

BC Partners for
Mental Health and
Addictions Information

Visions

BC's Mental Health and Addictions Journal

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Aboriginal
People



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bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, Jessie's Hope Society and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, for providing financial support for the production of *Visions*



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This issue of Visions stirs new ground like no other issue has. If you identify yourself as Aboriginal, First Nation, Inuit or Métis, you will likely find much that resonates with you in the stories ahead. If you don't identify yourself that way, you will still learn a lot from this issue about the role of identity, culture, empowerment and community. If you're a service provider and don't provide care even sometimes to members of the Aboriginal community, you may want to ask yourself why, after reading this issue. (And service providers especially, be aware that many of the insights raised will excite you, make you think about the way that our systems are designed, and turn some of your training on its head.)

One of the things that struck me and our editorial team the most was a reminder that there is no one way to think about mental health, mental illness, substance use and addictions. In the Western world, and our medical and treatment models, we have become so used to seeing illness as illness, as separate, as disease, and not seeing the whole person as part of a family, a community, a history and a worldview. At its most basic level, you will see instantly that many of the articles in this issue don't use the words that we, in the mental health and addictions fields, are used to. You'll often not even see the words 'mental illness' or 'addiction' used. Our amazing contributors have weaved mental well-being and wellness into a complex tapestry with spiritual, physical and social well-being, as well as the historical injustices and current realities faced by many Aboriginal people including family violence and abuse, child neglect, trauma, discrimination, poverty, and homelessness. The scars of colonization and residential schools are still visible—and healing continues.

I want to thank our contributors for their courage and grace in discussing difficult topics. I hope this issue is the beginning of a dialogue among and between Aboriginal people as well as other British Columbians. Reading the articles in this issue humbles me, makes me think about how my own culture shapes my identity and my views of health, makes me think about cultural responsibility, and makes me feel grateful to have been invited—even a little bit—into the hearts and minds of a resilient people. ■

Sarah Hamid-Balma

Sarah is Visions Editor and Director of Public Education and Communications at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness

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The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the member agencies of the BC Partners for Mental Health and Addictions Information or any of their branch offices

Cultural Pathways for Decolonization



Bill Mussell

Bill is a member of the Skwah First Nation, one of the 24 Sto:lo First Nations. He was first of his village to graduate from university. His career includes 15 years of professional work in corrections and over 30 years in post-secondary teaching. He is chair and president of the Native Mental Health Association of Canada and chair of the First Nations, Inuit and Métis Advisory Committee to the Mental Health Commission of Canada

Note: In this editorial, Bill employs “First Nation” to identify communities controlled under the Indian Act and known previously as Indian Bands. “First Nation” emerged as a new and more relevant name after Canada’s constitution was amended. The concept “aboriginal” refers to Canada’s three “First Peoples”—the Indians, Inuit and Métis—and “indigenous” is used to describe people of the planet who are also considered as “First People,” such as the Maoris of New Zealand.

Before contact with Europeans, Canada’s indigenous people enjoyed relatively good health and knew cures for many illnesses. Traditional wisdom and knowledge of the land as a resource for the community was essential for their health and well-being.

Since contact with—and colonization by—the Europeans, First Nations communities have experienced serious physical, emotional and spiritual ill health. This is evident in physical health problems such as diabetes, cardiovascular diseases and cancer, and mental health challenges such as violence, abuse, depression, suicide and dependence on addictive substances.

Colonization occurs when one people is conquered by another people through destroying and/or weakening basic social structures in the conquered culture and replacing them with those of the conquering culture.

Colonization robbed First Nations of most of their land and resources. First Nations people relied on the land for making a living in self-sufficient ways. Their food supplies came from the rivers, forests and meadows, and materials for clothing and shelter came from the trees and animals. They lived in collectives of families that shared responsibilities for hunting, ensuring shelter needs were met, preparing and preserving food, and raising children and taking care of the elderly. However, with access to their traditional lands seriously restricted, dependence on government and mainstream programs and services increased.

Families were relocated to a much smaller land base ‘on the reserve.’ At the same time, children were being removed from families and placed in the Indian residential schools. This had devastating effects on the people. They could no longer be self-sufficient, proud and purposeful. They were not able to provide adequately for their families and many experienced starvation. The sense of purposelessness was magnified, because the children were taken. Loss of the land base meant loss of the foundation for their traditional social, economic and cultural ways of life.

Colonization robbed First Nations of their cultural inheritance. The death of thousands of people through introduced diseases meant that their vast knowledge could not be passed on to the survivors. The right of parents to pass on what they knew of their culture to their children was blocked by oppressive residential schools. After two and three generations of the residential schools, traditional language and culture was displaced by a poorly taught foreign language and alternative lifestyle.

Colonization created stigmatization of First Nations. Colonizers viewed and treated Canada’s indig-

enous peoples as lesser human beings. The poverty, mental health challenges and other struggles faced by First Nations stem from colonial policies and practices. These include: the reserve system, laws banning spiritual practices, the residential school system and, more recently, the “’60s Scoop” of aboriginal children by child welfare authorities. Discrimination continues to this day; it is still enshrined in policies and practices of Canadian social structures.

Colonization has caused an epidemic of child apprehensions. Children are apprehended today mainly because of deprivation and poverty, not because of sexual abuse and violence.² Many caregivers did not learn how to care for and raise healthy children; in fact, most were not themselves parented because they were removed from family and community and put in residential school. They know institutional, custodial care, but not the healthy nurturing of traditional family life. Many of today’s parents and grandparents were deprived of an upbringing that would have:

- enabled them to develop a relatively secure personal and cultural identity³
- transmitted and strengthened the relational nature of their lives—the connectedness with the land, its resources and all other things of the Creator
- fostered growth and development that would facilitate meaningful bridging between cultures and nations

A way to regain dignity and a community of care

Decolonization refers to a process where a colonized people reclaim their traditional culture, redefine themselves as a people and reassert their distinct identity.

As a professional educator, mental health practitioner and consultant to First Nations, I see decolonization as the way to healing and restoring family and community health. The process requires:

- learning how to learn and undertaking a journey to wellness that involves self-care
- understanding forces of history that have shaped present day lifestyles
- discovering, naming and transmitting indigenous knowledge, values and ways of knowing, together with understanding selected Western ways
- applying and adapting both indigenous and Western knowledge, values and ways of knowing to address present-day challenges effectively

First Nations people must take positive control over their lives as individuals, families and communities. They must build on who they are culturally and understand history from an indigenous perspective. Re-

claiming and building on cultural strengths contributes to a secure personal and cultural identity for all First Nations and other aboriginal groups. Grieving and healing of the losses suffered through colonization is a further step toward collective wellness and self-determination

During my adult lifetime, I have seen such shifts in consciousness and perception of ourselves. In the 1960s, we usually referred to ourselves as Indians, adopting the name and status the Canadian government had imposed. But as we addressed more closely issues of aboriginal title and rights and increased our research, we began to identify ourselves with our tribal names.

Further change came in the 1980s connected with patriation of Canada's constitution and our self-government aspirations. "First Nations" became the popular reference for us. This is strong evidence of our growing consciousness of our ancestors, our relationship to the land and other resources, and the importance of traditional languages.

More and more First Nations leaders and workers are calling for healing, family restoration and strengthened communities of care. These people promote a renewal of cultural practices and teaching history from an indigenous perspective. They call for education and training that combines the best of mainstream and indigenous knowledge, and for building the capacity of workers to improve the quality of life in their villages.

A parallel process of consciousness raising must occur within Canadian society, so stigma and discrimination against aboriginal Canadians can be eliminated, both on the personal and the structural levels of society. ❖



footnotes

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Visions Journal continues to improve with each issue, both in the quality of the articles and range of coverage. The recent issue on Campuses demonstrated the attention and support to promote mental health on campus. But there was a significant theme missing—the role that fellow students and peers can play in assisting early intervention and treatment.

Counselling and health services ought to be not only actively involved in educating the student population about mental health issues and treating those that pass through their doors for help, but also recruiting, training and supervising students to integrate that information and support into the general student population. Peers are often the first to observe the symptoms, but have little knowledge as to how to proceed in a respectful and effective way. Knowing how to help their peers (listen to their concerns, help them identify options, and have up-to-date knowledge about referrals) is a must on college campuses.

—*Rey Carr, CEO, Peer Resources, Victoria BC*

As a fourth-year university student in BC who has dealt with mental illness for most of my life, I found the latest issue of Visions illuminating and encouraging. My own experiences with mental health support on campus have been positive.

During a family member's illness, I experienced an exacerbation in symptoms and decided to visit my university's health and counselling centre. After year of extremely helpful bi-weekly appointments with a university counsellor, I found myself needing more support. While my family doctor had difficulty finding me a psychiatrist, the health and counselling centre was able to set me up with a university psychiatrist within a week. When my personal safety became a concern, the school's doctors and counsellors supported me through a week-long voluntary hospitalization and afterwards remained very active and supportive in my recovery. I was able to withdraw from the courses I was taking without consequences to my academic record, and was given assistance with applying to my university's centre for students with disabilities.

I want to encourage all post-secondary students to seek help from you school if you need it, because help is there. It may be scary approaching strangers for support, but the consequences for putting your mental health last—behind readings, assignments, exams, work and family commitments—are much scarier.

—*Anonymous BC university student*

we want your feedback!

If you have a comment about something you've read in Visions that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.

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Footnotes Reminder: If you see a superscripted number in an article, that means there is a footnote attached to that point. Sometimes the footnote is more explanation. In most cases, this is a bibliographic reference. To see the complete footnotes for all the articles, see the online version of each article at www.heretohelp.bc.ca/publications/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 3.

Thank You: A huge thank you to the employees of Indian and Northern Affairs Canada whose images originally appeared in the Sharing our Pathways Calendar. Several Aboriginal employees from the calendar agreed that their images could be used for illustrative purposes in this issue of Visions. Thank you again!

Aboriginal Mental Health

The statistical reality¹

Saman Khan

Saman is a fourth-year undergraduate student in interdisciplinary arts at the University of British Columbia. She is also the Public Education and Communications Assistant at Canadian Mental Health Association, BC Division

It's well known that the Aboriginal people of Canada face a unique set of mental health challenges.² But what may not be so well known is that, in a 2002/03 survey, about 70% of First Nations adults living on reserves felt in balance physically, emotionally, mentally and spiritually. And, among Aboriginal people living both on and off reserve, those who did experience a mental health problem were much more likely than the rest of Canadians to seek professional help—a positive step towards healing. In some groups, the number of Aboriginal people seeking help was as high as 17%—compared to the Canadian average of 8%. These numbers would probably have been even higher if more mental health professionals were available in isolated areas.

In spite of this, there are serious concerns about mental illness and social ills such as substance abuse, addiction, suicide and violence among Aboriginal people and communities. The imposition of European culture and the loss of indigenous culture, lifestyle and self-determination is seen as a major cause of health and social problems in the population.

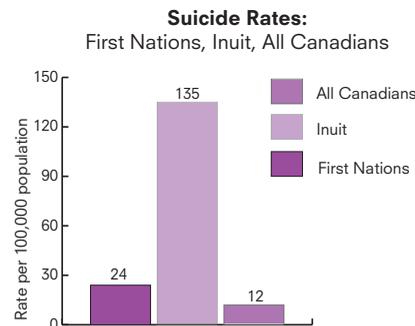
Mental health challenges

Suicide

The loss of human life through suicide is a tragic reality in First Nations and Inuit communities. These two communities experience a much higher suicide rate than the Canadian population as a whole.

Suicide rates among Inuit are shockingly high at six to 11 times the Canadian average. In Nunavut in particular, 27% of all deaths since 1999 have been suicides. This

is one of the highest suicide rates in the world, and it continues to rise, especially among youth.



For the First Nations population, suicide rates are twice the national average and show no signs of decreasing. However, these rates differ from community to community. Some communities have had “epidemics” of suicide, while others have had few or no suicides for several years.

In both Aboriginal groups, females attempt suicide more often than males. This trend is also seen in the general Canadian population, but the difference in rates is alarming. While the Canadian average is around 4% of females and 2% of males reporting they've attempted suicide, in the Aboriginal survey, it was 19% of females and 13% of males.

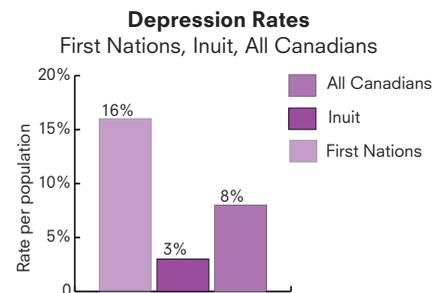
Rates of completed suicides, however, are higher among males. And young adults ages 15 to 24 represent the age group with the highest rate of suicides. Completed suicides among First Nation young adults is five to seven times the Canadian average for the same age group.

Youth with a close family member who had committed suicide in the past 12 months, or who had a parent who attended a residential school, were more likely to have experienced suicidal thoughts.

Depression

Depression is a common and life-changing mental illness in the Canadian population. This is especially true for First Nations people, who experience major depression at twice the national average. A 1997 survey found that 16% of First Nation adults living on reserve experienced major depression, compared to 8% of the general Canadian population. Of the First Nations people in the study who experienced depression, 26% said that depression interfered with their lives, compared to 16% of the overall Canadian population.

Depression rates among the Inuit, however, are far below the Canadian average. In a Statistics Canada survey, only 3% of Inuit had suffered a major depressive episode. Only 6% were at high risk of depression. These findings don't make much sense when we consider the extremely high suicide rate among this group. One possible explanation is that the scales used to measure depression accurately for the rest of the Canadian population, are not as accurate for the Inuit. Another explanation is that depression among men is not easily identified, as it often shows itself as alcohol or drug problems, violence or conflict with the law.



Alcohol and Drug Use

Alcohol use is of great concern to people in First Nations and Inuit communities. Surveys show that:

- Around 75% of all residents feel alcohol use is a problem in their community
- 33% indicate that it's a problem in their own family or household
- 25% say that they have a personal problem with alcohol

This is interesting in light of the fact that lower than average numbers of First Nations and Inuit people drink alcohol. Only 66% of First Nations adults living on reserve consumed alcohol compared to 76% of the general population. This suggests that those who do drink, drink heavily, consuming five or more drinks on one occasion on a weekly basis.

Figures drawn from hospital records in BC and Alberta show

that First Nations people, especially men, are admitted to hospital for problem substance use more often than other residents of these provinces. Cannabis use is also common among First Nations adults (27%) and youth (32%).

The good news is that about one-third of survey respondents reported that there was progress in reducing the amount of alcohol and drug use in their communities.

Treatment

Aboriginal people have a holistic view of mental wellness. Wellness means being in a state of balance with family, community and the larger environment. Because of this, European models of treatment that remove the person from their surroundings tend not to work for this group.

Culture and spirituality are the frameworks of treatment developed by first Nations and Inuit communities. Family and community have a key role in helping individuals regain their sense of balance. Effective treatment involves identifying the strengths of families and communities and developing programs that build on these strengths.

“You can't do it for us, you can only do it with us.”³ Aboriginal communities are motivated to take local control of health services and to come up with their own solutions for health challenges. This can create a sense of collective pride, which is positive step towards boosting Aboriginal mental health. ■

footnotes

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Charting the Future of Native Mental Health in Canada: **The NMHAC's Ten-Year Strategic Plan**

“**T**he strategic plan of the Native Mental Health Association of Canada (NMHAC) is a first in the history of Canada. It is a vision, mission and long-term plan to promote and enhance native mental health in Canada based on Indigenous worldview, a unique perspective that differs significantly from Western conceptions of mental illness and mental health.”¹

So begins the document that outlines a plan for realizing the vision of the NMHAC. That vision is “a Canada where First Nations, Inuit and Métis people and communities embrace physical, emotional, mental and spiritual health and wellness, maintain their diverse cultural and traditional values and beliefs, and share the same social justice and economic opportunities as all other Canadians.”¹

The road to the strategic plan

The Native Mental Health Association of Canada grew out of the Canadian Psychiatric Association Section on Native Mental Health, formed in 1975. Canada's first Indigenous psychiatrist, the late Dr. Clare Brant, established the NMHAC in 1990.² The association is a key contributor to the work of the Mental Health Commission of Canada and the First Nations Inuit Health Branch (FNIHB) of Health Canada, on behalf of Indigenous Canadians.

From the beginning, the board recognized there was a need for a national plan to address the mental health and wellness needs of First Nations, Inuit, and Metis people. They knew that most people working in the field were crisis oriented, with little energy or resources to do more.

M. Terry Adler

Terry is an adult educator, social worker and art therapist, who has taught and learned from Aboriginal people for 25 years, through Capilano University and the Salishan Institute. She has been a member of, and volunteer for, the Native Mental Health Association of Canada since 1990

The board did not have the funding necessary to do strategic planning until 2005. That year, FNIHB provided the NMHAC with funding to develop a 10-year national action plan.

A collaborative process began. Meetings were held in Ottawa, Montreal, Vancouver and Duncan on Van-

couver Island over a period of two years. “Thought leaders,” mainly of Aboriginal background and familiar with the realities of First Nations life, were brought together to come up with guiding values,

working principles aligned with these values, core goals and strategies for meeting these goals. The action plan was finalized in April 2008.

“Mental health is a sign of balance, harmony and connectedness among the interior aspects of the human person (spirit, mind and body) and the world he or she lives in. It is a characteristic of families and communities, as well as individual human beings.”¹

The plan’s guiding values

The foundation of the plan consists of value statements that serve as guiding principles for the actions of board members and other parties with an interest in the mental health of Aboriginal people and communities. These stated values provide a baseline against which the value of new projects and initiatives is measured. They help clarify and resolve issues, determine direction and build community. They include:

- **Respect:** The inherent worth of all people is implicit in all the work done by the NMHAC.
- **Honouring and including:** Inclusiveness and diversity are honoured, and the NMHAC is open to contributions from all those dedicated to health and wellness.
- **Sharing and caring:** The NMHAC is committed to creating environments where caring and sharing occur.
- **Connectedness:** NMHAC believes in the connectedness of all people to each other and to spirit, the land and its resources.
- **The Circle of Life:** NMHAC values people of all ages, the ceremonies that celebrate people as they move from one stage of life to another, and the spirits of our ancestors.
- **Cultural safety:** In a health care relationship, cultural safety begins with the practitioner. The practitioner must recognize structural inequities and power imbalances, and understand and challenge their role. Cultural safety includes openness to participating in cultures other than the one we are born into. It also includes owning our inherited cultural history and biases, and being aware of how these influence our beliefs, perceptions and actions. This increases our ability to relate to other people as whole human beings.
- **Literacy:** Literacy is about communicating, interpreting and translating messages; relationship build-

ing; transfer of knowledge; and awareness. Inherent in this is mental health literacy.

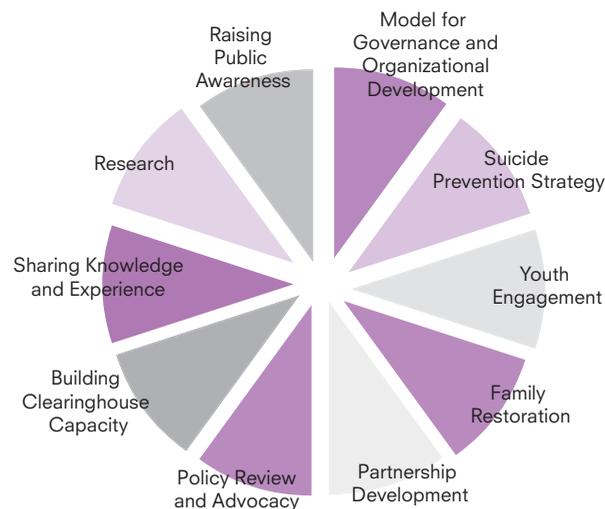
- **Personal and community empowerment:** Empowerment comes from a secure sense of personal and cultural identity, and is central to healing. The NMHAC supports all processes, practices and tools of knowledge that assist people and communities to build on their own knowledge and strengths to empower themselves.
- **Walking with grandmothers and grandfathers:** The NMHAC values the experience and wisdom of Elders and their vital role in transmitting culture.
- **Collaboration:** People demonstrate collaboration when they agree on a mutually important project and work together cooperatively for its realization.
- **Valuing the knowledge of First Nations, Inuit, and Metis cultures:** NMHAC values the knowledge, values and practices of Indigenous peoples within Canada and around the world. As we put values into practice, we model culturally good ways; we walk the talk.
- **Youth:** NMHAC is committed to improving its understanding of child and youth realities and to creating a safe environment for youth to become active members of the Association.

The strategic initiatives

NMHAC has committed to 10 goals or initiatives for enhancing the mental health of Indigenous people in Canada. These goals are interconnected and all are equally important (see graph¹ below). The board provides leadership and lobbies for initiatives that contribute to community, family and individual wellness; it does not provide services directly. Three such initiatives are:

- to develop a national action plan for youth suicide prevention
- to develop a strategy for youth participation

NMHAC Strategic Initiatives



- to champion a centre that promotes family restoration and community development

These goals represent a holistic approach that honours core Indigenous values of family, community and self-determination. These core values are conveyed through customs, rituals and ceremonies, which bring people together to enjoy the relational nature of life in the community. They also help community members connect with the teachings of their ancestors.

The outcome of such practices is a community of care—a way of life that was undermined by the effects of an oppressive colonial history and by discrimination that continues to disadvantage Aboriginal people.

The Strategic Plan in practice

The strategic plan serves a variety of functions. It guides decision making about education and training conferences. It helps the NMHAC determine priority activities such as the Symposium on Stigma held in Ottawa October 3 to 4, 2007, which was made possible through collaboration between the Mood Disorders Society of Canada and the NMHAC, with funding by FNIHB.

The plan guides decision making regarding staff, volunteers and future research. It provides information about the NMHAC, and a useful model for other organizations engaged in values-based strategic planning. The NMHAC

actively seeks partnerships to build better mental health in Canada for Indigenous people and all Canadians.

Toward reconciliation

For transformative change to take place, First Nations, Inuit and Métis people must grieve and heal from losses they have suffered historically. The relationship between Aboriginal people and other Canadians must be repaired and reconciled.

Canadians who wish to be part of the process of reconciliation can do so by:

- familiarizing themselves with Canadian history from an Aboriginal perspective
- familiarizing themselves with the publications of the Aboriginal Healing Foundation and the initiatives of the Mental Health Commission of Canada
- attending forums and conferences that address issues of importance to Aboriginal people

Print copies of the strategic plan are available from the NMHAC, nmhac@telus.net, or at the NMHAC website, www.nmhac.ca. 

related resources

Aboriginal Healing Foundation: www.ahf.ca

Mental Health Commission of Canada:

www.mentalhealthcommission.ca/index-en.php

footnotes

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Research Summary: Aboriginal Peoples' Experiences of Mental Health and Addictions Care

Aboriginal peoples in British Columbia and other areas of Canada face unique difficulties accessing mental health and addictions services. This is having negative effects on the mental health of Aboriginal people, their families and their communities. In addition, the overall mental health status of Aboriginal people in Canada is poorer than that of non-Aboriginal people by almost every measure.¹

Providing responsive mental health and addictions services that fit for Aboriginal peoples is of major concern to community-based leaders in Aboriginal health. This is also a concern for Vancouver Coastal Health (VCH), researchers and members of the primary health care sec-

tor. Because of this concern, these groups came together to conduct a three year study (2006-2009), now in its final year.

Seeking to improve Aboriginal people's access to care

The goal of the study is to understand how to improve mental health and addiction services so they are more responsive to the needs of Aboriginal people. The objectives of the study are:

- to explore Aboriginal clients' experiences of existing mental health and addictions care
- to explore, from the point of view of Aboriginal clients, how experiences with mental health and addictions services shape the way they use those services

- to explore, from the point of view of mental health and/or addictions service providers, the factors that shape how they provide care
- to analyze the experiences of both the providers and the clients, while considering the social, cultural, political, economic and historical factors that shape the way mental health and addictions services are provided
- to use the findings of the study to come up with recommendations about how to provide mental health and addictions care to Aboriginal people that is experienced as culturally safe and effective

To meet these objectives, we conducted in-depth individual and focus group interviews. Aboriginal

Victoria Smye, RN, PhD

Victoria is an Assistant Professor in the School of Nursing at the University of British Columbia. She holds a New Investigator Award from the Canadian Institutes of Health Research

clients who use mainstream and other mental health and addictions services were interviewed, as well as health care providers working in those settings. We also examined guidelines and policies of the organizations where we conducted the research.

Historical, political and social awareness is crucial

The findings of this three-year study point to the importance of recognizing and addressing the social, economic, political and historical factors that shape health and health care—to support Aboriginal well-being.

Most of the people interviewed in this study have profound histories of abuse. For many people, the abuse started in early childhood and continued into adulthood. Abuse and violence is most often the result of colonizing policies and practices (e.g., residential schooling).

“Who shares a room with a guy and what **impact does that have for those people with **abuse** histories?”**

Many people noted how their lives have been profoundly affected by the trauma enacted on Aboriginal peoples when children were forcibly removed from their homes to attend residential schools over a 150-year period. Although some people did not actually attend residential schools themselves, they were affected by the trauma experienced by their parents and grandparents (intergenerational trauma).

Not surprisingly, many of the people we’ve interviewed expressed a lack of trust, respect and safety connected to lifelong trauma. Unfortunately, these feelings are sometimes re-created, often unwittingly, by policies, services and practices within our health care system. This is what Paul Farmer describes as “structural violence.”²

As one female participant in the study noted, “I shared a room

with a guy [in the hospital]...then on the other side of the corridor, a friend of mine...is in the hospital too and she’s sharing that room with a guy. Like why didn’t they put us together?” This woman, who had experienced abuse and ongoing violence in her life, was retraumatized when she had to “share a room with a guy” in the hospital setting—now a common practice in hospitals in BC.

This example caused us to ask, who shares a room with a guy and what impact does that have for those people with abuse histories (female or male) or for those people whose beliefs conflict with such a practice? This particular woman didn’t feel she had the power to refuse to share a room—she was near homeless (impoverished), drug addicted, living with a mental illness and extremely ill. Policy makers need to reflect on the impact of policies such as ‘co-ed rooms’ in hospitals.

In another example, a male participant in the study describes his experience as follows: “Within the system there is some prejudiced people in there and I try not to get too mad with them when I find out that they’re prejudiced. They don’t like Natives

and they don’t like drug addicts.” Several participants in the study described experiences such as this, where they weren’t sure why they were being treated badly. Was it their drug addiction, being Native, being HIV+, being homeless or the fact that they had a mental illness that created the tension?

Race, class, gender, ability and so on can intersect to create a powerful oppressive force within systems of care. Health care providers need to reflect on the ways that their own attitudes and beliefs may impact the way they treat clients in these settings.

In a third example, a woman describes her living conditions: “There must be something wrong with me. I won’t go shower, I take sponge baths in my room...the hotel is so skungy...” This woman, like many others in the study, is living

with a mental illness, drug addiction and HIV illness. She’s afraid to use the bathroom she shares at the hotel where she lives because it’s so dirty—she’s afraid of catching something.

Most participants in this study are homeless or near homeless. The lack of safe housing in BC poses a serious threat to the safety and well-being of this client group. Housing is not adequately addressed within mental health and addictions systems of care.³

Many factors influence safe and effective care

These examples are not intended to suggest that Aboriginal people don’t have positive experiences with health care and good outcomes. Rather, they are intended to point out the risk of not taking into account all the issues that influence health and health care—peoples’ histories, poverty, racism, discrimination, stigma and so on. Social and political awareness needs to inform how health care is thought about and delivered, to ensure policies and practices are safe and effective for all people. ■

Acknowledgements

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Spirit Beads, Resilience and Residential School



Old Crow Baby Belt—A Cultural Form of Knowledge Transfer

In 1994, I made a trip to Whitehorse, Yukon, where I bought a baby belt that had been hanging in the Trading Post there since 1982, the same year it was made. The baby belt was made by a beader named Doris Fulban in Old Crow, home of the Vuntut Gwitchin First Nation and the only Yukon community north of the Arctic Circle. Belts like this are worn across a woman's shoulder and bosom and are tied at the back. They bind babies to their mothers, aunties and grandmothers for safety, security and finery.

The full length of the baby belt is decorated with showy but softly coloured, heart-shaped flowers and rich green leaves. Pearl-like grey beads cover the rest of the belt, except for the blue beads sewn all along the edges. Colourful trade beads and yarn tassels hang along one length of it.

I placed this magnificent piece of beadwork in my workspace so I could feast my eyes on it whenever I looked up from my work. I would gaze upon this beautiful baby belt, only to remember my mother, who drew heart-shaped flowers for the beadwork she never had time to do. My mother, who dreamed of having so many cows that the farthest one would be a mere dot on the horizon. My mother, the nurturer of many children who went away to residential school.

One day, after many months of training my eyes on the perfectly beaded baby belt, I was startled by some freakish beauty in it—the splash of colour, the echo, the home and the moment that can only be seen in stark contrast to faded colours, silence, homeless spirits and dying moments. A few dark-orange beads had been sewn among much lighter-coloured ones in one of the flowers. These beads were so out of the ordinary and so absorbing I couldn't help but marvel at them.

I had discovered what are sometimes called “spirit beads.”

I knew that some bead artists deliberately place spirit beads of competing colours in an otherwise per-

fect design. I was also aware that discovering the rogue beads is a gift, especially if lessons are drawn from them.

The spirit beads in this baby belt move me beyond simply appreciating this beautiful work of art. On the one hand, they show me how important and dignified being different can be. On the other, the spirit beads remind me that creative, therapeutic and perfectionist handiworks reveal both human strengths and frailties.

Resilience

Resilience has many meanings and manifestations.

Some see it as being able to bend without breaking and to spring back once we are bent.¹ In this case, resilient people usually manage to have good lives with steady jobs, long marriages and no mental illness even though they've lived high-risk lives and have had many problems.² Others say it is a search for success rather than an explanation for failure, especially where indigenous people, like First Nations, are concerned.³

Resilience is important for survival, but it is not always realized in a positive way. For example, gangs and drug dealers may show resilience, but their way of surviving does little to restore health and wholeness to families, communities and nations.

When it comes to resilience, spirit beads can show us how important it is to examine and re-examine the obvious. They teach us that resilience is quite simply getting along with people, getting through our responsibilities and getting out of situations that might cause us further harm.

Clearly, spirit beads are embedded in cultural traditions and customs. However, we Aboriginal people are not just cultural beings, even if we're often seen as such by the rest of Canadian society. While it's important to define who we are through our culture, this view becomes too narrow when it suggests that no one has to work hard on the non-cultural (social, political,

Madeleine Dion Stout

Madeleine is a member of Kehewin First Nation in Alberta and speaks Cree. She is also a Survivor of Residential Schools. Madeleine serves on the board of the Mental Health Commission of Canada, and lives in Delta, BC*

Note: In writings on the impact of colonization on Aboriginal people, certain words—such as Survivor, Residential School and Residential School Legacy—are often capitalized.

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Everything Is Related

Unemployment, mental health and addiction—and the need for cooperative action

Andy Sibbald

Andy has a master's degree in community development and has a passion for writing, teaching, providing training and helping communities address systemic health and social issues. Andy has a daughter in Yellowknife and presently lives with his wife in Nanaimo. He can be contacted at sibbald@shaw.ca

I lived and worked in the addictions field in Nunavut, the Northwest Territories and Yukon for a combined period of 20 years. I had the privilege of working directly with First Nations and Inuit people while in the North and have very fond memories of the people I worked and lived with there.

In 1983, the Canadian Mental Health Association (CMHA) came out with a report titled Unemployment: Its Impact on Body and Soul. I requested a copy from CMHA in 1986, because I was very concerned about the devastating impact unemployment was hav-

ing in the Nunavut community where I worked.

The report fit exactly what I was seeing in the community. It linked unemployment to addictions, family violence, mental illness and a host of other health and social problems. It confirmed that unemployment could destroy people, relationships and communities.

Too many suicides, too much pain

My first posting in the north was in Coppermine, NWT (now Kugluktuk, Nunavut). I moved there in 1985 to coordinate the local alco-

hol and drug program in the 97% Inuit community. Within a week of arriving, I found myself helping the Anglican minister put a man in his early twenties, who had committed suicide, into a plywood box.

I believe there were eight suicides that year in the tiny hamlet of 970 people. All were committed by men, all were Inuit and most were 19 to 25 years of age. I was 25 at the time and wondered why men my age were dying so often. I also thought that if the same percentage of people committed suicide in Toronto, it would be considered a huge national crisis. >>

Spirit Beads, Resilience and Residential School | continued from previous page

economic) aspects of our lives—not even Aboriginal people themselves.

But resilience is not merely a catch-all basket for resolving problems like substance abuse, poverty and child neglect. It is really a power shift, and it needs to take place within all of us.

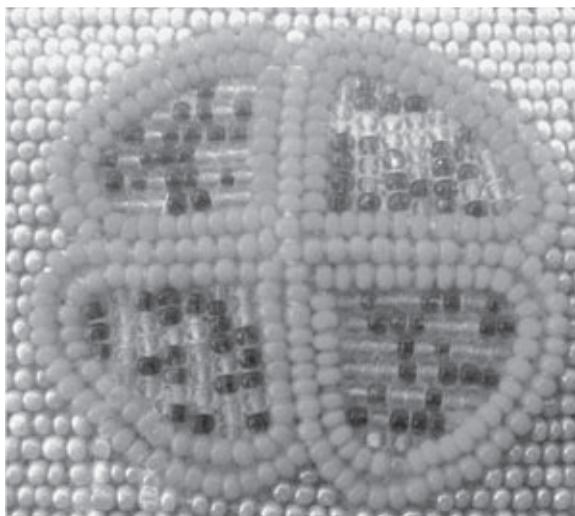
Difficult it is to move past our pain and to overcome the trauma we suffered from residential school. But, we are determined to get on with our lives and are doing this mostly in everyday living. Something as simple as taking time in one's day to reflect on a human creation such as the baby belt can transform that creation into a ready and relevant tool for analyzing our experiences in residential school. In this way, resilience becomes a part of living our lives.

Spirit beads push compassion into us and pull solidarity out of us. For its part, resilience praises doers and prizes doing. The spirit beads in the baby belt that is now in my hands are merely misplaced beads until they are reasoned out. And resilience is just a personality trait, if it is not lived by us. The residential school legacy will remain a place of worthless human suffering—unless it moves all kindred spirits to create and nurture caring spaces together. ■

How do spirit beads, resilience and residential school relate to one another?

It is now a well-known fact that residential schools have had a negative impact on survivors, their families and communities. In a BC-specific study of 127 survivors of the Canadian residential school system, only two subjects did not suffer a mental disorder.⁴

As survivors, we often remark on how dif-



Spirit Beads: One of Canada's Wonders

The community was in constant grief, and alcohol and drugs provided some relief from the constant emotional pain. I had never known the kind of despair I saw in that community.

Men, the hunter-providers, disenfranchised

As I watched what happened in the community, I began noticing that most of the suicides happened after a relationship had ended. The young men involved had few other sources of pleasure and self-worth. They often had no paid employment and a limited role in the community.

Unlike women, who retained their role as mothers and homemakers, the men's traditional role of hunter and provider for their community and extended family had been dramatically diminished by the monetary culture. Those most in need of meat for their families were often the least able to hunt. They didn't have the money to buy modern equipment—rifles, snowmobiles and boats, for instance—and fuel.

The males without jobs occasionally went hunting and otherwise wandered around town, pursuing fellowship and intimate relationships. If not in an intimate relationship, they were painfully aware that they had no constructive role. The response to this was directing anger inward through suicide attempts, or lashing out and then feeling great guilt and shame. It was sad to see this role loss manifest itself in domestic violence, alcoholism, depression and a host of other problems.

The need for coordinated services—and the lack of will

There are few ongoing programs, if any, that directly address the loss of the male role in Inuit and First Nation communities. Many small northern communities offer programs ranging from adult education and daycare to stopping family violence and alcohol abuse. Pauktu-utit, the National Inuit Women's Association, does a good job of bring-

ing up women's issues—but there is no comparable program for men.

Our small agency, the Coppermine Awareness Centre, was useful—over 30 people went to treatment in my first year there. As we made progress, however, we experienced some resistance. People who were unreliable in their jobs because of alcohol abuse were threatened by a pool of sober people ready to go to work. They wanted to get the sober people back to drinking.

After about nine months, I realized that counselling would not address the root causes of alcohol abuse problems in the community: the systemic issues like overcrowded housing, unemployment and poverty. Unemployment in this community was—literally—killing people.

I wanted to work with the local hunters and trappers association (Kugluktuk Angoniatit Association), federal unemployment and economic development departments, hamlet council and staff, Kugluktuk Housing Association and local contractors. I thought we could maximize jobs, start apprenticeship programs and stimulate the local economy by using local workers to build schools, arenas and houses. This would decrease dependency on outside expertise, put needed money in people's pockets and help local people develop the skills and experience necessary to gain employment in other communities.

I began to meet with local federal and territorial employees about developing a plan that would address the unemployment in the community. When I talked about a coordinated approach to dealing with health and social issues, they were seldom interested. I became very tired of being told—by people less aware of the despair and pain we saw every day in the alcohol and drug centre—that there was no relationship between housing, economic development, recreation, mental health and addictions, and the massive health and social issues facing communities. There seemed to be no willingness, leadership or vision to create employment, hope


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for the young or a comprehensive health and social plan.

The local social worker and nurses were so busy doing their own jobs that they had no time to initiate group efforts. The Anglican minister saw the need to work together, but found the same lack of cooperation.

When I saw 27 cases of liquor sitting at the airport one day, it was clear that my efforts at coordination were not resulting in any behavioural change. The liquor was for the local men returning from their three-week stint at a mining camp on Great Bear Lake. The men's return always occasioned one big party in the town, which caused a marked increase in public drunkenness, family violence, child neglect, assaults, sexual assaults and more.

The hamlet also held "beer dances," where you got six beers with your \$25 ticket. This also created huge problems in the commu-

nity, but the hamlet—which was a funder of our program—refused to acknowledge that there was any relationship between the beer dances and the assaults and so on that occurred on those nights.



tragedy. This happens regularly. A few days of help from an external "crisis team" answers the political question of what the government is doing about a crisis, but it wastes money and has few, if any, long-term benefits. And it excuses local agencies and people from taking responsibility for dealing with their own issues. Leadership in the North must help communities to find their own culturally appropriate, community-specific solutions to local problems.

Today, 25 years later, the observations contained in the CMHA report continue to be highly relevant. The devastating impacts of unemployment are still glaringly evident in small northern communities. And the need for coordinated approaches to complex health and social problems remains. ■

Fostering local responsibility

Government departments need to assume a real leadership role in making agency coordination happen at a local level. They need to stop sending in teams from outside communities to apply band-aid solutions when there's a major

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Earl Joe's Story

Donna Panitow

Donna recently graduated from Simon Fraser University with a BA in Communication and Political Science. She is currently working as Communications Assistant at the Canadian Mental Health Association, BC Division

This story is extracted, with Earl Joe's permission, from the full-length interview with Earl Joe that was used for making the DVD *Aboriginal Journeys in Mental Health: Walking the Path Together*

Trauma and lost identity

Earl Joe is a member of the Spallumcheen First Nation from Enderby, BC, a community of about 800 people. He and many other members of his community grew up physically, emotionally and spiritually abused in foster homes and residential schools.

"I lost my identity as being First Nations from resident school, because they brainwashed us [into believing] that we were savages." This led him to suppress his feelings until he was so numb he found it extremely difficult to express them. It was only later in life when he found a more effective healing path that Earl was able to feel again.

"I do a lot of crying just to release that anger and that bitterness," he says. "There's a lot of burdens that

a person carries, a lot of hurts and a lot of painful areas of your life."

A confusion of alcohol and depression

"I look back at my life—how I tried to destroy myself with alcohol—and all along I had this bipolar."

Earl experienced depression earlier in life, but he thought it was because of his drinking. Later in life, however, he received another diagnosis. "Because I had this disease of alcoholism, I relied on that [diagnosis] for years and years, and I thought I had that until 30 years later. Then I was diagnosed with bipolar."

He says, "I don't want to take a whole whack of pills—it's not me. I just want to zero in on that concept of bipolar, because that's my master. That leads to my depression; it leads to alcoholism."

"There are more better days today in the here and now, because I'm a recovering alcoholic... but I still have down days."

"What keeps me going is my sobriety."

“I just want to ZERO in on that concept of bipolar, because that’s my master. That LEADS to my DEPRESSION; it LEADS to ALCOHOLISM.”

Bipolar disorder—a scattered, twisted world

“I feel that I’m not a whole person,” Earl says of his bipolar condition. It’s “hard to explain because I’m all over the place, all over the map, and I feel like I’m all over the world, and living with this is very hard.”

Earl has general mental confusion and can’t properly communicate his thoughts and feelings. “You live in a scattered world.” Other symptoms he experiences are moodiness, restlessness, irritability and difficulty concentrating.

“I don’t even understand what I go through at times because it’s so messed; it’s so twisted mentally, twisted emotionally.” In order to understand his illness, he sometimes has “to sit back and get grounded and say ‘Hey, what’s the matter with me?’”

Earl goes through emotionally high states during which he is overcome with confidence and has extremely positive feelings about himself. He also goes through times of hyperactivity and sleeplessness.

But these times are always followed by disastrous plummets, so that once again he’s “stuck in that mesh of depression.”

Earl’s bipolar condition causes him to isolate himself a lot of the time. “Sometimes I feel like I’m nobody and that hurts, because it brings a lot of tears and I feel different from many other people”

He wishes others could understand the devastating nature of his illness. “Associating with my family, with bipolar—they don’t understand that I have this. Everybody thinks I’m weird. My whole community thinks I’m weird.”

Earl has seen how bipolar-related suicides have sent ripples throughout his community in the past. “It’s a deadly illness for anybody; it doesn’t matter what race you are.”

Moving toward health and wholeness

Earl recognizes that his bipolar disorder puts him at risk of suicide. “It leads to many dysfunctional feelings ... and there’s times that I want to commit suicide because I’m not all there.”

But he also acknowledges that he needs to reach out for help. “That’s a dangerous place... and I recognize today that I need to go out and get help for it; the help of treatment centres.”

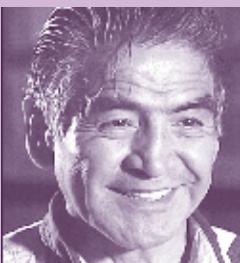
“I want to be somebody who lives a healthy life.”

Seeing a therapist and taking medication to treat his bipolar condition are helping Earl achieve a healthier life. He also strongly recommends attending self-help groups and making use of any available community resources.

Traditional and cultural practices play an equally crucial role in his healing. “Just listening to the drums and the elders... that really helped me.” He also takes herbs alongside his medication and attends sweat lodges, which helps relieve stress associated with bipolar disorder and depression.

Simple physical exercise makes a big difference to his well-being, as does finding time for stillness. “I have to go for a walk or take time out and meditate and say my prayers, and that’s one of the ways that I can help myself.”

Aboriginal Journeys in Mental Health: Walking the Path Together (DVD)



Aboriginal Journeys in Mental Health: Walking the Path Together is a 36-minute documentary featuring personal stories told by Aboriginal people who are recovering from and/or living with mental illness and by family members. The film captures the importance of balancing traditional Aboriginal approaches to healing with conventional approaches to assessment and treatment. The DVD was officially launched in 2006, funded by the Fraser Health Authority and produced by Bear Image Productions. Planning partners included Fraser Health’s Mission Mental Health, Mission Indian Friendship Centre Society, Sto:lo Nation Health Support Services, and BC Partners for Mental Health and Addictions Information.

For information on ordering the DVD, contact BC Partners at 1-800-661-2121 or 604-669-7600.

"I like who I am today, with the help of the teaching of the Elders." They've helped Earl recognize that he is not a "nobody," and that his bipolar condition doesn't have to isolate him from the rest of the community.

"There are a lot of spiritual helpers out there to help you to walk through your painful journey—because bipolar is a very painful journey."

In addition, family and community support are essential, as they comprise the backbone of the First Nation concept of being a whole person.

Earl advises people living with bipolar disorder to "go do things that you really like doing." For himself:

"I love to draw animals or listen to Native music that inspires me."

He also urges people to "stay away from drugs, go back to your people, and learn your traditional language."

Healing through helping

Earl aspires to be an addictions and substance abuse counsellor to help him stay on top of his illness and to help others.¹ "It's a deadly disease. What scares me is ending my life and I don't want that. I want to go out and help my people. This is number one for me."

He has accepted the challenges that come with bipolar disorder. "It's okay to have this illness." ■

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"Cowboy Dave"

Just one story from the Cariboo streets

Wayne Lucier

Wayne works as the Homeless Outreach Advocate for the Canadian Mental Health Association in Williams Lake. Before joining CMHA, Wayne worked as a life skills coach for the Cariboo Chilcotin Métis Association, where he also ran a daily lunch program for street people

My day usually starts with bringing coffee to the people who gather behind Lake City Ford, a common meeting area with benches that overlooks the stampede grounds. The number of people varies from day to day, ranging from three to eight people. Most are of First Nation ancestry from surrounding communities.

If people are there, it usually means that they've slept outside under bleachers at the baseball fields or under the overpass on Highway 97. Most of the them are older and have homes in the surrounding communities, but they come here to socialize, as not many people visit them when they're at home.

A few of them are truly homeless. They come to have coffee with the others, and to get in touch with me, because they know I'll be there. And I'd say that 75% of my clients are First Nation.

Some of the homeless people have been outside for more than three months. They were living in camps under the juniper bushes that used to dot the stampede grounds—until someone decided they shouldn't be there and complained to the city council. The City then had workers cut down some of the trees and take the people's

belongings to the dump. This happened just before I got my position as the outreach worker.

Cowboy Dave—A few new starts

The first person that I helped was one of the people who had a camp under a juniper and had returned to find the tree cut down and all his belongings gone. I found him a place to live and by the afternoon he had keys to his new home. Then I got him into the social assistance office.



Life slowly started to change for Cowboy Dave (a nickname that I started to call him). After being in his new place for a couple of weeks he approached me to ask for help to get into detox. It took seven days to get him a place in Kamloops. The bad news is, when he returned from Kamloops his friends had a party to celebrate—and got him evicted. This is a fairly common thing that happens when people come back from detox, and sometimes even when they return from treatment centres.

So we started over. This time Cowboy Dave found a place on his own, and I helped him move his belongings to his new residence. Once settled, he started talking to me about going back to work on one of the local ranches. He got a job and for a few weeks I didn't see him—until he came back to town with a broken wrist. He broke it when he got bucked off his horse. Just plain bad luck. Not being able to work, he started to slowly drift back to the streets and same old habits.

Cowboy Dave then decided to move back to his reserve, which is about a 40-minute drive from town. He decided that was the easiest way to stay off the streets and

stay away from his friends.

It's been six months now since Dave went back to his reserve. I still see him every now and then, when he comes in and does his shopping. He always has a smile on his face, and we sometimes go for coffee.

He still goes on a binge every now and then, but nothing like it was before, when it was an everyday thing. He now has a girlfriend in town and sometimes stays with her, but is sober when I see him. He also quite often checks on some of the Elders that he used to hang around with, to make sure they're okay, which I think is pretty cool.

I believe Cowboy Dave just got sick and tired of being sick and tired.

Finding housing takes a lot of luck

Things are not easy on our streets. Not that they're easier anywhere else, but our winters are pretty cold. The Cariboo Friendship Society shelter has been running at full capacity (35) for the past year and there is nowhere else to go.

Williams Lake has a zero vacancy and most landlords are now running ads that say they prefer working people. The average rent has increased by \$250 in the two years since August 2006. A three-bedroom house that would have rented for \$850 then, now, in September 2008, rents for up to \$1,500. Single people on income assistance cannot afford to live in our city.

The homeless count in our city is in the seventies when you count the number of people who are couch surfing from place to place, or the number of families that live together because they can't afford to live on their own. We also have one landlord who owns 75% of the apartments in our city, so that when he evicts someone, it makes it very hard for them to find somewhere else to live.

I feel helpless when I have no solutions for many of my clients. But I still get lucky and find places for some of them. When that happens it makes it all worthwhile. ■

Banishing the Shame From My Life

As a Métis man with bipolar illness, I have worn a mantle of shame—a sackcloth of self-loathing, fear of exposure and a deep sense of failure—for most of my life.

My Métis family has had roots in Western Canada since the 1780s. As half-breeds, we were always in denial of who we were and our proud history. Our greatest hero, Louis Riel, was at that time held to be a traitor, and we felt the scorn of the white community.

As an Aboriginal, I seem to have acquired this sense of shame very early in my life; I always felt

second-rate. Poverty and the way we lived, scrabbling a living from unyielding stony ground, reinforced my feelings of worthlessness.

And, as a young boy, I was sexually abused on several occasions by a drunken neighbour woman. I was ashamed and too terrified to tell my father and mother, because I knew I'd be beaten for making up stories. My father was a violent alcoholic who delighted in physically and mentally abusing my mother, my brother and myself.

In hindsight, it's clear to me that my bipolar illness manifested itself in my youth. Intense emotional outbursts and feelings, compulsive talking and dark days of hopeless despair were the cycle of my life. I was taken to a family doctor once or twice, but no firm

diagnosis was made. The doctor told my parents I'd "grow out of it." What "it" was, was never explained to me. And though no professional ever labeled me "retarded," my parents put that handle on me.

By extraordinary will power (many of us bipolar sufferers have it), I was able to function somewhat in the world. Though I was called "disruptive" and "uncooperative" in school, I maintained above average grades.

School, however, was a pressure cooker of adolescent emotions and feelings that I couldn't bear—so I quit.

I went into the construction trade, because it was "manly" and I didn't want my father to say I was weak and stupid. I come from a cowboy family where no one was ever allowed to say he was tired, hurting or just couldn't cope.

I married young and in four years we had three children—all boys. I wasn't prepared or equipped to be a father and sank into deep despair. I turned to alcohol for relief from these intense feelings. For a time, it did banish the despondency and gave me a feeling of peace and a heightened sense of self worth.

Alcohol, in its addiction, is the great remover. It can remove a little stain from your clothing, a feeling of nervousness when in stressful situations, or the anger that arises from frustrations on the job. In my case, it

"... I did journey toward that light—it was a place of peace for me—at last. But somehow I knew I couldn't stay there."

Ron Nunn

Ron was born in St. Laurent, Manitoba, where his family ranched, and he spent his teen years in Winnipeg. After working in the construction trade, Ron majored in First Nation Studies at the University of Northern British Columbia. He now writes for outdoor magazines and a Canada-wide Métis publication

removed my wife and job and any mental stability I'd had. Eventually, it almost removed my life.

When I was teenager, I attempted suicide and it was dismissed as youthful rebellion. In my late 20s, I diagnosed my self as hopeless and insane, and one night, after an unusually intense day of feeling despair, I decided to end my life.

In my insanity, I was unaware that my wife—terrified by my behaviour and threats of suicide—had called the police to our home, then had fled. My memory of this event isn't clear, but I was later told that I had a shotgun in my hand. Maybe I wanted to go out in a blaze of gunfire. When I heard a loud pounding on the door, I suddenly believed that a group of low-lifers I'd fought with outside the bar earlier that evening had come to get me. I fired up into the air—and then the front door crashed open. All I could make out was hands holding guns pointed at me. Someone opened fire and I felt the bullets strike my body; it felt like a punch that hurt deep inside, then a tightness and a burning sensation. I went down in pool of blood and was soon surrounded by police with

very worried faces. I wanted to die. A white light filled my eyes and I passed out.

This may sound trite, but I did journey toward that light—it was a place of peace for me—at last. But somehow I knew I couldn't stay there.

The next thing I knew, I was conscious of was a voice saying, "Breathe." I sucked in a big lungful of air—and was in the back of an ambulance with sirens screaming, on my way to the hospital. There, I underwent surgery to patch up the damage the bullets had done. My right arm was shattered and I lost most of my right kidney, my entire left kidney and about three feet of bowels.

Turning to the light of hope

My healing journey has been long and difficult.

After the shooting incident, a three month period in the hospital began the healing of my shattered body. Later, locked in a jail cell awaiting a bail hearing, I cried out in despair and anguish, asking God to help me.

I finally became willing to let Him take me to better things—I had come to a place of readiness to deal with my alcohol addiction and mental illness.

When I was released on bail, Alcoholics Anonymous (AA) became my place of recovery. After my trial and serving 13 months of a two-year sentence for assault with a weapon and endangering the life of a police officer, I stayed close to AA and the program of recovery. My mental illness, unfortunately, did not respond to the medications given me upon release from prison.

Fourteen years later, living in northern BC, I was still falling into cycles of depression and mania. I was diagnosed with all sorts of things, from dysthymia (i.e., chronic depression/low mood) to having a severe personality disorder. No medications were prescribed, save for a brief regime of Prozac.

Finally, while attending university—18 years after being released from prison—a psychiatrist at the regional hospital psychiatric outpatient clinic reviewed my history and came to the conclusion that I had bipolar illness. This was the first time that an accurate diagnosis of my illness had been made. Unfortunately, the antidepressants and mood stabilizers he prescribed triggered profound depression and a third suicide attempt.

After my 10-year second marriage ended, I moved to southern BC and was referred to a psychiatrist who specialized in bipolar treatment. A new regime

of medication was prescribed—and my life changed. The emotional intensity that had been so much a driving force in my life became manageable. The profound highs and lows of mania and depression became smaller bumps.

Recovery was still slow until, in later years, I dealt with the issues of my early life. Professional counselling helped me release the dark demons that drove me, and at last I was able to walk in the light of hope and peace.

Even though I've undergone many dark days of despair, I thank the Great Spirit for all the paths I've walked in my journey of self-discovery. I am of Aboriginal heritage and honour the ways of my Métis people and put that knowledge into my life to serve my fellow man. Not every day is perfect: there are still periods of depression and mania in my life. But I've been given the skills to cope with and survive the illness that would destroy me. I no longer wear the rags of shame, but walk with my head always turned toward the light. And I walk proudly. ■



Once Upon a Time in the Big City

A smart girl, but . . .

Growing up, I was always one of the good kids. Top student, perfect attendance, math awards, honour roll. I graduated early, with great marks and wanted to become a lawyer.

In September 2005, I moved into Winnipeg from my reserve to start university, fully sponsored by my Tribal Council. But when I saw all the money my friends from back home had—they were hustling crack—I was immediately addicted. Money, money, money—it’s like a drug! Hey, I could have all the nice things I’ve always wished for. I had a fresh sound system put in my car by one of my buddies—complete with a CD deck, two 15-inch subwoofers and an amazing amplifier. It was pounding! I loved it.

I never touched the crack, but I made money just by driving around with my buddies. They’d pay for my meals, hotel rooms, gas, entertainment—everything, basically. I felt like nobody could touch me.

My parents started getting calls from the university because I wasn’t going to classes, and my sponsorship was in jeopardy. I didn’t care; I was out having fun with “my crew,” you know.

In October, I was evicted from my apartment for having too many people come in and out, and my buddy went to jail. Then I met a guy who I thought I fell in love with, but he went to jail, too, not long after my friend did. I was left alone.

My school was slipping. What was once my favourite thing to brag about had become a big shadow over my mind. Growing up, I was always the smart one, the one people thought would go far in life. And here I was, alone, with nobody to talk to. I started doing coke heavily and partying whenever I could. It got so bad that I was kicked out

of school again. It was the third time—my mom kept fighting to keep me in my classes.

My parents came into the city to help me speak with my teachers and the dean university. Because my marks were great; it was just my attendance that was a major concern. They came to my auntie’s, where I was now staying, and started giving me shit because of how bad I was doing in the city. Then they went to their hotel, saying they’d be back in the morning. I started crying endlessly, trying to figure out what I was here for. I felt so bad because I’d let down the people I love the most, the people who cared for me more than I cared for myself. I started digging around my auntie’s place and found pills of all kinds—and took them. The last thing I remember was being really hot, and falling asleep on a book I was writing in.

The next morning, my mom came into my room, yelling because I was still sleeping. Then she noticed my speech was slow, I was moving really slow and my lips were going blue. She started freaking out, but she and my dad took me to a hospital emergency.

After they got the drugs out of my system and I had talked to a psychiatric nurse, I was let go. My parents had gone to talk to the people at the university. But what did I do? I walked out of the hospital with two bouquets of flowers went see this guy Shaun,* who was always supplying me coke and parties. When I got there, I gave one bouquet to his mom, but he was lying there with his baby’s mom. So I went down the street to one of my buddy’s crack shacks, where some of my friends worked. They

got kind of bugged at me for being so stupid—I still had my hospital bracelet on. I gave the last bouquet to some hookers who were there, and I left because my mom was at Shaun’s place to pick me up.

My parents told me I was allowed to go back to school again. I was relieved, but still had a gut feeling that I didn’t want to go to university any more. It just wasn’t growing on me.

Love and drugs and the whole darn scene

There was this guy, though, who did grow on me. My ex-boyfriend met him in jail and showed him my letters and pictures. This guy—his name was Sam*—started to fall for me. When he got out of the youth centre he started calling me. At first I was reluctant to talk to him, cause I didn’t have a clue who he was, yet he knew all this stuff about me.

Anyways, Sam and I started hanging out a lot. I was serious about this relationship, but he

“He’d make me believe all these lies and I’d be happy in love all over again. It was a WICKED cycle I was put through...”

wasn’t. He’d say he loved me, then turn around and phone his baby’s mom. And she started harassing me; my phone would be ringing 24/7 and I’d hear the same old name-calling and bullshit over and over again.

Sam and I started working for his sister Lola* and her boyfriend—it was like a pizza hotline for crack heads. We started making money and staying in hotels every weekend to get away from my auntie’s and his sister’s place. We started

Kristine Sinclair

Kristine grew up in a strict household, raised by both parents, and has what she calls an “eccentric” personality. She’s working toward a diploma and degree in business administration, and has dreams of being the head of a major firm someday

*pseudonyms



taking ecstasy and I wasn't doing coke as much. I felt like he really loved me, even though I'd catch him constantly on the phone with his baby's mom talking about their little girl. I hated it. It made me feel so low.

Then I started to notice a change in his attitude—and I found cans made into pipes. Sam got really edgy and was always mad at me, yelling at me to go away. And he'd be talking to his baby's mom. I couldn't take the pain.

Then one night, I caught him: he was stealing crack from his sister's stash and smoking it. I couldn't believe it. I was going out with this guy? His sister told me he'd smoked crack before—with their mom, who I hadn't met yet.

Anyways, Sam started getting worse and worse. I'd cry and cry to him and ask him not to work on the crack line any more, but he'd insist that I'd want money. And we'd slow up their little business, because he'd be tripping out, not wanting to go back and hand over the phone and crack because he'd

smoked it all. He started going into debt with his sister and her boyfriend, owing money left and right.

Then Sam's sister kicked him out because his addiction was getting out of control and he was staying with me at my auntie's place. He started feeding me lots of ecstasy because it made us very agreeable with each other. I'd be so x'd out I'd be okay with him smoking crack. I actually sat next to him under a blanket, listening to him make his pipe (out of a can). When I'd cry for him to stop, he'd get really angry and hit me. He'd say things like: "I can't stop." "You don't understand what I'm feeling" "You don't know what I'm going through."

The last time I caught him smoking, it was my 18th birthday. We were getting ready to go smoke some weed with friends downtown, and then go see my parents at The Keg for dinner. I noticed that Sam stayed in the bathroom, with the door closed, for a long time. Then he comes back into my bedroom and says, "Okay let's go," grabs his stuff and heads outside.

I just knew! I dug around in the washroom—and there it was: a can, hidden in my robe that was hanging on the towel rack. I felt so angry and sad, I blew up. I was fuming. I went outside and yelled at my boyfriend. He started heading to the bus stop to go to his sister's place. But I chased him, trying to get answers. I ran back to my car, drove to find him and told him to get into the car. He got in. We were both crying by this time. He said things like: "It's so hard; you have no idea what I'm going through." "You don't understand." Meanwhile, it's my birthday, he's my love and I was being affected by all this stuff... Ugh, what a day!

But it was the last time I caught him. Because he quit.

Crack, ecstasy, coke—ain't it all the same?

Sam stopped everything—crack and running back and forth between me and his baby's mom. Lola moved from the place she was

living, because there were drugs everywhere there, and Sam and I moved in with her.

I began to rebuild my trust in him. And Sam didn't go into any sort of rehab, because I was there for him, no matter how low he fell. I showed him the love, respect and caring he needed to get better. I believe my persistence helped him a lot. Everyone began trusting him.

And I stopped doing coke. Sam made me realize that it's the same thing as doing crack. His sister even stopped selling drugs and made sure her boyfriend stayed away from selling.

At times, back when Sam was smoking crack, I felt like giving up. I'd begin to fall into a deep depression—then he'd make me believe all these lies and I'd be happy in love all over again. It was a wicked cycle I was put through, but for some reason I felt I had to help him. He'd cry out sometimes, "I'm a good person, I really am. I'm sorry."

Today, Sam tells me he smoked crack because he felt like he had nothing. He said he felt that if he smoked enough one day, maybe he would die. But he says he'll never go down that road again, because now he knows he's better than that.

A happy ending

We're doing great now. I'm now the administration officer for a provincial Aboriginal emergency measures organization and I love it. And, I make great money. Sam started school. Most of the teachers thought he'd be one of the native "gangsta" dropouts they see each year. But he's actually excited to go to school each day and gets great marks.

We finally got a place of our own, a little two-bedroom bungalow. We just got our cable and internet hooked up last week. I'm excited to begin my life with such a great guy. I actually love him more because of all we've been through together. ■

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Harm Reduction and Abstinence

More Alike Than Different?

Alcohol and drugs have been a destructive influence in the lives of many First Nation, Inuit and Métis people in Canada, including in British Columbia. The forced loss of language, culture, land, tradition and identity has harshly affected the health and well-being of the original—Aboriginal—peoples. For some, this has resulted in mental health and addiction concerns, such as drug abuse.

A growing concern today is the injection of drugs like cocaine and heroin. Sharing the needles used to inject these drugs is a key mode of transmission for HIV among Aboriginal peoples in Canada.¹ A recent study of Vancouver's Downtown Eastside found that over a four-year period "18.5 percent of Aboriginal men and women who injected such drugs as cocaine and heroin became HIV-positive, compared with 9.5 percent of non-Aboriginal intravenous drug users."² A further study within Vancouver found that Aboriginal women who inject drugs are reported to die from HIV/AIDS, drug overdose and homicide at nearly 50 times the province's general female population.³

A hotly debated question is whether harm reduction should be a part of the solution to this serious health concern. For many, this is a hard question to answer, because most people don't fully understand, or are unwilling to look at, what harm reduction truly is.

What is harm reduction anyway?

For many people, the first thing that comes to mind when they think of harm reduction is Vancouver's supervised injection facility (SIF). This is likely because that's where most of the media attention has been placed. The public is receiving a large amount of information that pits moral arguments against research that supports the effectiveness of the SIF. For example, health minister Tony Clement commented to the Canadian Medical Association that doctors who support the use of the SIF lack medical ethics.⁴ The result is confusion on the part of the public about both the morality and the effectiveness of harm reduction.

There is likewise confusion when harm reduction measures are considered by Aboriginal peoples. Some First Nation, Inuit and Métis people maintain that harm reduction policies and practices go against their customs, traditions and beliefs. They believe using mind-altering substances causes a person to be "out of balance." Others, however, consider that there are similarities between a harm

reduction philosophy and traditional Aboriginal values. For example, respect is a traditional Aboriginal teaching—and respecting the choices of individuals, families and communities and "where they are at" is a premise of harm reduction.

In fact, the concept of choice underpins a harm reduction philosophy. Harm reduction policies and programs acknowledge that people and their communities are the 'experts' on their own experiences. As experts, they are best positioned to decide how to reduce the harm they experience because of substance abuse. Consider, for example, the Quesnel Tillicum Society Native Friendship Centre in northern British Columbia. Based on a need identified within and responded to by the community, the centre provides needles, condoms, swabs and needle exchange containers at no charge to community members.

Harm reduction, at its core, is simply a practice or strategy that reduces the harms individuals face because of their problematic use of substances.

Opposites? Or is one an aspect of the other?

From university classrooms to the front line in the addictions field, people too often think of harm reduction as the opposite of abstinence (i.e., not using any substances at all). In practice, however, harm reduction and abstinence actually have a core goal in common. They both aim to help people reduce the harms they experience because of their substance use.

Where the two philosophies are commonly believed to differ is in the concept of choice. While choice is a foundation of the harm reduction approach, it's not as apparent with an abstinence-based approach. One reason for this, among Aboriginal peoples and communities, is the historical support for abstinence-based

“Harm reduction, at its core, is simply a practice or strategy that reduces the harms individuals face because of their problematic use of substances.”

approaches. Abstinence has been favoured because the impact of alcohol and drugs has been devastating. It's been thought that it's better not to use at all than to use in a safer way. Also, the main source of treatment in Canada is offered by the National Native Alcohol and

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Drug Abuse Program (NNADAP). NNADAP was created nearly a quarter of a century ago when abstinence-based models were the norm.

There is, however, a strong illustration of choice in relation to an abstinence-based approach. The people of Alkali Lake, a Shuswap First Nation community in British Columbia, chose collectively to address its problems with alcohol by banning it altogether. The community “transformed its health conditions from within to suit its own self-defined needs.”⁵ This is choice.

A false separation has been made between harm reduction and abstinence. This is because people tend to focus on the differences between the two approaches, rather than on what they have in common.

The two approaches, when applied in treatment, can both be offered together. Some abstinence-based NNADAP treatment centres, for example, accept clients while they are on methadone maintenance therapy, which is a type of harm reduction treatment. Another example is an Inuit substance abuse treatment centre in Ottawa, the Mamisarvik Healing Centre, which offers its clients the choice of either reducing their use or not using at all while in the treatment program.

Again, underlying all of these approaches is the common goal of helping people reduce the harm they experience because of their problematic substance use.

Harm reduction, abstinence—only part of any solution

So, is harm reduction a part of the solution to alcohol and drug abuse among Aboriginal peoples? To answer this, we must first accept what harm reduction is. We must then work toward solutions that effectively reduce the harms to individuals and communities suffering from the impact of substance abuse.

It’s also important to know that harm reduction and abstinence are only a part of any solution. Substance abuse is a symptom of past and present social ills and inequalities faced by First Nations, Inuit and Métis across the country. Respecting Aboriginal peoples and their culture, along with ensuring strengthened social, political and economic well-being, is at the core of reducing the harms of substance abuse.

When we fall into the line of thinking that pits harm reduction against abstinence, we need to remember that both can exist together. Supervised injection facilities, policies that limit access to alcohol, needle exchange programs, and not using substances at all are among the possible responses. It’s up to individuals, families and communities, who know their experiences and needs best, to decide. And, it is up to everyone else to be wise enough to accept their choice. ■

footnotes

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Aboriginal Ethics Guide Ethical Research

Marlene Brant Castellano

Marlene is a member of Mohawks of the Bay of Quinte and an honorary board member of the Native Mental Health Association of Canada. She was a Professor of Native Studies at Trent University from 1973 to 1996 and served as Co-Director of Research for the Royal Commission on Aboriginal Peoples

Elder George Courchene of Sagkeeng First Nation in Manitoba, at a public hearing of the Royal Commission on Aboriginal Peoples in 1992, spoke of “Indian law” that was given to the people by the Creator at the beginning of time: “He gave them four directions. He gave them sweetgrass, the tree, the animal and the rock. The sweetgrass represents kindness; the tree represents honesty; the animal, sharing; and the rock is strength.”¹

Sagkeeng First Nation is one of many communities around the Great Lakes and southern Manitoba and Saskatchewan, also known as Ojibway or Saukteaux, that identify themselves as Anishinabek. Elders such as George Courchene have maintained ancient Anishinabek teachings and ceremonies, which are providing support for mental health among First Nations people.

The value of these teachings is also being discovered by teachers, counsellors, therapists and social workers seeking to help people reclaim balance and wellness in their lives. But helping professionals are urged to base their interventions on evidence of effectiveness. Policy makers are also looking for evidence-based strategies. Research is the source for such ‘evidence.’

Researchers and their wisdom, however, are often distrusted by First Nations, Inuit and Métis people. There are many stories of researchers who promised to do good with their studies but violated community rules of behaviour, reached conclusions that were contrary to what participants understood to be true, or failed entirely to report back to the community with their findings. One example of such behaviour was that of a researcher who invited members of Nuu Chah Nulth

communities in British Columbia to give blood for diabetes research. No new insights into diabetes were found, but the researcher went on to use the blood components for other purposes, without permission. This led to the researcher making statements about the genetic origins of the Nuu Chah Nulth that were contrary to their own history and sense of identity.²

Researchers are required to follow ethical codes of behaviour based on respect for human dignity. Valid research requires trust between researchers and the participants whose experience is being explored. The three agencies that distribute federal government funds for research—the Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council (NSERC) and the Social Sciences and Humanities Research Council

(SSHRC)—are now considering how the expectations of First Nations, Inuit and Métis people, and the ethics of research, can work together. Collaboration is widely accepted as the best means of producing sound human research on which to base more effective policies and services, including those in the field of mental health and addictions.

In May 2007, the Canadian Institutes of Health Research (CIHR) released guidelines for health research involving Aboriginal people.³ These guidelines promote research that is in keeping with Aboriginal values and traditions. The document begins with the recognition that researchers in the past have sometimes violated their own ethics requiring respect for human dignity.

The CIHR guidelines propose that research partnerships with Aboriginal communities be formalized in agreements balancing Aboriginal expectations of respectful behaviour and researcher ethics of respect for human dignity.

I serve on the Interagency Advisory Panel on Research Ethics, which is updating the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS 1998). The second edition of the TCPS, scheduled for release in 2009, will include a chapter on ethics of research involving Aboriginal peoples. It will build on the CIHR guidelines and will extend the

coverage of policy to all types of research involving humans.

In developing the new chapter in the TCPS, we recognize that Aboriginal or Indigenous traditions have much to contribute to our understanding of ethics. The language, however, may refer instead to “spiritual responsibilities to maintain right relationships.” For example, Elder Courchene’s words, as they apply to relationships between researchers and Aboriginal participants in research, may be expressed as follows:

- **Kindness** implies respect for the dignity of the others involved, not dominating or pressing our own agenda at the others’ expense
- **Honesty** involves communicating our principles and intentions as the basis for relationship and ensuring free, informed consent for actions taken
- **Sharing** recognizes that the common good requires give and take by all, with respect for the different gifts that each party brings
- **Strength** is courage to stand firm for our principles; in some cases, strength is resilience, as in the capacity to bend to circumstance while holding on to important values

Together, these virtues balance one another to maintain respect for self and others. All parties to a relationship are responsible for maintaining this ethical balance. While

words to describe relationships differ, it is possible to see the harmony between the ethics of “respect for human dignity” endorsed by researchers and the ethics of “right relationships” embodied in First Nation, Inuit and Métis traditional teachings.

Extending knowledge through research can lead to improved health. Research based on right relationships, drawing on Aboriginal knowledge along with scientific expertise, will benefit First Nations, Inuit and Métis peoples and Canadians at large as deeper insights into the sources of well-being are uncovered. ■

footnotes

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To learn more about developments in ethics and Aboriginal research, see the CIHR guidelines for health research at www.cihr-irsc.gc.ca/e/29134.html,³ and Marlene’s article in the National Aboriginal Health Organization Journal of Aboriginal Health,⁴ at www.naho.ca/english/pdf/journal_p98-114.pdf.






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Seeking Health Care at Emergency Departments

Access issues affecting Aboriginal people

Annette J. Browne, PhD, RN

Annette is an Associate Professor in the School of Nursing at the University of British Columbia. She holds a New Investigator Award from the Canadian Institutes of Health Research and a Scholar Award from the Michael Smith Foundation for Health Research

Many Aboriginal people have difficulty accessing health care services. I am a member of a team of university and community-based researchers¹ who want to see people's access to primary health care services improved. We have been conducting a study² to help us understand more fully the social and health factors that make accessing health services difficult for many Aboriginal people in inner city areas. As we discuss below, many of the people in this study were affected by mental health and substance use issues.

Overview of our study

Access to health care is heavily influenced by social, economic and political factors. For Aboriginal people who are living in inner city neighbourhoods, many experience high rates of poverty, unemployment and lack of access to adequate housing. Many people have also been affected by intergenerational trauma from residential schools. Together, these issues can result in higher rates of mental health problems such as anxiety or depression, or in some cases, addictions. Many people also experience discrimination on the basis of their status as Aboriginal people, poor people or people living with mental health and addictions. All these factors can make it difficult for some Aboriginal people to get the help they need.

The problem of accessing services is made worse because many physicians' offices do not accept new patients; this is partly because their practices are full. There are also some physicians who choose not to work with people who have complex health problems, particularly when these include mental health or addictions issues.

In the inner city neighbourhood where the study was conducted, there are many clinics and doctors' offices. However, a relatively high number of Aboriginal people seek help, at a particular inner city emergency department (ED), for "walk-in" types of health issues ranging from sprains, mild fractures and abdominal

problems, to requests for medications to relieve chronic pain. Once people started to explain their situation, however, it became clear that many were also living with addictions issues and/or mental health issues, and dealing with the effects of poverty.

The focus of this study was not on emergency visits for acute or life-threatening health problems. We interviewed (in depth) 34 people who self-identified as Aboriginal and who were, for the most part, "walk-in" patients seeking help at a non-urgent division of a large ED. The majority lived in an inner city neighbourhood recognized as one of the poorest in Canada. Many lived in very poor conditions, in rooming houses or in shelters. Some were homeless. Many had experienced trauma and violence as children and young adults, and now lived with chronic pain, anxiety and depression. Many lived with addictions to illicit drugs, alcohol or prescription drugs.

Highlights from the research findings

A major issue for many of the participants in this study was the challenge of getting help for chronic pain and related health issues. We know that people who have serious drug or alcohol addictions often live with chronic pain, and that people with

“They felt uncomfortable going to those places because they thought they would be negatively judged as drug seeking or not having real health concerns.”

chronic pain often have experienced severe emotional trauma or violence in their life. There are also links between people's mental health problems, experiences of chronic pain and histories of trauma.

What we learned from the patients in this study is that their chronic pain was not only physical in nature, but reflected the pain of "social suffering." Social suffering refers to mental, social and emotional pain people experience because of economic, historical, political and institutional power inequities.³ In the case of the Aboriginal people in this study, these health issues were the end result of personal and intergenerational traumas, marginalization, stigma and discrimination that are part and parcel of the history of colonization of Aboriginal people in Canada.

In terms of getting temporary relief for their chronic pain, for some participants, the ED was viewed as the “best bet.” That was because of their experiences trying to get health care in other places in the community. As the patients described, they often felt dismissed or not taken seriously when they went to doctors’ offices, community clinics or walk-in offices. They felt uncomfortable going to those places because they thought they would be negatively judged as drug seeking or not having real health concerns.

In some cases, people were concerned about how they would be judged by health care providers in community or walk-in clinics because of their “rough appearance” (rough because they were living on the street, were barely housed, or were living with severe addictions). As one man who lives with addiction, chronic pain and anxiety expressed about his experience at a walk-in clinic, “I don’t know if it was because I didn’t shave that day. I was all scruffy and I came in and just sat there... So, um, nothing against street people or that, I used to be one, but you know, if that was his [the health care provider’s] impression, he didn’t tell me. He didn’t say anything, but he just told me to go home. But the pain is bad and it’s been happening for quite a few months now.”

At the ED, they knew that they would be seen and treated—eventually—even if it meant waiting a long time. For some people, this was better than risking the chance of being sent home without being seen, or without having their needs addressed at community or walk-in clinics.

A 59-year-old woman in our study who lived with major anxiety and chronic pain told us how she repeatedly sought help at two EDs in her downtown neighbourhood—because she didn’t know what else to do to get help. At walk-in clinics or community clinics, she was often told there was nothing they could do for her. This only served to worsen her anxiety, and made her question whether she was, in fact, having pain. This process of second-guessing herself resulted in delays getting the help she really needed. Because she ended up waiting until she was very ill before coming to the ED, the nurses there questioned her decision to wait for so long before coming in. This, too, fed her anxiety.

This woman also spoke openly about how her experiences in residential school, and the anxiety and pain she attributed to those experiences, made it hard for her to relate to people in authority positions—including doctors or nurses. This also created anxiety for her about where to go for health care. As a result, she repeatedly came to the inner city ED.

The ED, however, was not always a good place for this woman to be. She, and many other people in the study, had mixed feelings about EDs. For example, she described the frustrations expressed toward her by some ED staff, who couldn’t relate to why she kept coming in. As she described, “He [an ED staff person

at one of the hospitals] said, ‘You know how many times you have been here?’ I said, ‘No.’ He said, ‘Thirty-three times.’ And I said, ‘Well, this is a hospital, right?’” She went on to say, “I didn’t really need to hear it, because I was really having a lot of problems with myself. And I didn’t understand it, because being raised in the residential school, you’re always told to shut up and we didn’t have any opinion about anything. So it was really hard for me to converse with doctors.”

This woman’s example, and others, help us to understand how challenging it can be for some Aboriginal people to get help with health or mental health problems they feel are legitimate. Although many of the people in this study did get the help they needed at this inner city ED, many also described the worry they experienced about how they would be treated the next time—not just at this ED, but in the wider system of health care.

Conclusions

Our study showed that people’s reasons for coming to the ED for walk-in issues are shaped by complex social, economic and personal factors. In the case of the Aboriginal people who participated in this study, these factors include:

- past experiences at various health care settings
- patients’ own assumptions about how they’ll be treated in walk-in clinics, doctors’ offices and community clinics, given their identity as Aboriginal people, their low socio-economic status, their appearance because of living on or near the street, and their mental health or addictions issues
- worries that their health concerns will be dismissed because of assumptions made about them by health providers in walk-in clinics, doctors’ offices and community clinics
- difficulty relating to authority figures as a result of residential school experiences or other traumatic issues in their lives

For the people in this study, these factors created an underlying anxiety about seeking health care in general—at EDs and at other settings. Until there are significant improvements in the availability of other responsive, welcoming and effective services, EDs may need to continue as non-emergency health access sites for many people. ■

footnotes

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Canada's Indian Residential School System

Historical trauma and the Aboriginal Healing Foundation

Wayne K. Spear

Wayne Spear is a Kanien'kehake (Mohawk) citizen of the Haudenosaunee (Six Nations Confederacy) and the Director of Communications at the Aboriginal Healing Foundation

*Assimilation takes place when a minority group adopts the customs and attitudes of the main cultural group. In this case, the Canadian government forced Aboriginal peoples to assimilate by putting them into residential schools. For more information on residential schools, see Bill Mussell's guest editorial on page 4.

The Canadian Indian Residential School System's century-long policy of forced assimilation* of Aboriginal peoples has left a legacy of destruction, pain and despair. Some of the problems facing Aboriginal people because of the assault on their cultures are:

- addictions
- abuse among victims and their families, self-abuse and violence
- suicide
- crime
- poor parenting skills
- poverty
- trauma
- difficulty forming healthy relationships

The Aboriginal healing movement had begun to address the conditions of communities even before the closing of the last government-run Indian residential school in 1996. With this movement has come a focus on addictions and mental health and a renewed commitment to traditional Aboriginal teachings—specifically, to a holistic view of individual and community wellness.

The Royal Commission on Aboriginal Peoples and the AHF

In November 1996, the Royal Commission on Aboriginal Peoples (RCAP) released a 3,200-page final report. The report detailed the historical relationship between Aboriginal peoples and Canada.¹ RCAP recorded many testimonies from survivors of residential school abuses.

On January 7, 1998, the federal government responded to RCAP by issuing a Statement of Reconciliation and a strategy to begin the process of reconciliation. The strategy was outlined in a document called *Gathering Strength—*

*Canada's Aboriginal Action Plan.*² The government also announced a \$350-million healing fund to help heal the legacy of residential school abuse.

On March 31, 1998, the Aboriginal-run, not-for-profit Aboriginal Healing Foundation (AHF) was created to manage the fund. The AHF was given an 11-year contract ending March 31, 2009.³ They had one year to organize themselves, five years to spend or commit the funds, and five years to monitor projects and write a final report.

The Aboriginal Healing Foundation completed its mandate well ahead of schedule. It released its three-volume final report in January 2006.^{4,6} The report traces the role of the AHF in the Aboriginal healing movement. It also presents data collected to evaluate the process and reports on promising AHF-funded activities.

A brief overview of the Aboriginal Healing Foundation's work

Healing—a long-term process, occurring in stages

The healing journey begins with awareness. An understanding of the impact of the residential school legacy on one's self and one's family follows awareness. It takes time for individuals and communities to reach the "readiness to heal" stage. Healing...

- requires that survivors feel safe
- addresses trauma issues
- reclaims healthy, productive lives

Based upon research and evaluation findings, the Aboriginal Healing Foundation proposes that 10 years is needed for a community to:

- reach out
- dismantle denial

- create safety
- engage its members in therapeutic healing

The minimum time needed to move through identifying needs, outreach and starting therapeutic healing is 36 months. In other words, on average, a minimum of 36 months is needed to initiate meaningful healing in a community. Ten years of constant effort is needed to bring about lasting change.

Stable funding is needed for communities to continue to heal.

Community-based healing projects

The AHF has funded the following types of community-based healing projects since 1999:

- 65% are direct healing services such as therapy, counselling and on-the-land, culture-based activities
 - 13% are prevention and awareness initiatives. These include books, workshops and education on the legacy of residential schools. They also include the prevention of violence (violence between victims, or among Aboriginal victims and members of their community) and abuse
 - 8% are in the area of building knowledge about the history and impact of the residential school system. Too many Aboriginal young people don't know enough about this
 - 6% fit into the category of training. Training healers is an essential part of the healing process
 - 3% are in the category "honouring history"
 - 3% are projects that assess needs
 - 1% are concerned with project design support and conferences
- AHF-funded projects found that 75,636 (37%) of people have spe-

cial needs (e.g., severe trauma, including alcohol abuse; suicidal behaviour; etc.).

So far, of the AHF-funded healing projects in communities:

- 20% are just beginning their healing activities
- 65.9% accomplished a few goals, but much work remains
- 14.1% accomplished many goals, but some work remains

Participants' experience with healing activity:

- 33% had previously participated in a similar program
- 66% were participating in healing activities for the first time

The four most commonly cited changes for participants were:

- improved self-awareness
- relationships with others
- knowledge
- cultural reclamation (revival of traditional practices, promotion of language, etc.)

Most of participants felt better about themselves because:

- they found strength
- they improved their self-esteem
- they were able to work through their trauma



For more information, or to receive free copies of the Aboriginal Healing Foundation's final report (and/or other AHF publications), visit www.ahf.ca or phone 1-888-725-8886.



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Unprecedented Collaboration

Four nations in Northern BC geared to “embrace life”

Sandra (Wesley) Olson

Sandra is the Director for the First Nations Action and Support Team (FAST).

FAST was created to provide suicide prevention and intervention services to northern BC nations, including the Wet'suwet'en, Gitksan, Tsimshian and Nisga'a

Four nations in northern BC—the Wet'suwet'en, Gitksan, Tsimshian and Nisga'a—have come together to form an unprecedented partnership. Their goal is to reduce the high number of suicide ideations, attempts and completions. It is with great hope and excitement that this partnership announced its recently created First Nations Action and Support Team (FAST) program.

FAST's mandate is: “Embracing life through suicide awareness and community empowerment.” The program will develop and train a team of service providers made up of members from each of the four nations.

This new program is not meant to replace or compete with existing resources, programs or initiatives. Instead, its goal is to complement these services. The idea is to facilitate a coordinated effort. Team members will educate and empower communities to act when an individual or a community as whole is in crisis.

FAST is similar to the groundbreaking approach of the Aboriginal Suicide Critical Incidence Response Team (ASCIRT) program on Vancouver Island. ASCIRT is a program of the Inter Tribal Health Authority. It is through their trials and errors that FAST was able build as quickly as it did.

“The strength of your heart comes from the soundness of your faith”

So says a Saudi Arabian proverb. But what happens to a people when an entire generation is forbidden to practise what was a way of life of their people for tens of thousands of years?

Strength of the heart weakens, and soundness of faith withers.

The heart is not only an organ that beats inside your body. It is also the spirit within. It is your mind, your intellect, your psyche. It is also your compassion, kindness and affection. It is what guides your life.

Faith represents confidence, trust, belief and dedication. It is what allows you to be proud of who you are and where you come from.

During the residential school era, the heart and faith of hundreds of First Nation children was taken and stomped on. Due to their resilience, those children, who are now grandfathers, grandmothers, fathers and mothers, are still here. But they were sent back to their communities with severely weakened hearts and severely fractured faith. Several generations of First Nation people have seen and felt the ripple effect of the residential school era.

Suicide is on the rise in the majority of our First Nation communities.¹ Although there are many other contributing factors, the traumatic and devastating events that took place in residential schools were, and still are, the root problem of most of the health issues in our communities today.

Of our people, by our people, for our people

FAST is a work in progress. An effective process to ensure services are provided as efficiently as possible is still being developed. We want FAST to work not only for the present First Nation partners, but also for other First Nations communities, who can adopt or incorporate our program as a tool for their communities.

The First Nations Action and Support Team members are diverse in terms of age, educational background, work experience, First Nation cultural background, gender, professions and individual life experiences. FAST has gathered addictions and/or mental health counsellors, a licensed practical nurse, a provider with a Bachelor of Psychology, a fire chief, administrative workers and youth workers to name a few.

In October and November 2007, the team members went through two intense, five-day training sessions. A much-anticipated celebration to introduce and uplift the FAST members was held on January 19, 2008. The team members were gifted with strength, encouragement and support. There was representation from the four nations, as well as the following invited guests:

- Okanagan Nation Youth Response Team
- Aboriginal Suicide Critical Incident Response Team
- First Nations and Inuit Health Branch (FNIHB)
- Chiefs Health Committee
- Union of BC Indian Chiefs
- Northern Health Authority
- Ministry of Children and Family Development (MCFD)
- A local MLA

The FAST members are trained to become trainers and will continue to receive newer and better training—FAST is committed to lifelong learning. The team members also learn a great deal from each other, making this already strong team even stronger. They will soon be ready to start giving back to their communities. And, because the FAST members know their communities, they know who you are, where you come from, your pain and your culture. Who better than your own people to help you in your time of need? ■

Members of FAST:

o Gitksan:

Angelina Lewis,
Audrelyn Westle,
Esther McLean,
Gary Benson,
Gloria Stevens,
Jennifer Sampare,
Robynn Muldoe,
Violet Sampare

o Nisga'a:

Don Leeson,
Jacquie Adams,
Lorna Azak,
Lydia Stephens

o Tsimshian:

Anne McDames,
Jada Seymour,
Janice Robinson,
Ron Watson,
Tamara Innes

o Wet'suwet'en:

Danette Gagnon,
Rodney Mitchell

footnotes

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Surviving the Fall

DVD uses storytelling, the Aboriginal way of transmitting knowledge, to educate about reproductive mental health

A young mother-to-be tells of anxiously watching the screen during her ultrasound—tears quickly form and stream down her cheeks as she realizes her baby's heart is no longer beating.

Another young woman speaks of the early days with her new baby: "It should have been the happiest time of my life. But I cried all the time—even when I did the laundry. I always felt alone, even when I was in a room full of my family—people who loved me."

"I would be driving along in my car and suddenly break out in tears for no reason. It was the strangest time. I felt that if I drove my car over the edge, then everything would be over—all the pain and the empty feelings I had," said another young woman.

These personal stories are among those courageously shared by six young Aboriginal women from the Stó:lō Territory, and their families. They've been captured on film for a new DVD, *Aboriginal Journeys in Mental Health—Surviving the Fall*.

The stories speak to the grief and loss of miscarriage and stillbirth and of the loneliness and isolation experienced with perinatal or postpartum depression—depression during pregnancy or following the birth of a child. The stories speak to the mental and emotional struggles, the pain, the frustrations and the sadness. They also speak to the recovery and hope gained from reaching out for help.

And in the telling, their emotional and heartfelt words continue an ancient tradition of the Aboriginal people—to share learning and wisdom through stories passed on through the generations.

"In the Aboriginal culture, learning is relational," says Brian Muth. Muth, a former mental health liaison for the Stó:l Nation Health Services, is Fraser Health's Aboriginal community engagement coordinator and a DVD project leader. "It comes from connections with others, from listening to stories and attending gatherings. This has been the way of the Aboriginal people since earliest times."

Perinatal depression—serious health consequences for mother and child

Alongside the stories offered by these women are messages from public health and mental health care providers and health care providers who work with the Aboriginal population. One of these providers is Dr. Shaila Misri, director of Reproductive Mental Health at BC Women's Hospital and a provincial expert in this field.

"In 1895, a French psychiatrist first made the connection between the post-partum (perinatal) period and insanity," Dr. Misri says in the DVD, stressing the increased understanding that has developed since that time. "That journey has been important in that at least today, woman no longer are dismissed because they're mentally ill when they become mothers."

Depression is the leading cause of disability for women in their childbearing years.¹ As many as one in five women in BC may experience depression related to pregnancy and childbirth.¹ And research shows that perinatal depression can seriously affect the health of both mother and child and, if left untreated, can lead to chronic depression.¹

"It is absolutely our responsibility to not only be able to diagnose and treat, but to understand that these women are suffering—and not because it is their choice . . . We must be sympathetic, understanding, cater to their needs and give them as much support in the community as possible," she adds.

Marie Nightingale

Marie is a Senior Communications Consultant with Fraser Health's Communications and Public Affairs Department



Fraser Health's Aboriginal Health Services identifier represents a culturally inclusive and caring organization. The hummingbird symbolizes health; the Métis flag and the Inuit Inukshuk represent the diversity of our Aboriginal population. The medicine wheel symbolizes balance and represents the four elements of life including mental, physical, emotional and spiritual health. The drum represents the heart beat of the Aboriginal Nation.

Toward the best journey possible for mothers-to-be

This DVD is one step toward achieving the goal of a recently developed Perinatal Depression Strategy. That goal is to ensure every pregnant woman in the Fraser Health region has the best journey possible from the onset of her pregnancy to the year after the birth of her child.

Copies of *Aboriginal Journeys in Mental Health—Surviving the Fall* are available through Leslie Schroeder at Fraser Health. Call, in Abbotsford, 604-851-3087.

A steering committee made up of representatives from Fraser Health services and the Ministry for Children and Family Development, as well as independent midwives, worked together to develop the strategy. Their focus was on an approach to perinatal depression that would involve every related health professional. The strategy includes an education and awareness program. It also includes an early identification, screening and treatment plan for pregnant and early parenting women in the Fraser Health region who experience symptoms of perinatal depression.

The partners involved in the DVD project include Fraser Health's Health Promotion and Prevention, Fraser Health's Mental Health and Addiction Services, Stó:lō Nation Health Services and Bear Image Productions.

Surviving the Fall was developed to serve as a culturally sensitive educational tool for reaching out to the Aboriginal population, and to public health, mental health and health care providers who work with the Aboriginal population.

"And," says Muth, "in using the cultural tradition of storytelling, I believe we have captured a distinc-

tiveness brought from the lived experience that is extremely powerful in supporting, educating and inspiring others"

The documentary focuses on holistic wellness. In doing so, it closely aligns with the Aboriginal concept of the medicine wheel—that wellness comes when the four areas of spirit, mind, body and emotion are in balance. This concept is also embraced by the Mental Health, Health Promotion and Prevention and Aboriginal Health Services of the Fraser Health region.

Leslie Schroeder, of the Tzeachten-Stó:lō Nation, is project director for Fraser Health's Aboriginal Health Services. She believes the DVD is extremely valuable. "It will help people in many ways by building greater understanding of the mental health challenges associated with pregnancy and childbirth, promoting early identification of symptoms, and encouraging women to be pro-active about their health and wellness," she says.

"In our culture, traditionally, women are seen as the strong ones—the ones who have the babies, take care of families—the ones to look up to," says Schroeder. "So it

is not surprising that when a woman loses a baby during pregnancy, or experiences depression in relation to her pregnancy or childbirth, that she may feel somewhat inadequate and reluctant to reach out for help."

"By providing glimpses into their personal experiences, these women and their families have also shared very powerful messages to others about the importance of moving beyond the stigma to speak out about what you're feeling, seeking support and the healing that can take place as a result," she adds.

"Their words will help others see that it's okay to feel this way and they're not alone."

The DVD also speaks to the importance of weaving mainstream medicine and practices with traditional Aboriginal healing. Through the words of the women and their families, as well as public health, mental health and Aboriginal care providers, the message is clear—a combination of both the conventional and the traditional can bring a stronger network of support. ■

footnotes

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Toward Blending the Best of Two Worlds

The Fraser Region Aboriginal Child and Youth Mental Health Teams

Janit Doyle, MSW, RSW

Janit is the Aboriginal Child and Youth Mental Health Team Leader, Fraser Region East. She is of Irish descent

Virge Silveira, MSc

Virge is the Aboriginal Child and Youth Mental Health Team Leader, Fraser Region West. She is from Lytton First Nation

In 2004, the Fraser Region Aboriginal Planning Committee (now the Fraser Region Interim Aboriginal Authority¹) and the Ministry of Children and Family Development (MCFD) formed a partnership. The aim of the partnership was to put together a plan for improving mental health services for Aboriginal children and youth. We were involved in the process of creating this plan.

Over the next year, we invited Aboriginal individuals, organizations and communities in the Fraser region, from Burnaby to Boston Bar to take part in community sessions. Those who participated in the community sessions told us they wanted better ways of getting services and wanted to have services that fit with how they see the world.

The information from the community sessions gave us planning goals. The goals that guided us in creating the Aboriginal Child and Youth Mental Health Plan (The Plan)² include the following:

- Improving access to child and youth mental health services by focusing on outreach and/or community-based services
- Focusing on designing services that are relevant to Aboriginal people by respecting Aboriginal tradition and "way of life," and including Aboriginal people in service delivery
- Ensuring the delivery of services is aligned with the direction of the Fraser Region Interim Aboriginal Authority order (see text box)
- Building bridges between Aboriginal communi-

ties and Aboriginal community-based services and mainstream child and youth mental health services. The Plan was approved in February 2006, first by the Fraser Region Aboriginal Planning Committee and Fraser Region MCFD, and then by the MCFD provincial office.

Aboriginal Child and Youth Mental Health

Aboriginal Child and Youth Mental Health is a program of the Ministry of Child and Family Development. Its purpose is to enhance child and youth mental health services for the Aboriginal population within the Fraser region. It will serve status and non-status First Nation people both on- and off-reserve, Métis, Inuit and anyone identifying as Aboriginal. ACYMH services are meant to help solve the problems Aboriginal people have identified with the existing services for children and youth.

The ACYMH teams

There are two Aboriginal Child and Youth Mental Health (ACYMH) teams serving the Fraser region. The Fraser Region Aboriginal Planning Committee divided the Fraser region into six circles of Aboriginal communities.² The West team covers the Burnaby, New Westminster, Tri-Cities, Surrey, Delta and White Rock areas (two circles). The East team covers from Maple Ridge and Langley east to Hope and Boston Bar (four circles).

Both ACYMH teams will have outreach workers, clinicians and guides. Our intention is to recruit Aboriginal people to fill all these jobs.

We are excited that the majority of outreach worker and clinician positions have been filled. About half the applicants are of Aboriginal ancestry.

We'll also be hiring people from the Aboriginal community to fill the role of a guide. Guides will help families who want to use MCFD Child and Youth Mental Health services, but don't feel safe using the system or don't understand it. In the community feedback, it was suggested that we have "a guide to ease feelings upon accessing the services." We acted on this suggestion.

Already in the works

Right now, we're providing educational services to the Aboriginal community. We're teaching communities about the way the mental health system is set up and how it runs, so people won't be fearful when looking for help. Again, in the community sessions, people pointed to a need to break down barriers. For example: "some people don't read" and "the paperwork that has to be completed gets in the way and doesn't always make sense."

We also provide information on what "mental health" means and do other prevention work with people in the community to lower the rates of mental illness. We'll work closely with other service providers. We believe that partnerships are very important for good work to be done.

The clinicians we've hired will be providing therapy and counselling. We will not be replacing the existing CYMH clinicians. Our clinicians, like our outreach workers, will go out into the community. Feedback also told us that "mental health workers should provide home visits." And that is what we have planned.

Another strong message from the community sessions told us there is "a lack of understanding by MCFD Child and Youth Mental Health about [Aboriginal] culture." They said that "mental health staff need to be trained re: historical events and impacts that have caused some of the problems for Aboriginal people."

So, we are holding Aboriginal cultural sensitivity trainings for all Child and Youth Mental Health clinicians. The week-long training provides a great introduction to First Nations, Inuit and Métis history and world view. Participating clinicians are invited to take part in traditional ceremonies and other cultural activities. In partnership with First Nations communities in the region, we have held two of the three trainings in local traditional long houses, to provide an experiential learning environment.

Finally, ACYMH is in the early stages of a project with Fraser Health. The project goal is to develop a model that will allow families and youth to have the choice of receiving both Western/European practices and/or traditional healing practices when being treated for anxiety and/or depression.

Toward . . .

In the near future, we see Aboriginal children and youth achieving mental wellness and balance with the support of these two different systems of care and ways of healing. And, care will be provided in a manner and location that is most suitable for the family, child and/or youth. ■



footnotes

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The Fraser River Interim Aboriginal Authority

The Fraser River Interim Aboriginal Authority (FRIAA) is made up of representatives from Métis and urban and land-based First Nations. The FRIAA is the Aboriginal planning committee responsible for the development of a community-based Aboriginal Authority for Children and Family Development for the Fraser region. (See www.fraa.ca/about.html#why)

The FRIAA will become the Fraser Region Aboriginal Authority (FRAA) through a legal process of the provincial government. Once it has been created, the FRAA will gradually oversee the delivery of services currently provided by the Ministry of Child and Family Development (MCFD) to Aboriginal people. (See www.fraa.ca/about.html#what)

Source: www.fraa.ca/index.html

Publications

- **Aboriginal Mental Health: What Works Best**. A 2001 discussion paper prepared for the Mental Health Evaluation & Community Consultation Unit www.carmha.ca/publications (click on: MHECCU Publications)
- **Emerging Trends in Research on Mental Health Among Canadian Aboriginal Peoples**. A 1993 report prepared for the Royal Commission on Aboriginal Peoples www.mcgill.ca/files/tcpsych/Report2.pdf
- **Mental Health and Wellness in Aboriginal Communities**: A 2003 Issue of In Touch magazine (a publication of the National Indian & Inuit Community Health Representative Organization) www.niichro.com/2004/pdf/INtouch/in-touch-vol-26.pdf
- **Acting on What We Know: Preventing Youth Suicide in First Nations**: A Health Canada report www.hc-sc.gc.ca/fniah-spnia/pubs/promotion (link to PDF at bottom of the page)
- **"The Mental Health of Aboriginal Peoples: Transformations of Identity and Community"** A paper from a 2000 issue of Canadian Journal of Psychiatry reviewing research on the Mental Health of First Nations, Inuit and Metis of Canada. ww1.cpa-apc.org:8080/Publications/Archives/CJP/2000/Sep/InReview.asp

this list is not comprehensive and does not imply endorsement of resources

Online Resources

- **BC Women's Aboriginal Health Program** www.bcwomensfoundation.org/health_centre_programs.php
- **Health Canada > First Nations, Inuit and Aboriginal Health > Substance Use and Treatment of Addictions**: Includes a directory of treatment centres around the province www.hc-sc.gc.ca/fniah-spnia/substan
- **NAHO: National Aboriginal Health Organization** www.naho.ca
- **Aboriginal Canada Portal** www.aboriginalcanada.gc.ca
- **Association of BC First Nation Treatment Programs**: Links to treatment programs around the province www.firstnationstreatment.org
- **Vancouver Island Health Authority: Aboriginal Health** www.viha.ca/aboriginal_health
- **Northern Health Authority: Aboriginal Health** www.northernhealth.ca/your_health/programs/Aboriginal_Health/
- **Interior Health Authority: Health Services directory** interiorhealth.ca/health-services.aspx
- **Fraser Health: Aboriginal Mental Health Liaison Program** www.stolohealth.com/mentalhealth.php
- **Vancouver Coastal Health Authority: Aboriginal Wellness Program** www.vch.ca/aboriginalhealth/wellness.htm
- **Aboriginal resources from the BC Schizophrenia Society**: www.bcscs.org/category/resources/aboriginal/



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