Mentally Healthy Communities: Aboriginal Perspectives

Canadian Population Health Initiative

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Canadian Institute for Health Information
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6

Phone: 613-241-7860
Fax: 613-241-8120
www.cihi.ca

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About the Canadian Population Health Initiative

The Canadian Population Health Initiative (CPHI), a part of the Canadian Institute for Health Information (CIHI), was created in 1999. CPHI's mission is twofold:

- To foster a better understanding of factors that affect the health of individuals and communities; and
- To contribute to the development of policies that reduce inequities and improve the health and well-being of Canadians.

As a key actor in population health, CPHI:

- Provides analysis of Canadian and international population health evidence to inform policies that improve the health of Canadians;
- Commissions research and builds research partnerships to enhance understanding of research findings and to promote analysis of strategies that improve population health;
- Synthesizes evidence about policy experiences, analyzes evidence on the effectiveness of policy initiatives and develops policy options;
- Works to improve public knowledge and understanding of the determinants that affect individual and community health and well-being; and
- Works within CIHI to contribute to improvements in Canada's health system and the health of Canadians.

About the Canadian Institute for Health Information

The Canadian Institute for Health Information (CIHI) collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

Introduction

The purpose of the current collection of papers is to promote dialogue on what may contribute to mentally healthy communities, with a focus on Aboriginal Peoples' perspectives, recognizing the diversity of First Nations, Inuit and Métis groups. With the present set of papers, the Canadian Population Health Initiative (CPHI) continues to build on the momentum generated by its 2008 publication, *Mentally Healthy Communities: A Collection of Papers*.[1] The current compilation offers an additional cross-section of perspectives. Many other viewpoints exist, and it is anticipated that these collections will inspire ongoing dialogue. This work reflects CPHI's ongoing commitment to fostering a better understanding of the factors that may affect the health of individuals and communities.[2]

CPHI commissioned the six papers that form the current collection from individuals whose work relates to Aboriginal mental health through their involvement in the domains of research, clinical practice, and program and policy development.[i] In order to provide context for the respective contributions, the authors were asked to address the following questions:

- What are mentally healthy communities?
- What makes some communities more mentally healthy or resilient than others?

The resulting contributions incorporate research, reflection and opinion. In his contribution, **Rod McCormick** describes an Aboriginal "worldview" and Aboriginal teachings and values as they relate to mental health. Dr. McCormick is an associate professor of counselling psychology at the University of British Columbia and is a member of the Mohawk Nation (Kanienkehake). He is also a senior Aboriginal mental health researcher, clinician and consultant.

The second paper in the collection was co-authored by four employees of Health Canada, **Rolina van Gaalen**, **Dr. Patricia Wiebe**, **Kathy Langlois** and **Eric Costen**. Van Gaalen and colleagues explore the concept of mental wellness and describe recent Canadian efforts toward developing mental health care services that are culturally appropriate for Aboriginal communities. In the third paper, **Patricia June Vickers** explores the subject of ancestral law. Dr. Vickers is a consultant whose emphasis is on facilitating positive change in First Nations communities.

i. The views expressed in this report do not necessarily represent the views of the Canadian Population Health Initiative or the Canadian Institute for Health Information.

Dr. Charles Brasfield describes characteristics of communities that are relevant to community mental health, based on his experience as a psychiatrist and psychologist who has provided mental health services to First Nations communities in British Columbia. **Jonathan Dewar** is Director of Research at the Aboriginal Healing Foundation. His contribution explores issues related to the diversity of Aboriginal Peoples. In the final paper, **Christopher Lalonde** examines the links between individual and community mental health in First Nations communities. Dr. Lalonde is an associate professor of psychology and Co-Director of the Centre for Aboriginal Health Research at the University of Victoria.

As noted above, fostering a better understanding of factors that affect the health of individuals and communities is a fundamental part of CPHI's mandate and is essential to its knowledge generation and knowledge synthesis functions. This collection complements CPHI's work in one of its key theme areas for 2007 to 2012: determinants of mental health and resilience.[2] It is our hope that this collection will inspire discussion and ongoing dialogue.

We welcome your feedback on this collection of papers. Please forward your thoughts and comments to cphi@cihi.ca.

We sincerely thank the authors for their respective contributions to this project.

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All My Relations

Rod M. McCormick
Department of Educational and Counselling Psychology
University of British Columbia

Rod McCormick is an associate professor of counselling psychology at the University of British Columbia and is a member of the Mohawk Nation (Kanienkehake). He is also a senior Aboriginal mental health researcher, clinician and consultant.

The definition of community for Aboriginal Peoples is complex and necessarily different than that of non-Aboriginal Canadians for socio-political and historical reasons. According to the 2006 census there were approximately 1.2 million Aboriginal Peoples in Canada. More than half (nearly 700,000) reported their Aboriginal identity as First Nations, with the remainder reporting Inuit, Métis or multiple Aboriginal identities.[1] Roughly 40% of the First Nations people live in 603 communities which are also called reserves. There are 53 Inuit communities in Canada and more than 100 Métis councils. For the First Nations people, many of their communities are individual nations with their own set of languages and cultural practices. This illustrates a small portion of why it is problematic to attempt to generalize for Aboriginal communities. This brief paper will instead endeavour to broadly illustrate a few perspectives on what may contribute to mentally healthy Aboriginal communities based on the research literature and on the author's own clinical experience with these communities.

The expression "all my relations" stated in the title of this paper in many ways encompasses an Aboriginal worldview and a pan-Aboriginal definition of interconnectedness that we as Aboriginal Peoples have with family, community, nation and creation. It is a clear declaration that we are all in relationship with one another in this world. In using an example of this teaching from my own culture (Haudenosaunee, also known as the Iroquois Confederacy and the people of the longhouse), the proper way to open any gathering is to recite a thanksgiving address in which our world is thanked as relatives. Those relatives may include mother earth, sky father, grandmother moon and our brothers and sisters in the plant and animal regions. "All my relations" also encompasses the spirit people—those who came before us and those not yet born. It is an affirmation of our interconnectedness to all of creation.

The Haudenosaunee, like most other Aboriginal Peoples, also have traditional values and teachings that provide guidance on how people should live together in a good way. Examples of those values are:

> To plan for future generations; to use consensual decision making; to have a strong sense of duty to family, clan, nation, confederacy and creation; to have a sense of strong self worth without egotism; the need to be very observant of your surroundings, the belief that everyone is equal and a full partner in the community no matter what their age; the belief that everyone has a special gift or talent that can be used to benefit the larger community.[2]

Amicable relations with settler societies were maintained through treaties known as the Kas-wen-tha or "two-row wampum belt" that asserted the respect, dignity and integrity of each culture and the importance of non-interference unless invited.[3] These Aboriginal ways of governance and how to live together in a good way had a significant influence on the development of North American democracy, federalism and the constitution of the settler society later known as the United States of America.[4]

Over the past six centuries Aboriginal communities have learned to become resilient. Historical records indicate that the policies and practices of colonization and assimilation used by the Canadian government were strategically designed to eradicate Aboriginal culture.[5, 6] A practice used in the process of colonization known as residential schools was only recently acknowledged as very wrong and apologized for by the current prime minister of Canada.[7] The impacts of colonization on Aboriginal Peoples have been well articulated in descriptions such as historical trauma, unresolved historical grief and intergenerational post-traumatic stress disorder.[8, 9]

Given the Aboriginal holistic view of community and the philosophy of "all my relations," it is not surprising that what promotes resilience in Aboriginal communities originates outside of the individual, that is, in family, community, society, culture and nature.[10] Aboriginal resilience clearly has a collective aspect combining spirituality, family strength, elders, ceremonial ritual, oral traditions, identity and support.[11] There are many definitions of resilience and not all of them fit for Aboriginal Peoples. One definition of resilience that comes close describes resilience by means of a relational rather than a linear worldview.[12] A relational worldview takes in the mental, physical, emotional and spiritual dimensions as well as the interconnected nature of humans. The "elastic band" model of resilience has also been challenged by the idea of resilient reintegration, in which a resilient response may not only restore the individual to some previous equilibrium but actually result in new insight and growth.[13]

In the author's own research on Aboriginal mental health, there is a re-occurring pattern of what facilitates healing within Aboriginal individuals and communities. That which is healing for Aboriginal Peoples seems to lead to one or more of five outcomes of healing.[14] Those five outcomes or factors are balance, belonging or connectedness, cleansing, empowerment and discipline. Balance as defined by Aboriginal teachings such as the medicine wheel is attained and maintained through a balance between the four dimensions of the self: mental, physical, emotional and spiritual. Belonging or connectedness is to attain or maintain connection with sources of meaning and guidance beyond the self, such as family, community, culture, nation, the natural world and the spiritual world. Cleansing is to identify and express emotions in a good way. Empowerment is to attain and maintain mental, physical, emotional and spiritual strength. Discipline is the traditional teaching that enables us to accept responsibility for our actions. Traditionally, discipline was taught through ceremony.

In one of the Aboriginal health research networks I have had the pleasure of leading, the British Columbia Aboriginal Capacity and Developmental Research Environments, my colleagues and I adopted a variation of the four Rs of Aboriginal education[15] versus the three Rs associated with classic western education: reading, writing and arithmetic. In the present paper, I propose that a different version of the three Rs—respect, reciprocity and responsibility—can be used to roughly describe the main teachings for attaining and maintaining mental health in Aboriginal communities. These three Rs are traditional teachings/values found in most if not all Aboriginal cultures. Respect means that we acknowledge and appreciate differences between us such as culture, personality and language. This is the basis of most Aboriginal teachings on how to co-exist, for example, as represented by the two-row wampum belt. Reciprocity means to give back and to share knowledge and wealth. This is also a traditional value of most Aboriginal cultures. Responsibility means many things, including the ability to respond to challenges, which has also been described as the ability to be "response-able." Becoming response-able is both a goal and a challenge for many Aboriginal individuals, families, communities and nations. As a result of the legal relationship Aboriginal Peoples have with the Government of Canada, the federal government has some responsibility in assisting in the restoration of the mental health of Aboriginal communities. Recently, the Government of Canada launched a Truth and Reconciliation Commission to address the legacy of the Indian residential schools.[16] Aboriginal individuals and communities hope that as part of reconciliation the Canadian government will assist Aboriginal communities to develop healing processes to address the legacy of sexual abuse cases that originated from the abuses suffered in the residential schools. Such efforts that go beyond bringing residential school survivor stories out in the open may contribute to Aboriginal community mental health.[17]

To become response-able many Aboriginal communities face an uphill battle because of their respective histories of trauma, oppression and disempowerment.[18] As Aboriginal individuals and communities, we are on a healing journey of community empowerment, engagement, ownership and self-determination.[19] The journey towards becoming a mentally healthy community is a difficult journey for Aboriginal communities, but it is one that we do not travel alone. Accompanying us on this journey are mother earth, sky father, grandmother moon, our brothers and sisters in the plant and animal regions and those who came before us and those not yet born.

All my relations.

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Reflections on Mental Wellness in First Nations and Inuit Communities

Rolina P. van Gaalen, Patricia K. Wiebe, Kathy Langlois and Eric Costen

We are non-Aboriginal employees of Health Canada. As such, we make no claim of writing from an Aboriginal perspective. In keeping with Health Canada's mandate, we work primarily in partnership with First Nations and Inuit communities. (The text box below provides further information.) The opinions expressed in this article are our own, as developed through this collaborative work. With this article, we hope to contribute to a dialogue on how best to facilitate the conditions necessary for communities to define and foster their own wellness.

Respecting and Valuing Diverse and Distinct Perspectives of Mental Wellness

Canada's *Constitution Act* (1982) recognizes three groups of Aboriginal Peoples: Indians (or First Nations), Inuit and Métis. These are three separate peoples with unique cultures, languages, and political and spiritual traditions.

- First Nations include those registered under Canada's *Indian Act*. First Nations are a diverse group of approximately 765,000 citizens living in 603 First Nations communities, as well as rural and urban areas.[1]
- Inuit are the Aboriginal People who inhabit Arctic Canada. There are approximately 45,000 Inuit living in the 53 Arctic communities in four geographic regions: Nunatsiavut (Labrador); Nunavik (Quebec); Nunavut; and the Inuvialuit Settlement Region of the Northwest Territories.[2]
- Métis are persons of mixed Aboriginal and European ancestry who identify themselves as Métis.

Health services are provided to all Canadian citizens by their respective provincial or territorial government; however, Canada's *Constitution Act* (1867) charges Canada's federal government with responsibility for Indians and Inuit, and this responsibility has included the provision of specific health services.

Adapted with permission from K. Langlois, "First Nations and Inuit Mental Wellness Strategic Action Plan," International Journal of Leadership in Public Services *4, 1 (2008): pp. 7–12.*

In 2006, more than one million Canadians, or 3.8% of the total population, identified themselves as Aboriginal persons.[3] The majority of Aboriginal persons (60%) identified as First Nations people, 33% as Métis and 4% as Inuit.[3] Considerable diversity exists both among and within these three groups in terms of demographics, languages spoken, regional representation, urban and rural concentrations and, in the case of First Nations people, on- or off-reserve residency.[3] Add to this variations in historical and current social, economic and jurisdictional contexts, and it is clear that we should not presume that all Aboriginal individuals, families and communities find meaning in their Aboriginal identities in the same way or to the same degree, or that there is such a thing as a uniform Aboriginal perspective on any one particular issue, including mental wellness.

Yet, it is also clear that there are views, beliefs and guiding principles—rooted in traditional cultures and continuing to evolve—that many First Nations and Inuit individuals, families and communities share. Many First Nations and Inuit partners have taught us that the concepts of balance and holism are central to their understanding of mental wellness.

According to this understanding, balance of the four dimensions of life—the physical, mental, spiritual and emotional—is generally viewed as the basis of wellness. Holism refers to "awareness of and sensitivity to the interconnectedness of all things: of people and nature; of people, their kin and communities; and within each person, the interconnectedness of body, mind, heart and spirit."[4] The fundamental concept of the inherent interconnectedness of individuals, families and communities implies that individual, family and community wellness must also be understood as essentially interwoven.

We have also been taught that for many First Nations individuals, families and communities, the medicine wheel—variations of which exist in different traditions—symbolizes the cyclical nature of change and transformation and the interconnectedness of all beings and things. This conceptualization helps to understand human development as following four sequential life cycles associated with specific developmental tasks, including learning of belonging; learning new skills and behaviours; service for the benefit of family, community and nation; and the giving away of wisdom. Traditional healing practices focus on restoring balance where this has been lost due to disruption of developmental tasks during one of these life cycles.[i]

Nomadic peoples until just a few generations ago, many Inuit view mental wellness as closely linked to one's relationship to the land and animals. In the words of Inuit elder Mariano Aupilaarjuk, "The living person and the land are actually tied up together because without one the other doesn't survive and vice versa . . . The land is so important for us to survive and live on; that's why we treat it as part of ourselves."[5]

In the course of working with First Nations and Inuit partners, we have had the privilege of learning about the importance of taking a strengths-based approach to mental wellness. Wellness is understood not only as the absence of illness, but also as a positive expression of well-being and strength that may be in evidence in individuals, families and communities, and in the relations among them. A powerful illustration of this is provided by Inuit, who know World Suicide Prevention Day as Embrace Life Day in Nunavut, Celebrate Life Day in Nunatsiavut and Live Life Day in Nunavik.[6] The holistic perspective furthermore recognizes the reciprocal relationship between mental wellness and wellness in a broader sense.

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i. While these basic descriptions of the concepts of balance, holism and the medicine wheel serve our purpose of illustrating some common traits of many Aboriginal worldviews, they should be recognized as highly simplified. For more detailed descriptions of these and related concepts, including a variety of holistic healing models, see the Aboriginal Healing Foundation's *Reclaiming Connections: Understanding Residential School Trauma Among Aboriginal People—A Resource Manual*, prepared by D. Chansonneuve (Ottawa, 2005).

We therefore may consider "an Aboriginal perspective" to signify that an individual, family or community may perceive some of these holistic concepts as fundamentally important to all aspects of life, including mental wellness. We also recognize, however, that Canada's First Nations and Inuit populations are highly diverse and we are committed in our work to respecting the full range of worldviews among individuals, families and communities.

Fostering Culturally Safe Approaches to Mental Wellness

In recent years, experts in this country have called for an increase in the availability of mental health care and substance abuse treatment programs that are culturally appropriate and safe for Aboriginal communities.[4, 7–9]

In Canada, the National Aboriginal Health Organization provides the following description of cultural safety:

> Cultural safety within an Indigenous context means that the educator/practitioner/professional, whether Indigenous or not, can communicate competently with a patient in that patient's social, political, linguistic, economic, and spiritual realm . . . Cultural safety requires that health care providers be respectful of nationality, culture, age, sex, political and religious beliefs, and sexual orientation . . . Cultural safety involves recognizing the health care provider as bringing his or her own culture and attitudes to the relationship.[8]

The concept of cultural safety (see text box) can help guide policies and practices in this direction. It originated in New Zealand during the 1980s in response to the Maori people's dissatisfaction with nursing services.[8] In the context of First Nations and Inuit communities in Canada, culturally safe services explicitly recognize, for example, the interconnectedness of physical, mental, spiritual and emotional needs, and the interconnectedness of individuals with their family and community.

Recognizing Historical Injustices and Contributing to Reconciliation

The past several centuries of Aboriginal history in Canada have witnessed severe disruption of traditional social structures, relationships, customs, value systems and languages.[10] The history of colonialism continues today to test the resilience of First Nations and Inuit individuals, families and communities.

For instance, the Canadian government's Indian residential school policy in many cases implied a forced separation of children from their families and communities. In a deliberate effort to force assimilation, children were forbidden to speak their own languages and engage in cultural practices. Although some former students have positive memories of the schools, many suffered neglect and abuse, including physical and sexual abuse. For much of the year, communities were left depleted of school-aged children, some of whom never returned.

In June 2008, Prime Minister Stephen Harper stood in the House of Commons and apologized to former Indian residential school students on behalf of the Government of Canada and all Canadians. In the words of the prime minister, "The government now recognizes that the consequences of the Indian residential schools policy were profoundly negative and that this policy has had a lasting and damaging impact on Aboriginal culture, heritage and language . . . The legacy of Indian residential schools has contributed to social problems that continue to exist in many communities today."[11]

The creation of Canada's Truth and Reconciliation Commission,[12] also in 2008, signifies the opportunity and imperative for the Canadian population at large to listen with an open mind, reflect, learn and engage in dialogue in the process of documenting this "sad chapter"[11] of our country's history, in order to foster reconciliation, toward introducing a new era of collaboration.

Acting on Evidence of Social Determinants of Health

Because of the interconnectedness of individuals and families with their communities, some elements of wellness can only be understood at the collective level. For example, research that focuses on the community as the unit of analysis involving First Nations youth in British Columbia shows a correlation between cultural continuity within communities and decreased risk of suicide. Practices aimed at preserving heritage culture and/or enhancing community control—such as land claims and control over health and other local services—were found to be associated with reduced youth suicide rates.[13] This research recognizes that suicide rates vary considerably among First Nations communities, with suicide essentially unknown in some communities. It highlights that First Nations communities represent a rich resource of effective mental wellness strategies that—by means of lateral community-to-community knowledge transfer—could benefit other Aboriginal as well as non-Aboriginal communities.[14]

A contemporary social science research stream focusing on determinants of health would appear highly compatible with an Aboriginal approach to knowledge. It offers an analytical framework that takes a broad, holistic approach to the analysis of social, economic, political, environmental and other factors that have an impact on mental health and community wellness. Numerous conditions have been demonstrated to negatively affect the health status of Aboriginal Peoples in Canada. These include (but are not limited to) access to quality education, employment opportunities, health practices, social stratification, social support networks, gender roles and relations, housing and crowded living conditions, exposure to environmental contaminants and hazards, and nutrition.[7, 15, 16] At an international level, Health Canada works with a number of governmental and non-governmental organizations in the area of First Nations and Inuit community wellness. For example, the department collaborates with the World Health Organization and the Pan American Health Organization to improve our understanding of determinants of health and policies and practices that support individual and community wellness.

A contribution to this field, aimed at inserting a historical perspective into the analysis of determinants of health, posits that post-traumatic stress resulting from loss of culture and historical and intergenerational trauma is an important determinant of health disparities between Aboriginal and non-Aboriginal Peoples. Implicit in this model is that mental health is a prerequisite to wellness in general, and that healing requires a holistic health care delivery model.[17]

Supporting Community Development and Control: Process as Product

Today, we have the opportunity to facilitate change that will help us move our collective history in a new direction by collaborating closely with First Nations and Inuit partners and ensuring that our work reflects the values and practices of Aboriginal individuals, families and communities. When working with First Nations and Inuit, process is product:[18] in other words, the process of engagement becomes an integral part of the ultimate product of that engagement. Including individuals, families, communities and organizations in the process of facilitating improved health outcomes itself engenders improved health outcomes.

In 2005, Health Canada established the First Nations and Inuit Mental Wellness Advisory Committee (MWAC), co-chaired with the Assembly of First Nations and Inuit Tapiriit Kanatami, and composed of federal, provincial and territorial representatives and non-governmental, First Nations and Inuit experts in mental health and addictions. MWAC developed a Strategic Action Plan to improve mental wellness outcomes for First Nations and Inuit focused on five priorities (see text box). Health Canada and its partners are translating these objectives into action, including by exploring new approaches to community-driven, culturally safe programs and services for individuals, families and communities. Initiatives will reflect the growing role culture is playing in health programming and will strive to maximize community engagement, build on existing community strengths and support continued capacity-building.

Other governmental and non-governmental organizations are also moving towards greater emphasis on collaboration and facilitation in fostering opportunities for community self-empowerment. A major step in support of First Nations control of health services was taken with the signing in 2007 of the British Columbia Tripartite Health Plan. This agreement between the First Nations Leadership Council, the Province of British Columbia and the Government of Canada reflects a shared vision of collaboration in the development and implementation of health programs and service delivery. A central element of the plan is the creation of a new governance structure that will enhance First Nations' control and improve integration of health services.[20]

The five priorities identified by MWAC are as follows: 1) ensure a continuum of services for and by First Nations and Inuit that includes traditional, cultural and mainstream approaches; 2) enhance traditional and mainstream knowledge development and sharing; 3) support community development; 4) enhance the knowledge, skills and recruitment and retention of mental wellness and allied human resources to provide effective and culturally safe services and supports; and 5) clarify and strengthen collaborative relationships between mental health, addictions and related human services and between federal-, provincial-, territorial- and First Nations- and Inuit-delivered services.[19]

Conclusion

Having evolved over a period spanning thousands of years, First Nations and Inuit approaches to knowledge, wellness and healing have been impacted significantly over the last several centuries. Nevertheless, fundamental concepts that provided a cohesive worldview survived in many First Nations and Inuit communities and are actively being restored in others. Aboriginal populations in this country have always been and continue to be diverse, and individuals, families and communities find meaning in their traditional culture to varying degrees and in varying ways. This tells us that health services developed, implemented and evaluated in partnership with First Nations and Inuit communities must reflect a range of perspectives.

We believe that healing and, specifically, understanding how history has disrupted harmony within individuals, families and communities is fundamental for wellness and a key consideration for health policy-makers. In addition, strengths-based family and community development and success in addressing a wide range of determinants of health offer great potential for fostering wellness, including mental wellness, within First Nations and Inuit communities.

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Ancestral Law and Community Mental Health

Patricia June Vickers, PhD

Patricia June Vickers is an ethno-consultant with more than 20 years of professional experience in the areas of education, mental health, conflict resolution and capacity-building. Her emphasis is on the integration of ancestral law to facilitate positive change within First Nations communities and the jurisdictions that interact with them.

As a Ts'msyen (also spelled Tsimshian) clinical counsellor, it is not necessarily a simple task to assess the state of well-being of the population I belong to. For example, more than 100 suicide attempts in 2007–2008 were handled by a single hospital in an area of northwestern British Columbia that serves primarily First Nations communities.[1] By this statistic, one might conclude that our mental health in the northwest region of B.C. is at a critical level. Yet to reach such a conclusion I would be denying the power of the Ayaawx (Ts'msyen ancestral law) to effect change.

The apology delivered by Prime Minister Stephen Harper on June 11, 2008,[2] finally brought a history of cultural oppression and violence against indigenous children in Indian residential schools out from under the rug. The formal apology brought injustices in Canadian history from hidden to open. Although our suffering has been and continues to be visible, reasons for our suffering have remained hidden to the collective national consciousness. The impact of the *Indian Act*, land loss, residential school atrocities and social segregation are all discriminatory events in Canadian history but not a part of most secondary school curricula. Colonial rhetoric identifying the Indian as a problematic beast, a savage with an inability to determine his or her future,[3] has been an underlying belief confronted in the past three decades by indigenous scholars. Historical information presented in postsecondary institutes is often from a European perspective rather than an indigenous perspective. Standing Rock Sioux scholar Vine Deloria Jr. writes concerning discrimination in postsecondary institutes:

> Social sciences on the whole have been hostile to Indians becoming professors and expositors of the cultures they represent, and thus very few Indians are able to translate the Indian side of the discussion into concepts that will have immediate recognition among Anglo academics as an explanation worthy of consideration.[4]

Accepting the reality of oppressive discrimination in Canada is choosing to no longer hide the shame of injustice and violence. Accepting oppression will in turn create the possibility of transforming oppression to freedom. Transforming oppression, as Paulo Freire[5] suggests, comes through reflection and action.

To engage in a meaningful helping relationship with indigenous clients, it is necessary to study the history of the "dis-ease" of cultural oppression in Canada. Oppression is a state of the disease of unjust dominance and must be aggressively treated as such. The first action is to identify the impact of cultural oppression on indigenous Canadians; the second action is to identify the impact on the indigenous clients' community, family and personal lives; and the third, but not last, action is to connect the distractive behaviours,[6] such as alcoholism, drug addiction, rage and neglect, to dehumanization that is associated with cultural oppression. Going further in action, education institutes must continue to be confronted and guided toward indigenous perspectives and epistemologies.

In Ts'msyen epistemology, the heart is the centre of one's reality, and the condition of the heart expresses one's well-being. In Sm'algyax, this may be translated as "goot" and is a reference to a place of power that holds and produces energy. For example, the heart can be sick, crying, lonely, happy, afraid and full (many inexpressible blessings). The blind spot that we must face as indigenous people is internalized colonization: the suffering we are inflicting upon ourselves due to our self-depreciating beliefs. For example, my father's lineage is rooted in Ts'msyen, Heiltsuk and Haida nations and my mother's lineage is rooted in England, with her parents immigrating to Canada. My physical appearance is obviously indigenous, which has caused me to experience discrimination at many different times and in various places. The most detrimental discrimination, however, has been my conditioned belief of inferiority that is inherent in oppressive dynamics. My belief of inferiority due to ethnicity has not been limited to myself: I've also unintentionally viewed other indigenous peoples as inferior to those whose ethnic roots were European. The awareness of such conditioning was initially disconcerting, but understanding that oppression is a human condition brought about a desire to change toward being open, honest and respectful. Developing respectful openness and honesty requires ongoing discipline and practice that includes meditation, reflection, non-judgment, acceptance and a desire to learn about the resources within indigenous culture.

~~L~~oomsk, which may be translated as "respect," is the abiding heart of the Ayaawx for Ts'msyen, Nisga'a and Gitxsan indigenous nations. Without respect for self, others and the land an individual is lost or spiritually unbalanced. Discrimination, cultural oppression, internalized oppression, distractive behaviours, violence and neglect are all symptoms of spiritual unbalance. The one place the Ayaawx can be witnessed in its authentic state is following the death of a loved one. As Ts'msyen, Nisga'a and Gitxsan, we are matriarchal societies with four distinct tribes (Eagle, Raven, Killer Whale and Wolf) with married couples being from two different tribes. At the time of death, the father's side feeds the bereaved, purchases the casket, clothes the deceased, assists the family with memorial and funeral arrangements and is present for compassionate active support. When my father died in April 2007, the Killer Whale tribe was the strength upholding my five siblings and myself throughout all of the necessary arrangements. The compassionate, respectful power behind active support not only supports the bereaved in the present; respect for the Ayaawx connects each participant with the wisdom of the ancestors.

Increasing the effective, directive power of ancestral law comes through traditional prayer ceremonies that connect the individual with the land and the supernatural world. Making the unknown known, as our ancestors have taught us, comes through intentional ceremonial action. Navajo woman surgeon, Dr. Lori Arviso-Alvord, states that we need both scientific and spiritual terms when addressing human needs.[7, 8] Every indigenous nation has ancestral law that determines protocol to restore and maintain spiritual balance. Health professionals can be active participants in assisting indigenous communities to access the resources in their ancestral law. In 2005, Nuxalk Health and Wellness called me into their community to address suicide. The first task was to meet with their helping employees to identify suicide attempts in their personal histories. The second task was, with the Nuxalk drug and alcohol counsellor, to meet with the elders of the community who could direct us in how to restore spiritual balance for the employees who had suicide in their history. The third task was to follow the necessary steps directed by the matriarchs of the community to assist employees in regaining spiritual balance. This involved gathering cedar boughs, red fabric strips and blankets and asking a matriarch to perform the brushing/smoking ceremony that would assist individuals with suicide attempts in their history to release the past and move forward, choosing respect for self and life. Following the ceremony, individuals had less fear addressing suicidal ideation with teens in the community and were ready to use their personal story as an example.

There is a process and protocol to address every conflict in indigenous communities in ways that can benefit all peoples. With the intentional action of both indigenous and non-indigenous health professionals, the power of ancestral law can be accessed to create positive change and restore spiritual balance from suffering.

The views expressed in this paper are those of the author and do not necessarily represent the views of the author's affiliated organizations, the Canadian Population Health Initiative or the Canadian Institute for Health Information.

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Polar Bears and Fireweed

Charles Brasfield, MD, PhD, FRCPC

Charles Brasfield is a psychiatrist and psychologist who has had a long-term interest in First Nations communities. He is in private practice as the director of the North Shore Stress and Anxiety Clinic in North Vancouver, British Columbia. He also provides regular outreach psychiatric services to the central coast communities of Bella Bella and Bella Coola by means of telemedicine video linkage. He also flies into communities for in-person consultation and treatment. He has been on clinical faculty at the University of British Columbia and continues to be on courtesy staff at Lions Gate Hospital in North Vancouver.

Mentally Healthy Communities

I have been asked to write a think piece from an Aboriginal Peoples' perspective. I am happy to do that but should immediately make it clear that I am not First Nations in origin. Rather, I am a psychiatrist/psychologist who has provided outreach mental health services to a number of First Nations communities in British Columbia.

There have been hundreds if not thousands of previous articles written about this topic. Many articles have been seduced by the ease of finding pathology in Aboriginal communities. I would like to focus on some key positive concepts.

Community

"Community" obviously refers to some identifiable shared experience. While it may be true that cockroaches share a great deal with people, there is little shared experience. Therefore, it seems likely that communication is one of the critical elements that must be shared to define a community. Thus, we may talk about language communities. Even that is too broad. While it is arguable that English is the most widespread language on the planet, it is unlikely that native speakers from St. John's, Newfoundland and Labrador, Mumbai, India and Atlanta, Georgia could easily communicate with each other. Therefore, it is not the formal language that counts; it is the culturally shared language that is important. This is particularly relevant for First Nations communities that have difficulty maintaining their languages. Some Aboriginal languages are particularly elegant in expressing cultural concepts. I know of one language that conveys in a single word the concept of "sitting down and talking to people long enough to know what they are really like." Obviously, simply hearing the word expressed conveys much more than the literal meaning of the word. In a single word, the culture itself is displayed.

First Nations communities also usually refer to a geographic location. Generally, that location is in a territory traditionally occupied by ancestors of the current generation. There may be specific cultural meanings attached to geographic features such as a mountain or lake. Similarly, there may be specific cultural meanings for flora and fauna found in the geography of the community. Polar bears and fireweed may both be of great cultural significance.

Community Membership

For each community, there are means of ingress and egress. For most people, ingress is a matter of being born to a community member and surviving sufficiently long to be introduced to the community as a new member. How long an infant has to survive and the means of being introduced to the community are variable. Perhaps a feast is held and perhaps a name is granted. In a similar manner, non-infants can be granted community membership. In those cases, it is often obligatory that the named person not only be introduced to the community but be granted membership in a particular family of the community. That is, he or she is adopted. Again, the activity of the community in recognizing membership is an expression of the culture.

In a similar manner, egress from the community is usually by death. However, recognition of the death often requires a culturally appropriate expression of mourning, a ritualized form of grieving with other community members and perhaps a feast. Following the death, surviving family members are often required to perform rituals such as burning food for the benefit of the spirit entering a new phase of being or "smoking" possessions to be distributed within the community or family. Again, each activity is an expression both of the community and the culture.

Community Mental Health

Mentally healthy communities, then, share language and experience related to community membership, community ingress and community egress. To the extent that the community has a continuing set of behaviours relevant to these issues and a language expressive of the interaction and meaning of those behaviours, it can be regarded as relatively mentally healthy. To the extent that the language is fragmented or lost, particularly if language concepts are lost, the community becomes vulnerable to distress.

For First Nations communities, there is a strong connection to the land. Thus, a mentally healthy First Nations community would be established on traditional lands, share a conceptual language and have maintained a range of appropriate rituals for ingress and egress to the community. There would also be appropriate rituals for rites of passage such as puberty, marriage, divorce and adoption.

Separately, a continuing means of earning income is relevant to community mental health. This might be by traditional activities such as hunting, fishing or production of artwork. Development of cash flow specifically does not refer to windfall profits derived in the short term from the sale of minerals or other resources. Indeed, outrageous excess of money can be as destructive as the absence of money.

For continuing community mental health, it is important to have a means of transmission of the language concepts (and perhaps the language itself), the rituals appropriate to the culture and the means of maintaining a continuing cash flow from one generation to the next. These depend on mechanisms by which the elders can communicate their experience to younger generations and some means of establishing the value of experience. The rituals of the community teach the younger generations.

For most First Nations communities, there is not such a clear separation between physical health and mental health as is found in Western allopathic medicine. There is often a feeling in such communities that anxiety and depression are states of health similar to the influence of infection, injury or poor diet. Increasingly, Western medicine is learning that perhaps Aboriginal People were right all along. With the reduction in traditional subsistence diets and increased reliance upon processed and packaged foods, there is increasing obesity and development of illnesses that can be attributed directly or indirectly to colonization.

Colonization has also provided vulnerability to substances of easy abuse like alcohol and tobacco. Traditional use of tobacco as a means of communication with the spirits, ratification of agreements and formalization of social interaction did not lead to ready abuse of prepackaged cigarettes. Similarly, the ability to brew beer of some sort did not lead to the toxic alcohol poisoning provided by grain alcohol. Both of these substances are now sufficiently toxic and sufficiently ingrained in many communities that a measure of community mental health is the degree to which abuse of these substances is managed and prevented.

Finally, mentally healthy Aboriginal communities rely upon mentally healthy government, both within the community structure and within the government as a whole. Communities are generally aware of the importance of language and language concepts, rituals, dependable income, appropriate diet and management of substance abuse. As well, communities are usually quite aware of traditional values and activities. Larger government structures may support such communities by being equally aware and respectful of those values and activities.

Mentally Healthy Communities: The Complexities of Diversity

Jonathan Dewar
Director of Research
Aboriginal Healing Foundation

Jonathan Dewar is Director of Research at the Aboriginal Healing Foundation. He is a past director of the Métis Centre at the National Aboriginal Health Organization and was the founding executive director of the Qaggiq Theatre Company in Iqaluit, Nunavut. He has government and non-government research and policy experience in a variety of First Nations, Inuit and Métis issues, including arts and wellness, language legislation and promotion, justice and crime prevention, youth social issues and land claims. He is of mixed heritage, descended from Scottish, French and Huron–Wendat Canadian ancestors. He is completing his doctorate in Canadian studies.

I have been very fortunate over the course of my relatively short career to have experienced and been able to explore concepts of health and wellness, particularly those with a community focus, across a variety of Aboriginal experiences and settings. Presently, I am privileged to work with the Aboriginal Healing Foundation (AHF) as its Director of Research, following the trail blazed by the late, esteemed Gail Guthrie Valaskakis and an inspiring network of Aboriginal and non-Aboriginal scholars on issues related to community-based healing in response to the legacy of residential schools in Canada.

Other authors will undoubtedly describe the complexities to be found in attempts to define community in Aboriginal contexts and note the diversity across and within First Nations, Inuit and Métis experiences. One such complexity is, paradoxically, the cliché-ing of the notions of Aboriginal worldview(s) and the inherent elements of holism, wholeness and interconnectedness, wherein and throughout which notions of community reside. These are concepts that do, of course, bear repeating but, most importantly, require acknowledgment and careful consideration. Often, particularly within programmatic responses to Aboriginal health issues, these important concepts seem, instead, to be platitudes expressed by rote: Serving Aboriginal People? Check. Acknowledgement of their holistic approaches to health and wellness? Check.

Promising Healing Practices in Aboriginal Communities, the third volume of the final report of the AHF says, "In the Aboriginal health field, there is little debate about the value of a holistic approach to healing, and the concept of wholeness is central to Aboriginal worldview . . . A holistic approach encompasses more than just the individual; it also considers relationships with and impacts of the family and community."[1] In the spirit of reconciliation, we may wish to expand the notion of community to the larger Canadian community; healthy Aboriginal communities contribute to a healthy Canada.

In 2007, the AHF received an additional $125 million through the Indian Residential Schools Settlement Agreement's healing fund, effectively extending its mandate to March 2012. The AHF was intended to be a response that honoured Aboriginal perspectives, engaging in its first mandate in consultation and research to better understand the ongoing processes of individual and community healing. The foundation's vision and values reflect the emphasis on holism.

> Vision:
>
> Our vision is one where those affected by the legacy of Physical Abuse and Sexual Abuse experienced in Residential School have addressed the effects of unresolved trauma in meaningful terms, have broken the cycle of abuse, and have enhanced their capacity as individuals, families, communities and nations to sustain their well being and that of future generations.[2]
>
> Values:
>
> Ours is a holistic approach. Our goal is to help create, reinforce and sustain conditions conducive to healing, reconciliation and self determination. We are committed to addressing the legacy of abuse in all its forms and manifestations, direct, indirect and intergenerational, by building on the strengths and resiliency of Aboriginal people.
>
> We emphasize approaches that address the needs of Aboriginal individuals, families and the broader community. We view prevention of future abuse, and the process of reconciliation between victims and offenders, and between Aboriginal people and Canadians as vital elements in building healthy, sustainable communities.
>
> By making strategic investments of the resources entrusted to us, and by contributing to a climate of care, safety, good will and understanding, we can support the full participation of all Aboriginal people, including Métis, Inuit and First Nations, both on and off reserves and both status and non status, in effective healing processes relevant to our diverse needs and circumstances.[2]

The notion of reconciliation—among Aboriginal Peoples, within communities, between Aboriginal Canadians and non-Aboriginal Canadians and within faith communities—is a principal focus today, too, in this post-settlement landscape. As the editors of *From Truth to Reconciliation: Transforming the Legacy of Residential Schools* write, "a reconciliation process that effectively addresses the impact of residential schooling can become a major turning point in the relationship between Aboriginal peoples and all Canadians."[3] This collection of essays was released in March 2008 to coincide with *Remembering the Children: An Aboriginal and Church Leaders' Tour to Prepare for Truth and Reconciliation*.[4] Since then, the Truth and Reconciliation Commission was formally launched and Prime Minister Stephen Harper delivered an official apology to former students of Indian residential schools in the House of Commons.[5]

The AHF has also pointed out, however, that:

> Compensatory redress . . . has become a large part of the process of addressing residential school system abuses—but these approaches do not deal with the long-term healing needed for the renewal of the relationships between Aboriginal and non-Aboriginal people in Canada. For the majority of survivors, the process of compensatory redress hinders or significantly delays much needed healing. The present process of redress is tagged with ever-escalating costs. The delays in getting compensation mean that tens of thousands of Aboriginal people live under intolerable stress, which sooner or later may be translated into a healing crisis. With its fixed funding capacity, the Aboriginal Healing Foundation supports grassroots projects which are attempting to respond to the healing needs of many thousands of survivors, their families and descendants.[6]

While there is little debate about the value and even centrality of holism in Aboriginal health and wellness, there is much debate about its complexities, a subject the AHF and its partners have explored in great detail over the last decade. Take, for example, James Waldram's statement from his introduction to *Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice*:

> [In] an urban clinic, effective treatment programs must be able to accommodate a wide variety of Aboriginal people: individuals from different cultural heritages; individuals who have no practical experience in Aboriginal cultural contexts as well as those who have; individuals who do not speak an Aboriginal language and those who do; individuals with no background in the spiritual traditions that underscore such treatment and those who do; and individuals who are avowedly Christian alongside those who practice Aboriginal spirituality and those who simply are not spiritual. This is a tall order. The fact that many of the projects we studied are open to clients from different Aboriginal cultural traditions reinforces the idea that a simple, singular one-size-fits-all model makes little sense.[7]

In evaluating the reports from AHF-funded projects, it is clear that the inclusion of elements of cultural practices can have measurable positive impacts; these practices include community-oriented activities such as feasts and ceremonies that honour the individuals—and communities—affected. This is particularly true in instances where those who have suffered severe trauma have blocked out the memories of these experiences and/or have sought to avoid situations that may trigger a response. In these cases, addressing the topic of residential schools and educating people about the effects of the experience through ceremony or other culture-based activity can help individuals overcome denial, create a sense of safety and begin to clear a path to reclaiming or learning anew aspects of one's cultural heritage, lost in the acculturating setting of residential schools.

Across the diversity of experiences, settings and different types of communities experienced by Aboriginal Peoples in Canada—on-reserve, off-reserve, urban, rural, isolated, remote, municipality—the AHF has learned that it is important not just what type of community one lives within but also where:

> Our experience suggests that the endowment we received will be insufficient to address effectively the intergenerational effects of physical and sexual abuse suffered in residential schools, for several reasons:
>
> - Only people who are ready to begin, or who have started their healing journey, can benefit from the fund;
> - Healing from the legacy of physical and sexual abuse in Indian Residential Schools requires more than 10-years;
> - More time is required to develop expertise and capacity among Aboriginal people; and
> - We are only beginning to reach remote areas (such as the North) and certain groups (such as the Métis).[6]

As Waldram problematizes, and as the final bullet point above notes, there are hard-to-reach segments of the population. From experience, I know that serving the needs of Inuit, Métis and northern Aboriginal Peoples is a great challenge.

Prior to joining the AHF in the fall of 2007, I served as director of the Métis Centre at the National Aboriginal Health Organization, a Métis-designed and -governed centre "dedicated to improving the mental, physical, spiritual, emotional and social health of all Métis in Canada [by] promoting Métis health issues through public education and health promotion."[8] This opportunity allowed me to return to my hometown of Ottawa after five years in Nunavut, where I learned many valuable lessons about health and wellness in Inuit contexts, working in the areas of arts administration, language legislation and promotion, justice and crime prevention, and land claims generally and, of course, specifically with the Nunavut Land Claims Agreement.

These experiences greatly enhanced my understanding of issues I had first pursued in my graduate studies, where I focused on the study of identity, connection to culture and forces of acculturation; I had, in fact, first moved to Nunavut to do research towards my doctoral dissertation. There was, I suppose, so much that made me feel at home that it became my home for those five years—and is the birthplace of my two daughters. It is not, however, my or their *homeland*, a concept that should be considered carefully by those looking to study concepts of healthy communities in First Nations, Inuit and Métis contexts. Homeland is a term that is particularly important to citizens[i] of the historic Métis Nation and should not be confused with land claim, title or land base, which, though related, are each deserving of careful consideration.

The issue is far too complex to discuss at length here; however, it is worth noting how it was used in *Northern Frontier, Northern Homeland: The Report of the Mackenzie Valley Pipeline Inquiry*.[9] As Thomas Berger noted, "There are two distinct views of the North: one as frontier, the other as homeland."[9] It is also notable that the Government of Canada established the inquiry to see what the social, economic and environmental consequences of a pipeline would be if one were built and that Berger called for a 10-year moratorium until native land claims had been settled. He said, "The choice we make will decide whether the North is to be primarily a frontier for industry or a homeland for its peoples . . . [W]e owe to the peoples of the North, and to future generations, a careful consideration of the consequences before we go ahead with such projects."[9] Berger acknowledged that economic development must be placed within a social and environmental context. He says we "may at last have begun to realize that we have something to learn from the people who for centuries have lived in the North, the people who never sought to alter their environment, but rather to live in harmony with it."[9]

Berger's report had, arguably, the greatest impact on southern, non-Aboriginal Canadians' understanding of First Nations, Inuit and Métis connections to the land—one that continues to resonate today, given the impact of the report and the ongoing Mackenzie Valley Pipeline saga. Despite this, however, it did not eliminate the complexities. More than 30 years later, Canada has still not resolved all outstanding land claims from this region. And while there was a degree of solidarity between First Nations, Inuit and Métis in the dialogue with Berger, the desire for recognition was anything but an approval of a pan-Aboriginal identity.

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i. Similarly, the issue of citizenship and/or membership within nations is complex and deserving of attention. For the historic Métis Nation, see the Métis National Council's definition (www.metisnation.ca) and the less subjective though similar definition within the *Report of the Royal Commission on Aboriginal Peoples*: *Volume 4: Perspectives and Realities* in Section 5: Métis Perspectives (http://epe.lac-bac.gc.ca/100/200/301/inac-ainc/royal_comm_aboriginal_peoples-e/biblio92.html).

Yet this remains a stumbling block in the mainstream provision of services to Aboriginal clientele; as an identifier, *Aboriginal* must refer to diversity across First Nations, Inuit and Métis. Approaches must, however and whenever possible, be specific to the communities within that diversity.

As a person of mixed heritage raised in an urban, multi-cultural setting, without a tangible connection to the cultural heritage of my First Nations forebears, and as someone who has focused much of his academic and professional work on Métis and so-called mixed-blood issues, I have experienced the importance of highlighting the challenges faced by these overlooked and misunderstood segments of the Aboriginal population.

I recommend at least a brief tour of mixed heritage nomenclature; suggested reading to that end begins with Section 5.1: The Other Aboriginal Peoples and Section 5.3: The Other Métis in the *Report of the Royal Commission on Aboriginal Peoples, Volume 4*.[10] While I recommend the entire report, I highlight these sections to underscore an important point about community and inclusion. If Métis "means a person who self-identifies as Métis, is of historic Métis Nation Ancestry, is distinct from other Aboriginal Peoples and is accepted by the Métis Nation"[11] and this Métis population forms "a small and too often overlooked part of the larger Aboriginal minority"[10] then persons of other mixed heritage "constitute a minority within a minority within a minority."[10]

The AHF, too, has made concerted efforts to address the unique needs of Inuit and Métis. As reported in the first volume of its final report, "Equitable access to the healing fund by diverse Aboriginal people and communities was a condition set out in the funding agreement," ensuring that the disbursement takes into account and honours "the geographical and demographic reality and the concentration across Canada of First Nations, Inuit and Métis . . . and those who are affected by the Legacy of Physical and Sexual Abuse . . . including the intergenerational impacts."[12] The AHF has also sought to educate the public about this diversity in its publications, including *Métis History and Experience and Residential Schools in Canada*[13] and *A Brief Report of the Federal Government of Canada's Residential School System for Inuit*.[14] The AHF was also a partner with Library and Archives Canada in supporting the Legacy of Hope Foundation's new exhibit, "*We Were So Far Away . . .": The Inuit Experience of Residential Schools*,[15] which went on display at Library and Archives Canada on January 29, 2009. An identical exhibit will tour across Canada. Inuit and Métis perspectives are also featured prominently in *From Truth to Reconciliation: Transforming the Legacy of Residential Schools*,[3] and *Response, Responsibility, and Renewal: Canada's Truth and Reconciliation Journey*,[16] which was released on June 11, 2009, the first anniversary of the prime minister's apology to survivors delivered in the House of Commons.[ii]

ii. A book-length publication with the working title *Inuit History and Experience and Residential Schools in Canada* is forthcoming.

The reality is that across First Nations, Inuit, Métis and "other" realities in Canada, there exists, historically and contemporarily, a systemic and misunderstood marginalization within and across communities. In an urban setting, as Waldram describes it, it is often difficult to see oneself reflected in the landscape. Urban centres are not—perhaps cannot be—homelands in a traditional sense, the kind articulated by the respondents to Berger's inquiry. But they are homes for many First Nations, Inuit and Métis—often happy, sometimes troubled. Often, too, they are merely the option of last resort. Whether these are dislocations—due to the legacy of residential schools or other factors—or part of the evolving nature of a person's mixed heritage, these are integral components of who these individuals are, which informs the make-up of their family and community. And these must be understood in these terms, in all their complexity.

The views expressed in this paper are those of the author and do not necessarily represent the views of the author's affiliated organizations, the Canadian Population Health Initiative or the Canadian Institute for Health Information.

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Can a Community Be Called "Mentally Healthy"? Maybe, but Only When the Whole Really Is Greater Than the Sum of Its Parts

Christopher E. Lalonde
Department of Psychology
University of Victoria

Christopher Lalonde is an associate professor of psychology at the University of Victoria. He is also the Director of the Vancouver Island Node of the Network Environments for Aboriginal Health Research and Co-Director of the Centre for Aboriginal Health Research at the University of Victoria.

The papers in this collection are meant to address what appears to be a straightforward question: "What contributes to mentally healthy Aboriginal communities?" One way of reading that question, however, perhaps an overly literal reading, raises the prospect that we may fall prey to a logical fallacy at the outset.

This arises because mental health is typically understood to be a property or feature of individual persons. That is, a person can be judged mentally healthy or unhealthy, or said to possess some amount or degree of mental health that may wax and wane over time. But to describe whole communities as either mentally healthy or unhealthy constitutes a sort of category error that takes the sum of individual differences and treats it as a psychological feature of the collective. To point to a community and declare it "healthy" courts what is called the "fallacy of composition." This occurs when one assumes that what is true of any one member of a class is true for all (for example, this teenager is rude, therefore all teens are rude). The "fallacy of distribution" errs in the opposite direction by assuming that what is true of a group is also true for all individual members (because Whistler is a ski resort, everyone in Whistler must ski).

I raise all of this not because I fancy myself some sort of language maven or amateur logician, but because there is a very real slippery slope here. To imagine that mentally healthy Aboriginal communities can be found and contrasted with counterpart unhealthy communities threatens to become a new variant on the prolonged historical practice of pathologizing and marginalizing Aboriginal communities.

In health research, the usual procedure for avoiding this error is to measure the incidence of mental illness within a population and to declare the population mentally healthy if the rate of illness falls below some more or less arbitrary set-point per thousand persons. We can acknowledge and perhaps even quantify the influence of forces beyond the individual level (for example, social determinants of health), but all qualifications aside, we need to be especially vigilant in our use of language when addressing the real and dangerous difference between "communities with high rates of mental health" and "mentally healthy communities."

The difference between these two phrases is especially apparent in sensationalized media accounts of the epidemic of suicide within the Aboriginal population. This fallacy of reasoning puts all Aboriginal youth at equal risk and paints all First Nations with the same broad and disparaging brush. Worse still, if, as our own research has shown, the risk of suicide is *not* evenly distributed across First Nations, then prevention efforts mounted at the population level will invariably waste resources within communities that don't need them while simultaneously under-resourcing those communities with the greatest actual need.

Having just warned against such talk, I now want to go on to argue that, at least in certain special circumstances, it actually *is* permissible to talk of mentally healthy communities and that it is *not* automatically wrong to apply concepts that arise at the level of individuals to whole cultural communities and vice versa.

For more than 15 years, Michael Chandler and I have been engaged in a program of research that examines the influence of culture on identity formation and well-being among adolescents and young adults. In particular, we have been interested in the concept of "self-continuity" or "personal persistence." What we wanted to know was just how it is that adolescents construct and maintain a sense of enduring identity during a period of rapid and often dramatic developmental change. If it really is the case, as many have suggested, that the job of adolescence is to create a personal identity, and if change is the hallmark of adolescence (changing social roles and social expectations, puberty and psychosexual change, changing relations with parents and peers), then how is it that young persons understand that they must somehow persist at being the *same* person despite (or within) this storm of change?

We have referred to this as the paradox of personal persistence: to qualify as an instance of what we normally take selves to be, the self must be understood to persist through time. If selves did not have this property of persistence or continuity, then any moral or legal authority to hold persons accountable for their actions would be irretrievably lost and there would be no reason to hope that we could ever reap the fruits of our own current labours toward some imagined personal future.

But if continuity is somehow constitutive or definitional of what it means to have or be a self, then how do young people solve this paradox of persistence and find sameness within a period of intense change? Because adolescents don't have clear and articulate thoughts on these matters sitting on the tips of their tongues, we needed to find some way of getting taciturn teens to offer up their best arguments in favour of their own self-continuity. The procedure we eventually developed included presenting youth with video and comic book versions of stories of personal transformation drawn from literary sources (for example, Scrooge in *A Christmas Carol* and Jean Val Jean in *Les Misérables*) and asking them to discuss how the protagonist could be understood to be the same person at the beginning and end of the story. This was followed by asking the participants to describe how they themselves had changed over time and how, despite these changes, they should still be understood to be the same person.

Having now followed these procedures with more than 800 young persons, three things have become clear. First, over the course of their adolescence, young persons typically pass through five distinct and increasingly complex stages of reasoning. Second, the costs of failure in this identity formation process are high: the only participants who were unable to warrant a sense of persistence through time were those who were known to be suicidal at the time of the interview. The association between suicidality and the inability to see oneself as persistent through time follows, we argue, from the fact that self-continuity provides us with a sense of ownership of our own past and an investment in our own future; when that conviction is lost, there is little to prevent young people from acting on even transitory self-destructive impulses. While this line of work may help us understand why suicide rates spike during the period of adolescence, it does little to explain the tragically high suicide rates among Aboriginal youth.

The third finding from our program of research is that the style of reasoning that young persons employ is strongly influenced by their cultural background. The majority of First Nations youth that we interviewed use a "narrativist" style in which self-continuity is found in the plot of a life story that weaves together periods of personal transformation. Among non-Aboriginal youth this style is rarely seen. Instead, most use an "essentialist" style in which change is discounted as superficial and continuity is found at depth within an unchanging core personality structure or set of values that remain untouched by change at the surface.

One reason for this observed difference may be that the narrativist style (with its emphasis on human relationships and the importance of place and time) is simply more congruent with First Nations worldviews than the essentialist style. Also, because the narrativist style provides for a more distributed notion of the self, it affords a stronger connection between individuals and the cultural worlds they inhabit. Where holding to a narrative view of the self binds one's personal story to the lives of others, the essentialist view does the opposite: the essence of the self is buried within the individual. But even if failures in self-continuity can help us understand the increased risk of suicide during adolescence, how can this line of reasoning help us in the search for mentally healthy communities?

Our approach to this problem has been to do what I said one should *not* do: to take a psychological concept developed at the level of individual persons and try to apply it at the level of whole cultural groups. The argument is simple: if individual selves are to persist through time, they must find some way of owning their own past and remaining invested in the person they are en route to becoming; this same logic applies to cultural groups. If a culture is to maintain continuity with itself, then some means of retaining ownership of a collective past must be found, along with a shared sense of investment in an envisioned collective future.

Our aim was to take the concept of self-continuity and move it to a higher level of abstraction. What we needed—while actively courting potential fallacies in logic—was some way to measure a sense of ownership of the past and commitment to the future, not at the psychological level but epidemiologically with whole communities as the unit of analysis. Toward this end, we developed a set of community-level indicators that assess cultural continuity and that index the degree of success that First Nations communities have enjoyed in maintaining their traditional cultural practices (ownership of a cultural past) and in securing local control over their own civic lives (commitment to a shared future).

These factors include measures of the history of land claims negotiation and litigation by the First Nations (meant to index success in maintaining access to traditional lands and resources), their efforts to preserve and promote the use of traditional languages and the construction of cultural facilities within the community. Other factors assess community success in attaining goals related to self-determination: control over health services, education, police and fire protection, the participation of women in local governance, programming aimed at youth—including cultural and occupational training—and especially those programs that connect youth with elders and that promote the inclusion of culturally appropriate curricula within local schools.

What our research has shown is that First Nations communities that have experienced success in these areas also enjoy lower rates of suicide and injury and higher school completion rates. Not only were each of these factors individually associated with lower rates of suicide, but within the set of communities in which all of the factors were present, suicide was entirely absent.[1, 2]

There are several take-home messages from this research. To claim that there is an epidemic of suicide within "the" Aboriginal population is not only incorrect, it is also insulting and dangerous. It is incorrect because, as our data shows, suicide rates vary widely from one community to the next. With a data set covering nearly two decades, it is apparent that this epidemic is remarkably selective, with some B.C. communities suffering rates of suicide many times higher than the provincial average while others have effectively solved the problem of suicide. What differentiates "healthy" from "unhealthy" communities within our data set is not some randomly distributed pattern of shifting suicide risk, but instead appears to be strongly linked to ongoing efforts at the community level to preserve and protect their cultural heritage and to control their own collective future. The epidemic view is also insulting because it ignores the diversity that exists within and between First Nations communities by focusing on "Aboriginality" as an explanatory variable. Worse yet, it is dangerous because it promotes the blind application of one-size-fits-all intervention and prevention solutions and outside resources to *all* Aboriginal communities without reference to the real needs of particular communities.

In closing, what our studies have demonstrated is that there actually *are* times when concepts commonly developed to understand the psychological life of individual persons can be usefully and appropriately applied to whole cultural groups. The search for mentally healthy Aboriginal communities can be informed by examining the relations between a set of continuity-preserving practices that operate at both the individual and the community levels. When persons feel a sense of connection to their own past and are invested in their future, they are protected from the risk of suicide. And when whole communities experience success in their efforts to preserve their culture and control their collective destiny, suicide rates fall. Individual health and well-being, at least within First Nations communities, is tied to cultural and collective health. But any grandmother might have told us that.

The views expressed in this paper are those of the author and do not necessarily represent the views of the author's affiliated organizations, the Canadian Population Health Initiative or the Canadian Institute for Health Information.

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This publication is part of CPHI's ongoing inquiry into the patterns of health across this country. Consistent with our broader findings, it reflects the extent to which the health of Canadians is socially determined, interconnected, complex and changing. CPHI is committed to deepening our understanding of these patterns.

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