Assessing the Training Needs of First Nations Mental Health Workers in Manitoba

by

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A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF ARTS

Department of Anthropology
University of Manitoba
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PREFACE

This document is meant to serve as a practical resource to First Nation communities in designing mental health programs. It also serves as partial fulfilment of the requirements of a Master of Arts in Anthropology at the University of Manitoba. In order to meet both of these requirements, I have broken the document into two sections: the thesis document, which contains the thesis in its entirety (sections one and two); and the community document which contains only the community research report (section two of the thesis document).

Manitoba First Nations communities are asking the question: what are the training needs of First Nations mental health workers? This research project contributes to answering that question. I have turned to local experts and community helpers as sources for the answers to this question because answers to problems within First Nation communities are contained with First Nations themselves. The main source of data is derived from key informant interviews conducted in three Manitoba reserve communities.

The thesis document is arranged to make finding information as easy as possible without necessarily having to read the report from front to back. The interview results are descriptive in order to allow the reader opportunity for their own analysis of this rich source of knowledge, but I have also endeavoured to synthesize

and summarize research conclusions. The table of contents is extensive and may help the reader find what they need. Key topics are summarized in tables for easy viewing; these tables are listed at the beginning of the work.

The resulting story about First Nations mental health training needs cannot help but be influenced by my twenty-two years of experience as a Registered Psychiatric Nurse, by my training in anthropology, and by the person I am. I have listened with openness and respect to the voices of the people I interviewed. I wish to express my gratitude to the people who shared their ideas and experience with me, and I hope that I have done them justice in presenting an analysis and summary of the knowledge they so generously shared with me. Each community was graciously accommodating during my visits and phone calls. I am grateful for what I have learned as a researcher, as a nurse, and as a person.

I also gratefully acknowledge a research grant from the Northern Scientific Training Program, administered through the Northern Studies Committee of the University of Manitoba which contributed greatly to the field research portion of this project. And finally, completion of this project would not have been possible without the support of my thesis advisory committee, Dr. K. Grant, Dr. J. O'Neil, and especially my advisor, Dr. Wm. Koolage.

Ekosani.

Karen McSwain

ABSTRACT

In the past there have been few mental health services in Manitoba First Nations communities, but currently First Nations are developing innovative approaches to mental health which uniquely suit their communities. There is a need for trained community workers to work within evolving First Nations approaches to mental health, but what special skills and training do these workers require? Answers to this question can be found within the knowledge of those already working in First Nations health and social services, that is, within the knowledge of those who are part of the process of developing their communities' approaches to mental health. Through open-ended interviews, people in three Manitoba reserve communities are asked the following questions: what does mental health mean; what are the problems, the causes, and the solutions to mental health problems in their communities; what training and skills do First Nations mental health workers need; what are the attributes of a good helper; and what supports do helpers require?

Health is a state of balance and harmony of all the aspects of the medicine wheel. The massive losses and abuses suffered by First Nations through the process of colonization have destroyed the wholeness and balance of First Nations. The priority mental health problems of depression and anxiety, suicide, and substance abuse are symptoms of imbalance and disharmony, and the consequences of the losses and abuses suffered. Healing means returning individuals, families, communities and the nations to states of balance and harmony. The solutions to mental health problems must include rebuilding community resources through political self-determination and rebuilding positive cultural identity. Mental health systems are being constructed by First Nations blending western health and social service models with native traditional approaches. First Nations mental health systems place emphasis upon public education and community development as well as upon treatment.

First Nations community mental health workers need strong working ties with mainstream mental health specialists for ongoing training, supervision, and consultation; they need to be members of the community team (including elders and the general public), but must also connect communities to mental health resources available in the rest of the province. There are six areas of training required by mental health workers in First Nations: counselling skills; mental health theory and practise; writing and agency skills; public education skills; community development skills; and spiritual/traditional training. The crucial attributes of a First Nations helper are self-healing/self-awareness, caring, and a First Nations background. Mental health is part of an attitude of healing and harmonious connection with all of creation; this attitude includes traditional values of respect and caring which must form the foundation of First Nations mental health systems.

Section One

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INTRODUCTION

The question, at first, seems straightforward "what are the training needs of First Nations mental health workers?" But meaning is always relative; it is formed through interaction and relationship with the whole. It is necessary to understand the concept of mental health in First Nations, and to do this it is necessary to examine its political, economic, structural and ideological context. In other words, the concept must be contextualized in order to assess its meaning. Not only is meaning relative to contemporary social context but, as will be shown, history is especially important to First Nations ideas about their mental health issues. Understanding what training is required by First Nations mental health workers entails examining the ways in which 'mental health' and mental health care are being constructed by First Nations.

This thesis holds that First Nations are actively constructing mental health approaches within a framework of healing, and that the healing process itself includes restructuring political self-determination and revival of cultural identity. These processes are interdependent. There is not one approach, not one distinct entity called 'First Nations mental health,' but rather each First Nation community seeks to shape its own visions and initiatives. There is not one voice speaking but rather many voices in dialogue with each other, many voices which negotiate and compete with each other in a continuous, dynamic process of social construction. However, it is possible to recognize common elements used in the construction of First Nations concepts of

healing and common emerging themes to First Nations approaches to mental health because of their common experiences and declared identity as Aboriginal people.

Because I am concerned with the social/cultural context of mental health in First Nations, and because I believe that approaches to First Nations mental health are actively under construction, I seek the answer to my research question within the lived experience of, and the knowledge held by, people working in First Nations helping roles. These are the people who have on-the-ground experience with the problems and solutions within First Nations and who, indeed, may be some of the people involved in constructing an approach to mental health care in their communities. The primary research tool of this project is the analysis of qualitative interviews with key informants within three First Nation reserve communities in Manitoba. It is from the authority of these voices that I base my analysis and interpretation.

Section two is a self-contained community document reporting on the results of these interviews which is meant to be accessible to First Nations for practical use. Section two describes the research methods, the interview results, and contains a summary and conclusions on the system requirements and training needs of First Nations mental health workers in Manitoba. In order to contextualize what people told me in the research interviews I conducted abbreviated ethnographies of each community and reviewed relevant literature on First Nations. The appendices contain introductory descriptions of the communities involved in the research which will be

particularly useful to those unfamiliar with reserve communities. The appendices also contain a description of the helping resources generally available in Manitoba reserve communities.

Section one discusses theoretical considerations and reviews relevant literature. Chapter one lays out a theoretical argument on the emerging construction of First Nations' understanding of their problems and approaches to healing. An important theme throughout the research interviews and throughout the literature is that the problems faced today within First Nations communities are the consequences of abuses and loses suffered through the process of colonization. Chapter two then details a history of the losses experienced by First Nations as a consequence of colonialism. These losses have resulted in the priority mental health problems of substance abuse, depression, anxiety, and suicide. Chapter three points out the implications of First Nations and western social constructions about mental illness. Chapter four discusses First Nations mental health problems as found in the relevant literature, and in chapter five I examine the problems inherent in contemporary mental health services available to First Nations.

Chapter One:
EMERGING FIRST NATIONS CONSTRUCTION OF MENTAL HEALTH

There are two key elements in the argument put forth on the causes of mental health problems in First Nations: the first is a holistic conception of health which encompasses all aspects of existence; the second holds that the balanced state of health of the First Nations within their world was fractured via the losses and abuses suffered through colonization. Following the logic of this argument, First Nations communities are now engaged in a process of healing, of returning to balance and harmony, and that this healing encompasses not only healing individuals but also the communities which support them.

Clarkson, Morrissette and Regallet articulate a framework for understanding the problems and challenges of indigenous peoples based upon their own experience as First Nations people within Canada (1992). They explain that traditional indigenous cultures evolved so that customs, beliefs, institutions, and social controls all worked harmoniously with the natural environment (1992:4). Spirituality, which is defined and expressed through culture, is the harmony, balance and connection to the natural law within the environment which is integral to the health and survival of the people. It is this 'spirit' or wholeness which has been destroyed by colonization and it is that which must be rebuilt. In rebuilding their communities, in reconstructing healthy lifeways, indigenous peoples must "create their own mechanisms of change based upon

the values, beliefs, and systems of their original teachings" (Clarkson et al., 1992:vii).

Clarkson et al. also recognize that "the effects of history are contained inside the indigenous people today" (1992:44). This has two ramifications. Indigenous people are caught in perpetuating the cycle of abuse that was started by the colonizers. This is evident in the problems of substance abuse and violence. But it also means that indigenous people today have assimilated aspects of the western worldview. This thesis holds that a constructionist view of society helps to explain the dynamics within First Nations which arise because of assimilated western worldviews and by the variety of traditions belonging to First Nations. A constructionist view holds that all societies have been and always are undergoing continuous processes of change and reconstruction according to a variety of influences within and upon them. Clarkson et al. also allude to a dynamic process of social construction when they discuss the need to decolonize contemporary First Nations' beliefs in order to 'rebuild' the wholeness of the nations using traditional knowledge. In the interviews of this research one can sense the tension between holistic constructions about healing and the pragmatics of contemporary reserve life which include assimilated attitudes toward health and health care.

The prevailing paradigm underlying First Nations approaches to mental heath is one of holism as represented by the medicine wheel encompassing the spiritual, intellectual, physical, and emotional aspects of the people (see Figure 1 at the end of

this chapter). The mental health problems experienced by First Nations are indicative of ruptures to wholeness, of disharmony, imbalance, and loss of connection between all the aspects of creation. First Nations mental health problems must be understood in the context of a colonial history and contemporary realities which disrupted or destroyed connections to the land and land-based economy, which disrupted or destroyed social structures for maintaining health, and which disrupted or destroyed positive cultural practices for nurturing self-esteem. Mental health must be understood in terms of the broader concept of healing. Healing means returning individuals, their families, their communities, and the land to a state of balance, harmony, wholeness, and connection—to a state of 'well-being.' Healing means recovery from the losses and abuses suffered by nations and individuals as the result of colonization.

Healing is multi-dimensional. The lack of sufficient resources for maintaining health underlies many problems, but economic development alone will not return First Nations communities to well-being. It is not just poverty, overcrowded housing, and lack of basic necessities for health which contribute to mental health problems in First Nations. A Cree elder explained to me that just building community structures such as recreation centres is not enough because "soon the buildings will look the way the people feel." Political disempowerment and cultural genocide have left communities short of resources and opportunities to solve their own problems, but they have also left many without the positive identity and hope necessary to sustain self caring. Self-determination (the ability to act for oneself) and strong cultural identity are necessary

to build and maintain healthy communities which nurture healthy individuals. First Nations communities are in the process of reclaiming and rebuilding political self-determination and cultural identity, and these processes are necessary to healing and to solving mental health problems. At the same time, healing must occur in order for self-determination to succeed. Neither one is possible without the other.

It was suggested to me by a traditional practitioner that what I think of in sociological terms, he thinks of in spiritual terms. First Nations understand the connection and interaction between the individual, the social world, and the physical world as the spiritual. Spiritual: that which connects all of creation and allows humans to function in harmony with creation. As an anthropologist, I understand the connection and interaction between the individual, the social world, and the physical world through the concept of culture. Culture: the means by which humans construct concepts, practises, and social institutions in order to survive and to exist in a state of well-being. It is through culture that we construct concepts, practises, and social institutions to express and actualize spirituality, or in other words, to bring about and maintain a state of well-being. If health is a state of balance, harmony and connection, and spirituality is that balance, harmony and connection to all of creation, then it follows that achieving a state of health, that is healing, is essentially a spiritual process. Healing, spirituality and culture are tied together.

In a discussion paper on traditional medicine and primary health care in

Canada, Brenda Shestowsky tell us that, "it is not possible to view Aboriginal Indian Traditional Medicine as separate from traditional Aboriginal Indian culture. It stems from and is intricately tied into traditional Aboriginal Indian philosophy, religion, and spirituality. Health and illness beliefs are integrated into religious beliefs" (Shestowsky, 1993:7). I would add that First Nations politics is also intricately tied into issues of philosophy, religion, spirituality, and health. The issues of health and health care are political issues, since defining health and health care practises are social tasks, and politics determines the power of a social and/or cultural group to define who they are for themselves. This is the meaning of the term 'self-determination'—the ability of a people to determine a way of life; the ability of a community to be responsible for its own operation; the ability of individuals to determine their own identities. Health or well-being represents an ideal about what is a good quality of life. The First Nations' call for 'healing' (or achieving that good quality of life) is a political statement of dissatisfaction and resistance against unacceptable living conditions.

Not only are First Nations calling for political self-determination, they are also asserting their right to a good quality of life through the use of cultural identity. In a way, they are saying 'this is who we are, this is who we have a right to be, and this is the way of being that is best and most healthy for us.' According to Naomi Adelson's work with the James Bay Cree, the Cree concept of 'being alive well' or well-being (i.e., health) is tied to living a good Cree life as it is defined through the authority of

tradition. Well-being is defined as being able to practise Cree land based activities (hunting, fishing, trapping, gathering) and Cree beliefs and values; what removes people from their Creeness, removes them also from well-being (Adelson, 1992:200). Regaining and maintaining health requires regaining and maintaining traditional Cree practises and control over one's own life. The well-being, or health, of each person's mind, body, and spirit is tied to cultural revival and to regaining self-determination. Health becomes embodied political action. Traditional culture is a tool in restructuring political self-determination. The social construction of 'Cree Traditionalism,' and the social construction of 'healing' are part of the political/social reconstruction of the First Nations; they are used to express resistance to dominant ideologies and to build alternate ideologies. (See Naomi Adelson, 1992) What rightly counts as tradition, however, is problematic and contested.

Tradition is not a frozen snap shot of the way things used to be. Tradition is a dynamic, contemporary construction of group identity using practises and beliefs which are considered to have belonged or are known to have belonged to one's own people over time. Tradition stands for Cree identity; it means more than 'this is who we were'; more importantly, it means 'this is who we are.' All things change, and the Cree identity of today is not the same as Cree identity prior to European contact. What gets counted as tradition is debated and negotiated within communities. In the research interviews there is evidence that many people use a western dualist view of tradition, separating traditions which involve land-based survival activities (hunting,

trapping, fishing, clothing, language) from native spiritualist traditions (fasts, sun dances, 'religious' beliefs). The social reconstruction of traditional identity not only has political ramifications but also has important implications for the construction of the 'self' of First Nations individuals.

The social construction of the self is an important part of well-being and mental health. A traditional practitioner Tom Campbell, in his presentation to the Issues in the North Lecture Series 1996, spoke about 'deep ecology' as a personal, experiential connection with the environment. This raises the issue of the role of one's relationship with the land, to the relationship with one's self. That is, that a cultural relationship with the land helps to construct one's relationship with one's self. First Nations peoples claim a cultural, historical close connection to the land they live upon. It was true, their everyday lived experience intimately connected them with the natural environment. What happens to the health, to the self esteem of a people who are severed from their land, from their land-based economic activities, and even more so, who come to view their land as tainted and spoilt as the result of such developments as hydroelectric projects on northern Manitoba rivers? At the core of well being, of mental health , is a positive sense of self.

Our sense of self, the continued existence of self, depends upon the land and its creatures, and upon the social system which helps to form and support who we are. For First Nations one of the dilemmas of self-identity is that the self, at least in part,

has been constructed by the colonizers. Christianity, school, television, consumerism are all part of modern First Nations life. These things are not only 'white' but they are also part of being 'Indian' in the 1990's. Ann Charter spoke eloquently on the concept of the colonized self in her presentation to the Issues in the North Lecture Series, 1996; she stated that: colonization is a holistic process including the economic, the political, and the psychological. I would add the spiritual as a colonized aspect of community and the self. Gerald Vizenor, in his book *The People Named the Chippewa: Narrative Histories*, discusses how the concept 'Indian' is a white construction invented by the colonizers (1984) . The colonizers have had the power to define the colonized as a 'people' and even to define the 'self' of each Indian person. The oral tradition, which was once a means of reproducing culture, has lost much of its power as a means of self-definition. First Nations have not been allowed to participate in the 'imagining' of their own world, their own selves. They are now reclaiming the power to create their own vision of themselves as a people and as individuals. Part of healing, of redressing the damages caused by colonization is the need to de-colonize the self of First Nations individuals.

Colonial history is considered essential to understanding the losses and abuses suffered by First Nations, and to understanding the cycle of abuse in which many are caught. The Assembly of First Nations study of residential school states clearly that "(h)istory provides a context for understanding individual's present circumstances, and is an essential part of the healing process" (1994:141). Healing will include not only

treatment but also education, community development, and political self-determination, and it will be constructed using tools of traditional culture. Spirituality, which is avoided in the medical model of healing, is essential to healing and well-being. Quoting the Assembly of First Nations study of residential schools again, "(w)hen a person is seeking help, whether for martial problems, or depression, he is, on an unconscious level, wanting to reconnect with his spirit" (1994:148). Health is a way of life which includes values, beliefs and codes of conduct.

The basic premise expressed here is that mental health problems are directly related to First Nations history as a colonized people, but what is more important is the question of how these problems should be addressed. These problems are best addressed by First Nations themselves, not as victims of their past but as survivors. The reason for noting the historical and political economic causes for First Nations' mental health problems is to set the stage for understanding that solutions to mental health problems lie within the social actions of First Nations communities themselves. The focus is upon the ability rather than the disability of First Nations to act on their own behalf. Although the focus of this thesis is on the actions of First Nations to achieve their own healing, it is recognized that this First Nations' construction of healing (which contains mental health) occurs within dynamic social systems, and in particular within the larger context of Canadian and global political and economic systems which have their own interests to protect. Chapter three will examine the theory of social construction as it applies to the western medical model of mental

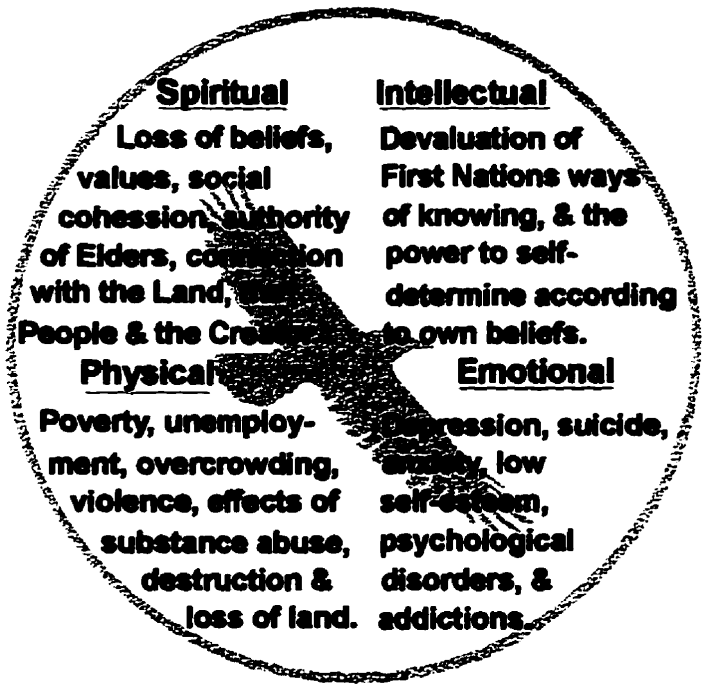
health and First Nations construction of healing.

In summary I have used the medicine wheel as a conceptual tool and visual representation for understanding First Nations constructions about mental health (figure 1, next page). The medicine wheel represented in Mussell, Nicholls, and Alder, 1991) contains the following elements of existence of the people: spiritual, intellectual, physical, and emotional. I have adapted their representation of the medicine wheel to illustrate the problems facing First Nations and the solutions to those problems. The medicine wheel helps us to remember that all things are connected and interdependent. The life of the Nations has been disrupted leading to the problems experienced. In the next chapter I discuss the history of losses which have been suffered and how these affect mental health, because history is so important to First Nations understanding of their problems.

Figure 1

The Medicine Wheel as a Conceptual Tool For Understanding First Nations Mental Health

Problems Facing First Nations



Solutions to Problems Facing First Nations

Adapted from Mussell, Nicholls, and Alder, 1991

Chapter Two:
A BRIEF HISTORY OF FIRST NATIONS LOSSES AFTER EUROPEAN CONTACT

The history of the First Nations since contact with the European colonizers can be described in terms of what has been lost. The sense of loss runs deep. As one woman put it in her interview, "we are always grieving." Part of the healing process is recognition of the loss and grief, working through the tangle of wounds, and moving on to reclaim self-determination, pride in identity, and hope for the future. The job for historians now is to re-evaluate the past not in terms of Indians as passive victims, but in more realistic terms of the struggles and strengths of the Nations. This overview is brief and focusses on an outline of the losses suffered by First Nations through the colonization process.

Several general categories of losses have had major affects on the First Nations in Manitoba: loss of economic viability; loss of self-determination (coming under the control of the Canadian institutions of religion, law, and medicine); loss of the function of the family and clan system; loss and destruction of their land; and, coupled with a loss of culture and social structures, the encroachment of foreign culture through the roads and television.

The first major event to bring about change was not necessarily negative in its immediate impact but its effects are far reaching: the integration of First Nations into the European economy through participation in the fur trade. The First Nations people were quick to adapt to, and take good advantage of, the economic activity of trapping and fur trading. Fur trade trapping became so well integrated into land-based traditional life-ways that today trapping is thought of as part of First Nations traditional identity. But there were negative effects also from incorporation into European fur trade: depletion of fur bearing animal populations (and hence the eventual decline in food sources); infectious diseases from contact with Europeans and from more clustered living conditions surrounding trading posts; and, as fur trading contact increased, First Nations increasingly came under the control of European systems of religion, law, and medicine. (See Fiddler, 1985:57-70 for an oral history account of starvation around the turn of the century due to declining wild life in Northern Manitoba; and Young, 1988:32-45 regarding the health consequences of contact in the Canadian central sub-arctic.)

With the decline of the fur trade, the land of the First Nations became more important than their labour to the emerging Canadian nation. First Nations lost most of their land base through the treaty making and complex processes of disenfranchisement. They became increasingly restricted to the least desirable lands, and their economic activities were curtailed through government interference. (See Shkilnyk, 1985 for an analysis of how government-imposed community planning

destroyed healthy community functioning.) Following the second world war, First Nations became subject to what has been called 'welfare colonialism'—a process whereby handouts replaced economic opportunities. (For an analysis of the role of government welfare programs in helping to destroy reserve economies, see Coates and Morris, 1993:20-21; also see Shkilnyk, 1985.)

The oppression and destruction of First Nations spiritual beliefs and practises was an essential part of colonial domination. Christianity is now an important part of many First Nations people's lives, but historically the political, oppressive aspects of Christianization were abusive. The prevailing attitude of white, Christian colonizers was that the Indians must be made to abandon their beliefs and religious practises, abandon their language and land-based life styles in order to survive in the new Canada. In other words, Indians must assimilate and disappear as a People. European society believed in Social Darwinism: societies evolve from an earlier and lowest form (primitive Indians) to the highest, civilized form (the European peoples). This belief system helped to rationalize conquering, converting, and taking control over the lives of First Nations peoples until they could be brought into a civilized state and prepared for Canadian citizenship.

First Nations were taught that their spiritual ideas and their ways of life were evil and primitive. They were encouraged to throw away, hide, and sell the material culture of their spiritual practises (medicine bundles, pipes, drums). Their religious

practises were banned (the Potlatch, give-away ceremonies, the Sun or Thirst dance) either through formal legislation (The Potlatch Law 1884) or through informal policies of the Department of Indian Affairs (Pettipas, 1994:88-105). The process of converting Indians to Christianity was much more than a religious issue. It was an essential part of the political defeat and oppression of the inhabitants of the new world in order in make room for European colonization. The Canadian government's Indian policies were aimed at religious oppression because the government recognized the "direct connection between indigenous worldview, ceremonial life, and the social, economic, and political structures of the community" (Pettipas, 1994:3). Katherine Pettipas gives an excellent account and analysis of government repression of indigenous religious ceremonies on the Canadian prairies, and the struggles of the Plains Cree against this process (1994). Pettipas makes special note of the importance of spirituality and traditional ceremonies to the health of First Nations individuals and communities; the destruction of the ceremonies in turn destroyed social institutions for maintaining health (1994).

When the First Nations made treaties with the British Crown they consented to the loss of most of their land in return for certain rights and guarantees, but they did not consent to the loss of their right to self-determination. But unfortunately,

> (w)ith passing of the Canadian Act of 1876, the social, economic, and political position of Indian nations was dramatically transformed into one of "dependence." This formalized relationship between Indian nations and the new Canadian state had not been negotiated, but, rather, it was unilaterally imposed (Pettipas, 1994:37).

Indian people were not allowed to use their own systems of social regulation but were subject to Canadian laws through the R.C.M.P. and Canada's Indian Act. The bands were essentially ruled by the Indian Agent (representative of the Crown). Initially the bands were subject to laws which inhibited their ability to be economically and politically self-sufficient: they could not vote; they could not leave their reserve without Indian agent approval; and they could not buy materials for economic activities without Indian agent approval. Through a pass system, Indian agent approval was required in order to leave the reserve; this system was used to prevent gatherings for Sun Dances and other ceremonies, to restrict parents from visiting their children in residential schools, to disrupt the nomadic nature of their economic system, and to prevent socializing and alliances between reserves and therefore to weaken social, kin and political ties (Pettipas, 1994:111-112). Every aspect of reserve life was run directly or indirectly by the Department of Indian Affairs.

First Nations people also became subject to European systems of health care and medicine. The first health care services offered by the European newcomers were administered by fur traders, missionaries, and R.C.M.P. as an adjunct to their other duties. Rudimentary medical services were offered by physicians on yearly visits accompanying treaty parties or supply boats for the trading posts. In some ways the health care system of the Europeans was sought after by the First Nations, especially to combat infectious disease, but the Europeans also actively suppressed indigenous

health care systems. Katherine Pettipas points out that although no legal prohibitions existed against indigenous health care systems on the prairies, informal sanctions were used to discourage people from using indigenous healers: the withholding of rations, jobs, and/or aid, and vague official threats (1994:159). Many northern peoples were essentially 'disappeared' through the process of removing tuberculosis victims to sanitoriums in the south. In 1956, 1,600 Inuit, or roughly one-sixth of the population, were in southern hospitals (Jenness, 1964:96). The practise of transferring northern women to southern hospitals for birthing has also contributed to the loss of indigenous control over health care and over their way of life (O'Neil, 1990).

Since the turn of the century, the federal government has gradually developed a system of health care services for First Nations communities. The first nursing station in an Indian reserve was opened in Fisher River, Manitoba in 1930 (Young, 1988:87). A three tier medical system with extensive communication and transportation links has since been put in place. The smallest communities have health stations where basic medical facilities and services are provided by a local resident with some training, a manual, and a radio-telephone to contact the nearest nurse or doctor. There are primary health care centres (better known as nursing stations) in communities of 150 or more, which are run by nurses and visiting doctors who consult with and refer to secondary level hospitals situated in larger centres such as Churchill and Thompson (Norway House is no longer a regional hospital). These secondary level hospitals have consultation and referral relationships with larger tertiary level hospitals such as

Winnipeg Health Sciences Centre and St. Boniface Hospital. The University of Manitoba, Northern Medical Unit helps to supply a wide range of visiting specialists, including dentists, pediatricians, and psychiatrists.

The indigenous health care systems were undermined and virtually destroyed in favour of the new Canadian health care institutions which also serve as agents of social control. The people and their problems are defined in terms of the institutions assigned to service them; health care is one of the institutions of social control used by the colonizing European society and the new Canadian society. Irving Zola states, "that medicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law" (1986:379). John O'Neil argues "that the structure of health services in northern Canada reflects an internal colonial political economy which is characteristic of most Fourth World situations" (O'Neil, 1986:119). Although he is referring specifically to the Inuit, his comments hold true for Canadian First Nations in general when he states that they went

> ... from a system where each individual had been involved in all dimensions of health care, to a system where health resources were controlled by outsiders. From a system where social relationships and health care were understood in a fundamentally integrated manner; the colonization of mind, body and community in the Canadian North resulted in a situation where people became alienated from their own well-being (O'Neil, 1986:122).

Not only have First Nations lost control over their own institutions of law, religion, and health care, but First Nations have also lost, to a large degree, the ability

of the family and clan to be the primary site for the reproduction of culture (the family and clan as the teacher of values, beliefs, spirituality, language, traditional land-based survival skills). The residential school system was a powerful instrument in the attempt to assimilate the First Nations. Although not everyone suffered the terrible abuses or has negative memories of their residential school experience, it can fairly be said that children in residential schools were subjected to losing their language, losing their respect for the practises, values, and beliefs of their families, and a restricted experience of normal family life. The residential school system was inherently abusive: poor funding led to inadequate care; and the dynamics of racism and power lead to horrific cases of abuse. Residential schools helped prevent children from learning the skills necessary for survival in their communities (e.g., hunting, hide tanning) and instead taught skills that were not useful in their home communities (e.g., domestic service, farmhand). The First Nations Health Commission report on residential schools states that the most obvious outcome of the residential school system for all First Nations individuals (whether they attended the schools or not) is a long list of losses resulting in a massive amount of grief which has been denied in general and specifically dealt with through the abuse of alcohol (Assembly of First Nations, 1994;167-8). The family holds an important place in the values of First Nations; it is seen as fundamental to healthy individuals and communities. The breakdown of families and marriages is a major concern to First Nations. (For a full history of native residential schools in Canada, see J.R. Miller, 1996.)

The destruction of the land through hydroelectric projects and/or the removal of bands from productive land to marginal land has had tremendous effect on the ability of the bands to support themselves. Dependency has become a way of life for many communities, and they are made to feel responsible for their failure to support themselves. People feel strongly that severing the connection with the land has weakened the First Nations, and certainly the loss of a viable economy has impoverished the people. This theme comes up repeatedly throughout the research interviews.

Elders told me that the introduction of roads and other connections to mainstream North American culture has had a tremendously negative effect on their communities. With the roads have come alcohol and drugs. Dependency on foreign systems has destroyed the balance of life. People have modern conveniences which replace human labour but do not improve the quality of life. Although they have some great advantages, modern conveniences such as indoor plumbing and store bought food have contributed to the lack of meaningful activity in people's lives. Obtaining food and water not only ensured physical survival but were also an integral part of the cultural, social, and spiritual life which nourished all aspects of health. Television is also seen as a negative influence, not just because it promotes a foreign and generally unattainable life-style, but also because it isolates people in their homes and replaces the social interaction which is so necessary to vital, functioning community life.

An elder explained to me that the mental health problems in his community are the result of women no longer breast feeding and people not eating country foods (locally hunted and gathered). At first I was impatient with this answer and tried to get a different one, but as he persisted and as I listened more respectfully, I believe I came to understand. The people are fed and nourished on foreign foods (and foreign influences) and as a result are no longer connected to themselves as Cree people, no longer in balance with their environment and with their own lives. As he said, "cow's milk is for raising baby cows, not baby Indians." Food is our most elemental connection with our world. Eating proper foods in the proper way is an important part of identity. His answer about 'breast feeding and country foods' is both literal and metaphorical. The basic elements of First Nations societies have been weakened—the land-base and economy, religion, self-determination over law and politics, healing systems, the family, language, and lifeways. These have been replaced with elements of the dominant Canadian society—the welfare economy, Christianity, the Indian Act, medicine and the Canadian health care system, English, reserve communities, and visions of a foreign lifestyle which are difficult, if not impossible, to achieve.

In this brief historical overview I have set the stage for the dominant themes in the interviews: that 'loss and abuse' resulting from colonization are primary causes of the most pressing First Nations mental health problems; that control over their own social institutions (or self-determination) is necessary to healthy, functioning communities and therefore to healthy, functioning community members; and that

spirituality and cultural traditions are part of how a society and individuals maintain their balance and therefore health.

Chapter Three:
SOCIAL CONSTRUCTIONS OF MENTAL HEALTH AND MENTAL ILLNESS

The terms health, disease, illness, and sickness can be difficult to define; their meanings depend upon cultural definition; their meanings are socially constructed. Health is defined by the World Health Organization (1958) as: a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health, idealistically, is a state of wholeness, balance, and well-being. The term 'mental health' is sometimes used in its positive sense as a component of our overall health. Mental health means we are coping well with whatever we are given in our lives. The term mental health can be used in the promotion of healthy coping skills and the prevention of mental health problems. But the term mental health is more often associated with the treatment of illness or disease.

Western medical science tends to focus upon disease states rather than upon a holistic sense of well-being. The medical model, and therefore the psychiatric model of mental health, is based upon dualism (the body and mind can be dealt with separately) and upon mechanism (all life can be broken down into smaller and smaller units and operate according to the same basic laws of physics and chemistry). Medical science can be quite successful at pinning down precise causes of dysfunction and at developing specific healing therapies, but it focusses upon isolated parts, often

ignoring the whole, and searches for linear patterns of causality. The term 'mental illness' refers to problems which involve a person's thinking, emotions, behaviour, or personality; it is a label we use to describe people whose problems cannot be explained by physical disease. Sometimes these sorts of problems are dealt with in other ways (e.g., spiritual counselling, prison) and don't get labelled as mental illness at all. Which problems and who gets labelled as mentally ill is dependent upon a variety of social, economic and even political factors.

Anyone can have a hard time coping because of the problems in their life, for instance: from a biological dysfunction in their brain; from being abused as a child; from experiencing a trauma; from never having learned good coping skills; and/or from the breakdown of their family. Everybody needs help and support from their family, friends, and community to be healthy and well. If someone can't cope they may get depressed (and even suicidal), or anxious (which can cause physical illness), or psychotic (crazy), or use destructive behaviours such as substance abuse or abusing other people. It is important to point out that the ability to cope is determined not just by the strengths of the individual but also largely by the problems the person has to deal with in their life, and by the amount of support they get from their family and their community. In Canadian society there are a number of professional and non-professional approaches to helping people cope with their 'mental' or 'emotional' problems: psychiatric treatment, psychological therapy, individual and family counselling, self-help groups, personal growth work, and spiritual supports.

The practise of psychiatry categorizes problems and symptoms into a wide range of diagnoses and bases treatment upon this categorization (ee the *Diagnostic and Statistical Manual of Mental Disorders 4th Ed. DSM-IV*, American Psychiatric Association, 1994). While the cause and even the validity of many psychiatric disorders is disputable, psychiatric medicine has good evidence that there are certain biological diseases of the nervous system which pose serious handicaps to individuals. For instance, Irving Gottesman gives a thorough discussion of schizophrenia in *Schizophrenia Genesis: Origins of Madness* (1991). Schizophrenia is a disease which affects a person's ability to think clearly and to have normal emotional responses. Schizophrenia is extremely difficult for the person and their family to cope with, and both need support to cope with the disease. Manic-depression is also thought of as a biological disease: the person can have extreme (and dangerous) depressed feelings or extreme, unrealistic high feelings and hyper-activity, neither of which they can control by themselves. A person can have a deep depression which causes (or perhaps is caused by) dysfunction of the neurotransmitters in their nervous system. This type of depression (referred to as an endogenous depression) can cloak the person in negativity and hopelessness which is way out of proportion to events in their lives. We have a physical body which is intimately connected to our emotional and spiritual selves. Depression causes changes in our biochemistry, and disturbances in our biochemistry can affect our moods. Specialized knowledge about mental health problems, and approaches for coping with them, can be helpful to those sufferers and to their families.

But mental health issues are also political issues. The Canadian health care and social service systems tend strongly toward the treatment of individuals with problems (labelled as sick) by individuals who are experts (professionals like doctors, psychologists, social workers). The trouble with seeing health problems as something wrong with the individual is that underlying social conditions (e.g., poverty) are made invisible and therefore ignored. In this way, a social problem (such as widespread starvation) can be defined instead as a medical problem (malnutrition, anxiety states), and the individuals treated with vitamins and medicines instead of food and jobs. (For descriptions of this process of medicalization of social problems in North-East Brazil see Scheper-Hughes, 1992, and in a Northern Canadian context, O'Neil, 1984 and 1986). Different human societies define what is normal, what is sick, and what is to be done about sickness in different ways. The ways in which a community chooses to maintain good community mental health and to treat mental illnesses are determined by cultural beliefs and by having political control over their own social institutions: this process is part of a people's ability to self-determine and to act autonomously. As culturally distinct, self-determining communities, First Nations need to define mental health and mental health care for themselves.

Our culture helps us to make sense out of our world (determine meaning). Our most defining feature as human beings is that we have 'culture'. We have complex ways of using symbols to construct and share meaning about the world around us. Through the marvellous, mysterious capacity of our minds to remember, to associate

ideas, to use symbols, we are able to build social units (families, communities, nations). We are able to construct social institutions (law, medicine, religion), technologies (hunting equipment, computers) and behaviour patterns (rituals, social rules) which support our survival and our well-being. We construct 'culture', and we pass this 'culture' along to our children. We are each the products of the social group and culture we belong to, but we also each play a role in the ongoing construction of the social and cultural world around us. Communities (whether a town, cultural group, or a nation) are not unchanging, perfectly unified groups whose members all agree upon how things should be; communities actively negotiate and construct their ways of life on an ongoing basis.

It is important to understand that mental illness categories are not objective facts of existence but are interpretations (constructions) of experience made by psychiatry, a branch of western medicine. These constructions of disease and their psychiatric treatments are sometimes useful. Suffering and/or loss of life can be prevented by recognizing and treating a psychotic illness, or by treating a severely depressed and suicidal person with anti-depressants. But I want to make it clear that assumptions about mental health cannot be understood just from one perspective. In other words, no one segment of society has a monopoly on the truth about human well-being. The concepts 'mental health', 'mental illness', and beliefs about appropriate treatments are socially constructed interpretations of reality; they are working models which are intimately tied to other historical, political, and economic aspects of the

community.

Psychiatry (whether it really wants to or not) functions as one of our social institutions for controlling unacceptable or dysfunctional behaviour; this is quite significant for First Nations since they are a culturally and economically dominated group within Canada. Atwood Gaines holds that the 'normal healthy individual' underlying psychiatry's Diagnostic and Statistical Manual III-R (psychiatric diagnosis and their criteria) is a white, male, Germanic Protestant; this makes it hard for 'others' to fit the culturally dominant description of normal (1992). I was told by one man that he didn't like to use the term 'mental health' when discussing problems because it's "just another way of calling Indians crazy." What he is saying is that Indian ways of being and Indian problems arising from their situation in society are sometimes discounted and/or labelled as abnormal, dysfunctional, or sick. 'Indian problems' can be decontextualized from their social and economic causes and treated as dysfunction within individuals, and even considered the result of dysfunctional communities and culture. What's more, the problem can then be framed as not about 'us'; the problem is that 'they' are not like 'us.'

As a social scientist I make use of the concept of 'culture' as an analytical tool for understanding. The concept of 'culture' helps me to see human societies as the dynamic product of human interaction; it helps me to view beliefs and practises as relative rather than absolute truths; and it helps me to understand that there are

complex social structures (e.g., politics, economics) which must be taken into account when studying any problem. Some of the components of western medical and social service models of mental health, mental illness and treatment are not appropriate for First Nations either because of cultural differences, larger structural issues, or because services are offered at great distance from the reality of their lives. In fact, what works for one reserve community might not be right for another. First Nations are trying build models (constructions) for mental health and mental health services which will meet their own needs but, of course, there are many challenges in that process.

One challenge concerns the diversity of the nations and the difficulty of achieving community vision, never mind a national aboriginal vision to guide collective action. There are many Nations and many traditions. What gets counted as tradition is disputed and contested. Which traditions are acceptable to revive are highly contested. This is the nature of social construction: debate, negotiation, competition. Some communities reject reconstruction of native spiritualism and are strongly oriented toward medical and mainstream models of helping agencies. These western models will certainly have some role in every community. Some communities embrace a First Nations community healing model and are working actively at developing skills in traditional approaches to healing. The specfic characteristics and the degree to which First Nations traditions are integrated into the approach to mental health will vary from community to community.

Another challenge for First Nations healing is their political and economic place within Canada. First Nations are using colonial history and social economic determinants as explanations for the problems faced in their communities. Following this logic, how can First Nations heal and improve their conditions without changes to the system in which they are embedded as fourth world nations? According to the First Nations healing model described in chapter one, healing is a returning to wholeness and connection which encompasses regaining self-determination, and revival of cultural identity. Healing must occur within the life of each individual and as individuals heal so do the communities start to heal; as communities grow stronger, that will support the healing of more individuals. The interdependence and reciporcal responsibility between the individual and the collective (community) is an important dynamic in the First Nations healing process. Restructuring a strong community life will help heal and support individuals; and it is the actions of individuals which will restructure community.

But the healing process cannot stop at the boundaries of reserve communities and the lives of aboriginal peoples. Achieving political self-determination and economic growth depends upon shifts in Canadian and global political, economic systems whose interests are met by continuing to exploit and subordinate aboriginal populations. Canadian First Nations are working hard at having an effective political presence in the Canadian system. First Nations are becoming more confrontational in demanding changes But why would the Canadian system make changes to

accommodate First Nations? The Canadian system may be forced through confrontational social unrest, or perhaps collaboration with First Nations may become in our best interests in face of environmental and economic crises.

One aspect of the First Nations healing model is the ideal that indigenous worldviews contain solutions to global problems of environment destruction. Traditional indigenous values and practises of living harmoniously with the land and knowledge of balanced social relationships can be integrated into world systems to save us from environmental destruction. The precariousness of our global system is seen as a potential opportunity for indigenous worldviews to be allowed to thrive and influence the world stage. The authors of "*Our Responsibility to the Seventh Generation*" proclaim that "Indigenous people are the poorest of the poor and the holders of the key to survival of humanity" (Clarkson et al., 1992: preface). The First Nations vision of healing extends out from the boundaries of the nations into the larger world. At the core of this apocalyptic vision of resurrection is the idea that massive structural crises in national and global systems will make possible the structural changes allowing indigenous cultures to regain power over their own lives.

Part of the First Nation construction of healing is the belief that First Nations have knowledge of great value to mainstream Canadian health and social service systems, and that by working collaboratively each can be enriched. I believe this is true, but there is danger that aspects of the First Nations healing model will be co-

opted or appropriated by health and social systems. Healing circles, medicine wheels, and healing process 'language' could well be taken up by mainstream health and social services giving the impression of change without any real structural change occurring. In order to avoid western approaches to healing invading First Nations system and appropriating cultural identity markers, First Nations helping systems must recognize and proclaim their unique approaches to helping and healing. Self-determination involves the ability to self-define problems and solutions according to one's own values and beliefs, and own evaluations of one's best interests. The social dialogue on First Nations mental health will include mainstream Canadian institutions of health and social services, but it must also include First Nations themselves. In the next chapter I will review some of the literature on First Nations mental health, and following that I will discuss current mental health services to First Nations.

Chapter Four:
FIRST NATIONS MENTAL HEALTH IN THE LITERATURE

Statistics on alcohol abuse, suicide rates, and death from violence and accidents indicate that there is generally a high burden of mental health problems in North American aboriginal populations. Surveys of North American aboriginal mental health problems find lower rates of psychotic illness and Alzheimer's disease (see Hendrie, Hall, Pillary, Rodgers, Prince and Norton, 1993 on Alzheimer's in Cree populations), but higher rates of substance abuse, suicide, anxiety, and depression. The depression found is qualitatively different than that found in the general population; it is associated with feelings of despair about poor living conditions and community health (Dr. Don Rodgers, personal communication). A survey of mental health needs and services in Manitoba reserve communities also finds that the depression and anxiety in First Nation communities is reactive in nature—in reaction to worry and hopelessness about the conditions and future of their community, their families and for themselves (First Nations Confederacy et al., 1985:34, 62-63). (For descriptions of Aboriginal mental health problems see Mala, 1985; Rogers, et al., 1994; Kirmayer et al, 1993; Kahn et al., 1988; Harvey, 1980; Garro, 1991; Young, 1988; Timpson et al., 1988; Campbell & Heinrich, 1990; Copper, Corrado et al., 1992; Fox & Ward, 1984; Gfeller and Hundleby, 1992; Meketon, 1983; Anawak and Cook, 1986; Rodgers and Abas, 1988; Gregory, 1988.)

The "Statistical Profile on Native Mental Health" states that Native peoples appear not to have higher rates of major psychiatric disorders (such as schizophrenia) than the general population but do have higher rates of depression and substance abuse (Medical Services Branch Steering Committee on Native Mental Health, 1991:26). This report cites a study of psychiatric admissions to the Lakehead Psychiatric Hospital which concludes that "(t)he many Native admissions are not primarily due to psychiatric illness, but rather are due to socio-cultural problems on the reserves" (Medical Services Branch Steering Committee on Native Mental Health, 1991:27). In 1978-79 Drs. J. Ledger and D.D. Rodgers surveyed the mental health needs of Manitoba Natives. They found the major mental health concerns were substance abuse (especially alcohol), education for children, and personal identity issues, followed by concerns over lack of services, solvent abuse and emotional deprivation in children, over-crowded housing and poor water supply, poverty, culture loss, and loss of self-determination. Ledger and Rodgers draw a connection between these same concerns and the major causes of death in First Nations (accidents, violence, and suicide) (1979:14-16). The loss of positive role models from their own culture, the loss of culture and 'white' cultural domination, the loss of power over their own lives, poverty, and alcohol all contribute to hostility which is then expressed as violence to self and/or others (1979:14-16). Simmering hostility combined with powerlessness leads to high death rates by accidents (often associated with alcohol or self-destructive behaviour), violent abuse of others (particularly family members), and suicide (the ultimate self-destructive behaviour).

The theme continues throughout the literature: the major mental health problems of Aboriginal people stem from socio-economic problems and the solutions lie in locally developed, community services which draw on local cultural traditions. Kahn's evaluation of an indigenous community mental health service on a Papago reservation states that the priority mental health problems of depression, suicide, family breakdown, poor educational achievement, and family violence are the result of cultural disruption, poverty and unemployment, and that the solutions lie in locally developed services which blend Western and traditional approaches (Kahn et al., 1988). The Indian Mental Health Research Formulation surveyed fifty-seven of sixty First Nations reserve communities in Manitoba on the topic of mental health. The major mental health concerns identified were alcohol abuse, anxiety, and depression followed by violence, truancy, attempted suicide, and child abuse. The survey found that socio-economic conditions and colonial oppression are the main determinants of health problems in aboriginal communities, and that healthy, self-determining communities are the solution to many health problems (First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak, 1985, see also Rodgers and Abas, 1988). The Keewatin Suicide Prevention and Intervention Study makes the following recommendations which are echoed throughout the literature on Canadian First Nations mental health issues: a multi-service network; delivery at the community level of crisis intervention and direct treatment; use of local paraprofessionals; a public education focus; combination of western professional and traditional approaches with emphasis upon skills transfer and training of local people

(Anawak and Cook, 1986:33-44). The Seattle Indian Health Board has developed a model Indian mental health training program for Alaskan Natives to work in their own communities. The program is based on the premise that mental health services must be culturally relevant (because the meaning of mental health is culture-specific) and utilize the culture's natural support systems (Mason, Hansen and Putnam, 1982).

Suicide is identified as a major mental health concern for First Nations. Suicide rates are commonly explained using theories on the effects of acculturation and social disintegration which are indeed implied in this thesis and much of the literature. Linda Garro studied completed suicides among status Indians in Manitoba between 1973 and 1982 looking for patterns in suicide rates (1991). Garro found that southern communities with ready access to non-aboriginal towns and cities have a suicide rate two and one half times the rate of northern communities which are more isolated and less acculturated (1991:page not known). She concludes that "although acculturation may be more significant in terms of explaining patterns of suicide rates, it may be through increasing social integration ... that decreases in the high rates reported can be achieved" (1991:page not known). She is implying that social disintegration is associated with acculturation. This seems a fair assumption given that social structures of First Nations were dismantled through acculturation while at the same time opportunities for new social structures and integration into mainstream society were blocked. J.W. Berry discusses the implications of acculturation in health status for northern people using a model composed of assimilation, integration,

separation and marginalization (1985). I suggest that, in general, First Nations in Canada are moving from conditions of 'marginalization' ("in which groups are out of cultural and psychological contact with both their traditional culture and the larger society") and toward 'integration' ("the maintenance of cultural integrity as well as the movement to become as integral part of the larger social framework") (Berry, 1985:23).

There should be caution, however, in framing First Nations communities as destroyed, sick and culturally voided. A comprehensive discussion of Aboriginal health care in Canada concludes that it is important to refrain from viewing Aboriginal peoples as helpless victims who are culturally disabled (Waldram, Herring and Young, 1995). Instead health improvements in Aboriginal peoples in Canada will come from supporting and collaborating with Aboriginal peoples, respect of differences in approaches, health care initiatives at the local level, skills sharing and training of Aboriginal people, and ultimately economic improvements and success in movements toward self-determination (Waldram, Herring and Young, 1995:270-271). The future of First Nations must be built with their own hands; First Nations must be able to self-determine solutions to mental health problems. A traditional practitioner explained to me that first his people must move out of denial into recognition of the grief and pain suffered through loss and abuse, but then, most importantly, comes the time for positive action moving themselves toward healing and a strong future.

Many First Nation communities are active in developing solutions to their mental health problems based upon their own cultural models (Wakegijig, Roy & Hayward, 1988; Mussel, Nicholls & Alder, 1991; Fox, Manitowabi and Ward, 1984; Gregory, 1988; Hagey, 1984; Native Women's Transition Centre Inc., 1990; Waldram, 1990; Young and Smith, 1993). Solutions can involve the use of the medicine wheel, healing circles, sweat lodges, native spirituality, traditional healers, and mobilization of community social action. The important common denominators are the utilization of cultural traditions and the building of local community structures for healing. Some example communities are: Brokenhead First Nation, Manitoba (Brokenhead Indian Band Mental Health Steering Committee 1989); Hollow Water, Manitoba; Alkali Lake, Alberta (The National Native Association of Treatment Directors et al., 1988) and Peguis First Nation (Cohen, 1994).

The definition of problems in the context of native spiritualism (particularly problems Western culture tends to define as mental health problems, such as: substance abuse, suicide, family dysfunction) is an important development. The role of ritual, ceremony, and traditional lifeways in rebalancing individuals and communities is especially important. Dow conducts an anthropological analysis of the concept of holistic healing and states that culture/language mediates between body, the self, and the social body in order to increase fitness in the ecological world (1986). The objectification of ideas and their formation into action through ritual is essential to a process whereby healing is used to rebuild the self-esteem of individuals and

reconstruct the cohesion of communities. The idiom of healing as achieved through the use of cultural traditions is an important mechanism of social change. According to Kapferer (1983), ideas and rituals arise from the conditions of existence but also influence and help to construct the conditions of existence. The act of developing their own healing models and social solutions according to traditions identified as their own helps to heal and rebalance communities. Regaining the ability to use their own healing models and social solutions will depend upon political action and social activism. The story of the Tobique women's struggle for housing (resulting in the reinstatement of Aboriginal women's rights in Bill C-31) illustrates how politics and social activism can affect the quality of life and therefore health (Silman, 1987). Mental health is not viewed as a separate category but as an integrated aspect of community life.

Community healing is a grassroots, social movement aimed at individuals and communities taking responsibility for their own healing. Its presence can be seen in many reserve communities and in the rhetoric of First Nations politics. Alkali Lake in Alberta is an early prototype of community healing (The National Native Association of Treatment Directors et al, 1988). John O'Neil makes the point that Aboriginal medicine is a way of life fundamental to cultural practises, and that "(i)t is more likely that various levels of Aboriginal government will be regulated by the authority structure of traditional medicine than Aboriginal political structures regulating traditional medicine" (1993:38). O'Neil further states that health, self-government,

socio-economic development and environmental protection are all integrated in the context of Aboriginal medicine (1993:27-37). (for an excellent interpretation of the concept of 'medicine' and other First Nations concepts see Aitken & Haller, 1990). In Dan Smith's (1993) review and analysis of Canadian First Nations' struggle for self-government, he stresses that healing and the community healing movement are essential to the goal of successful self-government. Healing is the key to successful, functioning individuals and communities. The process of defining Aboriginal approaches to healing and taking responsibility for healing are essential to the construction of strong self-identities and strong communities. (On First Nations political struggle for self-government see Sawchuk, 1993; Engelstad & Bird, 1992; Cassidy, 1991.)

Chapter Five:
MENTAL HEALTH SERVICES TO FIRST NATIONS

As citizens of the province of Manitoba, all First Nations people have a right to provincial mental health services (with the exception of provincial mental health workers as discussed below), but the actual availability and the appropriateness of the services is a serious problem. The Provincial mental health system is a patchwork of professions, agencies and self-help groups. Most people need a professional just to help them be aware of all the sources of help available, and unfortunately most services operate out of Winnipeg. The types of help are numerous, varied, and fragmented. Canadians can pay for help through the private practise of psychologists, social workers, counsellors, or by attending various types of personal growth groups. Counselling services are offered by various private organizations such as churches and occasionally the workplace. At this time, there are no regulations on who can call themselves a counsellor. Canadians receive some mental health services free (via Medicare) through provincial mental health centres (Selkirk Mental Health Centre), psychiatric units in general hospitals, and provincial community mental programs. The provincial government in Manitoba has a system of community mental health workers who service people throughout the province, although services are harder to get in rural areas. Provincial community mental health workers (nurses, social workers) offer assessment, counselling, case management, referral, and follow-up as part of the psychiatric services to the citizens of Manitoba.

Reserve communities receive medical services through a Federal government body called Medical Services Branch (MSB). Unfortunately there is a great deal of variability and confusion about which section of the *Constitution Act*, 1867 takes priority in assigning responsibility for delivery of some services to reserves: section 91(24) states that the federal government is responsible for "Indians, and Lands reserved for the Indians"; while section 92 which states the provincial government has responsibility for establishing and delivering human services (Scott, 1993:92. See also Barry Miller, 1994a:469). Because of this confusion, Medical Services Branch does not, as a general rule, offer psychiatric services as this is considered to be a provincial responsibility. Reserve communities have access to the provincial and municipal psychiatric facilities but provincial mental health workers do not service reserves; on-reserve services are considered a responsibility of the federal government (through MSB). As a result of this jurisdictional wrangling there have been few mental health services on reserves. Reserve communities in Manitoba have their mental health needs serviced mainly out of institutions—the Selkirk Mental Health Centre (SMHC), the PsycHealth Centre, Winnipeg, or the Northern Medical Unit, University of Manitoba (NMU). (See Barry Miller, 1994:475-476 for a brief description of NMU psychiatric services to the North.) With the exception of limited fly-in psychiatric service by the NMU, mental health services are often at a great distance from reserve communities and have little understanding of the culture or social conditions of reserve communities. These institutions can also seem foreign to the reserve communities members).

There is some hope for improvement to reserve community access to psychiatric services. The Thompson General Hospital has plans to open a 10 bed psychiatric unit, by the end of 1997. At present, there is one psychiatric bed for the initial assessment of committed patients under the Manitoba Mental Health Act. General medical beds are used for psychiatric admissions, although treatment is severely limited. The psychiatric unit is to include a community consultation team (psychologist, social worker, occupational therapist, psychiatric nurse) which will provide in-hospital and community services. The psychiatric unit and the community consultation team will provide some services to the 27 reserve communities within their catchment area, although how that might be possible has not been worked out (Smith, John, 1996). The Provincial Regional Mental Health Boards are intended to include reserve communities but how this will actually work is not yet known. The most concrete signs of hope come from the mental health initiatives Manitoba reserve communities are undertaking themselves.

There are three basic causes for the lack of and inadequacy of reserve mental health services:

1) Reserve communities do not have the same services available as urban centres.

Reserves are in rural sections of the province which generally do not receive many of the services available in large urban centres, and in particular, reserve communities are often in the most isolated areas of the provinces making delivery

of provincially based services even more difficult. Provincial mental health workers are not available due to government disputes about responsibility.

2) The mental health services which are available are fragmented and inconsistent. For instance, at the Norway House Hospital someone with a mental health problem might see a different doctor each time they visit, as patients are seen on an on-call basis and the turnover in medical staff is very high. Also the person in Winnipeg or Selkirk with whom the doctor consults by phone might be different each time a consultation is made. There is little communication between outside treatment facilities and community agencies, and post-treatment follow-up is often not available.

3) Reserve communities have become dependent upon mainstream Canadian helping systems which are not necessarily appropriate to the lifeways of reserve communities. Traditional helping systems have been systematically destroyed by colonial and assimilation policies of the Canadian government, and the development of local, community determined services have, until recently, been discouraged.

First Nations are developing community based health and social service systems which better meet the specific needs of First Nations. Most notable are the National Native Alcohol and Drug Abuse Program, the Medicine Lodge regional addiction treatment centre in Nelson House First Nation, and the Awasis child and

family services agency. But, at this time, help for mental health problems can be difficult to access, and may be spread out over several types of agencies which do not have mental health training. In addition, there is likely no one coordinating services for the individual or for the community. See Appendix B for a description of the types of reserve based helping resources generally found in Manitoba.

This concludes section one of the thesis document which set out the theoretical framework and background information to support the results of the research project itself. As noted previously, the appendices contain additional background information on the research communities. Section two will describe the methods employed in gathering and analyzing data and the results of the research interviews on mental health.conducted in three Manitoba reserve communities.

Section Two

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Chapter Six:
DESCRIPTION OF RESEARCH PROJECT

Rationale for the Research Project

First Nations are moving toward jurisdiction over their own health care systems. Within First Nations, mental health is seen as an integral part of the health and well-being of the community rather than a subdivision of an individual's health. Since there has been virtually no formal First Nations mental health services, many First Nations are currently developing innovative approaches to mental health services. Along with developing community mental health services, First Nations are faced with assessing the training and skills required by First Nations mental health workers. The need for an assessment of training needs was pointed out to me by the steering committee of the Northern Mental Health Outreach Program (a pilot project of the Northern Medical Unit, University of Manitoba).

Objectives of Research Project

- Assess training needs for mental health workers within three First Nations communities.
- Identify and describe the perspectives on mental health issues in these communities.
- Obtain this information primarily through interviews with community members involved in community service.
- Document these training needs in a manner useful to communities in their planning processes or future research.

Research Methods

The primary research method is a qualitative analysis of informal, open-ended interviews with key informants (people selected for their special knowledge). These interviews form the main data base, although I have also surveyed the relevant literature and community documents, and have collected basic information about the communities involved. The people interviewed work or volunteer in the health and social service fields in three First Nations communities—Norway House, Nelson House, and Cross Lake. My basic assumption is that those living and working in these communities have valuable information about what is required to meet their communities' mental health needs.

All interviews were audiotaped and transcribed onto computer files. All informants received a written transcript of their particular interview so that they could reflect on what had been said and have the opportunity to edit or add to their remarks if desired. The transcripts are analyzed for patterns, categories, and themes with the assistance of a computer software program, Ethnograph (Seidel, 1988). Each community reviewed the community description section for accuracy, and the Band Council of each community received final drafts of the community document.

Community and Key Informant Selection Process

The three communities involved in this research project are Norway House First Nation, Nelson House First Nation, and Cross Lake First Nation. These communities are chosen for purely practical reasons—they are within the geographic area required for Northern Scientific Training Program grants (north of Lake Winnipeg), they are accessible by all-year roads, and they agreed to participate. All three communities are Cree, members of the Northern Flood Agreement, and have relatively large populations. (See appendix B for the location and descriptions of each community.) I had previous contact involving mental health in Norway House First Nation which helped me design the research project to fit the characteristics of a northern reserve community and to prepare for field work. The research results from these three communities cannot necessarily be generalized to other communities, although certainly their experiences would be useful to other communities in examining their own situations. Although each community is unique (one of the exciting aspects of First Nations health initiatives is the creation of innovative models), the sharing of models and approaches is invaluable to other First Nation communities and to mainstream health care professionals.

I started the research project with knowledge of some job categories in reserve communities in which workers were likely to come into contact with issues of mental health; this was based upon my experience doing psychiatric consultations in Norway

House First Nation. The job categories I identified to start were: nurse, doctor, social worker, psychologist, community health representative, Awasis worker, NNADAP worker, school guidance counsellor, and band councillor responsible for health. Once in a community I approached people working in these areas to request an interview. People were incredibly accommodating. As part of each interview I asked who else I should speak with; this way I knew to approach others such as: community volunteers, traditional practitioners, elders, and band constables. In this way, I built up a list of all the categories of 'people helpers', and I interviewed them according to their availability. The people interviewed varied widely in their experience with mental health issues. Without exception, everyone I approached agreed to be interviewed if they were available; the only limiting factors were if people were out of town, or if I ran out of time during my visit.

Table 1 contains a breakdown of the characteristics of the people I interviewed. I interviewed twenty-nine people in Norway House First Nation, seventeen in Nelson House First Nation, and twenty-two in Cross Lake First Nations for a total of sixty-eight interviews. In my analysis, I have not attempted to match types of responses to any particular characteristic, e.g., whether men or women are more likely to suggest that helpers need to be caring. All of the people interviewed are in some ways 'helpers' in their community even though they are not all formally 'health and social service workers.'

Table 1 Description of People Interviewed

83.82% of people interviewed are either from a reserve community or a town adjacent to a reserve community. Thirty of those interviewed were women (44.12%) and 38 were men (55.9%). Many people fill more than one role so that the total here exceeds the total number interviewed.

SOCIAL WORKERS - 3
Social worker, school
Social worker, hospital
Social worker, province

AWASIS - 13
Child & Family worker - 6
Adoption worker - 2
Family Counsellor - 2
Child Protection worker - 2
Supervisor - 1

NNADAP - 8
Counsellor - 5
Solvent abuse worker - 3

SUBSTANCE ABUSE TREATMENT CENTRE STAFF -1

FAMILY VIOLENCE WORKER - 2

BRIGHTER FUTURES WORKER - 2

COMMUNITY HEALTH REPRESENTATIVE (CHR)- 6

PSYCHOLOGIST - 1

NURSES - 10
Public Nurse - 3
Nurse - 7

RELIGIOUS LEADERS -3
Roman Catholic
Pentecostal
United Church

TOWN SIDE - 2
Mayor, town side - 1
Health counsellor -1

Chief - 1

table continued next page

Table 1 Description of People Interviewed (continued)

BAND COUNCILLORS -6
Health Counsellors - 4
Other - 2

DOCTORS - 3

ELDERS- 4

TRADITIONAL PRACTITIONERS - 5

EDUCATORS - 5

BAND CONSTABLES - 2

RCMP - 2
RCMP special officer -1

ASSORTED OTHERS
High school student
Manpower Counsellor
Recreation Coordinator
Rental Agent
Treaty Entitlement Officer

VOLUNTEERS
Many people are also voluntary helpers in their community, but unfortunately I didn't record this information consistently at the time I did the interviews.

Relationship with Community

The research design called for a research assistant in each community to help me develop community relationships and to help the research stay focussed on the real issues in each community. This was quite successful in one community and less so in

the others. I attended several community committee meetings of helpers (social welfare committee, hospital meeting, community volunteer meeting, social services workshop run by myself). I attended several sweats as well. I mapped out the physical layout of each community and the institutional structures. I walked the roads, wandered the neighbourhoods, attended nursing station emergency treatments, and went out on house calls with the visiting doctor. I was unable to make a return visit with my preliminary results due to health problems (which was extremely disappointing) but I was able to maintain phone contact with a few people to discuss ideas. My first draft of the community descriptions section was reviewed by members of each community, and the community document (section two) was given to the chief and council of each community and other interested parties from the research communities for their own uses. Social science research is only as good as the connections which are made in the research community. Within the constraints of my research, I tried to make as many connections with the whole of the community life as possible.

Interview Format and Questions

Interviewing is a commonly used qualitative research technique which allows for the collection of large quantities of complex and varied data. This method enables the researcher to check her perceptions with those interviewed, and allows for

unexpected ideas to emerge. Furthermore, the research technique of interviewing respects participants' perspectives, allows the inquiry to be an interactive process, and is useful in producing a description based upon people's own words. The purpose of the interviews is to tap into the knowledge of key people on the topic of mental health in their communities. The interviews were informal and open-ended, allowing people to express themselves in their own way, but I also focused upon seven questions. Some people did not feel they could answer a particular question, and some interviews moved into other areas as directed by the informant. People tended to answer my questions by illustrating with a personal story. I respected the direction people took in the interviews, the result being I learned things I would not have known to ask about. Table 1 lists the interview questions.

Table 2 Interview Questions

1. What does mental health mean to you?
2. What problems in your community would you include as mental health problems?
3. What gets in the way of good mental health in your community?
4. What would help your community to have better mental health?
5. What training and skills are needed to help people with mental health problems?
6. What are the important attributes of a good helper?
7. What support do you need to be a helper?

Method of Interview Analysis

The research data is grounded in the lived experience of those working and living in close association with First Nations mental health issues. The job in this research project is to collect, organize, describe, and analyze concepts about mental health, and training needs for First Nations mental health workers which exist within the knowledge base of health and social service workers in the three communities under study. The analysis process I use moves from the concrete but extremely lengthy set of interview transcriptions (well over a thousand pages), to progressively more condensed, abstract, and highly interpreted categories. I hope to make this process fairly transparent so that people can access the data at different points in its journey from detailed lists of responses, to generalized categories, to abstract themes. I hope to offer concrete and practical recommendations on skill training requirements. The results of analysis of the interviews are presented in the following manner.

1) Description and discussion of the categories of responses made to each question.

   The responses to each question are grouped into categories and sub-categories based upon similarities and differences. The categories are presented in an approximate order of emphasis, where the categories more often mentioned and emphasized are discussed first. As I was building the categories I moved back and forth between proposing categories and themes, and checking them against the interview transcripts. Unfortunately I was unable to make a return trip to the

communities, but I was able to check out some ideas with people by phone, and I was able to explore the literature for similar categories and themes.

2) A summary of the interview results, themes, and conclusions.

This chapter summarizes the interview results and draws conclusions about emerging themes. Recommendations are made on job roles and skill requirements for various types of workers involved in First Nations mental health.

Chapter Seven:
WHAT DOES MENTAL HEALTH MEAN TO YOU?

At the start of each interview I asked the question, "what does mental health mean to you?" The term mental health means different things to different people, and I wanted to avoid misunderstanding each person's view on the topic. The responses people made are grouped into two broad categories: most frequently given, mental health as well-being (wholeness, balance, connection) and/or examples of a mentally healthy person; and less often mentioned, mental health as standing for mental illness or disease.

Table 3 Meaning of Mental Health

Well-being	Illness/Disease
- wholeness, balance, connection - characteristics of a mentally healthy person	

Wholeness, Balance, Connection

The descriptions of mental health have a strong tendency to cluster around such words as wholeness, well-being, connectedness, and balance. People used the example

of the medicine wheel to describe the balance which is mental health. Mental health is the result of a balance of all the areas in one's life (the environment, the community, the family, the self), and a balance of the all aspects of the medicine wheel (spiritual, physical, emotional, and intellectual). It was frequently suggested to me that the terms 'mental health' and 'mental illness' are difficult to translate into Cree, suggesting that the dualistic division of health into mental and physical components is an introduced concept.[1] Health is the balance of all the aspects of life; an imbalance in one area affects other areas of life. Restoring balance restores health. "The practice of medicine in the Indian way then becomes a direction in one's life such that it results in fulfilment and satisfaction, both at the personal and communal levels" (Aitken and Haller, 1990:33). This holistic concept of the medicine wheel stands in contrast to western medicine's dualist and mechanistic concept of health. Dualism implies the separation of mind, body and soul. Mechanism holds that all life can be explained by the laws of physics and chemistry and therefore implies that all dysfunction can be repaired through the application of those laws. (See Aitken and Haller on the cultural basis of Indian medicine, 1990:15-40)

Characteristics of a Healthy Person

Related to the concept of health as wholeness and balance are examples of the characteristics of someone with good mental health. The picture of a mentally healthy person is painted as someone who is able to care for and act for themselves by using

positive personal coping skills such as communication skills, problem solving skills, and stress management skills. The mentally healthy person has a positive self image, good contact with reality (awareness of themselves and the world around them), and is able to seek help from others when necessary. The mentally healthy person has strong, positive values and beliefs, and good relations with family and community.

Illness/disease

Some people answered my question 'what does mental health mean to you' by giving examples of what mental health is not. It seems that the term 'mental health' can stand for mental illness or disease. The description of someone who is not mentally healthy is drawn in more pathological (disease) terms that relate specifically to problems with one's thinking, to a disease of the brain, or to an inability to function normally. The mentally ill person may be thought of as crazy, sick in the head, their mind does not work properly, their behaviour is not normal, and they may even be seen as dangerous to the community.

It is important to note here that 'mental health' can refer to the overall well-being of the individual and the community (balance, connectedness, harmony), but can also refer to issues about mental illness or the care and treatment of people with mental illnesses.

Endnote

[1] The Cree verb 'mey-uyaw' means – he is well, he is healthy. There is also the verb, 'mey-mu'chehoo' meaning – he is well, he feels better, and the noun, 'meyomu'chowin' – good feeling, good health. These Cree terms point to an English translation of 'being in good spirits' but not in our present day sense of being in a good mood, but rather in the more general sense that one's spirit is well, is healthy, and that one is in touch with the goodness of Spirit. Someone can be ill, dying of cancer, and in pain but still be in good spirits, still have their spirit whole and at peace. One can be without disease and not be 'well', but be in a state where their spirit is not whole or intact. I owe thanks to Gordon Swanson of Norway House for this translation.

Chapter Eight:
WHAT PROBLEMS IN YOUR COMMUNITY WOULD YOU INCLUDE AS MENTAL HEALTH PROBLEMS?

A wide range of problems are given as mental health problems. Some of the problems mentioned would be recognized as 'mental health diagnoses' within the psychiatric model; these are grouped under the category 'problems recognized as mental health diagnoses'. This category is further broken into three sub-categories: substance abuse; depression, anxiety, and suicide; and other psychiatric disorders. Mental health problems are also seen as problems in functioning; I have grouped these problems under the category 'problems in functioning' and the following sub-categories: functioning of the community, functioning of the family, and functioning of the individual, and abuse (other than substance abuse). The answers to this question indicate that people are aware of and use mainstream mental health diagnoses, but also that mental health is defined mainly by a holistic state of well-being so that a wide range of problems in functioning are given as problems in mental health.

Table 4 Mental Health Problems

Problems Recognized as Mental Health Diagnoses	Problems in Functioning
- Substance Abuse - Depression, anxiety, and suicide - Other psychiatric diagnoses	- Abuse (other than substance) - Community - Family - Individuals

Substance Abuse

Substance abuse is considered a major mental health problem. Whether seen as a problem or a cause of mental health problems, it is recognized as a target area for healing. One woman pointed out to me that although only a certain percentage of individuals in her community are problem drinkers, many other family members, friends, and even other community members are greatly affected by each problem drinker. Other forms of substance abuse mentioned were solvent and drug abuse. Concern was expressed about street drugs coming into the community (e.g., marijuana, LSD, cocaine).

Depression, Suicide and Anxiety

Depression, suicide, and anxiety are also major mental health concerns. The type of depression found frequently in First Nations may be different than what psychiatry calls 'clinical depression' (considered a biological disease state), and may be better labelled as 'reactive depression' (in direct reaction to life events). *The Indian Mental Health Research Formulation Final Report*, a survey of fifty-seven Manitoba reserve communities, also identified depression and anxiety as major mental health concerns, and found that the "majority of the depressive symptoms referred to feelings of hopelessness about the future both for their selves and families, and of their communities" (First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak, 1985:34). Likewise the research found that

much of the anxiety was worry about the future, one's children, and community problems (First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak, 1985:35). If much of the depression, anxiety, and suicidal behaviour is in reaction to life circumstances, this, of course, has major implications for the types of mental health services required.

Other Psychiatric Disorders

A mainstream mental health worker would recognize a number of the responses as mental health diagnoses. These include a fairly wide range of disorders: mental retardation and brain damage, schizophrenia and other psychotic illnesses, and Alzheimer's disease. While these disorders may not be as prevalent as depression, suicide, anxiety, and substance abuse, they are particularly difficult to deal with for communities with few (or no) local mental health resources. Mental retardation and schizophrenia are the most frequently mentioned, and there are few services for individuals with these problems and their families.

Abuse as a Dysfunction

The term 'abuse' is frequently used in response to this question and throughout the interviews. It is used as a metaphor for the problems faced by First Nations. Any type of abuse is a problem in itself, but it is also clearly a symptom of dysfunction,

imbalance, and disharmony in a system, whether you are referring to the community, the family or the individual. "And all the abuses" was added by several people to the end of a long list of abuses: alcohol abuse, drug abuse, wife abuse, sexual abuse, etc. Abuse is seen as self-destructive behaviour which First Nations citizens inflict upon themselves (addictions, violence), but it also clearly stands for the abusive treatment they have received as part of their colonial experience. First Nations are trapped in a cycle of abuse. Having been abused, having learned abusiveness, the cycle of abuse reproduces from one generation to the next. Residential school abuse exemplifies the abuse suffered by First Nations through colonization: physical, emotional, and sexual abuse; the abusive destruction of language, culture, traditional economies, and undermining of family structure (see Assembly of First Nations, 1994 and J.R. Miller, 1996 on the residential school system in Canada). Neglect and abuse destroys self-esteem and breeds self-destructive coping mechanisms (i.e., substance abuse and suicide). Not caring about self (depression, suicide), and not caring for self (self-destruction through substance abuse and violence) are symptoms of this cycle of abuse.

Functioning Problems of the Community

Mental health problems are also identified by outward signs of imbalance and disharmony within communities, families, and individuals. When a community, family, or individual is out of balance (not well) they cannot function properly.

Communities show the signs of a breakdown in social functioning in the following ways: violence; teen pregnancies (a concern mentioned to me in several contexts) and single parenthood; lack of respect; ignorance, jealousy and racism; neglect of homes and buildings; and lack of support for women.

Problems are looked at holistically, as both cause and effect, so that the housing shortage (and therefore overcrowding) contributes to mental health problems, but is also seen as a symptom of a poor state of the community's health. Because people tend to use a holistic framework for understanding mental health, cause and effect do not necessarily have a linear, one-way relationship. For example, religious conflict is seen both as a symptom and a cause of disruption in the wholeness of the community. Poverty, destruction of the land base and the land based lifestyle, shortage of professional helpers, and other social concerns were given as mental health problems.

Functioning Problems of the Family

Families show signs of poor functioning through marriage breakdown, family violence, and child neglect. Marriage breakdown is a priority problem mentioned by people from all different perspectives: traditional practitioners, outside professional, and local workers. The breakdown of the family contributes to the neglect of children, the shortage of supports for individuals, and the breakdown of society.

Functioning Problems of Individuals

Signs of imbalance (or lack of well-being) in an individual include 'negative' emotions such as low self-esteem, self-destructive behaviour, burnout in helpers, anger, denial, frustration, lack of caring, powerlessness, worry, hate, guilt, despair, and fear. A person is probably not in a state of well-being if they have trouble functioning in the following ways: unable to think clearly, poor coping skills, poor parenting skills, poor problem-solving skills, and poor school or job performance.

Chapter Nine:
WHAT GETS IN THE WAY OF GOOD MENTAL HEALTH IN YOUR COMMUNITY?

I used the question, "what gets in the way of good mental health?" as positive way of asking about the causes of mental health problems. Only a few people suggested actions of the individual as causes of mental health problems. Even individual actions such as alcohol abuse are looked at more as a social, rather than just an individual problem. I think it can safely be said that all of the responses refer to socio-economic causes of mental health problems. In response to the question on mental health problems (question two), people demonstrate some agreement with disease labels, such as mental retardation and schizophrenia, but it is the socio-economic conditions which undermine everyone's quality of life. Quality of life for people coping with mental illnesses and the quality of mental health of the community as a whole are enhanced or reduced through socio-economic factors.

Table 5 Socio-economic Causes of Mental Problems

- Unemployment
- Abuses
- Poverty
- Overcrowded housing
- Welfare
- Losses
- Other socio-economic problems
- Politics
- Personal problems

Unemployment

Unemployment is emphasized as a major contributor to mental health problems. Unemployment affects a person by vastly reducing their financial resources, but it also affects their self-esteem and sense of independence. Unemployment underlies many of the problems people told me about: community poverty; family problems due to husbands being unable to support their families; low self-esteem; depression and anxiety; the desperate need for community recreation facilities and productive activity for adults and, especially, for youths.

Abuses

All but one person mentioned alcohol as a problem at some point in their interview so clearly alcohol abuse is recognized as a major mental health problem. When concern over alcohol abuse is combined with concern over other types of addiction (drugs, solvent, gambling – predominantly bingo) it would appear that dealing with addiction is a number one health care priority. Addictions destroy the mental health of individuals, their families, and can help to destroy a community as well. But addictions are also viewed as the result of underlying personal and social problems. Addictions are both a cause and an outcome of dysfunction in individuals and communities. Addiction contributes to the neglect and abuse of the self, the family, and the community. Abuse is 'mis-use': the morally wrong or destructive use

of something or someone. Wife abuse, sexual abuse, family or community violence in general causes mental health problems for the victims, but is also a symptom of problems in the abuser.

Poverty

Poverty is a major contributor to mental health problems. It is not just low income which defines poverty; poverty is also defined by powerlessness over one's own life, and hopelessness of making changes. Poverty is the root cause of many community problems which take away from good mental health: poor water and sewage, pollution, lack of helping resources. Poverty affects mental health by destroying esteem and empowerment, and by standing in the way of the development of healthy individual coping skills and community helping resources.

Welfare

Welfare is often mentioned as a problem both in the interviews and was identified by a social problems committee in one of the communities. The abuse of welfare (using the money to drink or gamble) is a social problem, but more importantly the welfare system itself helps to destroy independence, self respect, and initiative. In Anastasia Shkilnyk's book, *A Poison Stronger than Love*, she explains how the community of Grassy Narrows understands the destructive influence of the

welfare system and other government social service monies (1985). Government intervention contributed to the decline of traditional economic activities (trapping, hunting, fishing), and even wage labour activities such as guiding, by encouraging people to be dependent upon the relatively easy money of welfare, training programs, and community make-work projects. Shkilnyk suggests that the influx of government programs and spending were aimed at pulling reserve communities into mainstream Canadian economy and culture by destroying their own—in other words to bring about assimilation (1985). Coates and Morris in their article "In Whose Best Interest?" put forth the argument that the development of the Canadian system of welfare colonialism (following the second world war) was a means of forcing dependency on First Nations and shutting reserve communities out of the Canadian economy (1993). Whatever the intent, the results have been dependency upon government monies, and reserve economies which are based primarily upon government sources of income. It is not the money itself which is regretted. Many First Nations people believe that they are due compensation for surrendering their land, their livelihoods, and as treaty entitlement. What is regretted is the economy of welfare dependence.

Overcrowded Housing

Another cause of causative factor frequently pointed out is over-crowding in homes. The lack of housing and substandard housing is pinpointed as a major factor not only in physical health problems (respiratory diseases, accidental fire injuries) but

also in mental health and social problems. I was told that living in a crowded house without adequate space or privacy for individuals contributes to tension and stress, and therefore to violence, hopelessness and depression. Indian and Northern Affairs Canada contracted a study on the health effects of the housing and community infrastructure on Canadian reserve communities. The resulting study states that over-crowding "may be even a greater threat to mental health than to physical health. As crowding has been shown to contribute to inter-personal conflicts within the family and community, housing might be linked to high suicide and the homicide rate" (Young, Bruce, Elias, O'Neil, Yassi, 1991:executive summary). A 1984 national study of on-reserve housing found that 36% of reserve homes were seriously over-crowded (quoted in Young, Bruce, Elias, O'Neil, Yassi, 1991:13). Throughout my visits, people tried to impress upon me the importance of overcrowding as a mental health problem.

Other Social-Economic Problems

Social chaos and the general degradation of the foundations of community seriously affects mental health. People are concerned about the effects of outside cultural influences undermining the strength of their communities and way of life. Schools, TV, movies, and roads into the community have brought foreign products, values and aspirations; some of these values and aspirations are only fantasies (i.e., movies and TV), some are inappropriate or unrealistic to reserve life, and many tend

to devalue the native traditional ways. The residential school system is thought to have contributed to the destruction of healthy, functioning First Nations. People are concerned about the signs of fracture and social chaos in their communities (violence, stress, marriage breakdown, oppression of women, religious conflict, and child neglect). The Northern Flood Agreement is mentioned as having taken away from the good mental health of the community. The hydroelectric development of Northern Manitoba waterways has had a major negative economic and social impact on the reserve communities affected.

Losses

The word 'losses' stands out as an explanation for mental health problems. People tend to define the causes of poor mental health in terms of losses suffered as a Nation and as individuals. Much has been lost or damaged: the land (both through treaties and through hydroelectric development); a viable, independent economy; native religion; the wholeness of their culture; many traditions and values; self-government; a positive cultural identity; the family structure; language; as well as the tragic loss of lives which occurs all too frequently on reserve communities through violence and suicide. As one woman put it, "we are always grieving." These losses are expressed as mental health problems in two ways: an important mental health task for First Nations is coping with these losses by grieving, coming to terms with the past, and dealing with abuses in one's life; secondly, the loss of culture and healthy community

structures affects the ability of the community to help its members regain health. The loss of community wholeness and resources has affected the ability of individuals and communities to solve their problems.

Loss, like abuse, is a primary metaphor for explaining the problems facing First Nations. That is, people use the words 'loss' and 'abuse', to stand for a large complex of causes for their difficulties. As put to me so eloquently by one man, First Nations' problems arise from "a loss of connection to the Land, the People, and the Creator" (capitalization represents speaker's emphasis). It is a loss of the wholeness of a way of life, a loss of harmony and balance. Disharmony and imbalance are the very nature of disease and illness. Loss of land, loss of lifeways, loss of spiritual values and guidance are connected in this way to the loss of health of the people. Severing First Nations from their land and their land based economy disrupted social and spiritual systems for maintaining a healthy community. Community values, such as respect and sharing, have been weakened.

Throughout the interviews people expressed concern over parenting issues: teenage pregnancies, single parenthood, poor parenting skills, loss of family values, and loss of family as the basic unit of community. Self-esteem, self-reliance, a positive image of self, and positive vision for the future have been damaged both in individuals and communities. These things form the core of the healthy self. Also lost are elements of the culture, language, values, belief systems, and social practises

like the joking relationship, community feasting, and guidance by elders; these practises helped to hold communities together and helped communities maintain a good, healthy life for all its members.

Politics

Politics, the political process, is an essential part of maintaining good health in the community. Federal and provincial politics are mentioned as getting in the way of achieving good health for the community. People tend to believe that federal and provincial reserve services are part of a politically enforced dependency which governments are not anxious to change. The jurisdictional dispute between the federal and provincial governments over mental health care funding is certainly a concrete example of politics affecting mental health.

Mentioned more often than national or provincial politics though was local level (band) politics. Community development is a major route to better community health, so it stands to reason that band politics is an important issue. (See Larry Krotz's *Indian Country: Inside Another Canada*, 1990, for discussion on the political nature of reserve life.) Under question four, "what will help your community achieve better mental health?" people often answered "leadership." Funding, resources, and support for community health programs depends upon getting a community mandate, and the political will to act on it. Achieving self-government, and constructing local

resources and institutions requires leadership and political process. Problems in band politics can negatively affect mental health by increasing stress and insecurity, and by not providing leadership necessary for effective community action.

Personal Problems

In the final category are causes which focus more on the individual (stress, not working on personal problems, poor coping skills, denial and self-destructive behaviour). I have included stress here even though I believe people are referring to the stress of socio-economic conditions. The responses paint a picture of a person in an unhealthy state because of the history of their people, and because of the conditions in their life. Individuals are not blamed for their problems, but each individual must take responsibility for their own healing. This theme moves throughout the interviews: healing is both an individual and a collective responsibility.

Chapter Ten:
WHAT WOULD HELP YOUR COMMUNITY HAVE BETTER MENTAL HEALTH?

There are a large number of responses to the question, 'what would help your community have better mental health?' The types of services required help to the form a basis for assessing skills and training needed by workers. The responses to question four might best be summarized by three broad categories—public education, treatment, and community development. At this point I have used smaller categories to demonstrate the range of suggestions given and discuss them in approximately the order of emphasis given in response to question four. (See Table 6)

Table 6 Mental Health Supports

Public Education	Types of Workers Needed in Mental Health	Traditional/Spiritual Approaches
- Mental health - Lifeskills	- Outside specialists - Local mental health workers - Job titles	- Elders - Community healing - Native Spirituality - Land as healer - Language revival - Religion

table continued next page

Table 6 Mental Health Supports (continued)

Counselling	Treatment Programs	Improvements to Current Local System
	- Local treatment - Combination of outside & local treatment - Outside treatment resource - Prevention & follow-up - Substance abuse treatment	- Improve networking between agencies - Increase local health & social service resources - Mental health support for health & social services
Community Actions to Improve Mental Health	Personal Actions to Improve Mental Health	Community Support Programs
- Community development - Development of local healing resources - Strength of families - Strength of women	- Forgiveness - Deal with feelings and memories - Self-care, self-awareness, self-help - Other suggestions for good mental health	- Crisis support programs - Recreation programs - Self-help for alcohol problems - Support for the mentally ill & families - Personal growth support - Supports for whole community

Public Education to Improve Mental Health

People have different ways of putting it, but half of those interviewed said at some point in their interview that public education on mental health issues is needed. The only other responses given more often overall were alcohol and counselling. Public education is an prominent feature of a First Nations approach to mental health.

The development of community mental health approaches must be guided by a mandate from the band. Because there are so many pressing social priorities (education, NFA, health transfer) and because there is a general atmosphere of denial and stigma about mental health, some public education is needed to help people be aware of the importance of mental health problems and the possible solutions. Bands can be quite successful in reaching their goals once community awareness and mandate are achieved. Community conferences, public workshops, and TV and radio programs are useful tools for teaching about mental health.. Mental health issues which should be covered in public education include: information on community helping agencies and the services they offer; self-care practises; suicide prevention; alcohol, elder, and sexual abuse; and programs designed for use in the schools. Public education media can also be used for teaching skills to improve mental health: problem solving skills, budgeting, coping skills, life skills, assertiveness training. Parenting skills are emphasized as important life skills to be taught in the community.

Types of Helpers Needed in Mental Health

There is need for both outside professional specialists and for local mental health workers. Professionally trained counsellors and mental health specialists are needed to provide counselling and treatment to clients, and to provide ongoing training and support to local workers. Community members want the option of counselling provided by someone from outside the community. In a small community

confidentiality is a big concern and outsiders are less likely to have opportunities for breaking confidence with community members. Reserve community members want the same expert services available to them as is available to others in the province.

Some communities choose (or are fortunate to obtain) a psychologist working in their community full time to counsel clients, consult with local workers, and provide ongoing training and support to local workers. Some have a psychiatrist visit periodically to offer psychiatric services as well as consultation and training services to local workers. Some communities are developing their own specialists in First Nations mental health since this sort of expertise is quickly growing within First Nations communities. First Nations want to build connections to a wide range of helping resources for their members, and to encourage the sharing of skills and knowledge between different approaches.

Just as it is important to have access to outside specialists, it is equally important to have a community-based mental health program which is based on community values and ways of doing things. Mental health workers should be local people who specialize in mental health, who can counsel clients, consult with and train other community workers, provide links to other mental health services if desired, and be a resource for mental health. There should be a combination of mental health consultants, community-based mental health workers, and a network of community health and social service workers with some training in mental health.

People suggested a wide range of workers who can help improve community mental health (besides local mental health workers). Here is a list of the jobs suggested more than once and the number of people who mentioned each: psychologist (11), NNADAP worker (9), social worker (9), Awasis staff (5), volunteers for community programs (5), psychiatrist (4), family violence worker (4), CHR (3), Registered Psychiatric Nurse (3), and R.C.M.P.(3).

Traditional/Spiritual Approaches to Improve Mental Health

The concept of healing is a common undercurrent in my conversations about mental health with Cree people. Healing is seen not primarily as cure or recovery from disease but as a return to balance, harmony, and connection of the whole. According to Mussell, Nicholls and Adler mental health is not just being of sound mind, rather health is the balance and harmony of the four aspects of the medicine wheel—physical, mental, emotional, and spiritual—and therefore mental illness is the outcome of imbalance or disharmony in one or more of the aspects (1991:19). They describe the 'spiritual' aspect as the connection with the Creator and all of creation (Mussell, Nicholls and Adler, 1991). Healing is moving towards balance, harmony, and wholeness (health). Spirituality is the connection to wholeness; spirituality is the essence of harmony and balance. Healing is fundamentally a spiritual process. Prayer, the Bible, moral leadership, spiritual strength, religious practises can all be tools for helping to heal oneself. There are different ways of expressing spirituality in

First Nations, but I believe it is safe to say that most people (whether mainstream Christian, Evangelical Christian, native traditional spiritualist, or some combination) would agree to the necessity of some sort of spiritual guidance in order to heal.

There is dispute in reserve communities as to which traditional practises and beliefs were once practised in their particular community, and which practises and beliefs should be built on or revived. 'Traditional' can mean two things in reserve communities: traditional land based life skills and traditional values (the land itself, hunting, trapping, fishing, country foods, clothing design, language, the guidance of elders, moral values); and traditional spiritual practises (sweats, fasts, sun dances, piercing, vision quests). Some people separate these two meanings of traditional and are not comfortable with what they see as native traditional spiritual practises. The value and legitimacy of the latter traditional native spiritual practises is contested to varying degrees in First Nations but there are elements of traditional spiritual practises which are widely accepted and valued, such as healing circles, the medicine wheel, sweat lodges, and traditional teachings.

Healing circles, in particular, are widely used as a group healing (and teaching) technique, and are being readily adopted (or adapted) outside of First Nations communities. The medicine wheel is also widely used as a conceptual tool for explaining and understanding holism. Healing circles, medicine wheels, elders, and the sweat lodge are perhaps the most visible examples of developing native traditional

healing approaches; they serve as First Nations identity markers. For many people the path to healing involves gaining awareness and pride in oneself, especially in oneself as a First Nations person. The construction of 'Indianess' or 'Cree identity' is part of healing and resolving mental health problems. Revival of language, respect for elders, traditional values, traditional land based skills, and traditional spiritual practises can be an important part of learning about and having pride in oneself. This is related to the belief that a strong cultural identity and a strong community are necessary for good mental health.

Elder Advice and Guidance to Improve Mental Health

Tapping into and respecting the knowledge of elders as teachers is widely accepted and valued. The skills of elders are being used through community elder councils, community camping trips where elders teach land based skills, and through seeking the advice and blessing of elders for workshops, conferences and other public events.

The Land as Healer

The land itself is thought to be healing. Going out on the land to trap, camp, learn native traditional survival skills, or just to connect with the spirit of the land is healing. The land is a healer, a provider and a teacher. Life on the land and eating

land based foods are associated with a healthier past, with a healthier self-identity. Also the destruction of the land is frequently linked with the destruction of the health of the people (see Naomi Adelson's work on the James Bay Cree's concept of well-being, 1992). Bringing people together on the land can help to heal the community and its individuals by such activities as: learning cultural land-based skills and native traditional teachings; regaining pride in themselves and their community, and connecting and bonding with each other.

Community Healing to Improve Mental Health

Community healing is a term associated with First Nations communities in particular. It arises from a holistic view of health where the health of communities and the health of its members are intimately connected. I was told that when one person begins to heal, the community starts to heal, and as the community heals, more and more individuals will begin to heal. The concept of community healing lies at the root of many of the approaches to mental health suggested in this research: health as balance of all aspects of the medicine wheel; the need to resolve poverty and unemployment to improve health; the importance of values and traditions (including language) to health; the development of local community resources; and the emphasis on a public education approach.

During my research I was introduced to the concept of community vision. Vision is a necessary guide to action. Several people pointed out to me that what was missing in their community was a community vision. In order for there to be community vision, cohesive community action to solve problems, and community healing there need to be activities which bring the community together, such as: community gatherings (e.g., camping trips, treaty days), community feasts, and strong, clear community values (as supplied through native traditional teachings and the guidance of elders).

Counselling to Improve Mental Health

Talking with someone, getting your feelings out, and sharing feelings with others is considered to be healing. It is not surprising then that counselling is consistently emphasized throughout the interviews; counselling is the second most common response throughout the whole interview database. Sharing feelings can help with mental health problems, especially with the grief and depression arising from past loss and abuse. Dealing with the pain, anger, fear, and grief over the losses and abuses of one's past are important mental health tasks in First Nations. The first step in healing is recognition of the pain and moving out of the numb state of denial into a stage of personal awareness and emotional release. Ultimately people must move past this stage of grief and anger and on to a stage of action in order to restore their health and the health of their families and communities.

Specialized counselling services are needed— individual, sexual abuse, substance abuse, family violence, grief, and group counselling. Counselling is also a part of the job for all different types of health and social service workers—social workers, NNADAP workers, Awasis workers, CHR's, etc. Marriage and family counsellors are badly needed to help people repair damage to their families. Counselling should be available in Cree, especially for the elderly, and counsellors need to take time to listen and to be readily available when crises arise.

Treatment Programs to Improve Mental Health

It is important for people to have access to treatment and counselling services in their own community. It is also important to have access to outside specialist services (e.g., the Thompson General Hospital, Selkirk Mental Health Centre, counselling services either in or out of Winnipeg) for problems which overwhelm local resources and for those people who prefer not to be treated by members of their own community. The types of treatment programs suggested cover a full range of services: prevention programs, active treatment, and follow-up care. Counselling is the primary form of treatment suggested, but also mentioned are medications, hospital, psychiatrists, alcohol detoxification and alcohol treatment, and treatment programs for families. Follow-up in the community is required for the mentally ill and the recovering substance abuser. In the community, there needs be a centre where mental health assessment and treatment, counselling services, and mental health information

resources are available. Specialist clinics are needed for children with mental illness, adults with schizophrenia, and for abusive men.

Improvements to Current System to Improve Mental Health

Suggestions to improve current community health and social services fell into three categories: better networking within and between helping agencies; increased funding and support of community based services; and access to mental health information for community health and social service workers.

There are a number of helping agencies both within reserve communities and throughout the province making it easy for people to get lost in the shuffle. Sometimes needs may fall between the cracks, or the same service might be offered by two separate agencies, or there can be confusion if too many people are involved in helping one family or one person. There needs to be better communication and better networking between the various agencies involved in offering help to community members. Community health and social service workers want a better referral system. For instance, Awasis needs to know if a mother is returning to the community after treatment for depression and needs help caring for her children. The nursing station needs to know if there is a local healing circle which offers support to young women who have been abused. The local mental health worker needs know about the man who is feeling desperate and suicidal in the face of criminal charges. Co-ordination

within and between helping agencies is stressed as a problem area: each agency needs to work together as a team; community agencies need to communicate and support each other's work; outside agencies need to arrange with community agencies about follow-up plans; community agencies need good access to outside agencies for consultation and referral; and the various levels of government need to cooperate with communities in developing and maintaining services.

There is a well recognized need for more community-based services, for more workers/counsellors, and for increased funding for existing services. Community service agencies need stable funding, better facilities and equipment, and better maintenance of existing facilities. Uncertain year to year funding, or the practise of funding pilot projects and then pulling funding once they get established, is frustrating and disempowering to local people trying to build helping services in their community. Communities need to place trust in their own resources and the talents of their own people. Program development needs to happen from the grass-roots level.

Local workers in all types of health and social service agencies need access to mental health consultations so they can learn to recognize mental health problems, get suggestions on resources to clients, get advice on dealing with client problems, and play a role in planning discharge from outside treatment programs. Local health and social service workers would like resource people (e.g., psychologist, mental health worker) to offer skill sharing workshops. A manual on mental health issues for health

and social services workers was suggested, as was community support for professional mental health training of local people.

Community Actions to Improve Mental Health

Community and political leadership are needed to develop strong self-determining communities and community programs. Development of services should arise from the grassroots, from the consensus of the community, and should develop the talents of community members. There needs to be a combination of western and First Nations approaches used in community based services. Jobs, adequate housing, and resolution of the NFA would contribute to better mental health. Community attitudes about mental illness could be more accepting, and issues around sexual abuse could be dealt with more openly. Communities need to deal with the controversy over wet versus dry reserves; some people believe a dry reserve would help resolve alcohol problems, while others disagree and point to the problems caused by bootleggers. Communities rely upon the strength of the family to support health and well-being. The family is the centre of caring and well-being. Communities also rely upon the strength of women. As one woman put it to in me in her interview, "if a woman stands up, the whole nation will get up too." Communities rely on the strength of women, but women also need support and sometimes protection in their community.

Family violence is considered a serious problem by First Nations. The Aboriginal Circle (part of the Canadian Panel on Violence Against Women) quotes several sources to suggest the amount of violence taking place against First Nation women: from the *National Family Violence Abuse Study/Evaluation*—"between 75 and 90 percent of the women in some northern aboriginal communities are battered"; from *Breaking Free* by the Ontario Native Women's Association—"eight out of 10 Aboriginal women ... experience violence (and) of those women, 87 percent had been injured physically and 57 percent had been sexually abused" (Canadian Panel on Violence Against Women, 1993:156). Whether these dreadful statistics accurately reflect the amount of violence against women or not, the cycle of abuse and family violence are clearly considered important mental health problems in First Nations. Communities need to offer shelters for emergency safety of women and children, and problems of abuse must be recognized and dealt with by First Nations mental health workers.

Women lost their place of equality and authority within the traditional family, the clan, and the economy during the process of colonization. The loss of traditional systems of equality for men and women is one of the major contributors to violence against woman and children (Canadian Panel on Violence Against Women, 1993). Once again political action is necessary in order to bring about healing. Women are struggling to have their voices heard and to regain places of power and influence within their communities. (See Janet Silman, 1987 about the women of Tobique fight

for their rights and contribute to the reinstatement of Aboriginal women's rights in Bill C-31.) A return to equality and the strength of First Nation women is needed to heal and rebuild the nations.

Community Support Programs to Improve Mental Health

Outstanding in the data is an emphasis upon community support programs which help to care for all the members of the community—alcohol recovery support (AA, Al-Anon), child care, teen drop-ins, foster care, family support, elder care, personal growth workshops. Two specific types of personal growth groups were mentioned several times: Inner Child Workshops and Flying on Your Own. Families with mentally ill members need supports in the community. Group homes for the chronic mentally ill are one means of easing the strain on families and helping the ill gain greater independence. Two other types of community support programs mentioned—crisis programs and recreation—are important enough to be highlighted separately.

Crisis Programs to Improve Mental Health

Services which deal directly with the management of personal crises (in particular suicide) are needed. Communities have tried to meet this need by developing community crisis committees and crisis phone lines (sometimes run by

volunteers from their homes). This is an area for resources to be applied immediately. A crisis centre, a crisis line, and a community crisis committee are recommended in the interviews. Crisis shelters for abused women are also an important resource as discussed above.

Recreation Programs to Improve Mental Health

Recreation helps to develop and maintain good mental health in the community. The importance of recreation to mental health is pointed out in the *Indian Mental Health Research Formulation Final Report*; 77% of the 57 Manitoba reserves surveyed stated that lack recreation contributes to mental health problems (First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak, 1985:10-11). "Recreation is not seen as merely 'playing games' for amusement but as activities which build individual confidence and community strength" (First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak, 1985:11). Recreation is a means of maintaining good health and preventing mental health problems. With outrageously high unemployment rates, communities need to supply positive, purposeful activities for their members. Among the suggestions are recreation programs aimed at special groups (teenagers, children, the ill, the handicapped), and also recreation aimed at bringing the whole community together (feasts, festivals).

Personal Actions to Improve Mental Health

Individuals can (and must) act on their own behalf to improve or maintain their mental health. I have already noted under the heading of counselling that dealing with feelings, with memories, and with loss is important to good mental health. It is also important to forgive for yourself and to forgive others in order move on in healing. Perhaps the bottom line for good health is self-caring. We all need to care about who we are (good self-esteem), and take good care of ourselves (self-care). People suggested many tools for taking good care of yourself, such as hope, humour, love, exercise, relaxation, socializing, and of course, sobriety. Self-awareness is necessary to self-caring and to self-healing; coming to terms with your past and with your identity is part of the healing path for First Nations.

There is an emphasis throughout the data upon the importance of self-reliance and self-responsibility (no one can change your life but you), but there is also an emphasis on healing as a community responsibility. Healing is both a personal and a social process. Personal healing cannot take place without social supports, and community healing cannot occur without the actions of individuals. When an individual starts to heal, the community starts to heal, and as the community starts to heal more individuals will start to heal, and so forth in a holistic, interconnected process.

An Emerging Approach to First Nations Mental Health Services

An analysis of responses to the question "what would help your community have better mental health" suggests mental health services developing in these communities have distinct characteristics. These characteristics may hold true to varying degrees in other First Nations. Overall, it is safe to say that First Nations mental health care systems tend to be holistic, pluralistic, and focus not only upon providing treatment options but also focus heavily upon education, and community development. Mental health care will likely be holistic, including the spiritual nature of healing not only of individuals but of the whole community. Mental health care will be pluralist in that it will be a combination of western helping/healing models and native traditional helping/healing models, and will also combine locally developed and based resources working with outside expertise. These characteristics of First Nations community mental health help to determine the training and skills needed by mental health workers.

Chapter Eleven:
WHAT TRAINING AND SKILLS ARE NEEDED TO HELP PEOPLE WITH MENTAL HEALTH PROBLEMS?

This is the core question of the research. I asked people what skills and training they used in their current role in order to help people with problems that might involve mental health. I asked people what other skills and training they would like to develop in order to better help people with mental health issues, and I asked people what skills and training they felt a mental health worker would need in their community. Also included in this section are suggestions given on existing training programs. As well, people volunteered the personal characteristics of a good helper but I have included these in the next chapter. The numbers accompanying the responses represent how many people gave that response at least once in their interview. The numbers within a grouping cannot be meaningfully added together.

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Table 7 Training and Skills for Mental Health Workers

Counselling Skills	Mental Health Theory and Practise

- Specific types of counselling
- Skills of effective counselling
  - process skills
  - communication skills
  - therapeutic relationship
	- Psychiatry/psychology
	- Family
	- Abuse
	- Addictions
	- Child psychology
	- Crisis intervention
	- Running client programs
	- Suicide
	- Other

Writing and Agency Skills	Public Education Skills
Community Development Skills	Spiritual and Traditional Training - Religious training - Native spiritual training - Traditional practises

Counselling Skills

Counselling is overwhelmingly the predominant model for helping people to deal with their problems. Counselling skills are the most frequently cited training need. While a wide range of jobs require basic counselling skills, communities also need people trained in specialized areas of counselling (e.g., sexual abuse counselling or substance abuse). Table 8 includes the suggested types of counselling, while Table 9 groups basic counselling skills into three categories: process skills; communication skills; and therapeutic relationship skills.

The counselling approach of First Nations helping professionals has characteristic features. For instance, First Nations counsellors may tend to be more non-directive, make use of personal story (personal experience), make therapeutic use of humour, emphasize self-knowledge (including cultural/political identity), value flexible availability (i.e., 24 hour availability), incorporate nature and/or native traditional teachings, and have less of a hierarchical structure between counsellor and client because of their common experience, problems, and goals as First Nations people. One man pointed out that the values of respect, caring, unconditional acceptance and listening are 'traditional' values which can be used in the helping relationship. Another declared "the only gift I have is my own journey and the only thing I have to give is my own story." These two statements describe the approach of many with whom I spoke. A study of the particular characteristics of counselling within First Nations would be an interesting area for future research; such a statement could help First Nations counsellors to be more confident in the value of their unique skills and approaches.

Specific Types of Counselling

There are many counselling skills which are necessary and useful to any type of counselling situation but there are also specialized counselling techniques and approaches for dealing with specific types of problems. No one person could be trained in all of these types of counselling but workers in specific areas will require

some of these skills depending upon their job. (NNADAP workers need specialized substance abuse counselling training; Awasis workers may need training in counselling abused children, or in counselling teenagers). Communities need access to specialized counselling either through local specialists, visiting professionals, consultation, or referral. Each community will decide on its own priorities for specialized counselling services, but this study indicates a high need for marriage/family counselling and counselling for people who have experienced abuse.

Table 8 Specific Types of Counselling

- General counselling skills (30) - Counselling, group skills (2)	- Counselling, crisis (3)
- Counselling, marriage (10) - Counselling, family (7)	- Counselling youth (2) - Counselling teens - Counselling children - Counselling kids with puppets
- Counselling, abuse (8) - Counselling, abuse of children (2) - Counselling, sexual abuse (2) - Counselling, rape (2) - Counselling, child abusers (2) - Counselling, family violence	- Counselling, grief (2)
- Counselling, suicide(4) - Counselling in a suicide crisis (2)	- Counselling theory - Counselling, professional training - Counselling training for nursing station nurses - Counselling, psychological
- Counselling, alcohol abuse (3) - Counselling, solvent abuse	- Counselling for Elders - Counselling in Cree

Component Skills of Effective Counselling

It is probably safe to say that all health and social service workers need some basic counselling skills (e.g., active listening, being non-judgemental). Individual workers and the various types of helping agencies need to assess their own strengths, interests, job demands, and therefore, their own needs for counselling training. The skills required for safe, effective counselling can be divided into three groups: process skills, communication skills, and therapeutic relationship skills (see Table 9). People identified the various types of process skills which are required in counselling; these are tasks to be accomplished either in a counselling session or associated with the job of counselling (assessing problems and strengths, exploring options, problem solving, client follow-up, advocating for clients). Communications skills are, of course, essential to counselling. Many good communication skills appear to come naturally; we aren't even aware of them. But everyone can improve their skills through studying communication techniques, through supervised practise and feedback, and through ongoing support in avoiding the emotional pitfalls of counselling.

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Table 9 Components Skills of Effective Counselling

Process Skills	Communication Skills	Therapeutic Relationship Skills
- Assessment skills (9) - Exploring options (6) - Problem solving (5) - Follow up (5) - Advocate (3) - Coordinate resources for clients (3) - Case management skills(3) - Planning skills (2) - Evaluation of treatment (2) - Problem identification - Assessment in the home skills - Advising - Assessing emotional incongruence - Designing treatment plan - Focussing on strengths	- Communication skills (12) - Listening skills (12) - Non-verbal communication skills (6) - Interviewing skills (5) - Talking it out (4) - Knowing what blocks communication - Reading body language - Summarization - Clarification - Confronting others - Feelings, draw out - Giving feedback	- Dealing with own anger, pain & feelings in counselling (7) - Interpersonal skills (7) - Confidentiality (7) - Building trust (4) - Set limits, maintain boundaries (4) - Avoiding dependency in relationship (2) - Non-judgemental (2) - Empathy (2) - Giving support - Sharing of self - Dealing with manipulation - Neutral but caring - How to say no - Empower clients

Counselling is a human relationship and there are tips and techniques which help a counsellor develop and maintain a healthy, therapeutic relationship with the client. A therapeutic relationship is one in which the client is able to make improvements in their life as a result of the relationship. There are two major danger areas to avoid in the counselling relationship—dependency and transference. A counsellor is responsible for fostering the independence of people they counsel; dependency on a counsellor is not healthy in the long run. There must be a balance

between building a trusting, supportive counselling relationship, and maintaining the autonomy and independence of the client. One of the concerns raised in the interviews is how can counsellors maintain a heathy separation between their issues and the issues of their client, and especially, how can counsellors deal with their own emotions which are aroused during counselling (anger, pain, grief, fear). These are transference issues. Many of the community workers have had to deal with similar issues as their clients either in themselves, in family members, or in the community at large. For example, if an older male addictions counsellor is working with a young woman who was abused by her father, many of the issues and feelings the woman has about her father may be transferred to the counsellor and can therefore have a great effect on the counselling relationship. The skills of setting and maintaining boundaries, and dealing with the emotions and issues aroused in counselling are particularly valuable in avoiding burn-out problems. These skills can be taught. Although there is a large body of knowledge within counselling theory on transference and dependency issues, this knowledge has been formed within a western cultural framework. It is important that First Nations counsellors identify (i.e., construct theory) and share ideas (i.e., publish) about these issues within a First Nations framework.

Mental Health Theory and Practise

I have grouped here the skills (besides counselling skills as above) which are directly related to mental health as a specialty. These are required skills for any mental health worker. A mental health worker needs to be aware of the primary psychiatric diagnoses and the current types of treatment offered by mainstream mental health services. Mental health workers need to be aware of the effects and side-effects of medications prescribed for mental health problems. A mental health worker needs experience in conducting psychiatric assessments, writing referrals, and in counselling patients and families about mental illness. Most importantly, a mental health worker must have a thorough knowledge of all the sources of help available, especially local community resources. Mental health workers also need skills and knowledge in the areas of family problems, abuse, addictions, child psychology, crisis intervention, suicide, and running client life skills programs; these areas are covered to varying degrees in mental health training programs (e.g., psychiatric nursing) but are often gained more through experience, individual study, and educational upgrading and workshops. There is a great deal to be gained by different types of helping professionals sharing their skills and knowledge with each other.

Table 10 Mental Health Theory and Practise

Psychiatry - Mental health education & training(19) - Psychology principles (3) - Medications used in psychiatry (2) - Psychiatric practises (diagnosis, medications, treatments) - Assessment of psychological profiles - People with mental illnesses - Mental health training for nursing station nurses - Mental retardation - Understanding provincial mental health system - Assessing resources for clients	Client programs - Anger management (5) - Budgeting skills (4) - Parenting skills (3) - Stress management (3) - Life skills (2) - Assertiveness training (2) - Healthy coping skills (2) - Self-help and self-care skills (2) - Basic health education - Conflict management - Decision making skills - Anxiety reduction - Problem-solving	Child Psychology - Child development (4) - Child psychology - Play therapy
Suicide - Suicide crisis intervention (8) - Suicide prevention (6) - Suicide, assessment (5)	Abuse - Sexual abuse issues (3) - Signs of child abuse - Assessment of abuse - Dealing with emotional abuse cases	Family - Family dynamics(2) - Family mediation - Family teaching - Support to families - Violence in the family - Family systems theory
Addictions - Addiction education alcohol, drugs, & solvents (7)	Crisis Intervention - Crisis theory (2) - Crisis intervention skills - Dealing with violence	Other - Role playing, for therapy and training (2) - Mental health in cross-cultural setting - Supervising group homes

Writing Skills and Agency Skills

People are clear that they want to improve their writing skills because many writing tasks are essential to their jobs. A mental health worker (or any agency worker for that matter) must be able to keep records, write reports and make written referrals. Since many First Nations community services are actively developing, it is important for workers to have good writing skills in order to write proposals, training manuals, and public education material. First Nations community services require people with management skills, administrative skills, and especially, skills to build networks between the various community agencies.

Table 11 Writing and Agency Skills

Writing skills	Agency skills
- Writing skills (13) - Making written referrals (12) - Writing training manuals - Report writing - Pamphlet writing - Proposal writing - Writing job protocols (i.e., required skills for various jobs)	- Networking with other workers & agencies (10) - Management skills (5) - Knowledge of policy & procedure (4) - Administration skills (4) - Dealing with burnout (3) - Supervising other workers (2) - Organizational skills (2) - Research skills (2) - Reading skills - Team building skills - Knowledge of government laws & policies - Knowledge of child welfare act - Mediation skills - Computer skills - Conciliation skills - Accountability case management - Court testimony training - Education resource management

Public Education Skills

Along with counselling and development of community resources, public education is an important characteristic of a First Nations' approach to mental health services. Public education is important because of the emphasis on prevention, on holistic healing of the community, and on community development. These are practical skills which are needed by a wide range of community health and social service workers including mental health workers.

Table 12 Public Education Skills

- public education skills (14)
- planning & running workshops (9)
- TV/radio production (9)
- skill sharing training with co-workers (5)
- public speaking (3)
- planning & running conferences (2)
- advertizing/promotion skills (2)
- presentation skills
- educational program design

Community Development Skills

Many of the solutions to mental health problems suggested call for development of the community in general (jobs, self-government) and specifically for the development of local mental health resources. Community program development is done at the grassroots level utilizing the talents and expertise in the community, and meeting needs as defined by the community; it is, in part, a political process which

explains why politics and leadership are mentioned as means of improving community mental health. Public education skills, writing skills and the various agencies skills already mentioned are needed for dynamic, successful community program development. I grouped together other responses on training needs of mental health workers which would help them to work within a First Nations community development model.

Table 13 Community Development Skills

- Providing consultation and support to other workers
- Community healing skills
- Community awareness program skills
- Vision (building community vision)
- Goal planning at community & program level
- Grassroots development of job descriptions
- Lobbying skills
- Awareness of local politics
- Program development skills
- Understanding First Nations' self-determination politics

Spiritual and Traditional Training

Spirituality is fundamental to healing if healing is taken to mean a return to balance and wholeness. One of the most distinguishing features of the modern western world is the separation of spirituality from science and from the state. Medicine, social work, psychology, etc. are considered to be separate from issues of spirituality. Spirituality has come to be narrowly defined and sectioned off into the private domain of religion. One of the men interviewed suggested a concept which I

find useful in understanding the pervasiveness of spirituality in First Nations. He said that what I (as a university trained social scientist) define as social, he would define as spiritual. He suggested that what I might call social structures and social mechanisms, are inherently spiritual in that they are processes of connection or the means by which human groups maintain balance within all of Creation.

Aboriginal medicine is more than the specific plants and practises aimed at curing health problems. Aitken and Haller describe 'medicine' as that which has the power to bring about change (1990:34). 'Medicine' is, perhaps, the dynamic force of Creation. Aboriginal medicine is the practise of understanding and using that force. John O'Neil makes the point (in the Royal Commission on Aboriginal Peoples report on health and social issues) that traditional medicine is a way of life fundamental to cultural practises, and that "(i)t is more likely that various levels of Aboriginal government will be regulated by the authority structure of traditional medicine" than Aboriginal political structures regulating traditional medicine (O'Neil, 1993:38). O'Neil further states that "it is in the context of traditional medicine that issues of self-government, socio-economic development and environmental protection are best integrated with community health development for most Aboriginal communities" (1993:27-45).

Spirituality is fundamental to healing individuals and communities. There is no clear consensus on which is the best spiritual path to follow. Without getting into the value or virtue of these paths I have divided spiritual skills into three groups: religion, native spiritualism, and the native traditional practises which might be acceptable to both.

Table 14 Spiritual and Traditional Training

Native Traditional Practises	Native Spiritualism	Religious Education
- Healing circles (5) - Traditional values & teachings (3) - Guidance by Elders (2) - Community camping trips (teaching land based skills) (2) - Youth camps (teaching land based skills) - Using the land as a teacher	- Native spiritual training (4) - Fasting (2) - Sweat lodges (2)	- Bible training (3) - Christian education

Types of Training Programs

Some people suggested specific training and educational programs for First Nations mental health workers, but there is an overall emphasis throughout the interviews on the combined use of specialized training and supervision, with locally

developed expertise using elements of native traditional practises. First Nations mental health workers might receive training in established, institutionalized programs (such as nursing), but First Nations may soon develop institutionalized expertise and certified training programs particular to First Nations health issues.

Table 15 Types of Training Programs

Specialized Training Programs	Combination of Approaches
- Social work degree (4) - Nursing (2) - Psychiatric nursing - Training supervised by professional organization (maintaining universal standards) - Certification - Professional training - Sociology - Specialized training for particular jobs	- On the job training (5) - Combination of western and native traditional teaching approaches (4) - Combination of on the job and professional training - Workshops in community for ongoing training (2) - Skill sharing workshops among community workers - Community training of volunteer counsellors - Experience based learning (on the job) - 'Inner Child' workshops - Operational manuals on the job - Better selection process for community workers

Chapter Twelve:
WHAT ARE THE IMPORTANT ATTRIBUTES OF A GOOD HELPER?

I asked people directly what makes a person a good helper. People responded with some attributes of a good helper in response to other questions. I grouped all of these responses together into a list of attributes and I noted the major categories: self-healing, caring, personal experience as or with First Nations, and other.

Table 16 Characteristics of a Good Helper

Self-healing	Caring
First Nations	Other

Self-healing, self-recovery, and self-awareness are necessary to helping others. There is a quote in *Changing the Landscape: Ending Violence - Achieving Equality* which expresses this idea well: "(h)ow far healers go in their own healing is exactly how far they can take their own people" (Supernualt, 1993: 6-7, quoted by Canadian Panel on Violence Against Women, 1993:152). In order to be an effective helper, a person must be well-balanced, continue to work on their own healing, and understand and manage their own emotions. Being able to manage the difficult job of being a

helper demands good self-esteem, self-confidence, courage, assertiveness, maturity, responsibility, and honesty (you can't be honest with others if you are not honest with yourself).

A good helper is someone who has gone through some of the same problems as the people they try to help; someone who has walked the same road to recovery. For instance, many people believe substance abuse workers need to have recovered from substance abuse problems themselves. Personal experience with recovery and healing is a key element in the helping relationship. Some of workers I spoke with (generally older people) discussed how they use their own story as a tool in the helping process. This is significantly different than what would be expected from, for example, a nurse on a psychiatric ward where telling one's own story is considered inappropriate.

Another important characteristic of a good helper is caring. Caring is a difficult term to define; it is connected to other important attributes of a good helper—respect for the dignity of others, non-judgement, acceptance, and love. Caring involves respectful, non-judgemental attention (listening to and accepting others for who they are), combined with a concern for other's welfare. This 'caring' in the helping relationship may be similar to a fundamental principle of the psychological counselling relationship known as 'unconditional positive regard.' Caring, as fundamental to helping and healing, is sometimes overlooked in training helping

professionals because it is so subjective; nevertheless it is an essential ingredient in the helping relationship. Other words used to describe a good helper as caring include: a good listener, patient, understanding, empathetic, committed, tolerant, warm, supportive. Some people have a 'natural helping personality.' You can't teach someone to be caring but you can teach techniques for active listening, remaining neutral, suspending judgement, being supportive while fostering independence, and for keeping a healthy balance between caring for others and maintaining your own sanity. Helping agencies can structure the work environment to promote principles of caring, or in reverse, agencies can set up conditions which make it hard for helpers to be caring.

Connected to caring is ready availability. Particularly for the older helpers, being available on a twenty-four hour a day basis is expected in the helper role. Helping is being there when people need you; crises and readiness for help cannot be boxed into a nine-to-five, five-days-a-week, by-appointment-only job. This type of availability is different from mainstream, professional models of helping. Expectations for availability require special staffing arrangements and present problems for helpers if they work within an office, by appointment-only model. If First Nations use an office, by-appointment-only model for services, they may find it in conflict with community expectations. Ready availability needs to be considered when designing mental health services, and when training workers to cope with the problems it can cause such as lack of privacy and conflict of interest with family members. In small

communities, the role of a helper easily spills into everyday life—at the store, in the bar, with extended family members—and can add to stress and pressure on the helper.

It is important for helpers to not only be aware of First Nations' culture and history, but to be part of First Nations hopes and visions for the future too. Helpers need to speak Cree in order help those who don't speak English, and also to help revive the use of Cree and pride in one's identity as Cree. Community helpers need to understand something of the politics of self-determination and revival of cultural identity. First Nations people want jurisdiction over their own health care and they want members of their own communities providing health care in ways which reflect their own beliefs and values.

Spiritual faith is mentioned as an important attribute of a good helper; this includes faith in the Creator or God but also training in traditional First Nations values. Healing is a matter of the heart or the spirit so that these skills are foundational. Having a good sense of humour is mentioned as important to a helper. Humour should not be overlooked as a therapeutic tool. A First Nations helper also needs common sense, flexibility, perseverance, energy, hope, diligence and the ability to take risks.

Chapter Thirteen:
WHAT SUPPORT DO YOU NEED TO BE A HELPER?

In order for helpers to do their job they need support. No matter how good someone is at their job they will burn out quickly without the proper supports. In the high intensity field of helping professions in general and in First Nations helping professions in particular, burnout is a big problem. Because of concerns expressed to me by people in the research communities, I specifically asked what supports helpers need to combat burnout. The responses are grouped into the following categories.

Table 17 Support to Helpers in the Community

Supports in the Workplace	Personal Supports
- Networking & Teamwork - Counselling - Training & Ongoing Education	- Family & Friends

Supports in the Workplace

Networking and cooperation between community agencies is a major support to health and social service workers. A team atmosphere where people problem solve together and interact harmoniously is needed to counteract stressful work. It is also suggested that counselling services, employee assistance programs and support for the

individual worker's own healing process is needed in the stressful field of helping people. Community workers or members of their own families often have faced some of the same problems as their clients. Certainly issues around addiction, abuse, and grief touch all members of the community. Workers need support to address their own issues of healing and to be aware of the emotional impact upon themselves of the emotionally laden content of their work with clients. Workers need some flexibility and support in the workplace, for instance: stress leaves, stress management inservices, and employee counselling. This is an area where supervision and consultation with professional trained mental health workers, such as a psychologist, is helpful.

Training and Ongoing Education

Adequate and appropriate training is required or else staff will be under a great deal of stress. Communities could support the professional training (e.g., psychology, psychiatric nursing, social work) of its own members in order to increase the level of expertise within the community. Often, workers are placed in demanding jobs with little or no training and direction. This can be extremely stressful. I spoke with many staff who were doing wonderful work in jobs many highly trained professionals could not handle; they are innovating and creating an expertise that is not available in urban universities. But support, recognition, feedback, and supervision may be hard to come by in relatively small communities. Supervision, consultation, and ongoing training are necessary to combat burnout on the job.

Some are overwhelmed by the size of the healing task in their communities and feel that there need to be more workers hired in the health and social service field. More workers would help, but so would ongoing mental health training for all types of workers and volunteers within the system to spread the load out among more community members. It is also thought that as the communities themselves heal, more people will have the energy for helping other, and at some point healing will start to snowball.

Personal Supports

People also suggested a number of personal strategies to prevent burnout. These cover a range of self-recovery and self-care activities (such as, recreation, sports, religion, support from family and friends), as well as having commitment to your work and learning to set boundaries between work and personal life. At the top of the list is the having the understanding and support of family and friends.

Chapter Fourteen:
SUMMARY AND RESEARCH CONCLUSIONS

Strong Communities - Good Health

Mental health care needs in First Nations have been largely unmet. Traditional First Nations social practises for aiding individuals to develop healthy self-images and positive coping skills, and social structures for dealing with community problems have been weakened or destroyed through the process of colonization. First Nations communities have had medical, social service, and in particular psychiatric needs met (or not met as the case may be) through mainstream Canadian institutions which are culturally different and often difficult to access. First Nations believe that the only way to solve the problems in their communities is through having the jurisdiction and the resources to take responsibility for their own healing. Strong, functioning communties support individual mental health; positive cultural identity is essential to individual mental health. Self-determination for communities and for individuals is not only just, but is necessary to healthy survival. Political self-determination, jurisdiction over their own community social systems (such as health care), and the reclaiming of a positive cultural identity are essential ingredients of First Nations mental health services, and therefore are important in understanding the training needs of mental health workers within those systems.

Mental Health as Balance and Well-being

Mental health is understood within the holistic framework of the medicine wheel. For the most part, health is viewed as a balance and harmony of all the aspects of the medicine wheel (physical, mental, emotional and spiritual), but it is also recognized that disorder can show itself in any one of the aspects, for instance, as physical or mental disease. There are two ways of looking at mental health: a wellness (holistic) model; and a disease (dualist medical) model. Both views can be held as true by the same individual and, in particular, within the same community. The three First Nations communities of this research project recognize and are concerned about mental diseases (such as schizophrenia) and specific mental health problems (such as suicide, depression, anxiety), but place the highest priority upon healing and rebalancing the wellness of their communities as a whole.

Loss and Grief as Mental Health Problems

The priority mental health concerns of First Nations are: substance abuse; reactive depression; anxiety; and suicide. The problems of domestic and social violence, and family and marriage breakdown are also considered serious mental health problems. The problems of depression, anxiety and suicide stem from feelings of hopelessness and powerlessness over the difficult socio-economic conditions of their communities and their lives; unemployment, poverty, and the shortage of housing

contribute to these mental health problems. Accumulated grief over the massive losses suffered by First Nations (personal and collective) is also a major cause of mental health problems. The cycle of abuse started by the colonial process, (typified by the residential school system), is considered a primary cause of mental health problems. Abuse and substance abuse are the result of social, economic and political problems but they also perpetuate those same social problems. In fact, on the whole, the political, economic and cultural destruction of First Nations is held responsible for most of the mental health problems, as well as for the limited healing resources available to communities to resolve those problems. Even chronic disorders which are likely to have organic origins (such as schizophrenia, mental retardation, and Alzheimer's) are extremely difficult for communties to deal with without the proper resources.

Treatment, Education and Community Development

In "Breaking the Silence" (a study of residential school impact and healing), it is stated that healing must include treatment, education and rebuilding (Assembly of First Nations, 1994:147). These three foundations to healing are also reflected in the three main suggestions for mental health services made in the research interviews: access to treatment options; public education; and community development. First Nations must have access to treatment for mental health problems (e.g., psychotic crisis, alcoholism, or post-traumatic stress following a rape). Counselling, psychiatric

assessment, crisis intervention, and suicide counselling must be readily available. There must be access to treatment within the community and access to treatment resources from outside of the community. Each First Nation needs a central place for mental health information and counselling within its community. Each community should offer the option of treatment with traditional healers and/or treatment through mainstream health and social services.

Public education will play an important role, including: teaching mental health awareness to the general public and to health and social service workers; teaching life skills, coping skills, and personal growth programs to general public; teaching counselling, assessment, referral and other mental health related skills to health and social service workers; and ongoing professional development of local mental health workers.

Community development will play a big role in mental health programming because of the tendency toward a holistic focus and because of the push to rebuild strong, self-sufficient communities. Mental health will be improved through increasing job opportunities, developing recreation, improving educational opportunities, and solving the housing shortage. In some communities, a focussed 'community healing' approach will be followed, but in all communities the focus will be on the development of local programs and resources, networking of existing community resources, the use of native traditional teachings and practices, the revival of a positive

cultural identity, and the political process of establishing jurisdiction over their own resources.

Community development applies to developing supports for meeting the needs of all members of the community in order to foster good mental health; these include a range of supportive services: community feasts, day care, elder care, youth recreation. Individuals with mental illness (especially chronic, debilitating illnesses like schizophrenia) and their families need supports in the community too. Community supports for the mentally ill include: group homes (sheltered housing where people can have some measure of independence), day activity centres, and support groups for families. The most powerful aids for families coping with mental illness are information about the illness and the mental health care system, and support from others who understand.

Community development also has broader connotations. It implies cooperative community action toward shared goals. Each community will develop its own approach to mental health services. This will involve Chief and Council getting a mandate from the community and making policy decisions based upon that mandate. It will also involve individuals at a grass-roots level having support to develop innovations which suit the resources and the needs of the community. The system will need political will and leadership, it will need local mental health worker(s), and it will require connections to the provincial mental health care system.

Sharing the Journey - First Nations Helpers

The attributes of a good helper highlighted in the research interviews are: self-healing/self-awareness, caring, and First Nations experience. Other characteristics and skills that are suggested throughout the interviews include: using one's own story, drawing from one's own experience as a therapeutic tool; ready availability to clients according to their needs; using Cree teachings, values, beliefs and in some cases spiritual practises; and the therapeutic use of humour.

One of the threads running through the interviews is the need for self-knowledge and building a positive self-image in order to heal; this includes, to a large degree, learning about and taking pride in oneself as a First Nations person. It is important to reclaim a positive cultural identity. Through the processes of colonization and assimilation, the First Nations cultural identity was disallowed and degraded, and First Nations were exposed to negative, racist stereotypes about their identity. According to Emma D. LaRocque, "(o)ne of the many consequences of racism is that, over time, racial stereotypes and societal rejection may be internalized by the colonized group" (1993:74). An essential part of de-colonization of First Nations communities is de-colonization of the 'self.' A positive personal and cultural identity is necessary in order for people to care for and care about themselves, their families, and their communities.

A mental health worker within a First Nation must have gone through, and continue with, their own process of healing. Healing within First Nations is both an individual and a community process. As one individual heals this begins the healing of the community, and as the community begins to heal more and more individuals will be affected and begin their own healing as well. One man explained to me that it is not enough to just quit drinking or abusing drugs. He alluded to something much deeper and all-encompassing. Healing involves the whole person and the whole of their life. Healing is a spiritual journey. In order to help others begin their healing, it is important have begun healing oneself. In order to continue to work in the emotionally demanding field of human services, it is important to continue to be self-aware and working on one's own issues. Helping, in this model, is not just about applying techniques or prescribing advice learned in a classroom. A community mental health program must nurture the healing of its workers as well as its clients.

Caring is a personal characteristic which is considered fundamental to helping others. Caring is part of an attitude of respect which must permeate the entire workplace. Many of those interviewed feel it is important to be available when people need help; people do not plan their crises to suit office hours. Being available when needed is part of caring and having respect for individuals. The flexibility to be readily available needs to be built into the mental health care system or workers will be put in positions of great strain. Caring is non-judgemental attention and acceptance

for the individuality of others. Caring and respect are the principles underlying First Nations mental health care.

It is important for helpers to draw from their own experience and to be connected to the healing journey of the community; this means that a local person, who speaks the local language and understands the local culture and community will most likely have the right experience for the job. Helpers must not only understand the problems of the First Nation but must also understand the strengths and the vision of the community.

Nurturing the Flame - Supporting First Nations Helpers

Burnout is a serious concern for First Nations helpers. To help fight burnout, workers need support where they work and within their families. Helping agencies need adequate resources, manpower, and training, and active cooperation between agencies. Networking, teamwork, inter-agency communication and coordination are stressed as important to the work of health and social service workers and community volunteers. Ongoing supportive counselling, supervision, and in-service training are essential. No counsellor can work alone. Counsellors can suffer stress reactions themselves from counselling people with multiple losses and abuses, and from coping repeatedly with crisis situations. Judith Lewis Herman, in her discussion on post-traumatic stress counsellors, says that therapists require ongoing support to deal with

"vicarious traumatization" (hearing stories of trauma from others) which can produce post-traumatic stress symptoms in the therapists themselves (1992:141) (also see Dolan, 1991:218-223). Support and supervision for counsellors must be built right into the system.

Burnout is also a big factor in First Nations because of the size of the communities and the trend towards community members as counsellors. A mental health worker or counsellor in a relatively small First Nations community, who is from that community, who has many relatives and friends in that community, and who shares in some of the issues of that community can have problems in maintaining boundaries and coping with their own, stirred up personal issues. Ongoing training in counselling relationship issues and techniques for dealing with them are required. Families and children are major supports for health and social service workers but there are work related issues that families must deal with, such as: work life interfering with private life; the need for client confidentiality; and the special strains of the job. If First Nations want to put holism, respect and caring first then they must build mental health care systems which nurture and support those values.

A First Nations Approach to Mental Health

Mental health systems in First Nations are likely to be holistic in nature, that is, be only one facet of community well-being. First Nations mental health will focus

upon community health as well as individual health and will rely upon the broader definition of health as well-being. Holistic also means that community development, public education, and spirituality will play dominant roles, not act as mere adjuncts to treatment. First Nation communities will draw upon their own wisdom and strengths, upon the experiences of other First Nations, and upon the mainstream Canadian health and social services in constructing mental health services. In most cases, First Nations mental health services will be a combination of western approaches and native traditional approaches, and they will bridge outside mental health specialists to locally developed services. First Nation communities seek to develop their own community resources as part of rebuilding the strength of the community, and as a means of ensuring that helping services are appropriate to the lives and needs of First Nations people.

First Nations mental health service models must also suit and support the characteristics of a First Nations approach. Systems must have the flexibility to encourage workers to innovate and develop their own skills and program directions. Workers should be encouraged to reflect upon and nurture their unique talents and techniques as valuable (e.g., the use of personal story, humour, teachings, healing circles). I was told that the values of respect, caring, unconditional acceptance and listening can be construed as 'traditional' values to be used in helping and healing. Systems must support these values as well as the responsibility of each individual to their own healing, this means: making room for flexible working hours; making

allowances for innovations in counselling (such as, using the outdoors as a counselling setting); and building in supports for the ongoing healing of workers within the system. Systems must facilitate the ongoing training of workers, and support workers developing their skills in directions they assess as most appropriate to their work (e.g., technical writing skills, video production, training under a traditional practitioner).

An essential ingredient to a community First Nations mental health system is strong, collaborative relationships with outside mental health specialists. This collaboration is necessary for three reasons: community members must have a choice of treatment options; community workers need consultation, counselling, supervision, and ongoing training supports; and community workers need to understand and have connections with the provincial mental health system in order to act on behalf of community members.

Mental Health Education and Training

First Nation mental health systems are composed of five categories of people for the purposes of education and training: the general community; the network of community health and social service workers; mental health consultants; elders and traditional practitioners; and local community mental health workers. Suggestions on mental health education to the general community are listed in Table 18. Education

to the general public is conducted by local community workers and sometimes through workshops conducted by invited guests.

Community health and social service workers and volunteer helpers in the community will also benefit from the education programs aimed at the general public (as listed in Table 18), but they also require training in order to run life skills programs and community workshops, more detailed information on mental illnesses and the mental health care system, assistance with writing skills, and ongoing training in counselling skills. Training of these workers might be through the local mental health worker, the mental health consultant, through visiting or outside workshops, and/or through in-house training programs such as offered through NNADAP.

Table 18 Mental Health Education to the Public

Life Skills Training	Mental Health Awareness	Traditional/ Spiritual
- Parenting skills - Budgeting - Stress management - Anger management - Problem solving skills - Information on community agencies & their roles	- Dealing with loss & grief - Cycle of abuse - Substance abuse - Awareness of mental illnesses to reduce stigma - Information on resources available for mental health problems	- Healing programs in other communities - Teaching traditional land based skills - Teaching traditional values and practises - Community healing workshops - Healing circles

Table 19 Role of a Mental Health Consultant

- Provide assessment, counselling and treatment to community members as requested - Provide consultation services, training and supportive counselling to community health and social service workers as requested (e.g., NNADAP, Awasis, CHRs) - Provide ongoing training/consultation/supervision/counselling to community mental health workers - Assist in program development and/or public education as requested

Table 19 lists suggestions on the roles for mental health consultants within First Nations. Mental health consultants need professional training in the mental health field (e.g., through psychiatric nursing, psychiatry, social work, psychology), but they will also need training or experience in adult education and First Nations culture. Elders and others with experience in First Nations traditions (e.g., land-based practises, spiritual practises, teachings and values) must be involved in planning community mental health, in teaching the public, and in training community mental health workers and mental health consultants. Social systems which support the training and use of elders and traditional practitioners need to be nurtured within First Nations. Table 20 lists the roles First Nations community mental health workers need to fill. The main skills and training needed by First Nations mental health workers fall into six categories: counselling skills, mental health theory and practise, writing and agency skills, public education skills, community development skills, and native traditional and/or spiritual training.

Table 20 Roles for First Nations Mental Health Workers

Treatment and consultation roles
- Provide counselling and treatment services to clients
- Provide expertise in sexual abuse, domestic abuse, post-traumatic stress conditions, substance abuse, and resolving grief.
- Conduct mental health screening assessments (e.g., psychotic illnesses, suicide potential)
- Case management (overseeing care of clients involved with several agencies, maintain consistency and follow-up)
- Provide consultation to local health and social service workers on mental health issues
- Work in collaboration with mental health consultants

Education roles
- Maintain information about mental health care system and related resources available
- Provide resource centre on mental health problems and resources available (e.g., pamphlets, TV, and radio)
- Provide public education on mental health issues and/or arrange visiting workshops
- Provide education to local workers on mental health issues and/or arrange visiting workshops
- Help organize public education on lifeskills (parenting workshops, budgeting, anger management)

Community development roles
- Contribute to community health planning (i.e., crisis committee, community mental health committee)
- Assist in program development (proposal preparation, program planning, manuals)
- Organize family and individual supports for the mentally ill
- Speak the language of the community
- Aware of community and its resources
- Work with elders
- Work with spiritual leaders of community
- Aware of community's culture
- Aware of and network with other First Nations and their approaches to mental health

It is essential that mental health workers, consultants and community workers not be hired to see clients on a fee-for-service basis. This approach would promote

the isolated treatment of individual problems, and would do nothing to develop the community's resources. With a salary based worker the community can include the following roles in the job description: consultations with community agencies; ongoing training and supervision of community workers; and assistance with community program development. Any mental health worker will need to work as part of a community team and have close working relationships with mental health consultants and provincial services. The best model for a community mental health program includes local community mental health workers with supervision and support from mental health consultants, and from elders and/or traditional practitioners. It is possible to use the advantages of both approaches to healing.

Concluding Remarks

Good mental health is constructed through social processes both in the sense that the definition of health is socially determined, and in the sense that social institutions such as the family, religion, health care and political structures support the health of individuals. Mental health is part of well-being; it is part of living a good life. There are many problems interfering with a good quality of life in First Nation communities, and there are many strengths to draw upon also. First Nations are involved in the process of healing. In order to heal, community structures and cultural identities must be strong. It is through culture that we maintain health, through our beliefs and values, through family structure, through our social institutions such as

healers, through our rituals and practises which define what is health and how we should maintain health. Societies and communities are continually involved in processes of social construction. First Nations are actively involved in building political, economic, social, and spiritual constructions in order to support the health and well-being of their people. All these aspects of social life work together to produce health.

First Nations constructions about mental health (and healing in general) are built through social dialogue and interaction. Social constructions are dynamic; they are actively debated and contested. There is no distinct, unified 'First Nations approach to mental health'. First Nations (and indeed indigenous peoples around the world) interact with their own histories, with each other, and with mainstream Canadian health and social services in working out approaches which will suit their own particular needs best. These three key components used in emerging First Nations' constructions about mental health are identified within this research data: their colonial history; their own cultural traditions; and contemporary systems of Canadian health and social services.

First Nations' experience with colonialism is used to understand and explain the disharmony and health problems of First Nations today. The losses and abuses suffered through subjugation to the English and then the Canadian state have destroyed the wholeness and therefore the wellness of the Nations. Cultural processes of

cohesion, social structures, economy, and the power of self-determination have been severely undermined. Mental health problems arise from the grief and trauma suffered by the people both individually and collectively. Mental health problems arise from the socioeconomic problems experienced by First Nations within the Canadian nation.

Cultural tradition is used by contemporary First Nations because it is a group identity marker; a means of establishing resistance to and differentiating from other cultural groups; and a means of building positive identity necessary to well-being or good mental health. Using cultural tradition is part of drawing upon one's own strengths and part of building a collective vision to guide collective action. But the construction of native traditionalism is highly contested among aboriginal peoples. Just as there is no distinct, unified 'First Nations approach to mental health,' there is no distinct, unified 'native traditionalism.' There is diversity between the cultures of the various First Nations, and disputes as to which practises are actually traditional to a given group and which practises should be retained. But nevertheless, native tradition and native spirituality are extremely important in understanding mental health within First Nations. First Nations health and social service workers are developing unique approaches to helping and healing which derive from their cultural traditions. These include aspects mentioned throughout the interviews: traditional values of respect, caring, unconditional acceptance and listening; healing circles; the use of humour; the use of personal story; sweat lodges and smudging ceremonies; 24hour. availability;

extensive use of elders; the community healing model; teaching traditional land-based skills; use of the land as healer; reviving cultural identity in restoring health; traditional stories and teachings; community feasts, camping trips and other gatherings; the strong emphasis on education and community development.

The concept of healing—returning to wholeness, and balancing the aspects of the medicine wheel—is central to First Nations constructions about mental health. The connection between the Land, the People, and the Creator support the well-being of the people; "this is the birthright which has been taken from the Nations" (quote from research interview). These are the connections which must be reforged. In the medicine wheel, spirituality is the connectedness of all the aspects of creation. Healing is fundamental a spiritual process. This understanding is evident is throughout the research interviews. Although spirituality is not limited to any one cultural tradition, it is through cultural practises and belief systems that spirituality is understood and expressed. The cultural expression of spirituality is contested within First Nations. Christianity is as much a part of some aboriginal people's cultural beliefs as native traditions are; there can be conflict in resolving the two.

Healing, spirituality, cultural identity, and political self-determination are linked together. Naomi Adelson examines the use of the James Bay Cree concept of miyupimaatisiiu or 'being alive well' as lived (or embodied) resistance to assimilation into mainstream Canadian culture and imposed images of the 'self.' "The discourse of

miyupimaatisiiu is one of resistance in that it is part of the process of affirming a particular national identity" (Adelson, 1992:236). Cultural identity is a resistance to having one 'self' defined by others. Culture is a mechanism of self-determination. An elder advised me that in order for people to be well, to be whole, there must be a return to their roots, a return to the sweat lodge. The language must be preserved, along with the culture and the values that make the Nations distinct, otherwise self-government will end up looking like any other municipal government. Self-determination cannot succeed without the health of its people, and achieving self-determination is part of the process of healing

A dominant part of post-contact First Nations experience with healing and helping involves western models of health and social services. This has its negative aspects. The health care system in any society is a primary institution of social control and functions to help construct self and group identity. The healing and health care practises of a community help to construct and define the self of individuals, and it is also through healing practises that individuals construct the social world (culture) (Kapferer, 1983). In the past, the politically dominant Canadian society has had the power to define what is normal, what is sick behaviour, and how to treat sickness. The western health and social service models have played a large role in the disempowerment and enforced dependency of First Nations.

On the more positive side, people want to have access to the choices and options available to the rest of Canadian society. First Nations workers want access to knowledge and skills built by professional practises such as medicine, nursing, and social work. First Nations mental health care services are pluralist, combining traditional and contemporary aboriginal culture with western models of helping and healing. First Nations are, of course, contemporary people and live within Canadian society. The desire is not simply to bridge the two worlds; they are not actually separate. Both worlds are the reality of First Nations experience. A collaboration between mainstream mental health services and First Nations community is needed to address mental health problems.

I end with a quote from Ben Davidson who is referring specifically the nurse/patient relationship, but I feel the quote describes the collaborative relationship necessary between western, mainstream mental health approaches and First Nations approaches.

> But if the distressed and desperate states which are conventionally known as 'mental illness' arise out of our conduct towards one another, then their resolution too must issue from this interface between people, out of a healing common ground ... (Davidson, 1992:7)

Ekosani.

Appendices

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APPENDIX A:
FIRST NATION RESERVE HELPING RESOURCES

Each community has its own approach but reserve communities share some common helping resources. A great deal is often done with few resources other than the talent and hard work of community members. The following represents an overview of the helping resources I surveyed in 1994. My apologies for groups I may have missed. Each community has made progress in its approach to mental health since 1994. Nelson House First Nation has made great strides in the development of its own approach to mental health, and I hope someone soon will start to record the mental health innovations of each First Nations.

Nursing Station

- Medical emergency
- Suicide attempts
- Psychiatric emergencies
- Referrals for counselling or treatment
- Public health

Cross Lake and Nelson House are served by nursing stations. The nursing station at Nelson House, for example, is staffed mainly by three Medical Services Branch nurses and several community health representatives. Two General Practitioners rotate clinical duties every other week, Wednesday to Friday. A band-employed public health nurse works out of the nursing station and focuses mostly

upon immunizations. In 1994, Nelson House had plans to begin the process of transferring health authority and rearranging health care delivery. Nursing station nurses and community health representatives (CHR's) encounter people with mental health problems either while doing home visits, or more likely through the emergency or clinic at the nursing station. Treatment and care at a nursing station is generally short-term and focussed on physical problems. Nursing staff do not necessarily have specialized training in mental health and are frustrated with having no time for counselling or for helping people deal with the problems underlying their suicide attempts or self-abusive behaviour.

Norway House Hospital

There has been a hospital in varying forms at Norway House since the Department of National Defense opened a small hospital near the United Church Mission at Rossville preceding World War I. The current hospital was built in 1952 at the northwest end of Fort Island on non-reserve land and is currently operated by Medical Services Branch of the federal department of Health Canada. Norway House Hospital serves mainly the local population with occasional admissions and transfers from the outlying areas. Presently the hospital has 16 beds, although at one time the hospital had a larger bed capacity and served as a regional hospital. Norway House is currently beginning the transfer of health authority process, although it is unclear at this time which departments of the hospital might come under band authority. The

hospital supports general practitioners in providing emergency and primary care, as well as the practise of a variety of fly-in disciplines (e.g., eye doctor, physiotherapy). In the past Norway House has had fly-in psychiatrists through the Northern Medical Unit of the University of Manitoba, and was part of the Northern Mental Health Outreach Project which supplied psychiatric nurse practitioners in a pilot project. Norway House is in the process of negotiating with a psychiatrist to visit once a month for assessments, consultation, treatment, and some training with local workers. A health clinic is attached to the hospital. There is a Public Health Unit housed in the clinic although it is responsible to the hospital administrator. (Norway House, unpublished manuscript current to March 1990)

The hospital sees people with mental health problems during clinic hours, or through the emergency department after a suicide attempt or because of unusual and troublesome symptoms. Patients may be admitted to the hospital (after a suicide attempt all patients are admitted for assessment), and the doctor may phone for a psychiatric consultation to one of the large southern hospitals (usually the Selkirk Mental Health Centre). Patients may be treated with medications and monitored by a Norway House doctor, or they may be transferred to the Selkirk Mental Health Centre for intensive treatment. Follow-up and/or case management of people with mental health problems may be done by hospital doctors (usually only on an as-need-arises basis), the psychologist, the medical social worker, or one of the public health nurses.

Social Services

- Probation
- Psychologist
- Welfare worker
- Community Health Representatives (CHR)
- Youth & Recreation worker
- Family Violence workers & Brighter Futures workers
- Social worker

There are a number of social service workers who may come into contact with people who are having trouble coping with their lives. These workers can be important in recognizing the need for counselling, for mental health education, or for referral to a mental health specialist; they can also be important in helping people to learn healthy coping skills. These workers are a part of the community's support system. Youth and recreation workers operate social, recreational, educational and cultural programs which help people come together in healthy ways, such as: a community walking/running program; hiring young people to run community youth recreation; sporting events; community festivals. Psychologists offer professional counselling to community members, support to stressed health and social service workers, and can be a valuable teaching resource. Family Violence workers focus on the heart of many mental health problems – family violence, which is both a cause and a symptom of mental health problems. 'Brighter Futures worker' is a position arising from the Brighter Futures program (so is Family Violence Worker); mental health is one area of program development responsibility. Brighter Futures programming might include: community education programs such as stress management; community wellness conferences; elder and youth councils; cultural awareness programs; suicide

prevention; chemical dependency issues; feasts to build community unity; and rehabilitation support groups.

Many of the social service positions are developed by First Nations themselves according to their own experience, strengths and community needs. This reflects the developmental and innovative nature of First Nations helping services. For instance, one social worker has developed his skills as a community mental health worker. He essentially serves as a mental health worker in the community (amongst other things) and in doing so helps to build a model for First Nations mental health services. This approach of individuals pursuing training and job development according to their own temperament, skills, and community need allows for innovative development of programs which fit the current and particular circumstances of each community.

National Native Alcohol and Drug Abuse Program (NNADAP)

- Alcohol and drug counsellors
- Solvent abuse workers

Medical Services Branch developed The National Native Alcohol and Drug Abuse Program in 1975 as a pilot project; in 1982 NNADAP became a permanent project (Waldram, Herring and Young, 1995:93-4). NNADAP is a leader in the development of drug and alcohol assistance programs in First Nations, and has its own service structure and training programs. There is a wealth of expertise and experience within NNADAP, much of which was developed at a community level by those who

have experienced the realities of substance abuse in First Nations. NNADAP workers assess, counsel, refer, advocate for, and follow-up with clients. They are involved in the development of new programs and community education initiatives, such as the joint Norway House/Cross Lake production of the video on solvent abuse (The Ravens are Falling).

Substance Abuse Treatment Centres

- Regional programs (Medicine Lodge)
- Local programs (Family Healing Centre)
- Solvent abuse centre (first specialized solvent abuse treatment centre in province)

The Medicine Lodge, in Nelson House, serves as a regional treatment centre for alcohol addiction. It has a four month residential treatment program which is intense and comprehensive. The program uses native traditional teachings (i.e., Lodge members were on a traditional camping trip and fast most of the time I was in Nelson House), educational programming on drugs and alcohol, and counselling. In 1994, I was told there was not a post-discharge, follow-up program. There are plans for a solvent abuse treatment centre to be situated between Cross Lake and Norway House in the Whiskyjac area. Construction on this residential centre is to start in May/April, 1997 but treatment staff have already been hired and are currently working out of Thompson. In 1994, Norway House operated a community project for substance abuse, the Family Healing Centre, which focussed on the family and on addiction education.

Awasis Agency of Northern Manitoba

- Operations Manager
- Child Protection worker
- Services to Families
- Adoption Counsellor
- Child Family Workers
- Foster Care Worker

Awasis means child in Cree. The Awasis Agency of Northern Manitoba has been offering aboriginal child and family services in Northern Manitoba since 1983. Its mandate is to assist families to stay together and to ensure the protection and care of children within an aboriginal context. Awasis can be a resource for teenagers abusing substances, children who are coping with sexual or physical abuse issues, and families in distress due to substance abuse, domestic violence or emotional problems. Awasis is in a position to assess problems in the family, suggest referrals, offer counselling, and arrange supports for the family. The agency has its own training structure.

Nursing Homes

Reserve nursing homes offer residential care for the elderly and sometimes day services for those living at home. As with any nursing home, they may help the elderly with psychiatric problems, with emotional difficulties, or with problems related to organic brain disorders such as Alzheimer's Disease.

Law Enforcement

Cross Lake and Norway House have RCMP detachments, and Nelson House is expecting a detachment to be located in that community soon. All three communities have band constables. Police are a part of the community mental health system because they may be the first responders to psychiatric emergencies such as a suicide attempt or a psychotic panic, and because under the provincial Mental Health Act police may be required to take people for psychiatric evaluation or treatment. Band constables do an extremely difficult job often with little to no training. Inservices on psychiatric emergencies, the Manitoba Mental Health Act, and on coping with the stress of their own jobs would be beneficial.

School Resources

- Teachers
- Principal
- School counsellor
- School social worker
- Teachers' aides
- School psychologist
- Stay in school program

Education of young people is a priority concern for First Nations (Ledger and Rodgers, 1979:16; First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak, 1985:6-7). Schools are important for education but they are also primary sites of intervention into young people's lives. Nelson House and Cross Lake bands have assumed responsibility for their own schools. The Frontier

School system operates three schools in Norway House. A principal in one community wishes there was help for the more extremely troubled children, and also a better referral system and access to child psychiatric specialists. Nelson House has (in 1994) a part-time school psychologist working with the staff and students. On other business, I was present in one community when a teenager attempted suicide. The school social worker (who was working with the youth) was immediately involved in planning support for other students and in plans to prevent other suicides from being triggered. (For more on 'cluster suicide,' see Bechtold, 1988 and Tower, 1989.)

Churches

Churches can be a framework to support individuals, families, and communities. In a general sense churches are important to healthy values and lifestyles. In more specific ways, churches offer counselling to individuals with emotional problems, to married couples in crisis, and to families coping with substance abuse or violence. The church is important in helping people to deal in healthy ways with the landmarks of life: birth, marriage, child rearing, aging, and death.

Band Council

Band councillors for health are responsible for seeking a community mandate on health, for planning community action, for finding the means for programs

(funding), and for coordinating band programs. This is a tall order. Health and education transfer of authority, and NFA negotiations have tended to take priority with community members, but health councillors are actively developing approaches to mental health services in their communities. Health councillors are elected to be leaders and must maintain a delicate balance between leadership initiative and following the wishes of the band membership.

Community Committees

- Resource networking group
- Crisis committee
- Community volunteers
- Wigwam meetings
- Committee run crisis line
- Social problems committee

Each community has active committees and volunteers working to solve community problems. Cross Lake has a Social Problems Committee (consisting in 1994 of Awasis, Family Violence Worker, RCMP, band councillors, elders, youth representative, general community representative, CHR, NNADAP) which conducted an assessment of the social problems facing Cross Lake and made recommendations for community actions. Community action committees change and evolve but the following are some examples: crisis committee, crisis line, resource networking group, Pimechikamak Iskwaywak Organization (women's group). In Nelson House, I was introduced to a group of people who gather to research and discuss ways of teaching and healing in the community (called Wigwam meetings).

In each community there is a core of people committed to helping their communities heal. I received mixed messages about community volunteer spirit. On the one hand, I met many people who volunteered on several official committees and/or who worked informally but intensely helping others in the community. On the other hand, I also heard complaints that the community value of coming together to help others was much weaker than it had been in the past. It may be that both of these perceptions are true.

Community Action

- Ayamiscikewikamik Public Library Information Resource Centre
- Community conferences on healing
- Community conferences on health related topics (ie, AIDS)
- Workshops by outside programs
- Community festivals and feasts to promote community ties
- Traditional camping trips for youth
- Traditional camping trips for families
- Treaty days festivities
- Children's activities with holidays
- Locally produced television and radio public education
- Public education workshops on lifeskills (parenting, budgeting, assertiveness training, stress management)

I can hardly do justice to the wide range of community activities in such a brief overview. Healing is a community responsibility, and the community is also the focus of healing. The many community activities are aimed at education, prevention, recovery, and the building of strong social networks to support individual and family health. For instance, Nelson House held the "Healing Our Community Conference" in July/94. This was a community camping event which included workshops (on fear

and shame, caring, sexual abuse, sexual abuse prevention, elders' teachings), sweat lodges, pow-wows, sharing circles, and entertainment (Nelson House, unpublished manuscript, 1992). The Ayamiscikewikamik Public Library Information Resource Centre in Norway House makes available video and audio equipment to assist community members in presenting awareness workshops on health and social issues. Cross Lake social services has sponsored healing programs (e.g., Flying On Your Own, Healing the Inner Child) in the community for workers and the general public.

Traditional Practises

- Sweat lodges
- Fasts
- Healing circles
- Traditional land-based activities
- Elder's council
- Drumming group for young boys
- Dream interpreters
- Traditional healers

Native traditional practises, beliefs, and teachings may be integrated into any or all of the community activities and helping resources mentioned. There is not a consensus among First Nations about which practices are traditional to each community, nor as to the value of those practises today. But it is probably fair to say that restoring positive cultural identity is important to the health of all First Nations; it is an essential part of the integrity called health. 'Traditional' approaches in the health and social services can mean many things, but in its largest sense it means utilizing local knowledge, skills, values, beliefs, and practises. The principles of the sharing

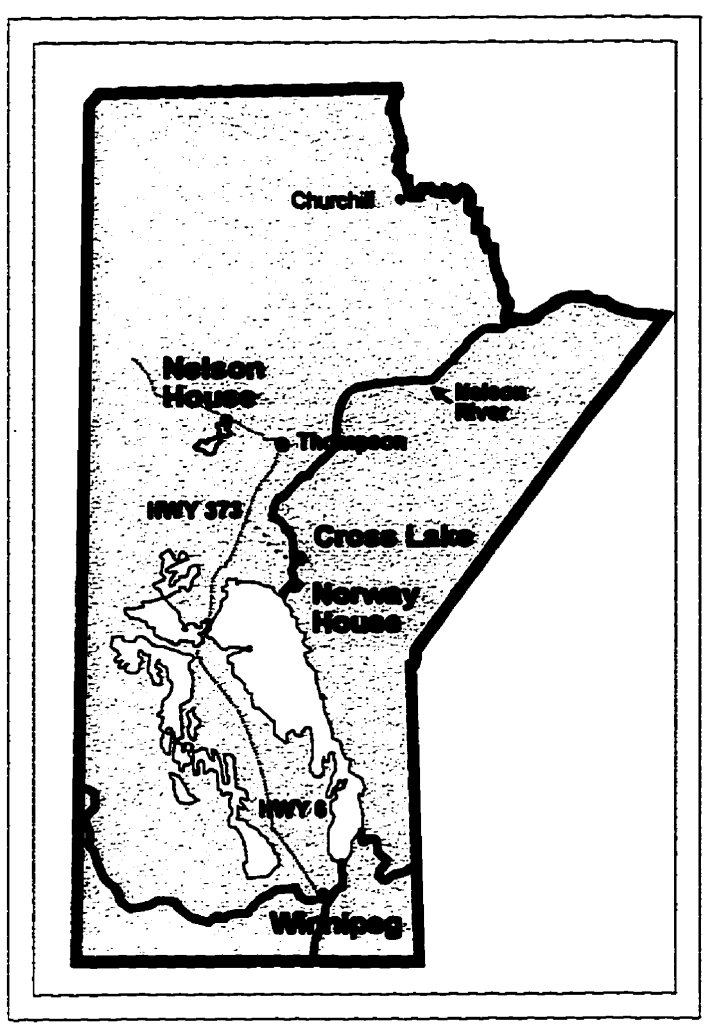
circle have been widely successful for helping individuals and communities to heal (Community Holistic Circle Healing at Hollow Water First Nation is an good example, Winnipeg Free Press, August 10, 1996:A6). Elder councils offer teachings and guidance to the community. Cross Lake held a camping trip for youths to learn native traditional land based activities and teachings from elders. Sweat lodges, fasting, and Sun Dances can offer spiritual strength. Some seek out traditional practitioners or dream interpreters for their problems.

This concludes my description of reserve community helping resources, although I have missed more than I have described. What is evident in this brief overview is that mental health is a community issue; it includes caring for and supporting all aspects of the community and all community members.

APPENDIX B:
COMMUNITY DESCRIPTIONS

All three of the communities in this research project are Cree reserve communities in Northern Manitoba, and all three are members of the Northern Flood Agreement (NFA). Map I shows the location of the three communities within Manitoba.

Map I Manitoba



What is a Reserve Community?

There are 61 reserve communities in Manitoba. They represent bands from the Cree, Ojibwa, Sioux, Dene and Ojibwa-Cree language groups. Reserve lands are those lands which the people's forebears were able to retain through treaties 1 (1871), 2 (1871), and 5a (1875) and 5b (1908-10) during the colonization of Manitoba by European peoples. Band membership in a reserve community means one is a treaty Indian and has status under Canada's Indian Act. Reserve communities often have neighbouring communities (often called metis communities) without reserve status. Reserve lands do not necessarily represent all the land which the bands are entitled to according to the treaties and so there remain unsettled land claims in Manitoba. The reserve communities also have land usage rights to crown land for the pursuit of hunting, trapping, and gathering, but there are disputes about the range and depth of these rights. Some of this crown land and reserve land have been seriously affected by hydroelectric development and, more recently, forestry projects (such as Repap Industries).

What is the Northern Flood Agreement?

The three communities in this research project are all part of the Northern Flood Agreement (NFA) which was negotiated (and is still being disputed) in an attempt to compensate (or some would say placate and silence) the NFA communities

for damages through Churchill/Nelson River Hydro Development Project. The NFA consists of 25 articles and 8 schedules jointly signed by the governments of Canada and Manitoba, Manitoba Hydro, and the Northern Flood Committee (Cross Lake, Nelson House, Norway House, Split Lake and York Landing). (South Indian Lake is also adversely affected but because it is not a reserve community their claims have been even more complicated.) The NFA, signed in 1977, sets out the terms by which the Bands are to receive compensation for the impacts of hydroelectric development upon their reserve lands, land-based economies and lifestyles (Waldram, 1988).

Norway House First Nation

Location

Norway House consists of a Cree reserve community and a non-treaty community on the east channel of the Nelson River approximately 29 kilometres north of where the Nelson River meets Lake Winnipeg. Norway House is 456 air kilometres north of Winnipeg and 190 air kilometres south of Thompson. There is an all-weather road (hwy # 373) from Norway House to Jenpeg and then on to hwy #6. Highway #373 is in poor condition and presents hazards from rocks emerging from the road bed and a badly gullied road surface.

Geography

Norway House is situated in boreal forest along the main river access to the north end of Lake Winnipeg. "The Norway House Reserve is located in the Canadian Shield, as a result, the reserve is interspersed with pockets of bedrock, muskeg, low wet overburden and uplands of shallow and moderately deep overburden.... The majority of areas which are capable of supporting development are already developed" (Hilderman et al, 1985).

Local History

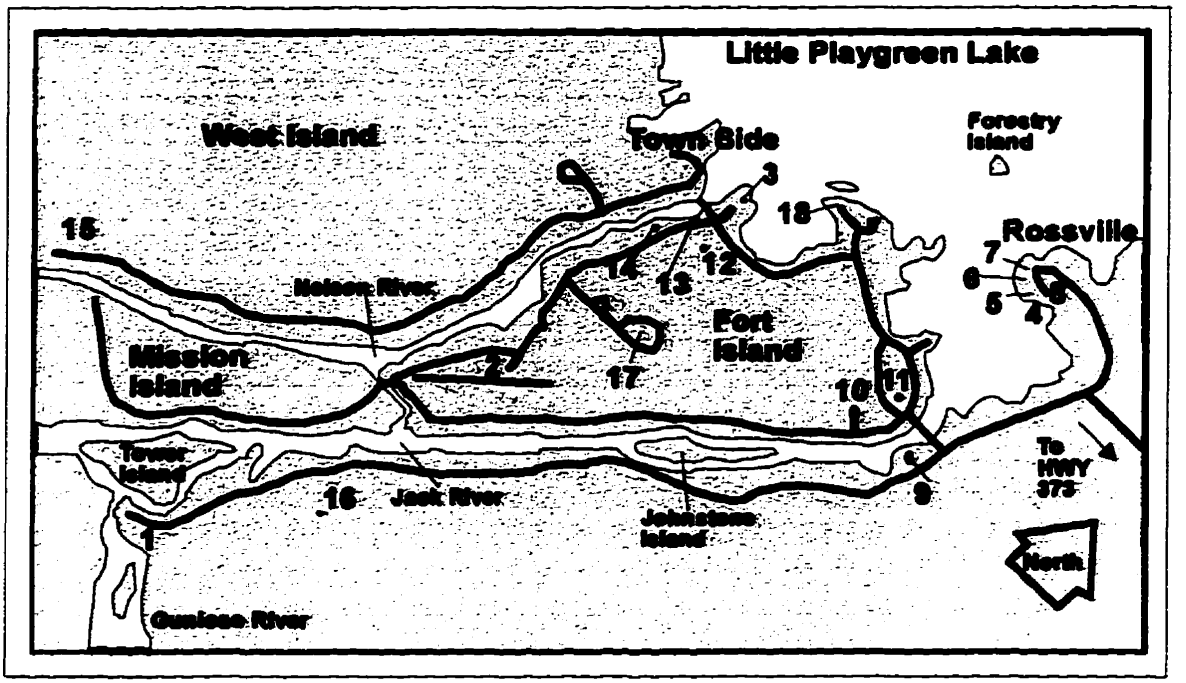
Norway House has a dominant place in the history of Manitoba and Canada. It was one of the original Hudson Bay Trading Posts and was once a major transportation node in trade between North America and Europe. Most Canadians have forgotten that Norway House had a central place in the economic activity and wealth of Canada. Visiting Norway House, you can see symbols of its past economic significance: a restored York Boat and the historic Hudson Bay warehouse. A monument at the original Hudson Bay site commemorates the Reverend James Evans who developed and introduced the Syllabic writing system throughout the North. The Northern Store (descendant of the Hudson Bay trading post) is still located at this historic spot (Rossville also has a Northern Store). Norway House was once the site

of a Methodist residential school (Miller, 1996:preface) and as well as a Roman Catholic residential school.

Town of Norway House

The metis community or 'town side' is located mainly on West Island and parts of Fort Island. The town of Norway House operates as a municipality with an elected mayor and town council under the jurisdiction of the Northern Affairs Act.
The town of Norway House (sometimes referred to as 'town side' or 'metis side') consists of approximately 200 housing units and a population of 507 (Manitoba Northern Affairs, 1993;105). The community shares some services with the reserve community such as schools, water sewer, and medical facilities. The community is served by a provincial social worker who lives in the community. For mental health services, the community members access the same resources as the reserve community (health care staff at the Norway House Hospital, the Selkirk Mental Health Centre) but coverage is under Manitoba Health Services and so extra costs for treatment are not generally covered (e.g., transportation to appointments or treatment in the South). At the time I visited, local residents volunteered on the Norway House Child Care Committee to assist families in crisis, to help children in trouble, and to find children temporary safe homes if necessary.

Map II Layout of Norway House First Nation



1 - Paupanekis Point
2 - Airstrip and Airport
3 - Norway House Hospital
4 - Pinaow Wachi, Nursing Home
5 - Radio Station
6 - Band Office
7 - U.C. Church Point
8 - Rossville School
9 - Cultural Centre
10 - High School
11 - Band Complex
12 - Arena
13 - The Bay Fort
14 - Community Council/Out reach
15 - Mowatt's Point
16 - Jack River School
17 - Lagoon
18 - RCMP

Layout of Norway House First Nation

The Norway House First Nation has a population of 4,739 (Indian and Northern Affairs, 1995). Rossville (which has the largest concentration of reserve housing) consists of 140 houses on 137 acres of land (Hilderman, 1985:22) Norway House is scattered over the mainland, Fort Island, Mission Island, Towers Island, West Island,

Paunpanekis Point, Rossville, and Jack River. Other identified areas include: Omand's Point, Forester's Island, and Johnstone (Horse Nose) Island. Although Rossville is set up in a grid pattern to be more economical, most people prefer isolated lots, large houses for extended families, locations near family, and access to the water (Hilderman, 1985:24). Reserve land suitable for development is scarce because of the rocky, marshy terrain.

Nelson House First Nation

Location

The Nelson House bands signed an adhesion to Treaty Five in 1908. The original settlement of Nelson House (at Three Point Lake) was flooded by the Churchill River Diversion (hydroelectric development) through the Rat River, and the settlement was moved to its present location on the north shore of Footprint Lake about 75 kilometres west of Thompson. Nelson House consists of two communities: the Nelson House First Nation Reserve (population 3,805 in 1993) (Indian and Northern Affairs, 1995); and the non-status community of Nelson House (population 78 in 1993) (Manitoba Northern Affairs, 1993:102).

Geography

The land around Nelson House is heavily forested, slightly rolling, and dotted with lakes and rivers. The flooding of the lakes has had a large impact on all aspects of the people's lives. The shoreline has been destroyed by flooding. There is no longer shore grasses for the ducks and geese to nest, which has greatly reduced hunting for food and as a pastime. Beaches for safe recreation are now gone. The water is full of dead heads making fishing difficult, and making boating and swimming dangerous.

Local History

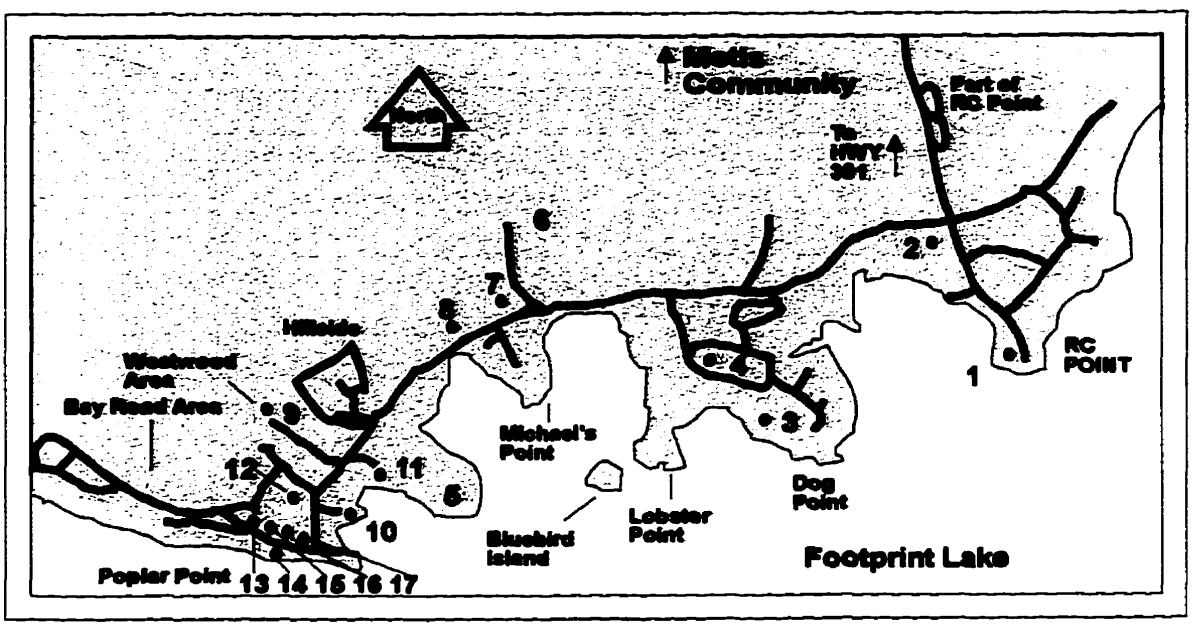
The original settlement of Nelson House grew around the church on Three Point lake, although people were settled at other points in the area also. There is one piece of local lore that seems to be an important part of how people see their history. When the missionaries came, an old man went around to the people gathering up all the pipes, drums, medicine bundles and material culture of the Cree beliefs. He took these items out into the forest to be hidden; today some people wonder if those items could still be recovered.

Town of Nelson House

There is a metis community with about 15 houses, only 10 of which are occupied. The members of this community used to live on the reserve at Three Point

Lake but established a separate community following adjustments to the Churchill River Diversion (Manitoba Northern Affairs, 1993:102). The lines between status-reserve and non-status-community residence are blurred. Residents use the school, nursing station, water and sewage facilities of the reserve community.

Map III Layout of Nelson House First Nation



1 - RC Church
2 - Store
3 - Community Gardens (one of several)
4 - Playground (one of several)
5 - Grave Yard
6 - Sewage Lagoon
7 - Wigwam
8 - Nelson House Forest Industries
9 - School
10 - Nursing Station
11 - Arena
12 - Restaurant
13 - Northern Store
14 - Development Corporation
15 - Awasis
16 - Band Office
17 - Band Police Station

Layout of Nelson House

Map III shows the physical layout of Nelson House. As well as being a smaller community, Nelson House is also more compact than either Norway House or Cross Lake. The community has recognizable sections, such as: RC Point, Bay Road Area, Hillside, as well as 'camps' along the highway.

Cross Lake First Nation

Location

Cross Lake is situated about 520 air kilometres north of Winnipeg and approximately 130 air kilometres south of Thompson upon the shores of the Nelson River and Cross Island. Cross Lake consists of two communities: the reserve community of the Cross Lake First Nation; and the adjacent non-reserve community of Cross Lake. The communities are situated 15 kilometres downstream from Manitoba Hydro's Jenpeg power dam and Lake Winnipeg control structure. Highway #373 provides access to Highway #6 as it does for Norway House.

Geography

Cross Lake is on beautiful lake shore and island surroundings with a causeway, a driving bridge and a foot bridge joining the sections of the community. There is

more soil cover and hence grass and meadow than its closest neighbour, Norway House, but Cross Lake still has the rock and marsh of Manitoba's north country. There is a sand beach within the community which was filled with children playing during my visit in the warmth of late June.

Local History

According to a local elder, Cross Lake, unlike most reserve communities, did not come to be settled at the convenience of white Canadians. People originally settled at Cross Lake to get away from the Hudson Bay Company and the influx of people moving up from further south. The elder told me that people chose Cross Lake because it had good fishing, hunting, trapping and grazing land for cattle. The Cross Lake band is a member of the NFA and continues to seek new reserve land within their traditional land use area as compensation for the impact of hydro development (Indian and Northern Affairs Canada, 1995:20). Cross Lake was once the site of a Roman Catholic residential school (Miller, 1996:preface).

Town of Cross Lake

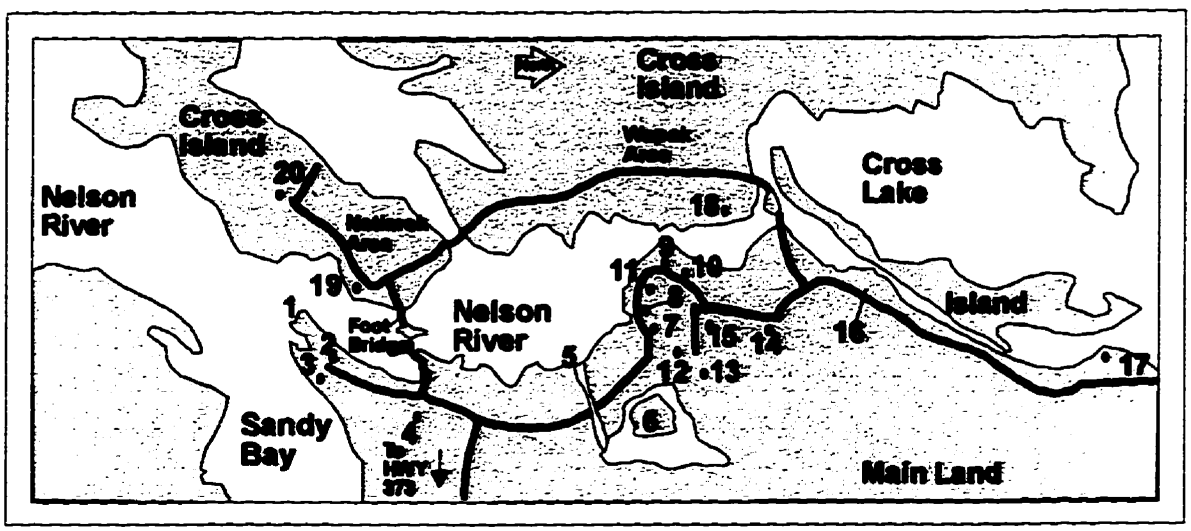
The town of Cross Lake is located on provincial crown land adjacent to the Cross Lake First Nation. As with the other communities I visited, some of the 'metis side' people have in fact regained their treaty status as a result of Bill C-31 (1985).

There were 401 people living in the community in 110 housing units; the community has a mayor and council, and its own school (D.R. Hamilton School of the Frontier School Division) which in 1993 had 119 nursery to grade 12 students (Manitoba Northern Affairs, 1993:39).

Layout of Cross Lake First Nation

In December 31, 1994 the Cross Lake band had an on-reserve population of 3,156, and another 1,454 band members living off-reserve (Indian and Northern Affairs Canada, 1995:20). The economic base of Cross Lake is considered to be trapping, hunting, and commercial fishing although there are real possibilities for mining development of titanium and vanadium deposits. Cross Lake has taken responsibility for education on the reserve through its own education authority. Recreation activities seemed to predominate in this community as evidenced by the number of people I saw out running, the numerous baseball games around town and other recreation activities such as swimming at the beach, fishing, hunting, arena activities, the playgrounds, and bingo. Cross Lake has an airport, local radio station, an eighteen bed nursing home, Awasis offices, a new band office housing the social service workers, and a Medical Services Branch nursing station.

Map IV Layout of Cross Lake First Nation



1 - Monias Point
2 - RC Mission
3 - Bus Depot
4 - Airport
5 - McLeod's Creek
6 - McLeod's Island
7 - IGA
8 - Northern Store
9 - Band Office
10 - TV and Radio Station
11 - RCMP
12 - Frontier School
13 - Arena
14 - Awasis
15 - Nursing Station
16 - Stanley Point
17 - BUNTEP
18 - Wapak Nursing Home
19 - Education Authority
20 - School

References Cited

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REFERENCES CITED

Aitken, Larry P., and Edwin W. Haller
1990 Two Cultures Meet: Pathways for American Indians to Medicine. Duluth: University of Minnesota.

Adelson, Naomi
1992 "Being Alive Well": Indigenous Belief as Opposition Among the Whapmagoostui Cree. Doctoral Thesis. Montreal: McGill University.

Anawak, Caroline, and Meryl Cook
1986 Keewatin Suicide Prevention and Intervention Study. Submitted to The Keewatin Regional Council, April.

American Psychiatric Association
1994 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). 4th edition. Washington DC.

Assembly of First Nations
1994 Breaking the Silence: A Study of Residential School Impact and Healing as Illustrated by the Stories of First Nations Individuals. Ottawa: First Nations Health Commission.

Bechtold, Donald W.
1988 "Cluster Suicide in American Indian Adolescents." American Indian and Alaska Native Mental Health Research 1(3) March. pp. 26-35.

Berry, J.W.
1985 "Acculturation Among Circumpolar Peoples: Implications for Health Status." Arctic Medical Research No. 40. pp. 21-27.

Brokenhead Indian Band Mental Health Steering Committee
1989 Native Self-Esteem. A Mental Health Program of the Brokenhead Indian Band Mental Health Steering Committee.

Campbell and Heinrich Research Associates
1990 Indian Mental Health: Services, Programs and Proposal in the Province of Manitoba. Submitted to the Medical Services Branch, Oct 5.

Campbell, Tom
1996 Public Lecture. Issues in the North 1996 Seminar Series. University of Manitoba.

Canadian Panel on Violence Against Women
1993 Changing the Landscape: Ending Violence - Achieving Equality. Ottawa: Minister of Supply and Services.

Cassidy, Frank
1991 Aboriginal Self-Determination: Proceedings of a Conference held September 30 - October 3, 1990. Winnipeg: The Institute for Research on Public Policy.

Clarkson, Linda, Vern Morriessette, and Gabriel Regallet
1992 Our Responsibility to the Seventh Generation: Indigenous People and Sustainable Development. Winnipeg: International Institute for Sustainable Development.

Charter, Ann
1996 Public Lecture. Issues in the North 1997 Seminar Series. University of Manitoba.

Coates, Kenneth, and Wm. R Morris
1993 "In Whose Best Interest? The Federal Government and the Native People of Yukon, 1946 - 199?." In Rebirth: Political, Economic, and Social Development in First Nations. Anne-Marie Mawhiney, ed. Toronto: Dundurn Press.

Cohen, Benita
1994 The Development of Health Services in Peguis First Nation: A Descriptive Case Study. Master Thesis, Department of Community Health Sciences. Winnipeg: University of Manitoba.

Cooper, M., R. Corrado et al
1992 "Aboriginal suicide in British Columbia: An overview." Canada's Mental Health. 40(3). pp. 19-23.

Davidson, Ben
1992 "What can be the relevance of the psychiatric nurse to the life of a person who is mentally ill?" Journal of Clinical Nursing 1. pp. 199-205. (The quote is taken from an email reproduction by Davidson on: psychiatric-nursing@mailbase.ac.uk September 26, 1995)

Dolan, Y
1991 Resolving Sexual Abuse: Solution-focussed Therapy and Ericksonian Hyponosis for Adult Survivors. New York: W.W. Norton.

Dow, James
1986 "Universal Aspects of Symbolic Healing: A Theoretical Synthesis." American Anthropologist Vol. 88 No. 1 March. pp. 56-69.

Engelstad, Diane and John Bird
1992 Nation to Nation: Aboriginal Sovereignty and the Future of Canada. Canada: Citizens for Public Justice.

First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak
1985 Indian Mental Health Research Formulation Final Report. copyright First Nations Confederacy.

Fiddler, Chief Thomas, and James R. Stevens
1985 Killing The Shaman. Waterloo, Canada: Penumbra Press.

Fox, J., D. Manitowabi, and J.A. Ward
1984 "An Indian community with a high suicide rate - 5 years after." Canadian Journal of Psychiatry 29. pp. 425-27

Gaines, Atwood D.
1992 "From DSM-I to III-R: Voices of Self, Mastery and the Other: A Cultural Constructivist Reading of U.S. Psychiatric Classification." Social Science and Medicine Vol. 35 No. 1. pp. 3-24.

Garro, Linda
1991 "Suicides by Status Indians in Manitoba." in Circumpolar Health 90: Proceedings of the 8th International Congress on Circumpolar Health. B.D. Postl et al. ed. Winnipeg: University of Manitoba Press. (quote taken from pre-publication manuscript).

Gfellner, B.M., and Hundleby J.D.
1992 "Family and peer predictors of substance abuse among aboriginal and non-aboriginal adolescents." Canadian Journal of Native Studies. 11(2). pp. 267-294.

Gottesman, Irving
1991 Schizophrenia Genesis: The Origins of Madness. New York: W. H. Freeman and Company.

Gregory, D.
1988 "An exploration of the contact between nurses and Indian elders/traditional healers on Indian reserves and health centres in Manitoba." in Health Care Issues in the Canadian North. D. Young ed. Edmonton: Boreal Institute of Northern Studies, University of Alberta. pp. 39-43.

Hagey, Rebecca
1984 "The Phenomenon, the Explanations and the Responses: Metaphors Surrounding Diabetes in Urban Canadian Indians." Social Science and Medicine Vol. 18 No. 3. pp. 265-272.

Hendrie, Hugh, K.S. Hall, N. Pillary, D. Rodgers, C. Prince, and J. Norton
1993 "Alzheimer's Disease is Rare in Cree." International Psychogeriatrics. Spring; 5(1). pp. 5-14.

Hilderman, Witty, Crosby, Hana & Associates
1985 Norway House Physical Development Plan. Unpublished manuscript prepared for the Norway House Band, Sept.

Indian and Northern Affairs Canada
1995 First Nations Community Profiles 1995 - Manitoba Region -. Ottawa: Minister of Indian and Northern Development.

Jenness, Diamond
1964 Eskimo Administration: II. Canada. Arctic Institute of North America Technical Paper No. 14.

Kahn, Marvin W., Linda Lejero, Marion Antone, Dorene Francisco, and Jerome Manuel.
1988 "An Indigenous Community Mental Health Service On the Tohono O'odham (Papago) Indian Reservation: Seventeen Years Later." American Journal of Community Psychology Vol. 16 No. 3. pp. 369-379.

Kapferer, Bruce
1983 A Celebration of Demons. Bloomington: Indiana University Press.

Kirmayer, Laurence
1993 Suicide in Canadian Aboriginal Populations: Emerging Trends in Research and Intervention. A Report Prepared for the Royal Commission on Aboriginal Affairs. McGill University: Division of Social and Transcultural Psychiatry, and Sir Mortimer B. Davis—Jewish General: Hospital Institute of Community and Family Psychiatry.

Krotz, Larry
1990 Indian Country: Inside Another Canada. Toronto Ontario: McClelland & Stewart Publishers.

LaRocque, Emma
1993 "Violence in Aboriginal Communities." In The Path to Healing. Royal Commission on Aboriginal Peoples, ed. Ottawa: Canada Communication group. pp. 72-89.

Ledger, J, and D.D. Rodgers
1979 Survey of Mental Health Needs of Manitoba Natives. unpublished manuscript, held in Northern Health Research Unit library, Community Health Sciences, University of Manitoba.

Lewis Herman, Judith
1992 Trauma and Recovery: The Aftermath of Violence - From Domestic Abuse to Political Terror. New York: Basic Books.

Mala, Theodore A.
1985 "Alaska Native 'Grass Roots' Movement: Problem Solving Utilizing Indigenous Values." Arctic Medical Research No. 40. pp. 84-91.

Mason, J.C., Thomas C, Hansen, and Julia Putnam
1982 "Paraprofessional Training of Indian and Alaska Native Mental Health Workers." White Cloud Journal of American Indian Mental Health Vol. 2 (4). pp. 3-7.

Medical Services Branch Steering Committee on Native Mental Health
1991 Statistical Profile on Native Mental Health. Report of the Statistical Data Working Group. Mental Health Advisory Services, Indian and Northern Health Services, Medical Services Branch.

Meketon, Melvin Jerry
1983 "Indian Mental Health: an Orientation." American Journal of Orthopsychiatry. 53(1) Jan. pp. 110-115.

Miller, Barry

1994a "The Northern Mental Health Outreach Project (NMHOP): Historical and Conceptual Background for a Demonstration Project in Northern Community Mental Health Outreach." Arctic Medical Research Vol.53: Suppl. 2. pp. 467-473.

1994b "The Northern Mental Health Outreach Project (NMHOP): Descriptive Anatomy and Operation." Arctic Medical Research Vol.53: Suppl. 2. pp. 474-479.

Miller, J.R.

1996 Shingwauk's Vision: A History of Native Residential Schools. Toronto: University of Toronto Press.

Mussell, W.J., W.M. Nicholls and M.T. Adler

1991 Making Meaning of Mental Health Challenges in First Nations: A Freirean Perspective. Chilliwack: Saltshan Institute Society.

The National Native Association of Treatment Directors, The Nechi Institute, The Four Winds Development Project, The Native Training Institute, and New Direction Training - Alkali Lake

1988 Healing is Possible: A Joint Statement on the Healing of Sexual Abuse in Native Communities. (Publisher unknown)

Native Women's Transition Centre Inc.

1990 Native Women's Transition Centre Inc. "Native Women's Healing Circle". Report #38. Winnipeg, Manitoba.

Nelson House

1992 Nelson House First Nations Community Health Plan Draft. Unpublished manuscript.

Norway House

1990 Norway House Indian Hospital, Norway House Manitoba. Unpublished manuscript, current to March 1990.

O'Neil, John

1993 "Aboriginal Health Policy for the Next Century." In The Path to Healing. Royal Commission on Aboriginal Peoples, ed. Ottawa: Canada Communication group. pp. 27-48

1990 "The Politics of Obstetric Care: The Inuit Experience." In Births and Power: Social Change and the Politics of Reproduction. W. Penn Handwerd, ed. Westview Press. pp. 3-27.

1986 "The Politics of Health in the Fourth World: A Northern Canadian Example." Human Organization Journal of the Society for Applied Anthropology Vol. 45, summer. pp. 119-128.

1984 "Observations on the 'Medicalization' of Inuit Social Life." In Circumpolar Health 84. Proceeding of the Sixth International Symposium on Circumpolar Health. Robert Fortune, ed. Seattle: University of Washington Press. pp. 419-422.

Ontario Native Women's Association
1989 Breaking Free: A Proposal for Change to Aboriginal Family Violence. Thunder Bay, Ontario: Public Inquiry into the Administration of Justice and Aboriginal People Library Collection.

Pettipas, Katherine
1994 Severing the Ties that Bind: Government Repression of Indigenous Religious Ceremonies on the Prairies. Winnipeg: University of Manitoba Press.

Rodgers, D.D., and N. Abas
1988 "A Survey of Native Mental Health Needs in Manitoba." Arctic Medical Research, Vol. 47: Suppl. 1. pp. 576-580.

Rogers, J., S.J.J. Freeman, J. Cochrane, and P. Goering
1994 "The Northern Mental Health Outreach Project: Evaluation Results, Issues and Recommendations." Arctic Medical Research Vol. 53: Suppl. 2. pp. 483-490.

Sawchuk, Joe
1993 "Anthropology and Canadian Native Political Organizations: Past and Future Trends." In Anthropology, Public Policy, and Native Peoples in Canada. Noel Dyck and James Waldram, ed. Montreal: McGill-Queen's University Press. pp. 271-292.

Scheper-Hughes, Nancy
1992 Death Without Weeping: The Violence of Everyday Life in Brazil. Berkeley: University of California Press.

Schultz, Emily A., and Robert H. Lavenda
1990 Cultural Anthropology: A Perspective on the Human Condition. 2nd. ed. St. Paul: West Publishing Company.

Scott, K.A.
1993 "Funding Policy for Indigenous Human Services" In The Path to Healing. The Royal Commission on Aboriginal Peoples, ed. Ottawa: Canada Communication group. pp. 90-108.

Seidel, Jon V., Rolf Kjolseth and Elaine Seymour
1988 The Ethnograph. Computer softwear. Corvallis: Qualis Research Associates.

Shestowsky, Brenda
1993 Traditional Medicine and Primary Health Care Among Canadian Aboriginal People: A Discussion Paper with Annotated Bibliography. Prepared for the Indian and Inuit Nurses of Canada 1991-1992. Ottawa: Aboriginal Nurses Association of Canada.

Shkilnyk, Anastasia, M.
1985 A Poison Stronger Than Love. London: Yale University Press.

Silman, Janet (as told to)
1987 Enough is Enough: Aboriginal Women Speak Out. Toronto: The Women's Press.

Smith, Dan
1993 The Seventh Fire. The Struggle for Aboriginal Government. Toronto:Key Porter Books Ltd.

Smith, John
1996 Personal communication. Director of Nursing, Thompson General Hospital. November.

Timpson, Joyce et al
1988 "Depression in a Native Canadian in Northwestern Ontario: Sadness, grief or spiritual illness?" Canada's Mental Health, June/September. pp. 5-8.

Tower, Margene
1989 "A Suicide Epidemic in an American Indian Community." American Indian and Alaska Native Mental Health Research, 3(1), Summer. pp. 34-44.

Vizenor, Gerald
1984 The People Named the Chippewa: Narrative Stories. Minnesapolis:University of Minnesota.

Waldram, James B.
1988 As Long as the Rivers Run: Hydroelectric Development and Native Communities in Western Canada. Winnipeg: University of Manitoba Press.

Waldram, James B., D. Ann Herring, and T. Kue Young
1995 Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives. Toronto: University of Toronto Press.

Waldram, James B.
1990 "The Persistence of Traditional Medicine in Urban Areas: The Case of Canada's Indians." American Indian and Alaska Native Mental Health Research Vol. 4, No. 1 Fall. pp.9-29.

Wakegijig, Chief Ron, Alan W. Roy, Carrie Hayward
1988 "Traditional Medicine: An Anishinabek Nation Perspective." Environments Vol. 19, No. 3. pp. 122-124.

Young, David, and Leonard L. Smith
1993 The Involvement of Canadian Native Communities in Their Health Care Programs: A Review of the Literature Since 1970's. Edmonton: University of Alberta Northern Reference Series No.2.

Young, T. Kue, Linda Bruce, John Elias, John D. O'Neil, and Annalee Yassi
1991 The Health Effects of Housing and Community Infrastructure on Canadian Indian Reserves. Northern Health Research Unit, Department of Community Health Sciences, The University of Manitoba, under contract for Quantitative Analysis and Socio-demographic Research, Finance and Professional Services, Indian and Northern Affairs Canada.

Young, T. Kue
1988 Health Care and Cultural Change: The Indian Experience in the Central Subarctic. Toronto: University of Toronto Press.

Zola, Irving Kenneth
1986 "Medicine as an Institution of Social Control." In The Sociology of Health and Illness: Critical Perspectives. 2nd edition. Peter Conrad and Rochelle Kern, ed. New York: St. Martin's Press. pp. 379-390.