ESTABLISHING RESEARCH PRIORITIES:

An Exploration of First Nations, Inuit, and Métis Women, Two-Spirit, Transgender, and Gender-Diverse People's Needs in Cannabis and Mental Health

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DRAFT REPORT

Native Women's Association of Canada

L'Association des femmes autochtones du Canada

Archipel Research & Consulting Inc.

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ACRONYM GUIDE

2SLGBTQQIA+: Two-Spirit, Lesbian, Gay, Transgender, Queer, Questioning, Intersex, Asexual, Plus people

ADHD: Attention Deficit Hyperactivity Disorder

BPD: Borderline Personality Disorder

CBD: Cannabidiol

CFS: Child Family Services

CRGBA: Culturally Relevant Gender Based Analysis

DID: Dissociative Identity Disorder

ER: Emergency Room

FASD: Fetal Alcohol Spectrum Disorder

FP: Family Physician

GP: General Practitioner

HSCP: Health and Social Care Provider

HIV: Human Immunodeficiency Virus

HRS: Harm Reduction Services

IBS: Irritable Bowel Syndrome

MD: Medical Doctor

MDMA: Methylenedioxymethamphetamine

MS: Multiple Sclerosis

NP: Nurse Practitioner

NWAC: Native Women's Association of Canada

OCD: Obsessive-Compulsive Disorder

PTSD: Post-Traumatic Stress Disorder

RCMP: Royal Canadian Mounted Police

SSRI: Selective Serotonin Reuptake Inhibitor

THC: Tetrahydrocannabinol

INTRODUCTION:

In 2018, the Canadian Government legalized, and regulated, the sale and use of recreational cannabis, making Canada the second country to implement this at the national level. As a result, there is an increased need for information and research surrounding the impacts of cannabis use on the mental health of Indigenous Peoples in Canada. There is no existing research that specifically examines the effects of cannabis use for Indigenous Peoples in Canada. Still, preliminary research on this subject points to many areas that could disproportionately affect Indigenous women, Two-Spirit, transgender, and gender-diverse people. Research related to Indigenous mental health in Canada focuses on the effects of colonialism and colonization on Indigenous Peoples, the dichotomy between Indigenous worldviews and Eurocentric perspectives, suicide, and substance abuse (Nelson and Wilson, 2017). In an Indigenous, holistic worldview, health is understood to be interconnected with relationships, environment, and culture. Therefore, the current model for mental health research does not accurately represent the lived and living experiences of Indigenous Peoples and values regarding traditional understandings of physical, mental, emotional, and spiritual wellness.

This document is the product of one of two knowledge products for the Canadian Institute of Health Research (CIHR) and the Mental Health Commission of Canada (MHCC) funded catalyst grant titled: "Establishing Research Priorities: An Exploration of First Nations, Inuit, and Métis Women, Two-Spirit, Transgender, and Gender-Diverse People's Needs in Cannabis and Mental Health." Through this project, the Native Women's Association of Canada (NWAC) explores current awareness and perspectives of Indigenous women, Two-Spirit, transgender, and gender-diverse individuals who use cannabis for mental health reasons. The first product of this project was a scoping review and environmental scan of best practices and initiatives related to cannabis health and educational resources available to Indigenous women, Two-Spirit, transgender, and gender-diverse individuals. This was conducted in 2020 through to 2021. Secondly, activities that led to the creation of this report included a series of Sharing Circles to capture distinct needs, concerns, and knowledge gaps related to relationships between cannabis use and mental health for First Nations, Métis, Inuit, northern and 2SLGBTQQIA+ Indigenous communities.

This report highlights the research priorities, policy, and programming needs concerning Indigenous mental health and cannabis use. A series of virtual conversations took place from across the country to identify key perspectives and experiences shared by Indigenous women, Two-Spirit, transgender, and gender-diverse individuals. Findings comprised of four main themes: stigma, Indigenous experience, safe use, and mental health. Recommendations from these findings highlight future research priorities and actions to be taken by health and social care providers (HSCPs) and medical regulatory authorities.

Through detailed recommendations, three central communities are addressed; first: HSCPs, defined by Health Canada as, "a person who is entitled under the laws of a province [or territory] to provide health services in the province [or territory.]" Second: Professionals developing policy and programming to support Indigenous communities with cannabis use. Lastly: Professionals, or academics, who research relationships between cannabis use and mental health. In discussions, participants were asked to describe experiences with HSCPs, but were not asked questions based on specific HSCP roles. If a participant referred to a particular profession in the transcripts, that specificity is left in the report. Otherwise, the term HSCP is used. Therefore, responses are not generalizable and do not necessarily represent all HSCPs.

While challenges outlined in this report point to well-known structural issues within health and social care, they are also profoundly personal to participants. For many, these issues have led to deeply rooted distrust between HSCPs and Indigenous women, Two-Spirit, transgender, and gender-diverse individuals. Further, the legacy of colonization in the health care system has also contributed to this sense of distrust. Though some of these experiences may be difficult to read, they are necessary to consider in discussions of Indigenous wellbeing, particularly related to mental health. Most importantly, this document seeks to advocate and support the needs of First Nations, Métis, Inuit, northern, and 2SLGBTQQIA+ Indigenous Peoples when interacting with colonial structures, such as the Canadian health care systems, academia, and other entities involved with cannabis and health policy and programming.

1. LITERATURE REVIEW: CONNECTING CANNABIS, MENTAL HEALTH, AND INDIGENOUS WELLBEING

This section highlights critical components to understanding relationships between Indigenous mental healthcare, wellness, and cannabis to inform the overall report and explore discrepancies in the findings. Various academic sources are cited, focusing on several emerging themes: Indigenizing mental healthcare, cannabis and mental health, and Indigenous community wellness.

By analyzing relevant literature, and key social, cultural, and medical themes that influence relationships between cannabis and Indigenous mental health, three overarching factors were identified. These include: Access to health services, culturally appropriate care, social determinants of health, and intergenerational trauma, providing necessary context for the lens through which this report was written, and is to be interpreted.

1.1. UNITED NATIONS DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES: **Borgelt et al. (2013)**

Rights of Indigenous Peoples to access healthcare has long been established. In 2007, the United Nations General Assembly adopted the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP). UNDRIP recognizes equal human rights of Indigenous Peoples to all other peoples, against any form of discrimination, and seeks to promote mutual respect and harmonious relations between Indigenous Peoples and Canada. UNDRIP also establishes the right to adequate healthcare and health sovereignty for all Indigenous peoples. Regarding healthcare and health sovereignty, UNDRIP states:

Article 21:

1) Indigenous Peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

Article 23:

Indigenous Peoples have the right to determine, and develop, priorities and

strategies for exercising their right to development. In particular: The right to be actively involved in developing and determining health, housing, and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24:

1) Indigenous Peoples have rights to their Traditional Medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals, and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2) Indigenous Peoples have an equal right to enjoyment of the highest attainable standard of physical and mental health. States shall take necessary steps with a view to achieving progressively the full realization of this right.

Article 29:

3) 3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining, and restoring health of Indigenous Peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

On June 21, 2021, *Bill C-15*: *The United Nations Declaration on the Rights of Indigenous Peoples Act*, received Royal Assent in Canada. This is an important consideration for this research report, as it demonstrates the Canadian Government's responsibility to support health sovereignty for Indigenous Peoples.

1.2. INDIGENOUS PEOPLE AND MENTAL HEALTH

When researching and understanding experiences Indigenous women, Two-Spirit, transgender, and gender-diverse people have with cannabis, it is necessary to situate findings in discussion of mental health for Indigenous communities. Issues concerning intergenerational trauma, social determinants of health, access to healthcare, and stigma from HSCP, were raised repeatedly throughout this project. This section is intended to reinforce these themes and contextualize these concerns in a broader framework of academic study.

1.2.1. INTERGENERATIONAL TRAUMA

Much work has been undertaken to study intergenerational trauma and the health of Indigenous Peoples. Brandon Fenton (2018) states:

> Indigenous people are … likely to have experienced multiple and overlapping cataclysmic traumas, starting historically with settler missionaries attempting to force religious conversion, as well as war and community massacres, followed by the creation of and segregation onto reserve lands, the state's broken treaty promises, attempts at forced assimilation, and the outlawing of cultural ceremonies, to the more recent state-mandated Residential Schools, and forced adoption programs that tore Indigenous families apart.

Amy Bombay et al. (2014) summarizes this mistreatment as ethnic and cultural genocide that was systematic, intentional, and state-led. The cumulative, ongoing effects of this trauma have resulted in "consistent health and socioeconomic disparities" between Indigenous and non-Indigenous people in North America. Looking specifically at the descendants of Residential School survivors, the authors establish an essential link between traumas their family members endured and an increased risk of interacting, "With stress-related pathways leading to increased risk of poor well-being," (Bombay et al. 2014, 333). The Truth and Reconciliation Commission of Canada estimates 80,000 survivors of residential schools live in all regions of Canada today. Intergenerational effects of survivors are exponential when considering the total number of lives impacted by suffering imposed by enforced assimilation systems. Intergenerational traumas caused by the legacy of Residential Schools is also associated with a higher risk of substance abuse. Regarding cannabis legalization, these distinct realities mean that Indigenous women, Two-Spirit, transgender, and gender-diverse people also experience more significant risks and harms associated with cannabis use, such as concurrent mental health and substance use issues, poly-substance use, and early use. Despite these concerns, cannabis can be beneficial to Indigenous women, Two-Spirit, transgender, and gender-diverse people in many ways, such as medicinal, harm reduction, and prevention strategies. This is a necessary correlation to address throughout this report, as the effects of intergenerational trauma were raised repeatedly by participants.

1.2.2. SOCIAL DETERMINANTS OF HEALTH

A key component to addressing Indigenous mental health care is understanding social determinants of health for Indigenous people. Many scholars have discussed this concept at length. Some of these include: Gender, culture, racialization, housing, income, physical location, and access to support services. Czyzewski (2011) argues that colonialism, itself, is a social determinant of health. Within a Canadian context, historical and ongoing effects of colonialism are root causes of many health disparities experienced by Indigenous communities. For example: Indigenous Canadians have a life expectancy 12 years fewer than the national average, and experience higher rates of preventable chronic diseases compared with non-Indigenous Canadians (Kolahdooz et al., 2015). The role of political and economic marginalization and intergenerational trauma on Indigenous health cannot be underestimated (Czyzewski 2011).

1.3. CANNABIS AND MENTAL HEALTH

The relationship between cannabis and mental health is complex, and current research on this topic is not conclusive. Cannabis can contain 400 different compounds and 80 different cannabinoids, the most known being delta-nine tetrahydrocannabinol (THC), (Borgelt et al. 2013). Cannabinoids interact with the body's Endocannabinoid System (ECS), an essential system in the body for regulating mental state, appetite, and sleep processes. In their article, Borgelt et al. (2013) outline numerous instances where cannabis can have beneficial health outcomes. Still, there exists evidence that cannabis use can negatively affect health. Research raises specific concerns about potential development of psychiatric disorders, namely schizophrenia, in youth who use cannabis. Borgelt's, et al. (2013) article offers an in-depth analysis of the potential pharmacological uses of cannabis, as well as potential risks and benefits associated with it. Relating to potential adverse mental health effects of cannabis use among Indigenous people, Chachamovich et al. (2015) found cannabis use disorder was significantly higher among Inuit participants who had committed suicide, compared to a control group of Inuit participants who had not. Ultimately, it needs to be understood that a wide array of positive and negative experiences can be related to cannabis use. The consumption method, the dose, amount used, frequency of use, the cannabinoid profile of the product, terpenes present in the product, the extraction method used on the plant and even the growing methods used all play a role in cannabis' effect on the body. The complexity is even more

remarkable when considering the unique circumstances of the person using the plant. There is no universal experience with cannabis, and this nuance needs to be understood when considering the findings of this report.

1.4. PAST PROHIBITION AND LEGALIZATION

Recreational cannabis was legalized in Canada in October 2018. However, the impact of past prohibition and the subsequent legalization of cannabis has undeniable effects on the use and access of cannabis in Canada today. As of 2014, at least 500,000 Canadians are estimated to carry criminal records for possession of cannabis with racialized people, including Indigenous women, Two-Spirit, transgender, and gender-diverse individuals, disproportionately affected by cannabis prohibition (Pressprogress, 2018). Despite similar rates of cannabis consumption across different demographics, laws are disproportionately enforced against racialized communities, leading to higher rates of criminalization (Haslam 2018). The consequences of this criminalization, including prison sentences and criminal records, are still being felt in racialized communities even after its legalization (Haslam 2018). As of October 2021, only 484 cannabis pardons have been granted under the federal record suspension program started in 2019. The parole board of Canada estimates that up to 10,000 people may be eligible for pardons under the program (Zimonjic, 2021). Thousands of Canadians live with the negative consequences of having criminal records for cannabis possession, making it challenging to secure a job or volunteer opportunities or travel outside Canada. These social barriers contribute to diminished career and economic potential; contribute to poverty and poorer health outcomes.

When recreational cannabis was legalized in Canada, the Ministry of Health (Health Canada and the Public Health Agency of Canada) committed to "taking a public health approach to legalizing, strictly regulating and restricting access to cannabis." A public health approach involves active intervention by the state and the strict regulation of cannabis businesses. Jean-François Crépault (2018) explains Canada's public health approach to cannabis; it was adopted by the Ministry of Health because, "The illegal status of cannabis causes harm to its users by exposing them to criminalization, which furthermore tends to be arbitrarily and inequitably applied," (Crépault 2018). By contrast, legalizing and highly regulating cannabis helps manage risks through the health system. Nonetheless, Crépault (2018) says this model tends to individualize public health and the, "Onus to avoid harm is firmly on the individual—not the entities creating, offering, and promoting these risky activities," (2018). Ultimately, Crépault (2018) suggests implementing a public health approach

to cannabis in Canada, which has had a positive impact.

1.5. INDIGENOUS MENTAL HEALTHCARE

It is essential to situate mental healthcare within a specifically Indigenous framework when understanding Indigenous women, Two-Spirit, transgender, and gender-diverse people, and their experiences with cannabis. Most medical research and practices prove to be a poor fit for Indigenous people, as they are rooted in Eurocentric culture, methods, rationale, and understandings of mental health (Bartlett 2005). Current evidence base for health research is from perspectives of Western Knowledge Systems that focus on deficits and problems, rather than strengths of interconnectedness between community, family, language, land, ancestry, and individual health and wellness (Health Canada, 2015). Judith Bartlett (2005) promotes the idea of an "Aboriginal Life Promotion Framework," which better serves unique experiences of Indigenous peoples as a framework grounded in concepts of Indigenous holism and interconnectedness.

Many research papers discuss the importance of offering culturally appropriate health services to Indigenous communities. See, for example, Howell et al. (2016), Martin Hill (2009), McCabe (2007), McCormick (1995,) and Weaver (2005). In their article entitled, "Sharing Our Wisdom: A Holistic Aboriginal Health Initiative," Howell et al. (2016) details that due to resulting colonial legacies, Indigenous peoples are at a higher risk of many health problems compared with non-Indigenous peoples. In addition, Indigenous Peoples were identified as recovering at a slower pace due to disparities in access to health services and systemic racism in the health care system. Through their work, Howell et al. (2016) examined whether engaging Indigenous healthcare frameworks and traditional practices better address health problems in Indigenous communities. It was concluded in their study that participation in Indigenous health circles improved the mental, emotional, spiritual, and physical health of participants (Howell et al. 2016). Howell et al. (2016) advocates for incorporating Traditional Indigenous healthcare practices when caring for urban Indigenous, which included integrating a connection to land and culture. For Howell et al. (2016), land and culture-based practices are essential to empowering personal healthcare and maintaining strong cultural identities. Research shows that First Nations communities who are actively engaged in rebuilding, or maintaining, their cultural continuity have a lower youth suicide rate (Chandler & Lalonde, 2008).

Identity is a core attribute of many Indigenous cultures and is an essential element of spiritual wellness derived from language, land, and ancestry (Health Canada, 2015). A culture-based model of mental healthcare considers how identity is expressed uniquely across cultures, with a stronger emphasis on prevention and the promotion of community strengths and resilience (Health Canada, 2015). This approach facilitates a greater acceptance of the importance and relevancy of culture to mental wellness. Indigenous mental healthcare builds capacity within communities to improve relationships, heal from intergenerational trauma, support education, and community development (Health Canada, 2015).

2. METHODOLOGY

2.1. TWO-EYED SEEING

A guiding principle used for this project included Etuaptmumk, a Mi'kmaq methodology and framework known as Two-Eyed Seeing. Founded by Mi'kmaq Elders, Murdena and Albert Marshall, Two-Eyed Seeing is learning to see from the strengths of two eyes. One eye represents Indigenous ways of knowing, while the other eye represents Eurocentric ways of knowing. This approach involves starting with Indigenous ways of learning and knowing, combining with Eurocentric ways, to use both knowledge for the benefit of all (Bartlett et al. 2012). Indigenous approaches to research are fundamental to ensure the development of culturally specific and decolonized understandings of the relationship between cannabis and mental health. Further, Etuaptmumk allows for an understanding of the nuances of this topic, tailored to the unique histories and realities of Indigenous women, Two-Spirit, transgender, and gender-diverse peoples.

2.2. DISTINCTIONS-BASED RESEARCH

Indigenous cultures are unique, alive, and continuously evolving. Therefore, it is necessary to structure this research within a distinctions-based framework to account for different ways of knowing that emerge from distinct Indigenous groups: First Nations, Métis, Inuit, northern, and 2SLGBTQQIA+ communities. This approach recognizes these five distinct groups have diverse experiences of colonization. These communities have different ways of navigating current forms of oppression and can be uniquely impacted by health policies. This approach allows for more inclusive and socially just policies and programs. A distinctions-based approach allows researchers to capture the diverse voices and experiences to understand

how Indigenous women experience issues related to cannabis and mental health (Badets 2018). The Government of Canada recognizes the work of forming renewed relationships based on recognition of rights, respect, cooperation, and partnership, which must reflect the unique interests, priorities and circumstances of all people (Government of Canada, 2018).

2.3. GENDER-BASED ANALYSIS

It is important to acknowledge the role gender can play in the habits of people who use cannabis. For example, some research shows that men are more likely to use cannabis recreationally, while women are more likely to use it for medicinal purposes (Government of Canada, 2017). With the social acceptance of cannabis use rising due to legal, social, and cultural changes, the rates of women choosing to use cannabis recreationally may increase over time. Gender also influences the consumption methods used by people who consume cannabis. Women are more likely to consume edible products, while men report higher rates of smoking, vaporizing, and use of concentrates such as hash and oils, (Government of Canada, 2017). This project took these discrepancies into account by tailoring specific messages for these communities and advocating for their inclusion in all Indigenous harm reduction services. The research team adhered to the culturally relevant gender-based analysis (CRGBA) framework developed by NWAC. This framework helps to ensure all research stages recognize and respond to the ways colonialism imposes hetero-patriarchal norms and structures on Indigenous people, cultures, and communities. CRGBA considers how biological factors influence how individuals respond to, and are affected by, cannabis use due to factors such as physical and hormonal differences (Calakos et al. 2017; Fattore and Fratta, 2010). Beyond this, gender norms and roles influence how individuals access services and how they are treated in healthcare facilities. For Indigenous women, Two-Spirit, transgender, and gender-diverse people, sex and gender need to be understood within a larger cultural context, and CRGBA is a valuable tool to do so. Using CRGBA, intersecting realities such as racism, sexism, ableism, and colonialism can be understood as factors that influence experiences and thus impact health outcomes. Ultimately, using CRGBA ensured voices, priorities, and vision of people of all genders were heard, prioritized, and supported during all phases of this project.

3. METHODS

The findings of this report are based on five engagement sessions held between July and October 2021. Throughout these engagement sessions, the research team aimed to answer three research questions:

1) What are the needs and priorities among Indigenous women, Two-Spirit, transgender, and gender-diverse people in Canada regarding cannabis and mental health research?
2) What is the relationship between mental health issues and cannabis use among Indigenous women, Two-Spirit, transgender, and gender-diverse people in Canada?
3) What mental health harms and benefits of cannabis use are experienced by Indigenous women, Two-Spirit, transgender, and gender-diverse people, and their communities?

3.1. SHARING CIRCLES

During this project, the research team used Sharing Circles to explore understandings, beliefs, and needs of Indigenous women and gender-diverse people, Indigenous community leaders, and HSCPs as they relate to cannabis and mental health understandings. Sharing Circles are imbued with Indigenous philosophies and protocols (Lavallée 2009), and are adept at gathering stories and capturing participants' experiences. Indigenous communities have used Sharing Circles to teach culture, tradition, promote and research health, and facilitate spaces for healing (Lavallée 2009; Rothe et al. 2009). They have been shown to build additional trust and rapport between researchers and participants, as well as nurture a sense of community, facilitate healing, and empower participants through group discussion. Sharing Circles can elicit deeper exploration and understanding of complex and, at times, sensitive issues related to Indigenous people's health experiences (Jacklin et al. 2017).

Sharing Circles allow community members in the Circle to contribute as partners in research, allowing their experiences to directly inform the development of cannabis and mental health resources and recommendations.

A good practice for community-based research is providing gifts to all those who took part in the research project, including Sharing Circle participants. In many Indigenous cultures, gifts represent respect, a forged bond, appreciation of the

exchanged Knowledge, and a manifestation of reciprocity. Following that ideology, NWAC provided each participant with a small token of gratitude in the form of a cash gift. Each Sharing Circle was led by an Indigenous facilitator, researcher, and leader. For each session, an Elder opened and closed the Circle. Participants were also given a brief presentation at the beginning of the Circle (Appendix 10.2).

3.2. PARTICIPANTS

The Sharing Circles were organized using a distinctions-based approach and were divided into five categories: First Nations, Inuit, Métis, northern, and 2SLGBTQQIA+. In total, there were 120 participants in the five engagement sessions. Participants were those who self-identified as using cannabis for mental health.

GROUP:	NUMBER OF PARTICIPANTS:	PROVINCES AND TERRITORIES REPRESENTED:
Northern	20	Quebec, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia, Northwest Territories.
Métis	27	Ontario, Manitoba, Saskatchewan, Alberta, British Columbia.
Inuit	8*	Nunavut, Newfoundland and Labrador, Ontario, Alberta, Northwest Territories, British Columbia.
2SLGBTQQIA+	35	Nova Scotia, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia, Yukon, Northwest Territories, Nunavut.
First Nations	30	Regional demographics were not collected for these engagement sessions, as NWAC wanted to collect minimal personal information. Addresses were collected starting with the second engagement session, due to advisement from NWAC's finance department, who required it for their records.

*Due to lower participation in the Inuit engagement sessions, NWAC sent a written questionnaire to several Inuit participants. NWAC received 20 additional written responses, in addition to the eight engagement session participants that were incorporated into this report.

It should be noted several of the Sharing Circles were larger than others, resulting in longer transcripts for those groups; however, representation in the report is evenly distributed among participants.

Participants were provided with an information sheet and consent form prior to the Sharing Circle that outlined the scope of the research project, the purpose of their involvement, and any potential risks or benefits from participating. Minimal personal or identifying information was collected from participants. Following the Sharing Circles, regional information was collected to distribute honorariums. Other demographic information, including age, disability, and/or Indigenous nation, was not collected.

4. ANALYSIS PROTOCOL

The analysis and preparation of this report were based on Indigenous-specific research methodologies rooted in Indigenous ways of knowing (epistemologies) and ways of being (ontologies). The research design of conducting distinct engagement sessions regarding cannabis use according to varying Indigenous groups (Métis, Inuit, First Nations), sexual and gender-diverse identities (2SLGBTQQIA+), and regional locations (northern), were employed to this end. An analysis of transcripts from the engagement sessions was also conducted separately.

The analysis methodology used to identify themes included a combination of inductive coding and summative analysis to best describe and organize the responses. A team of three researchers employed a multi-part, consensus-based, analysis protocol. First, researchers used Qualitative Data Analysis (QDA) software (Miner Lite, 2022) to identify significant and recurrent themes. Based on the importance of consensus making, researchers met regularly to review emerging themes, discuss any discrepancies, and decide on a final list of themes across the research groups. Researchers also consulted with a professional research methodologist to ensure the process was designed accurately and thoroughly. Finally, themes were divided amongst researchers to be written individually before they were compiled and reviewed collectively.

5. CONSIDERATIONS

As participants were encouraged to share only what they were comfortable with, some responses may seem to lack context or specific details. The participants' experiences are valid and authentic, but may also be skewed by how guarded health information can be by the elite and privileged. It is important to note that research indicates physicians are less likely to be Black, Indigenous, to have grown up in a rural setting, and/or come from a household earning less than $100,000 per year, compared to the general Canadian population (Khan et al., 2020). These socioeconomic disparities in health professionals may exacerbate inequalities in access to culturally safe health care and widen knowledge gaps for individuals seeking good, quality information for their personal wellness. Further, evidence suggests medical students from traditionally disadvantaged backgrounds, such as those who are part of visible minority populations or have rural or low socioeconomic backgrounds, are more likely to practice in areas with physician shortages (Khan et al., 2020). Closing the gaps in diversity for training programs for health care professionals could mean increasing access to full-time, primary care and other health services for rural, northern, and on-reserve Indigenous populations. In considering this background information, as well as the barriers to accessing health information, it is understandable how some participants' perspectives include misinformation. This also highlights how complex this topic is and how it reflects inequalities present in our healthcare system. Participant responses that may include misinformation were not altered, to protect the integrity of these comments and the participants' experiences, as well as to highlight a disconnect between many Indigenous people and health care information.

6. FINDINGS

6.1. STIGMA

6.1.1. SOURCES OF STIGMA

Stigma refers to negative attitudes regarding the relationship between cannabis use and mental health. It also refers to negative perceptions of, and discrimination against, individuals who use cannabis (see, for example, Lashley and Pollock 2019; Reid 2020). Participants discussed experiencing stigma for cannabis use from several sources, including HSCP, workplaces, communities, and Elders.

What We Heard:

Stigma from Health and Social Care Providers

In participants' remarks, stigma from HSCPs commonly resulted from these providers' perceived, or actual lack of knowledge about, uses of cannabis to manage mental health, including to alleviate symptoms, help with coping, and for the safety of using this substance with particular mental health conditions. Many participants expressed fears of disclosing cannabis use to social workers, as it would be met with negative judgement and may result in regarding their competency as parents as being reduced.

As a result of this stigma, participants found HSCPs reluctant to support cannabis use, including providing prescriptions for medical cannabis and using cannabis as an alternative to pharmaceuticals such as opioids and psychiatric drugs. While some participants felt the stigma around cannabis use reflected the biases of individual HSCPs, others also noted how ignorance about the potential benefits of cannabis use was a systemic shortcoming resulting from a lack of research and education available to HSCPs.

Stigma in the Workplace

Participants discussed working in industries where cannabis use was stigmatized or unacceptable, and therefore, they were not open about their cannabis use with employers and coworkers. Additionally, one participant expressed concerns about the possibility a workplace could access their medical records if it is believed, or known, that a workplace does not accept employees who use cannabis. This also impacts what cannabis users may disclose to their physicians.

Stigma from within Communities

Another source of stigma regarding cannabis use was the participants' communities. Participants discussed how bias from family and community was often based on assumptions that cannabis use leads to the use of other illicit drugs. Participants noted how these negative views about cannabis persisted in their community even after cannabis was legalized, often attributing the views to living in older, rural, and more conservative communities.

Stigma from Elders

Participants said Elders in their communities sometimes held negative views of cannabis, and even went so far as to tell some participants to stop using cannabis. In contrast, others noted that Elders' opinions regarding cannabis changed depending on whether cannabis was being used for medical or recreational purposes, with less harmful views on medicinal use. Participants noted that Elders' opposing views on cannabis impacted access to ceremony when sobriety was a requirement to participate.

Participants' Voices:

Across all groups, participants spoke of experiencing stigma related to cannabis use. Northern, First Nation, and 2SLGBTQQIA+ highlighted their experiences of stigma as coming from HSCPs. Métis and Inuit engagement session participants emphasized stigma from their community, Elders, and family.

Northern:

"I have a psychiatrist that I see sometimes, and he is kind of against cannabis. I tried to explain to my doctor that cannabis helps me and what I went through growing up. I feel I can have an open conversation with my psychiatrist, but he's still kind of against it, so I won't be able to get my own medical prescription for cannabis."

"I've never spoken to any health care provider about cannabis mainly because, I guess, if I was asked directly I would say I used it, but it's never come up in conversation, and I wouldn't be comfortable to share it unless I had to. Due to stigma, I do not feel comfortable sharing."

"I have had four NPs in the past year now. And I try to give them an idea of a picture of my mental health. There has been this awkward period of silence and judgement from them. It then becomes an over-explanation, and I feel like I have to stick up for myself. It's taboo, and I feel like I'm walking around in the dark without having that support."

"I think discussion with health care providers is taboo. It's still not recognized as medical care. So, when I bring it up in [my community], I get, 'Oh there is not enough research' and, 'It's not related to your health.' However, at the same time, there's medical prescriptions for cannabis."

Métis:

"As a mother, the stigma has me fearing Child and Family Service Agencies, and I still feel fear when discussing with social workers and medical."

"I work in medical field, and there's a negative stigma about cannabis. So, I'm not open about my use at work or with coworkers."

"[E]ven with Elders. For them to understand that cannabis is not just a drug. In my experience, Elders are accepting of alcohol but not cannabis."

"I'm Métis in a Métis community, and it's really frowned upon."

Inuit:

"We can't just walk into an office and ask for help because they just label you right away as a troublemaker. The RCMP came up to me and yelled at me once, judging me and making false accusations about me using drugs while pregnant etc. They don't see that cannabis is better than someone being drunk, out of control."

"My family would not dive into this conversation [about cannabis] and has a strong sense of discomfort."

"Currently, with my Inuit culture, cannabis is still seen as a hard drug and Elders and older people do not condone the use in any way. I think with more awareness and education around the positive effects of healthy use of cannabis, would be beneficial."

2SLGBTQQIA+:

"With my psychiatrist, I had, I asked about CBD, and he just said that he doesn't know anything about it and refused to look into cannabis further."

"I would like it if health care providers were open to sharing, or looking into, how cannabis interacts with medications. I have OCD and ADHD, and they can't give me a straight answer on how it interacts. It's hard to find out if interactions advice is based on evidence or if it's just that they don't want me to use cannabis. I want reliable information so that we know how things react together with cannabis."

"I have told my family doctor about my cannabis use. She won't prescribe it to me, and I guess she doesn't feel comfortable."

First Nations:

"Because there is still so much stigma about using marijuana, I try to hold off on disclosing my use of marijuana."

"I used to use. I would never tell my doctor because of the huge stigmas around it. It was always scary to think it would change their opinion on me."

"I have numerous medical issues that could benefit from cannabis. My MDs are too old school to approach about this."

"I've had healthcare professionals tell me they felt my use of cannabis was ok but that they were uncomfortable prescribing it."

"[W]hen I go to talk to the Elder at the conference or something, I gauge them, but then I ask them about their cannabis opinions. Their answers change when it's medical versus recreational. They have negative ideas about recreational use but less negative."

6.1.2. CANNABIS, DRUG USE, AND ADDICTION:

Participants discussed negative opinions regarding cannabis use related to addiction and to the classification of cannabis as a drug. These negative views about cannabis result from the stigma surrounding drug usage and addiction.

What We Heard:

Participants shared they felt negative opinions about cannabis due to once being an illicit substance in Canada, until recently. Participants indicated that when they disclosed cannabis use to HSCPs, providers often made inaccurate assumptions regarding use of other illicit drugs, or labelled them as "addicts." When this happened, it would negatively impacted their care as it meant they were directed toward addictions services rather than the services they solicited. Further, many participants emphasized how race and Indigeneity compounded their experiences with addiction-related stigma because negative views about cannabis build upon, and add to, harmful colonial stereotypes about alcohol use and addictions among

Indigenous people. Participants said stigma that associates cannabis use with drug addiction is even more damaging for Indigenous cannabis users who are caregivers of children; and if a Children's Aid Society worker and social worker holds such views, this stigma may result in child apprehension.

Participants' Voices:

All groups highlighted the assumption that cannabis use can be equated to addiction by HSCPs and the community. 2SLGBTQQIA+ engagement session participants further detailed this assumption related to race and skin colour.

Northern:

"I think there's still underlying stigma about cannabis, and a lot of practitioners feel it's a gateway to other drugs."

"[S]ocial workers consider it an addiction. There's a lot of stigma."

"I have shared with multiple doctors, and one told me I had drug problems and need treatment for it. The next doctor said that they didn't support it and weren't interested in continuing this conversation about getting a cannabis prescription."

"[B]eing native I'm tagged as a 'user' rather than what I've seen with white friends who get tagged as a 'medicator.'"

"A lot of the people that I know that use cannabis are moms, and it's a social thing for us to get to-gether, chat and smoke, and discuss which strains are good for daytime/nighttime and advice. [...] [M]any of us view cannabis as a medication. Many of use [it] to deal with sleep and stress issues, so being a mom, we have found it helpful. Being the stigma of a stoner mom is negative, but then wine-drinking moms are not stigmatized and aren't looked at as negatively as when someone is drunk, and when someone is high."

Métis:

"I have had instances where I've avoided talking about it [cannabis use], in a medical or hospital envi-ronment, to avoid being treated differently because they immediately categorize you differently than others who do not consume cannabis. I've contacted places like access 24/7 for mental health services, and upon learning I consume cannabis, I am always directed to mental health and addictions, even when the discussion I'd like to have isn't having to do with my cannabis consumption."

"A previous doctor started asking about addictions just when I only asked about cannabis. It was un-settling, so I didn't feel like I could be open again."

"I live in a small-town, rural community. There was a big stigma in our community that, as soon as can-nabis was legalized, it would mean there would be drug addicts all over our streets. Many thought it would affect our downtown businesses, and in particular, the older generation was very vocal about keeping it out of our community regardless of legalization. People that did smoke cannabis were then being identified and ostracized. I know some friends who have high anxiety about people in town find-ing out they smoke cannabis and potentially having it ruin their reputation as a business owner in the downtown."

Inuit:

"Most of my Elders think that if you use cannabis, you are a 'druggie.'"

"I think cannabis is overlooked as a harm reduction tool, and as a person who has BPD and PTSD, it helps me mentally, as well. I had alcohol addictions and was homeless. The medical providers just saw it as a drug or narcotic, rather than seeing how it benefited me."

2SLGBTQQIA+:

"I was in the ER recently and told the doctor I saw [after being asked about cannabis usage]. She im-mediately asked what other drugs I did and did not believe me when I said none. I understand asking for safety as mixing hard drugs with some pharmaceuticals can be life-threatening but having to repeat that I wasn't doing other drugs was frustrating. I was very ill, throwing up, severely dehydrated, and tired of trying to stay awake."

"I don't know how to phrase this, but I feel as though my community is harmed by social perceptions of Indigenous people who use drugs. For example: Growing up, and even now, I have white friends who, if they use cannabis, it is no big deal; it's more normalized. But myself and other Indigenous peo-ple, in later high school or college, there was more stigma of using cannabis."

"The only health provider in my experience who has a positive feedback and beneficial information has been my partner's doctor, but I think the thing is that my partner is light-skinned Métis person, and I feel like skin colour is a factor."

"I have discussed it [cannabis] with two practitioners. The first was a nurse practitioner at the universi-ty clinic when I was in first-year university, around when it first was legalized. On the intake form, you identified if you were Indigenous. I also identified I had anxiety. When I went into the office, the nurse practitioner looked me up and down and said, 'Yeah, I'm NOT going to be prescribing that to you.' When I asked if she could refer me to someone else I could speak with, she said she 'wasn't sure,' and I just left the clinic at that point."

"[P]rofessionals think that when I say I use it daily, they think I'm high all day. I actually use only a small amount without being high. Professionals don't realize how badly they treat Indigenous people. I don't drink or do other drugs, and it's hard to have to debate professionals like social family workers. I started using it [cannabis] medicinally, but I wanted to think about my kids. I feel that as a native mother, I'm afraid of speaking about this because of child welfare. I don't want to have psychosis. When I have a kid, I stopped because of their involvement. It's scary that I can get my kids taken away when I only micro-dose. … I'm an abuse survivor, and my parents are Residential School survivors. If that one puff saves me, then we need Elders and professionals to see us and listen, that we aren't getting high or being dangerous."

First Nations:

"[B]ecause there is still so much stigma about using marijuana, I try to hold off on disclosing my use of marijuana. Being a single mom and wanting to smoke a joint is not the same as being a single mom and wanting a glass of wine."

"I have discussed cannabis with two people who were wanting to stop using cannabis—my addiction counsellor; she sees cannabis as an addiction. She [is] old fashioned and wants the best for me."

6.1.3. EFFECTS OF STIGMA

Participants described several significant effects of stigma regarding cannabis use. These effects centred on fears of judgement, negative impacts on healthcare, and lack of support in using cannabis from HSCPs.

What We Heard:

Fear of Judgement:

Many participants noted they felt afraid of others' judgement for using cannabis. This was frequently expressed as a fear of being judged negatively by HSCPs. Some participants said feelings of judgement and shame were more harmful than any potential problems with cannabis usage itself. Participants also discussed how stigma makes them feel, such as not being heard, and knowledge about their wellbeing is undermined. Participants shared how the stigma of HSCPs directly contradicts their personal experiences using cannabis to benefit their wellbeing.

Negative Impacts on Healthcare:

Participants were concerned about how stigma regarding cannabis use may negatively impact the healthcare they received. They were concerned that they would be treated differently by HSCPs if they disclosed cannabis use. If they did not disclose cannabis use, participants were concerned that this could put their health at risk, for example, due to adverse drug interactions. These effects of stigma were felt most acutely by those who had limited access to HSCPs in their communities, including participants from the northern and Inuit engagement sessions, who did not have a permanent doctor in their community. These participants said they must repeatedly communicate what they need to new doctors and explain how cannabis helps them, which increases their risk of re-traumatization. Others living in remote and northern communities emphasized they rarely have the option of seeking care from other healthcare practitioners who are more supportive.

Lack of Support in Use and Self-Advocacy:

Participants said when they could not discuss their cannabis use with HSCPs, they were left to figure out usage on their own. Even participants who could get prescriptions for medicinal cannabis said they did not always receive support for ongoing use. Participants experienced challenges accessing support for cannabis

use when funding for programming related to cannabis use, including dependency and misuse, was limited. When they had limited support provided to them for using cannabis, many participants had to become advocates for themselves, including initiating conversations about cannabis use with HSCPs and using these conversations to evaluate whether providers were a suitable fit for their needs.

Participants' Voices:

All groups said stigma could impact their ability to communicate openly with their HSCPs. Further, all groups pointed to stigma leading to inadequate care, or care that goes directly against the patient's wants. Differences between the groups included: Point of access for Inuit and northern communities, fear of intervention from a Child and Family Services organization for 2SLGBTQQIA+, Métis, and First Nations communities.

Northern:

"I recently moved to my city, two years ago, and have been on a waiting list to get a healthcare provider for over half that time. But when I do get one, I'm pretty sure I will have anxiety about talking about it, in fears of being judged. I have a past history of drug abuse and alcoholism, and it always happens when I first bring it up."

"I think that cannabis and mental health is beneficial, but I think there's a lack of resources on how to use it properly, and you have to figure out on your own. … I think working with a doctor or someone to help guide the dose and when to use it [would help]. What is the healthy balance?"

Métis:

"I don't feel comfortable talking to my health care provider about cannabis use because I have a child, and I fear separation or involvement of CFS [Child and Family Services]. Even [though] it's legal, and my child is well cared for."

"I have had instances where I've avoided talking about it in a medical/ hospital environment, to avoid being treated differently, because they immediately categorize you differently than others who do not consume cannabis."

"I was, at first, open to suggestions from GP; however, since I am a recovering addict, they wanted me to take benzodiazepines. But I'm using cannabis as harm reduction and to step down from those. I found that my GP was working against me, instead of with me."

"I wish there wasn't so much stigma and that talking about it didn't make me feel shamed for using it."

Inuit:

"The budget and the money going out to different programs has made it difficult for us to get help with cannabis. There's too much racism and not enough help with dealing with trauma. We need better access rather than having to be scared to go and see our doctor. … There's not enough access to proper medicine. The stigma where, 'Oh, that person smells like pot,' and then switches sides of the street to get away from them. The money for supports and programs doesn't stay. There [is] only two nurses to service a whole community. It is lose-lose situation for everyone. Policy creating more issues than they help. Everything adds up. Barriers, the community wants to turn their head to it, but then the kids are watching this happen. It's heart-wrenching to watch."

"With my experience with healthcare providers, I work on FASD awareness. I want to be able to give [my] son with FASD the best life, and dealing with stigma from healthcare providers asking whether I drink. It creates a defensive response already, even if they didn't drink. I get the stink eye like, maybe I did drugs or drinking. Trying to teach our children about this, the system is always asking us if we're stoned, drunk, or whether we are taking care of our kids properly. Sometimes the steps are embarrassing. I know that cannabis will benefit my son and benefit because I can sleep all night. the barriers to getting referrals and everything. It's so daunting."

2SLGBTQQIA+:

"As a Native Mother, it's [cannabis] something I cannot talk about safely either. We are targeted much more by child welfare. White mothers are looked at under a glass; Native mothers are focused on with a microscope."

"I would agree that there's more harm in stigmatizing users, and the shame that it gives them, than using does."

"When I mentioned it previously, I was heavily stigmatized. I live in an area where family doctors are hard to come by, and thousands are without one. I worry that if I mention it, I will be without a doctor."

"I have a 'no bones in my closet' stance and even to a detriment. ...]I had a surgery with general anesthesia, and I had to be honest with the doctor and tell them I use CBD. ... There are interactions with CBD and the drugs they use when you have surgery, and if you're not open with them by choice, it can be dangerous."

First Nations:

"[Stigma] with CAS, having people lose their children due to cannabis use."

"It's scary that they might change their opinion of me if I discuss cannabis with them."

"Before legalization, women were prosecuted for buying or selling [cannabis], and now it's a stigma and a criminal record. It affects them when they get stopped by police randomly, now it stays with your record. They need to remove this for Indigenous women. The court worker at the Friendship Centre I worked at said they can stop you when crossing the border, so this is harmful. When you want to travel or work, the record harms you."

6.1.4. REDUCING STIGMA

Despite the challenges of stigma regarding cannabis use, participants had many ideas to reduce and combat stigma around cannabis in ways that would benefit individuals and communities. These suggestions were focused on the importance of education, awareness, and open communication about cannabis use. Additionally, participants emphasized the importance that HSCPs value and learn from the experiences of cannabis users.

What We Heard:

Education and Awareness

Participants discussed that it was vital for HSCPs to be educated about cannabis use—including benefits and harms—so they could provide evidence-based information to help their patients and clients. While research is available on cannabis use and mental and physical health, participants said they were often unable to access this information from providers who, as the participants perceived, were not adequately educated on the topics. Openness to learning on HSCPs helped participants feel more comfortable talking about cannabis and seeking support. Participants also called for Child and Family Services Agencies, workers, and police, to better understand how cannabis affects Indigenous people and intersects with past trauma, so these professionals can challenge their personal biases and better support individuals and families.

Open Communication

Participants emphasized the importance of open communication regarding cannabis usage to reduce stigma. They said when they were more open about their cannabis use with colleagues, families, and community members, it helped reduce others' stigma and their own internalized stigma about cannabis. Many emphasized that a prerequisite for open communication is that HSCPs approach these conversations without judgement. Withholding judgement regarding cannabis usage is especially important for providers working with Indigenous people who already face extensive stigma around accessing pharmaceuticals. Participants suggested open communication would be supported by building good, and ongoing, relationships between HSCPs and community members. Many said they would need to develop a comfortable relationship with HSCPs before disclosing cannabis use. Participants in the north said an increase in continuity of care would be necessary.

Valuing Indigenous Experiences

When communication is more open, participants indicated that HSCPs might further reduce stigma about cannabis use by learning from experiences of Indigenous people who use cannabis in beneficial, and harm-reductive ways. Participants shared experiences where their knowledge about cannabis was validated in this way. It was noted that listening to, and learning from, cannabis users' experiences

helped by allowing them to seek support and embrace an openness to learn from users' experiential knowledge, both of which was discussed as helping to reduce stigma.

Participants' Voices:

All groups said the way to reduce stigma is through information sharing, understanding, and open communication. The Inuit group pointed to access to adequate and consistent healthcare as a crucial step to reduce stigma.

Northern:

"I feel like I would be able to share [about cannabis use]; my doctor is always keeping informed with up-to-date information and willing to listen to my perspective before giving her advice."

"[I]f there's an understanding about you and why you use it, your history … then I feel you can have a good conversation about it [with health care providers]."

"I have a friend who is a Nurse Practitioner, and I had a more positive conversation with her than my own doctor. …]She heard me out and listened to my views and what I have learned through my own learning. And she agreed with me that cannabis could be positive because of experience with others saying it was good for people getting off drugs."

"Ideally, they would be receptive to the idea that cannabis could be used medicinally and per-haps they would be able to have a more in-depth conversation and WHY they use. Yeah, it might be a Band-Aid, but maybe there's deeper issues and motivations. With me, I only had one doctor option in the north and had negative reactions. So, if I had an option, I want to be able to have that in-depth conversation with better advice about lifestyle."

Métis:

"My new psychiatrist now is supportive of cannabis, but not on a consistent basis, and open to it being part of an overall treatment plan."

"I recently lost my doctor, but they were an Indigenous woman who supported my cannabis use. She moved since I'm in a small town."

Inuit:

"It would be great to have a consistent family doctor; one history, one explanation, and someone who will grow with us, and see how we're doing, and be able to follow-up with our case. That consistency builds trust. they should be here at least ten years so we can have better care. A shared decision-making and respectful relationship. That only comes after time and getting to trust them. It's more encouraging to have that recognition, and that they know what we need, and know that we know what we need too. If someone is right away judging me without knowing me, it's harmful and not helpful compared to having someone get to know me."

"With more info publicly available, it would bring more people who have questions about can-nabis use to approach front line workers to ask about the risks and benefits of cannabis. … I ex-pect frontline workers to be trained on addictions and cannabis for medical and recreationally. I want them to be able to help the person without the judgements, stereotypes, and stigmatization that's very strong against Indigenous peoples. Then, add on cannabis—it can go one way or the other, depending on the individual front-line worker. For whatever reasons, the worker can have a different response. We need public awareness info to get to them through radio, social media, and online, and print resources, about the benefit and risks. The frontline workers need to be aware that this is a legal product now, and if we're seeking help, it's because of addictions. And if we're not getting help, it's because we don't have as much support from our resources and frontline workers. People need to know where to go and not feel ashamed or embarrassed. We face repercussions repeatedly for this stigmatization. Everything we do is seen as a negative but asking for help is not successful."

"CAS and police need a better understand[ing] of how cannabis affects us and intersects with past traumas. I believe that not as many families would be torn apart from CAS if they under-stood."

2SLGBTQQIA+:

"For the future, if I wanted to have a new healthcare provider and a conversation, I would go about that by giving each other space for feelings and safe space where they are educated about cannabis, but listen to each other. If they don't know about cannabis, then they should know be-fore having a conversation with their patients."

"[N]ow that I also work as a healthcare provider in mental health, it is something I always make clear I am open to discussing with people I work with, in terms of information, harm reduction choices and asking the doctors on our team about any medication interactions."

"I do discuss [cannabis] with my doctor and therapist. I frequently have existential crisis about it with them because I feel bad about not doing other therapies. But they have since told me that it's okay. They helped me feel less bad about my use and have less guilt from society and stig-ma."

"I have a counsellor and a specialist who are open to researching more about cannabis and being open to learning from me since I worked at a dispensary. … Since getting a really good counsel-lor and good specialists, I was able to bring up cannabis use with them, and since legalization, I've been very open about my use. I feel that I got really lucky and got good doctors that were really good about my use. My substance abuse counsellor was worried, but she was open to hear-ing about my job at the dispensary and even asked if I had any resources she could have."

"It would be helpful for them to ask more holistic questions to understand why this path was se-lected so that it is from a place of exploration and understanding, rather than right or wrong."

First Nations:

"My HCP was different. He was surprised when I asked him about cannabis. No one had asked him about it before. So now he felt excited that he would need to learn more about it since others might now ask him about cannabis. So, once I was at the office, and the staff was very informa-tive and was able to speak with the MD about it and my issues I wanted to address."

"I have been diagnosed with PTSD and have been prescribed Prozac for antidepressants, and since then, I am open about it [cannabis use] everywhere I go: Social workers, MDs and psychia-trists. The psychiatrist didn't prescribe it but was open to it if it was helping me. I have talked to them with CAS [Children's Aid Society], and I was open with them about it because I found it helped my depression and addictions. CAS was okay with it because of the symptoms that it was helping with. Even RCMP officers have given it back to me after and were okay."

"I didn't feel any stigma when I started being more open about it with my colleagues. My col-leagues started coming to me with questions about how they can go about talking to their doctors about cannabis."

"I think it would be nice if practitioners, once you tell them that you use cannabis, if they asked questions about, 'Oh, what are you taking it for,' and, 'What are the effects it's having for you?' I want to have control and autonomy over my body, and I want them to have conversations about it with me. Cannabis isn't the best thing for everyone, but we should have interested con-versations with health care professionals because we use cannabis for a reason. We're not using it so we can sit around on the couch; we're using it so we can be functional, move around, and be better."

6.2. INDIGENOUS EXPERIENCES

6.2.1. CANNABIS AS MEDICINE

Participants across all focus groups explained they understood cannabis to have a role within Traditional Indigenous medicine. For these participants, cannabis was not just a recreational drug or a therapeutic or medicinal practice—cannabis was deeply interconnected with their Indigenous experience.

What We Heard:

When discussing cannabis as medicine, participants frequently spoke of the role of cannabis in a holistic approach to health. This reflects Indigenous understandings of wellness that encompass physical, mental, emotional, and spiritual wellbeing and includes considerations of the individual, family, and community. For example: Participants noted many holistic benefits of cannabis in treating mental and

physical health conditions—which are often interrelated, especially for those who have experienced trauma. Participants also spoke of wanting to use cannabis as an alternative to pharmaceuticals, with some understanding cannabis to be a herbal remedy or a Traditional medicine, and not as a drug. However, it should be noted that all participants did not share this view. Some felt research had indicated the use of cannabis before Western, or colonial, medicine deemed the plant to be a drug rather than a medicine.

Participants' Voices:

All groups highlighted the benefits of the use of cannabis as a medicine. The northern group pointed to the usefulness of cannabis to cope with life challenges. The Métis group cited cannabis's role in pain relief, coping, and alternative to conventional medicine. The 2SlGBTQQIA+ group mentioned the benefit of cannabis as a part of spiritual practice, holistic care, and as an alternative to conventional medicine. The First Nations group mentioned the benefit of cannabis use as a holistic care practice and an alternative to conventional medicine.

Northern:

"I want plant-based medicines, and Knowledge on how to talk about that. I think that would be powerful for some people. I lived on a reserve, and coming to the city was shocking for me, and I feel like I use it to cope. I want to feel like I am getting proper mental health care, that involves plant-based medicines too. I want to feel normal, and sometimes, the medications don't always make me feel like that, compared to cannabis. Decolonizing medicines, plant medicines."

Métis:

"Pain, and mental pain relief, and trauma pain, or spiritual pain relief. I don't know what it is to use it for purely rec [recreation]. When I look back, I now know I was using it for trauma coping, and I used cannabis to help cope with spiritual pain. Now I feel like I can use it to alter my mind state in a very gentle way and use it as a tool."

"Yes, I do [discuss cannabis] because my doctor understands I use western and Indigenous medicine at the same time."

Inuit:

"Currently, with my Inuit culture, cannabis is still seen as a hard drug and Elders, and older people, do not condone the use in any way. I think with more awareness and education around the positive effects of healthy use of cannabis would be beneficial."

2SLGBTQQIA+:

"I noticed that since I'm gifted when I get high. I see spirits, and I feel my gifts stronger with cannabis."

"I'm disappointed in the Traditional theme that cannabis is negative. There's like, a hundred years of history telling that story, and that's a colonization story. If you go deeper, this is medicine that has been used for a thousand years. So I'd like an Indigenous, holistic, perspective on using cannabis as a healing medicine."

"In general, [cannabis is] beneficial. 2SLGBTQQIA+ people already face stigma, and that can worsen mental health problems and isolate people depending on the level of support they have. This all, I guess, circles back to the need to look at things holistically and take all aspects of an individual's life into account when treating, helping, or supporting them, as there's no blanket treatments that will help everyone."

First Nations:

"I don't view cannabis as drugs but more like a great herbal remedy."

"Health care practitioners belittle the dignity that comes with coming with being able to purchase our weed. It is frustrating that something so great is being undervalued, like they don't want to discuss it, or they undervalue it. Like, as if they want us on four different drugs instead of one plant."

"I have found that when you create safe space for people in your life to be able to talk about using this medicine [cannabis], it can help them and you. People with severe pain in my life who use it found that it has made life significantly easier."

6.2.2. CANNABIS, SPIRITUALITY, AND CEREMONY

Participants spoke of connections between cannabis use and Indigenous beliefs and practices, including ceremony. This section includes instances where participants explicitly referenced their spiritual practices concerning cannabis use.

What We Heard:

Participants spoke of the role cannabis can play in spiritual practices and Indigenous ceremony. For some, cannabis use supported spiritual practices. For example: One participant shared that cannabis helps them access their spiritual "gifts," including seeing spirits. By contrast, others noted that cannabis is presently a barrier to participating in ceremony when sobriety is required of participants. Several participants discussed being excluded from Traditional ceremonies because of their cannabis use, and explained how this exclusion was harmful to them. These participants wanted to see more be done to help Elders and community members understand that cannabis use should not exclude them from participation in ceremony.

Participants' Voices:

All groups highlighted the conflict between the use of cannabis and attending ceremony. Northern and Métis advocated for acceptance of cannabis use at ceremony, while the Inuit pointed out that cannabis is harmful to ceremony.

Northern

"[Cannabis] with ceremony, and using cannabis as medicine in cultural healing, and finding the connection with land-based Knowledge."

Métis:

"Culturally, I have experienced being told I cannot attend ceremony because of my use of cannabis. This was damaging to my identity and to my connection to culture."

"Around ceremony and cannabis use. I feel that there is a need to discuss this. For those that use medications for mental health reasons, it is not obvious with no smell, etcetera, but with cannabis, there's visibility, or stigma, around cannabis. There was a time when I was using cannabis for mental health and spiritual journey. This plant

needs to be accepted as part of the medicines that we use when in this day we have issues to work on that need many forms of medicines."

"Around ceremony, views are changing. We find that people that use drugs are the ones that need ceremony the most. Cannabis is part of my spirituality, and my use does not harm my spirituality and growth."

Inuit:

"[Cannabis is] [h]armful for cultural aspect."

2SLGBTQQIA+:

"I was in so much pain and shaking that I would have to use cannabis just to get ready for that ceremony. And they told me, 'You have to be sober for the ceremony.'"

First Nations:

"[My daughter is] my supporter during my fast. She, on her own, is deciding to stop cannabis for that ceremony."

"[Cannabis is] harmful due to impairment to drive or go to ceremony but when used in a controlled way, then it's beneficial."

6.2.3. CANNABIS AND COMMUNITY

Discussion regarding community reflected Indigenous understanding of well-being, encompassing considerations for community and individual welfare. Participants emphasized that Indigenous communities ought to be part of future research into cannabis, including as researchers and Knowledge Holders of unique contexts of cannabis use in Indigenous communities.

What We Heard:

In contrast to personal benefits of cannabis, the community was often discussed by those who regarded cannabis as harmful to mental health. Individuals who viewed cannabis use as detrimental to wellbeing focused on the harms of cannabis at the social and community level. These included how cannabis may jeopardize others' well-being or lead users to withdraw socially. By contrast, others discussed how cannabis made them better parents and better influences for younger generations because cannabis improved their mental wellbeing. Other participants found cannabis helped them connect socially to others in the community.

Participants' Voices:

Views on roles and impacts of cannabis on the community were mixed among groups. Inuit expressed negative impacts cannabis has had in their community. Similarly, First Nations expressed mixed opinions on the impact of cannabis in their community. Northern, Métis, 2SLGBTQQIA+, and First Nations expressed an interest to explore further the role and impact of cannabis in their communities.

Northern:

"Cannabis may not be Indigenous to us, but it's important to look at its history and use with Indigenous perspectives."

Métis:

"The stress of not having clarity of identity—cannabis use was a means to find community for me. Having a good relationship with cannabis and seeing it as a medicine, and how can we use it as a coping mechanism, for [helping] that feeling of being lost as a young person. This is an important part of the relationship."

Inuit:

"On a community level I've seen social benefits, but I've also seen social exclusion—and it could lead to benefits but also lead to jeopardized health of others. My mother has been strongly against cannabis and believes that certain people that have used it, she made stories and assumptions about them. She saw my birth father use cannabis regularly and saw his mental health spiral, and she thinks that cannabis

use leads to other addictions and substance use. So, she's adverse to cannabis use and assumes those fates on me."

"I think there is a harmful relationship between cannabis and mental health. Issues that arise, that I've seen in my community, are a significant decline in wellbeing—physically and mentally."

"I think in my community, it would harm them if they choose to buy cannabis instead of buying food or paying bills or rent. I have seen some people buying cannabis instead of buying formula for their babies. In that effect, it harms the babies and the people around them."

"Harmful results of using cannabis leads to all of these negative effects on one's physical health, mental health. It negatively impacts them economically because [of] the high prices of general items, as it is, but adding an addiction on top of that is devastating. Also, socially, because there is so much trauma in our communities about addiction that it can be traumatic to have a family or friend who is addicted to a substance, which results in loss of those significant relationships."

"[G]rowing up, I've had people close to me be harmed by it: Daily addictive use of cannabis. Not only their [lung health] but just socially, not wanting to pursue a lot, or not being able to go anywhere without cannabis."

2SLGBTQQIA+:

"Indigenous ways and in our own terms. Research done in a healing way, a retreat on the land. In order to have this research, we should have a committee with people who actually consume cannabis and have people from our community on this research team. A healing on the land. This approach is much more important to establish before we write the proposal. Real-time research and nothing about us, without us."

First Nations:

"At Friendship Centres, they say to refrain from using cannabis, and I think there needs to be better info, and not just abstinence. Elders have said that you shouldn't use cannabis, but other Elders have said that it's okay. Mixed opinions."

"[O]ur Elders, what do they think about young people taking cannabis? On a cultural

level? How does it work with our protocols? We need to share our old ones' voices about it. For example: My community opened an on-rez [reserve] dispensary, and some people didn't like this."

"The effects on our dry reserve—we have had to ban people using drugs from our reserve because it's causing harm on our reserve. They suggested a medical dispensary, and there have been negative opinions. Having a dry reserve and having a balance between giving people what might make their lives better. We haven't figured out a solution yet. We want to help them without putting them in harm's way."

6.2.4. CANNABIS AND INTERGENERATIONAL TRAUMA

A key theme throughout the engagement sessions was the idea that cannabis could help participants face a colonial, and often cruel, world. For many participants, their struggles with mental health, stigma, and racism were part of a larger struggle related to intergenerational trauma, which refers to trauma resulting from the historic and ongoing mistreatment of Indigenous Peoples passed down through generations.

What We Heard:

Many participants spoke of negative impact of intergenerational trauma on themselves, and how in some cases, cannabis can help them cope with this trauma. They expressed interest in learning more about the role CBD and non-psychoactive cannabis could play in addressing intergenerational trauma. Some participants shared they already used cannabis to help with their experiences of intergenerational trauma. Participants discussed how in this way, cannabis use may have more widescale positive effects on Indigenous communities when used with education and open conversation. However, it was also noted that there are significant barriers to using cannabis for intergenerational trauma, especially when HCSPs do not have robust understandings of intergenerational trauma, or understandings of ongoing harm of colonization on Indigenous individuals and communities. Indeed, participants shared experiences where their intergenerational trauma, such as from Residential Schools, was dismissed by HSCPs. In this way, participants said it was often up to themselves to convince professionals about validity of their experiences of trauma and how the choices they were making regarding cannabis use were ultimately beneficial.

Participants' Voices:

Across all groups, cannabis was seen as being helpful to cope with trauma. The Métis and Inuit groups said being ignored, or devalued, by HSCPs when asking to use cannabis for trauma can be a form of re-traumatization. Northern, 2SLGBTQQIA+, and First Nations groups called for a deeper understanding of complexities of trauma, in relation to cannabis use.

Northern:

"For an Indigenous person, trying to find what's right to use, is missing. Motivation in using cannabis is a big question with our collective trauma. Where does the research begin to answer these questions?"

Métis:

"I discussed with family doctor, and I have young children. I have anxiety, and so does my significant other. My now-ex family MD dismissed cannabis and suggested pharmaceuticals. He denied the damage from Residential Schools. It was a horrible experience."

"I'm worried about talking to them about it. I think that they may brush off my concerns. Having my trauma brushed off over and over again makes it much worse. I haven't had the courage to talk about it with any of them, and I don't feel that I have strong relationship with them to discuss."

"I think, due to a huge prominence of generational trauma, marijuana has the potential to be very beneficial for our peoples if that use comes with the education, community de-stigmatization, and a lot of open, honest, conversations from a young age!"

Inuit:

"I think doctors and social workers, especially down south, they need to be more educated on the traumas and history and so that they can understand why we use cannabis, rather than just saying, 'It's an addiction.' They don't consider the intergenerational trauma."

"The budget, and the money going out to different programs, has made it difficult for us to get help with cannabis. There's too much racism and not enough help with dealing with trauma."

"The changes in my lifetime, for example: From Residential Schools, to having to go to university, to get jobs—[cannabis use] has been great. I know people with PTSD, and they use cannabis to get them through their days."

2SLGBTQQIA+:

"The world we live in now is so colonial, and feel that I can bring my full spirit, but with cannabis, it allows me to communicate with my full spirit and be in this colonial world. I am able to do these things because I smoked cannabis. When I smoke, I instantly feel that I am holding my inner child's hand and my spirit's hand and feel that I am ready to walk through this colonial world."

"I think there's definitely a relationship to be had with mental health and cannabis use, but I don't think it's as simple as beneficial or harmful. … [I]t all comes down to the person and their mental illnesses and their personal consumption. It's really easy to abuse our crutches as people who have mental illnesses and may have generational trauma."

First Nations:

"Trauma, just in general, all the intergenerational trauma. Underlying, we all have this trauma, as well as our own personal life trauma. I find providers only want to address the one problem, but we're complex and have more problems than just one."

"HCPs are looking at us individually, but we have collective trauma that's so complex."

"[I]t is beneficial to Indigenous People in Canada. All of us have inter-gen [intergenerational] trauma … For me, taking gabapentin, Seroquel was harmful, and I want to see cannabis being prescribed for Indigenous women instead of these pills."

6.2.5. CANNABIS AND EXPRESSION

The connection between cannabis use and expression was another important theme discussed regarding using cannabis as Indigenous People. Participants talked at length about cannabis, self-expression, and autonomy in healthcare.

What We Heard:

Some participants said cannabis helped them feel more themselves than other mental health treatments, such as psychiatric medications. Cannabis, as a tool for self-expression, was addressed by some participants in relation to their Indigenous identities. Some participants said cannabis helps them cope in social climates that make it hard to be Indigenous. Others shared how cannabis helps them deal with feeling disconnected from their community, which is an experience many Indigenous people share due to Canada's ongoing histories of displacement and erasure. A theme of self-expression was especially prevalent among the 2SLGBTQQIA+ participants, who shared that using cannabis for self-expression, and dealing with being ashamed of who they are, made them feel empowered, with autonomy over their health and well-being. In this way, research participants saw using cannabis as a way for Indigenous people to have autonomy over their health and experiences, which had broader cultural and community benefits. Some participants thought that openness around cannabis use and its contributions to improving mental health could also help others.

Participants' Voices:

All groups said cannabis use could be a tool for self-expression—developing a deeper connection with oneself and culture.

Northern:

"I was diagnosed with PTSD, and I had to use antidepressants to get through. I didn't like how those made me feel, so I had to look on my own for a holistic alternative to help me feel more like myself."

Métis:

"Sometimes I think I use because I have a void where my culture should be. I'm a bit disconnected from family and Traditional Territory. I should be going to ceremony, learning about cul-ture, but those things can be hard to find, and it's easier to smoke and feel better."

"I think that as women, and mothers, we're the holders of secrets, caregivers, the ones in the family that deal with the most. I prefer a natural means than pharmaceutical means, that doesn't seem to leave me feeling like me."

Inuit:

"It's a layered relationship and social factors, like stigma and shame; but on a personal level, there's a sense of self-determination on my mood or stress levels. I find it lowers the sense of self and shifts focus away from those."

"I've seen it be used in a self-determination way for women."

2SLGBTQQIA+:

"[Cannabis] can be very beneficial for our Two-Spirit community. I know people that medicate before they perform drag. And it helped them remove the layers of conditioning that made them feel ashamed about being Two-Spirit. Medicated, with the right medicine and doses, it can help us be our true selves and be comfortable."

First Nations:

"I want to feel my feelings and not be zoned out by medications so that I'm aware. That's why I also don't use any other drugs or drink."

"I have issues, but I am also a powerful Kwe warrior, and my mental health doesn't define who I am. When everyone in my community sees me, I make them aware of how I'm feeling as well, and they understand and respect that. I am willing to share

everything because it took me a long time to love myself. I'm learning to love me so

that I love others. Years went by, and now today, yes, I can say I love everything about me, and I accept me for who I am—and everything I went through, and I learned. I walk with pride for my younger generation."

"I want to have control and autonomy over my body."

6.3. SAFE USE

6.3.1. HARM REDUCTION

Harm reduction refers to policies, practices, and programs that limit the harmful effects of drug use, drug laws, and drug policies (see, for example: Klein, 2019). In the context of the Sharing Circles, harm reduction refers to prioritizing drug users' safety, ensuring access to a safe supply of cannabis, and using cannabis as an alternative to other substances in addiction treatment.

What We Heard:

Participants in all Sharing Circles discussed cannabis use in the context of harm reduction. As a harm reduction tool, participants spoke at length about how cannabis was helpful for those coping with addictions. Participants described how cannabis was beneficial in this regard because it is less harmful than other drugs and alcohol, including fewer adverse side effects and reduced risk of overdose. Participants further discussed experiences that help them stay sober after attending a treatment program. Some participants suggested that HSCPs working in the areas of addictions treatment should incorporate cannabis as a treatment option, just as they prescribe and offer other harm reduction medications such as suboxone, methadone, and hydromorphone.

Participants' Voices:

All groups highlighted benefits of cannabis as a tool for harm reduction. No distinctions between groups were identified.

Northern:

"[I]n my community there's a lot of addiction. I find people use [cannabis] as a crutch to get better, as harm reduction. It's a crutch that people use to get clean; I see that as a positive. Then eventually, they can get sober and move away from their addictions. In the meantime, they can use cannabis for their addiction."

"In general, [cannabis] is beneficial. Looking at how [people] react to alcohol to compare—alcohol affects [people in] more different and more extreme ways. When people smoke, you don't go home and [become violent], you raid the fridge, so I see cannabis as much less harmful compared to alcohol and drugs that destroy lives. So, I want to see less stigma and more resources and information about cannabis."

Métis:

"I'd like to see these injection sites with more cannabis information. I think it would be better to use instead of suboxone and opioid replacements."

"I'm currently in a community support work program and discussing mental health and social rehabilitation. We talked about harm reduction, and for me, I am an avid cannabis smoker. Currently in recovery. Cannabis has helped me maintain my sobriety and stay off of hardcore drugs."

Inuit:

"I think cannabis is overlooked as a harm reduction tool."

"I personally think it's a benefit because it's an option to deal with stress and PTSD in a way that doesn't have as many harmful choices."

2SLGBTQQIA+:

"I've seen it benefit my own siblings who are coping with using other substances. When they are ready to get off those substances, they call me, and they use cannabis to help get off them and help the withdrawal."

"After treatment, I continued to drink, and I still have alcohol. I really understood that if I continue to use alcohol, I would've been back to using cocaine. And cannabis has never once given me any sort of feeling that I would go back to that path of heavy [drug use]."

First Nations:

"I've had clients quit drinking by using cannabis, and it was much better for them economically, health, and socially."

"Since moving to another town without cultural resources and thinking about whether I should be open about cannabis. I used to have addiction to opioids, and I am getting support from cannabis."

6.3.2. AVOIDING DEPENDENCY AND MISUSE

Though many participants saw cannabis as a harm reduction tool and beneficial to mental health, others expressed awareness that cannabis can cause harm and offered suggestions for avoiding misuse.

What We Heard:

Participants saw cannabis as harmful if people develop dependencies on it, or if their use impedes daily functioning or impairs mental health. Many participants saw cannabis use as problematic when used to "escape" or "numb" oneself, and avoid addressing underlying issues. Notably, many participants expressed that they turn to cannabis because they experience barriers when accessing professional mental health support.

One of the most important ways to ensure healthy use of cannabis discussed by the participants was to have their use supported by their communities. Some participants thought that more support from HSCPs who could help monitor cannabis usage and would help avoid misuse. In wanting to access professional support for safe cannabis use, participants emphasized that health professionals need to listen to their patients' experiences and seek to understand without judgement.

Participants' Voices:

The groups were unanimous in understanding that cannabis use can be harmful, but cannabis can also be beneficial when monitored. There were no identified distinctions between the groups.

Northern:

"[I]f it was possible to go through a doctor for cannabis, then they could work with you for dosages and how to use properly. It would have been better to have someone monitoring my use at one point when I used heavily. … Having someone monitoring it would help keep everything in balance."

"I think that it's more harmful than beneficial because, in my community, I see it become more of a crutch. And sometimes needs to smoke it before I do almost any activity. … I see people using it before work and things. I have a friend who harmed her mental health with cannabis and had to stop. I think it becomes a mental and emotional crutch for some people who need it to relieve stress at the end of the day."

"[Cannabis] was harmful in that it was a coping mechanism and avoidance method. Not dealing with feelings and core issues."

Métis:

"For me, it's a balance. Anytime I've allowed myself to overuse, I notice my mood is lower. If I use it in a more regulated way, it definitely helps with anxiety and sleep issues."

"I believe there is definitely a connection between the two. In terms of [cannabis] being harmful or beneficial, I don't think it is that black and white. I've personally experienced both beneficial and harmful effects, and I think balance is important to preventing the latter. … It could be a negative coping skill, but for others, it could be used for relaxation and pain relief."

"Depends. [Cannabis] can be both [beneficial and harmful]. How are they using it? And how you use anything and the intention. Are they using it all the time to escape from problems, or is it a helpful tool to help cope?"

"When does the use become problematic? Using it to a point where it consumes your life, and it can be beneficial when using as a larger plan for health. Know yourself and what are the purposes that you're using cannabis for—for chronic health, or acute mania, and mental health to calm down. Or when used harmfully."

Inuit:

"I think, in general, it is negative, because many Inuk women, girls, and gender-diverse people are using it as a means of escape; not necessarily a positive way to seek change in behaviour or their lives."

"I have seen people use cannabis in the extreme to numb trauma or undisclosed mental health issues."

"I have seen community member misuse cannabis to an extent where they spend an absurd amount of money to fuel their addiction to smoking or vaping cannabis. They seem to smoke numerous times a day to avoid being with their own thoughts, and this has taken a toll on their families and work lives."

"Use and misuse—better understanding of what they are, risks versus benefits to mental and physical health. The benefits cannot be ruled out. Once someone is having negative symptoms and mood changes because they didn't get their cannabis, then well, it's a misuse. We need both good and bad in a balance."

2SLGBTQQIA+:

"Maybe part of it comes to the intention of using it—using it to 'numb' versus using it to help pain, etcetera. There have certainly been times when I used cannabis, and it was with a harmful intention: To numb myself. Or, I have done too much and ended up feeling super sick or paranoid."

First Nations:

"[I]t can be harmful when someone doesn't know how to use it as a tool, and they can get cannabis use dependence and use it just to party instead. When used irresponsibly, it can be harmful."

"I see dependency occurring along with PTSD and depression. Are they dependent on cannabis because of the other stuff in their lives? They could be coping with personal issues in their lives, [which] causes dependency on cannabis."

"Growing up, I hung out with guys who used cannabis but didn't use it the proper way. They used it to medicate themselves against life. They went on to harder drugs. It's sad that they didn't know how to use cannabis in a positive way. They moved on quickly to hard drugs that ruined their lives. We didn't want a drug to take over our life the way we saw it take over their lives. Now that I learned more, I'm more open to cannabis, and I see that it can be used medically."

6.3.3. SAFETY OF CANNABIS USE BY YOUTH

Participants in all engagement sessions expressed concern about cannabis use among youth. These concerns focused on the safety of cannabis use among youth, with participants calling for access to research on this topic, offering suggestions for reducing harm to youth.

What We Heard:

Participants said when they saw cannabis cause harm to youth, it was often because of misuse. Others wanted to see further research on the effects of cannabis use on brain development of youth, including immediate impacts on brain functioning and long-term effects of prolonged use after beginning cannabis use at a young age.

To reduce harms of cannabis use among youth, participants discussed wanting additional information and resources about how to talk to youth about cannabis. Participants emphasized the need to provide youth with reliable information about cannabis, including reasons to help manage their use. Participants also emphasized the importance of open, judgement-free conversations about cannabis use with youth, stemming from a harm reduction perspective. In these conversations, participants

did not advocate that youth should use cannabis; instead, they advocated for access to knowledge to foster informed decision-making and responsible autonomy.

Participants' Voices:

Northern, 2SLGBTQQIA+, and First Nations participants highlighted the importance of offering information about cannabis use to youth. First Nation, 2SLGBTQQIA+, and Métis participants felt it essential to ensure youth have access to safe, untampered cannabis. Inuit participants shared the most significant concerns for the harms of cannabis on youth.

Northern:

"There is a lack of resources for them [adolescents] to get information to seek help. And their source of information is their peers, which I don't think is always the best route to go."

"As a teen, if I had known more about cannabis and how my brain was developing—I probably started out using cannabis for the wrong reasons—and if I knew more, then I might not have started so young. My grandchildren, I've been telling them to wait a couple more years so that you'll be in a better place to use cannabis, and asking them questions about why they want to use it. When I was younger, it was just 'pot,' now we have CBD, oil, edibles, and knowing more about these different forms would have been helpful."

Métis:

"We should be able to have safe, accessible drugs, and especially for the kids' sake. Working with children, we need to take every protocol and take them to the hospital even if they're only smoking a joint."

Inuit:

"What are the effects of cannabis on our people and our communities? What about when 80 percent of people smoking cannabis use [it] in the house, and then it affects the children's brain development? It's something that we need to look at because, in the past, it was hush-hush and not looked at."

"High school students who smoke cannabis are unlikely to go to class."

2SLGBTQQIA+:

"One area of research would be generational relationships with cannabis. Because I know my parents' generation has a different relationship with cannabis than I do. And now, young people will be different as well. Different generations have different relationships with cannabis. I was an alcoholic in my life, and cannabis, in comparison or contrast to alcohol, has been a gentle healer and beneficial medicine—a friend. Alcohol was never a friend for me; it was a destructive enemy for me. Growing up queer, Métis, and Two-Spirit, as a weird little kid in rural areas—seeing my community and family abusing alcohol—I grew up with these relationships and start[ed] using cannabis. I was worried because of my relationship with alcohol. But, I don't feel like I'm addicted to cannabis, and it has been a gentle friend and healer. So, as a Two-Spirit Indigenous person, it has been beneficial for me. And I wish I could have been introduced to it earlier in my life, and maybe I could've avoided some dark, destructive times using alcohol."

"The only harm I can see in my community is the children that suffer from weed laced with other things and not getting the proper information they need to use safely. I think more could benefit from it if it was properly taught to them."

First Nations:

"For my daughter who's 15, she also smokes; it could be a phase that she's going through and figuring herself out. I asked her directly if she uses cannabis, and she said yes, and I didn't say anything else to her. She was open with me because she knows that I have a mental health issue, and she doesn't lie. So, I asked her where you're getting the cannabis and how you're smoking it, and she's getting random buds from friends, but I told her that I don't do that. They use an empty pop can and smoke cannabis with that. We're very open with each other. I respect that she tells me the truth. I buy her indica, but we don't smoke the same cannabis, and I know where her cannabis comes from now. She prefers using a bong, and kids are going to do what they're going to do. So, I listen and have conversations with her. I told her that you need to continue school and take care of yourself, and I don't know if she will continue for a long time. I agree that it's not the best choices, but I'm open with her. I'd rather her be upfront with [her cannabis use] and not behind my back."
"I never discussed with anyone; however, I think it really would have been helpful

to have felt comfortable about it, especially as a young person who wouldn't have necessarily known a lot other than what you hear from friends. It could have been a safer experience with proper guidance and warnings, etcetera. I think, when I was younger, it could have been used in a helpful way when I was really struggling with anxiety."

"I think how it impact younger populations since legalization. They are impacted intergenerationally. How does it impact the young brain in the long term?"

6.3.4. INFORMATION ABOUT CANNABIS USE

Participants said having access to reliable information about cannabis would help them use it safely. While this research and data does exist, it was clear in participants' experiences that this knowledge is not easily accessible, nor does it reach all audiences. Thus, there is a significant gap in knowledge transfer about cannabis use.

What We Heard:

Some participants wanted to know more about the safety of cannabis use for their physical health, including harms of smoking and second-hand smoke. Concerns were expressed regarding the safety of using cannabis, while managing pre-existing health conditions including diabetes and mental health conditions such as schizophrenia. Participants also discussed the importance of further information on the safety of using cannabis in combination with specific pharmaceutical and illicit drugs.

Many participants said they wanted further information about relationships between cannabis use and reproductive health. For example: Participants were interested research on the effects of cannabis on the cycles, and onset, of menstruation in youth. Others wanted to learn how cannabis affects fertility, fetal brain development when used during pregnancy, and how cannabis use during breastfeeding can affect babies' health and development. Participants said they wanted more research from a harm reduction standpoint on relative safety of using cannabis versus pharmaceutical medications to help with anxiety during pregnancy.

Participants also wanted accessible information and guidance on using cannabis, including details on dosages, strains, and forms of cannabis. Several participants shared detailed knowledge about using cannabis, especially those who have experience working in the cannabis industry. However, participants also emphasized

potential risks of harm and financial costs when individuals are left to figure out how to use cannabis without safe guidance. Thus, it is vital that information on cannabis use is accessible for everyone.

Participants' Voices:

All groups expressed a need for more information about the effects of cannabis use. Below are many different topics highlighted by participants, none of which are consistent enough to develop a distinction between the groups.

Northern:

"I want them [health care providers] to refer me to resources that are evidence-based and not bi-ased."

"People I've talked to at dispensaries can't give me medical advice, so I want more research and more information so I can make informed decisions."

"I would like to know how certain strains are helpful for different things."

"Access to how to find good information is needed."

Métis:

"More research, and not so much fear, so that you are able to make informed decisions. [S]tudies on use for anxiety, depression, and stress relief, pain relief, sleeping."

"I would love if I could have an open and honest conversation with a GP, maybe giving me some guidance and insight about what products could work for me and which ones to avoid. And, just some guidance on how to make medicinal marijuana beneficial for me, rather than navigating it myself through trial and error."

"End of life, hospice care, and people that need it for the end-of-life diseases like cancer and MS. I had family members use cannabis at end of life for these reasons."

"How it impacts brain dev [development] in young people. Since it's legal in AB [Alberta] for as young as 18 years old. How does this affect serotonin and prefrontal cortex dev [development]?"

Inuit:

"More info about edibles and risks. We need more info about the different product and ways to take cannabis."

"I would want to hear about frequency and safe practices and how to use cannabis for benefits like sleeping or anxiety, asking whether it would be safe through pregnancy or breastfeeding. What is cannabis effect with long-term romantic relationships and whether it would be positive or how to mitigate risks?"

"Reproductive health and cannabis—effects on unborn child."

"Different forms of info visual or in-person meetings to get support. Easy access to help people open-up. Modelling health behaviour and it's okay to talk and open-up. Create space for people to share."

"More studies on menstrual cycles and how smoking cannabis affects it. For youth: Does it af-fect when they get first period? Does it affect breastmilk? Fertility? Does it affect future concep-tion chances?"

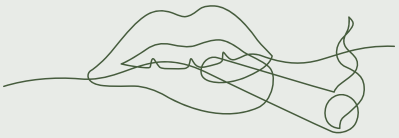
"Specific cannabis strains for specific personal outcomes—long term effects of cannabis use."

"Definitely the link between cannabis and schizophrenia. As well as more information on certain strains to see whether or not you can benefit from that particular one."

"I would like to know if there is a relationship with cannabis use and depression and obesity."

"I think that people need to learn more about the benefits. There's so much misconceptions and has been for far too long within our Inuit communities. It's time to talk about how beneficial cannabis use can be when used safely. It takes a while to get the right kind of cannabis to use for whatever is happening to the body, mentally or physically."

"I think the education around cannabis use for medical needs amongst the older generation is needed."



"Effects of second-hand cannabis."

"There may be info out there, but it's not accessible. How can we make the info easier to get, understand, and how can we share this good info?"

2SLGBTQQIA+:

"Medicinal properties need to be further explored. This plant has the potential and abilities to do so much more. … Studies into long-term usage, and more clinical research, as well as research that collaborates with a diverse population of individuals. Anything that helps people understand their own usage, benefits, and risk in all aspects of using—casual, regular, long-term, etcetera—so that everyone can make informed decisions about what is best for them."

"Cannabis pros and cons in relation to ADHD, anxiety, PTSD, etcetera. Dosing and mental health. Using cannabis as a treatment therapy for different experiences with substance use disor-der. Possible complications with other substances, for example: Cannabis and MDMA, or other 'party drugs,' or cannabis and SSRIs, cannabis and opioids, etcetera"

"Plus one for cannabis and SSRIs, MDMA, opioids."

"I also feel there needs to be more research into how cannabis works in combination with anti-depressants and anti-anxiety medications."

First Nations:

"[Want information on] differences in cannabis consumption methods."

"The different strains and what the effects are for different people. The strains will have differ-ences for different people. I like Indica for chronic pain, and I can go all day. Someone else, [it] might put them out. But for me, Sativa doesn't work for me. There needs to be more teachings so that people understand that some people will need different types to help with their problems. Now, I don't take any cannabis if I don't know what it is exactly. Different cannabis types for scenarios, problems, people."

What criminal activity happens with ppl who are only taking cannabis? Most studies are focused on alcohol and a combo of other drugs. Does cannabis actually impact criminality?"

"[W]hat are the pros and cons comparing the medications versus cannabis for your health prob-lems? We need more info to help ppl make these decisions."

"Cannabis and diabetes."

6.3.5. ACCESSIBILITY OF CANNABIS

Participants across all focus groups discussed how the accessibility of cannabis is related to safe use. Topics about accessibility included receiving prescriptions for medical cannabis, costs of cannabis, availability of licensed distributors, and access to safe supply.

What We Heard:

While participants discussed the importance of having access to supportive HSCPs to ensure they use cannabis safely, they also described barriers they faced when attempting to access this type of support. Some participants discussed the high costs of medical, or legal cannabis, as a barrier to safe use. For others, even if cannabis was helpful to their mental wellbeing, the cost of cannabis caused economic harm to individuals and families. When participants could not use health insurance to cover the costs of cannabis (for example: If they did not have a prescription for cannabis use), the expense of cannabis was experienced as a barrier.

While many participants discussed how purchasing cannabis from licensed distributors helped ensure they were accessing a safe cannabis supply, participants also discussed how financial costs of cannabis at licensed distributors were prohibitively expensive.

Other participants, particularly those from the northern and Inuit Sharing Circles, shared that they lived in communities with few cannabis retailers, which meant they had limited options for purchasing cannabis legally. Participants shared that when people cannot access cannabis through licensed sellers and retailers, they may turn to other, non-legal, sources that are potentially less safe. Participants from all Sharing Circles discussed concerns that cannabis purchased from illicit sources might be contaminated, or laced, with potentially dangerous drugs such as fentanyl.

Participants' Voices:

All groups advocated for access to cannabis through an HSCP and licensed retailer instead of other sources. The Inuit group highlighted the high cost of cannabis in their area as potentially debilitating when not supported by their HSCP.

Northern:

"I was lucky as soon as I gave my reason for wanting to get my medicinal license, my doctor was very receptive of my feelings and got the paperwork done right away, but I had been with her for years prior to talking to her."

"I haven't had a conversation with a doctor about cannabis, but I want to hear about how to get a prescription for medical cannabis. I smoke to relax, and I think it's more positive to use it that way. I don't think that I could get a prescription."

Métis:

"And with fentanyl crisis—it means that all street drugs could be contaminated. We should be able to have safe, accessible drugs. … People that use drugs need help too, and we need to support safe drugs."

Inuit:

"It's all about access. Access to cannabis, availability—to the person in their community—access without the shame or stigma. There not enough info about the process."

"Also, high prices of cannabis up north. Not all communities have a bank or have a credit card to use online, and there are many barriers."

"Food is very expensive in the north. People are choosing between their medical cannabis and putting food on the table. Especially with women, because they have more family responsibilities."

"The remoteness means that there's only one cannabis outlet in Nunavut. So, this means everybody's going to the street dealer."

2SLGBTQQIA+:

"I'm fortunate enough to have a family doctor here, but she won't prescribe me medical cannabis."

"I would suggest that it's the lack of coverage of cannabis by insurance providers that stops a person from obtaining a medical document. There's no point in getting such document if it's worthless. Not to mention it's A LOT cheaper, and better getting it from black market."

"We need to have fair and equal access to coverage for this, insurance wise. Or affordability of weed."

"I know a lot of people who have benefitted from cannabis. But there's something to be said about access to safe drugs. I remember going to a dealer's house to buy drugs but think of things that could've happened to me. Laced drugs. One time I was a teen, and there was this bag of crushed pills in it. And they wanted me to smoke it in front of them, and I said no. I brought it home and threw it out."

First Nations:

"I used cannabis medicinally for over 26 years, and I'm HIV positive, but I need to find a designated grower in BC. You need to complete forms and get your license in BC. There's so many different hoops and different methods to get cannabis. There's cost as an issue, GST fees. You don't need to worry so much about these issues when using a grower. Also, getting organic so that it's better."

"I'm glad that now I don't have to use drug dealers, and I can go to the dispensary instead, so I know what I'm smoking."

"Mixed beneficial if used in good ways and if not using black market products that could be lace. Like, buying from the street dealers, that can be laced with horrible stuff that can be really bad and cause overdoses. This is why I don't smoke joints anymore, since you don't know what's in it and whether it was bought from the street."

6.4. MENTAL HEALTH

Many participants shared how cannabis has aided in coping with mental health conditions and symptoms, stating that it helped them feel autonomous and in control of their health. The use of cannabis for managing mental health conditions and/or symptoms was explicitly stated as a tool for helping with various disorders. Whether cannabis was used in conjunction with other treatments for the various conditions is unknown. Some said they used cannabis under guidance from HSCPs.

Given the focus of this project, we recorded the number of participants who self-disclosed mental health challenges in reference to their cannabis use. Participants were not asked to detail their health backgrounds explicitly, nor were they required to have received a diagnosis; therefore, extrapolations of the occurrence of the health conditions mentioned below cannot be made. A complete representation of this data can be found in Appendix 10.2.

In all groups, the most prominent condition individuals mentioned was coping with anxiety symptoms, which was mentioned 33 times throughout the conversations. The following conditions and symptoms were also mentioned as being managed by cannabis: Pain or chronic pain (27 references), depression (22 references), addiction or harm reduction (20 references), post-traumatic stress disorder (PTSD; 20 references), and trauma (11 references). Other conditions mentioned between five to 10 times as being managed by cannabis use included (in descending order): Schizophrenia, stress, insomnia, bipolar personality disorder (BPD), and attention deficit hyperactivity disorder (ADHD). The following were mentioned as being managed by cannabis fewer than three times in the conversations: Fibromyalgia, lack of appetite, irritable bowel syndrome (IBS), multiple sclerosis (MS), endometriosis, menstruation symptoms, human immunodeficiency virus (HIV), obsessive-compulsive disorder (OCD), fetal alcohol syndrome (FAS), agoraphobia, mania, psychosis, and epilepsy.

6.4.1. RELIEVING SYMPTOMS

Many participants in this research indicated that cannabis was beneficial in helping them cope, manage, and function better with pre-existing mental and physical health conditions.

What We Heard:

Participants discussed how cannabis helped them relieve symptoms of mental health conditions, which directly improved their mental health. Participants also shared that cannabis use reduced symptoms of physical health conditions such as chronic pain. It was described as beneficial for mental health because it helped to "regulate," feel "normal," and stay balanced. For these participants, cannabis was a proactive tool to keep mental health balanced, rather than a substance that treated specific symptoms.

Participants' Voices:

All groups revealed that they had used cannabis to relieve symptoms. Below are some uses highlighted by participants, none of which are consistent enough to develop a distinction between the groups.

Northern:

"I think that, based on my personal experience, I use cannabis myself more for relaxation, depression, and ADHD. So, that is how I've used it primarily, and I used THC in certain points in my life for these things. Other people in my life use CBD regularly for joint pain, and I have taken it before. I know that yes, it does affect your mental health."

"For Postpartum Depression [cannabis] got me through that, nothing but beneficial and helped me a lot during this time."

"Most of my use has been for anxiety; I have a cycle of when I get anxious: I can't sleep and then if I can't sleep, I get worse. Cannabis has helped me for that, and I've found cannabis to only be beneficial to me."

"I would like to say that it is beneficial for me due to my health condition, which is epilepsy.

It really helps me with anxiety, PTSD, depression, and pain, but at the same time not. I'm on a fixed income and can't afford medicinal, and when I go without for roughly 36-48 hrs [hours], I can feel it. Similar feeling to missing medications."

Métis:

"I was given a prescription with no problems, for weed and for CBD/THC oil. That really didn't work, though. My therapist prescribed THC pills, and they work. I have fibro, PTSD, double depression, and a bunch more medical diagnosis."

"I had a similar experience a couple years ago with a psychiatrist. I have DID (dissociative identity disorder) and I had been using other drugs and instead of the cannabis, which helped the anxiety etcetera. He put me on Seroquel, and [it] wasn't a pleasant experience. Now I use cannabis to control it instead, but without a RX [prescription]."

"I was given prescription for CBD and THC through therapist. For fibro, depression, and other issues."

Inuit:

"I know people with PTSD, and they use cannabis to get them through their days."

"For mental health situations like anxiety, it would be beneficial for it."

"I feel the good benefits of smoking; it's good for pain and calming for me, anyway."

"Cannabis has many useful benefits that help ease with stress. CBD for pain and to relax or to keep busy depending on using Sativa or Indica."

"Yes, it has a good effect on people who often have schizophrenia. Cannabis can make him happier, relaxed, and talkative, or laugh more than usual. You may find that the colours and music are brighter and clearer. The pleasant effect is called 'high.'"

2SLGBTQQIA+:

"I use in a responsible manner. And I have chronic pain, nerve damage, and over the last two years, I've been learning to enjoy CBD more, giving me more physical pain relief. So, it helps my mental health because of that."

"Myself, it has particularly helped in a positive way as it reduces my anxiety, PTSD and IBS. It has also helped in other situations. Being a 60s Scoop Survivor, I get a lot of PTSD, and this is what works best for me."

"Having many mental health issues, cannabis use helps with my depression, definitely."

"I have suicidal ideation, BPD [borderline personality disorder], depression, PTSD, and social anxiety. Cannabis works for all my symptoms."

First Nations:

"I also use cannabis daily because I feel too anxious, and my energy level is always too high. When I smoke, it lowers the energy for me."

"I used [cannabis] for anxiety and joint, muscle pain from fibromyalgia."

"I use cannabis so that it helps me eat and sleep, and also with my agoraphobia and social anxiety. When I smoke cannabis, it helps me."

"[M]y kids who have dealt with suicidal thoughts and eating disorders, they both use cannabis vaporizers and edibles, and they don't have the suicidal thoughts, and they're doing better now. Sometimes I think it has saved mine and their lives. If I didn't have cannabis, I don't know what I would have chosen instead."

6.4.2. COPING WITH CHALLENGES

In addition to alleviating symptoms of mental health conditions, participants also discussed how cannabis can help them cope with mental health challenges.

What We Heard:

Participants said cannabis is helpful because it helps them relax, calm down, improve mood, and alleviate stress. In this way, cannabis was described by participants as a coping tool that helped them get through their day or deal with particularly stressful life circumstances. For example: Some participants discussed how they have been using cannabis to deal with increased anxiety during the COVID-19 pandemic. Some

participants also found cannabis helped with their daily functioning, including eating and sleeping, which positively impacted mental wellbeing in circumstances that were otherwise out of their control.

Participants' Voices:

The groups were unanimous that cannabis could be used to cope with challenges. No distinctions between groups were identified.

Northern:

"Since COVID-19 started, I've been using more because everything has been making me more anxious and out of control. It has been a coping strategy."

"I think there are many benefits, and I hear more positive things about using cannabis to get through hard times."

Métis:

"At nighttime [cannabis] helps me relax and get a good night's rest."

"I work in a recreational dispensary in a heavily Métis populated area. I have discussions every day with Métis women and gender-diverse people about how cannabis consumption is helping them maintain their mental in the current social climate that tolls the Métis identity."

Inuit:

"I deal with people who use cannabis to cope. My opinion is: That it's been more beneficial because of the stigma of dealing with social services, or police, and the complex things that come into play."

"We have so much happening right now with COVID and Residential School deaths. We need to help our people now to help with the suffering."

"Eighteen to 24 youth stage, they're out of control stress with university, and early career, and having that self-determination, and using cannabis while not being in an

unstable state ... you can still have that control using cannabis and [it] can be helpful during this high-stress time."

"I have benefited from the use of cannabis in regards to a sleep aid using edible cannabis. And this has helped me get a good night's rest without the use of prescription medication and has had a positive effect on my mental health, especially during COVID."

2SLGBTQQIA+:

"I used cannabis since age 13. It was my support, and the one thing that was comforting to my body and allowed me to eat, sleep, and feel safe."

"I certainly think it [cannabis] is beneficial. It allows me to continue with my day without being overwhelmed with everything."

"Some of the people I've used cannabis with they say it kind of normalizes them."

"A lot of my peers use cannabis on a regular basis, but many people I know use it in smaller doses. I know a lot of queer people who are also neurodiverse and use cannabis to help regulate their mental and emotional health. They take little, tiny, micro-doses, three times a day, and it helps them regulate."

"It was very difficult for me without it [cannabis] because I couldn't use it to help me get out of bed and function."

First Nations:

"Marijuana was the only thing that would help me sleep, eat, and be a little happier because I was really depressed after my son was apprehended."

"Thinking about the maintenance levels and that when I engage in cannabis, because it lets me be active and balance all the levels and things that need attention and learn lessons from."

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6.4.3. CANNABIS AND CONVENTIONAL MENTAL HEALTH TREATMENTS

Participants turned to cannabis for their mental health for a number of reasons. Some participants shared how they use cannabis with other mental health treatments.

What We Heard:

Participants who used cannabis alongside other mental health treatments insisted that cannabis was not a "fix-all," but instead was most beneficial when used in combination with other supports like medication, therapy, healthy eating, exercise, and yoga. Notably, many also discussed how the support of professionals, including physicians, therapists, and social workers, were important contributions as to why cannabis was helpful for them. In particular, HSCPs-trained in supporting cannabis use (for example, at cannabis clinics) helped them learn how to use cannabis safely and effectively to support their health. Participants noted how having the support of even one HSCP can help persuade other professionals of the benefits of cannabis.

Participants' Voices:

Northern, Métis, 2SLGBTQQIA+, and First Nations groups spoke about how cannabis use can be beneficial when used in conjunction with conventional medicine. The Inuit and First Nations groups said dialogue with HSCPs would increase the benefits of cannabis use.

Northern:

"Recently, I chose to bring [cannabis use] up because I wanted to be monitored and find out more information after doing learning on my own about cannabis. Since I

have money for a psychologist and find it helpful along with cannabis use."

"I have a therapist that I have had over a year now. And I've been very open [about cannabis use]."

Métis:

"Someone I know has BPD and BP and schizophrenia and is on medications for moods. Also, she uses high CBD low THC cannabis, which has helped her with emotions and sleep patterns. I've noticed a change in her and have seen that her mania and psychosis and been better since cannabis."

Inuit:

"I think they should know of my use so if my mental health—or physical or emotional health—changes at some point, they have all the facts in order to properly help me."

"I have talked with my family doctors with my use of cannabis to sleep and have a positive relationship with cannabis. And being able to have open dialogue with my doctor, and support from her to find the best fit for my sleep deprivation, which in turns has a positive effect on my mental health."

"For mental health situations like anxiety, it would be beneficial for it. I was recommended to take CBD cannabis, but I haven't gotten around to it."

2SLGBTQQIA+:

"I wanted to add that Knowledge of other forms or methods of healing to couple, or pair with, cannabis use can be super helpful with 2SLGBTQQIA+ who are processing tough emotions and trauma—past and present. When cannabis can be paired with things like yoga, qigong, therapy, art etcetera."

"This summer I started medication for anxiety, and since then I feel my relationship to cannabis has improved, and I use cannabis to help my mental state of mind."

"It is not a 'fix-all,' and definitely not for everyone. Yoga has been really helpful for me, too."

"It helps me tremendously to manage my mental health symptoms—PTSD and depression—but it isn't the end all, be all. Using it in conjunction with therapy and other supports has helped. So used alone, I don't know that it is enough—for me, anyway—for my healing. But it does help me manage unpleasant symptoms and makes that healing journey a lot more comfortable and easy."

First Nations:

"I have bipolar disorder and I've taken medications for many years but the medication didn't work, except for one type of medication. I also use cannabis daily because I feel too anxious, and my energy level is always too high. When I smoke, it lowers the energy for me. I also use Clonazepam. But I'm getting off clonazepam and using Zoloft and cannabis. I use a combination, and this is what I find works for me."

"[W]hen I went into the hospital for mental health reasons, they also ask about my intake of cigarettes or cannabis, but there were no other drugs in my system. They didn't want me to smoke cannabis while I was in the hospital, so they prescribed me medical THC instead. They were supportive of me. … I started walking, and I changed everything that I ate: Cleaner eating, no more pop, or chocolate, or coffee, because they were bad for anxiety. … I feel like I'm 12 years old again. I use cannabis everyday."

"I had to get a surgery that resulted in nerve damage, and now I've moved and have a new family MD. I went to him because the pain was too much, and didn't want to be on prescriptions that can damage my liver etcetera. He suggested cannabis. I don't want to smoke and don't like the smell. He suggested a clinic to go to for prescription cannabis. I see them regularly now, and I found the different strains that works for me. Now I have the option to order cannabis oils or gel caps from the gov [government] medical producers, and I like that I can take as much as I need day to day."

"I think that it would be useful if we knew the different effects and side effects of mental illness that contribute to our condition. While anxiety might not be an official diagnosis, it's part of PTSD, or a bigger issue. So, knowing that cannabis can be used complementary with other treatments to address all the symptoms, [we need] better advice on how to use cannabis well with other types of drugs. Thinking about which symptoms of my mental illness I can address with cannabis. Then we can start to cut out the medications."

6.4.4. CANNABIS AS AN ALTERNATIVE TREATMENT

Participants also discussed using cannabis as an alternative to mental health treatments, especially pharmaceutical medications.

What We Heard:

Some claimed that cannabis was a beneficial alternative to other mental health treatments because cannabis worked better for them than other medications. For many, this was because cannabis had fewer unpleasant side effects than pharmaceutical medications for mental health conditions. For those with personal and family histories of drug addiction who did not feel comfortable taking potentially addictive pharmaceutical drugs, cannabis was described as a helpful alternative.

Another critical theme regarding the use of cannabis as an alternative to other treatments was that many who use cannabis in this way do so because they do not have access to better support. Limited access to professional support was compounded by specific aspects of participants' experiences and identities. This experience was especially emphasized by those living in northern, remote, and rural communities, with limited access to HSCPs and programming supporting mental wellbeing. Lack of support was also compounded for Indigenous 2SLGBTQQIA+ individuals who struggle to find trauma-informed, supportive, accessible, and affordable, professional help and mental health services. In these contexts, not only does cannabis use signal a failure of health care systems to support individuals in their mental health, but the lack of professional support also means users are left to figure out how to use cannabis beneficially, on their own.

Participants' Voices:

The groups were unanimous that cannabis has been beneficial as an alternative treatment. No distinctions between groups were identified.

Northern:

"It's only been within the past year that I've been using it myself, and with ADHD, I've found the medications for it weren't always the best for me. So I'm using some cannabis to help cope with my mental health."

"I felt both beneficial and harmful in my experience. It was beneficial because smaller remote communities, you don't have access to counsellors and doctors, but you have access to cannabis."

Métis:

"I think that a lot of people who have issues with mental health are using cannabis as a treatment instead of taking the prescribed medications, which can have negative effects on you."

Inuit:

"As for the benefits, it would be very useful for anxiety or depression, especially if there's not the much therapist in the communities."

"Although there appears to be some health benefits to some individuals coping with pain, and where pharmaceuticals are not as effective."

"Benefits can be helping people without the use of prescription pills."

2SLGBTQQIA+:

"I personally use it [cannabis] to 'self-medicate,' to help with mental illness. I have tried prescribed medications, but most anti-depressants still leave you with lingering feelings of some darker thoughts. With cannabis and cannabis products, I have the ability to think clearer, perform any duties."

"[I]n general, I think [cannabis] is beneficial. Especially now that it is legal and more easily accessible, something that can't be said for mental health services for a lot of people."

"I started smoking cannabis to save my life. … I use cannabis because I can't get other help."

First Nations:

"[You get] better clarity and energy [with cannabis use] instead of with medications."

"Using cannabis for depression instead of antidepressants."

7. DISCUSSION

The analysis underlying these findings relied on distinctions-based methodology and emphasized differences in experiences. In the context of Indigenous-centred research, this approach is critical to avoid "pan-Indigenous," or overly generalized, understandings of Indigenous peoples as monolithic (Badets, 2018). Instead, this approach positions Indigenous Peoples as distinct individuals, nations, and groups—First Nations, Inuit, and Métis. Using a distinctions-based approach revealed both notable differences and some similarities among the groups. Below we discuss the findings, highlight relevant literature, provide valuable resources, and identify gaps in knowledge.

7.1 STIGMA:

Participants in this study expressed that they experienced stigma from healthcare providers, in the workplace, within their communities, and from some Elders. This judgement was often related to concerns about addiction, and participants identified that it stemmed from a lack of knowledge about cannabis. The ubiquity of perceived stigma among all groups is indicative of two phenomena:

1) Even though possession and consumption are legal for adults, many people still hold negative attitudes about cannabis; and
2) Rampant racism and discrimination that Indigenous People across Canada consistently face.

The most notable distinction among the groups was between northerners and those living in remote areas, who felt that experiences of stigma were heightened in these areas. Participants from both the Métis and Inuit groups referenced stigma toward cannabis within their cultures. What was prevalent across all groups was a desire to be educated, heard, and have health and social care experiences free of judgment.

While cannabis has been legalized since 2018, possession and consumption have been criminalized since 1923 (Ruston, 2021). Thus, the acceptability of cannabis use will take time. There has not been sufficient time for a plethora of rigorous research to occur, and a dearth of myths and stereotypes still exist today (Ruston, 2021). Many northern and Inuit participants echoed this sentiment, discussing how stigma regarding cannabis use is especially prevalent and harmful in rural, or remote, settings. Many shared observations that those living in rural settings generally hold more conservative views about cannabis use and indicated a reluctance to learn.

These were often expressed as negative opinions based on misinformation. In contrast, participants in cities found community members and HSCPs to be more open-minded and accepting of cannabis use. However, participants from all groups spoke of challenges they faced accessing cannabis information from their mental health care providers. Many admitted to withholding medical information from their providers because they feared experiencing judgment. Notably, rural and remote communities often have limited access to HSCPs, including not having permanent providers in their communities, few providers, and high turnover in providers. Approximately 7 percent of physicians in Canada work in settings deemed to be rural, with only 42 percent of physicians identifying as female (Smylie et al., 2018; Royal College of Physicians and Surgeons of Canada, 2019). Having less continuity in care was referenced by participants who reported they could not develop trust and rapport with their providers. These constraints compound the effects of stigma regarding cannabis use because users have limited options in seeking care from other, more supportive HSCP. Mistrust of healthcare practitioners is common amongst Indigenous People given the colonial legacy in healthcare, such as forced sterilization (Wylie et al., 2019). Therefore, HSCPs must do their best to listen to needs and challenges of people living in these communities, particularly regarding cannabis use.

The acceptability of cannabis is complicated by processes of racism, legacy of prohibition, and abstinence models in Canada. Given that racism is still prevalent in Canadian healthcare systems (Phillips-Beck et al., 2020), it is unsurprising that many participants endured stigma related to their race and cannabis use. Indeed, participants indicated they felt the need to defend themselves and their desire for cannabis information against stereotypes of addictions for Indigenous People. For example: After asking questions about cannabis as a mental health treatment, several participants, across all group,s were quickly redirected to addiction services, despite not disclosing challenges with addiction. Additionally, many of the participants who were parenting, experienced intense stigma about their cannabis use and their ability to care for children. They spoke of disparities between the stereotypes of Indigenous mothers who use cannabis to cope, and white mothers who drink wine or use cannabis as a reprieve. Participants highlighted potential consequences of negative views from social workers and child protection workers, which can result in the apprehension of their children. Participants noted this risk is particularly pronounced for Indigenous women, who have historically, and continue to be, disproportionately scrutinized on their parenting (Ontario Human Rights Commission, 2018).

Participants recognized how stigma toward cannabis use impeded their ability to access credible cannabis information and improve their mental wellbeing. They felt that their own knowledge about their wellness and ability to cope was undermined. There was a call for HSCPs to listen to and learn from cannabis users—recognize the ways that cannabis use intersects with trauma—and to value Indigenous experiences overall. To reduce stigma related to cannabis and mental health, participants want more awareness and open communication with their HSCPs, as well as improved access to education, information, and resources related to cannabis and mental health.

7.2 INDIGENOUS EXPERIENCES:

Participants in this study shared how their relationship with cannabis was shaped by their experience as Indigenous People. Some main themes included: Prioritizing Indigenous Ways of Knowing, while questioning Western medicine; using cannabis as Traditional Medicine and encouraging HSCPs to consider colonial histories and intergenerational trauma when discussing cannabis use for mental health.

One main distinction and critic of Western medicine from Indigenous wellness frameworks is the dualistic focus on mind and body, while forsaking the spiritual and emotional aspects of well-being (Tanner et al., 2021). Throughout the Sharing Circles, participants referred to cannabis as a medicine that enhanced their spiritual connection to themselves and their culture. Participants identified that cannabis has only been framed as a problematic substance for the last few hundred years, directly reflecting colonization practices. In contrast, Traditional Oral Storytelling precedes this, with thousands of years of teachings and medicinal practices related to cannabis use (Nyman, 2021). Viewing cannabis use as a plant-based, Traditional Medicine, was not only effective in participants' mental health symptoms, but also invoked a sense of pride and a reconnection to their culture. Some even connected cannabis use to the collective trauma that Indigenous people have endured since the onset of colonization and felt that cannabis use was helpful in spiritual pain relief for their community. Notably, some participants acknowledged that using cannabis can hinder their participation in ceremony because some Elders endorse abstinence from all drugs and alcohol for anyone partaking in Traditional practices. Participants respectfully contextualized the desire for abstinence was connected to experiences of Residential School survivors, but also called for more education as a way to increase access for those experiencing challenges with their mental health—who arguably need Traditional Healing the most.

Participants across all engagement session groups indicated many people turn to cannabis when they cannot access health care and/or social support that is culturally and personally appropriate. Interestingly, some participants felt using cannabis helped them cope in social contexts not specifically Indigenous, or did not feel culturally safe. They also used it to cope when they felt disconnected from their community, land, and culture. There was rich discussion among all groups regarding a need for culturally safe, and culturally appropriate, care. The need for cultural safety in healthcare settings is well documented in the literature (Cleator-Brooks et al., 2018; Gifford et al., 2019; McCall & Pauly, 2019); however, in this study, participants said culturally appropriate care requires HSCPs to have a deeper understanding of intergenerational trauma and to honour the painful history of Residential Schools. Participants believed HSCPs need a nuanced approach to trauma to effectively contextualize sources of addiction and how it is distinct from use of cannabis as a coping tool and spiritual practice. In line with this, participants in the 2SLGBTQQIA+ Sharing Circles called for HSCPs to consider complexities of each person's identity—gender, race, sexuality—when discussing mental health, cannabis use, and addiction.

In considering cultural violence toward Indigenous people since the onset of colonization, cannabis researchers, activists, and practitioners, must include Indigenous voices by listening to stories and trusting coping strategies that Indigenous cannabis users find effective.

7.3 SAFE USE

Throughout the interviews, participants demonstrated a thorough consideration of safety when using cannabis for mental health. They understood that more education, and improved access to resources, were critical for determining benefits, mitigating risks, and helping individuals make safe choices regarding cannabis use. Concerning safe use, most of the discussed benefits were centred around cannabis as a harm reduction strategy. Many participants had either started using cannabis instead of, or to reduce their use of, alcohol, narcotics, or other pharmaceuticals. Some benefits identified included more minor side effects, reduced risk of overdose, and lower costs.

Participants also said there were aspects of cannabis use they felt were a concern for their health and well-being. Many thought some of their community members were using it to avoid feelings, or escape problems, which was different than using cannabis to cope and improve overall function. Cannabis use disorder (CUD) is characterized

by a continued, problematic pattern of use despite negative consequences, causing significant distress or impairment in functioning, which can be associated with risks of psychotic disorders, cognitive impairment, unemployment, lower educational attainment, and lower life satisfaction (Sherman & McCrae-Clark, 2016). There is a need to help cannabis users recognize when their use becomes problematic and when resources for help can support users if cannabis becomes disruptive. Access to a legal, or safe, supply of cannabis was also a cause for concern. Fear regarding what strain they were getting, having to engage with illegal drug dealers, and that it may be laced with other potentially lethal substances, were discussed. This sentiment that cannabis may be laced with other drugs came up among participants in all Sharing Circles. Inuit, northern, and Métis participants specifically mentioning cannabis laced with fentanyl, even though the Ontario Harm Reduction reported in 2019 that there had been no laboratory-confirmed cases of fentanyl in cannabis in Canada (OHRN, 2019). These concerns were more pronounced in northern and Inuit communities, where participants had less access to legalized cannabis, and it was much more expensive on top of while facing extremely high cost of living (Food Secure Canada, 2016).

One of the most significant concerns among participants was the safety, health, and well-being of youth using cannabis. Participants wanted more information about the effects of long-term cannabis use on brain development and expressed concerns that cannabis use might interfere with young people's success in school. Their concerns echo what is present in literature: Early initiation, and regular use, of cannabis among youth have been identified as risk factors for problematic cannabis use, impaired mental health, and lower educational achievement later in life (Copeland & Swift, 2009). However, in recognizing abstinence programs are often ineffective, participants called for increased education for parents and professionals regarding how to talk to youth about safe cannabis use. Some areas where participants wanted to mitigate risk with increased knowledge included: Risks of second-hand cannabis smoke, information on different dosages and strains, potential reactions between cannabis and pharmaceuticals, how cannabis effects reproductive health, and infant development.

It is essential to recognize that academic literature, and other resources, are available on these topics. We see through this study that there is a disconnection between recent research and its availability to Indigenous People. This could be for several

reasons: 1) It lacks cultural specificity; 2) It is not presented through accessible mediums, and/or 3) It needs to come from a trusted healthcare professional with whom the participants have an established relationship. Participants felt that for them to make safe choices about whether to use cannabis for their mental health, they required access to research and information accessible and culturally specific to them. They also need improved access to legalized, and medicinal, cannabis. Additionally, they require their primary healthcare provider to be thoroughly informed about cannabis use to provide adequate guidance for their patients, which would alleviate participants from having to do their own trial and error methods.

7.4 MENTAL HEALTH

The relationship between mental health and cannabis use for Indigenous people is not concrete nor straightforward. Yet, participants in this study were able to contextualize nuances and complications by sharing their experiences and concerns, without judgment, while being mindful of good practices for their personal cannabis use.

Most participants were already using cannabis medically without the guidance of their HSCPs. This was predominantly due to barriers in accessing appropriate healthcare and social support. In particular, 2SLGBTQQIA+ participants indicated difficulties in accessing appropriate mental health supports and of needing to self-advocate for support. For some, this led them to cannabis as an alternative option to support their wellbeing. For participants in this research, challenges in using cannabis to support mental health were felt most acutely by those living in rural and remote communities, often located in northern regions, as well as those who identify as 2SLGBTQQIA+.

Many participants shared that in their experience, cannabis use helped provide relief to mental health symptoms, such as anxiety, depression, PTSD, and sleep dysregulation. Among this discussion, there was a lot of reference to cannabis helping people feel "normal," or helped them self-regulate or feel more balanced. Within this theme, and the discussion of balance, there is reference to a holistic approach to health and a callback to the medicine wheel: A Traditional Indigenous model of wellness (Tanner et al., 2022). Often participants spoke of balance in weighing out pros and cons of using cannabis versus other treatment options. Many indicated they experienced fewer adverse side effects using cannabis over other pharmaceuticals.

Others felt that for people who have histories with addiction (particularly with prescription medications), cannabis was a useful alternative. Participants expressed that all these benefits should be considered when creating treatment plans.

Importantly, participants emphasized the importance of cannabis as a tool of self-expression and autonomy. For these participants, cannabis gave them control over their health and helped them express themselves honestly and authentically. Many said being able to manage their symptoms, and not rely on undesirable pharmaceuticals, gave them a sense of dignity. These concerns are especially acute for 2SLGBTQQIA+ Indigenous People in Canada, who may face compounded discrimination due to their identities.

There was a consensus among participants that cannabis was valuable in coping with difficulties in their lives and allowing them to get through their day. Participants mentioned how they used cannabis to support their basic daily functioning. Cannabis use improved their appetites, the quality of their sleep, and their ability to feel safe. Others expressly referred to more sizeable social challenges, such as isolation during the COVID-19 pandemic, and having to experience child apprehension. In this way, participants' use can be described as a self-medication strategy within a health care and social support system that is far less than ideal. Experiences described by participants show how people are using cannabis to deal with their mental health, while enacting strategies for safe use.

Participants aptly recognized that cannabis use alone is not a "fix-all" and is more effective when combined with other interventions. Participants described two main ways cannabis users need to be supported: 1) Their basic needs are met, and 2) Their HSCPs are supportive of their cannabis use and are involved in the treatment plan. Cannabis researchers and HSCPs need to look beyond whether cannabis can be used for mental health reasons, and instead look to strengthening existing systems to support those who already rely on cannabis for mental health support. Research priorities should work to explore ways of improving social services and closing these gaps, while improving knowledge dissemination to HSCPs and the public. There is also an urgent need for better education on cannabis for HSCPs, increased access to health providers with cannabinoid therapy training, and more public health resources for those who can not get individualized cannabinoid therapy advice.

8. KNOWLEDGE GAPS

This section highlights the areas that could be further explored in research, as well as where there are issues in sharing knowledge among academics, HSCPs, governing bodies, government, and the Indigenous women, Two-Spirit, transgender, and gender-diverse people they serve. There is a need to create Indigenous-specific research that considers distinctions between Indigenous groups—First Nations, Métis, Inuit, northern, 2SLGBTQQIA+—and intersectionality of these groups. Although much of this information already exists, there remains a stark disconnect between Knowledge Holders and cannabis users. These Knowledge gaps identified during this project point to issues with our existing health systems and public health education on cannabis use. Many of the participants' gaps in awareness overlap with gaps identified during NWAC's first cannabis-related project. That project was funded by Health Canada's Substance Use and Addictions Program (SUAP) and was titled: A Community-Informed Approach to Cannabis Public Health Education and Awareness. As our main knowledge product for this first project, we have created a website titled: Cannabis Education for and by First Nations, Inuit, and Métis Peoples. Our online resource is full of information about health effects of cannabis for different life stages and circumstances, cannabis laws and regulations in Canada, cultural and historical information, and information about the plant itself. The website was informed by engagement with Indigenous women, Two-Spirit, transgender, and gender-diverse people and is trauma-informed, gender-based, and culturally safe.

TOPIC:	SUB-TOPIC:	RESOURCES AVAILABLE:	RESOURCE GAPS:
REPRODUCTIVE HEALTH:	**Effects cannabis has on:** • Brain development throughout the prenatal period, to childhood and youth. • Infant growth during pregnancy and breastfeeding/ chest-feeding. Menstrual cycles, fertility, and conception.	As part of the cannabis education website created by NWAC, we have a section titled: Cannabis and Pregnancy, Lactation and Fertility. Here, these knowledge gaps are addressed.	While there is enough information available to provide general recommendations and precautions, robust and high-quality data is still lacking in this area. Many studies exploring cannabis use during pregnancy and lactation have been done on animals due to ethical concerns about using human subjects. Those that use humans in their research designs are minimal in number and have difficulty providing consistent and accurate information about the amount, type, and timing of cannabis consumed during pregnancy and lactation.
CANNABIS AND PHARMACEUTICALS:	**Effects of cannabis:** • In combination with, and instead of, pharmaceutical drugs for different mental health conditions. • Interaction between cannabis and other medications, such as anti-anxiety medications, anti-depressants, SSRIs, opioids, and other painkillers.	As part of the NWAC's cannabis education website, we have a section titled: Cannabis for medical use. Here there is general information and guidance on where to go for professional advice regarding individual cases.	Participants were frustrated that dosage guidelines were not more available to them and that their health and social care providers were reluctant or unable to provide advice on specifics, causing them to experiment by themselves. Cannabinoids can also interact with some prescription medications and health supplements, which is why it is essential to increase the accessibility of cannabinoid therapy-trained health professionals and improve the education on cannabis for all providers.
PRODUCT-SPECIFIC INFORMATION:	• Impacts of the different consumption methods on the body and brain. • Specific information on different cannabis strains, how they impact the body, and how they have varying effects on different health conditions.	As part of theNWAC's cannabis education website, we have a section on: understanding methods of consumption, which offers general information about effects, onset, and dosages for cannabis products.	Currently, there is little guidance on the impacts of different cannabis products on health symptoms. The guidance is limited to crowd-sourced data from review web-sites. The only way to get appropriate ad-vice on using cannabis for medical rea-sons is to see a health care professional trained in cannabinoid therapy. There are no general guidelines on dosage and schedules that can be applied to anyone with the same medical condition.
COMMUNITIES AND CULTURE:	• Cannabis and the role that it could play in community and ceremony. • Cannabis and its role in global Indigenous cultures before colonization, and whether it can be used in a holistic approach to healing.	As part of NWAC's cannabis education website, there is a section called Elder's Corner. It features interviews with several Elders across Canada, who share their perspectives on cannabis use, ceremony, and provide advice for youth.	Participants were aware of implications of the dominant, Eurocentric, worldviews driving stigmas toward cannabis use.

9. CONCLUSION

From the five distinctions-based Sharing Circles—First Nations, Métis, Inuit, northern, and 2SLGBTQQIA+—participants offered their experiential Knowledge of the relationship between cannabis use and mental health. This report provided a holistic understanding of the complicated relationships between cannabis use and mental health.

We found that despite national legalization of cannabis in Canada, stigma around cannabis use persists from several different sources in the lives of Indigenous women, Two-Spirit, transgender, and gender-diverse people. These influences include: Stigma from places of employment, HSCPs, communities, and Elders. Stigma can lead to a lack of trust between Indigenous women, Two-Spirit, transgender, and gender-diverse people and their HSCPs; as well as exclusion from community events, lack of support from HSCPs, fear of intervention from Child and Family Services agencies, and fear of judgement from other community members.

First Nations, Métis, Inuit, northern, and 2SLGBTQQIA+ peoples hold different values and understandings of cannabis use than non-Indigenous Canadians. Therefore, it is necessary to highlight facets of these differences to understand participants' positions.

Throughout conversations held in Sharing Circles, there was considerable interest in using cannabis as an alternative to conventional mental health treatment options for various conditions, especially when conventional treatments were difficult to access. However, all participants wanted to ensure that cannabis was used safely in their communities. For participants, the key to avoiding misuse and ensuring safe use of cannabis was access to information about the impacts of cannabis; participants saw this as an essential role of HSCPs. Further, a barrier identified when supporting the safe use of cannabis was a lack of access to legal and regulated cannabis supplies, especially in northern, rural, and/or remote areas. These supplies included those offered by HSCPs and/or legal cannabis dispensaries.

Indigenous women, Two-Spirit, transgender, and gender-diverse individuals continue to search for information and autonomy regarding their mental health and wellbeing. Yet, there remains a significant, and harmful, disconnect between a paternalistic healthcare approach gatekeeping access to information about medical

cannabis and to offer support for informed care for this demographic in Canada. There must be increased awareness and attention paid on HSCPs, their governing bodies, and provincial, territorial, and federal government programs, for the gaps identified throughout this report. Until this happens, Indigenous women, Two-Spirit, transgender, and gender-diverse individuals must manage their cannabis use without clear, research-based, guidelines from healthcare providers. They are filling in the gaps and developing safe and proactive cannabis use systems for themselves and their communities. This knowledge must be incorporated into any formal learning and information channels.

10. A PATH FORWARD: RECOMMENDATIONS FOR HEALTH AND SOCIAL CARE PROVIDERS

It is necessary to acknowledge systematic inequities that create workplace challenges for HSCPs. Many HSCPs are chronically overworked and under-resourced. These conditions have been exacerbated and magnified during the COVID-19 pandemic. Keeping in mind these realities, this report offers thoughtful considerations for HSCPs.

HSCPs intimately know the vital role they play in supporting, and fostering, health for their patients. HSCPs' responsibility remains to offer adequate care despite exhaustive working conditions and changing healthcare landscapes. According to Canada's 2021 ratification of *Bill C-15*: *The United Nations Declaration on the Rights of Indigenous Peoples Act*, discrepancies in social determinants of health between Indigenous and non-Indigenous people must be addressed. Therefore, HSCPs are also responsible for recognizing, and addressing, colonial legacies and ongoing marginalization shaping healthcare experiences of First Nations, Métis, Inuit, northern, and 2SLGBTQQIA+ communities who request access to cannabis. From the findings of this report, we have created a list of recommendation and strategies that HSCPs can consider for taking action.

1) **Develop, maintain, and reassess culturally safe approaches to mental health at regular intervals and distribute them among various communities.** This involves developing an understanding of distinct concepts of mental health from Indigenous communities HSCPs work with. This could include First Nation, Métis, or Inuit understandings of mental health. This could also involve considerations of specific groups HSCPs work with, such as Algonquin, Mi'kmaq, Coast Salish, etc.

2) **Expand approaches to cannabis and mental health care to include holistic understandings.** Mental health treatment and cannabis education should consider unique and holistic perspectives of Indigenous people in regard to wellness that prioritizes Traditional Practices and Medicines over allopathic options. Understanding cannabis as a Traditional Medicine offers unique treatment options and strategies for care. Mental health care must also improve access to cultural support and Traditional Ceremony.

3) **Offer cannabis-based care to informs patients, with ongoing support when requested.** Indigenous women, Two-Spirit, transgender, and gender-diverse people are using cannabis to manage, and cope with, various illnesses, with or without the support and guidance of HSCPs. Participants said they were most successful attaining medical benefits of cannabis when they worked in collaboration with their HSCPs. Therefore, when a patient asks for support to use cannabis to manage illnesses, and where the patient would be a good candidate for cannabinoid therapy according to a health professional's medical regulatory authority, offer it to them. This is especially relevant in rural and remote areas where HSCPs are limited.

4) **Increase a safe supply of cannabis, particularly in northern and remote areas.** Many participants who live in northern and remote areas said a large barrier they face is accessing safe cannabis. Cost was also a significant factor for most. Therefore, it is important to bring cannabis prices down to meet average costs seen in urban areas. This means the burden of choosing cannabinoid therapy over conventional medications would be reduced. Patients would not have to suffer negative impacts of costly treatments if they prefer cannabis over potentially addictive pharmaceuticals.

5) **Adapt to, and understand, changing narratives and bodies of Knowledge on cannabis and mental health.** Participants from the Sharing Circles highlighted one of the main reasons for lack of support from HSCPs for cannabis use was a perceived lack of knowledge, or research, on the part of the HSCPs. It is then essential for HSCPs to acquire, and maintain, enough Knowledge about cannabis to answer their patients' questions—in the same way they do for other conditions and medications—and know the criteria for cannabinoid therapy.

6) **Develop a sustainable path of Knowledge transfer from academic institutions, medical regulatory authorities, practicing HSCPs, Indigenous communities, and Indigenous patients.** Indigenous women, Two-Spirit, transgender, and gender-diverse people need evidence-based knowledge regarding relationships between cannabis and mental health. HSCPs need access to current information to share with their patients and clients. Academic institutions, and medical regulatory authorities, can further develop pathways of knowledge to ensure that HSCPs and Indigenous patients can make an informed decision for a person's mental health.

7) **Continue taking steps to combat racism and prejudice toward Indigenous Peoples in health and social care fields.** Participants shared feelings of being disregarded, ignored, and treated differently due to their race and Indigeneity. Many Canadian medical regulatory authorities, including the Federation of Medical Regulatory Authorities of Canada (FMRAC), have made statements regarding racism and discrimination. Therefore, HSCPs and their regulatory bodies, are responsible for seeking out further education and resources to understand and address racism at individual and systemic levels. HSCPs are also encouraged to use a gender and 2SLGBTQQIA+ lens when considering health needs around cannabis.

8) Medical regulatory authorities should work to destigmatize cannabis use within their own mechanisms, as well as remove barriers for accessing information about cannabis for HSCPs and cannabis users. Participants from Sharing Circles highlighted stigmas they faced when discussing cannabis with their HSCPs. Much of this stigma is related to a lack of knowledge of cannabis among HSCPs and residual institutional bias from decades of cannabis being considered an illicit substance. Medical regulatory authorities could support open access publishing by providing funding to researchers to publish journal articles related to cannabis research, while also being accessible and strengths-based.

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12. APPENDIX:

12.1. SHARING CIRCLE QUESTIONS:

3) Have you discussed your cannabis consumption with other health and social service providers? For example: Family doctor, social worker, nurse practitioner, or others? If yes, who? If not, why not?

4) If you have discussed cannabis with health or social care providers, what kinds of conversations and/or reactions have you encountered? Or, if you haven't discussed cannabis with someone, what types of questions or conversations would you want to have?

5) Do you feel like you can have an open conversation with your health or social care providers about your cannabis use?

6) Thinking about our presentation at the start of the session regarding cannabis and mental health, what areas do you feel needs more research?

7) Do you think there is a relationship between mental health and cannabis use? In general, do you think it is harmful or beneficial?

8) What do you think are the harms and/or benefits of cannabis use in your community, as it pertains to mental health? Do you know anyone that has benefited from cannabis? Do you know anyone who has been harmed by cannabis? (For example: Harms or benefits can mean things that affect someone physically, economically, socially, or culturally.)

9) Do you think this relationship is particularly harmful, or beneficial, specifically in regard to Indigenous women, girls, and gender-diverse people?

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12 .2. PARTICIPANT SELF-DISCLOSED EXPERIENCES WITH MENTAL HEALTH:

GROUP:	CONDITIONS AND SYMPTOMS MEDICATED BY CANNABIS:
Northern:	ADHD (n=3), depression (n=2), PTSD (n=2), anxiety (n=2), postpartum depression (n=1), insomnia (n=1), chronic pain (n=5), and epilepsy (n=1).
Métis:	Anxiety (n=5), depression (n=3), PTSD (n=3), postpartum depression (n=1), dissociative identity disorder (n=1), bipolar disorder (n=1), borderline personality disorder (n=1), schizophrenia (n=1), and trauma (n=1). Participants also described using cannabis to deal with other health conditions that impact mental health, such as chronic pain (n=3), fibromyalgia (n=2), and restless leg syndrome (n=1).
Inuit:	Borderline personality disorder (n=1), PTSD (n=3), and anxiety (n=1).
2SLGBTQQIA+:	PTSD (n=11), anxiety (n=11), depression (n=7), OCD (n=1), sleep disorders (n=1), suicidal ideation (n=1), borderline personality disorder (n=1), and schizophrenia (n=1). Participants also discussed friends' experiences using cannabis for anxiety (n=2), addiction (n=1), and pain (n=1). Participants also described using cannabis to deal with other health conditions that impact mental health, such as pain (n=1), IBS (n=1), and addiction (n=1).
First Nations:	Anxiety (n=5), depression (n=5), PTSD (n=3), bipolar disorder (n=1), agoraphobia (n=1), and social anxiety (n=1). One participant had children that have used cannabis to manage eating disorders and suicidal ideation. Participants also described using cannabis to deal with other health conditions that impact mental health, such as pain (n=6) and fibromyalgia (n=1). One participant knew people who used cannabis to manage glaucoma.

12. 3. SHARING CIRCLE PRESENTATION:

Before we begin our discussion today, I'd like to take a moment to review what evidence we have found in regard to cannabis and the mental health and wellbeing of Indigenous women, girls, and gender-diverse people in Canada. I will review the findings and observations from our literature review, but first I will define a few of the terms that come up when looking at cannabis research.

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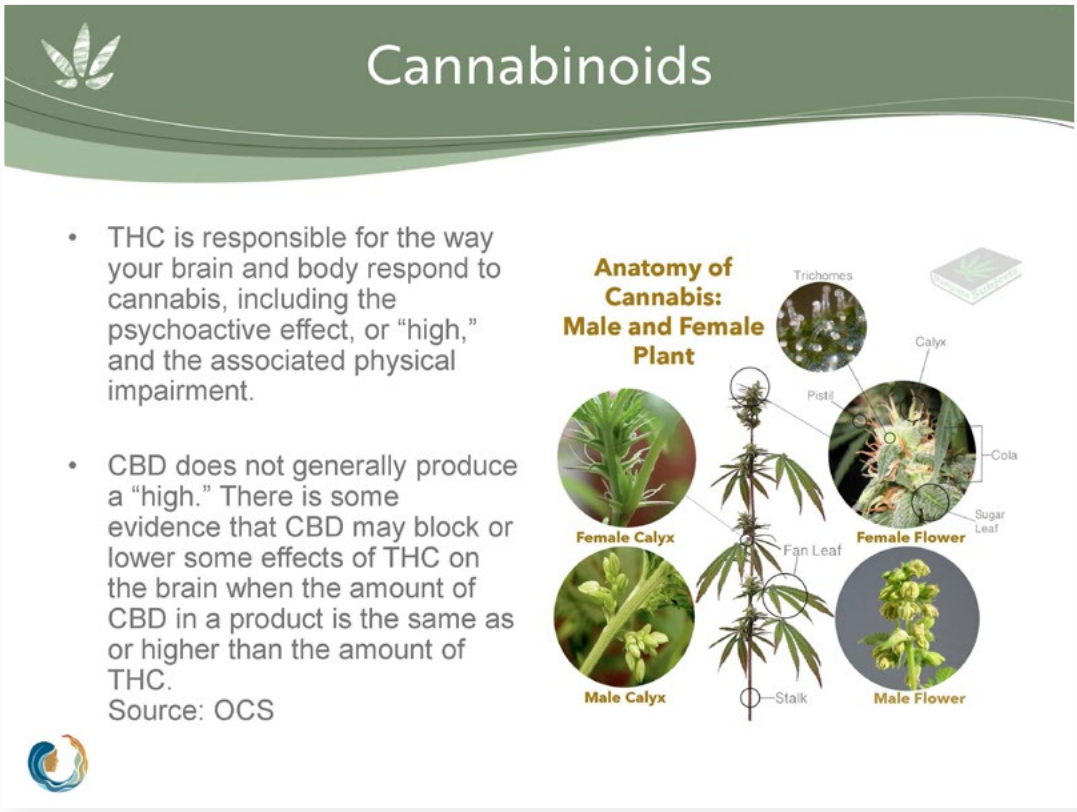
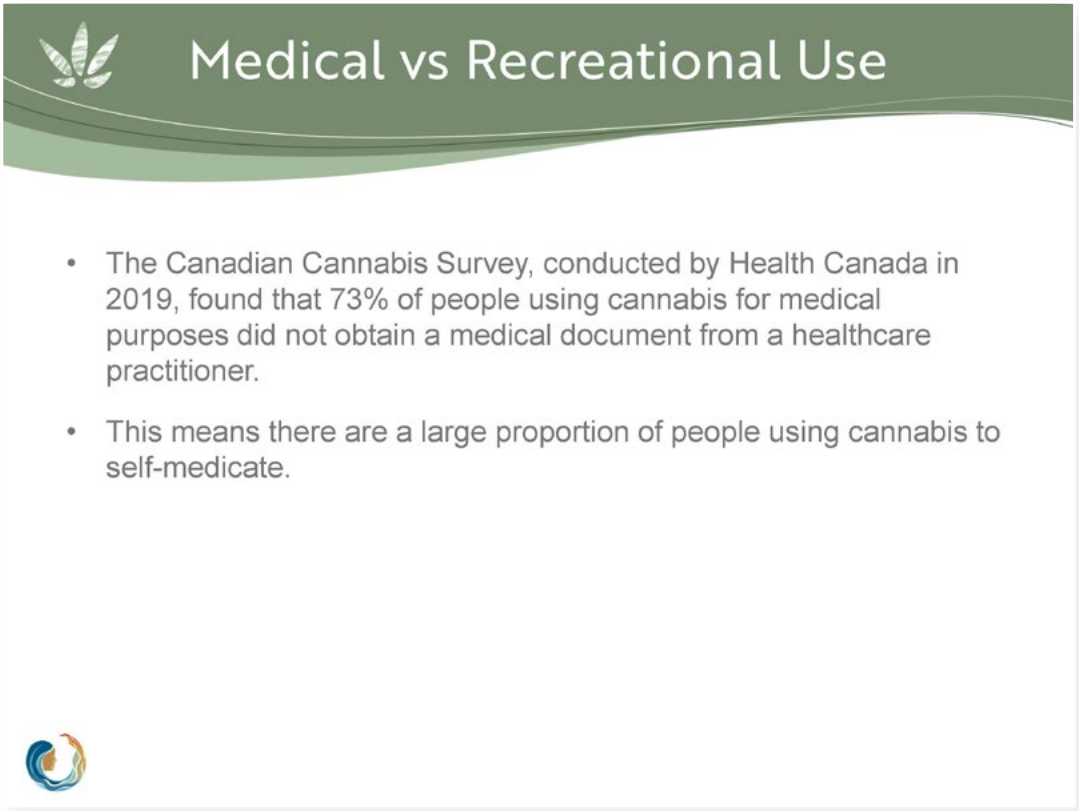


Active components in cannabis are called cannabinoids, and there are over one hundred different types. The two that are found in the highest amounts are tetrahydrocannabinol (THC) and cannabidiol (CBD). All cannabinoids interact with our body's Endocannabinoid System (ECS) in different ways.

Our ECS is a body system present in many different areas of the brain and body, and interacts with our immune system nervous system by impacting our mood and overall wellbeing. Our body makes its own naturally-occurring cannabinoids, which purpose is to interact with the different areas of our ECS.

THC directly interacts with the ECS, like a key into a lock and replaces our body's own cannabinoids temporarily. THC is the component in cannabis that causes the "high" feeling.

CBD's actions on the ECS are more indirect, and it temporarily "boosts" the functions of our body's natural cannabinoids. CBD does not generally produce the "high" feeling. It can also block, or lower, some undesirable effects of THC, such as nervousness or paranoia.



People who use cannabis recreationally typically seek the psychoactive "high" and use THC- dominant products. While generally, people using cannabis for medical purposes will favour CBD as their main cannabinoid; however, THC is also commonly used.

A Canadian Cannabis Survey, conducted by Health Canada in 2019, found that 73 percent of people using cannabis for medical purposes did not obtain a medical document from a healthcare practitioner. This means there is a large proportion of people using cannabis to self-medicate.

Although types and amounts of cannabis products people use can blur lines between medical and recreational cannabis, they are regulated slightly differently. There are benefits to pursuing medical authorization if it is accessible to you.

Benefits to getting medical authorization:

Accommodations for work, housing, and driving. An authorized cannabis patient has legal protections that a recreational consumer does not.

You can claim medical cannabis on your taxes, as it is a medical expense. Only receipts from medical licensed producers can be claimed at tax time.

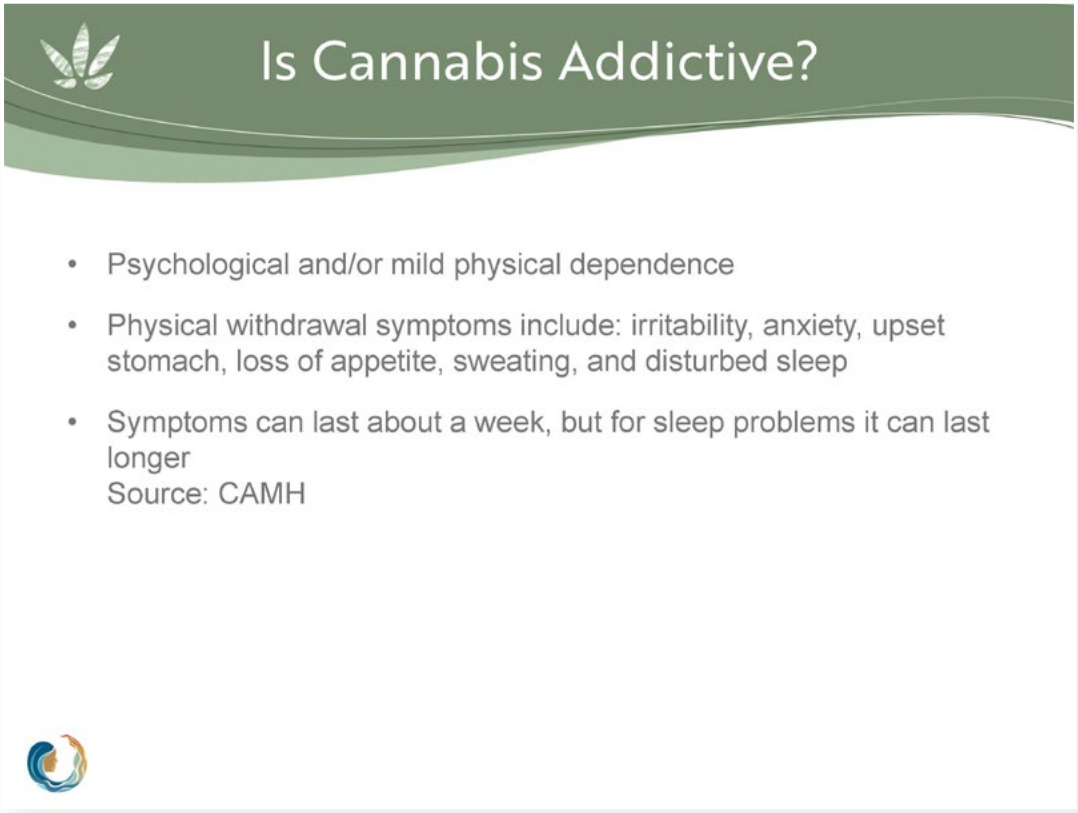
Access to compassionate pricing and high-quality variety of therapeutic options.

CBD products and topicals:

Drug interactions, dosing, and titration advice available. Both THC and CBD interact with supplements and medications, and recreational dispensaries cannot counsel or advise on this. This can lead to issues with medication side effects or lack of effectiveness, in addition to a risk of adverse events.

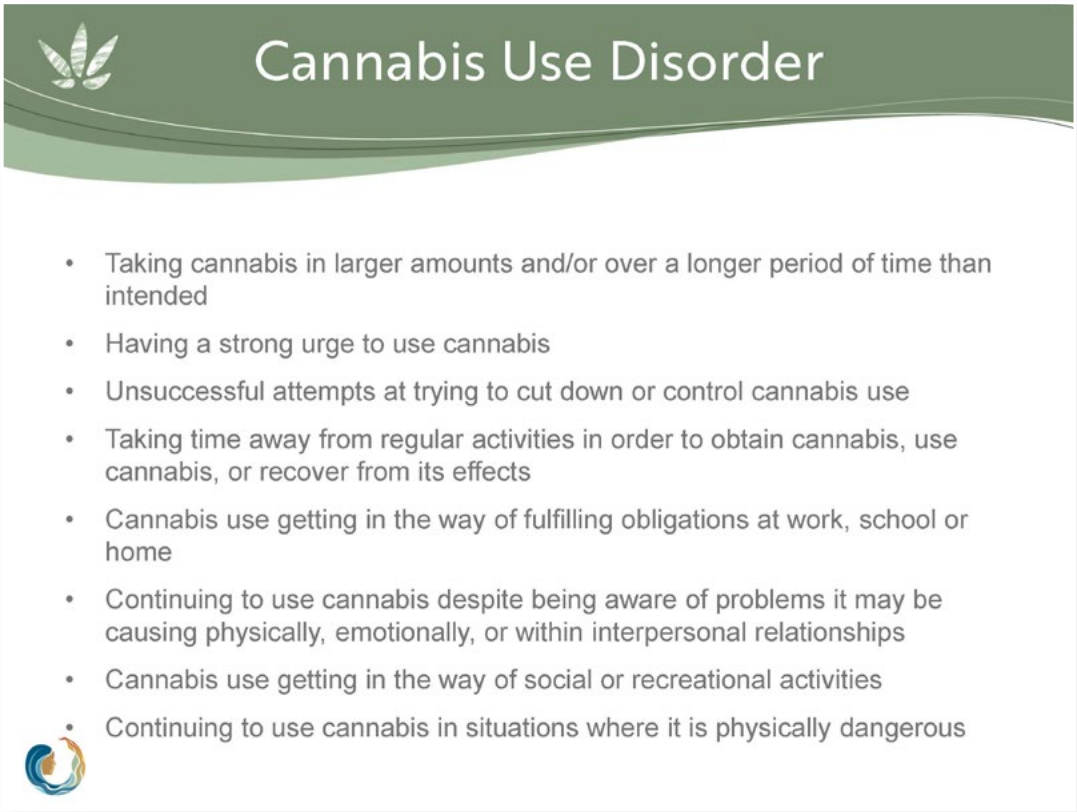
Possession limits are higher for medical patients. They have the right to carry up to 150 grams or 30 times their authorized limit, whichever is lower, in public.

There are many different clinics across Canada where you can get authorization, and most are available virtually.



A common misconception is that cannabis is non-addictive; however, after regularly using cannabis for a long period of time, people can develop mild physical dependence.

If they stop using, they may experience mild withdrawal. Symptoms can include irritability, anxiety, upset stomach, loss of appetite, sweating, and/or disturbed sleep. These symptoms generally last for about a week, but sleep problems may continue longer. Note: Not all people who use cannabis regularly will experience these symptoms.

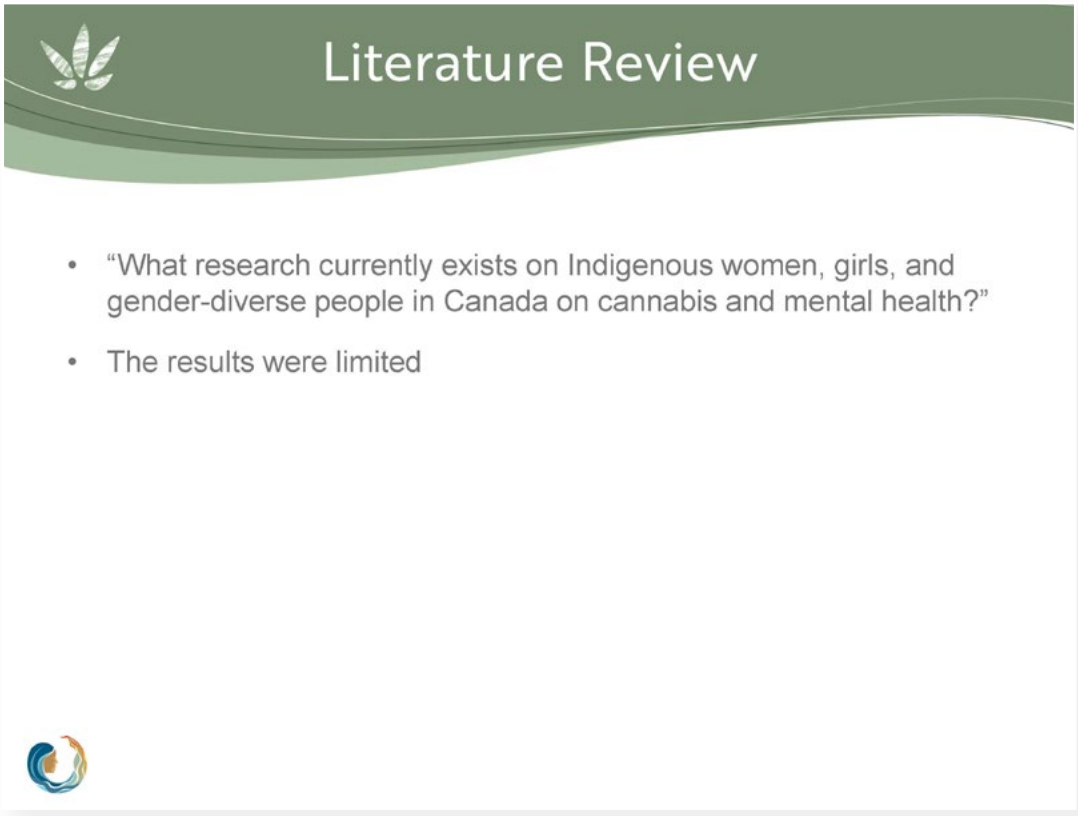


Cannabis Use Disorder (CUD) is the medical term for a spectrum of patterns of cannabis use. It can range from mild, moderate, to severe, depending upon how many of the symptoms described below are present. For someone to be diagnosed with cannabis use disorder, they must have more than two of the symptoms consistently, within a 12-month period.

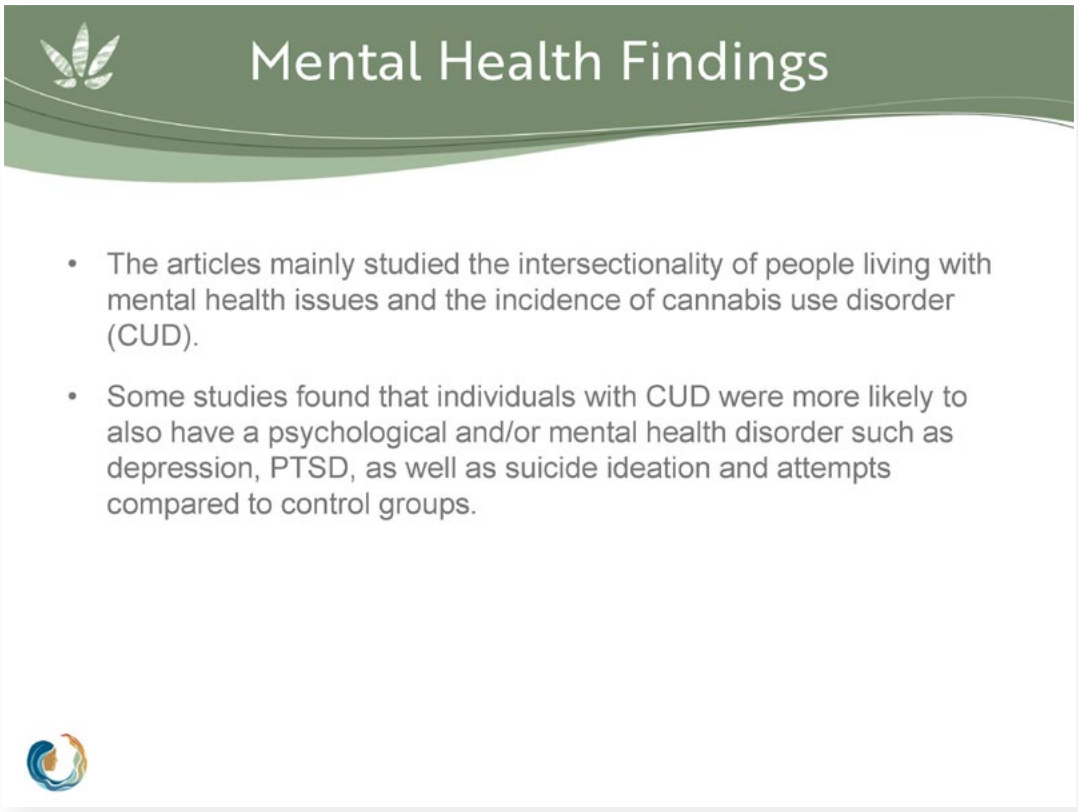
- Taking cannabis in larger amounts, and/or over a longer duration of time, than intended.
- Having a strong urge to use cannabis.
- Unsuccessful attempts at trying to cut down or control cannabis use.
- Taking time away from regular activities to obtain cannabis, use cannabis, or recover from its effects.
- Cannabis use getting in the way of fulfilling obligations at work, school, or home.
- Continuing to use cannabis despite being aware of problems it may be causing physically, emotionally, or in interpersonal relationships.
- Cannabis use getting in the way of social or recreational activities.
- Continuing to use cannabis in situations where it is physically dangerous.

While all of these symptoms can be defined under the term CUD, most people who use cannabis may not experience them.

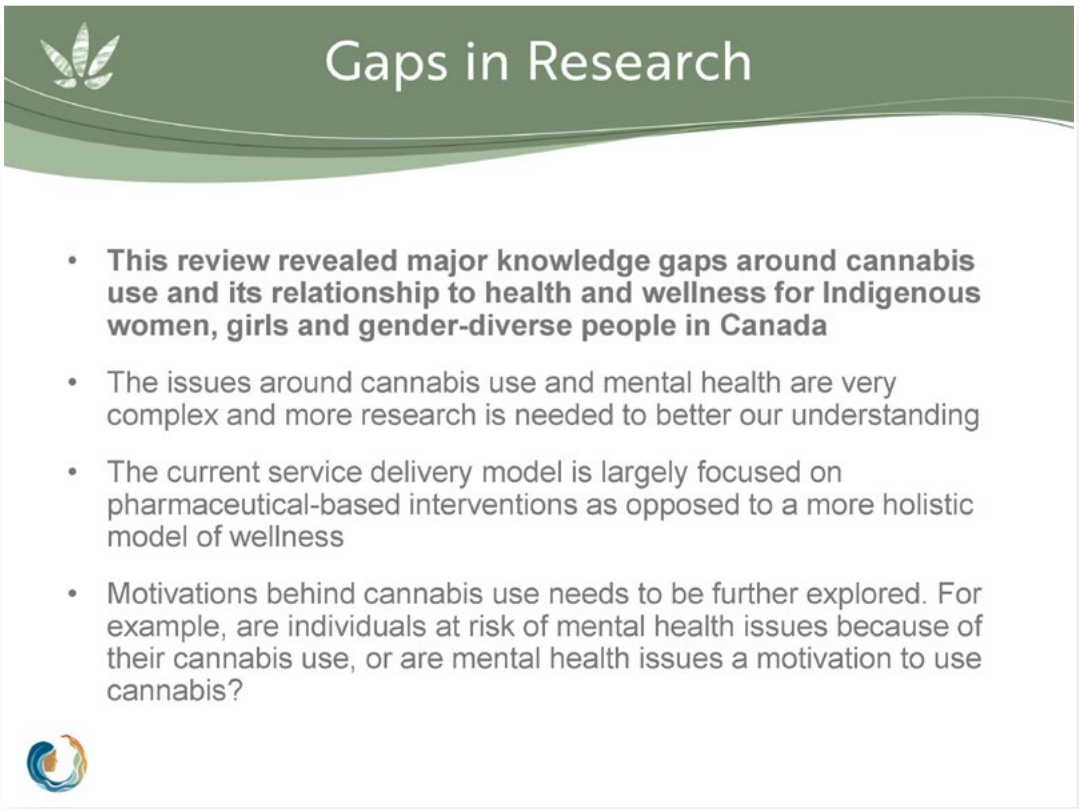
Source: Diagnostic and Statistical Manual of Mental Disorders (DSM-5).



We conducted a literature review to explore what evidence is currently available regarding Indigenous women, girls, Two-Spirit, transgender, and gender-diverse people in Canada on cannabis and mental health. The results were limited.



We found several articles containing mental health and cannabis as the main topic; however, they mainly studied the inter-relationships between individuals living with mental health struggles and CUD. Studies found individuals with CUD were more likely to have a psychological and/or mental health disorder, such as depression, PTSD, and/or suicide ideation or attempts, compared to control groups. Largely negative associations were found between cannabis use and mental health.

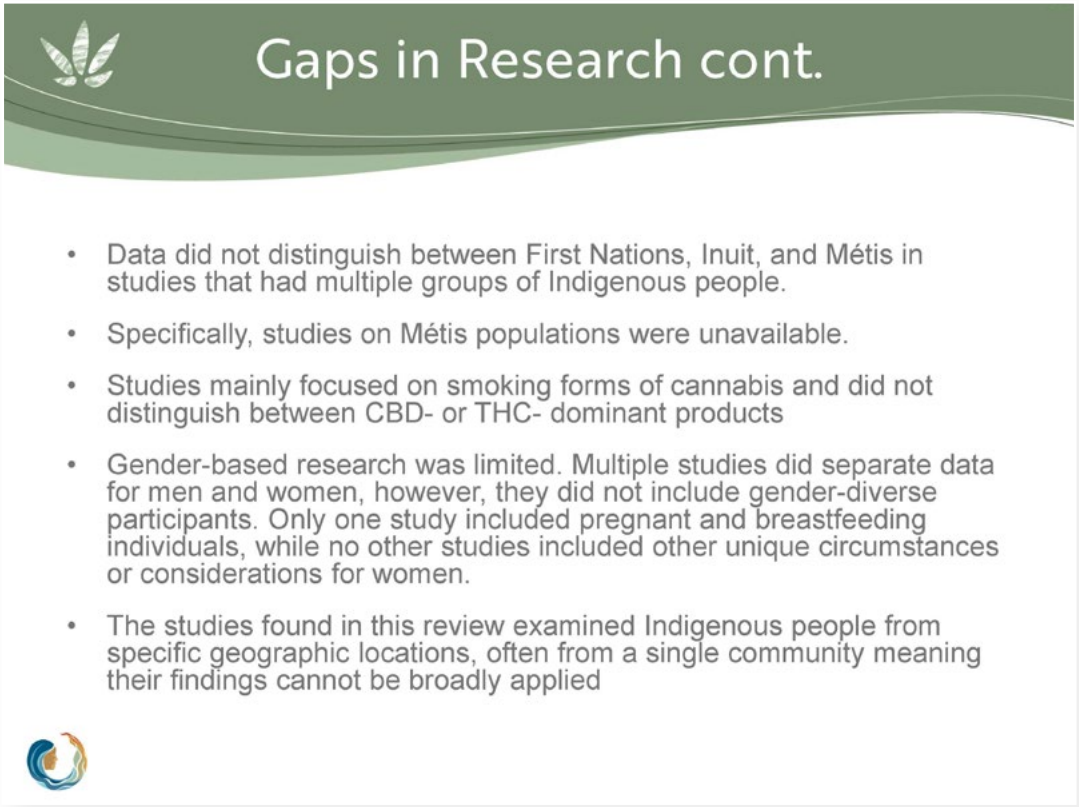


However, this review revealed major knowledge gaps regarding cannabis use and its relationship to health and wellness for Indigenous women, girls, and gender-diverse people in Canada.

Issues around cannabis use and mental health are very complex. More research is needed to better our understanding.

Current substance uses and mental health service delivery models are largely focused on pharmaceutical-based interventions, as opposed to a holistic model of wellness involving physical, emotional, spiritual, and mental aspects of a person who is in connection with their community family and natural environment.

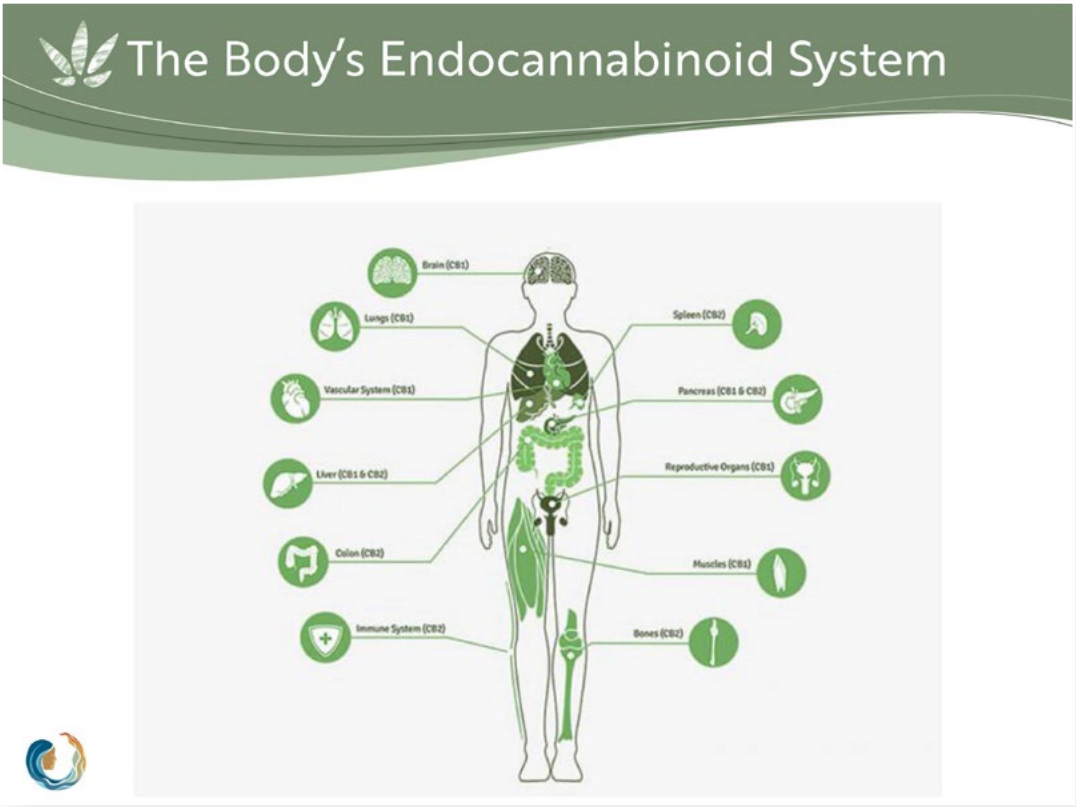
Motivations behind cannabis use need to be further explored. For example: Are individuals at risk of mental health issues because of their cannabis use? Or, are mental health issues a motivation to use cannabis?



Furthermore, data did not distinguish between First Nations, Inuit, and Métis in studies with multiple groups of Indigenous People. Specifically, studies on Métis populations were unavailable. Studies mainly focused on smoking forms of cannabis and did not distinguish between CBD- or THC-dominant products.

Gender-based research was limited. Multiple studies showed separate data for men and women. However, they did not include gender-diverse participants. Only one study included pregnant and/or breastfeeding individuals, while no other studies included other unique circumstances or considerations for women or gender diverse people.

The studies found in this review examined Indigenous People from specific geographic locations, often from a single community—meaning their findings cannot be broadly applied.



Cannabis is a complex plant. It has hundreds of different components with many effects on the body, which adds to the difficulty of studying it. The same cannabis product can affect different people in different ways. For example: People who have a history of psychosis, family, or personal history of schizophrenia, have been shown to be more sensitive to the psychoactive effects of cannabis compared to other people. This association is stronger when consuming high potency THC products and when cannabis use is started at a young age.

Complexities of cannabis, and its effects, makes it an exciting and potential option for many health conditions; however, it also means gaps in current research are barriers in our understanding about how to best use it. More research would allow us to get the most benefits for people, while lowering risks for those vulnerable to cannabis' negative effects.

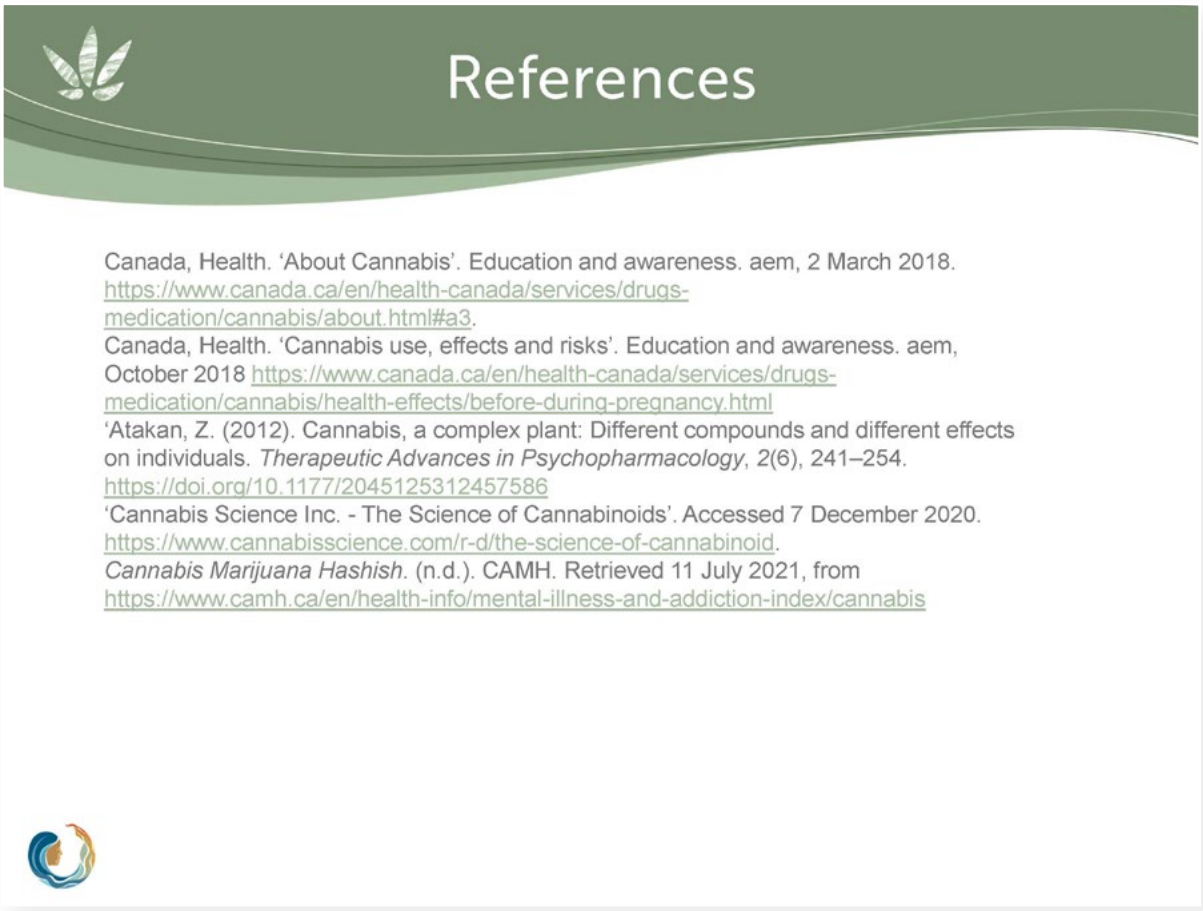
We know ECS plays a role in mood regulation, so in theory, it could be effective for depression and anxiety. However, evidence is mainly comprised of personal

testimonials, rather than clinical trials that prove this. Mental health struggles are complex, so treatments and/or pharmaceutical drugs with more detailed evidence, are typically better places to start treatment with instead of cannabis.

Cannabis can enhance positive feelings and immediately take away experiences of uncomfortable emotions. But evidence-based, psychological therapies—for many mental health issues—involve learning skills to confront and engage with difficult emotions, not avoid them. If cannabis is being used to avoid uncomfortable emotions, thoughts, and/or memories, then it can lead to developing, or worsening, of symptoms. In other words: Repeated, temporary relief from symptoms by using short-term, mind-altering substances, is not therapy and can even work against it.

With all of this uncertainty, we think that through this project, we can gain a better understanding of the necessary steps needed to improve the lives of people living with mental health issues and, more specifically, how these issues intersect with Indigenous women, girls, and gender-diverse people.

10.4. CRITERIA FOR NORTHERN PARTICIPANTS:



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Cannabis Marijuana Hashish. (n.d.). CAMH. Retrieved 11 July 2021, from https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/cannabis

10.5. PARTICIPANT INFORMATION SHEET:

INUIT PARTICIPANT INFORMATION SHEET

Title of Project: Establishing Research Priorities: An Exploration of First Nations, Inuit and Métis Women and Gender-Diverse People's Needs in Cannabis and Mental Health

Principal Lead: **Abrar Ali**, Native Women's Association of Canada

Inuit-specific Research Facilitator & Collaborator: TBC

Why am I being asked to take part in this research study?

You are being invited to attend an Inuit-specific community engagement session for women and gender-diverse people who care and are knowledgeable about the health and wellbeing of Inuit women and their families when it comes to cannabis use. The purpose of these sessions will be to get a better understanding of the distinct needs, concerns, and priorities of Indigenous women and gender-diverse people in each region at the community level.

This event is part of a Canadian Institutes of Health Research (CIHR) funded catalyst grant. The purpose of the project is to develop research questions based on the needs and priorities of Indigenous women, girls, and gender-diverse people in regards to cannabis and mental health. In order to inform our proposed research questions, we are hosting engagement sessions for Inuit, Métis, First Nations and Northern Indigenous women and gender-diverse people across Canada.

This series of online community-engagement sessions is to share perspectives and explore together Inuit women and gender-diverse people's specific public education, and awareness priorities. Your involvement would help inform the Native Women's Association of Canada's (NWAC) action, policy, advocacy and resources to support the health and wellbeing of Inuit women and their families.

This information sheet gives you information about what will happen if you choose to participate, and how your information will be handled and protected. Before you make a decision, the researcher facilitators will go over this form with you and you are encouraged to ask questions. You will be emailed a copy of this form for your records.

This community-engaged session is part of a larger project led by NWAC. They have received funding by Canadian Institute of Health Research to identify cannabis needs and priorities for Indigenous women, girls and gender-diverse people.

What is this reason for doing this study?

There is little information available that is specific to Inuit women, girls and gender-diverse peoples' mental health and wellbeing. This study is important to help assure that Inuit peoples' voices and knowledge is included to help identify specific needs and priorities for future research. More broadly, the research project will contribute to better understanding Indigenous gender-specific approaches and needs when it comes to the therapeutic use of cannabis for mental health issues and wellness and the experiences and attitudes of the effects of cannabis use on mental health.

What will I be asked to do?

If you agree to participate, we will ask you to attend one three-hour online gathering (via ZOOM online platform) with other Inuit women participants (maximum number of participants is 15).
Please note that you will require a microphone on either your computer or your mobile device to be able to participate on this online remote platform.

You will have two date options, TBC

The Inuit research collaborator will lead the event. They will EMAIL you with the guiding questions a week prior to the event. You will be emailed a ZOOM link providing you with the access information, password and invitation.

During the online engagement session, you will be encouraged to share ideas and knowledge about strengths, needs, barriers, and visions regarding mental health and Inuit-based resources that uplift the lives of our Inuit families. This will be shared with other Inuit participants and members of our research team (which will include a note-taker from NWAC). You can share as much or as little as you feel comfortable. During the session, you can use a pseudonym.

We will take written notes of the conversation. You will have an opportunity to review the transcribed text and provide additional comments or clarification. Any information that could identify you or your community will not be included in the transcribed text, including your name.

You will be invited (optional) to review the final draft report which will compile the information shared during these two events.

What are the risks and discomforts?

We will do everything we can to ensure that your information stays private, but we can not guarantee that all participants will respect others information. We may ask questions that some people are

uncomfortable answering, and you should only share information, as you feel comfortable. Sometimes the stories you share in the engagement session may make you identifiable. We will minimize this risk by always maintaining confidentiality and anonymity of the discussions. This means that you will be anonymous in papers, reports, and the study results. You can tell us that you prefer not to answer any questions. You may leave the session at any time.

There is a risk that the discussion may result in you feeling distress. If this happens, you may connect with an Inuit Elder for additional support during or after the Gathering as you feel necessary. We will provide you with contact information of an Inuit Elder prior to the session. You will be able to talk about your feelings with the Inuit Elder and they can connect you with other resources.

It is not possible to know all the risks that may occur in a study, but our research team has taken all reasonable safeguards to minimize any known risks to a study participant.

What are the benefits to me?

You will have an opportunity to share your ideas and knowledge about cannabis use, needs and priorities with other Inuit attendees in a remote learning environment. The information you share will potentially support Indigenous women, girls and gender-diverse peoples to make informed decisions about cannabis use that best suit their circumstances. This information may help other Inuit women and gender-diverse people and other Inuit organizations to create culturally safe, healthy programs and services. However, you may not get any direct benefit from being in this research study.

How do I find out what was learned from this study?

We will email you a draft summary report of findings by TBC. At that point, you may review and provide your feedback. Providing feedback on the draft report is optional and up to you. If you choose to provide feedback, we require that any feedback or comments on the draft report be submitted to us via email by TBC. The final report will be completed and sent to you by TBC.

Do I have to take part in the study?

Being a part of the community engagement session is your choice. If you decide to be involved, you can change your mind and stop at any time, and it will in no way affect any future research collaborations with NWAC.

You may also choose to only participate in parts of the conversation and are not required to answer any questions that you are not comfortable with.

You may request to withdraw from the LIVE session at any time. You can request that any information you provide be excluded from reports and publications up to two-weeks after the data has been transcribed by contacting the Co-Investigators, Collaborators, or Research Coordinators by phone or email to request that any or all of your responses be removed from the transcript. You also have the option of requesting the removal of your contribution during the session. Although, we would like to point out that it may be difficult to withdraw your information since it may contribute to a conversation and comments from another participant(s). There are no consequences for withdrawing your information. After it has been included in the final report or academic publication, you may not request to withdraw any information you provided.

Will I be paid to be in the research?

You will receive a $100 email transfer for participating in one of the engagement sessions. This may include if you chose (optional) reviewing the transcript and the final report. You will not receive additional payment for reviewing the transcript or final report. Following the session, NWAC will provide you with the $100 via email transfer.

Will my information be kept private?

During the engagement we will be collecting your ideas and knowledge specific to the purpose of this research. We will do everything we can to make sure that this data is kept private.

We will store all data in secured computers that only the research team will have access to as they compile for a final report to NWAC. Additionally, the research team will only be able to use the data as set it out in the research terms of agreements.

The only personal identifiers stored will be your contact information so that we can provide you with copies of the transcript, report, cash gift and keep you informed of the broader project.

No data relating to this study that includes your name or personal identifiers will be released outside of NWAC, or be published by the research team.

After the study is completed, NWAC and the Inuit researcher will continue to securely store the anonymized data that was collected as part of the engagement sessions.

While we will strive to protect the confidentiality of information collected during sessions, and will remind all participants not to share information, we cannot guarantee others who attended the sessions will do so.

What if I have questions?

If you have any questions about the research now or later, please contact the Research collaborator: TBC

This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the engagement session is being conducted you can contact:
The McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Research Office for Administration, Development and Support (ROADS)
E-mail: ethicsoffice@mcmaster.ca

This study is being funded by Canadian Institute of Health Research. The lead organization, NWAC, is receiving money from the funders to cover the costs of doing this nation-wide gender-specific study. You are entitled to request any details concerning this compensation from Marisa Blake, NWAC Cannabis Project Coordinator, email: mblake@nwac.ca

Should you want to take part in one of the two Inuit-focused engagement sessions, please fill out the enclosed consent form.

PARTICIPANT CONSENT FORM

Title of Research Project: Establishing Research Priorities: An Exploration of First Nations, Inuit and Métis Women and Gender Diverse People's Needs in Cannabis and Mental Health

Principal Lead: **Abrar Ali**, Native Women's Association of Canada

Inuit-specific Research Facilitator & Collaborator: TBC

Please answer the following questions:	Yes	No
Do you understand that you have been asked to be in a research study?	×	×
Have you read and received a copy of the attached Information Sheet?	×	×
Do you understand the benefits and risks involved in taking part in this research study?	×	×
Have you had an opportunity to ask questions and discuss this study?	×	×
Do you understand that you are free to leave the study at any time without having to give a reason and without affecting your future access to services?	×	×
Has the issue of confidentiality been explained to you?	×	×
Do you understand who will have access to the anonymized transcript and data analysis for your review?	×	×
Do you understand that you will need to provide personal information such as your contact information, such as an email address to access zoom link, and to receive information?	×	×
Do you understand that the final report and transcript will be anonymized to ensure confidentiality?	×	×
Do you understand that you are being asked to keep the information shared during the engagement sessions confidential?	×	×
Do you understand that to participate you will need to be live on the Zoom Meetings online platform		

with an operational microphone on your computer or mobile device?	×	×
This study was explained to me by:_____		

I agree to take part in one of the two community-engaged sessions.

_____ _____
Signature of participant Printed name

Contact information:

Address
Email:
Telephone Number:

Date: _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate:

_____
Signature of research team

Date: _____

A SIGNED COPY OF THIS INFORMATION SHEET AND CONSENT FORM MUST BE GIVEN PRIOR TO PARTICIPATION IN THE GATHERING

10.6. ENGAGEMENT SESSION AGENDA:

1 to 1:15 p.m. Opening Prayer (Elder)

1:15 to 1:30 p.m. Overview of Project and Obtain Consent (NWAC)

1:30 to 1:45 p.m. Presentation on Cannabis and Mental Health (NWAC)

1:45 to 3:45 p.m. Discussion (Facilitator)

3:45 to 4 p.m. Closing Circle and Prayer (Elder)

NWAC.CA

ESTABLISHING RESEARCH PRIORITIES:
An Exploration of First Nations, Inuit, and Métis Women, Two-Spirit, Transgender, and Gender-Diverse People's Needs in Cannabis and Mental Health

MARCH 24 2022

DRAFT REPORT

Native Women's Association of Canada

L'Association des femmes autochtones du Canada

Archipel Research & Consulting Inc.