



Culture & Mental Health Research Unit  
Report No. 8

## **Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities**

Proceedings of the Conference "Widening the Circle:  
Developing Partnerships for Aboriginal Mental Health,"  
September 26-28, 1997, Montreal, Quebec

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# **Widening the Circle: Collaborative Research for Mental Health Promotion in Native Communities**

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## **Preface & Acknowledgement**

This report presents the proceedings of a conference on developing partnerships for research on mental health and illness in Native communities. The conference took place September 26 to 28<sup>th</sup>, 1997 at the Institute of Community of Family Psychiatry of the Sir Mortimer B. Davis—Jewish General Hospital. Funding for the conference came from a grant from the Conseil québécois de la recherche sociale to the Native Mental Health Team. Co-sponsors were Waseskun House and the Native Women's Shelter of Montreal.

The purpose of the conference was to bring together university-based researchers and people working in First Nations and Inuit communities and organizations, to discuss and improve understanding of issues related to mental health and social services. It was hoped that this exchange would contribute to communities and organizations attaining the results they desire in terms of enhanced mental health, fewer social problems and more effective services.

For various social problems or mental illnesses, the conference participants attempted to answer the following questions:

- What kinds of programs are being delivered in Aboriginal communities to deal with the problem?
- Has research shown that particular types of programs are more effective than others and if so, is this applicable among First Nations and Inuit?
- How can research contribute to improving services or preventing mental health and social problems in Aboriginal populations?

The conference was organized by members of the Native Mental Health Research Team. The organizing committee consisted of Kathryn Gill, Laurence Kirmayer, Elizabeth Robinson, Caroline Oblin, Wayne Romansky and Jo-ann Stacey.

Marie-Anik Gagné coordinated the conference planning with great skill and energy. Staff of the Culture and Mental Health Research Unit worked with commitment and enthusiasm to make the conference go smoothly: Lucy Boothroyd, Consuelo Quesney, Suzanne Taillefer and Kay Berckmans.

We would like to thank all of the staff at the Department of Psychiatry of the Jewish General Hospital who assisted with preparations and arrangements, especially Louise Veillieux.

Rapporteurs at the conference enabled us to summarize some of the oral presentations for which no written text or tape was available; Greg Brass, Kaha:wi Joslyn Jacobs, Natalie Lloyd, Elizabeth Robinson, and Lara Stern ably performed this task.

Tapes of the conference were transcribed by Kay Berckmans and reviewed by the presenters. The text was copy-edited by Isabelle Fieschi, Marlene Caplan, Lucy Boothroyd, and Kathryn Gill.

We hope that the publication of these proceedings will contribute to the formation of partnerships between researchers and community-based practitioners, so that when it is appropriate to do research around a particular issue, the work will be done in a collaborative manner.

Montreal, September 1998

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### **Native Mental Health Research Team**

The Native Mental Health Research Team is a collaboration between workers at Native organizations and researchers from McGill University and other academic institutions to promote the development and evaluation of effective and culturally appropriate mental health programs for Native populations and communities in Quebec. The team is funded by the CQRS (Conseil québécois de la recherche sociale) under a special program as a partnership between practice and academic institutions. The principal co-investigators of the Native Mental Health Research Team are:

- Laurence Kirmayer, Division of Social & Transcultural Psychiatry, McGill University
- Serge Déry, Nunavik Regional Board of Health and Social Services (since 1997)
- Steve Hodgins, Nunavik Regional Board of Health and Social Services (1995-1997)
- Kathryn Gill, Addictions Unit, Montreal General Hospital
- Elizabeth Robinson, Public Health Module, Cree Region of James Bay
- Liesel Urtnowski, School of Social Work, McGill University
- Naomi Adelson, Department of Anthropology, York University, Toronto
- Adrian Tanner, Department of Anthropology, Memorial University, Newfoundland

Other organizations collaborating with the Native Mental Health Research Team include:

- Module du Nord Québécois
- Native Friendship Centre of Montreal
- Native Women's Shelter of Montreal
- Maison Waseskun House
- Centre de santé publique de la région de Québec
- Department of Anthropology, St. Mary's University, Halifax

## Contributors

**Naomi Adelson, Ph.D.**, Assistant Professor, Department of Anthropology, York University, Toronto. Prof. Adelson trained in medical anthropology at McGill and has maintained close ties with researchers here. Her ongoing fieldwork centres on the community of Whapmagoostui (Poste de la Baleine/Great Whale River) and its responses to social suffering and change. This work is linked to a U.S. SSRC project on “Community responses to social suffering.” She has conducted fieldwork in this community since 1988 and has received Band Council permission to continue her work through 1999.

**Abraham Bearskin** works for the Cree Regional Board of Health and Social Services. His workshops on traditional healing draw from his own extensive training in Native healing and his work with individuals overcoming traumatic and abusive life experiences. Mr. Bearskin is Cree from Chisasibi, Quebec and has been doing workshops for 6 years. He has been a keynote speaker in seminars and Healing Gatherings in various Native communities.

**Marilyn Bearskin** is a survivor of domestic violence, dedicated to fighting back and reclaiming her life. Despite open hostility from some men towards her work, she continues to write for “The Nation” on a voluntary basis. She reports the stories of abused women to encourage dialogue on domestic violence in Cree Society. Ms. Bearskin and the Regional Youth Council are in the process of setting up the “First Annual Cree Domestic Violence Conference.”

**Archie Cheechoo** has over 10 years of experience working with Native groups across Ontario and Quebec, bringing the traditional teachings and ceremonies to communities and individuals.

**John Curotte** is a member of the Turtle Clan and a resident of Kahnawake. He is a father, grand-father and husband. Mr. Curotte is a former iron worker and a teacher. He sits on the Board of Directors of the Native Friendship Centre in Montreal and presides over many of the important events at the Native Friendship Centre in Montreal.

**Lucie Dessureault** has been working for Health Canada for over 20 years, primarily as an agent and program coordinator for prevention and health promotion programs such as NNADAP (prevention, treatment, and training components), CHR and various HIV/AIDS initiatives. Her responsibilities have enabled her to participate on various committees at the national and regional levels and to work with First Nations and Inuit communities of Quebec as well as with the Chinese, Jewish, Greek and Italian communities.

**Jacques Ducharme** is a psychologist who has been working in the area of substance abuse since 1973. Mr. Ducharme participated in many of the developmental phases of the national substance abuse program that has fought alcoholism among Natives since 1984. His many roles have included programmer, advisor, consultant, evaluator and Wiseman at the community, regional and national levels.

**Martha Flaherty** has been President of Pauktuutit, Inuit Women’s Association of Canada, since March 1991, as well as an active member of the Executive of the Inuit Tapirisat of Canada where she served as Vice-President. Ms. Flaherty was at the forefront of actions to bring the High Arctic Relocation to the attention of the Canadian public, and the Government of Canada recently issued an official apology for its actions at that time. Ms. Flaherty attended schools in Carcross, Yukon and Churchill, Manitoba. She studied nursing in Fort Smith, N.W.T. and worked in this field for a number of years. Her experience in

interpreting for medical personnel in the North influenced her decision to enter the G.N.W.T. Interpreters Corps. Ms. Flaherty is recognized as one of the most distinguished Inuit interpreter-translators in Canada. Her accomplishments in this profession include her work as the Inuktitut/English voice in international, national, and regional television, video and radio programs, and her role as one of the select Canadian interpreter-translators for the Tungavik Federation of Nunavut prior to being elected as President of Pauktuutit. She is a steadfast advocate for Inuit women, and has addressed a wide variety of Canadian and international audiences. Ms. Flaherty was a member of the Canadian Panel on Violence Against Women which traveled across Canada and she also participated on the Panel on Economic Development for Canadian Aboriginal Women. She was a member of a Canadian delegation of representatives of national Aboriginal organizations in Canada that met with European parliaments and officials regarding the importance of protecting the harvesting rights of Aboriginal peoples. The delegation's mandate was to counter the vocal and powerful anti-fur lobby in Europe.

**Nicki Garwood**, B.A., B.S.W., M.S.W., is Clinical Coordinator at Waseskun House, a half-way house for male Aboriginal ex-offenders situated in Montreal. A graduate of McGill University's School of Social Work, she has worked in therapy, program development, community development and research. Ms. Garwood has worked extensively with sexual offenders from Aboriginal communities, as well as with individuals suffering from problems of addiction and violent behaviour.

**Laverne Gervais-Contois** is an Anishawbe woman, member of the Peguis Band in Northern Manitoba. She lived most of her life in Winnipeg before moving to Montreal in 1983. She is the mother of two adult children and is in her final year of studies at Concordia University specializing in Applied Social Science with a minor in Psychology. From 1990-94 Laverne was President of the Friendship Centre of Montreal, and was the Urban Representative for the Onen'to:kon Treatment Services. She is founder of the Incest Survivors In Support group and a volunteer member of the West Island Resource Centre board. Laverne was part of the initiative of the Urban Aboriginal AIDS Awareness Program (UAAA) and of Concordia University's Native Student Centre. Currently, she sits on the Waseskun House board; on the Quebec Native Women (AFQ/QNW) board as Urban General Council Director; is a representative on the National Action Committee for Women, and an Adjunct Fellow at the Simone de Beauvoir Institute. As the President of Aboriginal Women of Montreal (AWM/FAM) she represents the local on various working committees including the Aboriginal Workforce Association and the Aboriginal Women's Committee for Justice and Equality.

**Kathryn Gill**, Ph.D., Director of Research, Addictions Unit, Montreal General Hospital; Assistant Professor, Department of Psychiatry, McGill University. Dr. Gill is a psychologist who has worked extensively with Native peoples in the U.S., focusing on the interaction of genetic, psycho-biological and social factors in alcohol abuse and recovery.

**Roda Grey**, R.N.A., S.S.W., National Health Coordinator for Pauktuutit, the Inuit Women's Association of Canada. Ms. Grey is Inuk from Ungava Bay, Nunavik and was raised in the "Inuit traditional ways." She graduated as a Registered Nurse's Assistant from Ungava Hospital, Kuujuaq, Nunavik in 1978. She obtained her diploma as a Social Service Worker from Algonquin College in Pembroke, Ontario in 1992. Ms. Grey became interested in the health problems of the Inuit people in the early 1970s when she worked as an interpreter for Inuit patients in Quebec City. She is a national spokesperson on health issues for the Inuit.

**Laurence J. Kirmayer**, M.D., Director of the Culture & Mental Health Research Unit, Institute of Community & Family Psychiatry, Jewish General Hospital; and Professor of Psychiatry & Director, Division of Social & Transcultural Psychiatry, McGill University. Dr.

Kirmayer was a psychiatric consultant for the Inuit of Nunavik from 1987 to 1993. He has conducted funded research on Inuit concepts of mental health and illness; risk factors for suicide among Inuit youth; pathways and barriers to mental health care in an urban multicultural community; and somatization in primary care and specialty medicine. He currently directs the McGill Summer Program in Social and Cultural Psychiatry, and a research team on Culture and Mental Health funded by the FRSQ. Dr. Kirmayer is also Editor-in-Chief of *Transcultural Psychiatry*, a quarterly scientific journal.

**Fred Kistabish** is an Algonquin Native. He has been the Executive Director of the Wapan Treatment Centre since 1993 and is the Interim director of Maliotenam Treatment Centre.

**Richard Kistabish**, Health and Social Services Coordinator at Kitcisakik; Services Sociaux Minokin Grand-Lac-Victoria. Mr. Kistabish is the author of a critique on Quebec's mental health policies for Aboriginal peoples.

**Katie Moores**, M.S.W., Department of Social Work, Montreal General Hospital. Ms. Moores has been working with the McGill-Baffin Program since 1994. Her work involves locating resources for hospitalized Inuit from Baffin Island and counselling in bereavement, childhood sexual abuse cases and in crisis situations such as wife beating and newly-diagnosed life-threatening illness. Working with the Inuit population and its tragically high suicide rate, Ms. Moores has developed expertise in bereavement counselling.

**Caroline Oblin**, B.S.W., is a social worker for the Northern Quebec Module (Patient Services). Ms. Oblin initially became involved in the social work field as a community worker from 1982 to 1984 in her home village, the Cree community of Waswanipi. In 1984 she moved to Montreal, completing a Bachelor of Social Work degree at McGill University in 1988. She has been working as a social worker for the Northern Quebec Module since March, 1989. Her clients are patients from the Inuit and Cree communities of northern Quebec. She is a member of the executive board of the Native Women's Shelter of Montreal and Waseskun House (a halfway house for Native ex-offenders) and a committee member of: the Aboriginal Foster Home Committee, the Native Mental Research team and the Urban Aids Awareness Project.

**Kitty Pearson** is the director of Isuarsivik Treatment Centre in Kuujjuaq.

**Joan Pennell**, Ph.D., Interim Director and Professor of the School of Social Work at Memorial University of Newfoundland. Dr. Pennell has co-authored several articles and book chapters on the phenomenon of family violence and the family group decision making process, discussing the Indigenous structures for reporting family violence.

**Anita Pratt** is from the Cree Nation and has worked with Native people for the past 30 years in various capacities. Ms. Pratt has been the Executive Director of the Native Women's Shelter of Montreal since the shelter opened its doors in 1988. She is the mother of three, grandmother of three, and foster parent of two.

**Dianne Reid**, President of James Bay Cree Cultural Education Centre; member of the Waswanipi Band Council and the James Bay Cree Communications Society Board of Directors where she works with Elders on cultural development. Ms. Reid spent her college years in Nursing. University studies included linguistics and communications. Her experience over the last 20 years has included work in the areas of communications, politics, Aboriginal issues, health, education, culture and language, environmental issues, national Native organization movements, local and regional governments, and international, national, provincial, regional and local representation for the Cree Nation of Eeyou Istchee. Ms. Reid's experience working with the International Development Research Centre as liaison for



indigenous exchanges and projects has taken her to work in Latin America, New Zealand, Australia, Hawaii and Nepal, among many other places.

**Elizabeth Robinson**, M.D., M.Sc., Assistant to the Director of Public Health of Montreal and Responsible for Public Health in the Cree communities of James Bay. Dr. Robinson, formerly a family practitioner, now specializing in community medicine, was head of the Northern Quebec Module from 1986-1994. She has considerable experience in public health and clinical practice, as well as research experience with the James Bay Cree communities of Northern Quebec. Her two current research projects are: (1) prevention of gestational diabetes and (2) integration of traditional medicine into the Cree bush kit program.

**Bevan Skerratt**, M.Ed., of Saskatchewan Cree and Celtic ancestry, is currently employed as program coordinator at Maison Waseskun House, Montreal, a healing centre for Native males referred from federal and provincial correctional institutions as well as from communities in Quebec and across the country. Mr. Skerratt holds a Bachelor's degree in Applied Social Sciences from Concordia University, and a Master's of Education in Counselling Psychology from McGill. His interest is in deep healing work with traumatized individuals, groups, and communities, situated within the cultural/spiritual context of North American Aboriginal symbol systems. He embarked upon his own healing path in December of 1975, and he views his work as the sharing of an on-going journey towards wholeness.

**Adrian Tanner**, Ph.D., Professor, Department of Anthropology, Memorial University, Newfoundland, has conducted fieldwork among the James Bay Cree since the 1970s and is the author of a classic monograph on Cree spirituality "Bringing Home Animals."

**Elisapie Tookalak** is Coordinator of Social Services for the Hudson Bay Region of Northern Quebec.

**Elisabeth Urtnowski**, M.S.W., Associate Professor, School of Social Work, McGill University. Since 1982, Prof. Urtnowski has developed, coordinated and taught in the McGill Certificate Program in Northern Social Work Practice, funded since 1992 by the Ministère de l'enseignement supérieur et de la science, at \$100,000/year. In this capacity she has developed close professional links with Inuit community workers in most Northern Quebec settlements.

**Jim Waldram** has a Ph.D. in Medical Anthropology from the University of Connecticut and is Professor of Native Studies at the University of Saskatchewan. Specializing in Aboriginal health issues, he is the author of many articles and books, including "Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives" (with Ann Herring and T. Kue Young; University of Toronto Press, 1995), and "The Way of the Pipe: Aboriginal Spirituality and Symbolic Healing in Canadian Prisons" (Broadview Press, 1997). He is currently engaged in research on Aboriginal healing and mental health issues.

## An Overview of Mental Health Challenges and Programs in Quebec Aboriginal Communities

Caroline Oblin

*Module du Nord Québécois*

**Résumé:** Les problèmes majeurs de santé mentale dans les communautés autochtones sont, à présent, la dépression, le suicide, l'abus de drogues et d'alcool et la violence intra-familiale. Les causes de ces problèmes ne sont pas à chercher parmi les valeurs traditionnelles autochtones qui mettent l'accent sur l'aspect interdépendant des communautés. Au contraire, l'auteure implique l'introduction d'alcool et des valeurs de consommation qui ont accompagné le processus de colonisation, et la création des écoles résidentielles. Elle explique les problèmes actuels comme étant le résultat de griefs personnels, communautaires et culturels non résolus, menant en particulier à la perte d'estime de soi et à la dépression. Afin de combattre ces problèmes, l'auteure suggère de réexaminer les valeurs autochtones traditionnelles afin de garder celles qui pourraient être utiles aux sociétés autochtones contemporaines. Afin de réduire l'incidence des comportements autodestructeurs, elle suggère l'inclusion de tous les membres des communautés, ainsi que des professionnels de la santé, dans l'établissement de programmes culturellement adéquats et efficaces. Ces programmes auraient pour but de réduire l'isolement des individus, encourager un style de vie sain, développer les forces individuelles en laissant à chacun le choix de sa méthode de guérison. Enfin, tout projet de recherche entrepris devrait refléter les besoins des communautés et être orienté vers l'action.

**Abstract:** The Native communities in Quebec are faced with the challenges of finding solutions, programs and alternative ways of healing their community members. Most communities in Quebec are dealing with alcohol and drug abuse, suicide and suicide attempts, spousal abuse, incest, family violence, high unemployment and sexual abuse. Other Aboriginal communities in Canada and elsewhere are facing similar problems. Some programs and interventions that might be beneficial to people in the helping field will be discussed.

The purpose of this presentation is to provide a brief overview of mental health issues that are particularly relevant to the Cree and Inuit of Northern Quebec. Many of the points covered are equally relevant to other Aboriginal peoples elsewhere in Canada and throughout the world.

One of the key mental health issues affecting Aboriginal peoples is family violence. Family violence is weakening our nations because it is weakening our families. We all know what the problems are, what the causes are, and now, we need action.

Aboriginal people carry much unresolved grief from their past. This unresolved grief may be generated from personal losses, family losses, community losses, and quite often a combination of all three. There may also be unresolved grief in relation to cultural losses suffered as an Aboriginal person. The challenge for those of us who are in a position to affect change is to once again examine and re-evaluate the raising of children, many of whom have abandoned traditional values and beliefs. At the same time, we must consider where we are today, what we face as parents and teachers and how we can apply today those old values and beliefs that guaranteed safety and stability for our children.

In the early 50's, the Cree and the Inuit of Northern Quebec were scattered throughout the region. They lived off the land trapping, fishing, and hunting as they had been doing for centuries. Traditionally, Aboriginal families and communities operated as co-operative, interdependent units. The concept of an integrated whole was very much a part of Aboriginal society. Identity derived from the perception of one's role and involvement within the family and the community.

In order to survive in the often-hostile environment, it was necessary for this holistic society to be constantly evolving and striving for better ways of dealing with the environment. Therefore, innovation was a main ingredient for survival.

Traditionally, Aboriginal people slept when they were tired, ate when they were hungry, got exercise through the demands of hunting and fishing. They danced for recreation and avoided harmful stress by "going with the flow"; it is important for us to learn from this past, to live and work in the present, and to prepare for the future.

Things changed for Aboriginal people when they started settling in small communities in order to improve their standard of living in terms of access to medical services, electricity, water and sewage systems, schools, and so on. People had to adjust to living in modern housing and to full-time, permanent community living. Most significantly, the impacts of consumerism and mainstream values promoting the need for material goods, collided with the reality of a traditionally subsistence economy and a lack of jobs. Aboriginal spirituality diminished while new pressures and unemployment increased, resulting in a loss of well-being, depression, alcoholism and substance abuse.

From a psychiatric perspective, these are symptoms of alienation. Alcohol and drug abuse are usually rooted in low self-esteem. They are unhealthy ways of attempting to cope with the pressures of life, which for Aboriginal people often include adapting to rapid social and cultural change. The problem of alienation was compounded further for members of certain communities that were forced to relocate. This often resulted in being physically removed from a setting where people had been able to live off the land, to a situation where they were totally dependent on support programs. This situation destroyed initiative and created a cycle of dependency.

Another significant influence from non-Aboriginal culture that has affected many people was that of residential schools. The residential school system created cultural and spiritual confusion for many and affected child-rearing practices significantly. Children who have grown up removed from their family circle and within abusive situations such as often existed in the residential schools sometimes view abuse as normal behaviour. This leads to a cycle of intergenerational abuse including spousal and child abuse, incest and sexual abuse.

For many, traditional Aboriginal values and beliefs eroded to such an extent that they did not provide a firm philosophical foundation for living in contemporary society. This has been especially true for adolescents not deeply rooted in traditional culture and who are under tremendous pressure to conform to non-Aboriginal values. Many Aboriginal youth today are going through an identity crisis. There is a high dropout rate in schools and high unemployment for youth with low levels of formal education. The struggle of youth to find their place within their respective societies often leads to many of the health and social problems that exist.

Non-Aboriginal influences have eroded the cooperative, communal nature of Aboriginal life. There are many observable examples of the negative effects of the breakdown of Aboriginal cultures. For example, we may observe a mother who is angry or depressed because of

abuse, which in some cases has resulted in a broken home and the incarceration of an abusive spouse. Such women may also be at risk for neglecting or abusing their children. Another example is that of a woman who presses charges against her husband, then feels guilty about it and/or afraid of his possibly violent reaction when he is released. She must also contend with the fact that the legal process is a lengthy one in the course of which she may be confronted by her husband's presence and possible hostility and violence.

The overwhelming hardships and tragedies within some Aboriginal communities often lead to a collective grieving process. The first step in the grieving cycle is denial. There is a similar process among Aboriginal people in reaction to imposed pressures from the dominant culture. The denial of unwanted pressures is manifested by depression, which grows from the silent, unexpressed anger of the people. This anger is directed inwardly and is self-destructive. As well, many people feel ashamed because of problems within their families and suffer sadness, depression and anxiety in isolation.

Aboriginal people emphasize that family violence is not traditional; it is the outcome of colonization. Aboriginal traditions are of great value, but to retain their value the past must be used as a source of knowledge and experience to help plan the future. Using past experience to plan a new way of life can replace guilt and shame with a sense of self-respect and humility, providing the foundation for a positive and healthy attitude toward the self, others, and the environment.

The changing nature of life does not mean that everything that is old should be discarded and replaced with everything that is new. There must be modifications and adaptations to address new and changing circumstances. But traditional values that are functional for contemporary Aboriginal society should be maintained and non-Aboriginal values that are not functional should be rejected.

People in the Aboriginal communities must be encouraged to understand the factors that have contributed to mental health problems. Efforts must be focused on reducing the incidence of self-destructive behaviors. With understanding come solutions. All members of the community must be part of the solution. People must learn to care for themselves, which in turn will enable them to care for others and the natural environment. All are interdependent. Individuals must not be left feeling isolated with their problems. For example, in the case of women suffering the effects of intergenerational abuse, putting the responsibility of single parenting solely on their shoulders must be questioned.

The development of a positive lifestyle is important if people are to develop, maintain and enhance a sense of wellness. General health care, including treatment and rehabilitation, should be based on physical, psychological, social and cultural needs. A system that encourages community support, sponsorship and family healing creates a strong, closely-knit, healthy community. Living through experiences one at a time, and making the most of them, can lead to focused and purposeful lives. With clarity and purpose, mental health problems among Aboriginal people should decrease. In a community with unified values and beliefs, there is less likelihood of alienation and consequently, less likelihood of self-destructive behaviour such as suicide attempts. Individuals must seek their own personal strengths and resources and choose healing methods which best work for them, whether a return to traditional beliefs, humanistic values or a religious path. Within the health and social services fields, efforts must be made to enable Aboriginal people to maintain and enhance their well-being through the implementation of effective policies, programs, and services. There are fundamental resources that are needed before any intervention will be effective. Often, well-intentioned but misdirected efforts have put "brown faces on white programs" rather than building Aboriginal programs based on Aboriginal cultural values, justice and governing systems, life experiences and methods of healing.

Relevant research work and appropriate programs and services based on the particular needs of Aboriginal communities are an important part of the work which must be done to address problems relating to mental health. The intervention of non-Aboriginal professionals must complement the efforts of the communities in addressing mental health problems. Programs and activities must originate from the community, drawing upon all members for ideas. The people of the community know their needs and how to satisfy them, and they must provide the impetus for change. They must be pro-active they strive for a healthier lifestyle. Communities must identify their problems and define solutions.

An example of such a community initiative is that of the Stoney in Alberta. They introduced a program called "Self-Improvement through Empowerment" or S.I.T.E. The four steps in the S.I.T.E. program are: (1) healing; (2) life skills; (3) upgrading; and (4) work placement and employment.

The healing component of S.I.T.E. is composed of personal-growth workshops, which include learning to explore and rebalance personal medicine wheels; learning to build strong spiritual relationships; taking care of the body; rational and positive thinking; and releasing old pains and expressing feelings in a healthy manner.

The mental health concerns of many Aboriginal people and organizations include substance abuse, depression, family breakdown, and suicide. Governments must provide adequate resources for the full range of treatment and prevention programs needed to maintain and enhance the health of Aboriginal people who are suffering from these many problems stemming from alienation. One approach would be to set up an inter-agency committee consisting of professional interveners such as community workers, police, guidance counselors, addictions counselors, health workers, etc. The committee members would discuss problems and determine the programs and interventions for specific situations.

Punishing people by putting them in jail does not solve the problems underlying dysfunctional and dangerous behaviour. People need to deal with their inner feelings and motivations. There must be services such as residential treatment programs, or programs which incorporate going out to live on the land, directed at people who commit offences. In cases of abuse, this would also help make the situation more secure for victims.

Schools should be encouraged to use positive role models for young people, such as respected elders. This type of initiative can be further supported through the development of peer counseling programs within guidance studies courses. Aboriginal dancing and stress management techniques could also be introduced into the health and physical education curriculum.

Self-esteem, anger-management and parenting workshops should be offered to develop community well-being. An example of a positive community development is that of the midwifery program in Puvirnituk. It is a program that contributes to the creation of a strong family unit.

Teacher training programs should include courses on sexuality, nutrition, alcohol and drug abuse, and other significant community health issues. There should also be public awareness programs on such matters as child abuse, sexual abuse, and so on. There must also be community resources such as safe houses, abuser retreats and support services for mentally ill individuals and their families. A safe house provides support, sponsorship and accommodation for child and adult survivors until their own housing situation is safe. An abuser retreat provides a place where abusers can be temporarily isolated from their families or survivors and receive intensive, culturally sensitive, holistic-milieu treatment.

Support services for mentally ill persons and their families would consist of facilities where the afflicted individuals could get temporary shelter in order to provide relief to their families.

Solutions to mental health problems in Aboriginal communities must come from a concerted effort from both community members and health care and social work professionals. The responsibility cannot be assumed by only one or the other. Community workers are often overworked, are expected to be on call at all hours of the day, and must sometimes deal with threatening situations. Community workers often feel overwhelmed by the challenges they face and their difficult situation can lead to burnout if they do not have sufficient support within their community.

To briefly summarize some of the main points of this presentation, many of the mental health problems faced by Aboriginal people today stem from unresolved conflicts pertaining to personal, family, social and cultural issues. With support and involvement on the part of everyone concerned, solutions will emerge. Initiatives must stem from the needs of Aboriginal people in conjunction with assistance from social work and health care professionals.

## Research and Clinical Perspectives on Mental Health in Native Communities

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**Résumé:** Cette présentation donne un aperçu général de la santé mentale de communautés des Premières Nations et communautés Inuit du Québec basé sur des recherches en épidémiologie et en psychiatrie clinique. Quels sont les types et les taux de problèmes, des troubles de tous les jours aux troubles psychiatriques? Quels facteurs contribuent au bien-être et à une bonne santé mentale et quels sont les facteurs de risque et de protection face à la maladie mentale et à la souffrance sociale? Quels défis particuliers attendent les communautés autochtones comparativement au reste de la société canadienne? Comment la pratique conventionnelle en santé mentale peut-elle être modifiée afin de répondre à la réalité des autochtones? Cette présentation examine l'importance et les limites des informations existantes au sujet de ces problèmes afin d'identifier les priorités des recherches à venir.

**Abstract:** This presentation gives a broad overview of the mental health of First Nations and Inuit communities of Quebec based on epidemiological and clinical psychiatric research. What are the types and rates of problems ranging from everyday problems in living to psychiatric disorders? What factors contribute to well being and mental health, and what are the risk and protective factors for mental illness and social suffering? What distinctive challenges are faced by Native communities compared with the rest of Canadian society? How must conventional mental health practices in treatment, prevention and health promotion be modified to fit Native realities? The presentation examines the value and limitations of existing information on these issues in order to identify priorities for future research.

I am very glad to be here today to participate in this conference, which I hope will open the way to future collaborations. I am a research and clinical psychiatrist and my main area of interest is in the interaction between cultural and social factors and mental illness, especially depression, anxiety and physical symptoms like pain. My involvement in the area of Native mental health began in 1987 when I was invited by the medical director of Inuulitsivik Health Centre in Puvirnituk at that time, Dr. André Corriveau, to provide psychiatric consultation in Nunavik. I did this during trips to Puvirnituk and the Inuit communities of the Hudson Coast several times a year until 1993. My experiences trying to help individuals by working with the Inuit community workers, nurses and family doctors convinced me both that psychiatry has something to offer in this situation but also that psychiatry and other mental health professions are limited in their ability to address many of the health and social issues faced by Native peoples. A comprehensive and effective response to improving mental health and preventing illness will require the integration of community and culturally based knowledge with conventional mental health approaches.

In this presentation I will try to outline some of what is known from a scientific point of view about common mental health problems among Inuit and First Nations peoples in Quebec and Canada. This type of information can help to guide mental health promotion and illness prevention work. We are still missing much of the information we need to help to

develop effective mental health promotion programs. We cannot always assume that approaches developed for people from European background living in large cities will fit the culture, values or social situation of Native peoples living in small or remote communities. There is a need for close collaboration between people within Native communities and clinical researchers to gather the basic information we are missing and to learn how to adapt or modify conventional mental health practice to meet the needs and perspectives of Native peoples. There is also much to be learned from indigenous healing that can help health professionals do a better job in their own efforts and work collaboratively with other healers, helpers, families and communities.

### **Mental Health, Mental Illness and Psychiatry**

Mental health has a broader meaning than mental illness, since it includes physical, psychological, social and spiritual well-being. Mental illness includes many different psychiatric disorders—about 300 are listed in psychiatric manuals. Emotional distress may be due to a psychiatric disorder or arise from problems in living that affect everyone at some time in their life. Substance use and dependence (drugs, alcohol) are recognized as psychiatric problems in their own right but they are usually associated with other personal, family and social problems. Suicide is one of the most dramatic results of severe emotional distress. The majority of people who commit suicide have an identifiable psychiatric disorder, most often a major depression. However, suicide attempts may also reflect problems in living and adaptation that are common during adolescence; in particular, many youth have difficulty imagining a secure and rewarding future and this may contribute to suicidal ideation and attempts.

Mental illness is now recognized to be among the most important contributors to disability and decreased quality of life around the world and it should not be given a lower public health priority than infectious diseases or other physical illnesses. Mental health and illness are clearly linked to social problems: when people are economically disadvantaged, lack control over their own lives, or endure the appropriation and destruction of their culture and way of life they usually experience high rates of mental health problems. However, the obvious role of social factors should not lead us to neglect those individuals with more severe mental health problems who require specific and effective treatment. There is a tendency for some people, in their desire to 'normalize' mental illness, to explain it away as a 'natural' consequence of social problems; others may blame the victims for their problems. These negative attitudes—which are found among professionals as well as community members—must be changed toward greater acceptance of the reality of mental illness and understanding the necessity for treatment.

### **The Prevalence of Mental Health Problems**

In most societies and groups that have been studied, mental health problems appear to be very common. Research in the general Canadian, American and British populations shows that common mental health problems—depression, anxiety and related problems—have a combined prevalence in the community of between 15 to 30% (Goldberg & Huxley, 1992). Despite sometimes being viewed as minor disorders compared to other psychiatric disorders like schizophrenia or manic-depressive illness (bipolar disorder), they are associated with impairments in work, physical and social functioning comparable to those associated with chronic physical illness.

As we discovered while preparing reports for the Royal Commission on Aboriginal Peoples, there is relatively little epidemiological information available on the prevalence of mental



health problems among the Native peoples of Canada or Quebec. That is one reason we formed this research team. The overall impression one gets from the media is that there are very high rates of depression, substance abuse and suicide but, in fact, the rates seem to vary a great deal from one community to the next. For example, in Quebec the youth of Nunavik have a very high rate of attempted and completed suicide while their counterparts in Cree territory have a rate similar to or below that of the rest of Quebec (Quebec as a whole though has a higher rate than the Canadian average.) If we can understand the circumstances that make one community relatively healthy, compared to another where more people are suffering, we can use this information to develop community interventions to promote wellness.

Unfortunately, as of yet, there is no psychiatric epidemiology among any Canadian Aboriginal group that allows us to identify the prevalence of specific psychiatric disorders. Most research has looked at the overall level of symptoms of emotional distress, drug use, suicide and accidents. Santé Québec, a government agency, has conducted health surveys among the Inuit and Cree which included some questions relevant to mental health but these surveys did not use the best methods to identify specific problems.

The prevalence of substance use in Nunavik depends on how one defines the problem. For example, in the Santé Québec survey, while 13% of youth use alcohol weekly or more often, 31% were positive on the CAGE, an index of probable alcohol abuse and fully 51% of youth were positive on an index of alcohol abuse-related problems. The discrepancy reflects the fact that alcohol is usually drunk to excess only sporadically, when it is available, and then results in episodes of dangerous behaviour. Risk factors for alcohol abuse include a history of sexual abuse, mental or physical illness and cannabis use. The Santé Québec survey found that in the last year, 43% of youth had used cannabis, 7.1% cocaine or crack, and 7.1% solvents; 22% of youth have used solvents at some time. Solvent abuse is strongly associated with high levels of distress and family dysfunction among youth.

Based on the pattern of patients referred to psychiatrists for consultation, it appears the range of psychiatric disorders are present in Nunavik at rates as high or higher than in urban North American populations. Among the most common disorders are major depression, anxiety disorders, schizophrenia, bipolar affective disorder, substance use disorders, conduct and personality disorders, mental retardation and dementias. This implies an important role for psychiatry and other mental health professions in treatment of these problems, as well as in service planning, public education and preventative programs. However, since many of the mental health problems that face people in Nunavik affect the whole community directly or indirectly, they demand community-based solutions. The situation is similar for most other Native communities in Quebec.

### **Risk and Protective Factors**

It usually takes a combination of factors to make someone fall ill and multiple factors also contribute to someone staying well. One way to look at individual and social factors that influence groups of people is in terms of their tendency to increase the risk of having a problem or to protect against it. The study of risk and protective factors for mental illness has much to teach us both about the causes of problems and their cure or prevention. Much of what has been learned from this type of research in the general population in Canada and other countries probably applies to the situation of Native people. But there is still a need to look more closely at the specifics the Native populations and communities. To do this we need epidemiological information on large numbers of people who have experienced different combinations of life events and social and personal factors affecting them.

In general, the prevalence of common mental disorders in a population is correlated with the prevalence of other disorders including hypertension, obesity, and substance use problems. The most consistent risk factors for common mental disorders are low socioeconomic status (poverty) and female gender. The effects of employment on mental health among women are context dependent, i.e. it depends what the benefits and drawbacks are of employment. In many situations, women who work continue to do the largest part of child care and homemaking. As a result they experience a double burden and may be at risk of depression or other problems. Married women with young children and full-time jobs may be at especially high risk.

There are many different types of sociocultural adversity and their precise contributions to the risk of common mental disorders are largely unknown. This is one area where research in Native communities is needed.

Santé Québec does only the most basic analyses of its own survey data. With the permission of the Inuit and Cree Boards of Health and Social Services, we have undertaken to do more intensive analysis of the surveys to see what we can learn about risk and preventive factors. We have also done some small epidemiological surveys of our own and try to see what can be learned from clinical experiences helping people who have been referred to the consulting psychiatrist by other health workers.

Our own research and analysis of the Santé Québec Inuit Health Survey identify a number of risk factors for attempted suicide among youth. These include: male gender; ever having used solvents ('sniffing'); a history of psychiatric disorder; stressful life events in the last year; a history of problems due to drinking alcohol; serious illness in the last year; a parent with a drinking or drug problem and a friend who has attempted or committed suicide. There are also important protective factors that reduce the chance of a suicide attempt among youth, notably regular attendance at church and a family member going for help for a mental health problem.

The most general indicator of mental ill-health in the Santé Québec surveys is the scale of emotional distress. Our analysis of the data from this survey found that in the general population of Nunavik, the factors that were associated with greater emotional distress included: stressful life events in past year; a self-described poor relationship with community; alcohol abuse in past year (CAGE); younger age; sexual abuse; and psychiatric illness. The highest levels of emotional distress were found among young people and the factors associated with distress were slightly different for this group: self-described poor relationship with community; stressful life events in past year; sexual abuse; female gender; working; and alcohol abuse in past year (CAGE). This pattern suggests that both past and recent events contribute to emotional distress. Psychiatric illness is only one factor and the relationship to the community plays an important role. Young women tend to be the most distressed group and having work does not protect one from emotional distress perhaps because it is associated with greater burdens of responsibility.

A wide range of risk factors are common to many different psychiatric disorders including:

- developmental factors
  - prematurity, low birth-weight
  - low intelligence
- male gender (for ages 0 to 10, 20-30)
- female gender (for age 10-20)
- family factors
- severe marital discord
- social disadvantage

- overcrowding or large family size
- paternal criminality
- maternal mental disorder
- community factors
  - social disadvantage
  - disorganization
  - lack of community institutions

Different factors may contribute to the risk for different types of problems. For example, Table 1 compares the risk factors for major depression and for conduct disorder (troublesome or antisocial behaviour).

**Table 1. A Comparison of Risk Factors for Two Types of Problem**

<i>Depression</i>	<i>Conduct Disorder</i>
female	male
a parent or other close biological relative with a mood disorder (i.e. depression)	a parent or other close biological relative with antisocial behavior or substance abuse
low self-esteem, low self-efficacy, helplessness and hopelessness	difficult temperament hyperactivity
poverty	socioeconomic disadvantage (poverty, overcrowding, poor housing) social disorganization
severe stressors:	severe stressors:
<ul style="list-style-type: none"> <li>• loss of person, role or function</li> <li>• divorce, marital separation</li> <li>• unemployment, job dissatisfaction</li> <li>• chronic physical illness</li> <li>• traumatic experiences</li> <li>• (in children) learning disorder</li> </ul>	<ul style="list-style-type: none"> <li>• chronic ill health</li> <li>• family adversity</li> <li>• learning disability</li> </ul>

Each of the risk factors points to a series of protective factors: anything that reduces risk acts to prevent disorders. The most basic protective factors common to many disorders include:

- at least average intelligence and temperamental attributes (i.e., inborn early personality traits affecting mood and behaviour)
- good relationships with parents or parent substitutes that encourage trust, autonomy and initiative
- external support system that rewards competence and provides a sense of coherence

Additional general protective factors broken down by their level of action—individual, family or community—are as follows:

*Individual*

- positive temperament (easy going, responsive)
- above-average intelligence (IQ)
- social competence

- sense of coherence
- internal locus of control

#### Family

- smaller family structure (not > 4 children, spaced at least 2 years apart)
- in early childhood, close relationship with a parent who is responsive and accepting
- older children, supportive parents, good relationship with siblings, adequate rule setting by parents

#### Community

- peer relationships
- external support systems: church, youth groups, school, recreational activities
- good secondary schools

Prevention and mental health promotion programs are developed around these themes. Although it is likely that most of these same factors are relevant in Native communities, there is a need to think through and study how they may be modified or added to by variations in the social situation and by culturally specific values, attitudes and behaviours.

In most of this research there is a focus on factors that affect individuals. To identify factors that work at the level of the family or community or even whole populations, we need to do large scale comparisons. This is a very sensitive issue, since communities or groups may find it painful and embarrassing to be compared with other groups. Nevertheless, such comparisons may be an important way to find out more about what works to help a whole community.<sup>1</sup>

### Illness Prevention and Mental Health Promotion

To design appropriate interventions and plan for the future it is important to determine the factors that may contribute to illness (risk factors) or wellness (protective factors). Knowledge of risk and protective factors can allow us to: (1) identify individuals, groups or communities at risk so that they can receive appropriate help; (2) develop specific interventions to reduce specific risk factors; (3) develop prevention programs to promote and enhance protective factors.

There are three basic levels of prevention:

- *primary prevention*: attempting to reduce the causes of illness before it occurs (e.g. stopping smoking or drinking in a whole population)

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<sup>1</sup> Rose (1985, p. 33) distinguishes two types of etiological question: (1) causes of cases: why do some individuals attempt suicide? and (2) causes of incidence: why do some populations have high rates of suicide? Genetic and other individual factors will predominate in individual susceptibility but may explain little of population differences in incidence. Genetic heterogeneity is usually much greater within than between populations. On the contrary, environmental factors may help to account for population differences; thus, "migrants tend to acquire the disease rates of their countries of adoption." (p. 34). In general it is not possible to identify causes of illness from case-control and cohort studies if there are not sufficient differences in exposure within the study population; all that will be found are markers of individual susceptibility. Clues for the global causes "must be sought from differences between populations or changes within populations over time." This has implications for preventive strategies since the traditional approach will result in information only about individuals at risk and thus tend to support interventions that focus on at risk groups rather than the larger community.

- *secondary prevention*: identifying and treating individuals who are at high risk for an illness
- *tertiary prevention*: preventing relapse or chronicity among individuals who have had an illness

The most common approach to preventing psychiatric disorders involves treating those at high risk of disorder. An alternative approach works at the level of the whole population. Table 2 compares the advantages and drawbacks of each of these approaches.

**Table 2. Strategies of Illness Prevention and Health Promotion**

	<b>High-Risk Individual Approach</b>	<b>Prevention by Population Strategy</b>
<i>Advantages</i>	<ol style="list-style-type: none"> <li>1. intervention appropriate to individual</li> <li>2. subject motivation</li> <li>3. physician motivation</li> <li>4. cost-effective use of resources</li> <li>5. favorable benefit/risk ratio</li> </ol>	<ol style="list-style-type: none"> <li>1. radical</li> <li>2. large potential for population</li> <li>3. behaviourally appropriate</li> </ol>
<i>Disadvantages</i>	<ol style="list-style-type: none"> <li>1. difficulties and costs of screening large numbers</li> <li>2. palliative and temporary not radical</li> <li>3. limited potential for individual and population</li> <li>4. behaviourally inappropriate</li> </ol>	<ol style="list-style-type: none"> <li>1. small benefit to individual (prevention 'paradox')</li> <li>2. poor motivation of person</li> <li>3. poor motivation of physician</li> <li>4. benefit/risk ratio worrisome</li> </ol>

It is important to recognize that any prevention program may also have some negative effects particularly on people to whom it is not specifically directed. For example, talking about suicide to increase awareness and detection of suffering individuals may also increase thinking about suicide as a possibility in the minds of some people. The dilemma is that "in mass prevention, each individual has usually only a small expectation of benefit, and this small benefit can easily be outweighed by a small risk" (Rose, 1993).

The field of prevention in mental health is still in its infancy but there has been a great deal of interest in this area. Generally, psychiatrists know more about treating illness than about prevention. However, many governments and groups recognize that promoting the health of the population is more desirable than simply treating illness once it has already occurred so there is an effort to develop primary prevention programs. Several large reviews of programs have been completed and published (e.g. Mrazek & Haggerty, 1994; Paykel & Jenkins, 1994; Tudor, 1996). In our team, we are currently working on reviewing existing programs to try to identify those that may be most immediately applicable or adaptable to Native communities and populations.

To provide a basis for discussion, I will briefly summarize what is known about the existing prevention and mental health promotion programs based on published reviews, especially that of the Institute of Medicine in the United States. Most of these programs are still being developed and evaluated so it is not possible to know for certain which ones work or which are most effective. Table 3 summarizes some of the best-studied programs listed according to the ages of the people they designed to help.

**Table 3. Illustrative Preventive Intervention Research Programs**

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*For Infants*

- Physical health interventions
- High quality prenatal and perinatal care
- Immunization
- Parenting:
  - Enhancing parenting skills
  - Reducing damaging parental behaviors
  - Social support to mothers
  - Increasing use of community resources
- Tactile/kinesthetic stimulation program
- Specialized programs for premature infants

*Young Children*

- center-based early childhood education with preschool programs designed to enhance social competence and cognitive development
- home visitation to provide support and educational services
- parenting training and education to teach skills in care giving and effective behavior management
- family support services
- policy initiatives to address issues of child safety, health and education

*Elementary School Age Children*

- enhancing parenting skills
- enhancing social competence
- enhancing academic achievement
- specific programs for children of divorce, bereavement, those with conduct problems

*Adolescents*

- enhancing academic achievement
  - reducing substance abuse
  - enhancing social competence
  - social influence resistance training
  - promoting norms against drug use
  - policy interventions
  - reducing risk factors for specific problems:
    - conduct disorder
    - eating disorders
    - suicide
- 

Source: Mrazek & Haggerty (1994).

**Table 3. (Cont'd) Illustrative Preventive Intervention Research Programs**

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*Adults*

## marital relationship

- prevention and relationship enhancement
- coping with separation and divorce

## childbearing and child rearing

- coping with caesarian birth
- enhancing the development of new mothers
- coping with early child loss

## occupational

- occupational stress and coping with dual roles
- coping with job loss and re-employment
- adult children providing care for ill parents
- specific disorders
- depression

*Elderly*

- relieving caregiver burden
  - coping with widowhood and bereavement
  - mutual help-groups
  - involvement in helping people at other stages
- 

The evaluation research done to date on these programs does allow some tentative conclusions. Infants born to high-risk mothers and child at high risk can benefit from preventive interventions. In particular, home nurse visits can be effective. Intensive and prolonged early childhood education combined with home visits to families can reduce early developmental delays and academic failure.

For young children, the best programs involve multi-component interventions that address multiple risk factors and that are effective in improving the family life skills of parents and the social competence of children. Early childhood interventions can have long term effects through to adolescence. Effective programs are intensive, involving daily work with the child and close involvement of family.

For elementary school age children, intensive family preservation services are effective short-term but the long-term results have been less impressive. Preventive interventions to improve social competence can reduce early behaviour problems. The outcomes in terms of mental health of children and families are not known.

There is some evidence that it is possible to prevent early substance use among adolescents with school programs supporting explicit norms against drug use. The problem is that those at highest risk usually have already been exposed to parents using substances. In this situation, programs against substance use may create/increase family conflict or lead to rejection of the whole program by the adolescent. Substance use can be decreased by measures to restrict availability (e.g. banning alcohol in a community). Other more general prevention methods include programs to promote academic success, improve the school environment, and school reorganization to involve the community more actively, thus forging links between family and school.

A variety of programs have been developed to try to prevent depression. These aim to teach people about the nature of depression, and show how thoughts, activities and interpersonal interactions affect mood. Once this is learned, the person can learn to identify and change these behaviors that contribute to depression. These same principles of self-monitoring and self-control have been shown to be effective in the individual psychotherapy of patients with depression. To date, however, trials of this type of program in the community have not produced clear evidence of their efficacy for primary or secondary prevention.

### **Distinctive Features of Native Communities**

As mentioned earlier, there are distinctive features of Native communities that may affect the effectiveness of any specific prevention program. Compared to the urban centres where most of these programs have been developed, Native communities differ in:

- *Scale and remoteness:* The communities are small and many are geographically distant from major urban centres. This results in having fewer material resources for medicine and social services, and multiple roles being played by a few individuals. The geographic location of many Native communities also goes along with cultural values that emphasize a close relationship to the land and the seasons that shape ideas about self and community.
- *Lack of anonymity:* As a result of size, family ties, and shared history, there is little opportunity for the sort of privacy and anonymity that is part of the professional mental health or social service practitioners' role in big cities. This anonymity has both ethical and practical uses: it provides privacy and safety for clients who wish to confess to embarrassing matters and it allows the helper to have some respite from being constantly 'on the job'. In small communities, helpers are often related to the people they are helping and have no way to step back for a while from their role; this can rapidly lead to burn out.
- *Lack of resources:* For geographical, historical and economic reasons, there is a lack of resources available in many communities for mental health programs.
- *Lack of professional training:* Few Native people have had the opportunity to pursue professional training in mental health. This is improving and a new generation of people able to put together Native wisdom about health and healing with the most useful aspects of Western medicine is emerging.
- *Language:* Language is a basic conveyor of culture and most people are connected to their emotions and intimate thoughts most readily in their first language or language of every day life. Few outside health professionals have made the effort to learn local languages and little information has been translated. Translation is not just a matter of finding equivalent words but of exploring and understanding the different connotations of words that are only roughly equivalent.
- *Culture:* Culture is a broader issue than language and includes notions of how people work (ethnopsychology), of patterns of social interaction, and basic values that are central to any mental health program. Culture is not simply tradition, however, since all communities are evolving and changing to meet new circumstances. Native American spirituality and new expressions of Christianity or other religions are all important in the complex cultural mix of contemporary communities. These ways of life influence the form that suffering and its healing take.



- *Rapidity of culture change*: The most striking fact about the recent history of most Native communities is the rapidity with which social and cultural change has occurred. This has introduced the forces and facts of globalization even to remote communities. Rapid change has challenged Aboriginal identity and resulted in dramatic generation gaps between youth, adults and elders.

These are only some of the community wide issues that require rethinking the nature of conventional mental health theory and practice. This rethinking must be done by people within Native communities as there are many choices to be made. To choose wisely, people need the clearest and most complete information possible.

### **Conclusion: The Role of Mental Health Research**

Mental health models and services are often simply imported from the urban context. They fit professionals' training and skills but may not always fit the social and cultural context of Native communities. Research in the field of cultural psychiatry has provided much evidence that mental health problems and solutions are shaped by cultural and social factors. Accordingly, there is a need to identify what works in mental health interventions in the Native communities of Quebec, taking into account differences in social structure, culture and resources. This requires research and careful evaluation of new programs in their cultural and communal context.

The priorities in mental health that emerge from considering the issues raised in this talk include:

- (1) training of community workers, medical and mental health professionals;
- (2) public education on mental illness, coping skills, appropriate use of health and social services;
- (3) development of crisis intervention services (e.g., half-way house, family crisis team, etc.);
- (4) programs for family intervention for youth at risk; and
- (5) community programs to foster communication, life skills, cultural transmission, and political empowerment.

There are many important research questions that must be answered to guide the development of these services and programs.

- (1) We need to know the prevalence of specific psychiatric problems since different types of interventions, programs and resources are needed for different problems.
- (2) We need to understand the social course or evolution over time of psychiatric illness since social factors are known to strongly influence this; there may be features of Inuit and First Nations life that help to protect people with some types of problems and give them a better outcome than in urban settings. If so, these elements must be supported and strengthened.
- (3) We need research to identify what helps some individuals and communities to do well despite adversity.
- (4) Finally, we need research to develop and evaluate culturally adapted and community

based interventions.

The research strategy must support local initiatives for programs and provide systematic evaluation using appropriate methods (primarily qualitative ethnographic research because of the small scale of programs). This will allow the community to see what actually works and how it can be adapted to their own needs and those of other communities.

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## **Panel Discussion: Mental Health Promotion in Native Communities**

**Elisapie Tookalak**

*Social Services, Hudson Bay Region of Northern Quebec*

**Résumé:** Coordinatrice des Services Sociaux pour la Région de la Baie de Hudson, l'auteure déplore le fait que l'on attend des travailleurs sociaux qu'ils prennent en charge tous les problèmes d'une communauté. Leur travail comprend la thérapie, mais très peu de mesures de prévention sont en place. Il faut faire de la prévention à l'échelle communautaire et pas seulement individuelle.

My name is Elisapie Tookalak. I am the coordinator of Social Services for the seven communities of the Coast of Hudson Bay in Northern Quebec, from Salluit to Kuujjuarapiq. Paulusie Padlayat, who was supposed to speak here, is one of three people travelling around to do suicide prevention work. They travel by skidoo to every community up North. They have already spent two months visiting every community around Hudson Bay and in the Northwest Territories. When they arrive in a community, they meet the population, get on the local radio and hold meetings about suicide prevention. Now they are starting to use aeroplanes to get to certain communities they could not reach by skidoo. Right now they should be in Iqaluit but Paulusie was supposed to come down here to talk to you. He didn't so I am replacing him.

*LJK: Can you tell us a little bit about what else is going on in Nunavik in terms of mental health treatment, prevention and promotion. Are there any programs or things that you are aware of? I know, for example, that a couple of years ago there was a crisis centre in Inukjuaq. People tried to make a house that youth could go to when they were in crisis or in trouble. Can you tell us about anything like that, that you are aware of?*

**ET:** At this point, because I am not prepared, I cannot. But in my own work we deal with almost everything concerning Inuit mental health and social problems. Social Services are expected to do everything because right now our people don't know what to do, how to intervene and help each other when they have problems. Of course, they are supporting each other a lot, but when it comes to difficult issues or situations, all they can do is support each other without really giving each other any help for prevention. So, social workers like me are expected to do everything. In my field, community workers do a lot of counselling and help out people in crisis. In terms of mental health, specific mental health issues are not being addressed as much as they should be.

## **Panel Discussion: Mental Health Promotion in Native Communities**

Laverne Gervais-Contois

*Native Women's Association of Montreal*

**Résumé:** Les femmes autochtones en milieu urbain ont peu de ressources à leur disposition. Elles doivent apprendre à aller au delà de leurs traumatismes antérieurs sans l'aide d'une forte communauté autour d'elles. C'est pour cela que l'organisation pour Femmes Autochtones de Montréal a été créée. Les femmes s'entraident et apprennent à séparer les comportements familiaux pathologiques de ceux qui sont le fruit de leur culture autochtones, et apprennent ainsi à ne plus confondre les deux et à être fières de leurs racines. C'est un processus difficile, rendu encore plus ardu par le manque de connaissances politiques de base chez les femmes autochtones, les difficultés financières, la nécessité de constamment éduquer les non-autochtones autour de soi, et l'habitude qu'ont les individus des Premières Nations de ne pas exprimer leurs émotions "négatives". Pour guérir, les femmes autochtones doivent donc mélanger une connaissance des rouages économiques et politiques modernes avec une reconnaissance de leur passé individuel et collectif.

I came to this conference to learn, but I have been put to work (as a stand-in) at the last minute. I agreed to sit on this panel because I believe in the cause of Native people and in the process of overcoming abuse issues that we endure through no fault of our own as oppressed people. I'll introduce myself traditionally, as I like to do, by simply acknowledging my ancestors it's also a way of 'grounding' myself, because I'm nervous. This traditional introduction is a way of having people know who you are, what family you belong to and where you come from.

My grandmother Fontaine is from the Fort Alexander reserve. My grandfather Starr is from the Peguis reserve, grandmother Daniels is from the Long Plains reserve, all in Manitoba.

I have been asked to talk about Aboriginal women in Montreal and the social issues that we are dealing with today. I think I am a good representative for this because I live in Quebec but I am not from Quebec. As Aboriginal women we face many large issues. We do not have a political voice. To focus on one particular issue is difficult. I agree with Elisapie that besides political issues most of the problems I see have to do with burnout, that is, overworked frontline workers.

Before I go into that, I will tell you a little bit more about the Aboriginal Women of Montreal. We are a group of Native women living in the urban area who come from many nations and different provinces. In Quebec alone there are 12 nations. The association has been in existence for close to 15 years as far as I know, and for the past 5 years has been increasingly active. There are many Native women in the urban area who are in the same boat as I am, Native women trying to have a political voice in order to make changes for Native women and children.

When I talk about urban issues, I am not saying that they are necessarily different from rural ones. As Native people we are dealing with conditions that have been imposed on all of us, rural or urban, through generations. But there are definite differences as well.

As urban Aboriginals we have to organize and shape a community so that we can obtain culturally appropriate services. While there are some services in the Montreal area for and

by Natives, including the Native Friendship Centre (which is my home base), there are barely any other services, and those that exist are understaffed and do not provide referrals or resources specifically for women. If a woman who is dealing with a violent partner wants the company of other Native people and she goes to the Friendship Centre, she is bound to meet up with her partner. She does not have access to a safe environment, and we need that in order to begin empowering ourselves. The Native Women's Shelter provides a place for women who are in crisis and need refuge from a violent situation, but many Native women have other needs that don't necessarily include the need to be in a shelter.

I can honestly say as I stand here today there are no services for those women. As much as the Native Friendship Centre does offer services, these are limited. Core funding is still not available for a program specific to urban Aboriginal women, though there are non-Native women's groups who do receive core funding to provide services to women in need. As a local Native women's group we do not fit the criteria for available funding, and so we have no money to hire someone who can help create and coordinate projects and proposals that do meet the criteria for available project funding.

As an urban woman, and as someone who has been dealing with sexual abuse issues in my own life, I have come to the part in my healing where I have to learn to let go. I am trying to let go of the term "survivor of incest" because it seems to have limited my ability to move on. Now, I look at people and instead of saying, "I am an incest survivor" I say "I am a human being who is Native and who is dealing with sexual abuse issues." That frees me up to say to myself that I can move on and make changes. Being a survivor takes you to being a survivor; being a person on a wellness journey takes you to wellness. My point is where are the services that might have helped me in the past? None were there for me. Those that existed were expensive and not culturally appropriate. Many Native women live in poverty; existing services are not financially accessible to them.

In order to get on with my healing journey, I had to create a network of incest survivors. This was difficult on many levels, but it was essential to do and I succeeded. I did this by starting a network for incest survivors on the West Island, where no such network existed for women from any background.

What is being done about the social issues facing Aboriginal women is acknowledging that problems exist. That's as far as it goes; there are no culturally appropriate services for Aboriginal women in the urban area.

We are all familiar with the causes behind problems and issues facing Aboriginal people: historical and continued oppression, genocide, racism and multi-generational grief. I find we not only have to overcome experiences of helplessness and hopelessness, but also as a Native person I need to research my Native identity in order to continue my healing journey. My ancestral background has only started to be written up in the last five to ten years, and is being taught in schools today. I had to research my past, my identity. I lost my family and their values to alcohol and drug abuse. As someone who lived in the chaos of an alcoholic home, in order to deal with my losses and heal I have to look at these experiences and learn to decipher—to separate the dysfunctional behaviour of addiction from the valuable cultural, "normal" behaviour. This is part of the impact and legacy of the oppression and colonisation of Native people.

One thing I have learned as a Native person who has decided to work on a healing journey, is that we tend to be drawn into cultural, social and political action. This is stressful. The lack of Native people with secondary education and the many people who are working on their recovery as well as their education means that those of us who speak out have to be ten times better than everyone else. We are perceived to be representing all Native people

and thus to know all the answers to Native problems, and to be wise and shaman-like. There are many different First Nations in this world, but when someone sees that you are Aboriginal, suddenly they want you to teach them to build fires, to hunt, and to teach them what it means to be Native. This is part of the pressure.

There are many, many Native people out there and as far as I'm concerned we are all in the same process. I am trying to find out what it meant for my family to have been placed in a hopeless situation—taken away from the reserve and placed up in northern Manitoba, their identity lost. What does that really mean? My family grew up not wanting to acknowledge that they were Indian. Why? They would sooner acknowledge that they were Metis; to be Indian meant to be a 'drunken Indian,' a stupid person who knows nothing. This is an identity crisis that Native people are still trying to heal from. This is what my family has suffered, these are the realities I am still dealing with. If I don't stop this cycle, this identity loss, I will pass this on to my children and grandchildren. I have had to learn to believe in my rights as a human being as well as my Nateness. Is this acceptable? Recognizing ourselves as worthy human beings while overcoming the effects of oppression, genocide, incest, alcohol and drug abuse and teaching cross-cultural awareness at the same time. What other nation does this?

Depression is another issue for me, my family, and many Native people. This is partly related to the cycle of family violence which people are struggling so hard to overcome. Residential schooling resulted in no parenting skills and emotional sterility. In my family, my generation had almost no emotional support. There was very little talking amongst family members, but I have seen some positive changes in my lifetime.

There is unresolved grief. We were taught not to show negative or angry feelings in any way, never mind grief. In my healing journey, going back to the understanding of our traditional Native way, the spiritual way of the Medicine Wheel encompasses and allows all feelings. If you are in pain you are allowed to express that pain. I think this process of the Medicine Wheel is not really understood by most people. When they encounter pain or conflict of any kind they walk away; the mentality is "If you think positive then you don't need to acknowledge any negativity around you."

So, I've touched on a few concerns: the issue of unresolved grief and the imposed pressures that we are dealing with. There are many other concerns that a Native person on a healing journey has to deal with: rebuilding a family structure; overcoming racism; improving the educational system; establishing culturally appropriate services, self-government. As an Aboriginal woman developing and maintaining a voice for our concerns as oppressed women living in poverty, and as someone working in the helping field as an addiction counsellor, I had to overcome fears about speaking out and becoming involved in the mainstream. I think that most Native people in the helping fields have to become politically socialised in terms of mainstream government as well as in the Native world, as this is tied in to self-government. The information needed to accomplish this is not necessarily readily available or accessible. I really feel that any Native person on Earth who wants to make changes for their community has to scramble to get an education, employment, take Political Science 101, be 'mainstream friendly' and at the same time overcome helplessness, hopelessness and poverty. This kind of pressure is almost unbearable and produces burnout.

Among the pressures that I have felt while trying to overcome my own grief and losses is the separation from my family of origin. My ex-husband was transferred here and I decided to stay after my marriage ended. This actually has helped me to get on with my healing, as my brothers and sisters are still dealing with drug and alcohol abuse. As an urban Aboriginal I feel I have lost my extended family and have to organize and develop a new extended



family in order to maintain my culture. This is a difficult thing to do. In Montreal, with a population of 3 million and only 44,000 Native people, I am facing extreme assimilation. I have to find and get together with other Native women in the city so that we can shape our own community and maintain our culture.

When I talk about an “urban Aboriginal,” I am usually referring to my own life, but I know that other Native women come here intent on making changes for the social good of us all. These women go to university, often full-time, have young families, may be married and dealing with poverty, yet somehow they find time to get out there and work for social, political and economic changes for Native people in Montreal.

To stress what Elisapie was saying, we are overworked, and it is not by choice. We feel an obligation to make changes for future generations. There is a whole slew of issues and they are broad; I find it difficult to pinpoint something as a ‘mental health issue.’ I feel it is all a mental health issue. Aboriginal issues are big and it is sometimes difficult to remain positive. You are dealing with people who are hurting and who are negative. You are dealing with people who are constantly pulling you down when you try to make changes, and it is hard to stay positive but you do. A lot of Native people here understand what I am saying. It’s the reality. But here we have a group of Native women in the urban area, under the auspices of the Aboriginal Women of Montreal, who know that negativity and who are saying “Let’s get on past this negativity and support ourselves.” Basically, this is what we must do in order to create extended families and have those brown-faced aunties and uncles for our children.

The issues urban Native women are dealing with are similar to those for Native women in rural areas: family violence, drug and alcohol abuse, sexual abuse and poverty. I would like to stress again what specifically is being done: very little. We never seem to meet the criteria of the ongoing research or available funding. In order to organize and establish the services we need we have got to learn how to put proposals together, we have got to submit them, and often the reason we are unsuccessful in meeting criteria is because we don’t have a coordinator in place to do all these things. The Native women involved in making changes are hard at work studying full-time and meeting other obligations.

What specifically is being done? We are being researched to death. I would like to see some of that research money go into some ongoing development project.

Thank you.

## Child and Family Welfare in Aboriginal Communities: Introduction

Liesel Urtnowski

*School of Social Work, McGill University*

This afternoon we are going to talk about families, some of the ways life in families is experienced, and some of the problems and attempts at solutions. As was said this morning, we are here to share our knowledge and experience. We are also here as seekers of others' understandings of family and community.

My background is working with community workers in Nunavik. Currently I coordinate a McGill University certificate program for community workers from Nunavik. I think three of them are here today. During the years I was a sojourner in Nunavik I was often saddened by the tremendously difficult problems community workers have to contend with. I've also been heartened and encouraged seeing their immense efforts and creativity in trying to find solutions, and witnessing their commitment to and solidarity with their people. While the community workers of Nunavik are continuously exploring and learning about non-Inuit ways of addressing problems, they are at the same time firmly planted in their own culture and their own ways of being as families and communities in these times of great change.

This afternoon we are going to be talking about some of the problems experienced by family members. The first two speakers will be focusing on the problem of violence in families. Dr. Joan Pennell is here from Memorial University in Newfoundland, where she is a professor of social work. She has co-authored several articles and book chapters on family violence and family group decision making, a method that has proven helpful to both Aboriginal and non-Aboriginal families. Joan was co-principal investigator with the family-group decision making project for preventing the abuse of children and women. She was also one of the founders of the first shelter for abused women in Newfoundland and Labrador, and for many years Dr. Pennell was co-facilitator for groups of abused women, including Aboriginal women. She was a member of the National Crime Prevention Council, which served as an advisory body to the Minister of Justice and the Solicitor General of Canada, and she was chairperson of the Youth Justice Committee under that Council. Joan will speak to us first.

Our second speaker, Marilyn Bearskin, is a survivor of domestic violence and she is dedicated to fighting back, taking back her own life. Despite hostility from some men towards her work, Marilyn continues to write for *The Nation*. She reports the stories of abused women to encourage dialogue on domestic violence in Cree society. Marilyn and the Regional Youth Council are in the process of starting the first Annual Cree Domestic Conference.

## Family Group Decision Making for Preventing Abuse of Children and Women

Joan Pennell

*Memorial University, Newfoundland*

**Résumé:** Après avoir expliqué son intérêt dans la domaine de la violence intra-familiale, l'auteure décrit en détail un programme nouveau, développé en Nouvelle Zélande et essayé récemment à Terre Neuve, qui vise à rompre le cycle de la violence en donnant aux familles la possibilité de se parler franchement et de trouver leurs propres solutions à leurs problèmes. Le processus est bien entendu supervisé et tient compte des risques éventuels courus par chacun. L'implantation de cette méthode et la recherche sur son efficacité se sont faites en collaboration avec les communautés en question. A date les résultats sont très encourageants.

**Abstract:** Efforts to stop family violence against children and women have been weakened by a fragmented service approach that lacks sensitivity to the family and its culture. Government agencies, whether child protection or adult corrections, are authorized to respond to their mandated area rather than addressing all forms of abuse within the family. Violence against each and every family member needs to be addressed in a way that promotes healing of the family and affirms their cultural heritage. The Family Group Decision Making Project tested in Newfoundland and Labrador uses an approach called "family group conferencing" with referrals from Child Welfare and Parole. This model of family group conferencing was developed and legislated in New Zealand after strong protests by indigenous people against white, expert-driven approaches which eroded the strengths of their families and communities. In the Canadian project, the referred family met with their extended family and other close supports to develop a plan for stopping the violence against child and adult family members and for holding perpetrators accountable for their actions. To be put into effect and resourced, their plan had to be approved by the referring agencies. The presentation will overview the process and results of family group conferencing as carried out in three project sites: Inuit, rural, and urban.

I am very honoured to have been invited to take part in this conference. I listened with a great deal of appreciation and interest to this morning's discussions about the ongoing efforts in the North and in Quebec to address issues of mental health. Given the work I have done in the area of family violence, finding out how you are approaching these issues is a learning experience for me. As well, I appreciate the title "Widening the Circle" chosen for this conference. Creating family, community and government partnerships that respect people's cultural differences helps expand the circle.

The family group decision making project has been one approach to widening the circle. At its centre was the family group conference. This was a forum for bringing together the family over issues of, in these particular cases, child abuse and women abuse in order to help the extended family and other close, supportive people work out a plan for stopping the violence. To be implemented the plan then needed approval from the referring authorities, which in our case were child welfare, probation, parole, and youth corrections. In terms of 'widening the circle,' the intent was to break the conspiracy of silence around the violence without putting people at risk. I'll talk shortly about some of the strategies we used to accomplish that, including a system of checks and balances to ensure no one in this process was endangered whether they were classified as survivors, perpetrators, or other family members. The approach that we used for family group conferencing was very much indebted

to the work done in New Zealand, where they have legislated family group conferencing to address child protection and other justice issues. This legislation was implemented after very strong pressure by the indigenous Maori to replace white-expert-driven models with ones affirming family and community. The New Zealand model was very helpful to us, especially in the training phase. Family-group conferencing was considered something new to Canada when we first started using it in Newfoundland and Labrador, though I think in fact we often use these ways of trying to talk to each other in our own families. What is really new is trying to do this in a more structured way that brings together so many different partners.

Many of you here are of Aboriginal and Inuit descent, and may be asking yourselves the same question we often hear: “Why do the authorities have to give their approval?” I will talk about that in terms of checks and balances and I will also address that question in depth later in terms of our goal of developing indigenous structures for resolving issues of family violence. By indigenous, I don’t necessarily mean Inuit or Micmac or Cree or other nations indigenous to Canada. I am also talking about approaches that are indigenous to people of European descent, or Asian descent, or whatever; I do not see the approach I am describing as limited to people that are native to Canada.

Following today’s previous speakers I will share a little bit about my own background, and why I am interested in this kind of approach. I feel it is very important to identify one’s heritage and it is crucial to me that I do this in terms of my own values as a member of the Society of Friends, which is Quaker. As a Quaker, I’ve had a very long-term commitment to peace-making and to respecting the strengths within each individual, and in trying to bring these commitments together I became very interested in family group conferencing to address issues of family violence.

I usually start with my background as child protection worker. This was in Scarborough, Ontario, in the early 1970’s before there were really any shelters in Canada. Fresh out of my Master’s in Social Work program, I found myself constantly going into households where children were being abused and children were being neglected. My role as a child protection worker was to protect those children from their parents. Some of the parents I dealt with were pretty scary, but most often what I saw were single mothers going through a lot of distress; having dealt with or dealing with violence against them by partners, or by their teenage sons or by boyfriends. And I was supposed to be telling them they were not doing a good enough job with their children while they themselves were being abused—and this just did not make sense to me.

After working in that region for a while, I went down the road to Newfoundland, and became involved in setting up the first shelter for abused women and children in the province. This is something I am very proud of, especially twenty years later hearing from those women and children who are now adults about how important the shelter was—giving them a safe place to work out new directions in their lives. I continue to be a strong advocate of shelters, but I am very aware of their limitations as well. I went off and studied in the U.S., looking at shelters in Canada and the United States, and found the same issues coming up over and over. One of them was how to retain the original philosophy, which was the empowerment of women and children, though we didn’t use the term empowerment in those days. The other real concern I found over and over in the groups I facilitated for abused women was their great fear of leaving the shelter and their worries about sustenance and protection for themselves and their children beyond the doors of the shelter. These are very legitimate fears, as I am sure many in this group are aware. I moved to Manitoba, and a colleague of mine at the University of Manitoba for whom I have great respect, Elizabeth Hill—who is now deceased—told me that I was going to be involved in training people to work at Ma Mawi, which is an Aboriginal family violence program in Winnipeg. I told

Elizabeth I didn't see how I could be a trainer, particularly for a group that was going to be carrying out work within the Medicine Wheel tradition, which I knew nothing about at the time. With Elizabeth's insistence I ended up doing it anyway, but we very quickly redefined training as a cultural exchange, and it was a cultural exchange in many ways. This experience helped me recognize the importance of affirming culture and it also helped me to affirm my own heritage. To borrow an expression the elders in the group I was working with used, "like men and women walking side by side," elements of my own culture as well as elements of Inuit and Aboriginal culture could help in the creation of a non-violent society.

After being in Manitoba for about three years, I moved back to Newfoundland where a colleague of mine, Gale Burford, had returned from New Zealand. He talked about the approach being used in New Zealand to address family violence, child protection and youth correction; an approach where victims, offenders, and other family members get together to talk about how to stop family violence. If I hadn't experienced the program at Ma Mawi, which really did help create community, and really affirmed culture, the New Zealand model might not have made sense to me and I might not have gotten involved with it. And I continue to have a lot of concerns about couple's counselling or family therapy or mediation occurring in situations where you have victims and perpetrators coming together to work out some kind of resolution. I'm not completely opposed to this approach because I have learned from abused women that it can work, but I have become sensitive to how important it is to ensure no one is endangered by the situation.

I'd like to move on to the project itself, and give you a brief overview of it, particularly stressing its philosophy. We did an extensive amount of research and evaluation and I will present some of the outcomes of these. I realize I won't be getting through all the material I have here; I guess I thought it was important to start by grounding myself rather than just dashing into the project.

The family group decision making project took place in Newfoundland and Labrador, and three regions of the province agreed to take part in the project. These were all regions that had a really strong commitment to dealing with issues of family violence, and they were willing to try something that, for most of them, looked quite different. Nain, for those of you who may not know of it, is the northernmost settlement in Labrador. At the time the population was about 1200. We started the project before the Voise's Bay discovery of zinc, copper and nickel, and things have been changing in Nain since that time. The Port-au-Port peninsula on the west coast of Newfoundland, with a population of British, Irish, French and Micmac descent, also participated and we also did the project in St. John's, our capital city. Funding came from a whole range of federal funders, under the Family Violence Initiatives, and this range speaks to the fact that we were not just dealing with child protection, but also with violence against adults. The project was unique in that it dealt with both issues. Maybe some of you know otherwise, but I haven't yet heard of a program dealing with both violence against children and against adults, and I have talked to people in many parts of the globe.

In Nain the Labrador Inuit Health Commission co-sponsored the project. Their sponsorship was absolutely crucial in terms of providing guidance, and in terms of legitimizing the project in the community. In each of the communities there was a local advisory group that really guided the project. There was also a provincial protocol committee that included the senior bureaucrats, including chiefs of police and so on, who helped out in terms of figuring out the protocols. And extensive consultation with the Crown Prosecutor was needed in order to carry out the project. All of the partners involved in the project believed you couldn't simply take a model that had been used in another country, plunk it down in a very different legal, social and cultural context, and expect it to be a go. There was extensive 'community development work' that went on for about a year and a half—the planning of

the program and how to go about setting it up. Following that, in the Fall of 1993, we underwent training, and then the actual conferencing went on for about 16 months, and since then we've been looking at the outcome—the follow-up work—to see how the families and the communities are doing.

In terms of research, a book done by Janice Ristock and I includes an account written by two Aboriginal women, Betsy Hudson and Sharon Perreault, and me, on an empowerment approach to research within the tradition of the medicine wheel. This approach really provided a lot of guidance, particularly to me, in terms of undertaking this project.

The project had two research phases. The implementation phase included the community development/planning stage and the actual carrying out of the conferences. Then the outcome study followed up on the families for one to two years. I should note that in Nain, the project went through an approval process by the Labrador Inuit Association Health Sub-Committee before we proceeded with the research. The committee really grilled Gail and I, the two white academics, about how we were going about this, and we came to an agreement on how to proceed with the research.

This project had two main goals: one was cultural responsiveness, and the other was reducing abuse and promoting well-being. One of our assumptions was that to stop abuse you need to make sure people have support, protection and the opportunity to participate in decisions over their lives. One of the things I know we did right initially, during the development phase of the project, was to develop a consensus on the statement of philosophy. This statement really guided us throughout, in terms of what we were doing, why we were doing it, and how to go about it. Our position was that no one should be abused; that people who were committing abuse need to be held accountable for their actions; that people ought to have services to protect them; and that people ought to be able to take part in decisions that concern their lives. The last part was really a leap of faith: it proposed that with support, many families could carry out sound plans for resolving abuse between their members. This is probably the aspect of the project that prompts the most questions, questions like: "Can people who are mentally delayed take part in this? Can people who have been mentally ill take part in it? If they can't talk that well, can they take part? Does this only work for Aboriginals? Does it work only for people from rural areas?" In our experience, it works for all these people and many more. The issue is not people's individual characteristics. The issue is: can people come together and build partnerships?

Related principles of the project included addressing child abuse with the realization that it cannot be addressed without also confronting the victimization of adults within the same family. Often there is a history of abuse. In our project, much abuse was directed at mothers, but grandmothers might also be severely abused. In one family, there was abuse between husband and wife. We also stressed that to stop family violence, solutions can't be imposed from the outside, they have to be developed out of the culture of the community in which the family resides.

We also emphasized that this project should in no way be an off-loading of government responsibility onto communities and families. We did not want this to be seen as a cheaper way of doing business that would decrease government liability. Throughout the project we underscored the mandate of the authorities in terms of safety and in terms of resourcing, but we emphasized the role of the individuals and communities involved in determining the process. Finally, we stressed that where child-protection workers were involved, their first priority was the well-being of the child. If a child was truly at risk and needed to be taken out of his or her family prior to the conference taking place, the child would be removed, and this would also be discussed at the conference. If a woman needed to go to a shelter, this would be arranged. If a man were in a position to be charged, we would not be

decriminalizing family violence. What we were doing though, was trying to give people a voice.

Are there any comments or questions so far, or should I just keep moving along?

*Q: How will you make sure the program continues?*

Well, I guess there are a lot of responses I can give to that. I always have a lot of concerns about starting a program that then doesn't continue. From the start we made sure that each of the three the projects had local guidance. We did not hire people from the outside to go in and do the conferencing. We worked with the Advisory Committees to recruit and hire people who would coordinate the conferences as well as those who would be the researchers within the community. So we did not bring people in, and we also made sure that there was training, not just for the coordinators and the researchers, but also for the wider community in each site. For instance, in Nain the training included young people from the high school, the elders, the Inuit Women's Group, the police, the child protection workers and a whole range of people. On the Port-au-Port peninsula, a rural area, again there was a whole range of people. There, the Catholic Church was a very important part of the community, and they also took part. The Women's Centre was very important, so they took part.

We also produced quite a number of publications. One came out of the development work and conferencing. I've really gone over things quickly but there was participatory video work done in Nain before the conferences began there, looking particularly at issues around single motherhood in that community. It is described in the publication I just mentioned. There is also a coordinator's manual, and I have forms for ordering these. We're selling them at cost, this is not a money-making enterprise in any way. I don't have the manual with me, but we have a small video that talks about the process. It was made fairly early on in the project, and we're hoping to make another one soon.

What we found, and I'm flipping ahead to the outcome, was that when we first negotiated with Social Services for Newfoundland and Labrador they agreed to continue this program if things worked out well. In fact when the time came to renew funding there was a huge cutback in funds from the Federal government, which in our province just about decimated social services. In fact, Social Service doesn't exist as a department, they have been amalgamated with another group. So, things did not go ahead as they should have. Each of the communities that took part said they wanted to continue. Currently the province is considering putting it into legislation—where I think it really belongs if we are going to have effective, consistent mechanisms for child protection. What we learned, though, is that once families started doing family group conferencing, they didn't necessarily need a coordinator to get them together. They would just go ahead and have family meetings. We've heard this from quite a number of the families. We've also heard, especially in the case of Nain, that the conference was the first opportunity for many to really express the pain that their families had been experiencing for decades. There are quite a number of people who were relocated from Hebron to Nain, so there are a lot of issues around the relocation that are nowhere near settled within the community. And often, and I'm sure this is no surprise to people here, there were parents and children living under the same roof who could not speak to each other. In the conferences, we brought in translators, and this provided the first opportunity some families ever had to address the very severe pain and violence and alcoholism and so many other issues they were dealing with. They told us over and over again how important the conference was. An elder who participated in a conference said to the researcher: "You stress to the administrators that this makes sense in terms of our traditional ways. It isn't exactly our traditional way, but it makes sense to us."

There weren't enough conferences, we needed more. And we recognize that as a lack.

## Surviving the Abuse in Cree Society

Marilyn Bearskin

(Rapporteur: Lara Stern)

**Résumé:** Partant de son expérience personnelle, l'auteure décrit une situation d'abus sexuels et physiques, de tentatives de suicide, au sein de nombreuses communautés autochtones. Les victimes de ces abus reçoivent peu d'appuis de la part de leur entourage et doivent souvent faire face grâce à des services et des programmes qui ne prennent pas en compte leur origine autochtone. Il s'agit de changer les attitudes envers l'abus et les victimes de ces abus, au sein des communautés.

**Abstract:** Many women who are abused seem to think that abuse is normal, because of the way they were brought up. Separation and divorce are not part of our beliefs, but a man being the boss of the home is a belief held by many of our older people and only some of the younger people. Our beliefs and values get in the way of our women standing up to the abuse. When a woman takes action and makes the decision to leave, a common reaction from Cree society is that the woman gets treated like an outcast and people feel sympathy for the man.

Marilyn Bearskin works for the magazine *The Nation* in Chisasibi where she lives. She writes about domestic violence based on her experiences, thoughts and emotions. In addition to writing, she also speaks at conferences in her community and occasionally on the radio about the physical, sexual, and emotional abuse of Native women. She specified that she speaks here from a personal rather than academic perspective, based on her life experiences.

Abuse is prevalent in Native communities and there is a lack of resources available to help the victims. Native women who are being abused often turn to alcohol and drugs, neglect their children, households, and themselves, and often attempt suicide. Ms. Bearskin described with emotion the lack of self-respect that inevitably results from enduring such abuse. There is unwitting neglect of children by mothers who are being abused; there is an intergenerational pattern of abuse and neglect that she herself can trace from her own grandparents to her children.

People in Ms. Bearskin's community do not take domestic violence seriously. There is an absence of programs and counselling for victims of abuse, and help often can only be sought from White society and may not meet the community members' needs. When women finally do leave their abusers, they are often faced with harassment rather than support from the community. Ms. Bearskin noted that elders, community and even family members often advise an abused woman seeking support that she is being selfish, that men are "just like that," that women must stand by them, that people get treated the way they deserve to be treated, and that she should return to her husband.

Such experiences are not uncommon—the community will side with the men and blame the women who have managed to summon the courage to stand up for themselves. For those who have endured abuse and mustered the strength to leave, there are not sufficient resources to help. Support for victims of abuse is lacking not only in terms of programs and counselling, but also in terms of personal encouragement and moral support from community members. There is an urgent need for changing attitudes, public education for entire communities, and support programs for victims of abuse.



## Workshops

### Grief in the Inuit: A Social Worker's Response

Katie Moores

*Montreal General Hospital*

(Rapporteur: Natalie Lloyd)

**Résumé:** Mme Moores est un assistante sociale qui aide les autochtones venant à Montréal pour recevoir des services médicaux. Elle parle ici des différentes façon qu'ont les gens de faire leur deuil de leurs différentes pertes. Les autochtones ont souvent des pertes individuelles mais aussi des pertes collectives de leurs traditions et de leur mode de vie.

**Abstract:** The experience of loss is very common as Inuit people have struggled to survive the harsh elements for centuries. However, there is a newer, harsher element—the young people are dying, and by their own hand. Inuit patients coming to Montreal for medical care often express great sorrow over a recent or a remote death, not infrequently to suicide. The suicide rate in the Canadian Arctic is four times the Canadian average. This presentation deals with the subjective experiences of a social worker who works with the Inuit population when they come to a large urban centre for medical treatment. Traditional and contemporary approaches to grief are explored, and a guideline for intervention is presented. A theory of loss and recovery is being formulated that will help others who work with this population to gain a greater understanding of how to proceed.

Katie Moores works as a social worker with Inuit who come to Montreal for medical services with the McGill-Baffin Program. In her work she counsels Inuit people dealing with bereavement, childhood sexual abuse, physical abuse and newly diagnosed life-threatening illnesses. She also helps locate resources for Inuit from Baffin Island while they are here receiving medical services. One of the projects she is involved with is locating Inuit graves for relatives in northern communities whose family members came to Montreal in the 50's and 60's (usually for medical services) and died here.

Grief is not restricted to death; the loss of traditions and lifestyle due to relocation, and other significant events in a person's life can bring grief. It has been Katie's experience that loss permeates the Inuit culture through a history of relocation and death. When working with individuals who are grieving, a genogram reveals histories of suicides, other deaths, and adoption in and out of the family. This tool helps Katie form a picture of the losses experienced by the individuals she works with. Katie referred to statistics showing that in the Inuit community everybody knows somebody who has committed suicide. Statistics also indicate that a person who knows someone who has committed suicide is eight times more likely to commit suicide himself or herself.

After Katie raised the question of how each of us deals with loss, the workshop participants broke into small groups and discussed first experiences of death and the subsequent emotions. The words that emerged were: unreal, surprised, anger, confused, shock, denial, depressed. Katie presented a chart listing the emotions people commonly feel when they experience loss. Elizabeth Kubler Ross's stages of loss: denial, anger, bargaining,

depression and acceptance were also discussed. Katie noted that these stages don't necessarily occur in the order that they are listed.

The relevance of the following, developed by C. Murray Parks, was debated:

If a husband dies, a woman loses:

- her sexual partner;
- her protection from danger;
- income;
- companionship;
- a recreational partner;
- her children's parent;
- status;
- expectations;
- self-confidence;
- home life;
- a job;
- a person who assures her of her worth.

Katie talked about some of the statements she hears from the people she works with who are dealing with loss, statements such as "Feels like I will never lose the pain," "It is like a part of me died." These feelings and others are normal feelings for people grieving and it is important to realize there is no time limit on grief.

## Inuit Concepts of Mental Health and Illness

Roda Grey

*National Health Coordinator  
Pauktuutit Inuit Women's Association*

**Résumé:** Dans le domaine de la santé mentale, les autochtones attendent beaucoup des experts venus d'ailleurs. Ils s'attendent à des miracles, des guérisons. Mais la notion de santé mentale est très différente chez les autochtones car leur façon d'apprendre est différente. Une personne autochtone apprend à travers ses expériences et non à travers des livres et des théories. L'esprit est considéré comme étant incontrôlable, et l'investigation systématique, la catégorisation des choses comme étant "normales" ou "anormales" n'existe pas chez les autochtones. Toute recherche dans ce domaine doit prendre en compte ces différences.

**Abstract:** This is an opportunity to provide Inuit perspectives on mental health issues to conference participants. Mental health is a challenging area for Inuit peoples to explore and understand as it is associated with good and bad spirits. Indigenous peoples and Western scientists such as anthropologists and psychologists have different understandings of how the human mind works. The workshop will cover Inuit perspectives and theories on mental illness.

I am not sure how I am going to share my presentation on Inuit perception of mental illness with you. As Indigenous people we are orally oriented, and often have difficulty expressing or presenting our information in a paper or an academic context. So, I am not giving you an academic type talk today—we are basically oral people; we are very good at talking but when it comes to the written form, we tend to lose our thoughts or get scared of what is on paper.

First of all, I would like to tell you my personal experience, as an Inuk interpreter in the mental health field. I have been an interpreter for Inuit since the age of 14, when my English was very poor. At the time, I did not have a lot of vocabulary in English, which didn't help. Now I know that language is not the only barrier to better understanding between Inuit and Southerners. The lack of knowledge between two different cultures (Inuit and Kabloona health professionals) is a big factor. We all know that there are many books and documents written by Kabloona, but you can't know about other cultures by reading. The only way to understand Inuit culture is to live in the North for a long time and to live with Inuit as part of the community. Don't misunderstand me when I say "live in the North for a long time;" there are many people who have lived in the North for many years and still do not understand Inuit culture. It is not a simple process to adapt to a different culture. I have lived in the South for more than twenty-five years and I cannot claim that I am expert in Kabloona culture.

I have experienced frustration as an interpreter for Inuit and Kabloona on mental illness issues. Inuit have high expectations from the Kabloona to solve problems, as the Kabloona are seen as knowing everything because they have education. The description of education is very powerful in our language. When Kabloona are known to have professional qualifications, such as a psychiatrist or someone with a Master's degree in Social Work, Inuit have very high expectations of these people. This expectation is based on Inuit respect for knowledge: when Inuit elders were the traditional educators, they were highly respected

because they had knowledge. The elders who were passing on their life experience to younger people were the specialists on problems. I am only trying to point out that there are high expectations for you to provide solutions to the Inuit communities.

The objective of this workshop is to present to you Inuit perspectives on mental illness in comparison with scientific theories. This subject is not an easy one because it is complex. Inuit perspectives are not “theories” as they are in the western scientific world. The Inuit perspective on mental illness is not based on scientific explanations. As I said earlier, we Inuit and other Indigenous people in the world are oral people. For starters, Inuit do not ask questions in order to understand something, they learn from life experience. Learning about life is through living and experiencing. This is why Inuit elders were very important in our traditional society as teachers. They did not have theories about mental illness, they accepted the circumstances and had ways of dealing with mental illness. This is very different from the western and scientific world’s view of the concept of mental illness.

In western psychology, there are many theories from different schools. Inuit do not have access to that information. When I studied basic psychology and abnormal behavior in psychology, I found the explanations of why human beings’ experiences affect family members and whole communities very interesting.

When social workers and psychiatrists arrive in an Inuit community there is a lot expected of them because they are the ones with knowledge. You need to be aware that you are expected to find solutions, for example to provide cures for mental illness, eliminate fear and, most importantly, to provide medication (pills) which are seen to be a miraculous invention. We need to work with you, but solutions have to come from within communities.

As I mentioned earlier, Inuit rely on teachers who have special knowledge. Listening to the elders was the traditional Inuit way—young people did not have life experience, so they were given lessons, or I could say theories!

The mind, “Isumaq,” is very complicated and it is beyond Inuit control at its extremes. Unlike the Kabloona, Inuit have always accepted certain things as beyond their control, with no questions asked. For example, when there is death, it is beyond Inuit control and it cannot be helped (what can you do?). In the Kabloona world, if anybody dies of unknown causes there is always a follow-up investigation. The purpose of the investigation is to prevent future deaths by figuring out why the death occurred.

I don’t have a history of how the Inuit dealt with victims of mental illness. I was born when the government was starting to build the infrastructure—schools, nursing stations, and housing for the Inuit, so families would not be separated from their children when they attended schools. The Inuit were sent South for hospitalizations and I also know some of the Inuit were taken away to mental institutions. I can only tell you what I know. Mental illness is very scary. As outsiders coming from the South, you should really try to understand how families and community members feel about mental illness. It is what Inuit rely on you for, because you have the knowledge, and the cures or solutions are in your hands.

I will try to explain to you how mental illness is perceived by the Inuit. As I said earlier, it is *isumaq*, the mind, that is complicated to understand. When a person has a mental illness or something abnormal is happening, they start to hear voices or to see things that are not real. This can be observed and interpreted by Inuit as a person being possessed by evil spirits. This is the critical part you should understand. When I was an interpreter as a young person, it was very scary because the Kabloona did not understand Inuit culture.

“What is reality?” and “what is normal?” can be asked by the Kabloona people, but in our culture, and I believe in other indigenous peoples’ perspective, we do not ask what is reality or what is normal. You cannot take away the fear from the individual person unless you take them away from their communities. They will remain afraid as long as they are in that environment, where there is a belief that they are possessed by evil spirits.

When I was 14, my grandfather died. I was told he had gone to hell because he never went to church. I believed it, and so I used to have awful dreams that he was getting out of his grave. We were also told that we should not think too much about someone we liked because the evil would create that person in our mind. There were some people who had children that did not exist outside their minds. It was very important to have a Bible so you would be protected from bad spirits. It is a part of Inuit reality to have these values because it is part of their survival. It is beyond my ability to explain clearly to you what this means in our culture.

## The Native Women's Shelter of Montreal

Anita Pratt

*Native Women's Shelter of Montreal*

(Rapporteur: Elizabeth Robinson)

**Résumé:** Il est important de définir les limites des responsabilités des thérapeutes. On ne peut exiger de ceux-ci qu'ils soient complètement responsables des comportements de leurs clients. Ceux-ci doivent apprendre à être responsables d'eux-mêmes car la notion de responsabilité est au cœur de la dynamique historique entre autochtones et colons. Elle représente la clef de la guérison des communautés autochtones.

**Abstract:** The Native Women's Shelter of Montreal offers hostel services, support and counselling to women and children who come from all walks of life. For many of these women coming to the Shelter is a step towards changing a violent living situation. Our program is based on self-help and empowerment. Briefly, self-help incorporates: sharing skills, knowledge and life experiences on how to access services and counselling that will enable the women to once again assume their place in society. We are women sharing with women, and assuming responsibility for interventions that will end the cycle of violence. The workshop will discuss the impact of family violence and the overall welfare of women and children. Is it the sole responsibility of social workers, police, and doctors to intervene or do we involve other people in trying to stop the violence? What type of intervention helps victims?

Under the Indian Act, First Nations were wards of the state; thus the government took responsibility away from them. This is gradually being given, and being taken, back by Native people. Workers at the shelter see themselves as a support and a resource for clients. The clients are responsible for themselves. Often clients try to hold the workers responsible for getting them up in the morning, scheduling appointments, getting to appointments, etc. In working with clients, staff find that the word empowerment is more acceptable than the word responsibility.

The women's shelter program includes group sessions with various themes; these are open to both residents and to First Nations women not living at the shelter. The program is flexible and adapted to the needs of each client. Certain basic rules must be observed: getting up, being present at meals, sharing in chores, attending group sessions, etc. In addition to group sessions, clients may request one-on-one sessions with shelter workers. In some cases they may be referred for psychotherapy outside the shelter. Clients are thanked for coming to the shelter. It takes courage and strength to ask for help.

For decades the government held the responsibility for Native People. Now we are seeing that responsibility is gradually being given back to the people. Anita noted that while some feel this to be true, others still question: "what are we responsible for?" She suggested that we need to look at the many ways responsibility can be defined in order to better understand the direction this discussion of responsibility can take.

To use one example, the Oxford Dictionary gives the following definition for responsible: accountable, liable, answerable, reliable, respectful, reputable, trustworthy, dependable, ethical and honest.

Anita stated that she doesn't pretend to assume any clear and absolute definition of responsibility can be arrived at, but she emphasized the point that this issue of responsibility is something that affects everyone involved in the field of intervention. The purpose of her discussion was to brainstorm and try to come up with opinions and ideas that could be integrated into future intervention methods and into people's lives if they so choose. She offered the following questions as food for thought:

Does taking responsibility mean that we require our clients, patients, or communities to help in their therapy, therefore making them responsible, or do we feel that we have to do everything for the client?

Are we required to come up with a solution for the client, patient, or whole community?

Do we feel that the police, doctors, counsellors, etc. are re the ones that should be coming up with solutions?

## Family Group Decision Making

Joan Pennell

*Memorial University*

(Rapporteur: Kaha:wi Joslyn Jacobs)

After all the workshop participants briefly introduced themselves, sharing their backgrounds and their interest in the workshop, Joan began by emphasizing that in all of the communities where she and her colleagues had worked, community members first completed their own 'Needs Assessment.' This stressed the importance of the community addressing its own needs concerning the safety of community members.

Joan and her colleagues had wrongly assumed that small communities had family support systems. But in some cases people did not have many relatives, were not close with relatives or did not know who their relatives were. However, Joan noted it is important to realize that strong support systems can be built with people who are not biological relatives, when they are built on respect.

It was up to those involved—communities and families—to decide at what age children should participate in family conferences. For instance, in one community the age was 12, and in another it was 6. Concern about the attention span of younger children and their ability to sit through a family conference was one consideration. Joan pointed out that there are occasions when it is beneficial for family members having a conference to feel the presence of their children even if they are not physically there, by displaying a photograph or reading aloud a written statement from a child. In one case, a 12-year-old boy's written account of his feelings seeing his mother being beaten by his father was read during a conference. This helped the man understand how badly his son felt; hearing his son's words helped him remember his own feelings as an abused child. In another case, a teenaged girl sat in an adjoining area separated from the rest of the group by a divider, and recounted her experiences of sexual abuse. This girl came to realize that others in the group cared for her, and eventually, at a later conference, she joined them.

Joan made it clear that these conferences always take different forms; they are organized by families, not administrators, and the families decide on their format through consensus. Often the group follows the advice of a trusted leader such as an elder or a respected member of the family. Professionals are not present at family conferences, though they remain nearby in case they are needed. For instance, if any member of the group is wary of potential violence the coordinator is quickly available. Joan said that violence is rare in these conferences, and that the group develops strategies to deal with violence if it occurs. The group's judgement on whether to proceed with a conference is always respected.

Preparation for a family conference takes 3 to 4 weeks, and the conference usually lasts about 6 hours. Costs incurred include fees for specialists (such as anger management counsellors) when they are required.

Following family conferences participants have been asked to fill out evaluation forms. From this data, Joan and her colleagues have been able to conclude that overall, to date, people feel positive about the conferences. Negative feelings were mainly directed towards the non-attendance of people who had said they would attend. 64.5% of those surveyed reported



that their plans for the conference were carried out, and 66.7% reported that overall, the conference improved family relations.

In all, 85% of the activity plans developed by families at the 37 conferences to date were carried out. Positive effects of these conferences included enhanced family unity, improved communication between family members, motivation for change, increased inter-family support, and the benefit of access to more resources. Negative effects included the separation of family members, and the bad feelings family members experienced when plans made at the conferences were not carried out.

When asked about the pitfalls of using the Family Group Decision Making strategy to prevent the abuse of women and children, Joan emphasized the importance of working out a policy with local social services so that front line workers are available. Support for, and understanding of the procedures involved in Family Group Decision Making by various agencies is to the benefit of everyone involved.

## Overview of Research on Substance Abuse and Native Communities

Kathryn Gill

*McGill University &  
Montreal General Hospital*

**Résumé:** Les problèmes majeurs de santé mentale parmi les population autochtones sont le manque d'estime de soi, la violence familiale, l'abus d'alcool et de drogues, la dépression et le Syndrome d'Alcool chez le fœtus. Parmi ces problèmes, l'auteure s'intéresse particulièrement à l'abus de drogues et d'alcool et pense que le traitement efficace de ces abus pourrait servir à interrompre leur cycle de transmission au sein des familles et des communautés. C'est à cette fin que fut ouvert, au sein du Native Friendship Centre, un autre centre mettant en contact les individus en milieu urbain souffrant des ces maladies avec les centres de traitement appropriés. Jusqu'à maintenant, l'analyse d'utilisation démontre que ce centre dessert en proportions égales les personnes abusant l'alcool et celles abusant plusieurs drogues à la fois. L'utilisateur typique du centre est jeune, femelle, a déjà vécu en institution, a été abusé pendant son enfance et souffre maintenant d'un manque de contrôle de comportements violents et d'idées suicidaires. Malgré ses bonnes intentions, le centre a un taux de succès assez bas. Plusieurs facteurs, mis à part les difficultés intégrantes au traitement de ces abus, ont émergé. Parmi elles, les cartes d'assurance maladie et de preuve de statut manquantes, des difficultés quant au transport des individus vers les centres de traitement, les délais de traitement dus aux longues listes d'attente et au système d'entrée par cohortes, et enfin les critères d'admission aux centres eux-mêmes. Ceux-ci requièrent une période de sobriété avant l'admission, traitent préférentiellement les individus de certaines Nations, et refusent le traitement aux individus ayant des problèmes psychiatriques ou médicaux ou ayant été traités ailleurs pour leurs abus dans l'année précédente. L'auteure illustre son discours avec des exemples multiples.

**Abstract:** The overview will point out various issues regarding alcohol/drug use in Native communities including: the lack of accurate prevalence data; myths concerning different responses to (and metabolism of) alcohol in Natives; the extent of concern about substance dependence expressed within Native communities themselves and among health professionals, and the lack of critical evaluation of existing programs and policies for the prevention and treatment of alcohol/drug problems in Native communities.

My name is Kathryn Gill I am the Director of Research and Training at the Addictions Unit of the Montreal General Hospital and also a professor in Psychiatry at McGill University. My specialization is addiction, in the large. The majority of my current work is on the outcome of treatment for substance abuse. One component of my work is very biological, looking at the genetic factors involved in determining alcoholism and substance abuse. This was the way that I got into working with the Native American population, while living in Denver, Colorado. I started a research project on genetic factors in the development of alcoholism in the American Indian population, in collaboration with the Denver Indian Health Service and the Denver Indian Centre. They were very curious, as I was, about whether the Native population had a different alcohol metabolism compared to Caucasians and Orientals. I do not want to talk about this today—but rather the work I have been doing in collaboration with Urban Natives since I came back to Canada.

I approached Ida LaBillois-Montour, Executive-Director of the Native Friendship Centre of Montreal, about getting involved in doing research on the substance abuse problems of urban

Aboriginals. She said very flatly that she wasn't interested in research, she was only interested in services. With that in mind, together we designed a project—a drug and alcohol referral program—that provided a service and at the same time collected research information on how well the service worked, and whether or not people were getting what they needed from the service. Before getting to the results of our program, I want to start with a little bit of information about what is known about drug and alcohol problems in Native communities.

We already have some idea based on the discussions during the conference yesterday. I wrote down some words that kept coming up. They were alienation, low self-esteem, alcohol abuse, family violence, drug abuse, Fetal Alcohol Syndrome, depression. Alcohol and drugs entered practically every one of our conversations yesterday. Quite apart from our perceptions and concerns there is some information that comes from four large surveys conducted within Native communities as listed below:

In Canada, injury and poisoning are the leading cause of death among status Indians and Inuit. Injuries primarily involve accidents with motor vehicles--and are largely alcohol-related. (*Aboriginal Health in Canada, 1992*)

Alcohol and drugs constitute the most serious problems in northern communities and can be considered the direct cause of family violence, suicide, violent crime, accidents and accidental deaths. (*Rapport du comité interministériel sur l'abus des drogues et de l'alcool produced by the Quebec Secrétariat aux affaires autochtones*)

In a survey of Quebec Native Peoples, unemployment was viewed as the most serious social problem (68% of respondents) closely followed by alcohol abuse (61%) and drug abuse (48%). (*Aboriginal Peoples Survey, 1991*).

“The most visible problems related to mental health in Aboriginals are alcoholism, drug abuse, conjugal violence, sexual assault and abuse, and family dysfunction. These problems rarely occur in isolation...” (*Petawabano et al., Mental Health and Aboriginal People of Quebec, produced by Le comité de la santé mentale du Québec, 1994*)

According to the Aboriginal Health survey, injury and poisoning are the leading causes of death among status Indians and Inuit. It is very significant that injuries are mostly “alcohol-related” Another piece of information comes from a very interesting and enormous report produced in 1989 by the Quebec Secrétariat aux affaires autochtones. It was a very significant document that surveyed a large number of Native communities throughout Quebec and a reading makes it very clear that alcohol and drugs are the most serious problems in communities. The report made a significant number of recommendations that, as far as I am aware, were never followed up on. In another survey of Quebec Native peoples (*Aboriginal Peoples Survey, 1991*), a large percentage of the respondents, 61%, found that alcohol abuse was a very significant problem within their community, followed by drug abuse. This was on a ranking of all possible social problems. The most recent report, by Petawabano in 1994, again made a tremendous number of recommendations, as yet to be followed up upon. It stated that the most visible problems related to mental health among Aboriginals are alcoholism, drug abuse, conjugal violence, sexual assault and abuse, and family dysfunction.

In terms of the urban environment, the same kinds of conditions exist. As I said before, when I approached Ida LaBillois-Montour about doing some research, we started off by providing a service—the Drug and Alcohol Referral Program. This was largely due to the

fact that Ida was very aware of the problems in the Native community here in city. We have little concrete data to go on, but there have been a few studies such as the following:

- Urban Natives appear to be over-involved with the criminal justice system such that alcohol was involved most or all of the time in criminal charges against Aboriginals. The lives of inner city Aboriginals were "characterized by despondency and hopelessness and ... hard-core alcohol problems" as well as poor education, unemployment and victimization as children. (*LaPrairie, Seen but not Heard: Native People in the Inner City. Ottawa: Dept. of Justice, Canada, 1994*)
- Female urban American Indian substance experienced more family dysfunction, more family history of substance abuse, and a much higher rate of childhood emotional, physical and sexual abuse compared to males. Of the females, 84% reported emotional abuse, 74% reported physical abuse and 52% had experienced sexual abuse. (*Gutierrez et al., Sociocultural and psychological factors in American Indian drug use: Implications for treatment, 1994*)

In general, urban Natives are over involved with the criminal justice system. We see that in information that we have been collecting at the Native Friendship Centre. A huge proportion of our population is either on parole or has been referred by the justice system. We are also seeing a high degree of physical and sexual abuse. We know that there is a high degree of emotional disturbance in the urban population. I want to comment on something that also came up yesterday, when someone made the comment that "we've been researched to death." Well, we have a tremendous number of questions remaining and I think that we need to turn the question around to "What do we still need to know?" We need to take the opportunity to form the kinds of partnerships that we have been talking about to help solve the problems. One of the things that I think is significant is that research has shown that families play a huge role in transmitting and perpetuating child physical and sexual abuse. About one third of children who were abused or exposed to abuse become violent themselves later in life. I would like to suggest that successful treatment of addiction could be a point that interrupts the intergenerational transmission of alcohol, drug and physical abuse, and would also stop the intergenerational transmission of the effects of Fetal Alcohol Syndrome. I think this issue is very important, and worth researching further. We need to know more about good treatment. How should we go about treating individuals with alcohol and drug dependence? What is the best way to produce change and to maintain change over the long term? I think we have a number of research questions in this area.

I would like to turn to the work we have been doing at the Native Friendship Centre of Montreal (NFCM). First, I want to point out that a number of people have been involved in the project. In addition to my research partner Ida LaBillois-Montour there have been a number of assistants, interviewers and outreach workers including Kaha:wi Joslyn Jacobs (now a graduate student under my supervision in the Psychiatry Department at McGill), Natalie Lloyd (the primary research assistant on the project), Lana Pratt (who started the project and is now in graduate school at Concordia), and Delbert Sampson. We did a lot of street work out in the community, and Delbert was very important in identifying where we should go and accompanying our workers. We started the Drug and Alcohol Referral Program at the NFCM, and we had a number of contacts in the first year of the project. It became clear, very quickly, that people didn't want treatment, not in terms of what we were offering them. We were primarily offering referral to one of six Native-run treatment centres in Quebec. In addition, people could go to Portage (in Lac Echo), the Addictions Unit of the Montreal General Hospital, or Alternatives in Montreal. We were basically trying to find the best service for the individuals that were coming to us. Of the 80 contacts to the Drug/Alcohol Referral Program at the NFCM during the first year of operation (March 1996-1997) the clients came from the following nations: Inuit (26.9%), Cree (13.5%), Micmac

(9.6%). The requests for service fell into the following categories: Requests for Individual Psychological or Drug Counseling—57.1%, Information on Referral Program—64.3%, Information on AA meetings—32.7%, Direct requests for Referral to Native-run Treatment Centres—34.6%. If you look at what people were requesting when they came to us—it was largely individual psychological or drug counseling, not referral to treatment outside Montreal. It became very clear that people were not that happy about being sent away from the urban environment for treatment. They wanted to have something within their own milieu. They did not want to have to leave their families and kids behind and have to move away for 6 weeks (or longer) for treatment outside the urban environment.

**Table 1. NFCM Drug and Alcohol Referral Program**

**Characteristics of the Population**

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Major Problem	50% alcohol abuse; 50% poly-drug abuse
Gender	91.7% female
Average Age	28.5 years
Nation	66.7% Inuit; 16.7% Cree
Occupation	58.3% unemployed
Living With	41.7% with partner; 17% no stable home
Legal Problems	25% on parole; 42% awaiting charges (of these 25% were awaiting charges for assault); 8.3% had been in jail during the past month.
Childhood Abuse	75% experienced emotional abuse; 100% experienced physical abuse; 54.5% experienced sexual abuse
Psychological	50% experienced depression; 33.3% anxiety, 42% had trouble controlling violent behaviour, or had suicidal thoughts

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As shown in Table 1 above, there were other problems in the population, which were very significant. We have more than just alcohol problems in the urban population. We have about 50% poly-drug abuse, and this is largely alcohol + cocaine. Also, there is a large number of females: as you can see the majority of those who actually came for referral were young females, largely Inuit and unemployed. Twenty-five percent were on parole, and 42% were awaiting charges. This again is another issue: if you are awaiting charges, it is very hard to be sent away to a treatment program. You cannot necessarily leave the city for treatment. There was a very high level of emotional, physical and sexual abuse in this population. Also, what is very significant is the high degree of psychological problems such as depression, anxiety and trouble controlling violent behaviour. There is a potential need for other kinds of help and services for this population, in addition to treatment for substance abuse.

The message right now is that, in the urban environment, there are tremendous barriers for treatment. There is a tremendous need for treatment but there are barriers. I would like to go through some of those we found through the study. We will be documenting these in quite a bit of detail. What we are presenting here is what we perceive to be the barriers for treatment. Everyone who is working on this project is very aware of the difficulty and I think largely discouraged by it. The majority, 90%, who were referred to the NFCM for our Drug and Alcohol Referral Program, failed to enter treatment. That is extremely discouraging, especially when you consider the amount of effort it often takes to get a referral together: there are multiple telephone calls to the treatment centres, a lot of negotiating with the government over transport, and time taken to fill out the very large sets of forms required by several of the treatment centres. For someone not to get into treatment after all this work is quite discouraging.

### **Barriers to Treatment**

The majority (90%) who were referred from the NFCM Drug/Alcohol Referral program, failed to enter treatment. This failure occurred for many reasons:

- missing health cards, or proof of status
- difficulty obtaining transport and/or funds for transport to treatment centres outside Montreal
- in some Native-run treatment centres there is preference given to specific nations (e.g. Montagnais, Algonquin) with restricted access for urban Aboriginals.
- delays in entry to treatment due to long waiting lists or cohort entry (entry at pre-determined dates)
- a number of treatment centres require periods of sobriety prior to treatment entry. For many addicts this is difficult to achieve—and is the problem for which they are seeking treatment. This requirement results in a Catch-22 that prevents entry into treatment.
- a number of treatment centres will not take individuals with any medical or psychiatric problems, or those with physical disabilities.
- a number of Native-run treatment centres will not take individuals who have received treatment elsewhere in the past year. Substance dependence is well recognized as a chronic relapsing disorder—as such this regulation appears punitive.

As listed above, some of the significant problems preventing successful referral were missing health care cards, missing proof of status, and lack of funds for transport. Some treatment centres give preference given to specific nations. For example, one of the treatment centres has three beds that they keep open for urban Aboriginals and the remainder go to other nations surrounding the treatment centre. That again puts a limitation on how fast we can get people in treatment. Delays in treatment are often due to long waiting lists or cohort entry. Cohort entry is a very interesting concept. It means that a treatment centre has X number of beds and every 5 or 6 week cycle they will take in a new group of people. There may be drop-outs or their beds may not be full, but you cannot get in until the next cycle starts. So, for example, if you have a patient coming in today who really wants to get to treatment, you may have to wait 6 or 8 weeks before they can go, providing that they are

not put back on a waiting list. What is also difficult to accept is that a number of treatment centres require periods of sobriety, ranging from 72 hours to 2 weeks, prior to treatment entry. For many addicts this is difficult to achieve and defines the problem that they are seeking treatment for.

A number of Native-run treatment centres will not take individuals who have received treatment elsewhere in the past year. Addiction is defined as a chronic relapsing disorder. It is expected that individuals with addiction problems may require multiple cycles of treatment. This regulation in effect is punitive and a barrier to treatment.

### **Examples of Problems Making Referrals**

*Case 1:* N.Q. was an urgent case (in alcohol withdrawal with extreme emotional problems, agitation etc) who wanted to go into inpatient treatment (detoxification) due to a previous history of seizures. She required help to gain entry to a detox centre since she had already burned her bridges at the local hospital. Attempts to find transport to a detox centre in Cornwall, Ontario were very difficult. After many different appeals to both Kanasatake and Kahnawake, medical services from Kahnawake eventually took her directly to the detox centre in Cornwall.

*Case 2:* D.C. wanted to go to an English detoxification centre. The waiting list at St-Luc Hospital was long and she had already used the service many times. This time the difficulty in finding treatment for her, a woman of Inuit descent, was that she had been in Montreal for 7 years and no longer had a valid beneficiary number and thus could not access the mobile service.

*Case 3:* C.W. wanted to attend a treatment centre in the north and required travel arrangements to be made from Montreal. Health and Welfare Canada required proof of status before starting the process. Once this was accomplished a letter from the treatment centre was required confirming his acceptance. However, the treatment centre would not confirm acceptance until final travel arrangements were made.

The examples listed above are provided to give some insight into the kinds of problems we have making referrals. In each case, as I said, there is a lot of work involved in making the referral and in preparing people to go. The first case was very urgent. The client was going into alcohol withdrawal, and had a serious history of seizures. There were hours and hours of repeated calls to try and get somebody to transport her to Cornwall. Finally, Kahnawake Mobile Service took her directly to the detox centre. The second case was also an emergency. In this case, this individual wanted to go to an English detox. She had been to St-Luc (Hospital) multiple times in the past. St-Luc usually can take people pretty quickly, but she had already used it many times. The problem of finding treatment for her was that she was Inuit, and had been in Montreal for seven years and no longer had a beneficiary number.

The last case illustrates a problem that happens quite frequently. The client wanted to attend a treatment centre in the North and required travel expenses. Health and Welfare required proof of status, which was provided after some paper work. However, once this was accomplished, they required a letter from the treatment centre confirming acceptance into treatment. However, the treatment centre would not accept the client until they had proof that travel arrangements had been made. Neither of them would budge because they needed confirmation from each other. Finally, a major appeal was made and the treatment centre came through with a letter of acceptance and we were able to send the individual. These are the kinds of bureaucratic glitches and problems that come up when you do have

clients interested in referral. I want to point out again that the majority of the time people do not want to be referred for treatment.

## Questions and Answers

*Q: Have you looked at the model of harm reduction?*

**KG:** I haven't seen any treatment centres that attempt to do that. Harm reduction is a very interesting concept, but it hasn't filtered down very much in Quebec. At the Addictions Unit [Montreal General Hospital] the therapists have a very hard time accepting the idea of harm reduction, and they are very abstinence oriented. We are working on rethinking this. We are losing people because we insist on complete abstinence from all drugs. This is an argument we get into routinely with people. They may be seriously in trouble with alcohol, and using a little cannabis from time to time. We insist that they drop all drugs of abuse, while they may want to keep their little tokes from time to time.

I would suggest that part of the treatment plan is to try to work with what the client needs [and wants], much more than what the therapist thinks they need. That way, you hang on to them a little bit longer and bring them into the therapeutic process, and hopefully bring them to your viewpoint eventually, but not necessarily.

*Q: These barriers that were presented this morning, I think that most people working in organizations know that these are the barriers. When I say that we have been researched to death, I want to know where you take this information you get from research. Where does it go next? I think that the biggest cry for help in Drug and Alcohol Abuse Treatment is after-care.*

**KG:** Yes and that is what I want to get to. There are a couple of levels here. As part of the research, we have also been looking at solvent abuse. Remember, the Native Friendship Centre has been involved with this project from the beginning. We are collecting information that is going to be useful to them when they make their grant applications. So, it is not a matter of just knowing things, but also documenting them in ways that the majority culture will understand. We have to be able to do certain things to get the services we need. One of them is writing applications with appropriate documentation.

I am very confident that this research program has already produced changes and will continue to do that. It is an ongoing process and if we evaluate what we are doing, we may have something that will be useful to other communities, throughout Canada. If we can document a treatment or referral program that can work with limited resources, I think we will have done something useful. That is the orientation right now.

*Q: You have been doing research for a while in this field. Do you have any success stories, and if not, what are we doing wrong?*

**KG:** Do we have any success stories? (to other member of the team). Response from Natalie Lloyd: We have a few actually. By the way, I'm Natalie, one of the people working on the project. We have one young man who came in, and when I saw him he was in a serious state of withdrawal, he was starting to show signs of DT's. Right now he is in the process of completing his three month treatment and what I have heard from the team workers, he is doing very well. There are other people who have relapsed and have come in and said: "You know, I've been to treatment centres before and I don't want to go back there, but I just want help in getting linked up with different programs here in Montreal." We have worked together to find ways that they felt comfortable with. They may have a relapse, but I don't see relapse as a complete failure. I think it is a chance to learn and not just give up on



yourself. So, I think there are success stories. Sometimes Kaha:wi Jacobs and I may get a little overwhelmed by all the non-success stories because, as you can see, quite a few of the people who do come and see us really need treatment, but don't end up going through. But some do tough it out and seem to be doing OK. I guess that's what keeps us going.

*Q: I have a question: looking at before-care, is that part of the plan? Everything that you are talking about we do on a daily basis: the difficulty of no cards, of withdrawal. In terms of before-care, what is the approach that the team is taking? Because I know that for us, the women that come in to the shelter, if we are diligent with our before-care, we usually can get our people into treatment, and they usually don't walk.*

**KG:** Before they go to a treatment centre? I think that is what we are hoping to develop now. We have not had the resources to do counselling. We don't have the trained counsellors and there aren't the facilities at the Native Friendship Centre. But you are right—we need to do more pre-counselling.

*Q: I can't agree with you 100% because you are going right back again to dollars. We don't have dollars either, we don't have specialized counsellors to respond to the needs of our women. What we do try to do is to use the existing resources: we refer to the Friendship Centre, we refer to Portage, Kanesatake, Kahnawake ... Maybe I'm sounding like a stick in the wheel, but for us before-care is very important, and with some of our clients it may be even more important than the treatment. If they don't get the before-care, they don't get to treatment. My other question is, looking at the percentage of women, do you truthfully feel that it is a true story? I feel that women are more open to respond to what we try to tap into than the males.*

**KG:** The point was that those were actually the ones who came to us, those that wanted to try to get to treatment. So, clearly yes, the males were not coming. All I meant was that there were a high percentage of women who came for referrals. That's all, it doesn't mean that they had more problems, just that they were tending to come and ask for help.

*Q: What there needs to be is before-care. It does not have to be in a specific place. For example, if I am going to go for before-care and I'm not too comfortable with it, I might be thinking that if I walk into the Native Friendship Centre or the Native Women's Shelter, everyone in the Native community will automatically know about it. This is a problem that we have. I don't have any answers for you. All I am saying is that before-care is very important, and after-care.*

**KG:** What I would propose is a kind of drop-in. A place where people could just come and hang out, and talk, and they would not have to make any commitment to treatment. That way, over time, they would come back, hang out, and then start talking about the potential for treatment. This has not been possible in the current location, because of the physical arrangements. I still think that the idea of a place where people could come, without having to make a commitment about doing anything would be the right kind of environment to start the process towards treatment. And, at the same time, rather than insisting that people go out of the urban environment for treatment, once they are ready within the urban environment to do something more, then we should have the resources there for them, for counselling, for group, for healing circles. These are actually the projects that we are thinking about developing at the Native Friendship Centre, or the MGH Addictions Unit.

*Q: If I could just say a word here at this time. I think a bit of the spirit that we are dealing with now is the spirit of mistrust on the part of Native people because of things in the past. We have very much been exploited. I know that the word research is one that needs to be redeemed a little bit in the eyes of many people. There is this knowledge that research is a knowledge producing industry, and a lot of people are making a lot of money out of it. It can be funded by any particular political agency and the results of the research can be very political. Native people have been exploited a lot*

by many industries in the past, and we see people making a lot of money doing research and, where does the money go? To the people who are doing the research, not to the people who are being researched. So, I think the question here as I said is a little bit of that spirit of mistrust. I'm hoping that the spirit of this conference will be a step towards understanding the individuals that are here today and are involved in the research, but yet are coming from a different place of wanting to really do something to change that process that was happening in the past. I hope that we can keep an open mind, and be aware that we are trying to make a change. I think that this is what you are saying, that you want results. The people here are saying: when, how?

*Q: I do have a comment and that is that the Friendship Centre is working very hard to try and make some changes. I really believe that our organizations have to work together. I, as President of the Aboriginal Women of Montreal, I can tell you that what people have been saying is that there is a need for women. When someone is dealing with abuse, and the place they have to go to is the Friendship Centre, they go to the Friendship Centre and they are going to meet with the perpetrators. This is a need. We know what the barriers are, that is all I'm saying.*

**KG: I understand, and I've had long discussions about this. The original concept when I said that clients could see someone at the drug and alcohol referral service, or just hang out, was exactly this issue. Maybe we needed to move the program outside the NFCM. But we couldn't find the facilities, and location for it. I think we need to develop such a program for the urban environment. I think the process has begun. I have no doubt that we will work towards this process in the coming years.**

*Q: We have to see the other Native organizations involved in this.*

**KG: I would love to see it too.**

## **Perspective on Alcohol and Substance Abuse Treatment and Prevention**

Richard Kistabish

*Grand Lac Victoria*

**Résumé:** Après une brève description de l'histoire de la région de Grand Lac Victoria, l'auteur décrit le cheminement d'une communauté autochtone vers la sobriété. Il parle en particulier du rôle des enfants car ce sont eux qui ont amorcé le processus, du rôle aussi du centre de traitement Wapan qu'il a dirigé. L'auteur pense qu'une approche thérapeutique communautaire adaptée aux besoins particuliers des autochtones est préférable à la fois aux approches de guérison traditionnelles et à la thérapie de style occidentale, dans ce contexte.

**Abstract:** This talk focuses on a specific community program that has worked to change the patterns of drug/alcohol use. The ways in which the community was mobilized to produce change are discussed, along with the problems encountered, so that other communities may learn from the process.

Kitsusagige is the name of the place where the Algonquin people chose to stay after the Hudson Bay Company moved out in 1956. At that time they called it the Grand Lac Victoria post. It was a very successful fur post for the company from the 1850's to 1890's. At that time only one big community lived there, and they chose that name because it means big lake. Before I learned French I used to speak Algonquin, and then they forced me to speak English to be able to talk to you. I asked the organizers if they could translate some of the words I am going to use, which will be in French because I don't know them in English.

So, they started with fur, in the 1850's or earlier, and then through the decades and until the present other companies came along to do wood cutting, mining research, build Hydro dams and roads, and finally to create reserves.

All these things had a serious impact on the social lives of people. On top of everything else, religion was introduced. All this contributed to a new way of life. Algonquin people were hired to go and cut wood, to build roads and build dams. The whole lifestyle changed. The lack of rituals and ceremonies led to a very disordered social life. They didn't have any more guardians of morals, they just had a priest.

The priest was there for 30 years. His name was Edmond Brouillard. That priest abused kids for years in that community. So, there was a breach of trust in the representative of god. All the trust that Native people had had in relationships was being cut out and thrown away. There is an old church here, where the priest used to rape kids. The priest was sentenced in 1983 to five years in prison. He pleaded guilty at first, but his church asked him to plead not guilty, which would have required that the victims testify against the priest. Finally, wisdom prevailed and he pleaded guilty to 8 charges, instead of 15. He was ready to write down all the names of the kids he had abused during that period. This is the context that people were trying to survive in, despite the lack of values. When the pain came they resorted to booze, dope, gasoline. Alcohol and drugs and solvents are not the problem in that community, not at all. They are only the symptoms of a deeper pain.

At the beginning I guess we tried to solve the alcohol problem, but we found out that this was the wrong diagnosis. It is only a symptom. Many people in our community don't have an alcohol or drug problem, they have pain. That pain is created by all kinds of trauma they went through. The trauma that I explained to you before: the fur, the wood the mining, the Hydro, the lack of spirituality. Those things have been followed by rape, by violence, by low self-esteem. These are what we need to correct. Meanwhile, for years we spent millions trying to solve the "alcohol problem" but it was really a mistake to go in that direction.

When we arrived in Grand Lac to begin the healing process, it was 1980. Two doctors came along with us and found out that the kids were really suffering from hearing problems. They could not hear, they had otitis. They couldn't be successful at school because they couldn't hear. They had been classified as mentally deficient. The school board in Val D'Or received \$1500 for every Native student enrolled in school. But, when a child is classified as mentally deficient, the board gets \$4500 for the year. 95% of the kids from Grand Lac were classified this way, so the Val D'Or school board got lots of money. This took place until we came in with the doctors and solved the hearing problems they had. We thought, at that time, that it was the only problem in the community, but as we started digging a bit more we found even greater problems. It took us until 1983, when we faced a suicide attempt by a man named Gilles, to change our focus. We changed the way we approached the community and the way we tried to give services to people. Sure they had alcohol festivals twice a month there. 95% of the community was drunk for 1-2 weeks every month after welfare cheques came in and until the family allowance and old age pension cheques came in. That was the main activity, to wait for the cheques in order to get drunk. So we tried to deal with that, to cope with the alcohol problem. Then, instead of trying to deal with the whole community at once, we decided to focus on the children.

In order to educate people we used one family: Catherine and Augustin and their 5-year-old son. This child had health problems all the time, especially with colds and flu, because of the family's habitat. They were isolated, their home built of boards and paper. Everything was cold during the wintertime. Their big stove would be very hot at the beginning but get cold during the night. The variation in temperature made the kid very sick. Finally, they thought that if they built a new cabin, with insulation, the child would be OK. That is what they did and saw some results. So we used that example with other families. Other families came to visit the new cabin and saw that this family was no longer getting as sick so often. They also started building new cabins, insulated ones. The kids really started getting better.

In 1980, 95 % of the kids in the hospital in Val D'Or were from Grand Lac Victoria. When we corrected the housing situation, we emptied the pediatric ward at the hospital. The living conditions had improved. We used that example for healing: if you start to organize your life better, and work to prevent bad things through your habits, you can heal.

The people of Grand Lac don't have reserve status, they are still nomads and live in camps. They travel during the wintertime to their camps, and during the summer they stay at the Grand Lac post, on 15 acres, in 47 houses. In the wintertime they stay by a big Hydro dam without a turbine. They have no electricity and no running water. They still live under these conditions. Kids are moved away in September, exactly as in the residential school years. The 120 kids move to Val D'Or, about an hour drive away, where they stay in foster homes for 10 months. They get used to having light, showers, toilets and Nintendo games. In the summer months they have to do without all of that. They stay in Grand Lac for 2 months.

So, this community still lives like this in 1997. Three times in recent years, the federal government offered them reserve status, with houses and schools. Each time, the community refused these gifts from the government. Instead they want recognition of their land, before

starting the process. So, again, it is land claims that are limiting access to programs and services.

In 1987, during the annual community assembly at Grand Lac, kids were allowed to speak out. That was a turning point in the community, when kids took the microphone and asked their parents, and all members of the community, to stop drinking. The years when boats full of beer came regularly to the community were over then. At that point, the community collectively became conscious of its problem.

Some people stopped drinking in 1987. They were completely sober. Still the pain was there. Some people came to us when they were drunk and told us about their life. It is very difficult to cope with that kind of situation. Finally, in 1992, we created a program designed for the people of Grand Lac. It went OK for a while, and even the National Health [Health Canada] was involved in that treatment. Each person that came to treatment asked to be correctly diagnosed. You have to find the cause of their pain. They have to tell their entire life story, every trauma they suffered. From there, we established a treatment plan for each individual. Every person should receive this kind of care. We did this for 5 years. Then, for economic or political reasons, the National Health withdrew from the program. When you see the results of this you will see how it is a pack of chains for us.

Some people had treatment for 12 months, some people for 28 months. It depended on the severity of their trauma. But people that had quit drinking, some for up to seven years, still had the same pain. And one of the admission criteria for the program is that the individual has to have an alcohol problem to get treatment. These people had no alcohol problem, they just had pain. So they could not be accepted to the treatment program. For the past 2 years I have tried to change this admission criterion. I know that at the national level it is only the alcohol problem that we are dealing with. Other things are not looked at. For example, we have gambling problems in the community. I know some parents who spend all their money at Bingo. We calculated that people will spend \$4000 to win a \$2000 jackpot. These are problems. Most people who play Bingo in the Grand Lac community don't have an alcohol problem any more, but they want to escape so they go and play Bingo. For 3 hours they forget about their problems and have fun. We are facing things that are difficult to correct by treatment.

Another thing we focused on in the Grand Lac community was responsibility. Of all the things that people asked for, 'getting responsibility,' becoming responsible, was near the top of the list. That is a very hard thing to give people. We used all kinds of examples to show that responsibility was the main thing to achieve in order to correct your life. If you have no responsibility, you get in trouble, every time. Responsibility came up all the time. Maybe it is part of the culture to think 'Its not my fault, its the fault of you White guys who make me drink.' One of the tough things to admit in the healing process is that individuals are responsible for their actions.

Finally, in terms of culture and spirituality and ceremonies—I am a believer that culture, spirituality and ceremonies don't have a place in the treatment of pain. When a guy rapes a woman, whether it is a White woman, a Native woman or a Black woman, the pain is the same. The action is the same. The pain has no culture. To heal, you have to use other things. Most of the problems that we have are because we have encountered another culture, other values, and we don't know how to deal with those values and that culture's way of doing things. So we hurt ourselves, because we haven't had time to think about the ethical implications of this other culture's values. We just assume that it is OK to have all those nice things that the other culture brings. In order to correct the situation we do need to use things that the other culture has to bring. That is why we use social workers and doctors, psychologists and psychiatrists. They are helpful for this type of problem. Ceremonies,

culture and spirituality have their own place, not necessarily in the healing process but after, using those ceremonies to develop your full capacity as a human being. I am a strong believer that, before the White people came here, all these ceremonies were to prevent bad things, not to correct them. Correction was a community responsibility where every individual helped. They didn't use ceremonies to correct situations, but to prevent them and to help develop capacities and a sense of responsibility. Ceremonies are meant to bring people to a higher plane. These are my beliefs and I wanted to tell you about them. But I would be very happy to meet people who could change my mind about this.

Language is part of a culture. How you say or describe pain in your own language is a very strong part of getting rid of pain. The program that we started with Portage (a treatment centre at Lac Echo) has existed for 5 years and is going to end now because of loss of funding. Even Portage has a problem dealing with the people we refer to them, because most of them don't have an alcohol problem any more, they have only pain. They use all kinds of escape mechanisms to deal with their pain: Bingo, gambling, shopping for things they don't really need like videos. I have to tell you about this. In the camps, there are small generators, and when people go rent a movie it is an hour and a half drive to Val D'Or. They can't go back in the morning to return the movie so they rent a case of movies and watch them over and over again. Sometimes they keep them for a month before returning them. They get addicted to videos, they watch the same one four or five times in a row. Also soap operas. People who watch them want the lives they see in the soap operas.

**KG:** Does anyone have questions specifically for Richard Kistabish before we start the panel discussion?

*Q: I would like to make a comment to Richard. When I presented my workshop on responsibility, I thought maybe I wasn't on the right track. But it made me feel very good to hear that responsibility in our own life choices is so important to look at. I also have a question. When people have their strength taken away by the government or the system, or whatever we want to call it, do you perceive that we should be working with them in a particular way? Do you feel we can have an impact?*

**RK:** It took time to introduce that concept of responsibility to each individual, especially if that individual was not responsible for his or her own life. It's better to work with kids with this notion of responsibility. It is very difficult to try to compare the responsibility of kids with that of parents. It is a long process, hard work. You have to be patient, repeat the same speech again and again. I say it is easier in the community in Grand Lac because we deal with the same people every day. It might be more difficult to implement the same approach in an urban environment, because people are not stable, they are nomadic. You have to consider that factor. It is necessary to give time for the implementation of a sense of responsibility within each individual.

*Q (cont'd): And the perception of responsibility, because for so many of us in the past responsibility resulted in being ostracised. Are you finding within your community when you are working on responsabilising your members that it has to be defined in a way that it doesn't have any negative connotation? I'll go a little bit father with that. In the shelter we don't even use the word 'responsibility,' we cover it with another word: 'empowerment.' I ask people how they are able to deal with things, what skills they can use to serve themselves. What happened is that at our shelter, when we used the word 'responsibility' some women would come back to us and tell us that when they act responsibly no good ever comes of it. For example if they stand up and speak out against the abuse that has happened in their community, the repercussions are very dramatic and quite difficult. That is something we have to think about when looking at the role of responsibility.*

RK: When you use that kind of approach, it is very important to have resources around. The lack of resources will discourage people, mainly the intervention worker more than the person seeking help. There is a lack of resources available in the community and for any social situation we want to correct. The funding for resources is almost non-existent. This has to be corrected. All the approaches regarding programs already in place have to be reevaluated and refocused. I don't mean that our community has the right way of doing things, but we are trying to get it right. We experimented with many things in the past. Some things that didn't work in our community may work in others. We failed often and started over again. We didn't achieve complete success in our program, but we made a few steps in the right direction. There are things to be added. There are missing links: we don't have after-care or before-care, and we need them.

## Panel Discussion: Alcohol and Substance Abuse

### Position du PNLAADA

Lucie Dessureault et Jacques Ducharme

*Santé Canada*

Bonjour. Je suis très heureuse d'être ici afin d'apporter ma contribution à la discussion d'aujourd'hui sur l'impact de PNLAADA au sein des communautés autochtones. C'est une question importante mais aussi posée au bon moment. En effet, le programme est en activité depuis 1975, au moins sur une base expérimentale, et l'évaluation d'impact n'a jamais été considérée comme prioritaire. Bien sûr il y a des raisons derrière cette situation et nous pourrions en reparler sous peu. Mais la question est surtout posée au bon moment parce que l'ensemble du domaine a mûri suffisamment, et partiellement sous l'effet de contraintes financières, pour que les questions d'efficacité deviennent préoccupantes.

Un rapide survol historique du PNLAADA, dans une perspective d'évaluation, pourrait être utile à ce moment-ci. Le programme PNLAADA est le fruit du travail d'un groupe de représentants des Services Médicaux, du Département des Affaires Indiennes, et de la Fraternité des Indiens du Canada. A ce moment PNLAADA n'était pas encore un programme mais une idée à mettre en place. Une idée enfantée par la conscience que l'approche utilisée jusqu'alors n'était pas bonne et qu'un changement de paradigme était devenu nécessaire. Les gens des Premières Nations devaient devenir les premiers concernés par les problèmes de surconsommation qui pouvaient exister dans leurs communautés et les premiers architectes du développement de solutions culturellement adaptées. Cette nouvelle approche était perçue comme capable de composer avec les questions transculturelles dans le développement de programmes locaux.

En 1979, le point devait être fait et Santé Canada décide alors de statuer sur le programme et de se demander si ce dernier devrait devenir permanent. L'idée de procéder à une évaluation a été discutée mais a provoqué des inquiétudes. Ceci se comprend puisque l'enjeu était la survie du programme et la permanence de son financement.

La Fraternité a alors proposé de prendre charge du projet d'évaluation mais un compromis est apparu nécessaire: un comité d'orientation a été mis sur pied avec des représentants de tous les groupes concernés. La méthodologie qui est apparue ne prévoyait pas l'évaluation d'impact. Et il y a une bonne raison à ceci. Les données nécessaires n'avaient pas été recueillies depuis le début et, sans ligne de base, une évaluation d'impact est difficile à conduire sur le plan technique. A ce moment, les préoccupations se rapportaient d'avantage à l'estimation des coûts, à la disponibilité des ressources et à la cueillette des données. Évidemment, l'évaluation de 1980 a recommandé le maintien du programme et a insisté sur les questions de structures, de contrôle et de financement. Les questions d'évaluation dans ce rapport firent l'objet d'un unique paragraphe rappelant les obligations du programme en vertu des articles 26 et 27 de la *Loi sur l'administration financière*. L'évaluation n'est pas mentionnée dans le chapitre portant sur les *Questions d'intérêt particulier*. De manière évidente, PNLAADA n'était pas prêt en 1980 pour une évaluation d'impact.

Alors est venu 1989 et la seconde évaluation du PNLAADA. En tenant compte des recommandations de 1980, des problèmes que PNLAADA connaissait encore, des objectifs



(ex: formation du personnel) et du fait que les données utilisables n'avaient pas été recueillies, les orientations de la nouvelle recherche insistaient encore sur les questions de processus. Ramenée à sa plus simple expression, ce que la recherche a essayé de faire a été de comparer un échantillon de 37 programmes avec un modèle dont la valeur avait été établie, modèle dit « du meilleur modèle conseillé » (Best Advice). Ce que cette évaluation a permis d'identifier est que le programme, dans ses activités de prévention, ne savait pas trop quoi proposer, les agents de prévention étaient par exemple incapables d'identifier leurs propres modèles de prévention et les personnes ressources interviewées ne savaient pas s'il existait un programme de prévention dans leur propre communauté.

Les activités de réadaptation de leur côté ont été considérées comme faibles dans une perspective de soins continus et les approches jugées étroites dans leur variété. De manière significative, les directives nationales transmises aux centres de réadaptation (les taux d'occupation, par exemple) furent considérés par l'équipe d'évaluation comme au moins partiellement responsables de cette situation.

La formation des travailleurs PNLAADA avait été une priorité établie dans la foulée de l'évaluation de 1980. Le rapport de 1989 a indiqué qu'il existait de bons programmes de formation mais que ces derniers étaient peu utilisés sur le plan de la prévention. Le rapport restait silencieux sur la formation donnée dans une perspective de traitement. Une autre faiblesse identifiées a été celle du soutien technique aux étudiants une fois que ces derniers revenaient dans leurs communautés après la formation.

Les recommandations des rapports mettent l'emphase sur les modèles, le soutien technique aux travailleurs et le financement. Une seule recommandation (numéro 11) indique la nécessité de conduire des études d'impact dans l'avenir et de prévoir des budgets spécifiques à cette fin.

Nous sommes présentement en plein milieu de la troisième évaluation nationale. Très peu d'information est disponible actuellement mais une évaluation de résultats sera probablement encore une fois impossible à cause de limites techniques.

Ce qu'on peut résumer de ce survol rapide est que PNLAADA a trouvé son origine dans une nouvelle façon de voir qui voulait s'attaquer à la toxicomanie tout en permettant aux Premières Nations de s'approprier d'avantage de contrôle sur les mécanismes de solution. Dès le départ, le programme lui-même a été sérieusement affecté dans son développement par de la confusion relative aux orientations, pas à des problèmes de financement; par les limites de compétence du personnel et par des insuffisances des mécanismes de contrôle, pour n'en nommer que quelques uns. Le programme a résisté parce que le concept était valable et probablement parce que les Premières Nations elles-mêmes obtenaient plus de PNLAADA qu'un simple ensemble d'activités faisant la promotion de la sobriété. Le programme a contribué à attirer l'attention sur un problème sérieux et à créer un cercle autour. Il est vrai que PNLAADA n'a jamais été évalué quant à ses impacts conformément aux règles de l'art, mais il aurait probablement été inutile de faire cet effort avant que le programme ait atteint un certain niveau de maturité.

Ce qui vient d'être dit indique que ces diverses évaluations de PNLAADA ont jusqu'à présent été conduites dans un contexte social, politique et de gestion qui est à la fois riche en possibilités, complexe dans sa dynamique et, par-dessus tout, en mouvance constante vers une plus grande autodétermination. Santé Canada n'est plus seul à décider de la nature des services et les gens des Premières Nations ne sont pas encore entièrement seuls responsables. Tandis que nous parlons ce matin, par exemple, les trois quarts des programmes de Santé Canada au Québec sont déjà transférés. Beaucoup de chemin a été parcouru rapidement mais ce n'est pas toujours facile de s'entendre et de cheminer ensemble sur des sujets

importants quand le financement vient de Santé Canada avec les implications qui en découlent et que les responsabilités se situent de plus en plus du côté des Premières Nations. Ce voyage cependant mérite d'être entrepris dans la mesure où l'autodétermination autochtone en est le but.

Cette intention de cheminer ensemble, Santé Canada et les Premières Nations, a rendu possible au moins les évaluations de processus en 1980 et en 1989. Ceci déterminera le sort des évaluations dans l'avenir. Les programmes nationaux se fragmentent de manière à mieux répondre aux besoins locaux de chaque communauté. Le pays connaît présentement un véritable processus de décentralisation qui accordera aux communautés elles-mêmes le rôle principal dans les futures évaluations. Santé Canada se positionnera progressivement davantage dans un rôle de seconde ligne et de soutien. Un exemple des transferts permettra d'illustrer ceci. Les opérations des centres PNLAADA sont présentement en voie d'être transférées. Le processus permettant ce passage exige que les centres décident d'une évaluation dont les résultats doivent être transmis à Santé Canada à la fin du premier cycle quinquennal. Santé Canada ne décide pas des modalités de cette évaluation mais crée un contexte qui rend possibles les études d'impact. Jusqu'à présent au Québec, un centre, WAPAN à La Tuque, a opté pour une évaluation d'impact et tentera d'identifier les facteurs associés à la rechute. Ceci est garant de l'avenir et les communautés joueront progressivement un rôle plus central dans les questions de savoir si elles ont besoin d'évaluations et quelle forme ces dernières devraient prendre.

En terminant, je voudrais indiquer que malgré les problèmes de croissance du programme PNLAADA, il y a tout de même des signes encourageants sur le plan de la toxicomanie. La conscience augmente et les problèmes changent. Il est évident que l'ensemble du tableau reste attristant, même au sud du 60<sup>ème</sup> parallèle, avec des taux de suicide trois fois plus élevés que la moyenne nationale, un taux d'accidents deux fois plus élevé que la moyenne nationale et des signalements croissants relatifs à la violence familiale. Ces données sont mentionnées parce que ces problèmes sont souvent associés à la toxicomanie. Mais il y a des signes de progrès et d'espoir aussi. Le taux brut de décès a chuté entre 1979 et 1992 (21.4%). Le taux de suicide pourrait aussi être en décroissance au Québec avec une chute de 41% entre 1987 et 1993 dans les communautés desservies par la police autochtone. Il n'y a pas de données nationales sur la toxicomanie, mais un sondage fait en 1996 démontre que la population autochtone des Territoires du Nord-Ouest déclare un taux d'abstinence totale de 40% sur une période de douze mois.

Les communautés travaillent fort pour aller de l'avant et PNLAADA s'efforce tout autant de leur être utile en tenant compte de ses moyens limités. Il pourrait donc être trompeur d'affirmer, parce que l'impact n'a pas été quantifié, qu'il n'y a pas eu de progrès.

Merci beaucoup.

## NNADAP Position Paper

Lucie Dessureault and Jacques Ducharme

*Health Canada*

It is an understatement to say that I am happy to be here today participating in this panel on the impact of the NNADAP [National Native Alcohol and Drug Awareness Program] on Native communities. This is an issue that is important and timely; the program has been active since 1975 on a trial basis and impact evaluation has never been a priority, for various reasons which will be discussed shortly. At this point in the evolution of the program matters of efficiency (and efficacy?) are crucial preoccupations.

A quick historical overview of NNADAP will put this discussion in context. The NNADAP program resulted from a 1973 work-group made of representatives of Medical Services Branch, DIAND (Department of Indian Affairs) and the Indian Brotherhood of Canada. Initially a test project, the idea for the NNADAP program emerged from a growing awareness that the approach [to problems of addiction in Native communities] up to that point had not been very successful and a paradigmatic shift was needed. The work-group recognized that Native people should be the key stakeholders and main architects generating and designing realistic and culturally appropriate solutions to their own addiction problems. Developing programs locally would help ensure that transcultural issues would be effectively addressed.

In 1979 Health Canada had to decide whether this temporary project should be granted permanent status. The requirement of an evaluation was circulated which aroused understandable anxieties, since the survival of the program and the permanence of its funding was at stake. The Brotherhood offered to oversee the evaluation; ultimately a steering committee was created with all stakeholders represented. The resulting methodology *excluded* impact evaluation. There were good reasons for this. Data had not been collected from the start of the pilot, and without some sort of baseline impact evaluation is technically difficult to conduct. Initially the pilot program data concerned cost assessment, resource availability and data collection. The 1980 report recommended the continuation of the program and stressed issues of structure, control and financing. The final evaluation of the report is the object of a single paragraph, which points out the obligations of the NNADAP under sections 26 and 27 of the '*Loi sur l'administration financiere.*' Impact evaluation is not mentioned in the section on "Questions of particular interest." Clearly, impact evaluation was not considered an issue in 1980.

A second evaluation process occurred in 1989. Considering the recommendations of the 1980 report, the subsequent program management objectives, the existing problems of NNADAP, and the fact that the data reporting system did not collect information readily useable in impact studies, the new evaluation format again stressed process. Basically, the evaluation attempted to compare the NNADAP program and a sample of 37 programs nation-wide with a program model of acknowledged value, the Best Advice Model. The evaluation identified a lack of focus in the prevention component of the NNADAP program—prevention workers were unable to identify their own prevention model—and a lack of success in community penetration—community members were unaware that a prevention program existed in their community. Treatment activities were judged to be limited in approach and weak in terms of follow through. Interestingly, national guidelines issued to the treatment centres—education rates for example—were considered by the reviewing team to be at least partially responsible for this state of affairs. Training of NNADAP workers had been a priority established in the wake of the 1980 evaluation. The 1989 report stated that good training programs were available but little used in the arena of prevention. The report was silent concerning training in relation to treatment. A lack

of technical support for trainees returning from workshops to work in their communities was also noted.

Under recommendations the reports stressed models in orientation, technical support to workers and funding. One recommendation (number 11) stressed the need to conduct impact studies in the future and to set aside funding for this specific purpose.

We are presently in the process of a third national evaluation. Very limited information is available at this time but impact evaluation will again be improbable for technical reasons.

What can be summarized from this brief overview is that NNADAP started with the vision of addressing addiction while increasingly empowering First Nations people. From the start, the program was seriously plagued in its development by orientation confusion, funding problems, staff limitation and control weaknesses to name only a few. The program stood fast because the concept was valid and probably because First Nations people were getting more through NNADAP than just a set of activities promoting sobriety; it helped create a circle around a very preoccupying problem. It is true that the impact of NNADAP was never formally evaluated in terms of conventional evaluation instruments, but it would probably have been meaningless to attempt this before a certain level of program maturity had been achieved.

The evaluations of NNADAP have been thus far conducted in terms of management; the complex political and social dynamic within which NNADAP has evolved continues to offer many opportunities for increasing effectiveness and is, above all, constantly evolving towards self-determination. Health Canada is no longer alone in deciding on services to Native people, though First Nations are not yet the only stakeholders. As we speak this morning, more than three quarters of MSB's programs in Quebec are already in the process of being transferred [from Federal control to Native community jurisdiction]. A lot of ground has been covered quickly - it is not always easy to strike understandings and move together on meaningful issues when funding is coming from, and accountability is to Health Canada, while responsibilities lie increasingly with First Nations. This is, however, a voyage that needs to be undertaken if Native self-determination is the goal.

The collaboration of Health Canada and First Nations made limited but helpful evaluations of the program possible in 1980 and in 1989; more importantly they will help determine the type of future evaluations and subsequent improvements that will occur. National programs are breaking down to better fit the needs of local communities. The country is going through a process of genuine decentralization that will make the communities themselves the key players in any future evaluation. Health Canada will progressively position itself in a supportive and facilitating role. To illustrate, the operations of NNADAP treatment centres are currently being transferred. Within this new structure centres are required to decide from the outset on an evaluation process with evaluation results to be reported to Health Canada at the end of the first five-year period. Health Canada does not determine the format of the evaluation but creates a context in which impact studies are possible. So far one centre in Quebec, WAPAN in La Tuque, has opted for an impact evaluation in an effort to identify factors associated with relapse. This is the shape of things to come - communities will play a central role in deciding whether they need evaluations and what form these should take.

In closing, I would like to stress that despite the growing pains of the NNADAP program, there are encouraging signs out there, addiction-wise. Awareness is growing and solutions are evolving. Hard data is difficult to find and non-existent at the national level. The picture is still gloomy, even south of the 60th parallel, with a Native suicide rate three times the national average, an accidental death rate twice the national average, and increasing reports of family violence. These figures are mentioned because the problems they relate to are often associated with addiction. But there are signs of progress and of hope as well. The national crude death rate declined between

1979 and 1992 (21.4%). The suicide rate appears to be declining in Quebec with a drop of 41% between 1987 and 1993 in communities serviced by Native police. There is no national data on addiction but a survey done in 1996 showed that Native people in the Northwest Territories are reporting a 40% rate of total abstinence over a twelve-month period.

Communities are working hard to move forward and NNADAP tries just as hard to be helpful within its limited means. Just because impact cannot be quantified does not mean there has been no progress. Thank you.

## Panel Discussion: Alcohol and Substance Abuse

Kitty Pearson

*Isuarsivik Treatment Centre, Kuujjuaq*

**Résumé:** L'auteure est impliquée depuis plusieurs années dans l'établissement de centres de traitement de l'abus d'alcool et de drogues. Récemment, elle a entrepris la tâche de réorganiser le centre de Kuujjuaq, faisant en sorte qu'il réponde aux besoins culturels particuliers des populations avoisinantes. Ceci inclut la formation adéquate du personnel à travers d'autres centres de traitement pour individus des Premières Nations, et la recherche de fonds suffisants pour financer cette formation. La formation est destinée aux individus autochtones qui sont prêts à pratiquer et à promouvoir le bien-être personnel, à travers l'écriture et la lecture de leur propre langue, et qui sont capables de communiquer avec les clients avec empathie et sans jugement. Le programme a débuté en tant que programme résidentiel mais s'est agrandi pour inclure un programme de jour. A présent, il reçoit de l'aide financière de plusieurs organismes, et les résultats sont prometteurs.

My name is Kitty Pearson. I am an Inuk. I was born in Kuujjuaq in the Ungava region of Nunavik. Initially I registered here as a participant but I was asked to replace our mayor who was invited to be on the panel. I only decided to do this just before I came down so I appreciate that he trusts me to fill his shoes. I am very nervous. I am not accustomed to speaking in front of a large group of people who are unfamiliar.

I want to first say a little bit about myself and how I became involved in the field that I am in now. My story is similar to that of everyone else who spoke yesterday and today. My parents were among those relocated to another community when I was just a young child. We were isolated from our families, community and friends for a period of ten years. I can now understand why my parents drank alcohol. And having grown up in an alcoholic and violent environment, I myself fell into the same trap. It was when we moved down here a few years ago because of my husband's work that my alcoholism became unmanageable. I couldn't adapt to living here and I went into a deep depression. I got help for my depression from professionals but that never brought me to face my alcoholism. I was treated for depression for over a year. It did not help. I went deeper into depression to the point that I became suicidal and I ended up in a mental ward. Everything that was being done to me was trying to tell me that I was crazy. When I ended up in a mental ward, I realized that I wasn't crazy and I began to seek help myself. I went into treatment in 1988. I am glad to say that I will be celebrating my tenth year of sobriety next year. I went back to live in my home community in 1988. I had no job, and I had my children. I was approached to manage the alcohol and drug prevention program that had just started. Because I had just gone through treatment, I suppose they felt I would be able to be involved in this type of program. I agreed because going through treatment gave me a desire to help my people to find the help that they needed, as I had done. I managed the prevention program for a few years. Since then I've gone into the field of education and that has brought me to work in the area of treatment. I only came to work as a director of the treatment centre just over a year ago.

There are two treatment centres in our region: one is in Inukjuak for the youth, the other is in Kuujjuaq, for adults. I can only talk about the one in Kuujjuaq. Discussions began in 1993 in which our mayor played a major role in instigating the opening of a treatment centre for all the problems we faced with alcohol and drug abuse. I was asked to sit on that committee as somebody who had been a user and gone through treatment; that is how I joined the group.

The project started as a pilot project for the first year, and because of demand and pressure, the program was expanded to include the region about a year after opening.

We provide a four week treatment program. Our mission is to reduce the prevalence of alcohol and drug abuse, and the destruction caused by alcohol and drug abuse in our community. Our philosophy was to provide a culturally relevant program. The majority of our population is unilingual in our own language [Inuktitut]. The program started with the support of a treatment centre down here [Montreal], offering training to the staff that were hired to operate the [Kuujuaq] treatment centre. But the training was limited—the staff spent a couple of weeks down here, maybe twice. They would go into the treatment centre here and observe how the centre operates, and sit in on counselling sessions with clients. Then the program in Kuujuaq was handed over to this group. Once we had the treatment centre I think the community decided the centre would solve all its problems. Being on the Steering Committee from the beginning, from which the board of directors was formed, I was appointed Chairperson. As the Chairperson, and sitting on the Board, I realized the problems that we were facing. Among these was location. The centre was across the river from the town itself, and access was sometimes difficult because of freeze-up. Also, the training was limited, the demands numerous and communication lacking. This resulted in lack of staff, high staff turnover, burn-out, and relapse in part due to lack of support for our own workers in their sobriety.

I decided to take a year's leave of absence from my employer, which at the time was the Kuujuaq School Board, to take on the position of director of the treatment centre. Before I came in we had hired directors from outside the region and we had a program that came from outside the region. I realised that my expertise and knowledge meant that I could provide services. I began work as director in May of 1996. It was good timing; the centre was about to close in part because we could no longer use the site. We had lost most of our staff and our remaining staff were suffering. They were given a leave. It was a good opportunity to go back and look at what had happened and see what we could do. My task was to find people in the community who were involved with prevention, addictions and medical services, because I could not do it alone. So, I went to our regional alcohol and drug prevention program and our Nunavik Regional Board of Health and Social Services. There I found two people to work with. We were given the task of evaluating and beginning to develop a program. We had to close the existing program until it was assessed to have a renewed, stable foundation. All the various groups that had been involved in organizing the treatment centre had stepped back and left everything up to the treatment centre. I had to go and get all those people back and sit down with them and look at what had been done. Discussions began again with the initial group that had set up the treatment centre.

Since then our region has become very involved in support of our treatment centre, and we have taken ownership, to provide a culturally-based treatment program. In order to do that we had to provide support for individuals interested in working in the field. Part of our package is to provide training for our training staff and for our front line workers, social workers, mental health workers, hospital workers, and anybody involved in the helping professions. The training project is regional. We invited the Round Lake Treatment Centre to become partners in our training project. We went to a Native training institution to ensure that our people will get accredited training. I don't have any degrees or diplomas. I only do the work that I do thanks to the knowledge and experiences I've gone through. This is common in many communities, where training is provided in bits and people don't come out with any official kind of certification. So this time we want to make sure they come out certified as Addiction Counsellors. I've been working in the field of addiction for nine years but I don't yet have certification. I myself am included in this training project.

We had to go out and find funding. Our treatment centre was funded by two of the major organizations in our region: Makivik Corporation and the Nunavik Board of Health and Social Services. Our training funding also comes from the region, through the same organizations. The training project that we developed is geared to on-the-job training, enhancing employment opportunities and also to providing opportunities for front-line staff development. We began our training in April of this year [1997]. We brought in a team from Round Lake to provide a treatment cycle for the people that were interested in becoming Addictions Counsellors. Although many people have quit drinking on their own in our communities, they had never gone through treatment. We felt that they needed to experience going through a treatment cycle to know what it is that this work involves. That was one component of our training program, another is providing personal wellness and training assistance. The third is the Certified Addictions Counsellor Training Program, which is ten two-week training sessions that we are doing over two years. It is designed this way because we are a functioning treatment centre that has to continue to provide treatment as well as training, program development and evaluation. All this had to be taken into account, and so our training package reflects the fact that we continue to offer the services that are needed, and the mechanisms to ensure that the program is continuously developing. I guess you could say that in the first years of operation we went through growing pains, and we continue to grow. Now, everybody realizes that you can't just open a treatment centre and start fixing people. It takes many years, sometimes ten years, until you have a firmly established treatment centre.

Our counsellor training package offers courses in Counselling, Native Psychology; Effects of Drugs on the Human Body; Family Systems; Communication; Case Management; Sociology of First Nations Communities; Sexual Abuse; Special Issues in Counselling; Advanced Counselling and a practicum. As well, a fourth component of the program is community workshops in areas that we felt needed to be addressed immediately. One of them is 'Healing the Effects of Multi-Generational Grief;' the other, which will start in a few weeks, is 'Understanding and Developing After-Care Support Systems.'

Since April we've gone through our treatment cycle. We've had our personal wellness and training assessments. We have had three of our courses and we are now moving into after-care. When I first went through treatment and came back to my community, there was no after-care. It was through my work that I got support and was able to continue my sobriety, but I've also been involved in setting up AA programs in my community, which expanded into other communities.

We have very strict criteria for people in our training package. These are: to participate fully in the training/treatment cycle and participate in the personal wellness and training assessments—to be a beneficiary. The training that we want people to go through is for our people; it is for Inuit committed to practising and promoting personal wellness themselves, to writing and reading their own language, Inuktitut, and to training to obtain certification, so that they are able to communicate in a caring and non-judgemental manner with clients.

At our first treatment cycle we did a recruitment. Now I am proud to say that we have an all-Inuit staff, people who understand the culture and are able to speak the language. We started with a residential program but now, with our training program going on, we offer a four-week day program. We provide support for those who have gone through treatment, such as one-on-one counselling and support groups. We have support groups twice a week at the treatment centre which involve a healing circle. We also do sponsorship. I heard someone mention that anyone who has gone through treatment has to wait a year before they can go through treatment again. If anybody who has gone through our treatment program relapses, we accept them back in three months.



I can say we've come a long way. There is still a lot of work to be done, but we've begun to take ownership of our program. Our organizations are supporting us. In fact, one of the needs identified in our region as a priority was training. This is what we are doing now.

I would like to close by saying that, as I mentioned, we had to go through assessments. Some of those assessments included psychological testing. I myself went through one of those. It was the first time I had been through one. We recently had the results of our assessments. One of the things that was said about me was that, although I am a very dedicated and hard worker, I am somebody who prefers to be in the background. My instinct here was to speak to you from behind the curtain. Having learned this about myself and knowing it to be true, I decided that if I wanted to change I would have to come up here and speak in front of you. So I'm thankful that this has provided me to go another step in my personal wellness. Thank you.

KG: We had heard here at the Alcohol and Drug Referral Program at the Native Friendship Centre about your program, and we are glad that it is up and running now so that we can make referrals to you. I think the training issue is really essential. It is an issue for all the treatment centres in Quebec—whether Native treatment centres or not. We don't have enough training programs and I think, at McGill, as well as at the University of Montreal, we have to work on this issue. Are there any specific questions about this program?

*Q: With regard to the training, especially two of the courses: Aboriginal Psychology and Sociology of First Nations Communities. I wonder about your personal reaction to that training and whether it was adequate to specifically address Inuit cultural practices. Do you think that you need other courses that focus on specific groups.*

KP: This package doesn't include culture. That is something we are doing ourselves, having to sometimes relearn our culture and incorporate it. This is a training package towards accreditation offered by Round Lake. The cultural component is not something they can provide for us: we ourselves can provide our own culturally based program. We offer cultural programs by going out onto the land. You don't see it in here but that is something we are doing. I think the training we have had so far has provided us with knowledge. For myself, I did not know my own identity. Having to go back and look at my history, I can now say that I'm comfortable with my identity and I can see what has happened to bring us to this point. But I am more interested in what we do from here. We are still working on the cultural part of our program. I can't say exactly what it is but we indeed touch on the spiritual, physical, emotional and mental.

*Q: One of my little hobbyhorses is that we could incorporate that kind of teaching in our school system, so that the focus of our school system would be towards personal well-being.*

KP: We are hoping that having completed the training we ourselves will be able to go on as trainers. That is the future goal.

*Q (cont'd): Can you see doing that training in schools, with children, as a preventative measure?*

KP: I guess we can't do everything with our treatment center. I would be glad to help the schools do something like that.

When we went out to look for where we could get our training we couldn't find anything in this region so we had to go outside our region. We found Round Lake Treatment Centre, which had done a lot of work in our region already.

## Panel Discussion: Alcohol and Substance Abuse

Fred Kistabish

*Wapan Treatment Centre*

**Résumé:** Monsieur Kistabish, parlant du centre de traitement Wapan, met l'accent sur la nécessité de continuer le processus de guérison après la fin officielle d'un cycle de traitement pour être sûrs que l'individu réintègre bien sa communauté. Plusieurs thérapeutes du centre Wapan veillent à cet aspect de la guérison, organisant des conférences dans les communautés et restant en contact avec les individus ayant complété leur traitement. Quant à la recherche, l'auteur estime connaître les causes des problèmes dans les communautés autochtones: les écoles résidentielles ont joué un rôle prépondérant dans l'établissement de nombreux troubles émotionnels que l'on observe aujourd'hui chez les membres des Premières Nations. Il réitère le besoin d'avoir plus de services disponibles et d'avoir les fonds nécessaires pour procéder à l'évaluation du programme Wapan: qu'apprennent les gens à Wapan? Quelle proportion de ces gens n'arrive pas à rester sobre? Voilà les questions essentielles.

I have to speak English? Nobody understands me when I speak my own language. The problem is that I have many second languages. English is one of them, the fourth or fifth—it's not my language. Anyway, my English is poor. My French is poor also. My best language is Algonquin. It's bad to have to use another language, but I'll do my best.

My name is Fred Kistabish. I'm related to Richard Kistabish. Just before I arrived here yesterday, as I drove down from LaTuque, I was thinking 'Are they going to stop all their research one day?' Research on this, on that. I made a mistake when I arrived in LaTuque in 1993, I told them that I had worked with different communities, and I told them that I could help them with the medical researchers because I had seen many before. That was a mistake because since that time my phone rings every week.

I'm going to speak about Wapan Treatment Centre. Wapan Treatment Centre is one of five Native treatment centres in Quebec. When I arrived there in 1993, they were using the 12-step program. After a couple of years I found that more was needed than the 12 steps. We started doing research. I went around to different communities in our territory. Since I am involved with the Francophone Native community, I've been speaking French every day, and I'm learning Montagnais right now. At Wapan, we added the treatment of other addictions to the 12-step program. While the role of Health Canada concerns people who have an alcohol, a drug or a medication problem, Wapan Treatment Centre has another role: other addictions. This means anything coming from the pain inside. We found that a lot of people had stopped drinking for up to 15 years, like Richard said, but their mental health is not good. They are sick emotionally. We developed a program to deal with this. We spend about 85% of our time dealing with emotional issues and only 15% on booze or drugs.

Our future is based on outreach. If you asked me today to evaluate our program I could tell you that the need for a treatment centre is there 100%. That is not the problem. Real therapy starts after therapy when people go back home. This is our lack. We have two outreach counsellors. Maybe I should mention at this time how our outreach was formed. We hired a counsellor at the centre. He went through the whole program and it took him 6 months. The communities buy the centre's services. That is the deal we made with our catchment area, the Francophone groups. We have two counsellors. One works with urban Indian

communities, the other with rural communities. The reason I'm here, and it may be my last trip, is that I'm tired of research. I would like to see action. I'm ready to take action. We know the problems and the needs. We need action now. I'm going to receive our evaluation report and it is going to sit on a table in a corner like the other ones. I hope not. We talked about the NNADAP program, mental health. We follow course after course to respond to the needs of our clients. We just finished 90 hours on mental health with our employees, our counsellors. We already know where mental health problems come from. Residential schools are the main cause. As Richard was saying, people who went to these schools kept the pain inside for so many years, and it grows everyday. If you don't drink or take drugs to smooth the pain once in a while, it explodes, it becomes worse, and then you have a crisis. Usually they come to the centre when they are in crisis, stay a week and then want to go home. We don't work miracles at the Wapan Treatment Centre but we do the best we can. I think we meet most needs. Most people have already gone to therapy, one week here, one week there. But it takes more than two weeks. It takes four weeks just to start the process.

Concerning evaluations, it sounds like we are the only treatment centre at the moment with plans for an evaluation. We are going to start soon. It's nice and it's needed. We need to help Natives heal, but just doing therapy and sending people back home, and seeing them come back one or two years later, and on and on, is not enough. We know we should be doing more than that, that is the reason why I was saying earlier that our future is based on outreach. The funding for outreach is lacking. Once people are back home after therapy, they have nothing to do and they go back into their old pattern. You need action from the community or from the treatment centre. We are doing quite a bit, but not enough for us. As far as I know, we are the only treatment centre that has a few counsellors doing outreach. Our two outreachers are very busy. They do therapy and conferences on different issues in the communities, intensive therapy in communities. We also have a mobile team at the moment at the treatment centre. We did several cycles of therapy in the bush. I can tell you that is a very good thing. It is so different from doing therapy inside four walls, to do it in a tent. At the moment we can't offer that kind of therapy in English. We do everything in French. Maybe one day we can offer English therapy in a natural environment. Concerning the evaluation. In a couple of years from now we should have some results. What exactly is the evaluation of our program? What is the relapse rate? We need to learn from that. I think we need to look at what people learned at the centre, how they learned it. It doesn't matter whether they left or had to come back later, they learned something. We tell people all the time that they have a choice. They can leave if they choose to. They can choose new friends, choose a new group. If they want to stay the same, that is their choice too.

Do you have any questions?

KG: I did want to point out one thing, there is another Native treatment centre which has an outreach aftercare program as well, Onen'to:kon, which is outside Montreal in Oka. Aftercare has always been a big issue. At the Addictions Unit of the Montreal General Hospital, we don't have much residential treatment. We don't always find it useful to bring people in for 3, 4, 5 weeks then send them back to their community. We tend to want to work with them directly on an outpatient basis, because that is where they are encountering their problems, their triggers, their friends, the people that are trying to bring them back into using. Rather than isolating them from the community we want to work with them while they are in their community, especially with regards to relapse prevention techniques. Once they are able to be sober, they need a good deal of long-term help maintaining sobriety and aftercare is really the essential element from our perspective. I don't know how Onen'to:kon feels about it? I perceive it as a very important component of any treatment.

FK: Just maybe to add something concerning this. Urban environments are different. My centre is isolated.

**KG:** Other comments and questions for the panel as a whole. Maybe we can address the overall question. You said that you are tired of research, you want some action. Part of the question that I had addressed to the whole panel was: what needs to be done? What action do we need to take then? And who wants to initiate the action?

*AC: My name is Archie Cheechoo and I've been listening to everything that has been said in last couple of days. There is a healing approach that I am a part of. People define it with different terms: medicine, healing, there are all kinds of names for it. The work that we do goes for Native and non-Native people. I don't have a nine to five job so I put my trust in the people to take care of me. When I go to communities they give some money. I pay rent like anybody else. I rent a place on the reserve and I pay rent. When I pay rent I can't pay with tobacco. I would get kicked out. There has been a misunderstanding about all these kinds of things by Native people. I know the principles of spirituality. You cannot just go out and say you are a spiritual person—that has to come from teaching and experience. When we go in to communities, we have to live like anybody else. We have families, children who need clothes. It has been a difficult question. But we go into communities and help people and they help us. Some of them say, "Here, here is a little bit of money for you," and we appreciate that. In the communities there are poor people, not just Natives, and they don't have very much but they appreciate us. Richard is right, there is a lot of pain in everyone. We talk to non-Native people, we talk to doctors, psychologists, psychiatrists. They come to us for comfort because they are burnt out. We don't dissuade them, we help them, we tell them not to give up what they are doing because they are providing a service. Priests, ministers, rabbis, they have all come. We have sat and talked about the problems... Anger hurts people, it kills. We see that everyday on the streets. This is what we are dealing with. It is not just an Indian problem. This is a world problem. So, like the title says, what we are trying to do here is widen the circle and try to find what is best for each one of us. It is clear when you go out there and all you are trying to do is help people, then somebody drags you down, shoots you down. That is what we are trying to take care of. We go into these communities ... The first step is to admit that there is pain inside and then you can start to release it slowly. I finally let go of my anger.*

**KG:** Thank you. I have myself noticed a slight amount of anger in these proceedings so far, so it was nice for somebody to acknowledge it. Is there anything else that people want to bring up with regards to what we have been talking about this morning?

*Q: We started a mobile treatment centre. The youth at our annual assembly requested that mobile treatment centres be present in all the communities. Most of our young people today have families. During the time that they are going into themselves and dealing with the pain that we have acknowledged today they need that closeness of knowing that there is help in the community. They don't want to go to another place... What they requested was mobile treatment centres ... when we start to take responsibility it teaches us what it is that we need to do, it gives us direction.*

## **Overview of the Indigenous Healing Concerns of the First Nations in Quebec**

Dianne Reid

*James Bay Cree Cultural Education Centre*

(Rapporteur: Greg Brass)

**Résumé:** Utilisant comme point de départ sa récente visite au centre correctionnel de Sainte Anne des Prairies, l'auteure décrit la façon dont les organisations hiérarchiques empêchent le processus de guérison. La guérison ne peut s'accomplir que lorsque les croyances de chacun sont respectées et que les dimensions physiques, psychiques et spirituelles sont toutes adressées.

**Abstract:** This paper will introduce the topic of indigenous healing through an overview of the key Native mental health concerns of the First Nations peoples in Quebec and the ways in which they can be addressed through various healing modalities. Reid draws on her political and social involvement with Cree communities in order to highlight the critical issues which must be addressed by health researchers and workers.

Dianne began her talk by discussing her recent trip into St. Anne des Plaines, a super-maximum federal correctional institution north of Laval, Quebec. She said she was still reeling from the effects of visiting with inmates who are spending 20 or more years in prison. Though difficult, the experience was wonderful and gave her and the others she went in with an opportunity to reach out to the inmates. Now Dianne feels a need to reflect on what the experience meant, and to ponder the task of how to provide resources to those Aboriginal men in detention. The task of healing in this context is very difficult; simply getting resources to those in need means going through a labyrinth of walls and armed guards and many levels of bureaucracy and red tape. Dianne noted that though the inmates are the ones most in need of healing, they are very cut off from the world.

Dianne told us that for the last 9 years she has been witnessing a global awakening to traditional spirituality. There is a new approach to healing worldwide, and within this healing movement there are valuable lessons and experiences that Dianne believes need to be brought into Native communities here.

Dianne noted that in Quebec there is a province-wide healing movement which is generating both positive and negative reactions. The movement begins with individuals; all the imposed, western structures—regional health boards, social services, front-line workers—are being pierced by an organic movement. However, there is a struggle between the two approaches. While there is an attempt to integrate culture within the imposed structures that exist, the communities have their own realities and systems of beliefs; the analogy Dianne offered was that of a flower trying make its way through the tangled weeds and working hard to show its beauty.

In her own community of Waswanipi there is a struggle over belief systems (traditional, Pentecostal, evangelical and Roman Catholic). As a result of this struggle, and, probably as a result of criticisms from the community directed towards the Band Council, the Council took over responsibility for the healing movement in the community. At a general assembly organized by the Band Council there was a great deal of anger, but, Dianne noted, anger and

healing are inseparable. She also said that there are many approaches a community can take; while at the Waswanipi general assembly it was suggested the community set up a wellness group, Dianne pointed out to us that a wellness group is just one more in a series of structures that replace each other. Social services, wellness groups, youth protection, etc. are all part of attempts at solutions that ultimately fail, she argued. Dianne pointed out that while earlier suggestions during the conference included one that every community have access to mobile treatment centres and mental health care workers, this begs the question of who will pay for these services.

There seem to be battle lines between workers. While our teachers and educators say a holistic approach is needed, other groups argue for systems of segregation. Dianne remarked on the presence of psychologists, psychiatrists, social workers, and healers in many communities and underscored the need for a holistic or integrated approach to treating people. She told the story of a hospitalized patient diagnosed as suffering from mental, emotional and physical damage. According to the psychiatrist treating this patient, each of these afflictions had to be treated separately. However, an elder involved with the case showed that all of these states were intertwined, including a spiritual element which was missing entirely from the psychiatrist's diagnosis. The elder was able to disentangle the threads and heal the individual.

Addressing the Native Mental Health Research Team, Dianne emphasised that this conference should not be about widening the gap between individuals and approaches, it should be about widening the circle—at the level of individual, community, nation and the world. Research has its appropriate place in this task. For example, mental illness among the Cree of Northern Quebec is translated as *tish-qua* or crazy/mad person. The word '*tish-qua*' was used in the mercury poisoning issue to refer to '*tish-qua* fish' meaning crazed or sick fish. This approach, drawing on culturally meaningful ideas, helped to stop people from eating the fish that were poisoning their bodies.

Other areas that need to be addressed include the support needs of families in crisis. There is often a fear of mentally ill people in the community. Behind this barrier of fear are mentally ill people suffering and very conscious of their illness. The answer to their problems is not purely clinical. Often when a person is mentally ill he or she is sent south to see a psychologist and psychiatrist. There is fear in the communities that this can lead to a pharmaceutical response to mental illness; often the first thing that happens is that the sick person is prescribed pills. There is a story of a young man who was ill and came back from the psychiatrist with pills, which he absolutely did not want to take. The fear in the communities is that a chemical dependency is being created through this response to mental illness, while the larger social ills underlying these personal sicknesses are being overlooked. A traditional healer is able to disentangle the emotional states of psychiatric cases in their social context. Dianne has seen several instances of this and has faith in those healers.

There is a need to widen the circle and narrow the gap. Front line workers often say that they are experiencing a sense of alienation in their communities and that they themselves need healing as well. But problems and mistrust arise when groups and individuals try to maintain or gain authority and administrative power. The issue of authority is important as it points to concerns over control. This is something that needs to be addressed in order for organizations themselves to begin to heal.

Diane closed her talk with more reflection on her trip to the penitentiary, and told us that the act of sharing the story helped her to understand and feel revitalized by it. The spirit can open the heart and the mind, she reminded us, and all approaches must work together without trying to undermine each other.

Her story of the super maximum institution is a strong metaphor for both the issue of hierarchy and the mechanisms of authority and control. These issues of domination create problems when one is trying to heal others and be healed. They become barriers—emotional, mental, physical, and spiritual—to change. Prisons are all about closing people off from the world and preventing anything meaningful from taking place in their lives. We must not close ourselves off, instead we must widen the circle of support.

## Social Health and Community Healing

Naomi Adelson

*York University*

**Résumé:** De part le monde, les populations autochtones sont en plein processus de guérison. La guérison peut être physique, mais elle est surtout sociale, politique et spirituelle. Il s'agit pour des peuples entiers de récupérer à la suite de traumatismes culturels, économiques, politiques et spirituels. La guérison doit se faire à la fois sur le plan personnel et communautaire. C'est un processus amorcé maintenant car les peuples ont enfin trouvé leur voix. Chaque individu guérit à sa manière et c'est pour cela que de nombreux programmes de guérison existent. La plupart ont pour but simplement d'aller "au delà" de la douleur associée à l'appartenance à une Première Nation. Certains ciblent des populations autochtones particulières: les femmes, les enfants, les prisonniers.... Mais la guérison à l'échelle communautaire ne peut se faire que dans le contexte d'une réelle autonomie économique et politique. L'auteure cite Hazelhurst, une anthropologue australienne, pour décrire en détail les trois composantes d'une guérison libératrice: la décolonisation, la reconstruction communautaire et la libération spirituelle.

**Abstract:** Healing is as much a personal and spiritual phenomenon as it is a process of social and political recuperation. While this session focuses primarily on the active processes of healing, the underlying premise is that healing has as much to do with overcoming personal trauma as it does with the vitality of communities, and with the very essence of identity in an increasingly complex Canadian Native reality. While indigenous/spiritual healing is generating some debate at the community level, it is at the same time gaining acceptance and adherents in more and more communities across Quebec—in other words, there is a variety of responses to the growing healing movement.

What does healing mean? This is a question that I have been asking for the last couple of years, looking for the roots and branches, the history and the growth of the healing process at the community level. My own journey towards healing has been, I readily admit, an academic one. As a social scientist and, more specifically, as a medical anthropologist, I am interested in the ways in which healing has emerged as one of the most profoundly important contemporary activities and symbols of First Nation growth and empowerment.

The questions that I first found myself asking were: "What are people healing from?" and, then: "What are they healing towards?" For some, there are obvious answers to these questions. For others, the answers do not come as easily. My own work has allowed me to begin to understand some of the answers to those questions, and I have found that the answers always lead me back to the same point: *healing is political*. In the same way that the feminist movement asked us to understand that the 'personal is political,' I see in healing movements the world over the relationship between personal and social trauma as well as personal and social healing. There is, in other words, an inseparable link between the social and political move away from disenfranchisement, movements of empowerment and the healing process. From The Truth and Reconciliation Commission in South Africa to Aboriginal Australia to Native Canada, we are seeing the language of 'healing' speak to the processes of recuperation from social, political, cultural, spiritual and economic trauma.

Why, I then asked myself, do we speak about the vast changes that must take place in communities and with people as something that is contained within individuals or, within



the context of bodily health or illness? One answer is quite simply this: because the most profound result of the decades of power imbalances and domination within Canada has resulted in people quite literally becoming sick. In the language of medical anthropology, I speak about this as the embodiment of the effects and consequences of the power imbalance inherent to internal colonialism. Often we speak about these issues as individual problems, focusing, for example, on alcohol and drug abuse or violence or suicide or the profoundly damaging effects of residential schools. These are all, of course, real problems of real individuals who need real and viable assistance. I see them also, though, as symptoms of a larger societal process—or sickness, for that matter—of generation upon generation of oppression and vulnerability.

Where does individual and community healing begin? I will try to answer that with a quote from a member of the Whapmagoostui First Nation. He said:

*One of the things is to take a holistic approach about healing the community. Now when we say healing it doesn't [just] mean to heal the sick but to heal physically, mentally, spiritually and emotionally. And you have to start with one individual, yourself, and then only when you have established yourself on that road to healing and after you start healing, once you are healed then you can start healing as a family. And once you've healed as a family, then you can start healing as a community and only when you heal as a community then you can start healing as a nation.*

This quote speaks directly to the 'sicknesses' that must be healed and summarizes the essence of 'healing' as both individual and community process. Healing, in other words, is as much a personal and spiritual phenomenon as it is a process of social and political recuperation. While this session focuses primarily on the active processes of healing, the underlying premise is that healing has as much to do with overcoming personal trauma as it does with the vitality of communities, and with the very essence of identity in an increasingly complex Canadian Native reality.

This is not to say, however, that the healing process is either easy or smooth. There are a variety of difficulties that limit the healing objectives within communities. Everything from financial constraints to factional or religious differences mean that healing programs are far from universally accepted. In other words, there are various responses to the growing healing movement.

At the same time we can clearly see that healing, and in particular, spiritual healing programs and activities are gaining acceptance and adherence in more and more communities across Quebec and Canada. This session and, more specifically, its accompanying workshops, offer mental health and Native practitioners an opportunity to discuss paths of communication and integration of their respective healing services.

The last 25 years have been marked by the emergence and growth of a variety of healing programs nationally and internationally. Many are focused on specific treatment necessities: for example, The Nechi Institute, Poundmaker's Lodge and Waseskun House. These three in particular are exemplars of programs that have been so successful they are used as models internationally. There is, as well, a variety of community or urban healing programs that focus on particular aspects of healing. Healing, in many of these instances, tends to involve the process of moving past issues related to what has been referred to as the "pain of being Aboriginal;" that is, the traumas associated with residential schools, with the remembered abuses foisted upon individuals when they were children, as well as with the effects of alcohol or drug abuse.

There are other healing programs that are geared specifically towards Native women, children, teens or Native people with disabilities; there are also healing programs geared towards prison inmates. Sentencing circles, gaining popularity in the legal community, are also spoken of in terms of 'healing.' In one case, even the implementation of local self-policing has been viewed as a process of 'healing.'<sup>2</sup> The Aboriginal Healing and Wellness Strategy in Ontario has been set up to specifically promote healing and wellness in communities across Ontario.<sup>3</sup> There have been Canadian sponsored international healing conferences (Healing our Spirit Worldwide, Poundmaker's/Nechi Centre, 1992, with 3,000 Aboriginal people from around the world). Nationally, Elijah Harper's Healing Conference has received a lot of attention, as have documents such as *Breaking the Silence*, an AFN (Assembly of First Nations) First Nations Health Commission publication on the impact of residential schools and the subsequent healing processes that must be put into place. Nationally, as well, there is the Brighter Futures initiative and more recently, the call for a national Aboriginal Health Institute. There are also many, many Healing Conferences taking place throughout Canada's Native communities. It is clear that there is both a surge of healing strategies and a seemingly unrelenting need for such programs.

The question remains, why now? In particular, why has the healing movement become so central in the east in the last decade? Part of that answer lies in understanding the larger social framework in which the healing process is occurring. This is a time when people's voices are finally being heard; still not as loudly as many may want, but it is tremendously important to note that many people say they finally have the strength and ability to speak out—for the first time, to talk openly about the misery they have lived. It is these voices that are getting stronger—and it is the collectivity of these voices that have led, for example, to the sorts of apologies and attempts by the churches to redress the wrongs of the past. Some people are also reflecting on their ability to talk about things that were suppressed in past decades: ceremonies and practices that were forbidden are now being spoken about and, in more and more cases, re-vitalized for the first time in a long while.

While reflecting on all of the positive aspects of healing initiatives, I would suggest that there is a flip side to the healing movement that we must pay attention to. Alice Kehoe, in a recent review of a book on alcoholism on an American Reservation, as well as Jim Waldram and his co-authors of *Aboriginal Health in Canada* (1995),<sup>4</sup> have all cautioned us to think about the dilemma that arises if we only talk about the issues that have led to healing strategies. Gerald Vizenor, a Native author and professor of Native Studies in California, is more direct when he speaks of the "social science paradise of tribal victims." We must not, they

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<sup>2</sup> "...the new police station reverses a 118 year decline that began when the Blood, Peigan, Stoney and Tsuu T'ina gave up southern Alberta and retreated into reserves controlled by outsiders by signing Treaty 7. 'It's been a big hurt. For healing to begin, you have to believe in yourself and who you are. This (building) is like the hub of a wheel. This is where all the caring and prevention will begin—with justice as life support for the people.'" (Gordon Jarameko, 1995, *Policing Seen as Route to Healing*, Calgary Herald, June 24 [B3]).

<sup>3</sup> The Aboriginal Healing and Wellness Strategy reflects the unique relationship of Aboriginal peoples with the government of Ontario. The Strategy focuses on the empowerment of First Nations communities through the development of a range of culturally appropriate programs and services related to the promotion of health and healing and the prevention of family violence. Over the long term, the control of relevant programs, services and resources will be transferred to the First Nations communities.

<sup>4</sup> Waldram, J., Herring, A. and Young, T. Kue, 1995. *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives*. Toronto: University of Toronto Press.

all warn us, be consumed by the negatives or continually dwell on the negative to the exclusion of the gains being made and *how* they are being made.<sup>5</sup>

As I stated at the outset, community healing in its broadest sense can only occur with real economic and political autonomy. Autonomy, however described and enacted, will not be realized until the issue of Native self-government is resolved. Kayleen Hazlehurst addresses these same issues in her book on healing programs in Australia. Much of what she speaks about resonates with the situation here in Canada. She writes:

without the political will to create supportive institutional environments, or the imaginations to direct funding towards innovative community healing approaches, approaches which transform, rather than nurse the ills of Aboriginal communities, governments will continue to fail in the domain where they have had an historic opportunity to lead (Hazlehurst, 1994: xii-xiii).<sup>6</sup>

Perhaps, however, we should not look to the government for leadership. In fact, it is clear that those who are leading the way, in Canada as in Australia, are not the governments, nor the academics or clinicians. The ones who are leading the way, more often than not, are the people who are not in positions of power or authority. They are the people who are working—and struggling—daily to make the changes on a person to person level (Hazlehurst, 1994).

Hazlehurst (also an anthropologist) addresses the challenges of healing in Australia as a process of liberation. In other words, her approach clearly spells out the links between healing and the social and political strategies that must be put into place for long-term substantive community healing to occur. Specifically she outlines 3 kinds of liberation that are required for successful healing: decolonization, community reconstruction, and spiritual liberation:

**Decolonization**—release from dependency and tutelage can only occur through increasing decentralization of the management of Aboriginal affairs to Native agencies, Native governments, and organizations.

**Community Reconstruction**—revitalization of community life and the redrawing of the domains of community leadership through the taking on of more and more responsibility at the community level.

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<sup>4</sup> Vizenor, Gerald. 1994. *Manifest Manners*. Hanover: Wesleyan University Press.

<sup>6</sup> Hazlehurst goes on to say:

To continue to despise indigenous peoples for not taking charge of their own lives, while the custodians of power refuse them the legitimate means to do so is patently unfair, profoundly impractical and tiresomely expensive. We are all satiated with the news of the over-representation of indigenous peoples in prisons and the annual round of [blockades]. Yet to bring real change in the interactional and behavioural patterns which continue to support 'the problems,' will require nothing short of a colossal leap of imagination about what is possible within communities and [even] government administrations. Intellectually, spiritually, and socially, the kinds of practical and policy reforms which promote personal healing and community renewal represent one of the freshest, most exciting, and challenging of grounds upon which any social scientist... might advance (1994: xiii).

Hazlehurst, K. 1994. *A Healing Place: Indigenous Visions for Personal Empowerment and Community Recovery*. Queensland: Central Queensland University Press.

**Spiritual Liberation**—release from the shackles of racism or self-hate towards spiritual repair through creative and perceptive leadership locally and nationally; by the shaping of a ‘vision’ of a destiny and a future.

We have seen clear examples of all three occurring throughout Canada. We have only begun to understand the full extent, however, of what healing, and more specifically, community healing—in all of its depth and complexity—really means. What we know for certain, though, is that healing is always personal and spiritual as much as it is always social and political.

When we speak about healing, whether it is personal, spiritual, social or political, we are speaking as much about the people who are going through a ‘healing process’ as we are about the people who are helping them through it. This brings me to my next question: who are the healers? This is not an easy question to answer. For one thing, healing is not institutionalized, there are no formal remedies that can be prescribed like a pill; healing occurs in a variety of places and with the help of many different people. As well, healing is rarely a physiological process: one cannot simply cut out or bandage the sorts of ills that need to be healed. This being said, there are those who devote their lives to healing, and it is their strength and commitment that is fundamental to the healing process. The men and women who work as spiritual guides, intermediaries, educators, and healers are integral to personal, spiritual, social, and political healing.

But there are tremendous obstacles being faced by these elders and healers. Borrowing again from Waldram et al. (1995), I will point to 6 particular issues that impede their success: 1) for the most part, elders these days must travel into communities, as there are few resident elders who are either able or willing to assist people in this manner in any given community; 2) the funding for elders to come into the community must be found; that is, they are rarely integrated into any particular medical or social service strategy; 3) there are so many social ills, unfortunately, that those elders who do travel tend to be constantly moving from one community to next, with a full schedule in each community that they visit; 4) while there is a greater effort to integrate services—to find some sort of balance between biomedical therapeutics and Indigenous healing—there are far too few models of fair and equitable integration; 5) there are detractors; that is, this is by no means an accepted form of therapy for all First Nations peoples and any successful programs must be able to incorporate a variety of perspectives and beliefs; 6) there are no official boards of certification. This may be a good thing, but it may hinder good work being done by important and valuable elders. In the meantime, we must all learn to understand what constitutes a successful, competent elder/healer. Having said that, I also realize that each issue that I have raised in turn raises a variety of questions and concerns.

## Workshops

### Self-Esteem: Meeting the Challenge

Caroline Oblin and Katie Moores

*Module du Nord Québécois & Montreal General Hospital*

How we behave with people depends on how we feel about ourselves. Self-esteem is the value that we accord ourselves as people; it is our sense of self-worth and of competency. It is the knowledge that we can cope with any problems we encounter, and feel able to meet the challenges of life. Our emotional responses are a result of our level of self-esteem.

People who have suffered emotional abuse or who have feelings of hopelessness know all too well the gnawing sense inside that low self-esteem can bring. Developing self-esteem means that you can develop the ability to quiet that “gnawing sense” and learn to be gentle in what you expect from yourself, and even to put aside other’s expectations.

This workshop has been designed to help individuals value themselves, where they come from, and the things that they do. Through self-evaluation, participants will learn how feelings of self-worth affect their interactions in everyday life. Through the use of traditional tools such as the medicine wheel and the talking stick, participants in this experiential workshop will also learn the significance of a physical, mental, spiritual balance in their lives and appreciate the importance of their cultural backgrounds.

#### Self-esteem

No doubt you’ve heard the expression “so-and-so has high self-esteem/low self-esteem.” What does this mean? What is esteem? What is the self anyway?

*Having high self-esteem means respecting and caring for one's self. It is how we feel about ourselves and therefore it affects all our emotional responses. There are many definitions of self-esteem. The following are some of them:*

- Self-esteem is our sense of worth. It is how we value ourselves.
- It is our competency; that feeling that we can cope with our problems and with life’s challenges.
- It is a belief that we deserve to be happy, to have our needs met and to ask for the things we want.

When we speak of high self-esteem/low self-esteem we are measuring self-esteem. Is your self-esteem high or is it low?

There are many ways to measure self-esteem. For example, today, we will use the questionnaires and exercises that will make you more aware of how you value yourself. As well, in our manual, there is a declaration of self-esteem by Virginia Satir. Measuring, experiencing, making empowering declarations, as well as finding physical, emotional, spiritual and cultural balance helps us to improve our self-esteem by increasing our awareness of how we feel about ourselves.

Self-esteem includes trust, self-care, and independence, knowing who we are and being able to develop intimacy. Our sense of trust begins when we are very young and depends on our welcome into the world. First we learn to trust ourselves and then others. Through this experience, we begin to trust in our ability to choose people who are safe to be with and who will not hurt or take advantage of us. Taking care of ourselves is an essential ingredient of self-esteem. Independence comes when we work our way through different dependencies, and eventually become independent. Interdependence develops as we find that we have connections with others but we can exist separately from them.

Knowing who we are at each stage of life means that our self-esteem is challenged to undergo change and growth. As we come to know who we are, we grow and feel more certain. Intimacy develops from knowing who we are and from our need for connection to others. It is the ability to relate closely and to know the limits of closeness.

Developing self-esteem takes work:

- Start by figuring out what you like about yourself. For example: your looks, your mind, your abilities, your potential, your beliefs.
- Get comfortable with yourself. Never mind what someone else expects of you.
- Think about your achievements and congratulate yourself for them.
- Success involves risk. Set your goals. If you have a set-back, learn from it. Be a problem solver. Revising your strategies may be necessary—you may use self-defeating patterns.
- Try to be realistic! You are not perfect and that's okay.
- Be kind to yourself.
- Imagine being successful. Rehearse winning.
- Look after your health. Eat properly, get the sleep you need. Do some exercise (at least three times a week). Play!
- Find people that you can count on to listen to you when you need to talk.
- Forgive yourself. Forgive others.
- Remember that you are unique.
- Get in touch with your inner child. Recognize what your inner child needs in order to grow.

Build your child's self-esteem:

1. Self-esteem is your inner confidence and feelings of self-worth that allow you to feel positive about yourself.
2. Encouragement is the process of focusing on an individual's resources in order to build that person's self-esteem and self-confidence.
3. People who encourage are able to see what is positive in any interaction.
4. Self-encouragement involves building a positive relationship with yourself, using self-valuing statements, and changing your discouraging beliefs. Some common discouraging beliefs of single parents and step-family parents are:
  - “I must be in control and my children should not challenge me.”
  - “The children should and must love me.”
  - “I should be treated fairly.”
  - “I know what's best.”
  - “I must replace the absent parent.”
  - “I must make it up to the children for their having only one parent at home.”
  - “My divorce is a personal failure.”
  - “My family must prove its worth to the community.”
5. The courage to be imperfect allows you to take chances and make mistakes.

6. Encouragement improves relationships between parents and children, increases the cooperation in the family, and helps children develop confidence, self-reliance, and the ability to face challenges.
7. The skills of encouraging include:
  - Listening using eye contact and body language.
  - Responding to feelings, recognizing what the child believes and thinks.

#### **Four Conditions of Self-Esteem**

*(From Pepper & Steven's An Indian Perspective of Self-Esteem, 1991)*

The concept of the medicine wheel has been adapted to reflect a Native perspective of self-esteem. The four directions correspond to four necessary conditions for self-esteem: Connectiveness; Power; Uniqueness and Models.

1. *Connectiveness*: The east represents connectiveness because wisdom and illumination lead us to come to know our own relationships and our place among our people. East represents spring, birth and the protection of youth. Connectiveness is found in a sense of relationships, in the attention and affection of others.

2. *Power*: The south represents power, the source of our growth, and is related to innocence and trust as it exists in childhood. It fosters the power to grow with warmth and understanding and a philosophical view. Power is shown by a sense of accomplishment, success and competence.

3. *Uniqueness*: The west represents uniqueness. The west is associated with introspection, with one who looks within and who is faced with the conflict of indecision. The West also corresponds to growth as related to adults, to maturing. Uniqueness is a feeling of being special and a feeling of worthiness, of talents and productive contributions.

4. *Models*: The north represents models. Models are examples or representations of some real thing. The north is associated with wisdom. This reflects the wisdom of the elders and of healers. The north is also associated with control and intellect which give values and goals to guide us. Models involve the development of a sense of knowing that goals and standards are appropriate and important.

The following resources were used in the preparation of this workshop:

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## CRC Maison Waseskun House Program

Bevan Skerratt & Nicki Garwood

*Waseskun House*

(Rapporteur: Natalie Lloyd)

**Résumé:** Les deux présentateurs sont impliqués dans le programme de la Maison Waseskun, qu'ils décrivent ici. La Maison Waseskun est un centre de guérison pour individus ayant été emprisonnés pour agression sexuelle. Ils y apprennent à guérir par le biais de méthodes traditionnelles autochtones.

The CRC Waseskun House Program is rooted in an inclusive approach to Native cultural tradition, a here-and-now awareness of current global realities, and a proactive process of re-integrating male ex-offenders into their communities of origin. Using the symbolism of the Medicine wheel as a model for the developmental journey, and the balance of the emotional, physical, mental, and spiritual aspects of human nature as a tool for individual integration, community members are encouraged to examine their personal life experiences in the context of the principles fundamental to a traditional Native understanding of Reality.

Waseskun House group sessions provide a supportive environment wherein participants have the opportunity to develop and examine the processes, components, and skills involved in the creation of functional community. Group interaction becomes a catalyst for an individual healing process which allows clients to plumb the depths of personal trauma and to appropriately grieve the losses specific to contemporary Native experience. It is particularly significant to the CRC Waseskun House residents that they arrive at a re-valuation of their personal potential and the implications of this in terms of future generations and their impact on the global community.

This uniquely structured program, especially sensitive to individuals with a history of drug and alcohol abuse, includes: individual counselling; group counselling; Native family systems awareness; human sexuality; men's issues; conflict resolution; life skills; First Nations addictions awareness; anger management; physical balance; healing circles; cleansing ceremonies; sweat lodges; traditional teaching from Elders; and traditional feasts. During the summer months, residents and, where appropriate, their families are given the opportunity to participate in intensive camp healing sessions in a secluded environment.

Waseskun House was founded in 1988 as a private, non-profit, Native-owned and operated organization devoted to the healing of Aboriginal male, federal and provincial ex-offenders. Since the Native perspective on healing is a holistic one, including the offender, the victim, the families and the community, the Waseskun vision includes training for community workers, an Internet support network, and plans for a larger and more integrated Healing and Development Centre in a rural setting.

The intensive program offered by Waseskun House has been constantly evolving since its inception five years ago. The approach is based on traditional Native spirituality, and uses a unique adaptation of the 'Medicine Wheel' to give order and meaning to the often chaotic and emotionally laden experiences encountered on the healing journey. During the 20-week duration of the program the diverse Waseskun clientele experience the process of building a functional community and are given the opportunity to develop new skills in



communication, problem solving and conflict resolution. Personal “Vision Questing” is encouraged to prepare and assist the client in assuming a future role as an integrated and contributing member of his community of origin.

Participatory ceremonies and interactive experiential exercises are designed to help individuals move toward emotional, physical, mental and spiritual wellness, as well as identifying and releasing the blocks which prevent this process from taking place. Members of the Waseskun community are encouraged to integrate traditional values in the building of healthy relationships with each other and with the natural environment, which is understood to be part of the Self. Grieving the various losses inherent in an unhealthy past, letting go of artificial substitutes for authentic need fulfillment, and learning to express outrage and anger in safe and constructive ways comprise the deeper aspects of the healing process. The program cycle ideally culminates in a commitment to active forgiveness and a more mature re-direction of legitimate anger towards social change and interpersonal intimacy.

Due to time limitations, Bevan and Nicki were only able to share a small portion of the richly symbolic and experiential nature of the program, but the group got a good idea of the methodology and concepts involved in at least one of the sixteen program themes. To end the presentation Bevan and Nicki shared parts of a video depicting the Waseskun community involved in a variety of activities at both the summer camp location in northeast Quebec and the urban facility in downtown Montreal.

## The Integration of Biomedical and Traditional Medicine

Archie Cheechoo

**Abstract:** This workshop, led by an elder/healer, focused on the integration of biomedical and traditional healing practices with particular emphasis on the holistic approach central to Native healing. Mr. Cheechoo drew from his own experiences to address the dilemmas faced by individuals and communities as well as the possible avenues for their resolution.

I was not absolutely certain about the context of “integration.” The word is a red flag for me, as the days of residential school are reawakened by it. Nevertheless, for this workshop I looked at the pros and cons of the integration of biomedical and traditional spiritual practices. Access to both for clients or patients seems a reasonable goal.

There are some very practical impediments to integration, however. For example, the heavy use of smoke substances by traditional healers is restricted by others healers, thereby making it difficult to practice traditional medicine in conventional hospital or clinical settings. Also, in the traditional process of spiritual healing, healers and clients all have to abstain from consuming any alcohol or illicit drugs.

As traditional practitioners we do not discourage people from using biomedical services nor do we interfere in a person’s biomedical regimen. We have concerns about the many side effects of the medicines used, however, and about the way in which people are simply expected to cope with them. Some Native medicines do have side effects when people take more than the desired dosage; otherwise, these medicines have no known side effects.

As traditional healers we would prefer to have our own place to do our work. A traditional healing centre is vital to the establishment of an organized system of spiritual healing. In fact, I see “integration” to mean a consultative mechanism of referring patients between practices—and not incorporating one into the other. At a very practical level, we need the funds to build a healing centre and run it properly, as well as funds to continue our practice of travelling to communities.

In our work, whether a person is cured or not depends on a number of factors. First and foremost, both the healer and the client must have some spiritual belief (i.e. they do not have to share the *same* spiritual belief or necessarily believe with the same level of intensity). As well, the client must want to receive the healing. Once the healing process begins, the actual process is out of the hands of the healer and the client. Sometimes exceptional things happen, *even* miracles; we have no control over that. What we have learned, though, is that spiritual faith is vital to the curing process.

In a practical sense, biomedical and traditional medical practices can not easily be integrated. Rather, these two systems should operate independently of one another, but in concert, allowing for a reasonable consultative process that works in the best interest of the clients of both practices. The workshop discussion that followed my presentation seemed to echo similar sentiments about the difficulties of “integration.”

## Overcoming Traumatic and Abusive Life Experiences

Abraham Bearskin

*Chisasibi*

(Rapporteur: Greg Brass)

**Résumé:** A partir de son cheminement personnel, l'auteur explique la façon dont il traite les problèmes résultant de souvenirs traumatisants. Tout d'abord, il faut faire le bilan des émotions négatives accumulées: la colère, la jalousie, la haine, le manque de confiance et de respect. Cela aide à comprendre la douleur. Ensuite, chacun doit suivre son propre chemin, en respectant son propre corps, la sagesse des aînés, et toutes les autres créatures du monde.

**Abstract:** Abraham Bearskin led a workshop on traditional healing that drew from his own extensive training in Native healing and his work with individuals overcoming traumatic and abusive life experiences. This workshop focused on awareness, education, healing, and opening and closing on the wounded spirit of self. It touched on the effects of traumatic incidents on the self (damage to the inner self and unbalance of the "Spirit"). Acceptance, healing, and balance of the spiritual, emotional, physical and mental will be addressed.

Abraham gave us a good introduction to his approach to treating traumatic memory. His workshops are about his own life, his experiences of abuse and how he has recovered from these experiences and learned from them. He noted that a two-hour workshop was not sufficient time for him to go through the whole program, as a proper workshop would be four days long. What Abraham wanted to share in his workshop was his own sense of identity.

Abraham began by talking about his childhood, explaining that he carries within him that child. His birth was a very joyous occasion for his mother. Until his entry into residential school, his life was very happy. When he began school he suffered abuse by older people and this, he believes, was the source of the pain in his life. As he became older he became abusive himself, drank heavily, and at one time tried to commit arson.

When he began to undergo his healing, the door into this part of his life was the abuse he suffered when he was very young. At this point in his talk Abraham drew a rectangular box on the blackboard. He wrote within the box all the negative experiences in his life and the associated emotions: anger, jealousy, hate, mistrust, and disrespect. At the bottom of the box he made a small opening and explained that the opening represented the beginning of his journey. His journey has been about understanding the abuse and pain in his life. Throughout his journey it was women who helped him, which is why he has come to believe that women are stronger than men.

During his career in social services Abraham became very angry at the things he saw. He understands now that the children he was trying to help were himself; that is, the experiences he saw them living through were the same experiences he was still trying to recover from. This anger was strong; he wanted to gossip about the abusers and try to hurt them. Similarly, one day when he met the Bishop of the Anglican Church, Abraham accused

the Bishop of causing all the problems Native people currently have. He realizes now that by attacking the Bishop he was attacking himself.

People who are suffering accumulate problems the longer they go through life without trying to put down the burden of anger and pain. These people pass on that burden to their children. Abraham illustrated this idea on the board.

Now that he has begun his healing, Abraham always shows respect for his body and does not abuse what the Creator gave to him. He is traveling the Red Road and works hard to understand the Teachings the Elders give.

## **But Does It Work? Traditional Healing and Issues of Efficacy and Evaluation**

James B. Waldram

*University of Saskatchewan*

**Résumé:** Celà fait longtemps que les anthropologues et autres spécialistes se posent la question de savoir si les méthodes de guérison soi-disant “traditionnelles” sont efficaces. La question est de nouveau d’actualité vu l’existence de plus en plus fréquente d’initiatives incorporant ces méthodes avec la médecine biologique, et la nécessité qui en découle de convaincre les investisseurs potentiels de l’efficacité de ces techniques. D’une façon générale, les méthodes traditionnelles ont tendance à placer la maladie dans un vaste contexte psycho-sociale. Souvent la guérison se fait pour, et à travers, une communauté ou une famille entières, pas seulement un individu. Lors d’une comparaison de ces deux méthodes, il est important de ne pas utiliser les mêmes critères pour les deux car elles ont des bases complètement différentes. De plus, le problème existe de savoir qui détermine l’efficacité d’un traitement. Est-ce le guérisseur, le médecin, ou le patient lui-même? Enfin les méthodes traditionnelles offrent surtout des guérisons dans le long terme, sans définir de façon standard quand le patient est considéré comme étant guéri. La médecine biologique a souvent tenté de démontrer le manque d’efficacité des méthodes traditionnelles, qui bien souvent n’éradiquent pas la maladie mais permettent plutôt au patient de mieux vivre avec. Ceci est curieux étant donné que la médecine opère de la même façon dans le cas de maladies chroniques. Aussi, les guérisseurs sont souvent réticents vis à vis de l’intrusion que représente une étude “scientifique” de l’efficacité de leurs méthodes. Une telle recherche va à l’encontre de l’esprit même de ces techniques et rend la tâche quasi-impossible. Ainsi, notre héritage positiviste fait qu’une vraie collaboration entre les deux méthodes, allant au delà de la subordination des techniques traditionnelles à la médecine biologique, reste encore à être réalisée.

**Abstract:** The intent of this workshop is to critically examine the issue of the efficacy of traditional healing, and if/how traditional healing can be evaluated. Scientific studies of traditional healing have often yielded ambiguous results. Many questions emerge from this. Is this because the healing itself is ineffective? Or is it possible that science currently lacks the tools (and the inclination) to “see” traditional healing? How do healers view the issue of efficacy? What are their goals when they undertake healing, and what measures (if any) do they employ to determine success? Is efficacy as science understands it even an issue for traditional healers? Is the whole idea of questioning efficacy and developing evaluation programs even necessary? Is it possible that to undertake these we are violating the basic principles of the healing itself? Can traditional healing ever be understood by the dominant biomedical system? These questions are controversial, and lead to many more questions. This workshop will begin a dialogue that, it is hoped, will better inform those interested in developing collaborative projects with traditional healers.

## Defining the Issues

For many years, the biomedical sciences and other related disciplines such as medical anthropology have demonstrated an interest in other medical systems and healing traditions. From time to time, there have been studies to determine if these so-called “traditional” or “indigenous” medical practices are efficacious, in other words, do they “work?” Most studies have concluded that they do not work (leading to allegations of pseudoscience, fraud, or charlatanism), or else have been inconclusive. Studies that have demonstrated the efficacy of traditional healing have frequently been accused of being unscientific, of employing inadequate measures (eg. the lack of clinical, double-blind studies) and of relying too heavily on anecdotal, subjective assessments by patients. Medical anthropologists in particular have been singled out as being too quick to accept the efficacy of traditional healing in the absence of any real “proof,” a character flaw seen as related to anthropology’s general desire to find value in cultural systems through “emic” and culturally relative investigation.

Some might suggest that there really are no issues here. Traditional healing systems have continued to exist despite colonialism and the global spread and domination of biomedicine; there is no reason to believe they will now disappear. Indeed, recent studies in both Canada and the United States have demonstrated that the “alternative” or “complimentary” therapies (although epistemologically different from biomedicine) continue to thrive. The problem really stems from certain attempts to bring traditional healing more out into the open, to develop programs which are focussed on traditional healing or else involve collaboration between it and biomedicine. With these initiatives come two related scourges: the need to be accountable to those who provide the funding for such projects, and the intrusive eye of the biomedical system, looking both for evidence of charlatanism as well as to possibly discredit the competition. Hence, traditional healing has come face to face in many instances with the most complex of questions: does it “work?”

## The Complexities of “Efficacy”

Before we can get to a discussion of efficacy, we need to investigate the meaning of some important, related concepts which shed much light on the nature of the controversy that is brewing.

Traditional healing systems are those cultural systems which pertain to matters of health, disease and illness among peoples with traditional systems of learning and knowledge transmission. These peoples are best thought of as “non-western” or indigenous peoples. Today, of course, we see evidence of the intrusions of the biomedical system into these cultures, but vestiges of the traditional systems remain.

What is it that traditional healing systems seek to do? The answer to this question lies in our understanding of “healing” (as opposed to “curing”). Healing involves the mobilization of resources within the cultural system to maintain or restore physical, social or community health or, alternatively, to eliminate the threat to individuals or community caused by the existence of non-healthy states. “Illness” is the expression of the lack of health as experienced by an individual or as detected by the individual’s significant others. “Disease” represents a pathological condition, which may or may not include a lack of health.

Traditional healing systems seek to treat illness more so than disease, that is, they seek to heal more than cure. This is due, in part, to the relative lack of knowledge of disease pathology (although today there are traditional healers who employ biomedical concepts of disease). Illness represents a psychosocial state as much as a physical state, and while

there are often psychosocial dimensions to disease, the biomedical system is less equipped and inclined to deal with them. This means that treatment within traditional medical systems often looks very different than that within biomedicine. Treatment may not even involve invasive procedures: there may be no physical exam, no clinical questioning for symptoms, no surgery, no medicines, in fact in some systems the patient need not even be present for the healing to occur. And this pertains to conditions with both somatic and psychological dimensions. I think we can begin to see why biomedicine has a problem here. Furthermore, in some traditional systems, the healing is only partially targetted towards the patient; the family and the community may also be involved both in the treatment (and in some instances as collateral patients) and in the assessment of its outcome.

Some issues that emerge when investigating the efficacy of traditional medicine are as follows:

*1. Who determines the nature of the problem?*

Traditional healers, usually lacking in comprehensive biomedical knowledge, express the problem in culturally relative terms. Within these terms, the cause of the illness is identified, the logical treatment invoked, and a determination of outcome rendered. Scientists investigating traditional healing often offer a completely different diagnosis, based on biomedicine. If, in their view, the problem remains after treatment (eg. an anxiety disorder, a tumour), then the treatment is viewed as a failure. But are these scientists applying inappropriate criteria? How can a healer whose medical system does not recognize an anxiety state actually treat it as such? Traditional healing should, in the first instance, be evaluated according to the extent that it achieves success according to its own criteria and definition of the problem.

This is very much an apples and oranges argument. Is it appropriate to evaluate the quality of an apple according to criteria developed for oranges? Is it appropriate to assess the healing of an illness state according to criteria used to determine the curing of disease? If the traditional healer determines the problem to be the loss of "soul" or "spiritual essence," and biomedicine determines the problem to be one of depression, who is correct? Further, does it make sense to evaluate the healer's treatment of a biomedically defined "depression?" If it does, then logic dictates that the healer should be able to evaluate the psychiatrist's treatment of soul loss.

*2. How should efficacy or successful outcome be defined?*

It is often difficult for healers to explain why what they do is effective, even if they have a definition of efficacy that they employ. In my research with healers who worked in prison, few had given much thought to the issue of measures of success, and there certainly was no consensus. Healing knowledge is very particular to individual healers in traditional societies who, unlike biomedical practitioners and practitioners of other medical systems (such as traditional Chinese medicine) do not study in institutions from standardized bodies of knowledge (such as texts). Therefore, the measures a healer may have to determine efficacy are likely to be particularized as well, unlike biomedicine with its standardized definitions and measures.

*3. Who provides the determination of the success of traditional healing?*

Healers often declare that success has been achieved; is this sufficient proof? The patient's own assessment obviously needs to be considered. Other people may likewise have a say as to a person's behaviour or physical or mental state. Is it necessary to use an external

referent to determine success? Then, of course, there is the biomedical practitioner or scientific researcher who have their own views of diagnosis and efficacy.

Traditional healing is often a long-term process that defies the establishment of logical end-points which allow for determinations of success. At what point in the treatment can a patient be said to have been “cured?” Some Aboriginal healers I have worked with in Saskatchewan have noted that, for some conditions, there is no such thing as a “cure.” Like alcoholism, certain illness states allow only for management.

Overwhelmingly, however, biomedical investigations of traditional healing have been critical of the apparent inability to achieve a cure even where there is a clear improvement in the patient’s ability to manage with the illness. This is curious, since much biomedical treatment, such as the treatment of chronic conditions (eg. arthritis), is designed precisely to help the patient manage. The demand that traditional healing provide evidence of curing, or the elimination of disease or infirmity, thus represents an unfair burden of proof.

#### *4. Biomedical research is invasive and intrusive.*

Traditional healers are often reluctant to allow scientists to document their work or test for efficacy. This is not out of a fear of being discovered to be frauds. Rather, the problem lies in both the nature of the healing itself and in the broader relations between indigenous peoples and the colonizers. On the first matter, much traditional healing involves spiritual assistance or intervention, and this requires the following of very strict rules of protocol and appeasement. A healer may not be able to disclose the mix of herbs he/she uses, or allow recording devices inside sweat lodges, because it would offend the spirits who allow the healer to heal. On the second matter, indigenous peoples, having experienced colonialism and the ravages of European capitalism, are fearful of disclosing too much of their practices for fear they will be either stolen from them (eg. in the global search for new pharmaceuticals) or else banned by law (as occurred in the past). The result is that it is extremely difficult for biomedical researchers to get close enough to traditional healing to undertake scientific studies according to accepted scientific methods. And what science cannot see, is not allowed to see, or is incapable of seeing is invariably condemned as unscientific. Such is the legacy of positivism.

### **Implications for Collaboration**

I personally have yet to see an example of true collaboration between traditional medicine and biomedicine. Those cases of collaboration that I have knowledge of invariably involve the subordination of traditional healing to the biomedical or biopsychosocial model of treatment. Traditional Aboriginal healing is often used to appease Aboriginal patients or critics, to demonstrate that something is being done for Aboriginal peoples, or else it is used to leverage grant money from funding agencies likewise concerned with their public image.

For collaboration to occur, traditional healing obviously must not be subordinate. It is essential that the healers be able to determine their own understandings of the problem and definitions of efficacy. They should not have to prove to biomedicine that what they are doing is equivalent to biomedical understanding, for it is not and they will never win this contest. In the best case scenario, biomedical practitioners may be required to take a leap of faith, to support traditional healing despite not understanding how and why it works.



### For Further Reading

The following is a sampling of sources that deal with the issue of efficacy and traditional healing.

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## **Panel Discussion: Research on Mental Health Issues in Native Communities: How Can it be Useful?**

Elizabeth Robinson

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**Résumé:** Bien que la recherche soit considérée comme étant une activité importante, dans les sociétés occidentales non-autochtones, la perception au sein des communautés autochtones est qu'elles n'ont plus besoin de faire l'objet de projets de recherche mais ont plutôt besoin de services. Il est possible que cette perception soit en partie due à la façon dont la recherche est traditionnellement envisagée. La nécessité d'obtenir le consentement des sujets, et autres mesures d'éthique, existent depuis déjà quelques temps. Mais ce n'est que récemment que les chercheurs se voient dans l'obligation de rapporter les résultats de leurs recherches à leurs sujets et d'obtenir le consentement de la collectivité. L'auteure suggère que c'est important de continuer à faire de la recherche, ne serait-ce que pour évaluer l'efficacité des services en place. Elle met l'accent, par contre, sur l'importance d'entreprendre des projets en réelle collaboration avec les communautés, sur des sujets qui leur semblent utiles.

**Abstract:** Research involves looking deeply and systematically into an issue in order to answer questions or solve problems. Research is highly valued in the university milieu, and society supports it through funding programs. Northern communities have objected to research which seems only to take from the community without giving anything in return; this is a factor in the development of ethical guidelines for research in Aboriginal communities. Practitioners in northern communities often view research negatively because it takes up their time and energy which are already spread thin trying to provide services on tight budgets. On the other hand, some northern health boards receive money to do their own research and thus must make decisions about what research projects are most valuable for their population and organization.

First I want to tell you that I'm not an expert in mental health and I joined this Native Mental Health Research Team to learn. I'm going to speak a little bit about myself and how I came to be interested in Native mental health research. But I want to mention that in my culture it is not considered good form to speak too much about yourself because it is drawing attention to yourself and that's not good. So, I'm going to be brief.

Like most non-Native people, my ancestors were immigrants. In my case, my grandfather came from Ireland in 1905; the Canadian government was advertising in Europe at the time that there was free land to be had for people who wanted to come over and farm. So he was given land, 160 acres in Saskatchewan. I've realized of course since then that that land was not really the Canadian government's to give away. But, that's in my history.

I grew up in the city of Ottawa and I did not have any contact with First Nations. My first encounters with Aboriginal people were when I was a medical student in Montreal. I met June Delisle, a Mohawk woman I greatly admire, who was running the hospital in Kahnawake, and I ended up working there drawing blood from patients for blood tests. That was an experience that marked me, especially meeting June. She is a very powerful woman. Many of you know her and you realize that.

My second encounter with First Nations people was when then premier Bourassa announced the Hydro Quebec power project in James Bay, the “project of the century.” The James Bay Cree were often pictured in the newspapers protesting the project, and were successful in getting an injunction against the dam. This led to the James Bay and Northern Quebec Agreement.

These were my first encounters with Aboriginal people and my overriding impression was of strength and power in the face of difficult circumstances. After I graduated, I went to work in the James Bay Cree community of Fort George as a young general practitioner, then later went on to study preventive medicine. Now, I’m a specialist in public health and it is my privilege to work with the Cree Board of Health and Social Services (CBHSS). I’ve been involved in doing research but I’m not a full time researcher. The Cree Board of Health and Social Services gets a small amount of money for research from the Quebec Ministry of Health. I’m a member of a CBHSS committee, which solicits projects and encourages people to submit ideas for research, and decides which projects should be carried out with the money.

Throughout my life, I’ve heard many conflicting remarks about research. Because I’ve been connected with a university, I know that the most highly valued pursuits in a university are obtaining research grants and publishing papers, especially in scientific journals that a lot of other people read. Universities have a way of assessing how often a published article is cited in other articles, and they look at this when considering people for promotion.

In the last two days we’ve listened to people say they are tired of being researched. On the other hand, we’ve heard others say that there is not enough research and that we need more. We’ve heard about some very concrete research projects, such as Dr. Pennell’s Family Group Conferencing Project. We had a report on a project at the Native Friendship Centre, and although there were some critiques of that research—namely that we already know what the problems are—I think the strength of that research was that it was done in a very collaborative manner and was an attempt to put some very needed services in place.

At this point I think it might be useful to put forward a possible definition of research. There could be other definitions and I’m probably missing some components here, but I think we could call research a kind of systematic investigation or inquiry—an organized attempt to try and find out more about something, to look deeply into an issue, and to improve understanding. The product of research is new facts or understanding—more knowledge.

Whether the new understanding is perceived as useful or helpful in contributing to healing and well-being depends on who you are. There are a lot of players around the issue of research: for example, members of First Nations communities or organizations; health administrators (Native or non-Native); and health workers and practitioners like myself who again may be Native or non-Native. I consider myself in that group, as a practitioner. Then there are university researchers, some of whom are health workers. Finally, there are the government and other agencies that fund research. Our society values research: it has funded it for many years and will continue to do so. So research is probably here to stay.

While some players may feel that the new facts or understandings produced by research are important and sufficient in themselves, others may feel, like Martha Flaherty, president of Pauktuutit, the Inuit Women’s Association, that research is “part of a larger process of development or change ... of community development and ... action to change the status quo and improve the lives of Inuit” (1995).

I want to talk now about what has happened in the past with respect to the issue of First Nations people not finding research beneficial for their communities. There are two aspects

to research that we have to look at: the process of research and the actual question that the research is trying to answer. The research process refers to *how* the research is carried out—issues like obtaining consent from communities and individuals, informing the community about how the research will be done, providing regular progress reports to the community, and so on. The way research is carried out can be disrespectful and disturbing to people or it can contribute to community empowerment. The second aspect, that is the question that a given research project is addressing, is connected to the definition of research; the whole point of doing research in the first place to produce new or deeper understandings of a situation. When people say “we don't need to do that research, we already know what the problems are,” they are not objecting to the process but to the choice of research topic or question. It is important that the community perceive the choice of research topic or question as relevant. But even if it is, if the research process is not carried out in a way that respects people, the overall impact on a community can be quite negative.

One attempt to improve the *process* of research is through ethical guidelines. These universal guidelines the research topic were formally established in the late 1940's after World War Two, in the aftermath of the most extreme cases of research subjects being harmed by researchers—Nazis performing atrocious experiments on Jewish people who were in concentration camps. Ethical guidelines for research were set up so that people who are the subjects of research would not be harmed. Every university-based research project is subject to these ethical guidelines, and every project is reviewed by an ethics committee, which ensures that the people being researched are protected.

Initially, the guidelines were mainly concerned with issues of informed consent of research subjects and their protection from harm by any research. But First Nations communities found that despite those aspects being respected, they still didn't like what was going on research-wise in their communities. Some of the problems included communities not being informed of the results of research, and the fact that the community as a whole did not give consent; rather certain individuals were presumed to be representing the community. These concerns led to more detailed guidelines which took into account these other aspects. These guidelines were put out by groups such as the Northern Studies Centres of universities. In 1995 in Inuvik, NWT, an international conference on ethics in health research in Aboriginal communities was organized by the Canadian Society for Circumpolar Health. Unfortunately there are no written proceedings from that conference, but it was a big step forward in terms of Aboriginal people expressing their concerns about health research. There were many discussions about how to better conduct research in First Nations communities—beyond merely not harming communities to actually benefiting them. One interesting approach presented at this conference was a model research contract for use between communities and researchers regarding the rights and responsibilities of each developed by the Dene Nation of the Northwest Territories.

The latest thing to come out of the mainstream in terms of ethical guidelines is a draft Code of Ethical Conduct for Research Involving Humans. It is put out by the Medical Research Council of Canada, the Natural Science and Engineering Research Council of Canada and the Social Science and Humanities Research Council of Canada, and includes a long section on doing research with communities.

The development of special ethical guidelines for working with communities is one way of making the process of research more respectful of individual and community rights and needs. “Participatory action research” is another approach to improving the way research is done in collaboration with communities. Participatory action research means linking the research processes of data collection and analysis with social action and social change. To create this link, participatory action research demands a high level of participation of the people most directly affected by the research—the communities and the individuals who

make up those communities. Participatory research requires community involvement not only in determining how the research is carried out, but also in the choice of the research question.

In a published report from Haida Gwaii in British Columbia (Herbert, 1996) the researcher implies that community advice and guidance concerning the research topic led her away from sensitive mental health issues such as alcoholism and sexual abuse, towards the “safer” topic of diabetes. This raises a number of questions about research in the area of mental health in Aboriginal communities. Communities may want to know a researcher very well before trusting her to undertake research on such issues. On the other hand, outside researchers may feel that by restricting research on mental illness and social problems, community leaders are trying to sweep problems under the carpet. Researchers and practitioners from outside may feel concerned that individuals in the community are suffering from what they perceive as attempts to hide problems.

Managers of health and social services in Aboriginal communities have other sets of preoccupations about research. They are concerned with how research might help improve services for mental illness and enhance health and well-being; with what topics are appropriate and useful to research as well as timely; and with what kinds of problems actually are effectively addressed through research.

Administrators may raise these concerns when researchers approach them about doing a project, or when considering how to best use the budget allocated for research. An article written a number of years ago looked at when research was appropriate for community or public health activities (Dab et al., 1994). It suggested that research was most useful in three areas: measuring the extent of health problems and understanding them better; developing models of effective programs; and evaluating programs.

Research funding bodies, while not questioning the intrinsic value of research, are increasingly preoccupied with making research useful to society. In contrast to Aboriginal communities, they are not primarily interested in the community development potential of the research process. Funding bodies want to ensure that the knowledge produced by research is used for the maximum benefit of the general population. They talk about “research dissemination,” how to best get research results out to potential users. This is important, because in the past and still, now, much of the knowledge produced by research sits on shelves in unused reports.

Professional researchers are often university-based people who have specific training and do research full-time. They may have strong ideas about which research questions are appropriate and how research should be carried out. Their choice of research question is partly based on previously produced research and on the questions posed in scientific journals by other researchers. In my opinion, their voices are essential, but should not be the only voices heard when choosing research topics and methods.

From practitioners’ points of view, what I hear from health workers in Aboriginal communities is that “we don’t need research, we need services.” They also find that research takes their time and energy away from service: “There is not enough personnel and money for services and now I have to go and spend time answering questions for a research project.” A social services worker told me that for her “research is useful if it leads to setting up a new program to meet clients’ needs.” That’s what I hear. I would like to mention two types of research which could be useful for practitioners: 1) evaluation research which shows us which aspects of our services work and which don’t, and 2) anthropological types of research can help outsiders understand what is going on in the communities.

When people tell me that we need services, not research, what I usually say is "well, we have this research money and there are researchers who want to help, so what are your biggest problems and let's see how research can help with them." When you express it this way community nurses and doctors often say: "Yes, well I do have a problem with..." or, for example "In this community people use a lot of antacids, could research help us with that?"

I want to finish by reading an excerpt from a book on the issue of different points of view on research:

"There is a difference between what practitioners want and what academics can or will provide. One part of this is choice of topic and emphasis. What a practitioner or health worker feels *useful*, an academic may not find *interesting*. Both are right in their own ways. A practitioner has a responsibility for results, [say good health as my own example], an academic for understanding. Bridging the gap, research requested by practitioners or commissioned by practitioners can exercise a healthy discipline on academics, concentrating their minds and efforts...There is a large area of overlap between the *useful* and the *interesting*." (Chambers, 1983, my emphasis)

I believe this quote points the way forward. Research in Aboriginal communities can and should be carried out on topics perceived as both useful and important by the community, and of interest to the researcher. There is potential for the process of research and the knowledge gained to contribute to empowering Aboriginal communities and to improving health and well-being.

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### Panel Discussion:

## **Research on Mental Health Issues in Aboriginal Communities: How Can it be Useful?**

Martha Flaherty

*Pauktuutit*

**Résumé:** En temps que présidente d'une organisation qui veille au bien être des femmes Inuit et de leurs enfants, l'auteure n'a pas grand intérêt pour des projets de recherche qui ne mènent pas à des changements positifs au sein des communautés. Un critère minimum pour tout projet doit être la participation active et égale des communautés observées. Les projets seraient de préférence initiés par les communautés elles-mêmes, avec quelques aides techniques venant de l'extérieur. En ce qui concerne la santé mentale des populations autochtones, il est impératif d'établir des projets culturellement appropriés afin d'établir les causes et les outils efficaces de traitement et de prévention des différents problèmes. En particulier, les problèmes de violence familiale, de suicide, d'abus d'alcool et de drogues, et des peines de prison pour agresseurs sexuels, doivent être adressés. Les solutions doivent intégrer des méthodes de guérison "traditionnelles." De plus, des efforts doivent être fournis, à tous les niveaux de gouvernement pour informer les populations des services déjà disponibles et pour établir d'autres services utiles et efficaces. Ceci inclut aussi la formation d'individus autochtones comme professionnels de la santé. Enfin, il faut étudier comment les femmes autochtones, en particulier, pourraient être mieux servies dans le domaine de la santé mentale.

I would like to begin by thanking the organizers of this conference for allowing me to share the views of Inuit women in Canada. Pauktuutit has taken a firm position on research, and I will provide you with an overview of that position. I have also been asked to talk about what research may have been done on mental health and mental illness that is useful. In addition, I will provide you with a summary of a workshop on mental health held by Pauktuutit in 1993.

I am pleased to see the increasing debate on the issue of ethical guidelines in research, and some response to our position by researchers. We still, however, have a long way to go. While not related to health care, I recently had the distressing experience of attending the Inuit Studies Conference in St. John's, Newfoundland, where organizers had included a demonstration of igloo building by a man who lives in Yellowknife, but who is originally from Lebanon. This is deeply offensive to me, to say the least.

We are beginning to redefine the relationship between researcher and researched. I will now share with you some of the comments I made at the International Workshop on Ethical Issues in Health Research among Circumpolar Indigenous Populations in Inuvik in 1995.

As the president of an organization dedicated to improving the social, economic, political and health conditions of Inuit women and their families, I am not interested in research that does not lead to positive change in our life conditions. A good example of questionable research might be spending 20 years observing Inuit to determine if we are shrinking because we ride skidoos and carry babies on our backs—as noted on the front page of the *Globe and Mail* not long ago. This apparently was a valid research topic for someone at the University of Toronto—it is not a burning issue for Inuit women.

At its simplest, the relationship between researchers and research subjects can be analyzed in terms of power dynamics. Professionals, scientists, doctors and academics have more power, authority and influence than most people living in isolated northern communities. For the most part, they can choose to listen to or ignore the views, needs, wishes and concerns of people without their level of formal education and professional status. This is as true in the relationships between researchers and research subjects as it is between doctors and patients. Yet in the health field we have learned how important it is to the health status of individuals and populations to have control over their personal, economic, social and political lives. It is logical to me, and is my position, that the goal of health research, health care policy and medical practice in the North should be the empowerment of northern individuals and peoples.

With respect to research methodologies, the goal of empowering individuals and communities is best achieved through participatory action research. As a minimum standard, researching Inuit communities must include the participation of Inuit as equals. The very fact that we need guidelines about how to involve the subjects of research suggests to me that the researched are never truly considered equals, and that the researcher always retains control.

I would like to tell you a bit about a major research project Pauktuutit did on traditional Inuit midwifery. For thousands of years, Inuit women gave birth on their own or with the assistance and support of husbands, mothers, sisters and midwives. Over the years, Inuit midwives developed a body of knowledge and a set of skills that were passed on through generations of women. This began to change during the 1950's and 60's, when Inuit families moved from their traditional camps into permanent settlements. In the settlements, births took place in homes or at the nursing station, often with a nurse-midwife and Inuit midwives in attendance. Later, the federal government decided that all births should take place in a hospital. Inuit women living in communities without hospital services were evacuated by air to a regional centre or to southern Canada.

Inuit women expressed their concern about two particular aspects of these practices surrounding childbirth. The first relates to the removal of pregnant women from their families and communities during the latter stages of pregnancy and during childbirth. The second relates to the resulting loss of Inuit midwifery.

In response to these concerns, Pauktuutit undertook a research project aimed at documenting traditional Inuit approaches to pregnancy and childbirth. Because the midwifery research was undertaken by an Inuit women's organization, we did not have to deal with the disregard outside researchers often show for our history and our traditional ways of knowing and doing. Recognition of our traditional skills, knowledge, values and approaches to life is as necessary to the research process as it is to medicine.

I would like to make another point about the midwifery research project. Our research team included two academic advisors. Their technical expertise in areas such as research design and data analysis, and their familiarity with the relevant medical and ethnographic literature was invaluable. One of the reasons this partnership worked so well was because they fully respected the limits of their advisory role. Not once did the academic or scientific dimensions of the project overshadow the Inuit perspective, and Pauktuutit's ownership and control over the project was respected and supported throughout.

Ideally, I believe that research involving Inuit should be initiated by an Inuit organization or community, and not by outside researchers or institutions. If the group so chooses, academics, scientists and others with technical expertise could then be invited to join the research team, but they must be fully respectful of the limits of their advisory role. In this



way the relationship between researchers and research subjects is redefined from the beginning, and power and control reside where they should—with those most affected by the research. I also believe that even Inuit organizations and communities must be committed to adopting participatory methodologies.

For those of you who like things substantiated by research findings, I will refer to an evaluation of the Northern Mental Health Outreach Project, a three-year demonstration project undertaken by the University of Manitoba Northern Medical Unit and the Psychiatric Nursing Department of the Winnipeg Health Sciences Centre. The evaluation was done by the Clark Institute of Psychiatry and the University of Toronto. Findings indicate that the nurses who delivered services in the communities consistently rated the project objectives of “working with Natives to develop greater awareness and competence in dealing with mental health issues,” “assisting communities to develop community mental health programs,” and “providing training and knowledge to local service providers” as the most important of the eight project objectives. These objectives are consistent with those advocated by Pauktuutit. This is also consistent with the issues, concerns and recommendations of the 1993 Pauktuutit workshop on mental health, held in Iqaluit, Nunavut. This was the first conference of its kind in Nunavut, and brought together Inuit from many organizations, from all the regions in the North, with resource people from both government and non-governmental agencies to discuss the issue of mental health in Inuit communities.

I will now review the recommendations from our workshop:

1. Programs and research should be made available to specifically address the issue of Inuit mental health. Care should be taken in the design and delivery of these programs to ensure that individual needs of Inuit communities be acknowledged and that the unique nature of each community is recognized. Consultation with Pauktuutit and Inuit community organizations should be undertaken in order to maximize the effectiveness of these programs.
2. Research efforts should be made to investigate and record traditional Inuit methods of counselling and addressing mental health problems. Elders throughout the Inuit North should be closely consulted throughout all stages of a research project.
3. Efforts are required by the federal, territorial and provincial levels of government to improve the access that counsellors in the North have to information and training concerning counselling techniques. Training workshops held in the communities would greatly assist counsellors, increasing their effectiveness while reducing stress levels.
4. A series of workshops should be held in Inuit communities to address mental health issues with the clear intention of informing the communities as to how social problems can be dealt with at the community level, and how general mental health can be improved.
5. Research is required into how the justice system in the North can be altered to better reflect the concerns Inuit have in relation to sexual offenders. These include: having sexual offenders serve longer sentences; keeping violent sexual offenders in custody pending their hearings; extending more support and sympathy to the victims.
6. An investigation should be undertaken to look at the current social service programs available throughout the Inuit North, with the intention of considering how they can be made more flexible in terms of their application. As well, the investigation should consider how programming can more readily reflect Inuit values and traditions.

7. There is a substantial need for recruiting and training of more Inuit healthcare workers. Funding and programming should be organized in the very near future in order to ensure that adequate numbers of Inuit mental health-care workers are trained and given adequate support. These should be made priorities in terms of addressing the mental health needs of Inuit communities.

8. In order to better prepare non-Inuit workers going to Inuit communities, orientation training should be made mandatory. This training should include both video and written information that clearly explains Inuit culture and values.

9. Greater efforts should be made by federal, provincial and territorial government departments to inform communities about what current social and mental health programming exists, as well as information about how to access the resources available. This information dispersal should be coordinated into the community mental health workshops, suggested in recommendation 3. As well, Pauktuutit should undertake research into available social and mental health programming across the North and disperse the final handbook with a report to communities.

10. Efforts should be undertaken to develop a good parenting skills program in the North. Included in the program should be instructions on how to deal with anger and frustration within the family milieu, and advice to victims of family violence to help them begin the healing process. Inuit culture and values should be integrated into any programs that are developed.

11. More resources should be directed to institute a comprehensive suicide prevention program for Inuit communities. In particular, Inuit should be trained as suicide prevention counsellors, resources should be assigned for the development of support programs in each Inuit community. This may entail the recruitment of elders and volunteers working in close coordination with the local suicide prevention counsellors. Efforts should be made to ensure that professional support is made more readily available to communities in crisis. Holding regular suicide prevention workshops in Inuit communities would provide the community with a formal opportunity to voice their concerns and educate both the community and relevant government agencies as to what can be done to address the issue and how to improve the effectiveness of existing programs.

The topics proposed by the participants were broad in range, and seem far removed from many scientific and academic research questions. Here are just a few that were suggested:

- social, mental and other health issues of northern communities;
- how to help victims open up;
- how to help older angry victims of sexual abuse;
- how to aid individuals with little or no respect for themselves, nor any positive beliefs about themselves;
- the spiritual knowledge of Inuit;
- what is mental health?;
- defining the healing process;
- what do Inuit want in the area of mental health?;
- how to teach things that will last a lifetime;
- what has a daily impact on our communities?;
- defining the rights of Inuit people.

Many themes arose from the discussion, including:

- there is a lack of awareness of serious social/mental health problems;
- there is a need to improve healing processes for distressed people, using methods based on traditional Inuit practices;

- we need programs and services that work to keep young people in the educational system;
- three key problem areas were identified: youth, rape and sexual abuse;
- there is much concern about the well-being and future of children who live in violent environments;
- we need to discover Inuit knowledge of counselling.

These are our priorities in the area of mental health. Most of us are not particularly concerned about addressing Seasonal Affective Disorder because we are too busy trying to keep our youth from committing suicide, and abusive men from killing their spouses.

With regard to the broader health priorities for Inuit, many of us have concerns about the apparently very high rates of cancer in our communities, particularly in the High Arctic. I do not have quantitative data, but anecdotally I personally know of three people who died of cancer in Grise Fiord over the last two years. This is in a community of approximately 100 people. I have also heard of many cases of cancer in the Western Arctic and Inuvik area. These physical illnesses and resulting deaths have a serious impact on the mental health of entire communities. We have been asking for research on the current situation and on factors such as environmental contaminants that may contribute to these very high rates, but I don't know of anything that has been done. I recall during my childhood in Grise Fiord hearing of an incident during the winter, when we lived in months of darkness, when the entire sky lit up, as if by an explosion. This incident is also talked of in Resolute Bay. Many of us believe that the Arctic has been used as a testing ground, but no one seems to want to take us seriously or investigate our concerns. Those of us who were relocated to the High Arctic were used as human flags to assert Canadian sovereignty, but now that we have served our purpose it seems that no one cares if we live or die. These issues are real, and they are of utmost concern to us. As Inuit, we do not necessarily look at particular disorders in isolation from the context of a person's life, that is their social, cultural, economic and political well-being.

There is also a need to assist Inuit women to do research that is specific to their lives as women. Canada is often seen as having the best universal health care in the world, but Inuit do not have access to the same level of service as the majority of Canadians living in the south. We are now being told we are facing a crisis in our health care system. Let's look at health care in the context of violence against women as an example of what I mean. A recent study by the Centre for Research on Violence Against Women in London, Ontario, attempted to put a dollar figure on the annual cost of violence against women in our country. Researchers arrived at a partial and conservative figure of \$4.2 billion dollars a year, looking at only four policy areas, one of which was health care. If I were in a position to determine priorities in government spending, I would allocate far more resources towards the prevention of violence against women and children, which would create great savings for the courts, prisons and in terms of medical services for victims. Family violence has devastating effects on the mental health of Inuit women and children. We must have a fundamental shift in our spending priorities in this country to reflect the needs and priorities of all citizens of Canada.

We are also seeing many cuts to extended health care services, which often means that women, who are still seen as the primary family care givers, are now responsible for caring for their aging parents as well as their children. This tremendous burden being transferred from the state to the family, and by that I mean women, can prevent women from participating in the labour force, and keep women and their families in relative poverty. This is also a major mental health issue for Inuit women.

I believe there is a legitimate role for research on mental health issues in our communities. But it must be done in a partnership of equals, and on issues that we identify as needing attention. We are beginning to identify some of the elements that are required to develop truly Inuit services, and our efforts in this area must be supported. Supporting our efforts means transferring skills and knowledge to Inuit so we can do our own research.

Further to working to address specific issues, I would say that from the perspective of Inuit women, achieving true equality, both within our society and the broader Canadian society, will do a great deal to address the many serious social and health issues we are facing. While men and women may share many of the same goals, our priorities can be quite different. For example, I believe it is essential for Inuit to have healthy individuals, families and communities as well as self-determination. We have many serious obstacles to overcome before we can achieve a decent quality of life for all Inuit. By having equal numbers of women and men in governing bodies and positions of influence and authority, issues of concern to women would be given the same priority as other governmental issues, which can only benefit everyone.

In conclusion, I would like to say that research findings can influence policy and funding priorities, but I am becoming very cynical. Some of the most extreme causes of mental health problems are the housing crisis in our communities, family violence and child sexual abuse. There has been extensive research done in these areas, but it has yet to lead to positive change. Research processes and practices can empower us to make positive changes in our lives or they can support the status quo. The many research studies undertaken over the past few decades on the health status of Inuit indicate that the status quo is unacceptable. The challenge facing all of us involved in health research, health policy and health care delivery is to work towards positively altering this status quo.

Thank you for your time.

## **Panel Discussion: Research on Mental Health Issues in Aboriginal Communities: How Can it be Useful?**

Abraham Bearskin

**Résumé:** Afin d'aider le processus de guérison, les priorités de recherche doivent provenir des communautés elles-mêmes. Ce sont elles qui savent quels sont les problèmes et comment les adresser en des termes compréhensibles par la population. Pour les autochtones, la santé mentale comprend l'esprit et le corps. Il faut guérir les deux en redécouvrant notre passé et notre esprit d'initiative. Ce sont les changements aux structures politiques et à l'habitat naturel qui sont responsables des problèmes à l'intérieur des communautés autochtones, des problèmes de santé mentale de certains individus. On ne peut pas opérer de tels changements, oublier son passé, sans causer de dommage. Dans ce contexte, la recherche peut à la fois détruire et guérir.

I have no notes. It is the elders that teach me. What I say might offend some people but if I'm going to share I will share the truth. This is very different from when I went to residential school or college. Then, I used to have a lot of notes when I did a presentation. I want to change that and there is a reason why.

We talk about mental health research, and one of the things I have learned is that when you do research, research can hurt you. There is always an aftermath. It can damage an individual, it can damage a community, it can damage a nation.

The speakers before me touched on some of the issues relating to research, and spoke about grief, unresolved grief. The term I usually use is "historic grief." When we fool around with deep wounds without knowing exactly what we are doing, there has to be pain. You touch the body, the mind, the spirit of an individual, a group of people, a community, a nation. And right there, there is confusion.

We have to be careful. It is important to know what we are doing. We have a dilemma: we get political, we get angry, we fight. And that is like a cancer. It reaches individuals and communities. We struggle, we fight. Some of us are caregivers, some are administrators. I work for the Cree Health Board and I see how one team goes one way, another goes another way. These are our own people doing that.

We have a mental health section in our organization. They have been doing research. There is a section in Montreal headed by people that do research. Who determines the research? For me, if you are going to do research, it has to come from the grassroots level. We have to take the lead, but we are so overwhelmed that we have been using someone else's system. History has proven that this does not work. It is good to read history, it teaches us.

What is the mission of the Cree Health Board? In very general terms, it is to provide health and social services. But its mission has yet to be clearly and specifically defined, and this is the key to anything we do. People come up with terms. Somebody came up with the term '*mee-opimet-shewin*.' What is that? If you translate it, it means "to retain good health." But what is that to you? As a Native person, speaking to you in English, my way of thinking cannot be White. What I mean by the above term changes. Every time someone puts it into words it changes. They read it differently and understand it differently.

What is mental health? Again, my understanding might be very different than yours as a doctor, a professional, an anthropologist or psychiatrist. For me, the concept can be summarized in one word: nourishment. Do you know where I am from? I am from Chisasibi, in the James Bay area. When I look at the region, the nine communities, the Bay, it is like a dish: everything I need is there. There is food there, and water and medicine. But I have ignored this and taken somebody else's medicine. This is not to discredit that medicine, as I acknowledge its usefulness.

Something is happening out there, you don't have to do research to know that. There are illnesses that have reached the North. Once you fool around with some things, those things come back to affect you. Hydro development affected the environment, the social relations between individuals, communities. Yet at the same time that this development was occurring environmental assessments and research were taking place. Once you create something, then you have to do research on it: the plants, the human ones, the swimmers, the ones that fly, the ones on four legs, all are affected. One creation, one creator. So, we struggle, living beside one another and acknowledging one another.

I believe that if we are going to do an assessment, or research on identified priorities, then these priorities have to come from the communities. This has not happened yet so we continue to struggle and take the system that is foreign—we don't use what we have. No wonder we are struggling. We should take only what we need from the outside.

For example, we talk about the depletion of the ozone layer. This affects Native people; the melting of the icebergs up north affects everything around us. It is not right. Our elders have known this for a long time. But if we bring an elder in and a professional in to solve a problem, we are going to listen to the expert and ignore the elder who might have given us direction.

Our minds have oriented in such a way that we insist on working with things that we have adapted, that are not ours, and so we work against ourselves. The blame starts and we fight amongst ourselves, blame the people that work for us—for example, in the Cree Health Board, where there is no set, clear direction. If we could only come to one then we could go forward. And in some ways we do. I have read a lot of articles dealing with sexual abuse, rape, and incest. If you read up and you really want to do something about the issues, then you have to just go ahead and do it. Individually, you go for it. Collectively, you have to go through policies and procedures. But who established these? In the Cree Health Board we still answer to Quebec because it is the province that provides the funds and makes the laws that govern our organization. Somehow, we have to work with this. But in our hearts, we know that we have our own way of doing things. We struggle with this knowledge and it affects us.

Individually, when you want to do something about an issue that is a priority to you, you just do it. But the doers are often shut out from the system *because* they are bringing the truth. People get paranoid, the administrators get paranoid, key people who are supposed to be professionals get paranoid. So, if you are going to deal with something, you deal with it individually. Maybe there are others like you in the community. When those people come together, they've done something. This I see in the Health Board where there are people who have dealt with very sensitive things. They are in Social Work and their concept is different from the official policies and the social work Code of Ethics. They work with their own ideas to bring their own Native way of doing things. They bring in spirituality. When they do counselling, they do it in a circle. I have witnessed the dismissal of a social worker from the Cree Health Board because she worked in a way that she believed was more comfortable for her clients.

In my mind, that is sickness. That is disease. How do we get rid of it? That is what we are looking for. Someone spoke about healing and many terms were thrown around: “political healing,” “social healing.” Healing is simply when you do something about your issues and problems. The awareness has to be there, of course, awareness and education. Healing comes after.

When I look at research I ask, “Why is research being done?” There are needs and there are reasons, but there has to be more than that. Research has to lead to action, but often there is none. People invoke lack of funding. Yes, there is lack of funding, but why can’t Native people use something that was there before?

When I dealt with my own sexual abuse, I did not go to the social worker to get assessed. I knew there were procedures I would have to follow and I decided to ignore them, to go against them. I just left, took myself where I wanted to go and did something. Do you know what happened to me? I got demoted. Our own people did this because they were afraid.

That is what I mean when I say that research can hurt people. It has hurt Native people and other ethnic groups. At the same time though, and this may sound contradictory unless you listen well, I think research *can* help to find ways to heal. In the past, we worked with the mind. When you work only with the mind there is a lot of confusion. Mental health involves the whole being: the mind, the body, the spirit, the feelings. You cannot separate them. If you are really going to treat someone, you don’t just treat the mind or the body, or the spirit, you treat the three together as one.

I want to caution people that do research: be careful. I will not accept your agenda. We have to have our own agendas and follow them. I have my own agenda and that is what I must go by. I will not compromise that.

**Panel Discussion:  
Research on Mental Health Issues in Aboriginal Communities:  
How Can it be Useful?**

Adrian Tanner

*Memorial University*

**Résumé:** Beaucoup des participants à cette conférence se sont plaints d'être "étudiés à mort" par les chercheurs. Mais il ne faut pas oublier que ceci n'est pas seulement le cas des populations autochtones. En effet, dans nos sociétés de consommation, nos habitudes à tous sont observées. Bien que tous les chercheurs n'ont pas tous des motifs purs, et ne sont certes pas tout sensibles aux problèmes posés par leur présence, ceci n'est pas une raison suffisante pour bannir toute recherche. La recherche peut évidemment servir à des fins directement utiles, par exemple lorsqu'il s'agit de juger de l'efficacité de certains programmes. Mais on ne doit pas juger un projet de recherche seulement d'après le critère d'utilité immédiate. Toute recherche à des débouchés qui ne sont pas prévisibles. En ce qui concerne les populations autochtones, l'auteur pense que la recherche faite dans le passé a servi à éliminer quelques uns des mythes à leur sujet, dans les yeux des autres populations. Il s'agit de faire en sorte que les résultats des projets soient communiqués aux sujets de la recherche, et d'encourager une collaboration entre chercheurs non-autochtones et autochtones afin d'obtenir des points de vue différents et complémentaires.

When I accepted this invitation to be on a workshop panel, I expected something relaxed, perhaps a small group sitting in a circle. I didn't expect to find myself standing at a podium. Particularly since I am the person who seems to be expected to defend the apparently unpopular proposition that research is worthwhile.

As others at this conference have done, and with the same reluctance as Elizabeth (Robinson)—given our shared cultural background—I will first give a bit of an autobiographical introduction, as a way of explaining how I look at things.

In 1957, I lived for 15 months in Inukjuak, an Inuit village on the east coast of Hudson Bay, as a "useful" researcher: I was sending up weather balloons to help with meteorological forecasting. The first point I want to make is that this research had other consequences than those specified in any research plan or included in any research report. For me, the research I was doing on the upper atmosphere had the ancillary result that my whole notion of Aboriginal peoples was slowly and totally transformed. When not working I spent as much time as I could with Inuit hunters, learning the language, going with them to the floe edge, sleeping in igloos.

Perhaps one consequence of this experience, when I became a university student later in life and eventually specialized in anthropology is that one of my continuing interests has been the rehabilitation of the conceptions non-Aboriginal people have about hunters. Hunting was previously thought by anthropologists to be a somewhat primitive way of life. A new way of looking at hunters has now generally percolated throughout the entire anthropological community. I'm not sure it has gotten any further than this to the rest of the non-Aboriginal population: certainly, there are many non-Native people who still think of hunting as primitive.



The other thing that I became aware of while doing meteorological research in the north was that relocations from Inukjuak to Resolute Bay and Grise Fiord had just taken place, two years previous to the time I was there. The two RCMP officers who had been in control of the relocation operations had, coincidentally, returned to Inukjuak when I was there, so I learned what their perspective on this event was. As far as I know, neither of these men testified at the recent inquiries held into these relocations. One of them, Corporal Gibson, was by that time fairly sick. However, I did see letters he wrote to the newspapers defending his actions, but he is dead now.

Around the same time as this relocation, other Inuit were dying of starvation west of Hudson Bay. My awareness of the background to these two tragic events eventually led me to the view that both resulted from the kind of control exercised over the Inuit by a colonial system. Unlike Indians, the Inuit were being described at the time as having full Canadian citizenship, full citizen's rights. The Canadian government made this claim with a great deal of pride. But at the local community level there was an enormous degree of direct authoritarian control exercised over the lives of the Inuit. The prevailing attitude was "Father knows best" or "White Man knows best," even to the extent of putting Inuit lives at risk through these policies. I am sure my experience of this situation influenced my later research work.

Turning to the topic of research more directly, I am really very doubtful about the whole proposition of "research as useful," or as "necessary." I think the actual title of this panel is itself quite worthwhile; it asks: "how can research be *made* useful?" This suggests that research itself is not inherently useful, but that the outcome of research can be turned to useful purposes, after the fact.

This idea that research is not automatically useful certainly doesn't apply to all of it: some research is done to evaluate ongoing useful projects to see how effective they are. So there are certainly, in the social sciences, forms of research that are directly intended to be useful. But research, in the broader sense of inquiring into the causes of things, looking at the implications and the results of things, for this kind of real, open research we have to set aside any initial expectations of usefulness, and simply try to open up the inquiry. Finding the usefulness only comes later.

This notion of research without any prior established useful purpose is being challenged here at this conference by statements such as "We don't need research, we know what the problems are. We need action." That may well be true in some cases. I would suggest, though, that we need to look at the success rates of those programs that are under way; maybe we don't know everything we need to about these programs. However, I am not familiar with treatment programs in urban situations. My own research is not done under those conditions, so I do not feel like defending too closely the proposition that we, in fact, do need more research in these areas of treatment. But I will leave that thought with you.

"We are being researched to death" is another statement I hear. I certainly agree with the perception that Aboriginal communities, particularly isolated ones, are being targeted for research, and often feel themselves under the eye of the researcher. But I would remind you that we are all, in this society, being researched to death: we are being researched by marketers, and we are being researched by opinion-pollsters. But in the south it is not as intrusive as in the north. It is actually becoming more and more subtle—a profile of the consumer habits of anyone with a credit card can be quickly made without them even knowing it. Similarly, information about credit history is readily available, although we are generally unaware of it. So one problem for social science research in northern communities is that, first of all, the researcher is very obvious. Sociologists who work in urban environments and do statistical surveys with questionnaires are far more

anonymous—respondents just think of themselves as individuals answering questionnaires, not as samples representing whole groups. Whereas in a Native community when an outside researcher comes in everyone knows who this person is. So I think there might be somewhat of a perception by Aboriginal communities that “we are being researched to death,” whereas this is actually something that we are all burdened with in modern western society

What can be done about being “researched to death?” And, what can be done about “useless” research? I am not trying to deny that some researchers may not have the best of motives, or do not conduct their research in ways fully sensitive to the people it ultimately impacts and who, in fact, contribute their time. Indeed, communities make a considerable contribution to research for which they never get paid: hosting researchers, explaining things to them, helping them... This creates a real obligation for researchers. Most anthropologists that I am aware of acknowledge the debt that they owe the community for putting up with them. Each finds his or her own way of repaying this debt.

Not all research has immediate, obvious use. Later, I will give some examples of how apparently useless research does end up in having some useful outcomes. But at the beginning we cannot judge a piece of research, or a proposal that research be undertaken, purely on the basis of whether it can be shown to have any direct results in terms of usefulness. Of course, in this conference we are dealing with a special case, issues of social breakdown, of social problems, abuse, self-abuse, a whole topic focused on human misery, and this situation is one that cries out for a solution.

I want to say here that there are now mechanisms in place, and others under way, to address the suggestion that research should be more controlled by the local community. Elizabeth (Robinson) has mentioned some of them, to do with the ethical principles used in research. Here I am talking specifically about the conduct of university-based researchers. For these people to do research means, in most cases, obtaining research money from outside funding agencies which is administered by the university. In such cases researchers must undertake to follow certain procedures. Today these procedures are becoming more and more specific, with regard to how a researcher plans to fulfill the formal ethical requirements of the university and the funding agency. They include, for example, ensuring informed consent is given to participants, ensuring the involvement of the community in the planning, and ensuring participants can remain anonymous if they wish. All of these are difficult issues, they are not simple issues, and they are being taken seriously.

Another issue sometimes raised about research is “research just results in reports that gather dust. Nobody reads them.” That is sometimes true but, again, research funding agencies are now responding by requiring that a percentage of the research money must be spent on the communication of results to the communities, to the public, and to other researchers. Sometimes researchers used to feel at the end of the work that, as long as a report is sent to someone, they can just move on to the next project. But today researchers are being required to include a portion of their time and budgets on feedback, to spend a certain amount of money on getting results out to the right people. Some researchers are better at doing this than others. Certainly, participatory research, a topic we have heard about at this conference, meaning research undertaken with the full involvement of the community, requires this kind of feedback. The requirement is usually included as a formal agreement, and not only obligates outside researchers, but inside researchers—the community members involved—as well, to ensure the rest of the community is involved. This community feedback can be done in a variety of ways, including video. Sometimes written reports are not very appropriate.

An earlier point I was making was that research has many different kinds of results. Researchers take away with them all the experiences they have had, and these experiences

go well beyond the topics they planned to research. Afterwards, they talk to others about these experiences. In this way they help to change general perceptions people outside the community have about a place, or about the particular issues it faces. It seems to me that enormous changes have taken place over the past few years in the way Canadian society looks at Aboriginal communities. Part of this change is the unconscious process of breaking down the myths that we held twenty, thirty, forty years ago about Aboriginal communities and, whether we are fully successful or not, of trying to rehabilitate or change governments' ideas about Native communities, and in this way change policies and policy direction. Outside researchers have contributed in a major way to this process.

Returning to my autobiographical theme, after I left Inukjuak I went to university and coincidentally met an anthropology student who had been doing research in Inukjuak while I had been there. Gradually, I discussed and thought more deeply about my experiences. University was a very mind-opening experience for me. It was only in my last year that I turned to anthropology and went to the Yukon Territories to do my first anthropological research. After that I ended up in a PhD program at McGill, and worked on something called the McGill Cree Project.

One of the issues you face in research is the realization that there are myriad ways of framing a question. Reality does not present itself just in one single way. But perhaps because the human mind is limited in the way it can perceive reality, it seems we have to frame reality in one specific way, and in so doing we have to set aside other possible ways of looking at the same issue. The notion that "we already know what the problem is and how to deal with it" suggests that a frame for looking at the problem is already there. I am suggesting that any particular frame is only adequate for its own purposes, and within its own terms of reference. But there are always other frames, other possible ways of looking at reality.

The 1965-69 McGill Cree Project's way of looking at the Cree, before the announcement of the James Bay Hydro Development, was that the Cree were undergoing acculturation. The project's research frame was that the Cree, having recently been drawn into living in village settlements, for purposes of schooling, material benefits and services like health and welfare from the state, were acquiring a desire for money, and regular wage employment. This was seen as an inevitable acculturation trend, a move away from a traditional bush-oriented hunting society, towards a way of life similar to other European-Canadians in the same region, based on logging, mining, line cutting, and other occupations that were predominant and moving into that area.

In the 1967 research I conducted for the McGill Cree team, however, I concluded that although these were indeed the facts, this way of framing these facts was not very useful. Instead, I saw the Cree as neither wanting to continue the traditional hunting-gathering way, nor wanting to become like the local white workers. Perhaps they themselves were not altogether sure where they wanted to go, but they did seem to want their own third option, and they were in the process of building towards something new. I therefore designed a doctoral research proposal around this frame, research without any useful purpose whatsoever. By contrast, I think the McGill Cree Project was to trying to be useful, by assisting in what they assumed, based on their way of framing the question, was an ongoing assimilation process.

What about the usefulness, or lack of it, which came from the McGill Cree project research? One subject we neither looked at, nor tried to be useful about, was alcohol abuse. As researchers, we knew about the enormous degree of drinking going on at certain times, as well as long periods of no drinking while people were in the bush. The word 'alcoholism' did not seem appropriate for this, because there did not seem to be any kind of dependency,

even though drinking was widespread, disruptive and followed a definite pattern. In other parts of the north anthropologists were also observing this same pattern, but at the time very few of them wrote about it. One reason was that we felt that the pattern was not endangering to the Cree, but was simply a different way of consuming alcohol than the one we ourselves used. The principle of 'cultural relativism' was held at the time by anthropologists, asserting that whatever a cultural group does should be valued. That, perhaps, may have been a mistake.

One thing we did look at was the educational system, and particularly at the residential schools. In my view one of the main causes of the illness we are discussing in this conference was the imposition on groups like the Cree of a foreign educational system, particularly the secondary and tertiary implications of suddenly forcing parents to put their children through school without making adequate provisions for the devastating social results that followed. This policy decision was made entirely by non-Natives. The McGill Cree research definitely contributed to the abandonment of the LaTuque residential school for the Cree, and its replacement by local village schools and family-style residences, where the children of people who went in the bush could stay. This idea was based on the understanding that the Cree had a continuing hunting and gathering way of life, one that needed to be accommodated within the emerging industrialization. The understanding came out of our research, even if it was not what we were looking for. Whether our criticism of educational policies had any useful results is hard to say, but it probably did contribute to preparing the way for the kind of changes to Cree education contained in the James Bay Agreement.

I will wind up my remarks now. I could give you many other examples of research in which I have been involved and which I think succeeded in enlightening outside people, even if that was not its main purpose. Changing how a whole people look at reality is a long process. In my view it is very useful to have non-Native Canadians doing research and thereby becoming more aware of the situation in Aboriginal communities. It takes time to take the scales off people's eyes and to get them to become enlightened into another way of seeing reality. To accomplish this researchers must continue to be allowed into communities. Hopefully they will learn how to not be too disruptive, and they should not be expected do anything for a year or so, until they have actually learned something.

Some people might respond to this: why not let local Native people do this research? And in fact there are a number of projects to train local Aboriginal people to do research. I personally favour the participatory research approach, using a combination of an outside and an inside viewpoint. Insiders feel the pain, anger and frustration of the situation, but they are not always in the best position to design programs to change things, nor to influence governments to change policies. We also need the input of people from the outside who have a comparative knowledge from other parts of the world, and who have ideas about what is likely to work and what will not. We need to combine the outside research viewpoint with the absolutely essential perspective of the people who are inside the system they are trying to change.

Thank you.

## **Panel Discussion: Research on Mental Health Issues in Aboriginal Communities: How Can it be Useful?**

Dianne Reid

**Résumé:** Ayant travaillé pendant plusieurs années pour le Grand Conseil des Cris, l'auteure identifie plusieurs mesures nécessaires à la recherche au sein des communautés Cris, dans le futur. Tout d'abord, il faut entreprendre des recherches qui bénéficient les populations. Il faut que la recherche soit faite de façon collaborative et égalitaire. Pour cela, la souveraineté des peuples autochtones doit être reconnue. Plusieurs projets utiles pourraient être entrepris. Parmi ceux-ci l'auteure identifie en particulier la nécessité d'une véritable recherche sur les besoins des familles dont un membre souffre d'une maladie mentale. Quelle aide reçoivent-elles? Comment font-elles face? Les aides sont-elles efficaces? L'auteure espère également voir une convergence des idées traditionnelles autochtones, en particulier le respect des aînés, avec une approche de recherche plus moderne.

Back in 1985 I worked as a communications officer for the Grand Council of the Cree. At the time I was responsible for writing communiqués, organizing press conferences, and preparing briefs, documents, and submissions to parliamentary committees and other organizations on the Council's position on any issues of concern to the Cree. It was a very stressful period; we had deadlines to meet, and we were often in the political spotlight and in the media, promoting and defending Cree positions. For five years I often worked 70 to 90 hours per week, and it feels like I actually worked there for fifteen years.

It was during that time that I developed an aversion to writing speeches, and I have chosen to go the route of our culture: sharing with others through oral history; speaking from the heart, and connecting to the spirit of our culture and our elders' teachings.

I think we are here today to look at how we can arrive at a convergence of thinking and to consider both biomedical and traditional approaches to mental health care. Eventually, on the way to understanding, we may create that convergence. That is what I hope to see beginning over this week-end, and I think this is a constructive way of approaching these discussions, in terms of some action resulting from this conference.

I would like to give you an overview of what is happening in the Cree world. I have heard many things about research, both pro and con, and this can also be an avenue of convergence: to say what we need to say.

In the Cree Health Board over the last few years, there have been discussions about research and ethical guidelines for research. In 1995, at the General Assembly of the Cree Nation, a resolution was passed regarding research and the need to have more sensitive research and more cultural understanding on the part of researchers coming into Cree communities. Most of the documents that resulted are still internal working documents and can't be circulated at this point. The Cree Health Board also developed a document called "Ethical Guidelines for Conducting Research in Eeyou Istchee." The Grand Council Cree Regional Authority subsequently developed a document to look at guidelines for scientific research. Eventually, I hope to see a convergence of these two guidelines, since they are coming out of two different Cree entities. However, for the moment they at least constitute a starting point to provide a framework on behalf of the whole Cree Nation, or Cree communities, for research.

Following up on what Martha (Flaherty) and Adrian (Tanner) said, if we look back at the history of First Nations peoples regarding research and studies, we have been accommodating, very accommodating. And we have overextended ourselves in many ways, without any guidelines, because of who we are. Now, the time has come for us to look at a different approach and for the people to set the terms of the research. What is happening, I think, is that we are starting to realize there is a fine line between research and research generated projects, and the appropriation of cultural traditions, knowledge, information and teachings. After decades of being examined and analyzed without much protest or input, we are pulling back and are doing something to address this. Let us set the guidelines for ourselves as a Nation.

What is happening in the realm of academic research? Who controls the information? In many cases it is the individual researcher and/or research organization. The Cree Health Board document I mentioned earlier is part of an effort to develop collaborative approaches to research. One of the interesting principles that came out of this document is the primary principle of sovereignty. It defines the recognition of Eeyou as a collective people who possess political sovereignty within the territory of James Bay. I'm sure the Quebec government would love to hear that! That is a principle defined within the document by the Cree Health Board, but there is still the connection to be made with the larger political entity. Two years ago the Assembly of the People passed a resolution to create a political declaration regarding ethical guidelines. That is a process that has yet to begin. This document is still in a consultative phase with the communities. The resolution was sent to the communities last Spring for feedback from various entities, including the Band Councils. The document on scientific research by the Grand Council/Cree Regional Authority has not even gotten to the Council Board level, it is still being drafted by a consultant.

You might wonder why I always go up against consultants and lawyers. They try to determine our destiny and the approach to take when relating to our people. They love me sometimes because I am very blunt when I speak to them—they have to be careful! Many times I tell them: "I don't say this to you to win a popularity contest, I say it because it is what I hear from the people. It is what I hear from the women, from the youth, from the elders and local leadership." That is the hardest part—promoting that perspective, because we have accepted and adapted for so long external solutions for our communities. Now we are trying to look inward—that is what is happening at the grassroots. People have gone to conferences to gather information and bring it back to their communities, but it is not being disseminated; it remains with the individual conference goers. I hope that somehow we can create a process for communicating ideas and information and research.

There is a lot of work to be done to develop ethical guidelines incorporating the grassroots perspective. The Cree Health Board, the Cree Regional Authority and the Grand Council can be thanked for starting the process. But the importance of hearing the people who are affected by what we do is enormous. We have no choice but to include their perspective.

I hope that we do see the day when any research done on First Nations people is retained and controlled by them. It is their culture, their approach, their issues that we are dealing with. I know it is going to be a long road, a struggle, but we cannot overlook the work that universities, independent studies, and researchers have done for the development of programs within the communities. The only way to get a program from the government is by doing a big thick research project. I wonder how long it will take for the recommendations of the Royal Commission to be implemented. We require resources, and we therefore sometimes have no choice but to accept these conditions. But on what terms?

The attitude that we are “being researched to death,” is a very common one. Even the elders say this when I work with them. They have had anthropologists and many experts come from the outside to talk to them about culturally appropriate ways of doing things. Once you’ve exhausted the accommodation and over-extension of a people, it is time to listen to them, and recognize that research affects individuals and communities and must ultimately benefit them.

There is a need for a total reversal, a shift, in the whole research approach. What are some of the real research needs in the communities regarding mental health? There are a few. In the Cree communities we see people walking around who are either manic-depressive or schizophrenic, who are feared and shunned by the community, and further isolated. Families are unable to deal with this because of a lack of understanding of these illnesses, choosing not to do anything at all, further alienating and isolating these individuals. There is a great need to look at what type of support is required. At this point, these people have medical attention. They go and see doctors in the communities; they come down to Montreal and see psychiatrists and psychologists, spend a brief time in therapy at the Allan Memorial Institute, or a longer time at the Douglas Hospital. Then, they are sent back to their communities. Sometimes they are in the same state as when they left. Looking at issues of support should be one of the priorities of any research, especially for the Native Mental Health Research Team. There are mentally ill people who call my home from their communities. Sometimes their sense of loneliness and isolation is so great that they call me fifteen times in one day. This affects my family, since it is my children who answer the phone, and they don’t understand why this is happening. I just ask my children to be patient with these people. These are people who critically need support. When I speak to their families, some are ready to provide support to their ill relatives, some are not. If we start with the ones that are ready, maybe we can help overcome the fear that causes mentally ill individuals to be shunned. Perhaps this is one way to begin to help. We talk about Native Mental Health and we put people in categories, defining them as mentally ill, but all the social issues are linked with their mental health problems. Our priority should be to address this, not to focus on those of us working in the field.

I hope to eventually see research done in the North in which there is convergence between biomedical and traditional approaches. There are people who have the ability to do this. I see some of them in this room, and there are elders. The James Bay Cree Cultural Education Centre has been working towards setting up the Council of Elders for the Cree Nation for two years. We had a particular request brought to the elders: a proposal for funding for research which included looking at the sweat lodges. We were going to talk about it with the executive, but the elders said they wanted to talk about it. They gave me a very clear perspective on how they feel about people coming in to research traditional spirituality and traditional teachings.

The document was in English, so we translated it into Cree to explain the proposal to them. Two elders, the most respected elders of the Cree Nation, sat then. You could tell they were reflecting on this document. Then one of them said: “It is hard to accept something like this. Within our traditional concepts we do not pay someone to learn about the sweat lodges. It is something that this person has to experience. That is how they learn. We cannot pay people to come in and appropriate the traditional teachings and retain control of the things that they take out of our communities. We cannot fund this proposal because this person has to take that first step without pay, to learn about the sweat lodge, they have to go in there and connect and heal.”

That was a very rude awakening for us as administrators because this is a whole different approach. The more this Council of Elders is active, the more they will make these very direct decisions on many of the research proposals. That is tomorrow’s reality.

This is what I wanted to share with you. Thank you. Somewhere along the way I am sure you will see the documents I have been talking about and maybe give your input. I would appreciate input from anyone.

ER: Thank you very much Dianne. It has really been a privilege for me to sit and listen to all the speakers this morning. I learned a lot. Thank you all for coming. Now it is your chance to speak. It is 12:00 and we are supposed to finish at 12:00 but I would suggest that we have a discussion of about 20 minutes if people want to, and then Dr. Kirmayer will wrap up and we'll ask Mr. Curotte to say his prayer. Is that OK? So the floor is open. Could the people that were speaking this morning come and sit up here? Archie I saw your hand go up first.

AC: Thank you. I have two points after listening to the speakers. I was reminded of when I went to Chisasibi and one of the elders told me: "Our community was moved towards a swamp area. So a lot of people got sick when they moved." It made me think that this elder has knowledge that goes back thousands of years not 50 years as we have. These elders have been able to live on this land of which they are sovereign for all this time. Nobody listened to them when they moved the community, so all these people got sick because of the swamps. The elder also said that he watched the movie *Job's Garden*, which was on the flooding of the land in Chisasibi. He said, "I look at how those elders talked on the film and they all died of a broken heart. The hunting and fishing on that land was only a small part of their jurisdiction. Their jurisdiction was all the land." That is how he framed it when he talked about Aboriginal rights. That came to my mind as we were talking about the knowledge of elders, and I wanted to share that with you. We must listen to our elders because everything they had said would happen has happened. My grandfather told people of Chisasibi 40 years ago what was going to come to the land of Chisasibi. Many of them knew what was coming. So I think there has to be a deep discussion among experts about the validity of traditional teachings, and the truth which these elders speak. When they speak, it does happen. That's all.

LG-C: What I heard this morning made me reflect on a lot of my concerns. What I heard from most of the speakers is that we are researched to death. I don't want to overshadow that we have been researched to death, but my frustration is because of a lack of services. I understand the importance of links and the importance of research to obtain a program. But I really hope that the fact that research has to be defended doesn't overshadow the fact that we are still dealing with a lack of services. I would also like to point out that the Mental Health Research Team, as far as has been presented in this workshop, has been the Native Friendship Centre. When we talk about communities, I think we have to seriously look at the urban community. It is not just the Friendship Centre. Like I said, the Friendship Centre is my home base but there are other Native organizations in the Montreal urban community. There is Waseskun House, the Women's shelter, Aboriginal Women, Baffin House—there is a community there and I would like other people to acknowledge that, it doesn't just consist of the Native Friendship Centre. As part of that research, the rest of the community should be in there.

Q: *I was looking at your chart this morning while you were giving your presentation on research, where you had community and health workers and administrators and universities and sources of funding. That is the way it should be now, the way you drew it. But the way it has been directed is by universities. Somebody in Anthropology or Social Work is working in a particular field with a professor and they decide what the questions are and then go and find answers. They should first go and ask the community. They tend to find the funding then go to the community, or to the health administrators, then go to the community and do the research. The way you drew it today is the way research should be conducted. The research that Michael and I and the rest of our research team*



*are going to be doing came out of the Canadian Association of Suicide Prevention Conference in 1994. The research that we are going to be conducting on suicide prevention and risks in the Baffin was requested by the community. It came from the people. The steering committee came from the community. Then we went and looked for funding and it has taken us about a year. But that is how I think research should be done. It should come from within the community saying "we're having a problem in this area, or we're not clear on this area..." We as a people have to go to the professionals and say "help us" instead of having the professionals come to us and tell us what they are going to do.*

AT: Maybe it is not working well, but what you are describing is already a requirement. Most social science research in universities is funded by SSHRC, or Indian Affairs via SSHRC. The ethical requirements are that there is a committee in the university that oversees these things, which requires that there has been prior consultation with the community, that the community is aware of the plans to do the research, and then, before the first cheque arrives, there has to be documentation, that is our correspondence with the community saying that this research is understood and approved. That has been a requirement for about ten years. It may not always work. It differs from community to community to what extent the Band Council or others take this whole thing seriously and consults with the rest of the community. It is a burden on the community, I admit, to have to do this. More and more what is happening is that researchers are making sure that they informally work in a team approach, where they know that what they are working on is something the community wants. I have been involved in several situations like this, where before we even think about starting research we look to the community for approval. Partly it is in our own self interest since it takes about a year of quite intensive research to get a major grant through and we don't want to then find that it has been turned down by the community. SSHRC will not hand over the funds. So, we are moving in that direction. I fully agree with the intent of what you are saying.

ER: Thank you. Unfortunately, sometimes research slips through and things get published. We even had an example which we discussed with our team where something got published and nobody even knew that the research was going on. So, there are still loopholes. Progress is being made. Mr. Curotte?

MC: I'll make it short. What we hear all sounds very good. But we always go and depend on the government because that is where the money comes from. If we had all the money we would do a lot more than what the government has done for us. The research that is going on, how much money do they get. They haven't got enough to go around and see the people, to talk to them, to talk to the elders and to the children. They haven't got the time or the money for that.

I heard it said that the Cree and the Inuit are strong. Sure they are. But the government is stronger because it's got the army and soldiers and lawyers on side. Not on your side, not on the White people's side. On the government's side. And what he (the government) wants he is going to get. An Indian goes to court, he's already lost before he gets there, he's already in jail. The same thing happens to someone else and they let him go. At home, my friend got shot. The shooter claimed it was self-defense. My friend only had a stick and the two guys had guns. They killed him. It makes you mad.

When I was young we were a family, the whole town was one family. If anyone got sick, people from the other end of town would come and help him or her get better. We didn't have any doctors then, but we had plenty of medicine from our mothers. At that time you got a lot of help from old people, young people, even children. I learn a lot from children, they tell you more than grown-ups. I haven't got any education. I only went to school for three years and I learned how to speak English about ten years ago. Before that I was afraid

to talk even to those that were close to me because I was afraid of making mistakes. Today I can talk to thousands of people because I feel that the Creator put me here to pass on what I learn during my time on earth, pass it on to other people. I do counselling for people. Some of them are older than me, some of them younger. I don't look at books and read out of them to people. I don't know how to read, I can say long words but I don't know what they mean. But people understand. In the meantime I go to different places to talk to people, I talk and people tell me the things I am supposed to do. If I did more I wouldn't be here today because there are so many things that need to be done. There are so many things that people are afraid of. That is the thing, people in the communities are afraid to speak out because they are afraid that someone is going to hurt them. In my time, everyone spoke out. I can talk about many things but I don't think you want to listen to me talking all day. I know that there are a lot of things to be done. I like what people said. I like the what everyone said, what came out of this. You are never too old to learn, I don't care if you are 100, there is always something else to learn. Today, I learned many things I didn't know before. Now I can go out and talk to people and tell them what was said here. We have to get together, no matter what nation we are from. Families are broken up, they are not together. Before the priest controlled the town. Whatever he said, everyone obeyed. Finally in 1969, people thought about why they should listen to him. So everyone broke up and spoke out and people stopped going to church and started saying they were going to talk to the elders. We had lots of elders then. Today they are all gone. I am the elder now. I don't know if people listen but we still talk.

*Q: My English is not very good. I think that research in mental health should go a bit further. There have been lots of researchers in our community and because we have not seen the results of that research, you are hearing that we have been researched to death. But most research was not on mental health issues. Today, most of the population does not understand what healing is. Mental health has to be researched more.*

## Conference Schedule

Friday, September 26th, 1997

8:00 - 9:00 Registration

9:00 - 9:30 Prayer: John Curotte

Welcome: Laurence Kirmayer, Caroline Oblin, Bevan Skerratt

### **Mental Health Promotion in Native Communities** Chairperson: Laurence Kirmayer

9:30 - 10:00 *An Overview of Mental Health Challenges and Programs in Quebec Aboriginal Communities* - Caroline Oblin

10:00 - 10:30 *Research and Clinical Perspectives on Mental Health in Native Communities* - Laurence Kirmayer

10:30 - 11:00 Coffee Break

11:00 - 12:30 *Panel Discussion: Mental Health Promotion in Native Communities* - Elisapie Tookalak, Laverne Gervais-Contois & Caroline Oblin

12:30 - 1:30 Lunch

### **Child and Family Welfare in Aboriginal Communities** Chairperson: Liesel Urtnowski

1:30 - 2:15 *Family Group Decision Making for Preventing Abuse of Children and Women* - Joan Pennell

2:15 - 3:00 *Surviving the Abuse in Cree Society* - Marilyn Bearskin

3:00 - 3:30 Coffee Break

3:30 - 5:00 Workshops

1. *Grief in the Inuit: A Social Worker's Response* - Katie Moores
2. *Inuit Perspectives and Theories of Mental Illness* - Roda Grey
3. *The Native Women's Shelter of Montreal* - Anita Pratt
4. *Family Group Decision Making* - Joan Pennell

Evening Event

6:30 - 10:30 Healing Circle - Delbert Sampson (at ICFP)

Saturday, September 27th, 1997

**Alcohol and Substance Abuse Treatment and Prevention in Native Communities**  
**Chairperson: Kathryn Gill**

- 9:00 - 9:30** Overview of Research on Substance Abuse and Native Communities  
 - Kathryn Gill
- 9:30 - 10:15** Perspective on Alcohol and Substance Abuse Treatment and Prevention  
 - Richard Kistabish
- 10:15 - 10:45** Coffee Break
- 10:45 - 12:30** Panel Discussion: Are Quebec's Programs for Alcohol/Drug  
 Prevention/Intervention Successful? What Needs to be Done?  
 Lucie Dessureault, Jacques Ducharme, Kitty Pearson, Fred Kistabish  
 and Kathryn Gill
- 12:30 - 1:30** Lunch

**Indigenous Healing**  
**Chairperson: Naomi Adelson**

- 1:30 - 2:00** Overview of the Indigenous Healing Concerns of the First Nations in Quebec  
 - Dianne Reid
- 2:00 - 2:30** Social Health and Community Healing - Naomi Adelson
- 2:30 - 3:00** Discussion
- 3:00 - 3:30** Coffee Break
- 3:30 - 5:00** Workshops
1. Self-Esteem: Meeting the Challenge - Caroline Oblin & Katie Moores
  2. CRC Maison Waseskun House Program - Nicki Garwood & Bevan Skerratt
  3. The Integration of Biomedical and Traditional Healing Practices  
 - Archie Cheechoo
  4. Overcoming Traumatic and Abusive Life Experiences - Abraham Bearskin
  5. But Does it Work? Traditional Healing and Issues of Efficacy and Evaluation  
 - Jim Waldram

Evening Event

**POW-WOW - organized by the Native Friendship Centre**  
**Bonsecours Market, 350 St-Paul East, Old Montreal**

Sunday, September 28th, 1997

**Research on Mental Health Issues in Aboriginal Communities**  
**Chairperson: Elizabeth Robinson**

**9:00 - 10:15** Panel Discussion: *Research on Mental Health Issues in Aboriginal Communities: How Can it be Useful?* - Elizabeth Robinson, Martha Flaherty, Abraham Bearskin, Adrian Tanner and Dianne Reid

**10:15 - 10:45** Coffee Break

**10:45 - 11:30** Open Discussion

**11:30 - 12:00** Closing Comments: Laurence Kirmayer

Prayer: John Curotte

