the space for you to explain or describe what's occurring. (enn fleur di pwayzoon)

Feel listened to, I think that would be the biggest thing that would . . . yeah, just being listened to and not being brushed off because I'm high functioning and I'm Métis and there are no resources for me . . . I think that would be the biggest . . . just listening and someone just . . . even acknowledging that, "Hey, there isn't a whole lot, but I'm going to try anyways." (la gratelle)

One participant spoke about wanting a service provider to acknowledge that they "have knowledge about their own bodies" (zayon faroosh) and to believe them when sharing their symptoms:

I think taking the time to acknowledge that everybody . . . knows the most about their own selves and just because you're a doctor, you still met me five minutes ago, and acknowledging that people have knowledge about their own bodies that can't necessarily be backed up by bloodwork or different things like that, but just believing that when somebody says they have certain symptoms or when somebody has a theory . . . I think just acknowledging that and respecting that because . . . people have to live with themselves every day and so often people do a ton of research around what their condition might be or what might be the best route, and I think if health care providers could just acknowledge that, and trust in the patient, that would be a really amazing thing to see happen. (zayon faroosh)

Building on having a service provider that listens, one participant shared how that they like "when a doctor takes a minute" (lii paabinaan) to get to know them and builds a relationship:

They just have been very in and out, like, "Let's diagnose you. Get out," which I understand . . . they're busy and they see . . . so many people a day, but as a patient, I like it when a doctor takes a minute and they're just, like, "How's your day?" you know? Get to know you more and form a relationship with you. Because usually you're talking about things that are very personal, usually . . . and there's a lot of things about your health that can be very scary and . . . I wouldn't want to get any bad test results or something from . . . someone I don't have a relationship with. (lii paabinaan)

## Discussion

This research demonstrates that Métis women, two-spirit and gender diverse people carry practical solutions for improving access to health and social services for the Métis community in Victoria, British Columbia. These recommendations are directed at creating health and social service spaces that are culturally safe for Métis. Cultural safety can only be claimed when the people who receive the care, identify it as culturally safe (National Collaborating Centre for Aboriginal Health [NCCAH], 2013). For the Métis women, two-spirit, and gender diverse participants in this research, a safe health service space is one that is warm and inviting, has local Indigenous artwork, provides services through a holistic lens and recognizes the physical, emotional, spiritual, and mental connections, has service providers that understand Métis Peoples' histories, who are non-judgemental, and trauma informed.

Some of these recommendations echo those shared in previous service access literature (Monchalin et al., 2019; NCCAH, 2013). For example, Author 1's doctoral research findings as well as a 2013 NCCAH fact sheet about culturally safe health care for Métis patients align with many of the Victoria recommendations. Specifically, both recommend the incorporation of Indigenous artwork in health service spaces. While the Toronto study highlighted the importance of having locally relevant Métis artwork, the Victoria study emphasized the value of local Indigenous artwork to acknowledge and honour the territory. This preference reveals the importance of avoiding pan-Indigenous approaches when providing culturally safe services. Furthermore, Métis women in Victoria highlighted that, while it is important to have Indigenous artwork, it cannot be a replacement for providing safe and friendly care. The NCCAH (2013) fact sheet also stresses that "cultural safety involves deep systemic change and is much more than interior design" (p. 7).

When asked about which traits a health service provider should possess, participants stressed the importance of having service providers who are non-judgemental, trauma-informed, willing to listen, and who will believe Métis women and not minimize their experiences. Similarly, Métis women in Toronto spoke to the importance of non-judgemental service providers who would listen and possess an awareness of issues surrounding power, privilege, and oppression in health care (Monchalin et al., 2019). Firestone and colleagues (2019) found a similar recommendation when evaluating a programme called Niiwin Wendaanimak, a health service for urban Indigenous people experiencing homelessness. Results reveal that clients who accessed the programme felt a sense of safety due to health service providers being trauma informed, resulting in them being non-judgemental (Firestone et al., 2019). Trauma has been found to negatively impact individual health and how individuals respond to health interventions, which can result in delaying service access (Shimmin et al., 2017). This demonstrates the critical importance of implementing a trauma informed approach when attempting to improve health service delivery for Métis.

Both the Victoria and Toronto findings highlight the importance of having service providers who identify as Indigenous, and who hold knowledge and understanding of

Indigenous Peoples' histories. Métis women in both Victoria and Toronto also underscored the need for cultural safety training to educate service providers about Métis Peoples unique experiences. This contrasts the common pan-Indigenous approach to cultural safety training currently offered in Canada. Wylie et al. (2021) explored how to improve cultural safety training in Canada and found that: "Local Indigenous community members felt that [cultural safety] training needed to be specific to their communities and needs, rather than general information about Indigenous Peoples and histories" (p. 328). Community specific training may result in improved health and services as the specific contexts and experiences of diverse Indigenous Peoples is considered during screening, diagnosis, treatment, and support. Nevertheless, the Victoria recommendations highlight how cultural safety training must be evaluated to keep service providers accountable. Churchill and colleagues (2017) echo this statement, arguing that the impact of cultural safety training must be evaluated "both in the short-term and long-term to accurately assess the extent to which the cultural safety training program improves how Indigenous peoples are treated by health care providers" (pp. 8–9).

Another recommendation from both Victoria and Toronto participants was having an Indigenous or Métis specific clinic. In Victoria, participants spoke to the need for an Indigenous specific clinic with Indigenous health care providers. Toronto results also demonstrated that existing services should incorporate a Métis specific space within the service (Monchalin et al., 2019). One significant difference between the two cities was that Métis women in Toronto shared that SGMAT was an ideal culturally safe health service space (Churchill, 2015). Whereas the Métis women in Victoria did not share an exemplary health service where the majority felt safe. This signals the critical need for a culturally safe Métis health service space in Victoria.

Despite these aligning recommendations, challenges persist in putting these needs into action. For example, a Yellowhead Institute Report lead by Jewell and Mosby (2020) highlights the lack of progress with accomplishing the Truth and Reconciliation Commission's (TRC) Calls to Action released in 2015. TRC Call to Action number 23 states that all health care professionals must complete cultural competency training. However, this call to action has become a *checkbox* on service providers to-do list (Jewell & Mosby, 2020, p. 12). Wylie et al. (2021) highlight how cultural safety training is often delivered online, which comes with limitations when trying to initiate behavioural and attitudinal changes. Wylie and colleagues state that, while online cultural safety training is an excellent first step, cultural safety training should be delivered in multiple modalities and integrated throughout service providers careers. These researchers also reveal that, to appropriately inform their practice, service providers require training that is specifically tailored to their roles and responsibilities (Wylie et al., 2021).

To act on these recommendations, health resources and funding needs to be made accessible to Métis communities (Monchalin, 2019). Métis specific funding will provide support for Métis people in leading the development of specific cultural safety training that is both designed and led by the community, in addition to developing an Indigenous

specific clinic that is accessible for Métis in Victoria. Acknowledging the need for Métis specific funding, the Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019) states:

We call upon all governments to fund and to support culturally appropriate programs and services for Métis people living in urban centres, including those that respect the internal diversity of Métis communities with regards to spirituality, gender identity, and cultural identity. (p. 211)

In the meantime, existing health and social services in Victoria must begin to act on the recommendations provided by Métis women, two-spirit, and gender diverse people in this research. This can include allocating funds to making services warm and inviting through attainable undertakings, such as incorporating local Indigenous artwork, calm lighting, plants, and comfortable chairs; engaging with resources developed by Métis people to educate staff and service providers, such as making the books *From the Ashes: My Story of Being Métis, Homeless, and Finding My Way* by Jesse Thistle, or *Halfbreed* by Maria Campbell mandatory readings; and if not yet completed, having staff and service providers enrol in available cultural safety trainings. Finally, both mainstream and Indigenous specific health and social services in Victoria can create awareness on eligibility, informing the Métis community of what and how their services are available and accessible.

### Strengths and limitations

While our sample was random, the recommendations may not be representative of the entire Métis community in Victoria as we only shared the recruitment poster on the Facebook group, *Métis Nation of Greater Victoria* (n.d.). Despite this limitation, COVID-19 stay-at-home measures created travel savings, which allowed us to allocate funds to conduct additional interviews. At the same time, while COVID-19 created flexibility for conducting conversations, it only allowed those who had access to a phone or computer to participate. Another observation made by the Author 1 was that, due to COVID-19 and participants having one-on-one conversation from their homes, this impacted their recommendation responses around the physical aspects of a service space. Author 1 found that participants in Toronto often drew inspiration about an accessible service space from where the in-person interview took place. This research in Victoria may have been impacted participant responses given they were at home. Despite this possible limitation caused by COVID-19 stay-at-home protocols, the Métis women, two-spirit, and gender diverse participants thought of unique and creative recommendations to make health and social services in Victoria more inviting. Further, this research contributes to the limited literature surrounding access to health and social services for Métis People, and is the first of its kind regarding the Métis community in Victoria. While the Métis community in Victoria is unique, these recommendations have shown to have significant overlap with recommendations made in Toronto (Monchalin et al., 2019), and may be applicable in other urban Canadian contexts.

### Conclusion

Recognizing the diversity among Métis communities across Canada, and the need for a locally tailored approach to culturally safe service delivery, this research demonstrates that Métis Peoples experience major gaps in access to culturally safe health and social services in urban settings. At the same time, this research demonstrates that Métis women, two-spirit and gender diverse people carry practical solutions for improving access to health and social services for the Métis community.

### Authors' note

**Renée Monchalin** is an Assistant Professor in the School of Public Health and Social Policy at the University of Victoria, and an Assistant Professor (Status Only) at the Dalla Lana School of Public Health, University of Toronto. Renée was born and raised in Fort Erie, Ontario, and is a citizen of the Métis Nation of Ontario. Her current areas of research include culturally safe health service access with a specific focus on abortion access, Métis Peoples' health at the intersections, public health feminist praxis, qualitative and decolonizing methodologies, and community-based participatory research.

**Monique Auger** is Métis—a proud citizen of the Métis Nation British Columbia, and Métis Nation of Greater Victoria. She is a Trudeau Foundation scholar and a PhD candidate in the Social Dimensions of Health program at the University of Victoria. She is a passionate researcher and educator, with more than a decade of experience in Indigenous health research.

**Carly Jones** is Métis with mixed Ukrainian and Scottish settler ancestry. Her family comes from the historic Métis community of St. Adolphe, Manitoba. Carly currently lives on the unceded ancestral lands of the Songhees, Esquimalt, and W̱SÁNEĆ people, where she works as a program evaluator aiming to increase access to culturally safe supports for Indigenous survivors of gender-based violence. She is also a recent graduate of the University of Victoria Master of Social Work - Indigenous Specialization program, where she completed a research-based practicum with a focus on access to health and social services for Métis people. Her wide-ranging research interests include Urban Indigenous health access, Métis arts-based methodologies, and Indigenous birth experiences.

**Willow Paul** (she/her) holds a Bachelor of Social Work from the University of Victoria with a specialization in Indigenous child welfare. She is enrolled to complete a Master of Arts in the Social Dimensions of Health with a focus on Indigenous peoples' health. Willow has been working at the University of Victoria as a research coordinator on a variety of projects under Dr. Renée Monchalin from the school of Public Health and Social Policy. Willow recently completed a project with Dr. Monchalin that aimed to identify the culturally safe service gap for Métis women, Two-Spirit, and gender diverse community members in Victoria, BC. From this research, Willow has an upcoming publication about Métis community members navigating racism and discrimination while accessing health and social services. Willow is currently assisting Dr. Monchalin in researching culturally safe abortion access for Indigenous women, Two-Spirit, and gender diverse people in Canada.

**Charlotte Loppie** is a Professor in the School of Public Health and Social Policy and the Associate Dean Research in the Faculty of Human and Social Development at the University of Victoria.

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