EXPLORING THE MENTAL HEALTH NEEDS OF ABORIGINAL PEOPLE IN THE CAPITAL HEALTH REGION

by

Laura Hummelle

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We accept this thesis as conforming
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Jim Bayer, Dean, MACAM

Elizabeth Cook, Academic Advisor

Darlene McGougan, Project Sponsor

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CHAPTER 1   INTRODUCTION

The purpose of this research is to begin to build a knowledge base about what may be done to improve the mental health of Aboriginal individuals, families and communities both on and off reserve in the Capital Health Region (CHR) of British Columbia.

The Capital Health Region's Manager, Aboriginal Health, Darlene McGougan has indicated that there exists a lack of appropriate resources within the current mental health system to address Aboriginal mental health concerns. She has also expressed concern that health practitioners unaware of cultural differences may misdiagnose Aboriginal people highlighting the need to consider the cultural values implicit in western concepts of mental health and illness. It also raises the importance of cultural safety (discussed in Chapter 2) in the provision of care as well as the need to consider the underlying relationship between cultural identity and mental well being.

Aboriginal people in general have also cited lack of access to mental health programs and services as a problem. Even those who do access the mental health system often worsen, and there is usually nowhere else for the individual and their family to turn for support.

A 1999 Environmental Scan of Mental Health Programming and Services Among
First Nations Communities conducted by the Assembly of First Nations, the Inuit
Tapirisat of Canada, and the Medical Services Branch of Health Canada (AFN-
ITC-MSB) Mental Health Working Group indicated that "Mental health is
considered one of the areas of greatest need, by community leaders, the
National Chief of the AFN and by representatives of the federal government, but
paradoxically gets low priority and low profile almost everywhere." (p. 7)

This report also concluded:

> All across Canada there is increased awareness and information among
> the general public and within governments (federal, provincial, territorial)
> about the importance of First Nations mental health. There appears to be
> a broad consensus on the fundamentals (broad holistic orientation,
> community-development approach) (p.7).

Australia and New Zealand appear to have made much more progress than other
countries in their thinking about how to address the mental health needs of
Aboriginal peoples. Research from these countries provides a useful parallel to
the experience of Aboriginal people in Canada. The colonial forces that have
affected the lives of Aboriginal people is very similar in terms of loss of culture,
and identity, history, land, economics and politics. Indigenous people worldwide,
share a common connection to the land, their ancestry and sense of community
as well as a drive for self-determination.

British colonization in each of these countries has had similar effects on Aboriginal peoples:

- loss of land, culture, spirituality and identity;

- loss of self-esteem;

- institutionalization;

- discrimination and isolation;

- abuse and violence;

- loss of population through introduction disease;

- grief and loss

The Aboriginal Health Handbook of The Aboriginal Health Association of BC, describes mental ill health as a lack of balance and harmony within and among each of the four aspects of human nature: physical, mental, emotional, and spiritual. The authors of this handbook also stress the need of Aboriginal peoples to gain an understanding of their past in order to make sense of the present. This understanding will help to uncover the manifestations (such as high rates of substance abuse, suicide, accidents and violence, educational failure, unemployment and incarceration) of a deeply destructive history dating from 1850.

The scope of this research (discussed in greater length in Chapter 3) includes processes and discussions underway at the national, provincial and community

levels that are endeavoring to address Aboriginal mental health. Some of the organizations involved in these processes are:

- Health Canada's Medical Services Branch;

- Provincial Ministries of Health and the Ministry for Children and Families;

- the Assembly of First Nations;

- Mheccu's Aboriginal Mental Health Advisory Committee;

- Aboriginal Health Association of BC

Community level input was sought from Community Health Representatives (CHRs) and alcohol and drug counsellors on and off reserves to help identify Aboriginal cultural understandings of mental health and illness outside of the traditional western clinical context. These people were also asked what needs to be done in order to improve the mental health status of Aboriginal people in the Capital Health Region and how they would suggest going about making these changes.

Organizational level input, especially that concerning urban Aboriginal people, primarily living off reserve, was sought through face-to-face interviews with key contacts identified by the Manager for Aboriginal Health and included the Victoria Native Friendship Centre; Aboriginal People's Council; and Nil/tu'o Child and Family Services.

A review of the literature (see Chapter 2) concerning cultural safety, community capacity building and transcultural psychiatry provided background to the problems associated with current approaches to Aboriginal mental health as well as successful problem-solving in Aboriginal communities. Social identity theory was also explored in order to aid in understanding the societal forces at play in the formation of Aboriginal peoples' identities.

The significance of this research lies in the evaluation of cultural values implicit in western concepts of mental health and illness and how these relate to the increased risk of Aboriginal people being misdiagnosed and mistreated.

> Cultural identity is a primary factor in well-being. For the dominant culture the reinforcement of cultural identity is the norm. In this way culture becomes invisible; members of the non-dominant culture become defined as the "other." For the groups thus defined, the task to re-establish and maintain an identity separate from the dominant culture is inseparable from the struggle for survival (Smallwood, 1996, p.2).

Culturally inappropriate methods of assessment increase the risk of misdiagnosis of Aboriginal mental health concerns. Research in Australia has demonstrated a significant disparity between the diagnoses of schizophrenia in the Aboriginal population (70%) compared to the non-Aboriginal population (42%) and "Being Aboriginal carries a threefold increase of involuntary psychiatric admission to state-hospitals, and being a metropolitan Aborigine carried a five-fold increased risk of compulsory admission" (Smallwood, p.5).

Chenier (1995) indicates that suicide among aboriginal youth is five to six times higher than non-Aboriginal youth. Feelings of helplessness and hopelessness were attributed to culture stress, that is the loss of confidence in the ways of understanding and living that have been traditionally taught in a particular culture:

> [Culture stress] comes about when the complex of relationships, knowledge, languages, social institutions, beliefs, values, and ethical rules that bind a people and give them a collective sense of who they are and where they belong is subjected to change. For Aboriginal people, such things as loss of land and control over living conditions, suppression of belief systems and spirituality, weakening of social and political institutions, and racial discrimination have seriously damaged their confidence and thus predisposed them to suicide, self-injury and other self-destructive behaviours (p. 3).

In summary, the central research questions explored in this research are:

- What processes are underway at national and provincial levels to address Aboriginal mental health concerns and what, if any linkages between these processes are being proposed?

- How do Aboriginal people in the CHR define mental health?

- How do Aboriginal people in the CHR define mental illness?

- What are the main impediments to improving Aboriginal mental health in the CHR?

- How could Aboriginal mental health be improved?

- What would an Aboriginal mental health program look like?

CHAPTER 2   REVIEW OF LITERATURE

The main themes, interpretations and schools of thought discussed in relation to Aboriginal mental health were cultural safety, community capacity building, social identity theory, and transcultural psychiatry. These are discussed individually in the sections that follow.

2.1   Cultural Safety

Developed in New Zealand, the concept and practice of cultural safety argues that people should not all be treated the same and that the "...supposed 'neutral' position on race or culture is a reinforcement of the dominant culture" (Clinton and Nelson, 1996)." Cultural safety is defined as "a manner, which affirms, respects and fosters the cultural expression of the recipient. This usually requires nurses to have undertaken a process of reflection on their own cultural identity and to have learned to practice in a way, which affirms the culture of clients and nurses," and in contrast, "Unsafe cultural practice is any action, which demeans, diminishes or disempowers the cultural identity and well being of an individual" (New Zealand Nurses Organization, 1995).

Ramsden states that denial of the differences between people and their different needs "constitutes harmful practice" (as cited in Smallwood, 1996, p.7). Cultural safety stresses the importance of culture to health, and cultural appropriateness to care. The end result of a health system that neither

recognizes nor adapts programs to Aboriginal beliefs is a system which leaves

Aboriginal people with mental distress that is unnoticed or is misdiagnosed or

wrongly treated.

2.2   Community Capacity Building

The main theme for addressing the mental health concerns of Aboriginal people,

as identified by the sources in Section 2.1, is community capacity building. The

Canadian Nurses Association (CNA) has identified a number of areas of

community capacity building that need to be considered in the delivery of health

care services to Indigenous peoples and in the behavior of the health care

providers with respect to indigenous peoples:

- addressing the socio-economic roots of ill health;

- access issues;

- using existing strengths, resources and models;

- recognizing the contribution of traditional healing;

- education of indigenous health care providers and managers;

- increasing primary health care resources;

- more applied and participatory research.

The Aboriginal Health Association of British Columbia in its Regional Health

Authorities Handbook on Aboriginal Health (pp. 75-84) discusses what questions

need to be addressed in developing strategies for Aboriginal health. Included in

these questions is the need to define determinants of health, on all levels

including physical, social, economic, cultural, spiritual, emotional, intellectual,

educational, and environmental health, from the perspectives of Aboriginal

communities. This will help to ensure that any given strategy will relate to the

communities' values and vision for health care.

The 1997 BC Provincial Health Officer's (PHO) Report indicated that in relation to

their goal of improved Aboriginal health:

> "a process to finalize specific objectives and indicators must include the
> extensive involvement of Aboriginal peoples, and must complement the
> other processes and negotiations that are underway concerning Aboriginal
> health, First Nations self-government, and other key issues. Therefore, no
> objectives or indicators are being presented at this time (Appendix E p. 4).

In terms of how Aboriginal people view mental health, Mussell, Nicholls, and

Adler (1991) of the Sal'i' shan Institute offered the following description:

> In First Nation cultures, from traditional times to present time, health
> means balance and harmony within and among each of the four aspects
> of human nature: physical, mental, emotional, and spiritual. Over-focusing
> or under-focusing on any one aspect upsets the balance of the four. For
> example, living too much in your mind without being in tune with your
> emotions is an imbalance that leads to ill-health. Thus, mental health in
> First Nation cultures is inseparable from emotional, physical, and spiritual
> health. Mental illness is an outcome of the lack of balance or harmony in
> one or more areas (p.19).

The 1995 Royal Commission on Suicide Among Aboriginal People

acknowledged that non-Aboriginal control has resulted in little or no

improvements in provision of resources or changes in policy regarding Aboriginal

mental health. It recommended, through its Framework for Action, establishment

of a Canada-wide three-part community-based response to suicide, leading to community development and ultimately self-determination, healing and reconciliation.

The Assembly of First Nations (AFN) Health Priorities, 2000-2001calls for the government to support capacity building and training opportunities for First Nations at the community level. The AFN states that it is crucial that First Nations communities be supported in their recruitment of health professionals and receive more resources for training and development. Communities must receive equitable compensation for community-based health professionals on a scale equivalent to the rest of Canada, in order to encourage recruitment and retention.

2.3   Social Identity Theory

Northrup (1989) discusses how identity factors into conflict. He defines identity as "an abiding sense of the self and of the relationship of the self to the world." He goes on to explain the identity "is a system of beliefs or a way of construing the world that makes life predictable rather than random. In order to function, human beings must have a reasonable level of ability to predict how their behavior will affect what happens to them" (p. 55). Northrup's definition of identity stresses the psychological aspect of self. He argues that when a conflict affects this core sense of identity, the conflict is more likely to be intractable as is

the case with conflicts involving Aboriginal people's identity and the issues that have been carried forth from one generation to the next.

Furthermore, Rothman (1997) explains that "Identity driven conflicts are rooted in the articulation of, and threats or frustrations to, people's collective need for dignity, recognition, safety, control, purpose, and efficacy" (p. 6).

Tajfel (as cited in Northrup, 1989, p. 66) differentiates between personal and social identity and states that "personal and social identity may be differentially salient under particular circumstances. More important, social identity may in some contexts function almost to the exclusion of personal identity." Tajfel defines social identity as "the individual's knowledge that he or she belongs to certain social groups together with some emotional and value significance to him of that membership." It includes a cognitive component (categorization of self into particular groups), and an affective component (the positive or negative valence attached to group membership).

2.4   Transcultural Psychiatry

Studies in transcultural psychiatry such as that of Chandler and Lalande (1998) show how cultural continuity or lack thereof affects the mental well being of youth in BC. In communities where cultural practices still largely exist, a zero or low level of suicide is found, whereas extremely high levels of suicide exist in communities where cultural practices are not apparent.

2.4.1 Values, Acculturation, and Mental Health

Hallowell discusses how loss of culture in Aboriginal communities has led to "ineffective personal/psychological functioning (mental health)" (as cited in McSwain, 1998, p. 19). Hallowell explains how loss of common social values negatively affects the day to day functioning of the individual and the community and points to the extreme changes in Aboriginal individual and group characteristics that were brought on by colonization. These changes are directly related to the decline in the Aboriginal people's social and economic functioning and self-esteem. Hallowell describes a process whereby traditional economic and social structures and values that were highly functional, have now been translated into a "passive dependence" on welfare.

McShane discusses the relationship between culture change and mental health, otherwise referred to as "acculturation stress", and describes problems in the delivery of appropriate mental health services in terms of differences between western therapists and Aboriginal communities in the following areas: culture, socio-economic status, geography, language, education levels, history, and technical resources (as cited in McSwain, 1998, p. 7).

He shifts the paradigm from "...what is wrong with Indians to what is wrong with the service delivery system" (p.7). He explains that modifications need to be made to therapists' cognitive and emotional orientation, to treatment modalities,

to client expectations, and to negative role/relationship expectations. He also

suggests that Aboriginal communities must gain control over the hiring, training,

and evaluation of mental health service personnel (p. 7).

Gaines in his paper From DSM-I to III-R: Voices of Self, Mastery and the Other:

A Cultural Constructivist Reading of U.S. Psychiatric Classification, deconstructs

the American Psychiatric Association's Diagnostic and Statistical Manuals (DSM)

and their development. Gaines explains how the DSM classification process

serves to "classify people rather than diseases" (as cited in McSwain, 1998, p. 4).

According to Gaines the DSM disease classifications are socially, not

biologically, constructed and "they serve to delineate the idealized self (define the

normal, healthy person)" according to the values and expected characteristics of

a German, Protestant, adult male. The psychiatric diagnostic categories,

definitions of normal, and treatment modalities therefore reflect the cultural

values of the politically and economically dominant, and regard the cultural and

social characteristics of the 'Other' as biological, pathological differences.

CHAPTER 3   METHODOLOGY

The relationship between research methodology and the research questions, design and theoretical framework represents, as Rothman (1997) points out, the first step in addressing identity-based conflicts as an interactive engagement where needs and values are discussed thus promoting voice and recognition. Engaging Aboriginal communities in the CHR is essential in determining what constitutes Aboriginal mental health and in beginning to assess what would promote mental wellness. The literature on cultural safety (see Chapter 2) also points to the need to work from within a given cultural perspective in order to understand the problems and to determine what will work to alleviate the concerns of that cultural group.

3.1   Review of National and Provincial Processes Underway to Address Aboriginal Mental Health

A review was conducted of the documentation provided by the organizations listed below, of processes underway on a national and provincial level addressing Aboriginal mental health concerns and endeavoring to determine what if any, linkages between these processes are being proposed. The organizations concerned are:

- First Nations and Inuit Health Programs, (FNIHP) National Mental Health Working Group;

- Mental Health Evaluation & Community Consultation Unit (Mheccu), Aboriginal Mental Health Advisory Committee.

3.2   Consultations with Aboriginal Organizations

Face-to-face interviews were conducted with key informants of the Victoria Native Friendship Centre and Nil/ tu,o Child and Family Services, who were identified for me by the Manager, Aboriginal Health. These informants were asked the questions listed in Section 3.3.

3.3   Community Consultation

A letter, approved by the Manager, Aboriginal Health, was sent to the Chief of each of the nine reserves in the Capital Health Region. The letter sought permission from the Chiefs to visit their community and discuss with the Community Health Worker and alcohol and drug counselor, the following questions:

- How do Aboriginal people in the CHR define mental health?
- How do Aboriginal people in the CHR define mental illness?
- What are the main impediments to improving Aboriginal mental health in the CHR?
- How could Aboriginal mental health be improved?
- What would an Aboriginal mental health program look like?

Chiefs were asked to contact the Manager, Aboriginal Health by a pre-determined date to discuss any concerns they had with the process. Unless the Manager, Aboriginal Health received word to the contrary from the Chiefs, one month following the postmarked date of the letters, interviews were then scheduled by telephone. Confidentiality was insured to the respondents during the scheduling phone call and at the beginning of the interviews.

The interview data was then recorded in written form by the interviewers (myself and the Manager, Aboriginal Health). Approximately two hours were allotted for each interview. Discretion was used in determining whether to allot additional time in order to be respectful of the cultural norms regarding time, as well as to provide the respondent more time for reflection.

3.4　Analysis and Presentation

The responses were categorized into primary themes along with an indication of the frequency with which each primary theme was noted in responses. The data is presented in Chapters 7 through 9 in the following order:

1. Definition of the conflict situation

2. The characteristics of the conflict situation

3. The intensity of the conflict situation

4. Cultural dimensions of the conflict

5. Contextual factors of conflict

6. Conclusion and Recommendations

CHAPTER 4   REVIEW OF NATIONAL AND PROVINCIAL PROCESSES UNDERWAY TO ADDRESS ABORIGINAL MENTAL HEALTH

The following organizations have process underway to address Aboriginal mental health.

4.1   The Assembly of First Nations

The Assembly of First Nations (AFN), in their First Nations Health Priorities, 2001-2002 has identified mental health as one of seven priorities concerned with the absence of federal or First Nations policy or programs addressing mental health. The AFN recommends that: "A national First Nations Mental Health Program should be established based upon discussions with First Nations communities" (p. 3). The Health Priorities document further states that:

> First Nations youth (35% less than 15 years of age) are committing suicide at extremely high rates compared to the overall Canadian populations – 8 times higher for First Nations females, and 5 times higher for First Nations males. Currently, there are no federal resources available to address suicide prevention among First Nations (p.3).

Another Health Priorities recommendation was:

> The federal government must direct resources for community-based suicide prevention and intervention programs, including adequate regional resources for training citing the "...need for the development of a community crisis response strategy for suicide and other crises such as family violence" (p.3).

4.2 The University of British Columbia (UBC), Department of Psychiatry, Faculty of Medicine, Mental Health Evaluation and Community Consultation Unit (Mheccu), Aboriginal Mental Health Advisory Committee

The Mheccu Aboriginal Mental Health Advisory Committee was formed in 1999 in response to concerns that mental health service delivery, including community psychiatry, did not adequately or appropriately deal with the needs of Aboriginal people. The Committee's work is funded by the BC Ministry of Health, Adult Mental Health Services, and is administered by Mheccu. The Advisory Committee has identified key areas for its work, including the need to:

- develop and disseminate guidelines specifically related to best practices in Aboriginal mental health;

- conduct research into Aboriginal best practices and effective service and program models;

- examine alternative models of service delivery that are accessible, culturally appropriate and accountable for Aboriginal people.

An Aboriginal Mental Health Best Practices Working Group has also been formed to develop best practice guidelines regarding Aboriginal mental health to assist health authorities in the planning of mental health reform in their regions.

4.3 Aboriginal Health Association of BC

The Aboriginal Health Association of BC, recognizing the need for increased knowledge on the part of non-Aboriginal governors of Regional Health Boards and Community Health Councils, has developed an <u>Aboriginal Health Handbook</u> that provides a historical context of the factors contributing to mental ill health in Aboriginal populations.

Another purpose of the Handbook is to provide a basis for planning for transfer of responsibility for health programs and services from the federal government to the various Aboriginal governments. The premise of the Handbook is "We will not know where we are if we do not know where we have been" (p.1).

CHAPTER 5   CONSULTATIONS WITH ABORIGINAL COMMUNITIES AND ORGANIZATIONS

5.1   Aboriginal Peoples' Definitions of Mental Health

A number of characteristics were used to describe a mentally healthy person, including being able to cope with day-to-day living, stresses, crises, and being able to ask for help. Other indicators of mental health were considered to be the ability to make one's own choices and to sort out and to deal with one's own issues in a good way. For some respondents mental health was seen as a measure of the stage a person has reached in his or her own adaptation or of coping with living and dealing with the rest of society.

Having a sense of one's identity and knowing who one is, where one fits in society and knowing the spheres of the medicine wheel and how to balance them were also cited as important factors in mental health. This way of being was summarized as "walking the path of balance." Having a clear understanding of one's culture and way of life and the spiritual part of Aboriginal culture and mental health were seen as important aspects of mental health. Access to the long-house and sweats and to the Elders were seen as important contributors to mental health.

Some respondents found it difficult to define mental health as so many people in their community were "taking something" (i.e. ingesting controlled substances)

that it made it difficult to say what a mentally healthy person would be like. In fact one Elder defined mental health as "having a medicine cabinet that wasn't full of prescription drugs." He explained that the average person in the community wouldn't know what was being talked about when mental health was mentioned.

Perceptions of mental health differed within and among communities. For example, one community representative indicated that moving from one community to another was a sign that your ways weren't acceptable to the community where you had previously lived. In some communities a behavior such as paranoia would be seen as quite acceptable while in others it would be seen as abnormal.

The definitions of mental health and illness can be easily blurred when speaking of people who have visions and/or hear voices. It was explained that these people are often seen as being gifted, depending on how they fit into their community and how the individual and the community perceive this experience. Respondents felt that having a common belief system within the community often resulted in a positive response to these types of experiences. Having a connection to Elders and their teachings about an individual's path was mentioned as an important factor in how these experiences are handled by the individual and the community. Traditionally, Elders would teach children at an

early age if they were going to be a "healer" and explain the types of experiences they would have as healers.

Some communities indicated an overall acceptance of individuals in their own right regardless of their behavior or mental health status. They were seen as each having his or her own way of making a contribution to the community regardless of how they behaved.

It is thought that Aboriginal people have a greater sense of interconnectedness to family, community and mother earth, and that this understanding has a lot to do with their identity. Participants explained that the more Aboriginal people affiliate with mainstream society, the more they lose touch with their ancestral identity.

5.2　Aboriginal People's Definitions of Mental Illness

Rather than define mental illness, several respondents explained that Aboriginal people have different interpretations of some unusual behaviors than non-Aboriginal people have. What non-Aboriginal people might consider mental illness, Aboriginal communities may consider a valid phenomenon such as having visions or hearing voices. It was also stated that the traditional belief systems of some communities are multi-faceted therefore, mental illness versus mental health is a vague concept. A Community Health Representative stated, "We've been somewhat mixed up with mainstream population due to inability of doctors and psychiatrists to identify what is a medical issue versus a cultural

experience such as having a vision or hearing voices." Another community representative described excessive crying as "weakening the person and leaving them open to a spiritual takeover."

Many respondents made reference to substance misuse and its relationship to mental health issues. Many of the issues behind substance misuse were described as being associated with or the result of residential school and other abuse. It was reported that as people work through their addiction to alcohol and/or other drugs, they begin to see other options, such as seeing a psychologist, that are available to help them work through their problems. Once a decision has been made to see a psychologist, a variety of other problems such as sexual abuse, incest and grief come to the surface. It was explained that people will talk about others' abuse, however, there is a great deal of difficulty in getting people to talk about their own abuse. Generally respondents indicted that people want to see results, so they sit back and observe and if they see something that works for others, they will try it out for themselves.

One respondent indicated that mental illness to her community would mean that a person "would be crazy and would go in the nut house." That the person would be shunned by their community afterwards, because of a lack of knowledge within the community about people who have been in facilities like the Eric Martin Institute (EMI). It was also reported that the community has a lot of fear because

of a lack of knowledge about facilities such as EMI and about mental illness in general.

Residential schools and adoption were cited as having interrupted the identity of aboriginal people, causing them to be "lost and wandering." It was explained that this process of wandering goes uninterrupted because of Aboriginal peoples' belief that the Creator has a larger plan that should not be interfered with. Mental illness was also associated with a loss of identify caused by the loss of traditional teachings within the culture and community. People's identify was thought to be totally connected to their spiritual core (soul).

Mental illness according to these respondents takes on many faces including addiction and depression, and multiple symptoms. Contributing to the problem is the lack of a holistic approach towards people and the application of the medical model which has focused on brain disease and changing the cognition but missing out on the spiritual element which is fundamental to Aboriginal health. Some people viewed "bad mental health" as just "acting out" rather than having a true mental illness.

5.3 Impediments to Improving Mental Health in Aboriginal Communities

This section summarizes the impediments to improving Aboriginal mental health such as prescription drug use, poor nutrition, ineffective physician services, grief and trauma that were described by informants.

5.3.1 Prescription Drugs

A major impediment that was reported throughout the interviews was the harm caused to Aboriginal people who are referred to the Eric Martin Institute and subsequently labeled as having a mental health problem, thus ending up on medications. Many of these Aboriginal people already have addiction problems and the doctors are not taking this fact into consideration. Some doctors give known addicts huge supplies of medications with just one prescription.

Another part of the problem was described as doctors and psychiatrists seeing too many patients and therefore not having the time to assess and treat the patient properly. The doctors do not talk to their clients about contraindications, the addictive quality of the medications or the side effects such as mood alteration. The depressive quality of some medications has a huge impact on Aboriginal people. A high number of prescription drug overdoses occur, and when people who overdose are sent to EMI, they are given more medication; reactions to medication take over and suicides frequently result.

Aboriginal people, have access through prescriptions, to large amounts of prescription drugs. Aboriginal people are seen as placing a lot of faith in doctors and in responding to what they are directed by doctors to do without question. Aboriginal patients think their doctor is God and when they are labeled as schizophrenic, for example, they believe it, when in fact they really have an addiction problem. Respondents indicated that doctors are always willing to refill Aboriginal people's prescriptions regardless of what the problem is, and that alternatives to prescription medicine are never discussed. People sometimes use the label of "mentally ill" just to obtain prescription drugs.

The use of prescription drugs by Aboriginal people is thus seen as causing a constant imbalance that takes them further and further away from being able to deal with their problems. One respondent mentioned that the situation is so bad that many people who are addicted to prescription medication won't even talk to you before they take their medication.

Many young Aboriginal people become depressed especially when they have moved into the city and find it a difficult transition and end up on medication; this gives them quick relief, thus leading them to continue on with the medication.

Fear of failure was reported as being "a big thing" for Aboriginal people with the end result of people overdosing on prescription drugs because of this fear. Use

of prescription drugs was commonly associated with suicide especially amongst Aboriginal women.

Respondents indicated that the lack of limitations on patients' use of prescriptions drugs results in Aboriginal people being given a lifetime label of mental illness by doctors. This label contributes to people taking more and more mood altering prescriptions in order to "stay up there." If they run out of prescription drugs, they will go to street vendors. Patients are also known to stockpile medications and to take drugs from other people's medicine cabinets if they run out.

It was thought that rather than people being taken out of detoxification facilities and put into Eric Martin Institute, if left long enough in detoxification they would get back on the right track. However, respondents felt that it is easier for the system to label them and give them a prescription. A parallel was drawn between doctors prescribing Ritalin to children without considering parenting problems.

Rather than seeing themselves as being more predisposed to addiction than other races, respondents indicated that because Aboriginal people are a minority group, they stand out more and are therefore seen as being more addictive than other races. They felt that some people are just better at hiding it than others.

5.3.2   Nutrition and the Environment

Respondents indicted that Aboriginal people often live on fast food diets and because traditional foods in the area are contaminated due to pulp mills and marine oil spills. This contamination prevents Aboriginal people from going back to their traditional foods.

5.3.3   Physician Services

Many respondents indicated that the current system is not working for aboriginal people because of the lack of time that doctors spend with patients. As mentioned in Section 5.3.1 above describing problems with doctors' prescribing patterns, doctors were seen as "...just processing patients and counting their money, just like a check-out counter."

5.3.4   Narcotics

Respondents indicated that there is a cocaine epidemic and that there are dealers everywhere including all over the reserves.

5.3.5   Residential School Trauma

Many mental health problems were cited as being the result of experiences in residential schools. Community representatives indicated that some of their Elders are still silent about residential schools, that "it still hasn't gone away" and

that "we're just at the tip of the iceberg when it comes to the impacts of residential school."

One of the effects of residential schools was described in terms of children nowadays being taken away because people do not know how to be parents as a result of having been raised in a residential school. These children who are taken away and placed in foster care are believed to be "…getting into the drug scene."

5.3.6   Grief and On-going Trauma

Respondents explained that because of the ongoing trauma that Aboriginal people experience as a result of the incidence of disease, motor vehicle accidents and suicides, there is insufficient time to grieve, as another person always needs help. When people enter into programs that deal with trauma it was reported that these programs really open up issues and consequently many people drop out of these programs. The provision and availability of ongoing community trauma and grief counseling was seen as inadequate and greatly needed.

Amongst the Elders there is a great deal of depression, loneliness and helplessness because of family and community breakdown and the Elder's lack of financial ability to help families in their communities. The breakdown of families and traditions were seen as having a major impact on mental health in

children especially as children are no longer growing up experiencing the family structure and do not know how to bring structure into their own children's lives. Substance misuse was seen as having a huge impact on individuals, families and communities from one generation to the next.

5.3.7   Spiritual and Cultural Beliefs

Respondents emphasized how spiritual and cultural beliefs play a large part in the way in which mental illness is handled. They also reported that communities no longer have people trained in these belief systems who can deal with mental health in these contexts.

5.3.8   Stigma

While some communities seemed to be very accepting and supportive of people with mental health problems a number of communities reported that because of stigma associated with having a mental health problem, people generally do not seek help. It is difficult for Aboriginal people to acknowledge a problem like schizophrenia, as conditions such as this have only come to their attention in recent years. Now if a person has a mental health problem he or she is labeled and the community doesn't associate with that individual.

Respondents mentioned that people are often embarrassed if they think they have a mental health problem, and that some may think they have a problem

arising from the crossing of familial blood-lines. Because of the associated stigma, quite often people who have problems "haven't come out". People would rather go to jail than have the stigma associated with having been in EMI. Even heath care providers expressed a negative perception of EMI. Many respondents saw EMI as the last resort.

The use of the term "mental health" was seen as carrying a stigma in and of itself. It was thought that a more positive way of referring to mental health programs and services is needed because of the negative association between the term "mental health" and the use of needles and electrotherapy in these programs and services.

5.3.9   Privacy Issues

Respondents felt that because of people want to protect their privacy, many who need mental health treatment are willing only see their doctor rather than other health professionals such as psychologists.

5.3.10   Life Experiences

Respondents expressed that their people have had to deal with unhappiness from the beginning of their lives and that they have had to learn to "grow out of it".

One respondent estimated that only about 20% of Aboriginal people have had a happy life and that it can take a whole lifetime to find happiness because people are too proud to ask for help.

5.3.11   Community and Family Attitudes

Some families do not want community health care to be involved after discharge from a treatment program or facility while others do. Some people do not want help of any kind, and have limited contact with their own community. After a while, the community pretends the person is not there. The community was thought to need help in determining whether or not and how to intervene in situations where people isolate themselves or exhibit strange or threatening behaviors.

5.3.12   Mental Health Programs and Services

There are few Aboriginal-specific mental health programs in existence and there is little consistency in the provision of service especially in rural communities where there are fewer mental health professionals. A need for long-term assistance as opposed to the present crisis-oriented approach was stressed. In most communities residents must choose one of two psychologists and not all people want to see either of them.

A lack of awareness of programs and services offered by Eric Martin Institute (EMI) was reported in all communities. One community health representative mentioned that after working in the position for last 5 years, she was still not aware of EMI. Many respondents were not aware of EMI's emergency response team that goes into the community.

A number of respondents expressed that Eric Martin Institute is associated with "crazy people" and that health workers need to have a tour of EMI to become aware of what EMI offers. Such an orientation would assist community health care providers in determining whether EMI is a "safe place" to send their community members. This may also help people to see EMI as being a less foreign environment and to understand the healing approach that is taken at EMI.

5.3.13   Family Involvement

Inclusion of the family in the client's treatment was seen as being very important because of the ongoing care provided by the family during and after treatment. Respondents indicated that in most cases the family members are excluded from the client's treatment and are therefore, unaware of how they could be of help.

A major concern was that people do not complete their treatment at EMI because of being alone and cut off from their families. When the family attempts to be involved, they are continually dismissed and made to feel that they are exaggerating the problem. One of the problems associated with not informing

and/or including families in the patient's treatment is that the patient is often treated differently or even shunned by the community when they return. As part of counseling, it is often recommended that the patient seek community support. However, because the family and community are not informed of the patient's treatment the community does not know how to respond or how to be involved. Ultimately the patient is left at risk of the original problem continuing or reoccurring.

Confidentiality was reported as one of the stated reasons for excluding family from the treatment process and communication about the patient.

5.3.14   Waitlists

Waitlists for treatment were also seen as a major obstacle to people accessing care for mental health problems. People who reach the point of agreeing to treatment typically have to wait three to six months before someone is available to see them. For many people who live on the reserve, off-reserve treatment programs and services are seen as being less valuable than ones offered in their community. While Ledger House was mentioned as one program that does benefit Aboriginal people the need for a doctor's referral and the long waiting period were seen as obstacles to helping people who are in need of care.

5.3.15   Access to Treatment

Another problem was that people who seek emergency treatment are often sent home when they should have been admitted to a hospital. It was reported that a person cannot "get into the system" if they do not have a place of discharge: an address or a bed somewhere such as Street-link. Many Aboriginal people do not have a fixed address or they live on the streets and are therefore not permitted into the system. It was also stated that being on medication is a pre-condition to receiving treatment, housing and other benefits.

5.3.16   Treatment Restrictions

Limitations on what Health Canada psychologists would allow in their counseling services posed major obstacles for Aboriginal clients. It was reported for example, that psychologists would not provide counseling services related to residential school abuse, relationships, and substance misuse. The limitation on the number of visits was also seen to be of great concern given the degree of counseling that was needed for problems that have occurred over several generations.

Overall, respondents felt that the system protects itself from change and that individuals working in the system protect what works for them rather than responding to the needs of the client, family and community.

In addition, there are not enough financial resources available to people for mental health programs and services. This lack of resources was seen as contributing to a crisis-oriented approach to mental health problems. The BC Medical Plan was seen as taking a band-aid approach, and funds have been increasingly cut. The Department of Indian and Northern Affairs funding for mental health was reported to be specifically targeted for certain treatment resulting in many areas of treatment being overlooked.

Smaller communities seemed to be especially affected by limited funding for services and travel (because of per capita funding). The amount of money available, it was explained, doesn't match the need for services. On the other hand, some respondents reported that their community received substantial funding from the federal government but that it doesn't reach the people who are then out of pocket.

When band members do not wish to see either of the two funded psychologists, they end up paying for counseling services. Individuals must also pay for the "Choices" program, as bands have been running out of funds. Those who have been through "Choices" are involved in fund raising in order to assist other band members who wish to enter the program.

The cost of transportation to attend appointments was reported to be another funding issue especially for those communities where there is no bus service.

Respondents indicated that there is little staff development funding and little recognition for education. Unless a staff member is doing direct client care, then the position is not validated and therefore, no training dollars are allocated.

5.3.17   Language and Culture Barriers

Language barriers were seen to be a problem in relation to conceptual differences between Aboriginal and non-Aboriginal people with regards to mental health. The use of terminology that was unfamiliar to Aboriginal people also posed a problem. It also was reported that many Elders are afraid to talk to because of language barriers.

Significant cultural differences, in terms of medicine and healing, were seen to exist between Aboriginal and mainstream culture. In mainstream and western medicine for example, the mind and body are separated and different health care providers are seen for different problems whereas Aboriginal people view the body, mind and spirit as being very much connected and believe in a holistic treatment approach.

Due to the high incidence of illiteracy and the shame that Aboriginal people have of being illiterate, many Aboriginal people avoid communicating with health professionals.

5.4 Ways to Improve Aboriginal Mental Health

5.4.1 Role Models and Support Systems

Respondents stressed the importance of seeing people who have been sober and off drugs for a long time. One respondent compared the significance of seeing being progressing, to Alcohol Anonymous, where once people see others sober up, they learn from that example. When people finally find something that gives them meaning in life and some hope, they begin to feel better. Having visible, healthy role models that people can go to for guidance and support was seen as being important to helping people along the way in their healing.

5.4.2 Culture and Traditions

Respondents indicated the need to go back to their traditions in order to be healthy and to make themselves whole. They need to speak their language and sing their songs. They also need to go back to their foods, staying away from food with sugar and other additives, and the government "should give them back their fish." The need to recognize that the Aboriginal community has a different approach to what an Aboriginal mental health program would look like was emphasized.

The need was expressed for programs and services that are culturally sensitive and friendly with a spiritual component where local traditions are emphasized. Respondents explained that ceremonies and teachings are re-immerging and

that the mainstream medical field does not have an understanding of this. It was stated that mainstream society needs to learn more about how Aboriginal people view the world and that linkages need to be formed between the Aboriginal system of healing and the western medical system by talking to the Elders and community members. The use of the medicine wheel was emphasized in order to address clients' needs holistically.

The need to train more people to do psychological assessments was reported. There is also a need, to explore with Elders who are in the Alcoholics Anonymous program (AA) the value of a residential AA program. Community education on how to deal with Fetal Alcohol Syndrome/Effects (FAS/FAE) is also needed.

5.4.3   Relationship Building

Because of the Aboriginal people's distrust of the system, there needs to be some bridging between Aboriginal people and mental health facilities. There also need to be people who are truly educated in what the community needs, taking the time to establish a relationship with the community. Respondents expressed the absolute necessity to maintain the position of Manager, Aboriginal Health for the Capital Health Region.

5.4.4 Communication, Awareness, and Education

Respondents expressed the need to start changing the way in which their youth and parents see mental health issues including development of educational materials that are culturally sensitive and that provide access to appropriate types of gatherings with food.

5.4.5 Expectations

The need to recognize that there will be a down time before Aboriginal people heal and that people need to speak up and say it like it is was expressed.

5.4.6 Treatment Approaches

Treatment approaches that respond to self-healing on all levels including the body, mind and spirit and those incorporating traditions were suggested. Respondents emphasized the need to recognize addiction treatment as a common gateway to mental health services. They also emphasized the need to look at dual-diagnosis (the diagnosis and treatment of a combined mental illness and addiction to drugs and/or alcohol).

One of the most pressing needs was for access to client-focused treatment services provided in one's own community by a team that would involve the family. It was suggested that urban Aboriginal people could be reached for treatments in their homes. Also needed is a person on reserve to monitor people

in order to see where problems are occurring and to keep in touch with mental health at Capital Health Region. Community based programs to treat people who suffer the effects of residential school abuse is seen as critical to dealing with violence and anger in certain families.

While some respondents indicated that community members had benefited from group counseling at Eric Martin Institute (EMI), they also stressed the need to observe what goes on at EMI. They also expressed the necessity for people from the mental health system to see what the communities are like. Respondents felt that Elders and front-line workers need to be convinced that EMI is a place that helps people. As well, the fears that Aboriginal people have of institutions and the connected paperwork needs to be addressed. These fears are largely related to the multigenerational effects of residential school. Respondents also stated the need to educate the community that EMI is not a last resort but can be used before reaching the crisis point. It was recognized that some people who have received proper medication through EMI are now functioning well in the community. Education as to the benefits of medication was mentioned as one way to increase understanding of how mainstream medicine could be of benefit to people with mental health problems.

A dire need for counseling services in the areas of suicide and eating disorders was reported. One particular suicide was viewed to have had a large impact on the entire community. The need for training on what symptoms to watch for in

relation to suicide prevention, eating disorders, stress, substance misuse, and Fetal Alcohol Syndrome and Fetal Alcohol Effects (FAS/FAE) was stressed by several communities. One family was reported to have five out of seven children with FAS/FAE.

5.4.7 Evaluation of Aboriginal Models of Care

The need was expressed to do evaluation of existing Aboriginal mental health programs such as those which exist at the Smithers Friendship Centre, the Kamloops Inter-Indian Friendship Society, and the Aboriginal Health Council's mental health projects.

5.4.8 Community Capacity Building

A community capacity building approach is needed to help people generate knowledge, skills and ability within the community for long-term provision of care within and by the community.

5.4.9 Need for Variety of Programs and Services

Because of confidentiality issues, some families need access to mobile treatment programs. There is also an expressed need to have a choice of community or outside programs and services. Where off-reserve programs are used there is a need for transportation outside of the community. There is also a need for ready

access to mental health professionals, rather than having to seek them out. Outreach by service providers such as the Queen Alexandra Hospital is also a necessity. Emphasis was placed on having services delivered to the family in the community. Respondents felt that because the family often knows more than the professional does and is left to care for the individual with the problem, they should be involved in the treatment.

5.4.10 Desired Characteristics of an Aboriginal Mental Health Program

An efficient Aboriginal mental heath program would focus on the medicine wheel in order to bring about balance between the body, mind and spirit. The medicine wheel recognizes the connection between individual and community healing. It was suggested that more and more healing would occur if people realized this connection.

Respondents stated the need to look at the system from a First Nations point of view, including the Elders' perspectives. It is also important to look at the perpetuation of intergenerational thinking, issues and fears.

An Aboriginal mental health program would recognize that there is more to people than what is going on at the molecular level. It would have a broad focus rather than focusing on one small piece of the person.

Patients should be in an environment where they can be observed over a period of time to see when psychotic episodes occur and where they can receive help before they reach a crisis point. Such a facility would be staffed by Aboriginal people and offer both western and Aboriginal medicine. There should be liaison across systems to gain mutual understanding, otherwise there will always be two separate systems. People would be identified from both systems to serve as liaisons.

Educational resources should be provided in the form of workshops such as Manitoba's "Walk a Mile in My Moccasins" training. Cultural competence training would be provided to caregivers.

The program would accept people as they are so that they would not have to lie or hide. There would be honesty, willingness to do the work, interconnection between the systems. There would be connection to nature.

An Aboriginal mental health program should be a starting point to working with the community and bringing information back to the system. There should be exchanging of experiences between the mental health programs to see where inadequacies exist in order to increase understanding rather than placing blame.

A circle would be created to further the vision of where Aboriginal people need to go and to legitimize this process. People would be asked what needs to be done

rather having a vision imposed on them. A community development process would be used to help community recognize and articulate their vision, values, external and internal resources and to develop ownership. Additional counseling, awareness, acknowledgement and acceptance of others as well taking action would be incorporated into people's thinking.

Ideally, more psychologists would be available, as well as healers who can help with issues that are not dealt with by psychologists. A team approach should be taken to determine who could best assist an individual. Treatment choices and choice of health care worker should be available. Health care workers or psychologists would not be watching the clock and a relaxing, welcoming, safe environment would be provided.

These are the goals to be worked towards in realizing a system of care that will address the high incidence of mental ill health among Aboriginal people.

CHAPTER 6   ANALYSIS AND PRESENTATION OF RESULTS

6.1   Definition of the Conflict Situation

The conflict situation is the alarming state of mental ill health amongst Aboriginal people in the Capital Health Region of Vancouver Island, British Columbia and the lack of appropriate response by the Capital Health Region to the mental health needs of Aboriginal people in the region.

6.2   Characteristics of the Conflict Situation

A lack of knowledge exists on the part of the Capital Health Region (CHR) as to how to approach working to improve mental health amongst Aboriginal individuals, families and communities in the CHR.   According to the Manager, Aboriginal Health, the CHR lacks capability and sensitivity in responding to the mental health needs of Aboriginal individuals, families and communities in the region.   The CHR also lacks a relationship with the Aboriginal communities for problem-solving and community capacity building.

6.3   Intensity of the Conflict Situation

The intensity of the conflict can be described from a number of perspectives including the intergenerational effects of residential schools which as expressed by one Elder as "We're just at the tip of the iceberg when it comes to the impacts

of residential school." The physical and sexual abuse, abduction, isolation and cultural genocide, which occurred at residential schools, to this day has a devastating effect on Aboriginal communities. These effects are seen in the deterioration of the family structure and children are still being taken away from parents who are suffering from these effects. As previously stated, there is ongoing grief and trauma in the lives of Aboriginal people, with no time to process and deal with it because another person always needs help. The availability of ongoing community trauma and grief counseling is greatly lacking. There is a great deal of depression, loneliness and helplessness because family and community breakdown also exists.

Spiritual and cultural beliefs play a large part in how a mental health condition is handled, but without community members who are trained in these belief systems there is no one to deal with mental health in these contexts.

6.4   Cultural and Historical Dimensions of Conflict

The Aboriginal Health Association, Handbook on Aboriginal Health describes the various contexts that have contributed to Aboriginal mental ill health over the course of history, including:

- the loss of traditional territories which were critical to making a living;
- confinement on small land areas known as reserves;
- significant loss of life due to foreign diseases;

- the removal of young children from their families in order to christianize, train and indoctrinate them into a new way of life;

- the loss of traditional ways to transmit elements of the culture from one generation to another because of the separation of the generations;

- the undermining of traditional ways of knowing and creating new knowledge;

- the imposition of a foreign governing system designed to control and protect First Peoples, and promote their dependency on others;

- the effects of the introduction of alcohol which, even today, controls the lives of many Aboriginal people;

- the effects of cultural disrespect and devaluation;

- the virtual elimination of traditional economies, which relied upon the wisdom, knowledge, and skills of men and women;

- the exploitation of Aboriginal women by immigrant men;

- inferior education that did not prepare young people to be contributing members of their societies, nor equip them to compete for gainful employment;

- the introduction of passive maintenance by government in the form of social welfare funds and economic make-work projects (p. 54).

Ultimately, a generation to generation legacy of loss on all levels has resulted in a state of Aboriginal mental ill health that manifests itself in interpersonal conflict, conflict with the law, and a wide range of abuse and violence.

6.5   Other Contextual Factors of Conflict

Another contextual factor contributing to the problem of Aboriginal mental ill

health is that treatment of many of the behaviours associated it with it, such as

alcohol and drug use, suicide, and abuse, have not taken into consideration the

historical contexts of Aboriginal peoples' lives. The disease model of addiction,

for example, is now being examined for the harm it has caused as it ignores the

accumulation of loss and grief over generations and how this has controlled

Aboriginal peoples' lives. Theories that examine the effects of oppression

suggest that, through capacity building, individuals and communities can work

through unresolved issues behind the addiction and develop tools for their

healing and restoration of well being. It is thought that in order to move forward,

Aboriginal and non-Aboriginal people need to:

> ...possess knowledge of the history of Aboriginal health in Canada and an
> understanding of the relationship of poor health indicators...(alcohol/drug
> abuse, high rate of smokers, teen pregnancy, suicide, low life expectancy,
> FAS/FAE, and unemployment)..., to colonialism and decades of alienation
> and devaluation experienced by Aboriginal people...(AHA, Handbook on
> Aboriginal Health, p. 78).

Also contributing to the conflict are the differences between the Aboriginal

contexts of healing and justice and those of non-Aboriginal people in Canada.

According to Gloria Lee, a researcher and curriculum developer, traditional

Aboriginal healing seeks to understand the underlying causes of the illness or

conflict, such as a spiritual or emotional imbalance, in the individual and/or their

environment. The intent of the Aboriginal healing process is the restore the

balance in the individual and their environment.

Unlike the Canadian justice system that emphasises punishment and deterrence through the threat of punishment, the purpose of the Aboriginal justice system and similarly the healing system is to "restore the peace and equilibrium within the community, and to reconcile the accused with his or her own conscience and with the individual or family who has been wronged" (Lee, 1996 p. 2).

Because of the differences in the underlying beliefs of the Aboriginal and the Canadian healing and justice systems, it is clear how the imposition of Canadian systems onto Aboriginal people has resulted in Aboriginal mental ill health and conflict. Lee points to the difficulties inherent in a system that does not conform to one's fundamental beliefs, and acknowledges that "due to the differing perception of what constitutes justice, the justice system of the one cannot work for the other, for in their eyes, what is being delivered is not justice" (p. 5).

The Royal Commission on Aboriginal Peoples, Final Report , Volume 4 - Perspectives and Realities explains a number of contexts related to the differing worldviews of western society and Aboriginal peoples. It also acknowledges the various contexts of Aboriginal women, youth, Métis, Aboriginal people of the north and urban Aboriginal peoples. The context of the Elders is also described.

The Elders who are seen by Aboriginal people as being the "link to traditional knowledge" and "the keepers of traditional culture," describe how qualities of Aboriginal culture contrast and conflict with those of western culture. They also

state that their ways and teachings form the very foundation and identity of

Aboriginal people, and without these teachings and transmissions of culture, their

identities would die. Dumont (as cited by the Royal Commission on Aboriginal

Peoples, Final Report, p. 7) describes Aboriginal "intellectual tradition" as having:

> all-around vision" in contrast to the "straight-ahead vision" of modern
> thought. Areas such as the study of dreams and the knowledge of
> spiritual planes do not form part of the western intellectual tradition but are
> integral to the all-around vision. Because of differences such as these, it
> can prove difficult to discuss the Elders' holistic way of explaining
> phenomena with those trained in a linear way of thinking. For the 'all-
> around' thinker, the natural and supernatural intertwine. Past, present and
> future mesh in the life of an individual. The realm of the sacred becomes
> part of everyday experience (p. 7).

CHAPTER 7 CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

While a number of processes are underway to examine Aboriginal mental health, there appears to be no coordination of these processes or resources between governments and communities. Similar to the approach that is being taken by Health Canada with regards to promoting the mental health of the general population, an integrated strategy for promoting Aboriginal mental health is needed. This strategy like that of Health Canada's "needs to recognize that mental health is influenced by many forces and factors outside the traditional health "box" (Rock, 2001, p. 5)

As federal Health Minister Allan Rock recently commented at the 26th Congress of the World Federation for Mental Health – World Assembly for Mental Health, the government of Canada does have direct responsibility for delivering health care services in Aboriginal communities. He also stated, "the rates of suicide, substance abuse and depression among the First Nations and Inuit communities in this country are unacceptably high and there remains a disturbing disparity between the overall health status of First Nations and Inuit Canadians and the populations at large (Rock, 2001, p.8).

As stated in the Introduction, the purpose of this research is to begin to build a knowledge base concerning what may be done to improve the mental health of Aboriginal individuals, families and communities (on and off reserve) in the Capital Health Region (CHR) of British Columbia. Based on the information gathered through interviews with Aboriginal communities and organizations, as well as a review of the literature and the processes underway to address Aboriginal mental health, the following recommendations are offered to the Capital Health Region:

7.2 Recommendations

Develop an Aboriginal mental health team consisting of an Aboriginal Health Liaison person, a full-time psychologist, a consulting psychiatrist who can prescribe medication, and a full-time dual-diagnosis psychiatric nurse who report to the Manager, Aboriginal Health.

This team would be responsible for developing and implementing a strategy to address Aboriginal mental health in the Capital Health Region this strategy would:

- include a holistic world view;
- recognize the history of Aboriginal health and have an understanding of the relationship of poor health indicators to colonialism and the history of alienation and devaluation;

- promote education and awareness on a range of topics such as mental illness, stigma, traditional and non-traditional treatment of mental illness, spirituality and other cultural beliefs, as well as consumer-oriented information on how to access services, and issues related to cross-cultural services delivery;

- promote awareness of the programs and services available through the Eric Martin Institute, while at the same time recognizes and seeks to address the limitations of EMI by providing culturally appropriate services elsewhere on and off reserve;

- build relationships and facilitates communication and cooperation between the system of health care and social services providers and Aboriginal individuals and communities;

- ensures that clients are linked up with a comprehensive set of coordinated services that meet their mental and health and related services needs and that also assist in coordinating a comprehensive service plan;

- respond to community-based psychiatric emergencies.

In terms of the need for future research in the area of Aboriginal health, Darlene McGougan, Manager, Aboriginal Health for the Capital Health Region, offers the following suggestion in regard to methodology:

> This research project was conducted using a feminist action approach, which is inclusive of the people in the community who will be impacted by the action component of the research. This method for research fits well with the First Nation communities and peoples. Historically, First Nation communities have been "studied" using a data collection and analysis method. The perspective of the community resulting from those

experiences is that of helping outsiders with research about Native people but never seeing any results or any change for the better in the health or living conditions of the people. This has left a bad feeling about research being conducted. Feminist action research is aimed at mitigating that historical perspective by recommending action that addresses the issues raised by the people and resulting in improvements in health that the people living the experience see as being helpful. In my opinion research in First Nation communities must reflect the voice of the people, it must not be for the sole purpose of collecting data and analyzing results but result in actions that address the issues that are seen as important by people living in the circumstances.

This research is a small step towards addressing the disparity between the overall health status of Aboriginal people and the populations at large, through the gathering of valuable information generated by Aboriginal communities in the Capital Health Region. It is hoped that this information will be used to make changes that will begin to address the mental health needs of Aboriginal people in a way that respects their view of health.

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APPENDIX B   LETTER REQUESTING PERMISSION TO DO RESEARCH IN ABORIGINAL COMMUNITIES

Chief

I am writing to request your permission to visit your community in the month of May in order to speak with the Community Health Representative and Alcohol and Drug Counselor about mental health concerns of people in your community.

As the Regional Manager for Aboriginal Health for the CHR it is my responsibility to work with communities in the Region to provide services that are culturally appropriate and accessible. It has come to my attention on a number of occasions that the mental health system is not meeting the needs of our First Nation people in the Region. This has lead me to request the assistance of Laura Hummelle, a Master of Arts student/researcher at Royal Roads University in Victoria, in exploring the following questions with Aboriginal people in the Capital Health Region communities:

- How do people in your community define mental health?
- How do people in your community define mental illness?
- What are the main barriers to improving mental health in your community?
- How could mental health be improved?
- What would an Aboriginal mental health program look like?

Through face-to-face interviews with service providers in your community we hope to develop a better understanding of what steps need to be taken in order for the Capital Health Region to become more responsive to the mental health needs of people in your community. We also wish to learn of your successes in addressing mental health concerns in order to build on these successes.

Should you wish to contact me to discuss our consultations with the Community Health Rep. or the Alcohol and Drug Counselor or any matter related to our visit, I can be reached at 250-370-8455 or fax at 250-370-8544.

We look forward to the opportunity to visit your community and to receiving guidance on how to improve mental health services for Aboriginal people in the Capital Health Region.

Sincerely,

Darlene McGougan, R.N., B.S.N.
Regional Manager
Aboriginal Health
Capital Health Region