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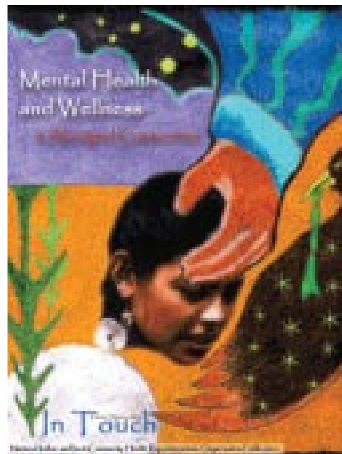
National Indian & Inuit Community Health Representatives Organization

IN TOUCH

MENTAL HEALTH AND WELLNESS IN ABORIGINAL COMMUNITIES



Aboriginal Health and Wellness

by Ian Brown

What is the difference between stress and distress?

In aboriginal communities across Canada today, there is an acute awareness of the need to address mental health problems and issues. In the last ten years this need has become urgent in the light of high rates of suicide, family violence, and mental illnesses such as depression and anxiety. In this article, we will take a closer look at these problems, their causes, and possible solutions to them. In considering mental health problems on an individual level, we need to make a distinction between two related but different concepts, stress and distress.

Everyone experiences stress. It is not only normal but within acceptable limits, plays a positive role. An Inuit hunter waiting for a harp seal to appear feels a kind of stress that produces alertness and determination. However there is a difference between day-to-day stress (looking after children, work demands, transportation difficulties, etc.) and distress.

Stress may produce physical and nervous tension but we are still able to cope. When stress becomes too great and lasts too long, we may start to experience distress – a state in which our coping abilities begin to break down. Distress means that stress has gone beyond acceptable limits.

Stress becomes distress when it is:

- unwanted
- unexpected
- ongoing
-due to serious life-changing events or situations (e.g. family violence, death of a family member, divorce, separation, a jail term, etc.)

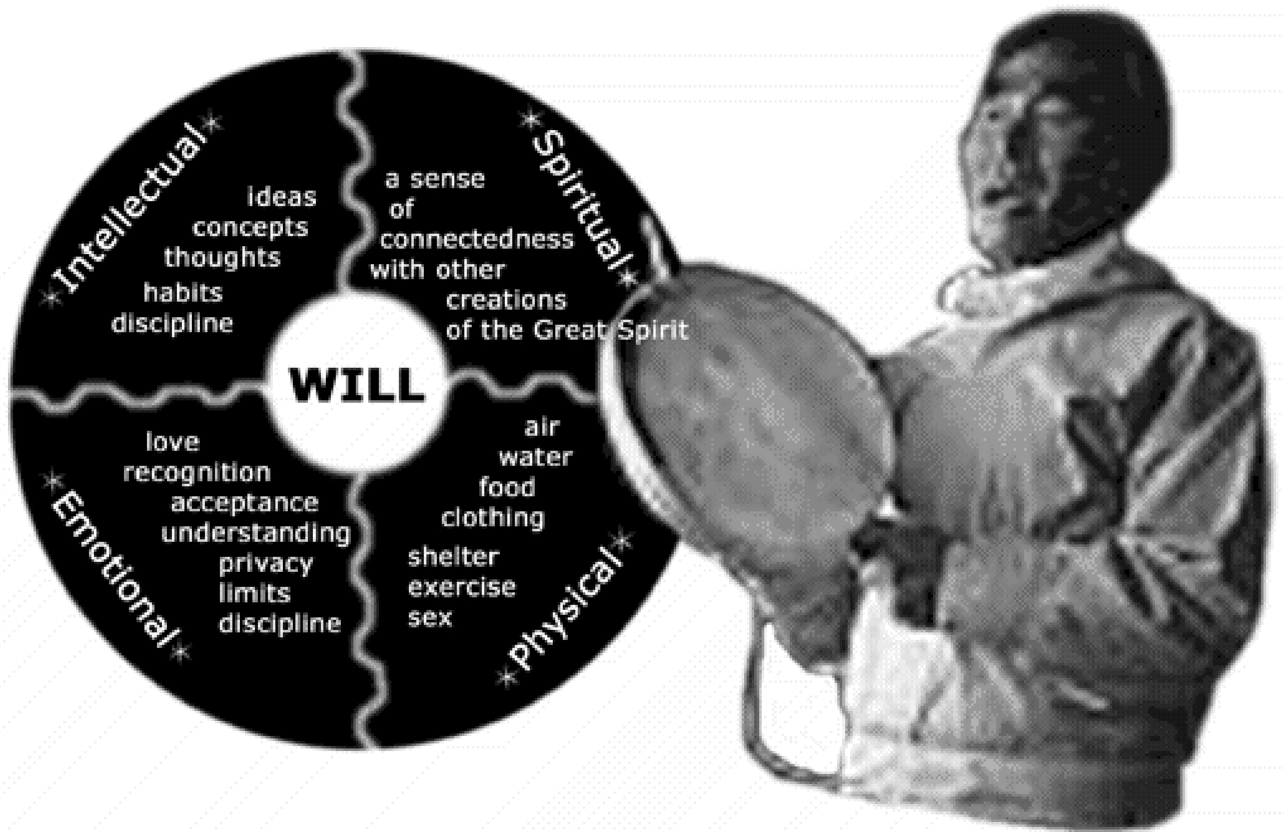
When we experience distress, we are out of balance. In this case, our bodies and minds cry out for some kind of help. This call for help may take many forms such as moodiness, irritability, depression, anxiety, insomnia, or physical symptoms such as stomach upset or headache. In the case of great distress, a more serious imbalance may result. Depression may lead into a numbing of thought processes and unwillingness to act. A sense of meaninglessness may develop into thoughts of suicide. Nervousness and anxiety may intensify to the point of incapacitating fears such as agoraphobia (fear of being in an open space) or obsessive habits (repeatedly washing one's hands or cleaning the sink due to exaggerated fears about dirt and germs).

If the imbalance becomes too great, good health breaks down, whether on the level of the body, the spirit, the emotions, or the mind. If the load on the nervous system is too great, 'burn-out' or breakdown can occur, just like in any other electrical system. Mental illness refers to ill health of whatever kind that has affected the emotions, the spirit, or the nervous system (including the mind).

In the case of the aboriginal population, the most serious mental health problems are depression, substance abuse, family violence, high rates of suicide in certain communities, mental disorders, and grief (individual and collective) over multiple losses and disruptions of lifestyle. Before taking a deeper look at these problems, their causes, and possible solutions, we can gain some perspective by asking the following question:

What are aboriginal perceptions of mental illness?

In the aboriginal tradition, mental illness cannot be seen as a problem separate from the other aspects of an individual's life. As is demonstrated in the Medicine Wheel, physical, emotional, psychological, spiritual, and environmental health are seen as interrelated.
"**The Medicine Wheel or Drum** has become a popular symbol for helping First Nations people articulate a definition of health:



The circle represents wholeness and movement or action. Having effective ways and means to satisfy physical and emotional needs, a person is able to focus energies on creating knowledge or working tools which will equip him/her to define, redefine, and pursue his purpose on this earth."1
In Inuktitut, there is no general term for 'mental illness'. Disease is seen as a state experienced by the person and not, as in western conception, a characteristic attached to the identity of the individual. Someone is not stuck with a label, e.g. he/she is 'a schizophrenic'.

The two terms most commonly used by Inuit people when they refer to mental health problems are revealing. Isumaluttuq implies 'too much thinking'. Such heavy thoughts can lead to depression, anxiety, insomnia, and even violence or suicide. Isumaqanngituq, on the other hand, means literally 'having no mind'. Typically, this term has been used to describe individuals with severe mental retardation. However, it has also been extended to cover people with severe mental disturbances whose behaviour was clearly unpredictable.

Some people say that there is more tolerance of unusual behaviour in aboriginal (as opposed to non-aboriginal) communities. If this is the case, it has both positive and negative implications. On the one hand, it should be easier to treat and integrate disturbed individuals within the community. On the other hand, such tolerance could be seen as delaying the recognition of serious conditions such as depression and suicidal intentions. Whatever the case, there continues to be much misunderstanding about the nature of mental illness.

There is a great need for public education in this area because of both ignorance and superstition. People do not like to admit problems of 'mental illness' exist because of the stigma attached to these words. As in the case of alcohol abuse, there is a sense of shame in admitting to such a problem. It is easier for many people to admit that they have a heart condition than a mental condition.

For example, Dianne Reid, President of the James Bay Cree Cultural Education Centre, put it this way:
"In Cree communities, we see people walking around who are either manic-depressive or schizophrenic, who are feared and shunned by the community. Families are unable to deal with this because of a lack of understanding of these illnesses, choosing to do nothing at all, further alienating and isolating these individuals … sometimes their sense of loneliness and isolation is so great that they call me 15 times a day."[2]

Needless to say, if an individual has been sent to a psychiatric hospital in a far-off city, the chances for stigmatization are often increased upon his/her return to the community.

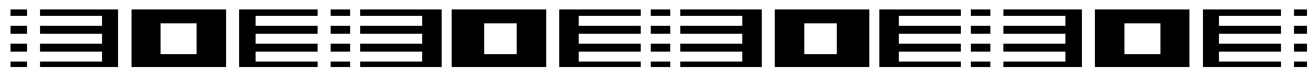
There are also different perceptions of the usefulness of prescription drugs for mental illness. Some people welcome the 'miraculous' changes that have occurred due to recent advances in medication for depression and schizophrenia. Others are afraid of both over-prescription and chemical dependency, or that such a focus on individual sicknesses may result in larger social problems being overlooked. This matter will be dealt with in more detail in following sections.

It is hardly the case that there has been agreement on the nature of mental illness and the role of psychiatry in non-aboriginal circles. Since the 1960s, there has been an 'anti-psychiatry' movement based primarily on the theories of R. D. Laing and Thomas Szasz. Some people make the point that even the words psychology and psychiatry derive from the root word psyche, the Greek term for 'soul'. It is also the name for the goddess Psyche who travels alone to the underworld in order to bring back lost souls. This perception of 'mental illness' having to do with soul loss is close to shamanic traditions in which an unbalanced person was seen as having become dis-spirited (i.e. lost their spirit). It was the shaman's role to find and bring back the missing spirit.

In some communities, the church has taken on the role of the shaman. For example, in the far north of Canada, churches such as the Pentecostal Church have become popular because it views hallucinations as being an indication of demon possession. It is not unusual to find an individual who has received treatment from (a) traditional healers, (b) a doctor who views the problem as schizophrenia, and (c) the church who would focus on how to exorcise the demon(s).

These differing belief systems can and do produce friction and conflict. “There seem to be battle lines between workers,” said Dianne Reid, who went on to tell 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 dimension which was missing entirely from the psychiatrist’s diagnosis. The Elder was able to disentangle the threads and heal the individual.”3

Addressing the Native Mental Health Research Team in Montréal, Dianne emphasized that discussion of aboriginal mental health “should not be about widening the gap between individuals and differing approaches, it should be about widening the circle - at the level of the individual, the community, the nation and the world.” Given the presence of psychologists, psychiatrists, social workers, and healers in many communities, there is a need for a holistic or integrated approach to treating people.

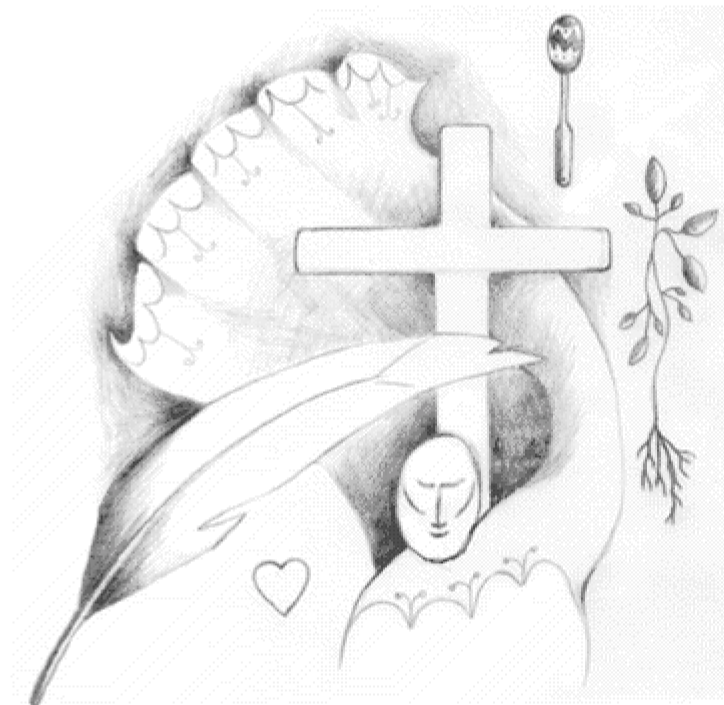


Main Problem Areas in Aboriginal Mental Health

by Ian Brown

(illustrations by Star Horn)

‘Mental Health / Illness’ are very broad terms.
In this article, we will focus primarily on suicide, family violence and the three main mental disorders of depression, anxiety and schizophrenia.



[1] Suicide

Suicide amongst Aboriginal peoples has been described as an epidemic. The suicide rate among Aboriginal people of all ages is between three and four times higher than among non-Aboriginals. This is a rate that is said to be the highest reported for any culture in the world. Specifically, the suicide rate is 3.3 times higher for Indians and 3.9 times higher for Inuit. For Aboriginal youth between the ages of 10 and 19, the rate is five to six times higher than for their non-aboriginal counterparts. The situation becomes still more alarming when one considers the fact that 38 per cent of all registered Indians are under the age of 15, meaning that if a remedy is not found, the suicide rate may rise still further.

In addition, these statistics do not cover Métis or non-registered Indians and consequently show rates that are lower than is believed to be the case for the total Aboriginal population. It is also estimated that 25 per cent of 'accidental deaths' are really unreported suicides, a fact that would result in further under-reporting.

In 1992, in the community of Big Cove, New Brunswick, there were 7 suicides and 75 attempted suicides. Community caregivers formed a group to look into how the community could take responsibility for improving the situation. A week-long community gathering for mourning and healing was arranged. As an example of the 'widening the circle' approach, the process combined Mi'gmaq spirituality, Christianity and western psychotherapy.

Statistics are one thing. Hearing the voices of those affected is another. Here are the words of one who lives in a community that has a high rate of suicide:
"My father committed suicide … I've heard it and I've seen it before, in my brother, in my daughter and in my brother-in-law. … I've seen my brother's writing … he wrote notes … and he tried to hang himself. My daughter tried that too. She tried to hang herself. And my brother-in-law has stabbed himself. I mean, cut himself up. My husband talks about suicide. And I myself have thought about it. I know I won't do it, but there are days and times that it comes to thinking about it. For me, I don't say anything to anybody. I don't say I want to commit suicide … I feel like disappearing, maybe without dying or with dying, I don't know. I mean, there are times when I think about how I'm going to do it. Am I gonna hang myself? Am I gonna overdose? Do I slash my wrists? What, what, what? How will I do it? You just get tired of what's happening around you."4

[2] Family Violence

Like the term 'mental illness', family violence is broad in its meaning. It covers sexual abuse, physical abuse, emotional and psychological abuse, and neglect in the area of child care. A short time ago, in February 2003, the National Indigenous Sexual Abuse Conference was hosted by the Mikisew Cree First Nation and held in Edmonton, Alberta. The conference coordinator, Allan Beaver, made the point that "the prevention of sexual abuse is a long-term effort and it requires fundamental changes to attitudes and values of individuals and society as a whole. We can start by talking about it and begin to take one step at time."5

Within the last decade, the Canadian Panel on Violence Against Women has surveyed both Aboriginal and non-Aboriginal communities across Canada. **Here are some of their findings:**

-Hospital and social service reports show an extremely high rate of violence against women and children in both Aboriginal and non-Aboriginal communities.

-In the 1990s, the occupancy rate at Iqaluit's women's shelter tripled.

-Sexual assault reports in the Northwest Territories are four to five times higher than in the rest of Canada. Those at highest risk for sexual abuse were females from 13-18 years old, followed by girls aged 7-12.

-A Northwest Territories survey found that 80 per cent of girls and 50 per cent of boys under the age of 8 had been sexually abused.

-A survey in southern Ontario found that 71 per cent of an urban sample and 48 per cent of a reserve sample had been assaulted by current or past partners.

-Seventy-five to ninety per cent of women in some Aboriginal communities are physically abused.

-The Ontario Native Women's Association reported that from a total of 104 completed questionnaires, 80 per cent of respondents reported personal experience of family violence, approximately eight times the rate estimated for Canadian women as a whole.

-The kinds of abuse identified as features of family violence were mental and emotional (89 per cent), physical (87 per cent), and sexual (57 per cent).

-Serious effects of abuse included aggressive behaviour, hyperactivity, antisocial behaviour, social withdrawal, learning disabilities, somatic symptoms, low self-esteem, depression and P.T.S.D. (post-traumatic stress disorder).

In a presentation called 'Surviving the Abuse in Cree Society', Marilyn Bearskin makes these additional points: Native women who are being abused often turn to alcohol and drugs, neglect their children, households and themselves, and often attempt suicide. There is a pattern of abuse and neglect that continues from one generation to the next. People within the community often do not take domestic violence seriously. When women finally do leave their abusers, they are often faced with harassment, rather than support from the community. Finally, there is an absence of programs and counselling for victims of abuse.7

[3] Depression

There is general consensus that there are high rates of major depression among Native groups. For example, a recent survey of leaders of 57 reserves in Manitoba found that 47 per cent of respondents considered depression to be a serious problem in their community.8 In the Baffin region, Young and colleagues (1993)9 reviewed records on 581 referrals for psychiatric consultation and found that reasons for referral were:

depression: 27.9%
suicidal thoughts / attempts: 24.4%
relationship / family problems: 14.7%
grief reactions: 10.5%
violent / abusive behaviour: 9.5%
psychotic or bizarre thinking: 7.5%

A Story

**(summarized from 'The Story Of Don',
published by the Aboriginal Health Association of BC)**

Don lived in a run-down rooming house on the East Side. His room consisted of only a foamy mattress - filthy and rank, one chair and a box for clothes that resembled rags.
Don wasn't always an alcoholic. He grew up in a home with two hard-working loving parents and close-knit siblings who looked after each other. Things changed for Don when he started school. For him, school represented pain and confusion, and hurt. Along with his friends and relatives he was ridiculed, called down, pushed around and beaten up by the white boys. He did not know how to tell his parents so he kept it a secret. He learned how to withdraw into himself so he wouldn't feel the pain.

When he was ten years old his neighbour abused him. That fateful day changed Don forever. He changed from a carefree, happy-go-lucky boy into a quiet, lonely one. He entered the cold, dark, hopeless world of depression. He kept to himself, did not do well in school, experimented with drugs and alcohol and had his first suicide attempt at the age of twelve. He did all these in vain - he could not forget or talk about what happened to him.

Depression was a constant companion throughout his teenage and young adult years. Don's emotions flipped in and out of hopelessness, anger, fear and guilt. He did not know how to ask for help. He could not even talk about what had happened to him. He quit school in grade nine and ran away to the big city. His parents did not know how to help him or what had changed him. He refused to see his family.

Don tried to cover up his depression and suicidal tendencies by self-medicating with drugs and alcohol. His days were spent walking the streets begging for money and drinking cheap rice wine. His little room became a flophouse for people he met on the street. Don spent ten years on skid row. One day he woke up and found he could not move. His body had become so badly poisoned from alcohol he was barely recognizable. His face was swollen and puffy, he had lost at least sixty pounds, his stomach was distended because his liver was losing the battle to alcohol and his body, including his eyes, was yellow. That was how his parents found him.

**This story illustrates the realities of depression and
also how substance abuse, depression and suicide can become intertwined.**

[4] Anxiety Disorders

Individuals with anxiety disorders experience excessive fear or worry. This can cause them either to avoid situations that might set off the anxiety or to develop compulsive rituals that lessen the anxiety. Everyone feels anxious in response to specific events - but individuals with an anxiety disorder have excessive and unrealistic feelings that interfere with their lives in their relationships, school and work performance, social activities, and recreation.

Types of Anxiety Disorders

(a) Generalized Anxiety Disorder (GAD)
Excessive anxiety and worry about a number of events or activities occurring for a period of at least six months with associated symptoms (such as fatigue and poor concentration).

(b) Specific Phobia
Continuing fear of certain objects or situations (such as flying, heights, cramped spaces, etc.).

(c) Post-Traumatic Stress Disorder
Flashbacks, persistent frightening thoughts and memories, anger or irritability in response to a previous terrifying experience in which physical harm occurred or was threatened (such as rape, child abuse, war or natural disaster).

(d) Social Phobia, also known as Social Anxiety Disorder
Exposure to social or performance situations, such as public speaking, usually sets off an immediate anxiety response that may include palpitations, tremors, sweating, gastrointestinal discomfort, diarrhea, muscle tension, blushing or confusion, and may cause a panic attack in severe cases.

(e) Obsessive-Compulsive Disorder
Obsessions: Persistent thoughts, ideas, impulses or images that cause marked anxiety or distress. Individuals with obsessions usually attempt to ignore or deny such thoughts or impulses or to counteract them by other thoughts or actions (compulsions).
Compulsions: Repetitive behaviours (such as hand washing, ordering or checking) or mental acts (such as counting or repeating words) that occur in response to an obsession.

(f) Panic Disorder
Presence of repeated, unexpected panic attacks, followed by persistent concern about having additional attacks. Worry about the meaning of the attack or its consequences.
Panic disorders can come from a feeling of being trapped, for example not being able to escape an unpleasant social situation.
The basic feature of the panic attack is an experience of intense fear or discomfort that is accompanied by at least **4 of the following 13 symptoms:**

~ Palpitations, increased heart rate or pounding heart

~ Sweating

~ Trembling or shaking

~ Sensations of shortness of breath or smothering

~ Feeling of choking

~ Chest pain or discomfort

~ Nausea or abdominal distress

~ Dizziness, unsteadiness, light-headedness or fainting

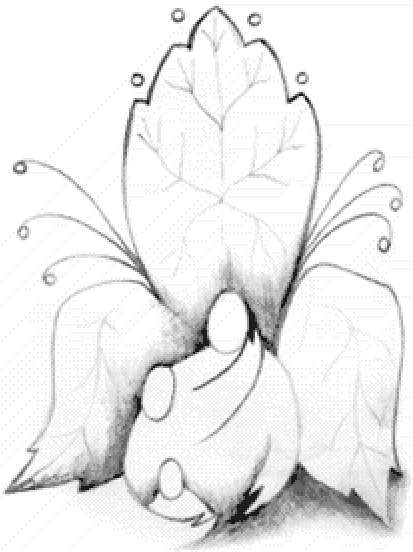
~ A sense of unreality and confusion over who you are

~ Fear of losing control or going crazy

~ Fear of dying

~ Numbness or tingling sensation in hands and feet

~ Chills or hot flashes



[5] Schizophrenia

In a recent report from Health Canada, schizophrenia is defined and described as follows:

"Schizophrenia is a brain disease and one of the most serious mental illnesses in Canada. Common symptoms are mixed-up thoughts, delusions (false or irrational beliefs), hallucinations (seeing or hearing things that do not exist), and bizarre behaviour. People suffering from schizophrenia have difficulty performing tasks that require abstract memory and sustained attention. The signs and symptoms of schizophrenia vary greatly among individuals. There are no laboratory tests to diagnose schizophrenia. Diagnosis is based solely on clinical observation. For a diagnosis of schizophrenia to be made, symptoms must be present most of the time for a period of at least one month, with some signs of the disorder persisting for six months. These signs and symptoms are severe enough to cause marked social, educational or occupational dysfunction. The Canadian Psychiatric Association has developed guidelines for the assessment and diagnosis of schizophrenia."10

Symptoms of Schizophrenia
- Delusions and/or hallucinations
- Lack of motivation
- Social withdrawal
- Thought disorders

Over the years, there has been much disagreement about what schizophrenia is, and is not. For followers of Thomas Szasz, R.D. Laing and the anti-psychiatry school, the symptoms described above could all be indications of a transforming experience, a 'breakthrough' rather than a 'breakdown'. Laing suggested that the term 'schizophrenia' be replaced by 'metanoia' – meaning 'change of mind' or 'conversion'. More recently, another famous psychologist, Stan Grof, instigated an organization called the 'Spiritual Emergency Network', to provide an alternative view and support system for those in mental turmoil. Meanwhile, a Christian fundamentalist might see these symptoms as signs of 'spirit possession'.

According to traditional Inuit culture, some illnesses were considered to be the result of an interaction between the soul of a person, place or thing and the individual affected by the illness. Humans are considered to have three types of souls – the name soul, the life breath, and the shadow soul. In the past, each type of soul was subject to treatment by shamans to cure disease. Certain types of abnormal behaviour and mental illness were seen as due to the interaction between souls and spirits of other people or animals.
Three types of possession resulting from these interactions have been identified: Uuttulutaq, Nuliarsalik/Uirsalik and Christianized 'Satanic' possession.

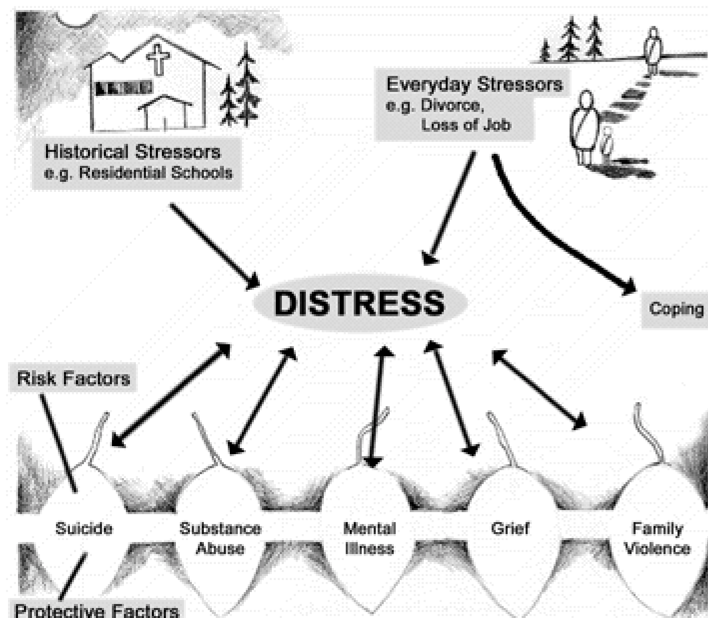
What Are The Causes of These Psychological Problems?

by Ian Brown

(illustrations by Star Horn)

In the first section we talked about the difference between stress and distress. In looking at what factor caused which problem, it may help to use diagrams.

[1] What Are The Origins of Individual and Collective Distress?



The first important thing to realize is that the signs of distress, i.e. such things as family violence, grief, mental illness, substance abuse and suicide, are all interconnected. One problem (e.g. depression) can, and often does result in another (e.g. thoughts of suicide). This is what the horizontal list of words in the leaf-like shapes is supposed to indicate. The vertical arrows are double-headed because, just as one can say that suicide, for example, is a result of distress, it is also a potential cause of yet more distress (for other members of the family). Much has been written about the 'risk' and 'protective' factors for mental illness, specifically suicide, and that is what we will turn our attention to now.

[2] What Are Risk Factors For Suicide and Other Forms of Mental Illness?

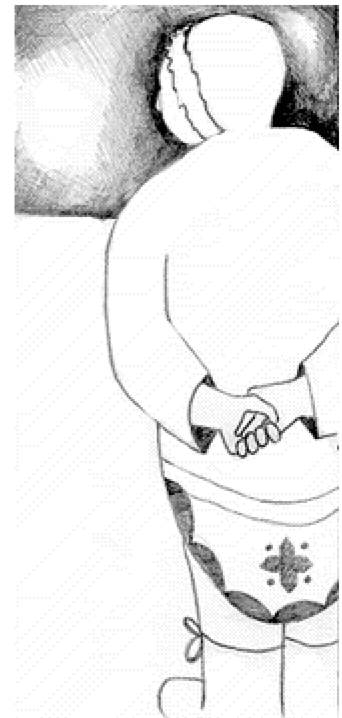
There is now agreement between First Nations and the Canadian government that the historical stressors referred to in the above diagram are a prime cause of much, if not all, of the distress. The 1995 report entitled Royal Commission on Aboriginal People (RCAP) says:

"The profile of mental disorders among Aboriginal people is primarily a by-product of our colonial past with its layered assaults on Aboriginal cultures and personal identities."

In other words, the self-destructive behaviour of Aboriginal people cannot be analyzed primarily in terms of 'mental disorders', but must be looked at in the context of historical colonial relations. Canada's Indian Policy's original goals were that of 'Protection, Civilization and Assimilation', which in turn suggests that Native people were an inferior, uncivilized group, lacking the moral qualities of the colonizing societies. The internalizing of feelings of inferiority has been referred to as 'psycho-colonization'. Historically, it produced a state of mind that played an important role in the development of such ailments as clinical depression and anxiety disorders.The following five areas have been identified as risk factors for suicide: psycho-biological (i.e. mind and body), life history, situational, socio-economic, and culture stress. The following is a summary of the main findings with respect to each area.

[a] Psycho-biological

Health providers suggested that unresolved grief may be a widespread psychobiological problem. Grief comes from the heartache of losing someone or something dear to you. As has been pointed out many times, the history of aboriginal peoples in Canada is one of losing one thing after another: loss of language, loss of culture, loss of land, loss of tradition, loss of lifestyle. Loss of family members, friends or neighbours due to suicide adds yet another aspect to this pattern of multiple loss. With respect to unresolved grief, Katie Moores, a social worker who gave an address entitled 'Grief In The Inuit' (Widening the Circle, 1997, pp. 40-42), 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.



[b] Life History

The individual may have experienced trauma due to a life history of:

- disrupted relationships with caregivers
- unexpected death in the family
- abuse (sexual, physical, emotional, psychological)
- chronic family instability and multiple home placements
- family dysfunction and breakdown
- conflict and rejection in significant relationships
- criminal justice encounters
- substance abuse
- lack of religious and/or spiritual connections

[c] Situational

The stability and security of the individual's home environment may have been disrupted due to:

- residential schools
- adoption
- forced relocation
- fly-out hospitalizations

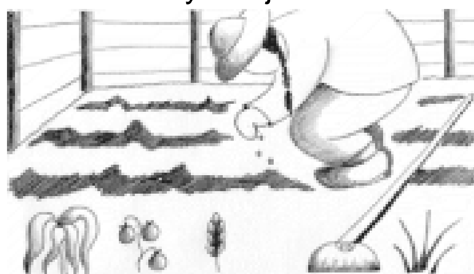
The first three items, the removal of children from their families to attend residential schools, adoption, and forced relocation (in some cases of whole communities) were all part of the Canadian government's policies of assimilation.

From 1879 to 1973, the Canadian government mandated church-run boarding schools to provide education for Aboriginal children. Over 100,000 children were taken from their homes and subjected to an institutional approach that tried to re-mould them with a new, more 'acceptable' identity. Studies have shown that children who went through this system report overwhelming feelings of loss, depression and loneliness. In addition, separation from family and community also resulted in the inability to develop effective parenting skills.

Aboriginal parents were not necessarily seen as 'unacceptable' parents, but as incapable of 'educating' and passing on 'proper' European values to their children. Beginning in the 1960s, the federal government handed over responsibility for Aboriginal health, welfare and educational services to the provinces. Child and Welfare services focused on the prevention of 'child neglect'. Such 'neglect' was mainly linked to poverty and other social problems. However, improving care within the family was not given priority and provincial child welfare policies did not include preventive family counselling services, as they did in the case of non-Aboriginal families. In fact, Child and Welfare services did not even try to keep the family together physically. As a result, social workers usually chose adoption and long-term foster care for Aboriginal children that they took into care.

By the end of the 1960s, fully 30 to 40 per cent of the children who were legal wards of the state were Aboriginal children – in stark contrast to the rate of 1 per cent in 1959 (Fournier and Crey, 1997).

Forced relocations were a particularly devastating form of stress as they involved a complete change of circumstances. The 'experiment' of relocating Inuit to the Far North to protect Canadian sovereignty was just a late chapter in the process of forced culture change (Dickason, 1992). The effect was not only to take away control from individuals and communities but also to undermine their trust in outside authority and justice.



[d] Socio-economic

forced transition from living off the land to wage earning and welfare economy
limited employment opportunities
high rates of poverty
inadequate housing
inadequate health services
deficiencies in sanitation and water quality

The shift from an economy based on living off the land to one based on wage earning has left many people, young and old, feeling like strangers in their own culture. In many aboriginal communities there are few jobs, and those that exist are often demanding and out of reach for those with low levels of education.
In 1991, the average income for Aboriginal people was about 60 per cent of that of non-Aboriginal Canadians. Despite efforts at income assistance and community development, this gap has widened over the decades since 1980. While traditional subsistence activities (hunting, trapping, fishing, etc.) have become less profitable, culture contact with the mainstream society has created a demand for new goods. The presence of mass media even in remote communities bombards everybody with the values of consumer capitalism and creates feelings of deprivation and lack where none existed before.

In Inuit communities, ill health has been strongly associated with a lack of 'country foods'. In Nunavik, elderly Inuit reported a need for beluga whale skin because it is reported to alleviate feelings of depression by energizing the system through its effect on the blood and hence the body and mind.
The unemployment rate for Natives both on and off reserves is generally high. Studies show that mental illness and rates of suicide are strongly connected to both poverty and unemployment. The poor economic conditions affecting most Native communities damage self-esteem and can result in depression, drug and alcohol use, and family violence, all of which contribute to the high suicide rate.
In terms of housing conditions, dwellings with more than one occupant per room are 16 times more likely on reserves, and often water supply and sewage disposal are inadequate. Community mental health facilities are nonexistent in the majority of communities: these communities lack the financial and human resources to undertake mental health programming independently. Many tragic outcomes of distress could be prevented if supportive and crisis intervention services were available. Hospitalization, violent acts and mismanaged child sex abuse disclosures are frequently the outcome of long waiting lists and an inability to access appropriate services.
As for low levels of education, one example of this is literacy rates. Studies show that 45 per cent of all status Indians living on reserves are illiterate, contributing to the difficulty of competing in the job market and impairing the communication of traditional culture.

[e] Culture Stress

"Culture stress is a term used to refer to the loss of confidence in the ways of understanding life and living that have been taught within a particular culture. It comes about when the complexity of relationships, knowledge, languages, social
institutions, beliefs, values, and ethical rules that bind a people and give them a collective sense of who they are and where they belong is subjected to change. For aboriginal people, such things as loss of land and control over living conditions,
suppression of belief systems and spirituality,
weakening of social and political institutions, and racial discrimination have seriously damaged their confidence and thus predisposed them to suicide, self-injury and other self-destructive behaviours." (RCAP, 1995)
This definition of 'culture stress', however, omits to mention the fact that 90 per cent of the indigenous population of North America died as a result of the direct and indirect effects of culture contact with European settlers. Estimates of this population range upwards from about seven million prior to the 18th century. For example, Northern Iroquoian peoples may have shrunk from about 110,000 in the 16th and early 17th centuries to about 8,000 by 1850.

[3] What Are Protective Factors For Suicide and Other Forms of Mental Illness?

In 1997, an Australian study of youth suicide listed the following protective factors that can decrease the risk of suicide:

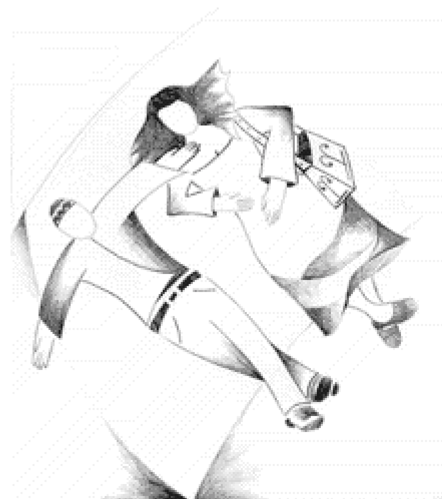
- a strong sense of the value and meaning of life
- individual and collective self-esteem
- belief in survival and coping
- fear of suicide and moral objections to suicide
- skills in stress management, communication and problem-solving
- support from peers and family
- family responsibilities
- community support networks
- a sense of belonging

But what about the situation in Canada - specifically, Aboriginal youth suicides? Earlier in this article it was reported that for Aboriginal youth between the ages of 10 and 19, the rate of suicide is five to six times higher than for their non-Aboriginal counterparts. As Kirmayer and associates point out (1999), "there are specific developmental issues in adolescence and young adulthood that contribute to making this age group most vulnerable to suicide in Aboriginal communities. Youth are involved in gradual differentiation from their families of origin and the development of a network of peer relationships. When families have been troubled, this process of separation can be complicated and upsetting. Given the limited job opportunities, young people may have few positive expectations for the future.

Meanwhile, through mass media, they are confronted with images of a global youth culture that seems to enjoy great freedom and material wealth. Most importantly, as has already been discussed, the transmission of cultural tradition and identity has been disrupted due to generations of cultural oppression. As a result, the processes of initiation and integration into adult society that once gave youth a sense of their past and a valued role in their community have been replaced by the improvised attempts of peer groups to create a sense of belonging and identity."

It is this factor of cultural discontinuity that is focused upon in a recent study of youth suicide in British Columbia. Chandler and Lalonde (1998) did research in which they traced back to their band of origin every known Native youth suicide that occurred in British Columbia between the years 1987 and 1992. They succeeded in calculating not only how many suicides occurred within the province as a whole, but also the actual number of such deaths that occurred in each of the province's different Native bands and tribal councils.
They discovered that more than half the bands experienced NO youth suicides while others suffered rates more than 800 times the national average. Some 90 per cent of known suicides occurred in less than 10 per cent of these extended communities.

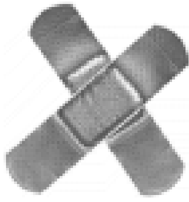
Having discovered this startling fact, they set out to find the reasons why. They discovered that some bands are successful in insulating their young from suicide in ways that others are not. Specifically, they found that of the 196 Native bands of British Columbia, those that took an active role in establishing local control and the preservation and continuation of culture had substantially lower youth suicide rates. The authors identify six indicators of the kind of local control that can facilitate what they call 'cultural continuity', i.e. a sense of psychological connection between past, present and future. **These are:**



community control of fire and police services
community control of health
community control of education
existence of local facilities for cultural activities
self-government
involvement in land claims

Other protective factors against suicide have been identified as good school performance, regular attendance at church and a good relationship with the community. Given that youth suicide rates are highest for males, it is also important to note that many people have pointed out how beneficial it has been for young men to spend time in the bush. The Cree, for example, continue to practice traditional hunting activities, which provide not only an important source of food but also a way of life with significant social and spiritual meaning, which contribute to a sense of well-being.

In Quebec, where the Inuit, Attikamekw and several other nations have very high rates of suicide, the Cree population has rates no higher than the rest of the province. (Petawabano et al., 1994)



History of Interventions OR the Need to Heal

by Ian Brown

What Are Some Holistic Solutions To Mental Health Problems?

The Recuperative Process

In the new South Africa, following apartheid, Nelson Mandela realized that in addition to political reconstruction and empowerment for the indigenous black population, there needed to be a healing process for all citizens. The result was The Truth and Reconciliation Commission.

How can trust and respect be restored after great injustice and pain has been inflicted? This is an important question in considering solutions to aboriginal mental health problems.
In Canada in the last 10 years, there have also been attempts to promote healing on all levels (national, local, individual).
In 1993, The Anglican Church of Canada made a formal apology for the tremendous wrongs that were committed in the name of Christian conversion.

In 1995, Elijah Harper brought Aboriginal and non-Aboriginal peoples together from across Canada to find a spiritual basis for healing and understanding.

From this Sacred Assembly, people developed a
Reconciliation Proclamation and a Statement of Principles and Priorities.

In 1998, George Erasmus headed a new
organization entitled the Aboriginal Healing Foundation whose purpose was to oversee a $350 million fund to address the legacy of physical and sexual abuse in the Residential School system. This fund, secured after a contribution agreement with the Government of Canada, constituted a significant element of 'Gathering Strength – Canada's Aboriginal Action Plan', announced on January 7, 1998. As part of that announcement, the Government of Canada offered a Statement of Reconciliation acknowledging the government's role in the development and administration of the Residential School system, and said it was deeply sorry to those victims who suffered physical and sexual abuse.

Government Health Services Intervention

In a recent report from Health Canada, the problem of access to health services was seen as related to (a) geography and,
(b) culture and knowledge issues.

(a) Problems of access to health services because of geography

With respect to geography, the government formulated two strategies.

These were:

-to set up a video-conferencing ‘telehealth’ system to allow specialized medical assistance to be delivered electronically over great distances. In the area of renal medicine, a National Telehealth Community Care Pilot Project was set up in New Brunswick, and a project entitled the First Nations National Telehealth Research Project was launched in Western Canada. The results of these video-conferencing experiments have been mixed. They were expensive to implement and participants reported being frustrated with both the new technology and its unreliability.

-to develop local capacity. The second strategy of developing local health services has had more success. The Régie régionale de la santé et des services sociaux de Nunavik has been particularly successful with its program entitled ‘Putting in Place An Integrated System for People with Severe or Persistent Mental Problems’. A re-integration centre was set up in Inukjuak which provided 24-hour care in a structured milieu. The service was for individuals in need of short-term or long-term residential care and respite care. It also offered crisis intervention, day programs and community follow-up. The Centre was staffed by Inuit, which further enhanced local skills while addressing concerns about cultural sensitivity.

Health Canada has a new approach to the provision of health services known as the New Public Health. This is the practice of promoting health holistically through social and community development. The Inukjuak centre is a good example of the New Public Health in practice. The RCAP addressed the need for a holistic approach when it suggested that many of the problems now confronting Aboriginal communities could be addressed more effectively in a health promotion framework rather than with a curative approach.

(b) Problems of access to health services because of culture and knowledge issues

Even if services do exist, people are often hesitant to use them if they feel that the staff are strangers when it comes to local language and culture. To combat this problem, several ‘outreach’ programs have been set up. In these programs, medical services have been provided in storefront centres that are easily accessible and set amongst other familiar buildings like the local bank or post office. Another approach has been to hire liaison workers who are able to play the role of facilitators, i.e. helping clients to negotiate the health and social services system. It has been found that as a result of these workers, there have been fewer missed appointments, and improved cooperation with respect to treatment programs. At the same time, health professionals have been able to develop a better understanding of the health needs of their Aboriginal clients.

In general, there has been a shift in government policy in the last 10 years towards what has been called ‘Native solutions for Native problems’. This policy shift has been encouraged for the autonomy it has given some Aboriginal groups to deal with mental and social health issues in a manner appropriate to their own culture. However, the problem remains that too often government policy is a scrambled response to a crisis (e.g. an increase in the occurrence of suicides) rather than a gradual and ongoing development of local services and expertise as part of a coordinated program of constructive change.

RECONCILIATION PROCLAMATION

We, the delegates to Sacred Assembly '95, gathered together in Hull, Quebec on December 6-9, 1995, having come from the four corners of this land—East, West, North, and South—and having brought with us diverse spiritual backgrounds, and having listened to and prayed with Elders, spiritual leaders and with each other, are now able to assert the following:

We share, as part of our common spiritual foundation, the belief that: the Creator, God reigns supreme over all things; the land on which we live was created for the benefit of all;
as the original inhabitants of this land, Aboriginal peoples have a special right and responsibility to ensure the continuing integrity of the land and the unity and well-being of its inhabitants; and non-Aboriginal Canadians also share in these responsibilities.

We share the recognition that reconciliation between Aboriginal and non-Aboriginal Canadians must be rooted in a spiritual understanding of land as a gift from the Creator, God; the sins and injustices which have historically divided Aboriginal and non-Aboriginal peoples remain active in our society today; concrete actions must be taken by Aboriginal and non-Aboriginal peoples alike to overcome these injustices and to bind up the wounds of those who have suffered.

We share an understanding that the starting point for healing and reconciliation lies in a personal communion with the Creator, God; while change must take place at all levels of society, it must be rooted most firmly in the communities; and relations based on justice will require respect for past treaties, a fair settlement of land rights disputes, the implementation of the inherent right of self-government and the creation of economic development opportunities and other institutions to support it.

We share a commitment as individuals to seek the personal guidance and counsel of Elders and spiritual leaders in order to walk more closely with the Creator, God; to return to our communities and develop ways to continue the process of healing and reconciliation that has begun at Sacred Assembly '95; to continue to explore with each other our sacred foundations, in order to bring about spiritual reconciliation, Aboriginal justice and the fulfillment of political responsibilities in this country; to continue to respect the differences in our spiritual journeys, even as we seek to discover the common spiritual link between us. As churches and faith communities: to continue the process of healing and reconciliation with Aboriginal peoples by providing the forums and supports needed to heal the wounds created in the past; to become stronger advocates for justice and reconciliation in the current and future public affairs, and to hold our governments accountable for their implementation of just policies; to recommit ourselves to a program of education and action on issues relating to land rights, self-government, economic development and racism.

As First Nations and Aboriginal communities and organizations: to work towards healing and reconciliation within our communities; to accept the challenge issued by Youth to create an environment in our communities that encourages a healthy view of oneself and respect for others, and addresses community conflict that prevents Youth from finding their path.

What Is The Relationship Between Psychiatry and Traditional Medicine?

by Ian Brown

Pills, pills, pills! Are they helpful? Do they work? How do they work? What are their side effects?

The relationship between traditional healing practices and psychiatry is an uneasy one. There is a fear in some communities that if a person is referred to a psychologist or psychiatrist, they will be prescribed pills. Specifically, the fear is that a chemical dependency is being created through this response to mental illness while the larger social ills are being overlooked.

On the other hand, there are other communities [illegible] medication as a miraculous invention. For example, the new family of anti-dep[illegible] Prozac, Zoloft, Paxil, etc.) are seen by many as non-addictive, effective against depression, and a better choice than 'drowning one's sorrows' in large amounts of alcohol. The other kind of pill that has had considerable impact is the new family of drugs designed to treat schizophrenia. As in the non-Native community, the greater concern is with 'sleeping pills' and 'muscle relaxants' such as Valium and Ativan, which are known to be addictive.

In recent years, pan-Indian healing movements have enjoyed increasing popularity in Aboriginal-run treatment centres. There has been an emergence of a form of pan-Indian spirituality in prison settings and halfway houses. In some cases, traditional healing approaches have been combined with standard methods of western psychotherapy. These new combinations have proved to be effective and meaningful to a large proportion of Aboriginal clients with different cultural, linguistic and personal backgrounds.

In the ongoing debate about traditional medicine and psychiatry, the important questions are (a) which healing methods are effective? and (b) which healing methods are appropriate?

There is always cause for caution where the interests of the pharmaceutical industry are concerned. On the other hand, some people (e.g. medical anthropologists) have been criticized as being too quick to accept traditional healing methods without 'proof' of their effectiveness with people in mental / emotional / spiritual distress.

Government programs that provide funding for health services require explanations and justifications for how money is spent. That is reasonable enough. However, the problem is that the focus of traditional healing is broader and more holistic than that of the biomedical approach.

Take an individual who has been referred to health authorities for depression. While biomedicine may say that the solution lies in the prescription of anti-depressants, the traditional healer may determine the problem as being loss of 'soul' or 'spiritual essence'. Who is correct?

What complicates matters is that traditional healers are often reluctant to allow scientists to document their work or test it for its effectiveness. Much traditional healing involves spiritual assistance or intervention, which has strict rules as to how it is carried out. A healer may not be able to disclose the mix of herbs he or she uses, or allow recording devices inside sweat lodges, because it would offend the spirits who allow the healer to heal.

There is little scientific evidence for or against the effectiveness of current treatment programs based on traditional Aboriginal healing practices, but from a mental health perspective, whether or not traditional medicine will get rid of specific symptoms, it is likely to be effective in increasing morale, providing meaning and hope, and promoting community solidarity. Csordas (1992) gives examples of therapeutic results such as these in referring to traditional Navaho healing practices such as chants, sand painting, crystal- or coal-gazing, peyote rituals, the sweat lodge and Christian faith-healing.

Healing ceremonies are not just for individuals. Individual-centered therapies encourage people to think of themselves as autonomous, separate, powerful agents whose goal is to identify and achieve their own goals. Success or failure in life is seen in terms of these individual goals. In other cultures, family values and belongingness are central so that, far from viewing parents and others as causes of suffering, the emphasis is on what has been gained from them. In Japan, for example, Naikan therapy was developed as a method of treatment for young people with delinquency problems; the client was encouraged to meditate on all he owed to his parents.

The technique was reported to be successful. There is much literature about how mental illness is directly related to a sense of disconnectedness from family, community, culture, and God. The French sociologist, Emile Durkheim, in his classic study entitled Suicide, said one of the main causes of suicide was what he called 'anomie', which means lack of structure in your life (e.g. the vacuum experienced following job loss or divorce). Other writers have talked about how the capitalist system, with its big bureaucracies, creates alienation, i.e. lack of connection to the means of production, to the sources of power, and ultimately to community and family. Loss of structure, loss of connection, loss of meaning – forces that can, and do undermine emotional, spiritual and mental health.

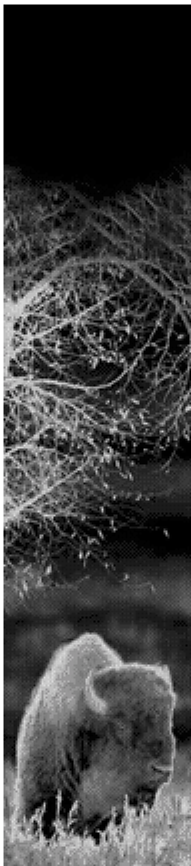
Traditional practices such as the sweat lodge are not just for individual healing experiences. They must be viewed in the light of how they can help regenerate a sense of Aboriginal identity, and hence connection to something larger than one's self.

None of this is to say that traditional healing practices should be 'off-limits' to critical examination. Nor does it mean that psychiatry (whether pills, one-to-one consultations or group therapy) is 'bad', or 'inferior'. Not many people question the use of aspirin or heart medication. Anyone who doubts the potential value of pill medication for depression or schizophrenia should listen to the grateful testimonies of people who suffered for many years before being relieved of their distress once and for all by the ingestion of a chemical whose positive effects, they say, vastly outweigh real or imagined negative effects.

The approach of taking what is best from different areas of the healing movement seems to make sense. Those who are distressed need practical help now. They do not need to become pawns in yet another political power struggle between conflicting interests.

Mental Health Programs and Projects

by Ian Brown



The mental health concerns of Aboriginal people and organizations include substance abuse, depression, family breakdown, and suicide. Governments must provide adequate resources to deal with the causes and effects of these problems.

One approach that has gained support has been to set up inter-agency committees consisting of professional workers such as community workers, police, guidance counselors, addictions counselors and health workers. The members of such committees have the opportunity to discuss problems and determine the programs and interventions for specific situations.

It has been pointed out that 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 that 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.

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 joint 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.

The following are programs and services already in existence in Canada:

The band membership of Six Nations totals approximately 20,000 individuals, making it the largest First Nations community in Canada. Six Nations Mental Health Services is a community mental health clinic, which opened for service in June 1997 on the Six Nations of the Grand River Territory reserve in southwestern Ontario. It is the first mental health clinic of its kind in Canada, being staffed by four mental health nurses, one mental health outreach worker, one counsellor and two psychiatrists – all, with the exception of the child psychiatrist, being of Aboriginal ancestry.

The nurses participate in the psychiatric consultation and follow-up processes as well as providing intensive case management for individuals with serious mental illnesses. The most common problems have been depression, suicidal thoughts and anxiety.

The clinic holds public education workshops twice a year to coincide with the national mental health awareness weeks. Clinic staff submit regular columns dealing with a variety of mental health issues to the two community newspapers. They also participate in a phone-in show on the community radio station every two to three months.

Prior to the clinic opening, there was a lack of mental health services, which resulted in the ‘revolving door’ syndrome. An individual who was perceived to have a mental health problem was sent to hospital psychiatric units in the city and then later discharged without any follow-up services being available in the community. As a result, the individual often deteriorated, which led to readmission to the hospital, and so on. In those years, 17 individuals accounted for 54 separate admissions to hospital. It is a measure of the success of Six Nations Mental Health Services that during their first year of operation, there were only three individuals who accounted for five admissions to hospital.

Two important goals of the Six Nations Mental Health Services are: (1) to get rid of the stigma of mental illness, and (2) to improve access.

(2)Waseskun House Program

Waseskun House, located in Montreal, 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 Waseskun House Program is rooted in an inclusive approach to Native cultural tradition and a here-and-now awareness of current global realities. It takes an active and responsible approach towards 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. Vision questing
(a ceremony where a person goes out into the woods to seek answers and guidance) is encouraged to prepare and assist the client in assuming a future role as an integrated and contributing member of his community of origin.

Waseskun House group sessions provide a supportive environment wherein participants have the opportunity to develop and examine the processes and skills involved in the creation of functional community.

Group interaction helps the individual healing process. Clients are given the opportunity to re-experience the depths of personal trauma and to appropriately grieve the losses specific to contemporary Native experience. 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.

Participatory ceremonies and interactive experiential exercises are designed to help individuals move toward emotional, physical, mental and spiritual wellness, as well as identify and release the emotional and psychological blocks that 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. Deeper aspects of the healing process involve such things as:

(a) grieving the various losses coming from an unhealthy past; **(b)** letting go of artificial substitutes (e.g. alcohol) for genuine self-care; and (c) learning to express outrage and anger in safe and constructive ways. The program ends with a commitment to both the willingness to forgive and to directing legitimate
anger towards improving conditions in aboriginal communities.

(3) Hollow Water Community Healing

The Hollow Water Community Healing program in Manitoba is a model of the contemporary blending of traditional and modern approaches to health and 'healing'. It is a blend that is determined and driven by the Anishnawbe Seven Sacred Teachings and healing customs. The Hollow Water Community Healing program for dealing with the problem of first-time sexual abuse offenders has a reputation of having had tremendous success, and has received significant interest from Canadian and international health and social service professionals. Unique to this program is the integration of treatment of the offender with that of their victim(s), their respective families, and the entire community. The following discussion lists selected key characteristics of the success of this program.

The success of the Hollow Water approach is seen as revolutionary by a number of health and social service professional observers, inside and outside of Canada. For example, Canadian psychologist and internationally recognized authority on sex offender treatment, Dr. W. Marshall, describes the significant success of the program as follows: "The real advantage of the Hollow Water program is that it is holistic in the sense of integrating treatment of the offender and the victim, their families, and the whole community … most non-Aboriginal people are hostile to the reintegration of sexual offenders … non-Aboriginal people can learn from Aboriginal approaches rather than our traditional strategy of attempting to foist our ways on other people…" (Marshall, 1997)

The Hollow Water Community Healing program is revolutionary for several reasons:
-The program successfully maintains a deeply rooted sense of the individual in connection with the complex dynamic that makes up the self-family-community triad.
-The program successfully facilitates and ensures that both victim and victimizer proceed at their own pace in learning
accountability to self, and to family and community. It also
successfully assists victimizers in taking responsibility for their
actions and in making amends to the community. The program
successfully facilitates victim and victimizer in learning to deal with shame, and in learning to forgive self and others.
-Within the program, victimizer and victim are not labeled or blamed, but are treated as equals whose spirits remain essentially whole, but who have temporarily become unbalanced.

(4) Putting in Place an Integrated System for Persons with Severe and Persistent Mental Problems

This pilot project tackled growing problems and high suicide rates in Nunavik by housing, supporting, and employing people suffering from severe and chronic mental health problems who might otherwise be sent to Montréal.

During the first nine months of the centre's operation, 12 clients were served and achieved greater independence. The majority managed to deal effectively with their addiction problems; only one client was hospitalized during the program. As a result of this project, there is now a new resource in Inukjuak, and the study concludes that the materials developed by the project might be useful in other isolated communities.

(5) The Stoney in Alberta

The Stoney in Alberta 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.

(6) Mheccu (The Mental Health Evaluation and Community Consultation Unit)

Mheccu's purpose is to improve mental health outcomes for British Columbians and for Canadians in general by linking research, education and policy making at the community, clinical, administrative and broader systems levels.

Mheccu provides the following services in the area of mental health:

-Mheccu's Aboriginal Mental Health Advisory Committee
Based in Vancouver, Mheccu's Aboriginal Mental Health Advisory Committee has been meeting regularly since July 1999. The Advisory Committee was formed in response to concerns that mental health service delivery, including the field of community psychiatry, did not adequately - or appropriately - deal with the needs of Aboriginal people. Funding to support the Advisory Group is provided by Adult Mental Health Services, Ministry of Health and administered by Mheccu.

-Emergency Mental Health Services
The primary goal of the Emergency Mental Health Services initiative has been to improve the crisis response/emergency psychiatry capacity in rural and remote communities in the province of British Columbia. One manner of achieving this goal was to provide education, training, and evaluation to support hospital-based emergency mental health care in communities lacking in-patient psychiatric services. Mheccu received one-time funding from the Ministry of Health and Ministry Responsible for Seniors in 1999-2000 and one-time funding again in 2000-2001.

-Suicide Prevention
Key activities of the Suicide Prevention component of Mheccu include the development of user-friendly resource materials based on research literature, distribution of up-to-date suicide data, and the facilitation of connections and links between communities.

-Centre for TeleHealth at Mheccu

Mheccu received one-time funding from the Ministry of Health and Ministry Responsible for Seniors to provide under-serviced communities with increased access to mental health consultations and distance education through the use of interactive video-teleconferencing technology. The Centre for Tele-mental Health at Mheccu has since expanded its operations with support from individual health regions and Health Canada.

(7) Training of Community Wellness Workers at Yellowquill College

This Diploma program resulted from a partnership between the University of Manitoba, Yellowquill College, and First
Nations stakeholders: the Assembly of Manitoba Chiefs, Manitoba Keewatinowi Okimakanak, the Medical Services Branch and the Manitoba Community Wellness Working Group.
This Diploma was developed to provide First Nations with Community Wellness Workers who would have accredited post-secondary education that is responsive to the mental health/ wellness education needs and priorities identified by First Nations. The Diploma is also an appropriate post-secondary education opportunity for other First Nations health and social service providers. It offers a challenging program of studies in the field of mental health wellness for First Nations community and regional health services.

The curriculum consists of 16 three-credit-hours (48 credit-hours), and 2 six-credit-hours (12 credit-hours) of existing faculty courses from the faculties of Social Work, Arts, Nursing and Pharmacy. The 60 credit-hours of courses are fully transferable to the Bachelor of Social Work degree. The program will also provide 33 credit-hours applicable to an Arts degree, and will fulfill the elective requirements for a Nursing degree (27 or 30 credit-hours), for students who choose to proceed towards completion of a baccalaureate degree in these faculties.

(8) Institute for Aboriginal Health (University of British Columbia)

The First Nations Health Careers Program is a division in the Office of the Coordinator of Health Sciences but is located in the First Nations House of Learning (FNHL). Being based in the First Nations House of Learning allows First Nations health, research and training to be rooted in academia while being responsive to important health concerns expressed through linkages with indigenous communities in British Columbia, Canada and abroad.

The current program is sponsored by the division of First Nations Health Careers through the First Nations House of Learning, the Office of the Coordinator of Health Sciences and in collaboration with the Faculty of Science and the School of Nursing. The Division of First Nations Health Careers has developed and offered the following courses:

-Biology 448, Section 212: Contemporary First Nations
-Health Issues and Traditional Healing
-Biology 448, Section 212
-Ethno-biology Nursing 490: Issues in Native Health
-Social Work 425: First Nations Social Issues

A Native Health Awareness day is held annually for the benefit of health sciences students and faculty with presentations and displays on Aboriginal health issues. This has come to be called The Gathering, is held in February and attended by more than 200 students in health programs throughout the University.
Summer Health Institutes have been held annually since 1995. The goal of these institutes is to provide training and information on issues identified by Aboriginal communities. These institutes have been successful and cost-efficient. In 1997, the topic of the one-week institute was Diabetes in First Nations Populations.

Division of First Nations Health Careers
The goal of the Division is to increase the number of First Nations health care professionals. This includes:

-Recruiting and improving access
to health and human service programs at UBC;
-Providing support services for First Nations students enrolled in these programs;
-Collaborating with health and human service faculties, departments and schools in developing courses and seminars relevant to Aboriginal health needs;
-Creating cultural awareness among Aboriginal and non-Aboriginal health and human service students, staff and faculty;
-Communicating with health and human service professional associations, and encouraging interest in the health care professions at the high school level.

For information about health and human service programs at UBC, please call or write to:

Rosalyn Ing, B.S.W., M.Ed., Ph.D.
Institute for Aboriginal Health
Division of First Nations Health Careers
UBC Longhouse
188 - 1985 West Mall, Vancouver, BC V6T 1Z2
Phone: (604) 822-5613
Fax: (604) 822-8944
Secretary's e-mail: dmhughes@interchange.ubc.ca

Division of Community Liaison
The Division is focused on Aboriginal Communities in urban and rural environments, and extends to secondary and post-secondary institutions. The Division:

-Enhances and maintains close links with Aboriginal and non-Aboriginal front-line health and human service professionals who work with bands and tribal councils, and urban and rural health organizations;
-Helps create 'laddering' processes from either high school or college to the University by developing curriculum transfer courses, access initiatives, or programs with other post-secondary institutions and
on-reserve programs.
-Promotes health professions and health issues via summer youth programs and the Summer Health Institute.

If you are a health care worker (Aboriginal or non-Aboriginal working with Aboriginal people) and have concerns about Aboriginal health issues, please call or write to:

Heidi Verburg, M.S.W.
Institute for Aboriginal Health
Division of Community Liaison
UBC College of Health Disciplines
408 - 2194 Health Sciences Mall, Vancouver, BC V6T 1Z3
Phone: (604) 822-5677
Fax: (604) 822-2495
E-mail: hverburg@interchange.ubc.ca

(9) Miyupimaatisiiuwin Wellness Curriculum

The Miyupimaatisiiuwin Wellness Curriculum presents a comprehensive school-based approach to health promotion and, by extension, to long-term suicide prevention. It has been developed for the Cree Public Health Module to be used in the James Bay region.

The general features of a suicide prevention strategy, as set out in the guidelines section of this report, are present in the curriculum. Briefly, these include:

-suicide prevention being taken on as the responsibility of the entire community;
-a focus on children and young people;
-a holistic approach reflecting the complex nature of the problem;
-a comprehensive approach, including long-term approaches and interventions;
-evaluation viewed as essential;
-cultural ownership.

The curriculum planning initially involved extensive consultation with the Cree community and included input from the Cree Board of Education. The Miyupimaatisiiuwin Wellness Curriculum is comprehensive, covering a wide range of wellness issues in a practical, teacher-friendly format, including ready-to-use lessons and preparatory material. It is a preventive program with an emphasis on wellness through health promotion for kindergarten to grade 8. As such, it provides long-term support to children, while the information also reaches parents through a planned parental informed consent component built into each lesson. Relevant issues are extended and developed through the grade levels in a spiral manner, as opposed to isolated presentations, with issues reappearing at each level in more complex form.

For more information:
Barbara Reney
SWEN Productions
3622 rue De Bullion #2, Montréal, QC H2X 3A3
Phone: (514) 849-8478
Fax: (514) 849-2580
Email: reneyb@colba.net

(10) Let's Live!

Let's Live! is an example of a school-based awareness and intervention program that meets some of the RCAP (1995) general guidelines for suicide prevention approaches. The student program is taught in grades 8-12 using five theme-driven lesson plans. The British Columbia Council for Families, which developed the program in 1992, provides this overview in the Inservice Guide:
"The purpose of this Inservice Guide is to provide you with the guidance and support you need to initiate and maintain a suicide awareness and intervention program in your school. It contains information on teaching an inservice workshop to heighten educators' knowledge of the factors contributing to and affecting teenage suicide, and to familiarize school staff with the Let's Live! program. It also provides specific direction for dealing with crisis situations."
(p. iii)

The program guide covers the inservice workshop and provides the content and procedures for two sessions. Resources and materials, including handouts and a teacher's manual, are followed by theme-based lessons for students, covering the following topics: What is Suicide? How Can I Tell if Someone is Suicidal? Why Do Teenagers Attempt Suicide? How Can I Help Someone Who is Suicidal? and How Can I Get the Most Out of My Life?

Designed to educate students about suicide by promoting self-awareness, self-esteem, and a sense of personal power, the problem of teen suicide is acknowledged, and efforts to under and do something concrete about it are encouraged. The teacher's manual provides advice on creating "a classroom environment that promotes compassion, empathetic listening, and friendship" (p. iii).

The evaluation of this program included pilot testing in the spring of 1992. Let's Live! was pilot tested in School District #43 (Coquitlam, B.C.) at four secondary or junior high schools. Successful implementation of the program was attributed, amongst other things, to a successful peer counselling program, and highly trained and skilled guidance counsellors.

For more information or to order manual:
Cheryl Haw
Director, Publications Department
B.C. Council for Families
204-2590 Granville Street,
Vancouver, BC V6H 3H1
Phone: (604) 660-0675
Fax: (604) 732-4813
Email: bccf@istar.ca
Website: www.bccf.bc.ca

(11) First Nations National Telehealth Research Project

This project studied how telehealth might improve the access to health services in isolated rural communities – terms that describe a third of all First Nations and Inuit communities. Five First Nations communities were chosen to pilot this 2.5-year telehealth project. The goals were for families to "visit" distant hospitalized patients via video-conferencing, for patients to be treated in their communities through electronic connections with health experts, and for isolated health staff to access training, information, and expertise.

Costs were incurred through the introduction of technology and the need to service that technology (infrastructure costs averaged $245,000 to $305,000 per community). The technology raised legal and technical challenges regarding privacy and confidentiality, and it also introduced a need for training and technical support.

(12) Native Parenting Program

This is a 12-week course, run twice a year for 15-20 participants, that starts with the Nobody's Perfect parenting program (combined with the Native Kisewatotatowin Parenting Classes) and is followed by a Native Cultural Program. Most of the participants are of Aboriginal ancestry. The goals of the Native Parenting Program are to engage people in speaking about their own experiences, help participants gain a deeper understanding of their emotions and anger, examine Native customs and parenting skills, increase cultural pride and self-esteem, promote recognition of risk factors, and increase knowledge of the resources available and how to access them.

Nobody's Perfect is an education program designed for parents of young children (0-5 years), and has been implemented in 10 provinces and the Northwest Territories (these sites include a number of Native communities). The program uses easy-to-read materials, and relies heavily on group support and adult education techniques to help parents recognize and build on their own strengths. An informal, non-lecture style is used and the program is suitable for parents who have few resources available to them. It is not, however, intended for families in crisis or those with serious problems. The content includes child health and safety, emotional health and behaviour of children, problem solving, and uses five core books (at home) that address the body (health and illness), safety, mind (child development), behaviour, and needs of parents. All resource materials are practical, easy to use and can be purchased from Canada Communication Group. This program is also available in French, as Y'a personne de parfait.

This program is suitable for individuals with a limited educational background. The Native Parenting Program sessions always open with Native ceremonies such as burning sweetgrass and sage and talking circles. The activities offered as part of the Native Cultural Program include Native crafts and a food resource class in which nutritious and inexpensive meals are prepared. Participants can also apply for a leadership training course. Various incentives are offered to encourage and enable people to take part; daycare and transportation assistance is provided. The Native Parenting Program is fairly inexpensive as it only requires space (e.g. in someone's home or at a community centre), a group facilitator willing to learn the course material (a volunteer, nurse, or community worker), and some volunteers to keep young children occupied or provide transportation.

For more information:
Louise McKinney
Native Health Worker and Parent Educator
Westside Community Clinic,
631 20th Street West, Saskatoon, SK S7M 0X8
Phone: (306) 664-4310

For more information about Kisewatotatowin Parenting Classes:
SkyBlue Mary Morin
c/o Saskatoon Aboriginal Parenting Project
P.O. Box 8552, Saskatoon, SK S7K 6K6

For more information about Nobody's Perfect:
Fearon Blair
B.C. Council for Families
Phone: (250) 372-1873

To order Nobody's Perfect Resource Book for Facilitators:
Emily Franco
B.C. Council for Families
204-2590 Granville Street, Vancouver, BC V6H 3H1
Phone: (604) 660-0675
or (604) 732-4813
Email: bccf@istar.ca
This resource book can be purchased for $25.

To order Nobody's Perfect resource materials:
Canada Communication
Group-Publishing
Ottawa, ON K1A 0S9
Phone: 1-800-561-4334
These materials include an administrative manual, flip chart, leader's guide, parent resource kit, promotional brochures (100), promotional posters (10), training manual, and VHS video.

(13) Family Workshop: Parents and Problems Parenting Program

The Family Workshop: Parents and Problems Parenting Program, developed in the U.S., has been implemented in the First Nations community of Big Cove, New Brunswick. Each of the seven sessions of the program is carefully designed to foster discussion and interaction among the adults and their adolescent children. The goals are to enable parents to better understand their own behaviour towards each other and their adolescent(s), how adolescents perceive the behaviour of their parents, and what makes adolescents behave as they do. In this way, the program aims to prevent mental health problems, drug and alcohol abuse, and criminal activity among adolescents. Both the parent(s) and the adolescent(s) are encouraged to participate in the workshops.

The number of participants varies from 9-14 (that is, a maximum of three or four families). The workshop leaders need not be therapists or experts in family dynamics, but concerned community members willing to be trained in how to facilitate the sessions. This training takes place in Big Cove, with follow-up telephone and fax contact. It is preferable to involve two facilitators in the sessions. The group meets weekly to cover the following topics: Through the Eyes of Youth. Do Adults Understand Me? Do My Parents Love Me? But They're My Friends! Adolescent Sexuality, and Why Can't I Do It My Way? The last session, I Don't Have Two Parents, addresses the unique issues of single parenting and an adolescent's behaviour in this context.

Each session (about three hours in length) generally starts with a discussion of the previous week, a review of the new session material, and then group discussion and exercises. Reading materials (at the junior high school level) are distributed for the following session. The program materials include a leader's manual, seven Parents and Problems pamphlets for each family, and exercise materials for each participant.

For more information:
Harry Sock
Director, Child and Family Services
Big Cove Indian Band
Site 11, Box 1, Big Cove, NB E0A 2L0

(14) An Evaluation of Integrated Services for Families of Aggressive School-Aged Children

This project in Battlefords Health District, Saskatchewan, provided mental health services to aggressive school-aged children by moving those services from institutions to schools, homes, and the community. In doing so, it hoped to integrate services and reach children who are usually overlooked. The study involved 13 children from "multi-problem" families; the majority were of First Nations ancestry, male, and living in single-parent families or extended families. Most lived in lower-income households, all exhibited aggressive or defiant behaviour, and many were felt to be at risk for criminal conduct. Mental health professionals and social workers involved teachers, school administrators and families, and services were provided after hours.

(15) Child and Family Resource Centre

This program, operating in Cranberry, Manitoba, involves varied activities including: a community kitchen, a family literacy program, an Aboriginal culture component teaching children Cree story-telling and crafts, a lending library (for books, toys), a monthly newsletter written by parents and distributed to the community, and resources and parenting courses for high-risk parents. The goals are to support/empower children (0-6 years old), provide services for pregnant women at risk, promote healthy living and parenting, and create supportive environments for mutual aid and learning. Resources required are a community worker or professional to give parenting courses and a supervisory board. An evaluation was carried out by interviewing staff and participants, attending board meetings and reviewing the strategic plans (no other information available). Parents provide ongoing feedback.

For more information:
Wendy Trylinski, Program Coordinator
Child and Family Resource Centre
Box 212, Cranberry Portage, MB
R0B 0H0
Phone: (204) 472-3671
Fax: (204) 472-3714
Email: childfam@mb.sympatico.ca

(16) Kishawehotesewin: A Native Parenting Approach

This seven-session program developed by Jocelyne Bruyere in 1993 (Nee-Nah-Win Project) has been used in Alberta for First Nations parents and expecting parents, and follows the seven traditional Native teachings. The sessions can be presented weekly or as a three-day workshop.

Activities include sharing in a circle, readings, videos, role-playing, discussion and assignments. The program assists and supports parents in identifying and realizing their goals, helps them listen to their children, encourages them to share their knowledge about Native traditions, provides general information on resources, allows parents to reconsider their parenting styles and situations, and provides culturally relevant materials. The only resource required is a trained facilitator. The manual can be purchased for $6.50 (English only). The materials have been presented in Native languages with the use of a translator.

To order manual:
Human Resource Centre, CPHA
1565 Carling Avenue, Suite 400, Ottawa, ON K1Z 8R1
Phone: (613) 725-3769
Fax: (613) 725-9826

(17) Northwest Territories School Health Program

This seven-unit school education program was developed in the NWT in the late 1980s for kindergarten to grade 9 students. It is a required curriculum that is user-friendly and all-inclusive. Its goal is to prevent or reduce health problems by encouraging individuals to be responsible for their health, facilitate the development of skills and positive attitudes, and create a supportive environment in the schools.

The recommended time allocation is 60 hours per year and the content includes family life, alcohol and other drugs, nutrition, safety/first aid, dental health, growth/development, and mental and emotional
well-being (as the central unit).

The lessons involve objectives, teacher background information, student activities, and teacher notes, and incorporate small group discussion, brainstorming, role-playing, and a "question box." Resources required are teacher training with the curriculum. A territory-wide teacher survey was carried out in 1991 to find out the extent to which the program was being used and whether the teachers were getting help from others to deliver it (e.g., nurses, Elders). A high rate of use of the program was reported and about 40 per cent of teachers were using others for the more sensitive topics such as mental health and family issues. A new survey is being considered.

For more information:
Barbara Hall (barbara_hall@ece.learnnet.nt.ca)
Department of Education, Culture and Employment, Government of the NWT
Box 1350, Yellowknife, NWT
X1A 2L9
Phone: (867) 873-7678
Fax: (867) 873-0109

(18) Seniors Group

This program, operating at the Portage Friendship Centre, Portage la Prairie, Manitoba, has Elders working with children (0-5 years old) on a weekly basis to pass on language skills, teachings, and legends. The goals are to restore the self-esteem and self-confidence of Elders, teach the children about their culture and identity, and build cultural pride. Outcomes of the project have been a book profiling the Elders and a colouring book of the stories and legends. Resources required are a program coordinator and Elder volunteers. Observations from the centre show that the program has been very successful for the children and the Elders.

For more information:
Garda Sinclair Moran
Executive Director
Portage Friendship Centre
20 3rd Street NW, Portage la Prairie, MB R1N 1N4
Phone: (204) 239-6333
Fax: (204) 239-6634
Email: portagfc@portage.net

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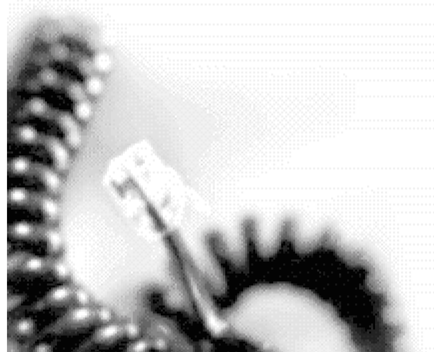

Additional Resources & CRISIS LINES

Websites to visit

Children's Mental Health:
Aboriginal Youth Suicide Prevention and other
Aboriginal initiatives.
http://www.amhb.ab.ca

Aboriginal Health Association of B.C. Provides information on health issues facing Aboriginal peoples, reports, upcoming events, and Aboriginal Health Handbook. Includes 'Aboriginal Health Report' article: Early Childhood Development: Give Your Child the Best Fight for Life! http://www.ahabc.bc.ca

"Advocacy for Native Adoptees" is an organization responsive to the needs of First Nations people, who as children were removed from their community and adopted or put into foster care in non-Native homes.
http://www.advocacyfornativeadoptees.org/

Reports

"Cultural Continuity as a Hedge Against Suicide in Canada's First Nations." Michael Chandler and Christopher Lalond. Correspond with: Dr. Michael Chandler, Dept. of Psychology, University of British Columbia, 2136 West Mall, Vancouver, B.C. V6T 1Z4. Email chandler@interchange.ubc.ca

Videos

The Youth Suicide Prevention Package: Patrick's Story (24 min.). Remembering Tom (24 min.).
2-Video set available from the National Film Board of Canada, Order number 193C 9100 121/ EC011. Fax your order to (514) 283-7564

One-hour video documentary (1985) events in community since 1985 (critical situation re alcohol abuse)
Alkali Lake Indian Band, Box 4479,
Williams Lake, BC V2G 2V5
Phone: (250) 440-5611
Fax: (250) 440-5721

Books

His Bright Light: The Story of Nick Traina
By Danielle Steele

This book is written by well-known author of romance fiction, Danielle Steele. In this true story, Ms. Steele takes the reader through the too-short years she spent with her son Nick, who suffered from bipolar disorder before he committed suicide at age 19. One reviewer describes this book as follows: "This is the story of an extraordinary boy with a brilliant mind, a heart of gold and a tortured soul. It is the story of an illness, a fight to live and a race against death."

Available at Amazon.ca and Chapters bookstores
Quote this number when inquiring/ordering: ISBN 0385333463

Manuals

Northern Lifelines: Suicide Information and Resource Manual
This is a manual, produced in 1992, that covers prevention, intervention and 'postvention' for caregivers and community workers. It can be purchased for $60 (plus $10 shipping and handling).
For more information:
Algoma Child and Youth Service, Sault Ste. Marie, Ont.
Phone: (705) 945-5050
Fax: (705) 942-9273

Walking in Balance: A First Nations Suicide Resource Manual
This is a manual, produced in 1993, that is designed to assist those in a helping role. It can be purchased for $25 (including shipping).
For more information:
Union of Ontario Indians, Toronto
Phone/fax: (416) 693-1620

Youth Suicide Awareness Presentation Package

This is an 80-page instructional guide with a set of 32 overhead transparencies, designed for use by trainers and caregivers. Its goal is to examine the suicide issue in a two-hour to half-day workshop with adult groups, but it can also be adapted for an adolescent audience. The package can be purchased for $150 (plus $8 shipping and handling).
For more information:
Suicide Prevention Training Programs (SPTP)
201-1615-10th Avenue SW, Calgary, AB T3C 0J7
Phone: (403) 245-3900
Fax: (403) 245-0299
Email: siec@siec.ca
Website: http://www.siec.ca

Pamphlets

How to Listen, Understand and Answer a Cry for Help

This is an information pamphlet on suicide warning signs and what to do for a suicidal person. Written in both Cree and English, it was produced by the Northwest Regional Interagency Suicide Prevention Program, Grande Prairie, Alberta in 1991.
For more information:
Suicide Prevention Program
Phone: (403) 539-6680

You've Got a Friend: Suicide Prevention and Intervention

This is a pamphlet, produced in 1992, that contains poetry, art and personal stories from members of a support group. It can be purchased for $7 (including shipping).
For more information:
Kwagiutl Urban Society
#4-3023 Carroll Street, Victoria, BC V9A 1R1

Services

Centre Nutshimiu Atusseun
1035 Brochu Street, Box 182, Sept-Îles, Quebec
G4R 4K5
Phone: (418) 962-1266
A sixteen-week training program (eight-week stay in forest). Goal is to train professional trappers and in so doing, develop Innu identity and self-confidence; for jobless youths (18-24) who have dropped out of school.

Native Training Institute of Quebec
234 St. Louis Street, 1st floor, Loretteville, Quebec
G2B 1L4
Phone: (418) 843-6857
Fax: (418) 843-7339
Offers College level diploma. Program in 'Social Intervention in Aboriginal Milieu'.

Waseskun House,
1295 Laprairie Street, Montreal, Quebec
H3K 2W1
Phone: (514) 932-1424
Provides services to ex-offenders to make the transition from detention back into society.

Institute of Community and Family Psychiatry,
Sir Mortimer B. Davis Jewish General Hospital
4333 Côte-Sainte-Catherine Road, Montreal,
Quebec H3T 1E4
Phone: (514) 340-8210
Fax: (514) 340-7507

Native Mental Health Association of Canada,
Box 89, Shannonville, Ontario K0K 3A0
Phone: (613) 966-7619
Fax: (613) 966-0670
Association provides short intensive courses and written materials intended for caregivers.

Mental Health Evaluation and Community Consultation Unit (Mheccu)
Department of Psychiatry, Faculty of Medicine
University of British Columbia
2250 Westbrook Mall, Vancouver, B.C. VGT 1W6
Website: www.mheccu.ubc.ca

Mental Health and Family Services Division,
Bag 200, Station 1033, Iqaluit, NU X0A 0H0
(867) 979-7680
or check: www.baffinhealth.com

Helpline Western Arctic,
c/o C.M.H.A. - NWT Division,
P.O. Box 2580,
Yellowknife NWT X1A 2P9
1-800-661-0844, 7 days a week, 7-11 p.m.

CRISIS LINES

British Columbia

Squamish Nation Crisis Centre (604) 904-1257 24 hours

Alberta

Blackfoot Reserve 1-800-667-8089 or crisis line 1-877-303-2642
Blood Reserve 1-800-667-8089 or crisis line 1-877-303-2642
Eden Valley Reserve 1-800-667-8089 or crisis line 1-877-303-2642
Peigan Reserve 1-800-667-8089 or crisis line 1-877-303-2642
Stoney Reserve 1-800-667-8089 or crisis line 1-877-303-2642

Northwest Territories

Kamatsiaqtut Baffin Crisis Line, P.O. Box 419 Iqaluit, N.W.T. X0A 0H0
1-800-265-3333 (9-12 p.m.)
or crisis line (819) 979-3333

Keewatin Crisis Line, General Delivery, Rankin Inlet, NWT X0C 0G0
(819) 645-3333 Mon-Fri 7-10 p.m.
Kugluktuk Awareness Centre, P.O. Box 58, Kugluktuk, NU X0B 0E0
(867) 982-4673