HEALTHCARE TRANSFORMATION IN ONTARIO: EVOLUTION OR REVOLUTION?

The theme of Making Gains 2006, examines the response of mental health and addictions to rapid change in the healthcare system.

This year’s conference will put the spotlight on how to make change for the better, and truly transform the system into one that works better for consumers and families. It is in our responses to transformation both individually and collectively that will determine whether this happens. How we manage the change - maintain a positive focus on the needs of consumers and their families by forging new partnerships and collaborations leading to better outcomes and quality of life - is the challenge of transformation.

Transformation, whether it be evolutionary or revolutionary, will extend us beyond our traditional boundaries and will challenge us to think broadly and boldly of how to incorporate the determinants of health as we conduct research, plan, develop, and implement the necessary services for consumers, families and our communities.

Conference    November 5 - 8, 2006   Toronto, Ontario

For more information please visit www.makinggains.ca
Healing the spirit
Aboriginal paths to health and wellness

COMING FULL CIRCLE
Cultural restoration for First Nations wellness

SACRED SMOKE, SILENT KILLER
Spiritual use or tobacco abuse?

LONGING TO RETURN HOME
From intergenerational trauma to intergenerational healing

DOING TIME TO HEAL
Treating aboriginal offenders through tradition

Moving on, moving in
Sexual minority youth tackle homelessness

Youth resilience
International project identifies youth strengths
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Focus: Healing the spirit
Aboriginal paths to health and wellness

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Kirk Brant is a member of the Mohawks of the Bay of Quinte, Tyendinaga Mohawk Territory. Kirk is a graduate of the graphic design program at Algonquin College in Ottawa.

Kirk Brant, original serigraph on paper, 16” x 6.75”
The poor health status of Canada’s Aboriginal Peoples is a well-known fact and a serious concern not only for Aboriginal Peoples but for all Canadians. A recent United Nations report shows that Canada’s ranking on the UN human development scale would substantially drop if Aboriginal – First Nations, Inuit and Métis – health, social and economic conditions were addressed. Aboriginal peoples experience ill health, inferior health care, lower life expectancy and poverty. They have extraordinarily high rates of disease, substance abuse and suicide. As Health Canada stated in 2000, “Canada’s aboriginal people, as a group, are the most disadvantaged and have the poorest overall health status.”

To give voice to Aboriginal Peoples’ experience, many of the articles in this issue of CrossCurrents are written by aboriginal people or those who work with aboriginal clients. Bill Mussell, chairman of the Native Mental Health Association of Canada, begins the theme section with his thoughts on healthy aboriginal communities. He believes that the spirit that holds a relatively healthy group of families together is embedded in community and that bringing addiction and mental health resources together at the community level could do a great deal to restore family and community wellness.

Cornelia Wieman, Canada’s first female aboriginal psychiatrist, discusses how traditional aboriginal teachings and Western clinical practices can complement each other to create a culturally sensitive model of healing. Joseph Winter describes the difference between commercial and traditional tobacco use and how aboriginal communities need to use tobacco responsibly and respectfully.

Peter M Enzies, manager of Aboriginal Services here at CAMH, discusses intergenerational trauma – the impact of multiple generations of Aboriginal Peoples experiencing trauma after being removed from family and community. He argues that consideration of intergenerational trauma in the diagnosis and treatment of addiction and mental health issues among aboriginal people requires an appreciation for the political, historical and social environment from which aboriginal individuals, families and communities have emerged.

Rick Mayoh, a residential counsellor at Canada’s only Inuit-specific trauma and addiction treatment centre, discusses Inuit approaches to healing within the context of the trauma that group has experienced within a relatively short period in Canadian history.

Astrid Van Den Broek profiles a substance use treatment program for aboriginal offenders. The Royal Commission on Aboriginal Peoples has stated that the Canadian criminal justice system has failed Aboriginal Peoples in all territorial and governmental jurisdictions. A culturally specific program may be a good start to addressing the unique needs of aboriginal offenders.

The Q&A poses questions about benzodiazepine overprescription among aboriginal women.

Following up on the Last Word column in the summer issue, this issue presents a consumer/survivor perspective on supportive housing.

Enjoy this thought-provoking issue. Send us your comments and ideas. It is your input that furthers the dialogue around mental health and addiction issues.

Hema Zbogar
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On May 31, the Smoke-Free Ontario Act came into effect, reducing the number of places where smokers can light up. The Act’s goal is to protect Ontarians by decreasing opportunities for smokers to smoke. Still, staring scientific truths in the face (e.g., reading warning labels on cigarette packs), having fewer places to legally smoke and paying more for the product hasn’t helped many longer-term smokers quit.

Now, Ontario’s Ministry of Health Promotion and the Centre for Addiction and Mental Health (camh) in Toronto are running a study focused on helping longer-term smokers who are ready, but haven’t yet been able on their own, to quit. By distributing free nicotine replacement therapy (nrt) in the form of patches or gum to eligible smokers, camh will measure and assess nrt’s value and effectiveness.

“It has always been a problem and frustration for public health nurses knowing there’s a product that can help smokers quit, but knowing many can’t afford it.”

“Tobacco dependence is the number one addiction in Canada,” says Dr. Peter Selby, clinical director of addiction programs at camh and stop’s principal investigator. “It kills more people than all other addictions combined. We know how to help people quit other drugs, so why not develop a strategy to apply that knowledge and help people quit nicotine?” Selby partnered with government and Pfizer Consumer Health Care “to make sure we got this medication out to people in a way that equalizes access issues across the province.”

“Studies have shown that nrt doubles the quitting success rate,” says Nancy Hamilton of the Middlesex, London Health Unit, also involved in stop. “It has always been a problem and frustration for public health nurses knowing there’s a product that can help smokers quit, but knowing many can’t afford it.”

With stop, that barrier is gone: “From a social justice perspective, you can’t make it hard for people addicted to nicotine to access treatment because that creates unintended consequences and problems that come from not helping those people,” says Selby.

Launched in fall 2005, stop comprises four phases: During Phase 1, nrt’s were distributed through 3,000 10-week treatments at camh, the Ottawa Heart Institute and the Regional Cancer Centre at Thunder Bay General Hospital. Phase 2 involved referrals from doctors, pharmacists and dentists to a smokers helpline (a similar nrt giveaway took place in 2005 in New York State), which mailed 14,000 five-week treatments to qualified participants. Phase 3 involved 3,000 10-week treatments through public health units. Phase 4 is underway through pharmacies. camh will follow up with participants at three, six and 12 months post-treatment to assess the results.

Addiction maintains a powerful grip on the lives of many smokers. “Some people are somewhat terrified to try quitting,” says Louise Wilson, a public health nurse with the Simcoe Muskoka District Health Unit, involved in the study. “It’s a major change in their lives. If you’ve been smoking since you were 15, and now you’re 40, there’s almost nothing you do more in a day, other than blink.”

Studies have found that smokers who quit use the health care system less than continuing smokers. “You can save lives by getting people to quit now, rather than simply preventing them from starting smoking,” says Selby.

Smokers need to be psychologically ready to quit, too. Carol Bossenberry at the Oxford County Public Health Unit cites the transtheoretical model of change: “You work with people at the stage they’re at,” she says. Most people who have called say they want to quit as soon as possible. “It’s called the Readiness Ruler,” explains Bossenberry. “On a scale of 1 to 10, most people have said they’re at 9 or 10,” which means they’re ready to quit.

Selby ultimately hopes that stop “will help the government realize there is a demand for this, that there are smokers out there who do, and can, benefit from nrt. How can a provincially charged organization not address the number one addiction that is killing the most people when we have the expertise and knowledge to treat them?” says Selby. “If we can use innovative ways of reaching out and get the treatment where people are at, that is an important and ethical activity.”

Elizabeth Scott
Sexual minority youth speak out about homelessness

ABIGAIL PUGH

At a downtown Toronto youth centre one recent evening, the summer's worst rainstorm was raging outside. But around the table in the basement, nobody noticed. The group gathered there was eating spicy mango salad, catching up on news and sharing photos from previous meetings. They had met to discuss a complicated document they had co-created: a letter of intent, aiming to secure funds to launch a larger project.

“Income and housing are the biggest stressors in life. If you’re youth and look queer, it’s hard.”

Topics raised were large and complex (gender politics, mental health fundamentals, status, power and inequality), as well as more personal and specific (coping with the threat of eviction because a roommate isn’t paying rent, couch-surfing due to a recent breakup, painful complications from recent surgery).

This meeting marked the “end of the beginning” of a joint initiative between Toronto’s shout clinic, the Centre for Addiction and Mental Health (camh), a youth consultant and several youth informants. The initiative – Queer Youth Speak – has sought to explore what life is like for lesbian, gay, bisexual, transgendered and queer youth facing multiple vulnerabilities: being young, experiencing substance use or mental health issues and struggling to find or maintain safe and affordable housing.

Participants refined, through painstaking research and discussion, the most crucial research priorities facing this diverse population. Their findings? Nathan, a participant, puts it best: “Income and housing are the biggest stressors in life. If you’re youth and look queer, it’s hard.”

The project started in 2005 with an enabling grant from the Wellesley Central Health Corporation. With a budget of $8,500, Queer Youth Speak’s intent was ambitious. “We wanted to bridge the gap between lived experience and professional experience – to bring the two together in an equitable and inclusive way,” says project co-ordinator Melanie Ollenberg.

The founding shout/camh team used participatory action research to meet its goals. After a disappointing experience using focus groups to recruit youth, the team changed tack and decided to invite Ayden Scheim, himself a member of the target population, to partner with them to reach out to youth in one-on-one consultation sessions. Once these sessions – 40 in all – were finished, the team created a steering committee to analyze its findings.

What were steering committee meetings like? “Heated,” “engaged” and “intense,” according to youth participants. Logically so, says Nathan: “That’s how we learned to survive when we didn’t have any help. Whether it’s sex work, drugs, eating out of garbage cans – that’s what we’re passionate about fixing.”

Information-gathering wasn’t the only outcome. “The grant was both to increase the capacity of the community and that of agencies to help the community,” says Ollenberg. Adrian, one of the youth, says, “I got to know interesting people and learned how to use wording (in written documents).”

“Whether it’s sex work, drugs, eating out of garbage cans – that’s what we’re passionate about fixing.”

The “non-profit-speak” was initially intimidating for Nathan: “I was nervous; it was the same feeling as at school, and it brought back memories. I have ADD [attention deficit disorder] and a reading and learning disability and the group was talking about things like letters of intent, grants and research.” Most of his fears were calmed after a couple of meetings. “There’d be good suggestions, like a reading corner (where steering committee members could read aloud to each other). To decide on our highest research priorities, we used big chart paper and red sticker dots as a voting system. It was innovative.”

This CrossCurrents reporter – heterosexual, adequately housed and hardly “youth” at 37 – had little idea what to expect from the meeting that evening in the basement at shout. An initial go around, however, defied the cliché: these youth were stuck in a rut. Quite the opposite: Constant change and evolution seemed to define their lives.

If its advanced research funding bid is successful, Queer Youth Speak will live on. Having now identified housing and income as barriers to health, stakeholders will devise an expanded research project and identify strategies to improve lives. The final report notes: “In future projects, the ideal is to start with the (steering committee) so they can be involved at every stage because they have so much to offer the research process.”

Christine O’Rourke, a health promoter with shout, and part of the youth initiative, agrees. “The youth that worked on this project have taught me so much about youth empowerment and the meaning of true community-based research collaboration. Also it was so refreshing to work with a team at camh that doesn’t just ‘talk the talk’ about community-based participatory action research, but actually ‘walks the walk.’”
Most of us are fortunate to live comparatively privileged lives. We enjoy much more than just the life-sustaining basics every day - plenty of food to eat, a roof over our heads, clear running water, accessible medical care and education and, hopefully, peace, both in and outside of our homes. Most of our children are lucky enough to live in a world of opportunity, not limitation; theoretically, their chances of reaching self-actualization are reasonably high.

But are less fortunate youth who have grown up in adverse circumstances destined, because of their status, to do poorly? The short answer is "no." Youth resilience researchers have long known that some youth, according to their culture's expectations, do very well, whereas others do not, but deciphering and understanding why poses a challenge.

Youth resilience researchers have long known that some youth, according to their culture's expectations, do very well, whereas others do not, but deciphering and understanding why poses a challenge.

"People all over the world seem to be talking about this idea of trying to understand how kids survive and thrive, what that means inside their own cultural contexts," says Dr. Michael Ungar, principal investigator of the International Resilience Project (irp), a new international initiative grappling with this very question. Most existing resilience research has come out of North America, but "there's quite an interest now in trying to look at these ideas across different cultures to try and understand them in different ways," says Ungar, who is also a professor of social work at Dalhousie University in Halifax, Nova Scotia.

According to a 2005 article in the Journal of Social Work Research and Evaluation, the irp is "the first known attempt to design research that addresses the challenges of comparing resilience-related data across diverse international cultural and environmental contexts."

Resilience as a concept in the social sciences is relatively new, says Dr. Linda Liebenberg, irp project manager since the project's inception, but taking a "very Western concept" and going "in the opposite direction" is groundbreaking. Like other resilience research, which over the past 30 years has focused on individual capacities, coping styles and protective mechanisms, the irp is looking at how young people navigate and negotiate the risk factors that surround them in their environment. This evolving ability - navigating and negotiating risk factors, challenges and problems - is the basis for building resilience. The irp team describes four aspects to resilience: individual traits and characteristics, relationship factors, community contexts and social and political aspects of culture.

The irp received initial funding in 2001, which facilitated the project launch in 2002. Through word-of-mouth, a culturally relevant to them for their own purposes and use.

The irp found, as expected, that certain challenge themes exist for youth in some countries, but not in others. For example, economic and political upheaval impact youth in Russia and China; racism in southern Florida; crime and violence in Columbia and South Africa; war in Israel and the Palestinian Occupied Territories; poverty in India; social disintegration among the Innu nation youth of Labrador; mental health and addictions problems in Halifax; and life in care or on the street in Winnipeg, Manitoba.

Dr. Quinton Adams at the University of Stellenbosch near Cape Town, South Africa, says his country's biggest problem is poverty - people who have empty pockets and don't have any food to eat. Hopelessness is pervasive, especially in the squatter camps, where there is no infrastructure like roads and sanitation. But as the three-year irp study unfurled, the youth began to trust and "started to open up," says Adams. "Then we could see that there is resilience, but someone needs to mediate and foster that resilience."

For Dr. Mary Armstrong, Boothroyd's colleague in Florida, "One of the surprising findings of our study of girls here in the u.s. ...
was the importance of their relationships with their mothers.” While relationships with teachers were important in terms of helping youth get through school, “girls talked about their mothers as being the most important person in their life, much more than their friends.” Another surprising finding? “Seventy per cent of daughters exhibited signs of depression in at least one year of the study. There was a lot of depression, which we did not expect,” says Armstrong.

It’s clear what is on the minds of youth involved in the irp in both South Africa and Florida. The question that scored the highest site mean (i.e., most frequently answered affirmatively in the context the question was framed) was Is getting an education important to you? Two other questions in the top 10 mean scores were common to youth in these two countries: Do you feel safe when you are with your family? and Are you proud to be ____ (nationality)?

Many factors influence a person’s resilience-building capacity, says Ungar: “A growing number of studies are showing that it’s not just individual temperament and personal abilities, mentoring, relationships and caring adults and peer relationships and attachments that are important,” says Ungar. “We are also seeing some notions that if you are in a cohesive community, one that has some sort of sense of purpose and cohesion, and is safe and provides for your material needs, that is also important, as well as having a cultural identity and some sort of religious or spiritual sense of the world.”

In Gambia, West Africa, traditional rules and practices, which include religious teachings, may have too tight a grip on the psyche of young citizens. “The culture and religion hold people back and hold them down,” says Louanne Devanney of the Nova Scotia Gambia Association, the ngo that administered their irp in Gambia. “They tend to be somewhat fatalistic, where you believe that other people are in control of how your life turns out, that what you do isn’t really that important,” she says. As a result, young men (but not young women) suffer “the nerves” or “the urge to travel.” Devanney explains: “A young man gets that when he’s perhaps in his late teens and he’s starting to realize there’s no future for him in his own country and he wants to get out, to go somewhere where he can, perhaps, through his own efforts, make something of himself.”

Many of these young men pay “pirates” for a seat in a wooden fishing boat to ferry themselves over to the Canary Islands or to Morocco. Unfortunately, many of them drown en route.

But other young men stay in Gambia and succeed: “A young man who started working with us as a teenager on peer education, through the past dozen years or so has moved up and he’s probably now one of the most respected development workers in the country. He came from extreme poverty and received assistance to go through high school and worked very hard,” says Devanney.

“So again, when you talk about resilience, you ask, ‘Why are these people special, what is it about them, what do they have that kept them from succumbing to ‘the nerves,’ and instead they stayed in their own countries and have families and good jobs and are well-respected? What is different for them?’”

For Liebenberg, two findings have impressed her: “The first one is how many people are out there who, in whatever capacity they can, have really committed themselves to understanding and working with youth. The second thing is what a clear understanding youth have of their lives, just how they seem to have analyzed their context and their situation. It’s really clear that they have spent a lot of time thinking, ‘What do I need to do to be regarded as successful by my community, and how does that align with my idea of success?’”

Ungar hopes this first pilot study will lead to more research in the irp communities and beyond: “What people really want to do is run much larger studies of more kids in their communities and then move from theory to action, find out what it is that really predicts which kids will survive best, and then develop interventions and programs and some sort of community-wide initiative that actually creates the conditions where those kinds of things the kids themselves are saying help them survive are available.”

In 1999, resilience researcher Marc A. Zimmerman noted that more is actually known about the pathology of at-risk children than about why youth in at-risk situations become well functioning. The findings of the irp will likely go far in redressing that knowledge gap and promoting youth resilience.

For more information about the irp, visit the web site at www.resilienceproject.org.
**Breast milk reduces withdrawal symptoms in babies of addicted mothers**

Feeding breast milk to the babies of drug-dependent mothers can ease the infants’ withdrawal symptoms, according to researchers at the Royal Hospital for Women in New South Wales, Australia. The study included 190 babies born to drug-dependent mothers between 1998 and 2004. Of these, 85 were fed breast milk (either breast fed or fed expressed milk by bottle or tube) and 105 were fed formula. Most of the mothers were addicted to opiates, and most were on methadone treatment during the period of the study. (Methadone is now believed to be safe for breastfeeding mothers and their infants.) The incidence of infant withdrawal, known as neonatal abstinence syndrome (NAS), was the same for both groups of infants. However, withdrawal symptoms during the first nine days of life, as measured on the Finnegan objective scoring system, were much lower among infants fed breast milk. Time to withdrawal among infants fed breast milk was significantly longer (10 days) compared with formula-fed infants (3 days). Breast milk also reduced the duration of hospital treatment for NAS by about 20 days and reduced the need for medication to treat NAS. Women were discouraged from breast-feeding if they were intoxicated and could not ensure the safety of the infant. The researchers suggest that health care professionals encourage the mothers of infants at risk of NAS to breastfeed when safe to do so.


**Nicotinic agonist improves cognition in schizophrenia**

A proof-of-concept trial from the University of Colorado Health Sciences Center in Denver indicates that the alpha-7 nicotinic agonist DMXB-A can improve neurocognition in people with schizophrenia. An estimated 80% of people with schizophrenia smoke, with an average consumption of 30 cigarettes per day, apparently in an effort to self-medicate with nicotine. The hope is that nicotine might be replaced by a more effective nicotinic agonist such as DMXB-A, thus allowing people with schizophrenia to realize even greater neurocognitive benefits without the health risks associated with tobacco use. Researchers in this trial studied 12 individuals diagnosed with schizophrenia who were being treated with neuroleptic medications. The participants were all nonsmokers for at least one month prior to the trial, which took place from April to August 2004. Patients were given oral doses of DMXB-A (150 or 75 mg), followed by half doses (75 or 37.5 mg) two hours later. Others were given a placebo. Significant neurocognitive improvement was found on Repeateable Battery for the Assessment of Neuropsychological Status (RBANS) scores, but only for the lower DMXB-A dose compared with placebo. The authors report that “two patients spontaneously remarked that the drug helped them think more clearly and maintain concentration.” A third patient reported that her voices had “shrunk to whispers.” The only reported side effect was moderate drowsiness. A phase II trial has been initiated, involving the administration of DMXB-A over a period of one month.


**Children of depressed parents at risk for mental and physical disorders**

The offspring of depressed parents face an increased risk of anxiety disorders, major depression and substance dependence, research from Columbia University and the New York State Psychiatric Institute suggests. The study included 101 offspring of moderately to severely depressed parents and 50 off-spring of non-depressed parents. At the beginning of the study, participants were between age 6 and 23. They were followed for 20 years, to an average age of 35. Data were collected in four waves over that period. At the 20-year follow-up, the offspring of depressed parents were approximately three times as likely to suffer from anxiety disorders (mainly phobias), major depression and substance dependence. The rate of bipolar disorder among the offspring of depressed parents was 14% at the study’s conclusion; none of the offspring of non-depressed parents developed bipolar disorder. Interestingly, although 83% of the at-risk group reported some form of mental illness, only 38% received treatment. The offspring of depressed parents were also five times as likely to report cardiovascular problems and twice as likely to report neuromuscular disorders. Overall, they were twice as likely to report physical health problem. At 20-year follow-up, the offspring of depressed parents were functioning more poorly overall, at work and in their extended families. Given the risk of psychiatric and medical problems, the researchers suggest that improved treatment of depressed parents may have beneficial effects on the physical and mental health of their children. They also recommend efforts aimed at early detection of psychiatric and medical problems in offspring.


**Gender differences seen in consequences of domestic violence**

Research from Columbia University in New York finds that women are more likely than men to experience psychiatric disorders as a result of domestic violence. Using data from the Dunedin Multidisciplinary Health and Development Study in New Zealand, researchers followed 1,037 individuals from adolescence to early adulthood. Psychiatric disorders were diagnosed at age 18. Partner abuse was measured between ages 24 and 26, and psychiatric disorders were again measured at age 26. Thirty-eight women and 37 men had become involved in abusive relationships as determined using the Partner Conflict Calendar. Men and women reported the same rates of victimization. Psychiatric disorders at age 18 predicted involvement in abusive relationships for men and women. Among women, abusive relationships were predicted by major depressive disorders and marijuana abuse; among men, they were predicted by major depressive disorders, marijuana dependence, alcohol dependence and anxiety disorders. However, when controlled for previous psychiatric history, abusive relationships predicted subsequent psychiatric disorders only in women. The resulting disorders included major depressive disorders, marijuana dependence and post-traumatic stress disorder. In contrast, men’s psychiatric disorders tended to reflect their psychiatric history in adolescence. The authors recommend that clinicians routinely ask questions about partner abuse in evaluations of young women and be prepared to refer clients to the appropriate resources.

Behavioural problems predict substance use in teens

Aggressive teens are more likely to experiment with tobacco and marijuana, according to new research from the National Institutes of Mental Health in Bethesda, Maryland. Previous research has indicated that teens with attention-deficit/hyperactivity disorder (ADHD) are more likely to experiment with illicit substances; however, there has been speculation that this is actually due to associated conduct disorder (CD). This four-year study followed 78 adolescents between age 12 and 14 in the metropolitan area of Baltimore and Washington, D.C. Twenty-eight were healthy subjects, and 50 were diagnosed with either ADHD or CD. Externalizing symptoms (including aggression, impulsivity, hyperactivity and conduct problems), social problems and somatic complaints were assessed at study entry. After four years, 37 of the teens had used no substances, 41 had experimented with at least one substance and 29 had tried more than one substance. Twenty-seven had used tobacco, 36 had used alcohol and 22 had used marijuana. The level of use for all substances was generally low — only three cases amounted to substance abuse. Psychiatric diagnoses (ADHD, ADHD and CD, ADHD and either depression or anxiety) did not predict substance use. In general, externalizing problems were more closely associated with substance use initiation. After logistic-regression analysis, aggression turned out to be the only significant predictor of tobacco and marijuana use initiation; impulsivity predicted alcohol use initiation. Linear-regression analysis showed that aggression predicted the use of the greatest number of substances. The fact that impulsivity predicted alcohol use and aggression predicted marijuana and tobacco use suggests that different biological vulnerability factors underlie initiation of use for these substances. The researchers suggest that efforts to identify at-risk youth should focus on behavioural symptoms rather than psychiatric diagnoses.


School anti-bullying programs can be effective

Anti-bullying programs can reduce school bullying, especially if they are accompanied by written policies against bullying, according to a two-year study from the Netherlands Organization of Applied Scientific Research in Leiden. The study followed 3,816 children aged 9 to 12 attending 47 elementary schools. The schools were divided into three groups: an intervention group of 15 schools that implemented anti-bullying programs and two control groups comprising the remaining schools. Teachers at the intervention schools participated in two-day training sessions on bullying and six of the intervention schools drafted written anti-bullying policies in the first year of the study. By the end of the first year, the number of bullied children had decreased in the intervention schools from 18% to 15%, but had increased from 15% to 17% in the control group. Children in the intervention schools also reported a decrease in depressive symptoms and an improvement in relationships with peers. However, by the end of the study's second year, there were no longer any significant differences in bullying activity between the intervention and control groups, as intervention schools discontinued their anti-bullying programs. The differences in depression and peer relationships had also disappeared. However, children at schools that had implemented written anti-bullying policies fared slightly better. The researchers conclude that, to be effective, anti-bullying programs should be continued every school year and include written anti-bullying policies.


Coffee protects against alcoholic cirrhosis of the liver

Coffee appears to reduce the risk of cirrhosis of the liver, especially cirrhosis resulting from long term alcohol abuse, according to new research from the Kaiser Permanente Medical Care Program in Oakland, California. Researchers there examined 128,580 men and women who were initially free of liver disease when they entered the study between 1978 and 1985. By the study's conclusion in 2001, 330 participants had been diagnosed with cirrhosis, 199 of whom had alcoholic cirrhosis. The researchers found that each cup of coffee consumed per day was associated with an average 22% reduction in the rate of alcoholic cirrhosis, while the comparable reduction for nonalcoholic cirrhosis was 8%. They found that consumption of alcohol increased levels of liver enzymes (aspartate aminotransferase and alanine aminotransferase) that are considered indicators of liver damage and liver disease. However, those enzyme levels were lower among those who consumed coffee in addition to alcohol. Tea drinking did not reduce rates of cirrhosis, suggesting that coffee's protective effect may not be due to caffeine, although tea has less caffeine than coffee. The authors speculate this protective effect is due to one of the many other active ingredients in coffee — an ingredient whose identity has yet to be determined. They also caution that the best way to guard against alcoholic cirrhosis is to reduce alcohol consumption, rather than drinking coffee in addition to alcohol.

Archives of Internal Medicine, June 12, 2006, v. 166: 1190-1195. Arthur L. Klatsky et al., Department of Medicine, Kaiser Permanente, Oakland, California.
Coming full circle
Cultural restoration for First Nations wellness

BY BILL MUSSELL

VOICES CALLING FOR SERVICES TO ADDRESS FIRST NATIONS mental health, addictions, youth suicide and mental illness have increased in recent times, thanks to the fine work of the Royal Commission on Aboriginal Peoples, the Standing Senate Committee on Social Affairs, Science and Technology and other national entities such as the Canadian Alliance on Mental Illness and Mental Health.

The Senate Committee underscored the unique mental health challenges faced by First Nations and Inuit people as an issue of primary concern for federal, provincial and territorial governments: to improve mental wellness outcomes for these groups and to have the perspective of First Nations and Inuit people more closely linked to the development of policies, programs and services.

For over two decades, the First Nations and Inuit Health Branch of Health Canada has funded First Nations addictions treatment and counselling services. It is evident at the community level that it is vital to provide complementary mental health services and extend these to more First Nations. Canada's Inuit, like First Nations leadership, stress the importance of community-based decision-making, establishing culturally rich programs, new service networks, treatment resources, capacity-building opportunities and integration of services.

To honour principles of wholism, connectedness, togetherness, cultural ways of knowing and core cultural institutions such as family and clan, the following definition of “mental wellness” presented in the 2002 Mental Wellness Framework, has gained popularity: “Mental wellness is a lifelong journey to achieve balance of body, mind and spirit. It includes self-esteem, personal dignity, cultural identity and connectedness in the presence of harmonious physical, emotional, mental and spiritual wellness. Mental wellness must be defined in terms of the values and beliefs of Inuit and First Nations people.”

For many First Nations Peoples, mental health is not a function simply of the individual but of social structures outside the person that teach practices to maintain, support and restore balance. Key aspects of these structures are family and community, which contain systems responsible for education, recreation, special care and employment, and other valued aspects of life. Mental illness is the outcome of a lack of balance or harmony in one or more aspects of these essential systems, a lack of which may be a consequence of forces that deprive or overwhelm these systems.

According to the Royal Commission on Aboriginal Peoples, good health is the outcome of living actively, productively and safely, with reasonable control over the forces affecting everyday life, with the means to nourish body and soul, in harmony with one’s neighbours and oneself, and with hope for the future of one’s children and one’s land.

When all things of the Creator are respected and honoured, especially the land and its resources, care of human life becomes foremost among values. Such care, when given, ensures that ill health is prevented, healthy infants are born, young people are engaged in everyday and special activities so that their lives are culturally rich and the needs of elders receive priority attention.

Colonization brought changes that attacked, undermined and devalued the aboriginal worldview, while at the same time drastically altering the conditions of life. Through their government, the churches and residential schools, the colonizers imposed the European worldview, values and beliefs upon Aboriginal Peoples. Through the introduction of foreign diseases, the imposition of the reserve system, prohibitions against spiritual practices and speaking of traditional languages, and the introduction of alcohol, all aspects of aboriginal life deteriorated. Colonization brought negative, extreme and rapid changes to aboriginal life, while denying the validity of the tools traditionally used by First Nations to cope with change.

Among the consequences we see today are stressed aboriginal communities and, too often, the absence of a clear set of values, beliefs and strategies necessary to guide people in their efforts to cope with stress. When physical and emotional safety and security are lacking, fear, anxiety and anger build. In these states it is very difficult to act in caring, rational ways, to learn, to be reflective and to create understanding both of themselves and their world necessary to bring about positive changes.

No mental health care system or social service system has been provided to First Nations. The more traditional and natural ways of caring have been displaced by Western ways that continue to be foreign to these communities.

It is essential that First Nations learn their family and community history and explore this history in the context of worldview. Such knowledge builds understanding, reveals the relationship of the past with the present and the future and provides tools necessary to engage in the process of making personal and social change. Some communities have access to mental health services on an as-needed basis, but not to funded programs or service systems that are culturally based and feature wholistic healing.

Practices based on traditional ways would be preventive. Caregivers would intervene at the first signs of difficulty. This approach to care shows that the caregivers do not expect the worst to take place – they are not crisis-oriented. It shows attunement to one another and awareness that imbalances experienced by one individual affect others if they are ignored. Bringing addiction and mental health resources together at the community level could do a great deal to restore family and community wellness.

The spirit that holds a relatively healthy group of families together is embedded in community. This strength is connected with living on the land that has been home for many generations. For its members, the healthier community offers physical, psychological, intellectual and spiritual resources. Social and emotional health link each person to family, community and the earth in a circle of dependence and interdependence. Community members enjoy wellness.

W. J. (Bill) Mussell, who is of Sto:lo (First Nations) heritage, is manager and principal educator of the Salishan Institute in Chilliwack, British Columbia, and chairman of the Native Mental Health Association of Canada.
Sacred smoke, silent killer

Spiritual use or tobacco abuse?

BY JOSEPH WINTER

TO MOST NORTH AMERICANS, TOBACCO IS SIMPLY AN addictive, recreational drug, readily available in cigarette, pipe, cigar, chewing and snuff forms. Tobacco is considered a commercial product made from the leaves of a plant raised by farmers, processed by factory workers, and sold by neighbourhood stores, gas stations and other locations.

But for many Native Americans, tobacco is like sacramental wine – a sacred substance with the power to heal, transform and create. And just as wine can addict and kill, tobacco is so potent and powerful – in some tribes achieving the status of a deity – that it sickens, kills and destroys when used improperly.

A Navajo friend who raises wild mountain tobacco (Nicotiana attenuata) for ceremonial purposes explained to me that lung cancer and other tobacco-related diseases are caused when people use tobacco – any kind, commercial or traditional – the wrong way. “They [tobacco] grow on their own,” he told me. “Every year they reappear from new seeds to give me power. They are Diyin – holy people – holy spirits, like Yelii, with great medicine. And they’re very dangerous. You have to use them with respect, as prayers and offerings in ceremonies, so they’ll reward you. But if you use them without respect, if you smoke them like cigarettes, their power will kill you.”

Another friend – a cancer specialist at Johns Hopkins University – has good news and bad news for Native Americans. The good news is that their overall rates of lung cancer, heart disease and other tobacco-related diseases are lower than the rates for non-natives. The bad news is that their rates are rising, as more First Nations people smoke or otherwise use commercial tobacco on a regular basis, and fewer use native tobacco in traditional rituals and ceremonies, where the amount is carefully controlled.

Tobacco is the heart of aboriginal religion and culture. Many First Nations people continue to use it in a sacred manner, and others smoke, chew and snuff it in the same manner as non-natives – as an addictive, recreational drug. For the traditionalists, there is nothing recreational about tobacco, for it is a sacred plant, a life-affirming force, a food of the spirits, at times a god itself. From southern Chile to Alaska and northern Canada, aboriginals have used and continue to use Nicotiana rustica, N. tabacum, and other tobacco species as a ritual narco-stimulant – a psychotropic, mind-altering substance that serves as a medium between the ordinary world of humans and the super-ordinary world of spirits. Tobacco leaves are smoked in cigarettes, cigars and pipes. Leaves are chewed, sometimes with lime, and often eaten. Concentrates and resin are licked. Infusions are drunk, occasionally with Datura and other hallucinogenic plants. Tobacco powder is snuffed. Leaves are used medicinally as poultices and smoke is blown on the body. Tobacco incense is burned. Tobacco offerings are buried, cast on the ground, into the air, onto the water. Tobacco gods and related spirits abound. Cihuacoatl, the Aztec earth goddess and mother of other gods, appeared on earth in the form of a tobacco plant. Morning Star, one of the principal Crow deities, turned into tobacco. The very act of creating the universe could not take place until Earth Mother and Sky Father – two of the most important Navajo gods – smoked tobacco, so they could think about the awesome task that lay ahead.

Tobacco sprouted from the brain of the Iroquois mother goddess after she died and was buried. The Iroquois False Faces crave tobacco and depend upon it for life. In return for regular offerings of

Joseph Winter is former director of the Traditional Native American Tobacco Seed Bank and Education Program at the University of New Mexico, and the Native American Plant Cooperative.
WHEN I FINISHED MY SPECIALTY TRAINING IN 1998 AND became the first female aboriginal psychiatrist in Canada, I regarded the landmark not so much as the height of personal achievement but as the beginning of a working journey to help improve the mental health status of Aboriginal Peoples in this country. I had spent many years living in major urban centres, attending post-secondary institutions and acquiring the necessary knowledge and experience to practise as a psychiatrist. These years also instilled in me a desire to return to and work in a First Nations community. When I began working at Six Nations Mental Health Services, a community mental health clinic based on the Six Nations of the Grand River Territory reserve near Brantford, Ontario, I felt relatively confident that I had most of the tools I would need to provide quality psychiatric services. But I soon learned that I had about half of what would be required. I realized that I would have to learn about and establish a connection with the community and its members, including the keepers of indigenous knowledge and traditional healers, in order to be most effective in my role.

Six Nations of the Grand River Territory is the largest First Nations community in Canada. It has a total band membership of over 22,000 people, over half of whom live on-reserve. The community is actually comprised of six different First Nations: the Mohawk, Oneida, Onondaga, Seneca, Cayuga and Tuscarora peoples, who together are known as the Haudenosaunee peoples. There is some division within the community between those who have maintained their traditional beliefs and lifestyles and those who have adopted a more westernized way of living. There remains a schism within the community between those who have maintained their traditional beliefs and lifestyles and those who have adopted a more westernized way of living. There remains a schism between those who support the federal government-supported elected Band Council and those who maintain the traditional, hereditary chiefs system of governance.

The community also experiences stress at times of broader crises, such as the recent and ongoing land claims blockade in Caledonia. Being a member of the Little Grand Rapids First Nation (Ojibway) in northern Manitoba meant that, although I am an aboriginal person myself, I had a lot to learn about the community that I had chosen to live near and practice in.

When Six Nations Mental Health Services was established in 1997, a great deal of effort went into the planning of a mental health service that would meet the standard of care that one could receive at any mainstream outpatient psychiatric clinic but that would also be respectful of and relevant to our aboriginal clients. There were several major challenges to be met. It is an unfortunate part of Canada's past and present that its Aboriginal peoples have suffered historical traumas, including colonization, the residential schools experience and racism. These multiple traumas are sometimes a factor in Aboriginal Peoples' reluctance to seek help in times of distress and are also a social-cultural determinant of health that contributes to the gap in health status between aboriginal people and the general Canadian population.

Within the Six Nations community, there is a strong sense of pride and a will to preserve many of our traditional ways, including languages and traditional forms of healing.

Aboriginal Peoples have been under-serviced in terms of health care generally and continue to experience difficulties in accessing medical services, including psychiatric services, whether they live in a remote northern community or in a large urban city. Aboriginal people are sometimes discriminated against even when they are able to access services. A 2004 opinion poll conducted by the National Aboriginal Health Organization (NAHO) found that only 56 per cent of Aboriginal Peoples felt they were treated as well as non-aboriginal people in the health care system. Stigma about mental illness and those who suffer from mental illness is a significant factor in many aboriginal communities.

Within the Six Nations community, there is a strong sense of pride and a will to preserve many of our traditional ways, including languages and traditional forms of healing. When our clinic was in its initial phases, staff spent a significant amount of time with several well-respected traditional healers in the community, trying to reach an understanding of what each of us could offer as well as establishing a way of working together for the benefit of our clients. I felt it was my role as psychiatrist to complete an assessment of each client and...
then work with each individual to formulate a “problem list” of what each client wished to work on and a management plan that included a list of treatment options the client could choose from. If the client wished to pursue traditional healing concurrently with the western medical approaches I was trained in, then I had to respect that. It was not an unusual scenario for us to have a client attending our clinic, being followed by me and the nurse case manager and taking prescription medications while seeing the traditional healer and perhaps even taking “Indian medicines” concurrently. In this case, we ensured that the client, our clinic staff, the pharmacist and the traditional healer were all aware of the combined approach so the client could be monitored closely for any adverse effects (e.g., drug-drug interactions if clients were taking both prescription medications and Indian medicine).

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In a more subtle way, as our model of delivering mental health services developed over the years, the nurses and I began to realize that being aboriginal ourselves, although not traditional healers, we had incorporated many of our traditional teachings into how interacted with clients. We furnished the clinic to provide a warm, welcoming environment. Our client interview room resembled a living room more than an office, to put people at ease. We decorated the clinic walls with works by local indigenous artists, partly to help instill a sense of pride and increase awareness that aboriginal people can succeed in Canadian society in diverse ways. If I was running late for an appointment, it was not unusual for me to pop my head into the interview room and offer an apology and a cup of tea for the waiting client. This may sound quite simple and intuitive, but these are ways in which we showed respect and established trust with clients in a way they could understand.

I was not opposed to referring clients for standard forms of psychotherapy such as cognitive-behavioural therapy or interpersonal psychotherapy, but during the eight years I practised at Six Nations, I developed my own style of being “psychotherapeutic” that I felt was more consistent with our traditional ways.

My years of training during my psychiatry residency taught me how I was to appropriately interact with my patients. For example, if a patient were to ask me a personal question, such as “How old are you?” I was trained to answer along the lines of “Why do you think it is important to you to know how old I am?” During some of the earliest encounters with my Six Nations patients, I was often asked how old I was. I would simply answer, “33. Next question?” and we would both have a bit of a laugh and the clinical interview would continue. I learned that it was an important part of establishing trust in the therapeutic relationship to be able to offer some of my own history to my clients. Many of them were curious about me and how I managed to become a psychiatrist. It became part of my role at the clinic and within the Six Nations community to serve as a role model, especially to young people.

I was not opposed to referring clients for standard forms of psychotherapy such as cognitive-behavioural therapy or interpersonal psychotherapy, but during the eight years I practised at Six Nations, I developed my own style of being “psychotherapeutic” that I felt was more consistent with our traditional ways. One way that Aboriginal Peoples have coped with adversity over the years is by developing a strong sense of humour. It is present in many of our stories and songs. I laughed often with my clients, even when they were deeply distressed, while at the same time being sensitive to that distress. I grew to care for my clients, many of whom I followed for years and with whom I experienced life’s milestones. I was present the day one of my long-term clients gave birth to a daughter. I attended the funerals of my patients and some of their family members. When my father died in 2005 and I had to miss a week of clinics to travel home for the funeral, I was sincerely touched by the cards and small gifts my clients had brought to the clinic in my absence. I learned to practise psychiatry keeping our seven traditional teachings in mind: wisdom, respect, love, bravery, honesty, humility and truth. I learned that I could not practice in the community without becoming a community member myself. I realized that after all the years of being away at school, I had finally been welcomed back home.

Cornelia Wieman, M.D., FRCPC, is an Assistant Professor and Co-Director of the Indigenous Health Research Development Program in the Faculty of Medicine, University of Toronto.
NUMEROUS THEORIES HAVE BEEN OFFERED TO EXPLAIN the high rate of addiction and mental health issues among Aboriginal Peoples. I am a mental health and addictions clinician and First Nations person, so this debate has both professional and deeply personal implications for me.

Many of these theories posit that a predisposition exists among Aboriginal Peoples, due to biological, genetic/physiological or psychosocial/economic conditions. But these theories offer a limited perspective of both the cause and impact of addictions and mental health on individuals, their families and the aboriginal community.

Emerging from this discourse are a few more recent voices from within the psychosocial/economic discussion that provide an opportunity for clinicians to revisit their understanding of why a disproportionate number of aboriginal people have mental health and/or addiction issues. Intergenerational trauma has emerged in the last decade as an explanation for an array of social phenomena experienced by aboriginal people at rates disproportionate to the general population (see sidebar).

Intergenerational trauma requires the counsellor to review the person symptomatically from a historical perspective. We need to consider the individual as a member of both an extended family and a community, with a distinct social and political history.

The relationship between Canada's first peoples and the Canadian government is unique. The first people to reside on this land have been subjected to differentiated policies and programs, which have contributed to the current social, political and economic conditions and health of Aboriginal Peoples. As a tool of government, Canadian social policy has been instrumental in creating institutions that have eradicated value systems that had existed for thousands of years, replacing them with doctrines that continue to disrupt life for Aboriginal Peoples today. Three specific policies have directly affected traditional aboriginal life, contributing to the social disenfranchisement experienced by many aboriginal people: the Indian Act, residential schools and the child welfare system.

When the Indian Act was introduced in 1876, the Indian Act immediately established the federal government as the “guardian” of Aboriginal Peoples. To this day it continues to define who is “Indian” and who is not, restricting opportunities available to certain people while relegating the responsibility of others to a social and economic policy vacuum. Canadian government used institutions, including the Roman Catholic Church, to bring about widespread social change in aboriginal communities. Residential schools acted as vehicles of assimilation and cultural extinction by removing children from the care of their families and communities and instilling the values and language of another cultural group. Numerous reports have documented that many children in these institutions were subjected to psychological, emotional, sexual and physical abuse. While estimates vary, it is generally agreed that approximately 100,000 children attended these schools. What we need to keep in mind is that approximately 80,000 to 90,000 residential school survivors are currently living, according to Statistics Canada.

With the closure of residential schools, child welfare policies replaced institutions as the key instrument of acculturation. Over the last 40 years, a disproportionate number of aboriginal children have been removed from their homes and communities and placed in non-aboriginal foster care or adopted by non-aboriginal families across North America and Europe. Their displacement has resulted in the loss of language, traditions, family connections and community.
Today, it is believed that there are 22,500 Aboriginal children in care across Canada.

The impact of multiple generations experiencing trauma after being removed from family and community has only recently been explored within Canadian Aboriginal communities. In a 2000 issue of the Canadian Journal of Psychiatry, Kirmayer, Brass and Tait suggest: “The emphasis on narrating personal trauma in contemporary psychotherapy is problematic because many forms of violence against Aboriginal people are structural or implicit and so may remain hidden in individual accounts. … Individual events are part of larger historical formations that have profound effects for both individuals and communities.”

In my doctoral thesis “Orphans Within Our Family: Intergenerational Trauma and Homeless Aboriginal Men,” I explored the link between intergenerational trauma and homelessness among aboriginal men in Toronto. Many of the men interviewed for the study disclosed physical, sexual and emotional abuse at the hands of caregivers, including family members. For many, their personal traumatic experiences were often shadowed by the experiences of parents and grandparents who had similar life histories. Many of the men indicated they had no connections to their families, community and nation. In fact, most had limited knowledge of their community’s traditions, heritage and ceremonies. Some of the men even wondered what they were doing in these bodies, and expressed concerns of discrimination and racism. In regards to their immediate future, many of the men saw no future – most had no idea what or where they will be the next day. The intergenerational model emerged from this exploratory study as a tool with which to understand an array of indicators experienced by the men. These indicators can occur in four distinct realms: personal, family, community and nation. Rather than pathologize the individual behaviour (i.e., addiction, mental health condition), the model requires that individual responses be examined in the context of public policy and cultural affinity.

As a frontline therapeutic team, Aboriginal Services at the Centre for Addiction and Mental Health (camh) in Toronto uses history and culture as a basis from which individuals come to explore their addictions and mental health issues. Using a multidisciplinary approach to assessment and treatment, our aboriginal therapists and a community-based psychologist work with the team’s cultural Elder to help our aboriginal community members explore these connections. As a treatment team, we frequently refer to our nation’s history and can identify the links between historic public policy and current issues experienced by many of the individuals we support. It is important that these links are explored in great detail and with a lot of patience. Engaging in this type of therapeutic process is a commitment not only to the client but also to the aboriginal community as a whole. This type of intervention does not have a time limitations or estimate times of completion; rather it is an intervention that can last for many years.

I have been working with one man for more than six years who illustrates this reality, and who has made incredible gains. When I first met him, he was sleeping on a heat blower in downtown Toronto and smelled of alcohol. He agreed to attend the medical detox and residential treatment at camh and to continue with aftercare programs. At first I would see him for two sessions a week that ran between two and three hours. In these sessions we explored many of the issues confronting him using both Western (cognitive behavioural therapy) and aboriginal intervention (aboriginal life stages) methods. Today, he is living in an apartment, attends a post-secondary institution and has been sober for more than four years. He is excited about what the future holds for him.

Consideration of intergenerational trauma in the diagnosis and treatment of aboriginal people requires an appreciation for the political, historical and social environment from which aboriginal individuals, families and communities have emerged. In order to go forward, we must learn from the past.

Peter Menzies is Manager of Aboriginal Services at the Centre for Addiction and Mental Health in Toronto.
Inuit trauma/addiction program tackles massive challenge

BY RICK MAYOH

AT AGE 25, GEOFF KILABUCK ALREADY HAS KNOWN 33 PEOPLE who have committed suicide. The suicide rate among Canada’s aboriginal (First Nations, Métis, Inuit) youth is six times the national average. Even more staggering, the figure among Inuit youth climbs to 11 times the national average, one of the highest rates in the world, according to the National Inuit Youth Council.

Kilabuck is from the Nunavut capital of Iqaluit, population 6,000, on Baffin Island. Ten of the centre’s 13 full-time staff are Inuit. Tungasuvvingat Inuit (“a place where Inuit are welcome”) provides social, cultural and counselling services to Inuit locally and Tungasuvvingat Inuit’s clientele is a blend of Inuit living in small communities, says Tungasuvvingat Inuit’s version of the biopsychosocial model. “It’s a very flexible, holistic approach. We decided to go with harm reduction and abstinence to give people choices.” Chouinard says the substances of choice are primarily marijuana and alcohol, with crack cocaine rising rapidly. Most clients choose harm reduction for the former and abstinence for the latter two.

Tungasuvvingat Inuit’s residential program began in September of 2003, with funding from the Aboriginal Healing Foundation (ahf) to operate Pigiarvik House, a nine-bedroom facility in central Ottawa that can accommodate 12 people in each cycle. The agency has about 200 open files (including 70 men) and treats about 60 people each year. A contract with the Government of Nunavut to treat 20 clients annually began in 2004. The agency receives $570,000 from the ahf and $170,000 from the Government of Nunavut each year.

Programming is delivered in Inuktitut and English in a beautiful old house nearby, filled with Inuit artifacts and the wafting aroma of staff cook Jeanie Schofield’s offerings, which include traditional “country food” such as caribou, Arctic char and, occasionally, seal.

Family, couples and individual counselling also are available. Day programming is offered to Inuit living in Ottawa or staying with relatives. Following an intensive eight-week cycle, continuing care is available three times a week for a total treatment term of two-and-a-half years. Family, couples and individual counselling also are available.

The sculptures shown here are the work of Manasiah P. Akpaliapik, an internationally acclaimed Inuit artist who attended Tungasuvvingat Inuit’s program.
“Most clients are in their early 30s and up, although we get some 20-year-olds,” says program director Pam Stellick. “At least half of the people score high on our post-traumatic stress disorder screening tool, and 90 per cent or more have residual trauma issues. We see very high rates of childhood physical and sexual abuse.”

“Success here can be a healthier lifestyle or a safer environment,” says Stellick. “It’s not a black and white thing. It could be getting your kids back from the Children’s Aid Society or not getting them apprehended in the first place.”

Training staff is of key importance to the program, says Stellick: “For this to be an Inuit-specific program, it has to be delivered primarily by Inuit.”

“Our strength is the character of our staff,” adds Chouinard. “My biggest hope is that we can train Inuit counsellors to work in the North and that it won’t be taken over by Southern culture. It’s not about doing the white man’s stuff.”

Chouinard says she knows her agency is a success because whenever she is in the North and the program is mentioned, people smile.

Although many clients are familiar with the South, some from small Arctic settlements face huge adjustments and experience culture shock just coming to Ottawa. One client absolutely beamed after his first encounter with a forest. Therapist Evic-Carleton moved to Ottawa 17 years ago from Pangnirtung, a Baffin Island community of 1,400, and says she relates to that client’s experience. “When I came down, there were all the cars, the buildings, the heat, the trees, too many choices for everything, such a fast way of living,” she says. “It’s very important for clients to be surrounded by people who speak their language, especially about the very deep things in their lives.”

Inuit people thrive in group therapy, so much so that weekday programming consists of group from 9:30 a.m. to 4 p.m., punctuated by breaks and lunch. Inuit history, assertiveness training, goal-setting and trauma and art therapy are among the focal points.

Each weekday begins with the ceremonial lighting of the qulliq, the traditional seal oil lamp once essential for heat, light, cooking, melting snow and drying clothes in an igloo.

There is plenty of fun and laughter during the program, as well as tears. On evenings and weekends, there are activities involving therapeutic recreation such as taekwondo and the ymca, Alcoholics Anonymous meetings and invited guest speakers. The program takes advantage of being in the nation’s capital, with visits to local landmarks, festivals and sports events.

Studying Inuit history has proven to be a powerful healing tool. Inuit are dealing with the intense intergenerational trauma of having their world turned upside down through federal government interventions in a very short span from the 1950s to the 1970s. In just two decades, a nomadic way of life that had flourished for thousands of years largely came to an end because of forced relocation into settlements. Inuit children were put in residential schools at age five and told not to speak their own language, resulting in an enormous disconnect with their parents.

Last year, Parliament’s Standing Committee on Aboriginal Affairs and Northern Development began a study into Inuit charges that tens of thousands of their beloved sled dogs were slaughtered by the RCMP across the North in the 1950s and 1960s to facilitate Inuit movement into settlements. “No wonder my parents and grandparents were drinking,” says one client. “They were angry. They couldn’t do anything about it. My mother lost our three dogs when she went to get wood for the fire. She said the RCMP shot them still in their harness. The old patterns I learned are going to stop with me,” she says. “I came here for my drinking problem and went through healing I didn’t expect. I think I’ve opened the door for my family. I feel rich in my heart.”

Therapists Evic-Carleton and Barbara Sevigny, who is originally from Iqaluit, present Inuit history in group. “It’s wonderful when people start looking and ask ‘Where is the pain coming from?’” says Sevigny. “A lot of people died of starvation, died from the cold and even died from being in so much pain because of the impact of residential schools, relocation and dog slaughter.”

One day client says he appreciates going back into Inuit history and the professionalism of the staff: “Even though there were times when I didn’t want to hear what the counsellors were telling me, it was what I needed to hear.”

Inuit elder Meeka Arnakaq is an Arctic College educator from Pangnirtung and is a unilingual Inuktitut speaker who serves as an elder with Tungasuvvingat Inuit. She compares Inuit pain to an iceberg, most of it still hidden below the surface: “Physical abuse only started very recently when we were put in communities,” she says. “People who were born in the 1980s are not aware of the things that were snatched from us.”

“I see the father having the most problems,” says Arnakaq. “Men don’t have that much protection. A man has to be proud. I see men who are ashamed of who they are. We see men with their heads down and their sons will grow up like them. If the sled is toppled over, it cannot go. It is stuck. The man is underneath. This is how Inuit men are today. They are stuck. Their responsibilities have been taken away. The qamutik (sled) has to stand up; the dogs have to start running. ‘Who is going to stand them up?’”

Rick Mayoh is a residential counsellor with Tungasuvvingat Inuit.
GEORGE FELT LIKE HE FINALLY FOUND A SUBSTANCE abuse program that worked. In the programs he had been involved with as an inmate at Stony Mountain Institution outside Winnipeg, Manitoba, he felt the atmosphere wasn’t always respectful or open to sharing issues. But that has changed with George’s participation in the Aboriginal Offender Substance Abuse Program (aosap), which is available at Stony Mountain, among other federal institutions. “Coming to a program that’s culturally based helps me to explore things a lot more in-depth,” says George, who is Ojibway. “It’s also created an atmosphere where you can open up more and feel better; it’s more respectful.”

Aboriginal people are overrepresented in federal institutions: 15 per cent of inmates are aboriginal, while only 2.8 per cent of the Canadian population is aboriginal.

With its unique focus on the cultural history of Canada’s Aboriginal Peoples, the program tackles offenders’ substance abuse problems and most importantly, addresses relapse, which is higher among aboriginal offenders than non-aboriginals, according to the Correctional Service of Canada (csc). “aosap focuses on developing a cohesive sense of who you are as an aboriginal person. The idea is in part what you need for community healing,” says Virginia McGowan, director of special populations research for csc in Ottawa. “It’s also a process of symbolic healing, where there are ideas and ways of doing things that are learned and become identified with that strong and coherent community identity. They become a vehicle for healing.”

Culturally specific treatment is certainly needed. Aboriginal people are overrepresented in federal institutions: 15 per cent of inmates are aboriginal, while only 2.8 per cent of the Canadian population is aboriginal, according to the csc. This percentage is even higher in Alberta, Saskatchewan, Manitoba, the Northwest Territories and northwestern Ontario, where the percentage of aboriginal offenders averages 39 per cent and reaches a staggering 64 per cent in some regions.

aosap began in a demonstration phase in 2004 with five institutions across the country. Intent on reducing Aboriginal offenders’ risk of relapse to substance abuse, it is designed as a holistic approach to dealing with addiction – one that looks at addiction through the physical, mental, emotional and spiritual facets of aboriginal culture.

With input from three csc branches – the Addiction Research Centre, Reintegrations Programs and Aboriginal Initiatives – the program features five modules, each with a specific goal. The program begins with an introduction to the cultural background and orientation to the program. The second, “trauma and healing” module examines aboriginal history and how it affected the community then and now. The third module looks more specifically at the relationship between substance abuse and the aboriginal community and introduces standard rehabilitation concepts and ideas, such as identifying triggers or high-risk situations. The fourth module addresses relapse.

ABORIGINAL PEOPLE AND CRIME IN CANADA

In a judgment rendered in 1999, the Supreme Court of Canada said that prison has replaced residential schools as the likely fate of all too many aboriginal Canadians. The excessive imprisonment of aboriginal people is only the tip of the iceberg as far as the estrangement of Aboriginal Peoples from the Canadian criminal justice system is concerned. These statistics show the extent of the problem:

- 69% of aboriginal offenders are under age 35 when they enter the system, compared to 55% of non-aboriginal offenders.
- 68% of aboriginal offenders are First Nations; the remaining 28% are Métis and 4% are Inuit.
- aboriginal offenders entering the system tend to be unemployed and have little education: An estimated 26% of aboriginal offenders entering prisons have less than a grade 8 education (compared to 18% of non-aboriginal inmates); and 75% of aboriginal offenders are unemployed coming into the system, compared to 66% of non-Aboriginal offenders.
- Aboriginal offenders tend to be released further in their sentences than non-aboriginal offenders.
- While aboriginal people make up only 6–7% of the general population in Manitoba and Saskatchewan, they comprise 72% of provincial jail admissions in Manitoba and 55% in Saskatchewan.
- In 1999, 35% of aboriginal people reported being a victim of crime, approximately 10% higher than for non-aboriginal people. Aboriginal people are also three times more likely to be victims of violent crimes than non-aboriginal people.

Source: Correctional Service of Canada, Profile of Aboriginal Offenders in Federal Facilities and Serving Time in the Community (www.csc-scc.gc.ca/text/jbict/forum/ e143/e143f_e.shtml); Canadian Centre for Justice Statistics, “Aboriginal Peoples of Canada.”
offenders have a different history and are coming from a different
cultural perspective, says Varis. “The biggest difference with this program is that Aboriginal
offenders have a different history and are coming from a different
cultural perspective,” says Varis.

Dr. James Waldram, a professor in the Department of Psychology
at the University of Saskatchewan, agrees about the importance of
culture in treatment. He explains that treating a sub-population such
as aboriginal offenders means group members can share their com-
monalities. “Studies across North America show a decline by middle
age in substance abuse for men still living in their reserve communi-
cies,” says Waldram. “The influence of the family in reserves keeps the
abuser more grounded in daily responsibilities. In northern and rural
communities, binge drinking remains a common pattern, with long
periods of abstinence. Thus, individuals do not become completely
disconnected from their families,” he says.

“Discrimination and racism play a role in the lives of aboriginal
men, more so than others,” adds Waldram. “It is more difficult for
them to get employment. Structural racism, in the form of poorer
access to education, still remains a problem. Other issues aboriginal
offenders may have dealt with include dysfunctional families. Foster
and adoptive experiences are common, and having parents who
themselves are abusers is also common.”

Intent on reducing aboriginal offenders’ risk of relapse
to substance abuse, aosap is designed as a holistic
approach to dealing with addiction – one that looks at
addiction through the physical, mental, emotional and
spiritual facets of aboriginal culture.

Varis is quick to point out that treating aboriginal offenders with
substance use issues is not entirely new to CSC. “When the Addiction
Research Centre was established in 2000, we noted there were aborig-
in substance abuse treatment programs across the country, but they
varied,” he says. “There was quite a variance by region. So when our
centre was created, it was in our portfolio to create a national aborig-
in offender substance abuse program.”

The program, whose emphasis is more on teaching than relying
on participants sharing and talking (for more one-on-one help, par-
ticipants are encouraged to sit and talk with an Elder, or get help from
the prison’s psychology department) is not as clinical perhaps as most
traditional treatment programs. “Every day we start the group with a
smudge ceremony. Any of the men participating go to the medicine,
mix it in a good way for them and then come to the circle and smudge
each person and offer a prayer,” says Tom Dahl, a Métis correctional
program officer at Stony Mountain. “After that, we sit in a circle and
pass the feather and every man is free to talk in any way he wants.”
Other aboriginal traditions and rituals include concepts such as the
Medicine Wheel, thinking about inner fire and the Seven Teachings.

To date, no formal research has yet been conducted (a formal
evaluation will be done at the end of the pilot), but anecdotal feed-
back from participants like George is positive. “Before the program, I
never thought about trauma,” says George. “I never thought about the
inside and outside of me the way I do now.”

“Coming to a program that’s culturally based helps me
to explore things a lot more in-depth. It has also
created an atmosphere where you can open up more
and feel better; it’s more respectful.”

McGowan agrees that the reaction from the inmates is positive.
“We have waiting lists of people wanting to get in. And the Elders
working with the offenders are giving us good feedback.”

As a work in progress, the program has required some fine-
tuning. Varis notes that early on, some module shuffling was in order.
“Trauma and healing was the third module and the information and
impacts of substance abuse was the second,” he says. “But we found
the men were ready to get into the trauma and healing work early
in the program, and they were very motivated to get at some of the
core issues. So we reversed the module order and built in additional
sessions”

aosap still faces challenges, namely life in prison. At any time,
institutions can get shut down for days or even a whole week at a
time, due to reasons such as security threats or even training for
institutional staff. “This program has to be consistent,” says Gordon
Nepinak, an Elder who works with aosap at Stony Mountain. “To
interrupt what we’re going through, to postpone what the men have
in their minds another day and another day and forgetting what we’ve
talked about is a problem.”

“We’ll be looking at whether we’ve actually reached the target
population, whether the facilitators and Elders are able to adapt the
program to the specific needs of their group, and whether it’s able to
be implemented as designed, and that the program’s integrity is
maintained,” says McGowan.

For now, it’ll be largely feedback from inmates such as George
driving the program. “It’s working really well for me,” he says. “We’re
like a unit, a small group that goes through a lot together. It’s much
deeper than other programs, with its cultural understanding. You
should see my binder full of material!”

*not his real name
Medication overprescription among aboriginal women

DAN WERBY

This Q&A is based on an interview with Amy Salmon, a researcher with the British Columbia Centre of Excellence for Women’s Health and lead author of a recent report on gender and benzodiazepine use among older aboriginal people.

Describe the problem of benzodiazepine use among aboriginal women in Canada.

In 1996, central nervous system agents, which include psychotherapeutic medications and painkillers, accounted for 34 per cent of pharmacy costs incurred by the Non-Insured Health Benefits (nihb) program, which covers prescription drug costs for registered First Nations and Inuit peoples. Benzodiazepines account for 18 per cent of these prescriptions. In 2000, psychotherapeutics (primarily tranquilizers and antidepressants) accounted for about 13 per cent of prescriptions in b.c., making them the largest group of prescribed drugs. A 2000 study of benzodiazepine use among First Nations in the Western provinces showed that women accounted for two-thirds of benzodiazepine prescriptions, with an average age of 41. International data show that problem benzodiazepine use increases with age, and that between 20 and 50 per cent of women over age 60 are prescribed benzodiazepines.

But there is a lot we don’t know. The only data available from the First Nations and Inuit Health Branch of Health Canada pertains to health claims for people registered under the Indian Act and those on reserves. However, most aboriginal people do not live on reserves and many are non-status, so it is difficult to assess whether the patterns are constant across groups. And because the data are not disaggregated by geographic region, cultural group or gender, it is unclear whether First Nations, Métis or aboriginal women and men have different rates of prescriptions. Because provincial data on prescription drug use in non-aboriginal populations are collected and reported differently from nihb data, it can also be difficult to track differences in prescription drug use in aboriginal and non-aboriginal populations.

Why are aboriginal women prescribed more benzodiazepine than other groups?

Prescription rates for women in the general population have always been higher: Women are 50 per cent more likely to be prescribed benzodiazepines than men for the same or similar complaints. In aboriginal communities, post-traumatic stress disorder, a common diagnosis among residential school survivors, is often treated with benzodiazepines. So it is important to recognize that overprescription has its roots in the legacies of colonization. Health practitioners often use medication to help women cope with social problems like violence and poverty, when it isn’t a pill they need, but social support and safe housing. Women are also more frequently prescribed other kinds of psychiatric medication; for example, 70 per cent of antidepressant prescriptions under the Non-Insured Health Benefits Program are filled by women.

How does overprescription affect aboriginal communities?

In aboriginal communities, elders play a central role in the life of the community, so we are concerned when medication might impact older people’s ability to remain independent, for example, by impairing their motor skills, cognitive functioning or sense of balance that can lead to injury and accidents. Making the problem even more difficult is the fact that Aboriginal grandmothers are often in the position of parenting their grandchildren with minimal financial resources and community-based supports, so the caregiving responsibilities of aboriginal women are extended over their lives.

We recommend culturally appropriate psychogeriatric assessment tools to meet the needs of older aboriginal people. Using inappropriate tools means that aboriginal elders can be at risk for misdiagnosis of psychopathology and inadequate or inappropriate treatment.

What role do health care professionals have? Are they to blame for overprescribing?

In many circumstances, we can hold them accountable. There is a clear need for better monitoring of problem benzodiazepine use, especially for prescriptions that exceed the current low-risk threshold of less than four weeks use at a time. In Canada, one in 10 Canadians are prescribed benzodiazepines every year, and most continue to use those drugs for at least a year. We would like to see more careful monitoring of prescribing practices, and more information made available about the potentially harmful side-effects of benzodiazepines, as well as alternatives to their use.

To their credit, physicians are usually receptive to information about alternatives. For example, the Sleep and Anxiety Management project, conducted by the b.c. College of Family Physicians and the University of British Columbia, was very well received by physicians, who were happy to get information about alternatives that often aren’t discussed in medical school.

The other problem that arises with prescriptions, especially with aboriginal communities, is that many of these communities are located in rural or remote communities where culturally appropriate mental health facilities aren’t available. It often falls to a general practitioner who might visit a community once a month to help residents cope with diverse problems. Benzodiazepines may be prescribed long-term because there simply are no alternatives. That being said, we do not want to excuse physicians and pharmacists from their culpability.

You call for culturally appropriate programs and treatment. What are some examples?

Health treatment services need to be tailored to the communities in which they are offered. We would argue for more comprehensive and holistic approaches so treatment services are able to recognize and address the trauma, poverty, violence and health care inequities that drive benzodiazepine use among aboriginal women.

For the full report, visit the website of the Centre of Excellence for Women’s Health at www.cewh-cesf.ca and under “Publications,” select the Research Bulletin, Spring 2006 issue.
FOCUS ON ABORIGINAL RESOURCES

CANADA

Library and Archives Canada
For a feast of resources, including visual, visit Library and Archives Canada, Aboriginal Resources and Services at www.collectionscanada.ca/aboriginal/indexe.html. One resource to highlight is Native Residential Schools in Canada: A Selective Bibliography (www.collectionscanada.ca/native-residential/indexe.html), compiled in 2002 to accompany the exhibit Where are the Children? Healing the Legacy of Residential Schools (www.wherearethechildren.ca).

Information Centre on Aboriginal Health
The Canadian gateway to health resources for Aboriginal Peoples is the Information Centre on Aboriginal Health (www.icah.ca), a service of the National Aboriginal Health Organization (NAHO) (www.naho.ca). The ICAH database includes all types of resources, from directory information to full-text reports. To search by subject, go directly to the A–Z Listing, or, if in doubt, check the glossary. For each heading, you will find resources grouped by category, so it is easy to zero in on the type of information you seek, whether it be videos, kits, fact sheets or reports. If available, there is a link to the full text.

Canada – Youth
Aboriginal Youth Network www.ayn.ca
This national network is operated for and by Aboriginal youth, ages 12–29. The Health Centre, which can be entered from the main page or found through the Inside AYN section, covers many topics – abuse, addiction, eating disorders, mental health, suicide – and includes basic facts, games, quizzes, links and a Get the Facts section with excerpts from statistical reports. For example, the suicide section provides statistics on native suicides with comparisons to the general population.

SPECIAL ISSUES

Fetal Alcohol Spectrum Disorders
As a result of serious social problems, First Nations communities have been hard hit by FASD. They have been very proactive in Canada in putting FASD on the prevention/health promotion and intervention agenda and providing culturally sensitive approaches. The Ontario Federation of Indian Friendship Centres (OFIFC) offers key resources accessible directly from the main page of the OFIFC website (www.ofific.org). See both the FASD Tool Kit for Aboriginal Families, a resource for frontline workers working with children, adults and families affected by FASD, and Aboriginal Approaches to Fetal Alcohol Syndrome/Fetal Alcohol Effects, which highlights strategies to promote healing and wellness. For more First Nations-specific resources on FASD, check out ICAH, under FAS/FAE or the Canadian Centre on Substance Abuse (www.ccsa.ca) and under Aboriginal Peoples select the topic Pregnancy and Alcohol (FASD) and look for aboriginal-focused resources.

Solvent Abuse
Sniffing or huffing solvents is a widespread problem among at-risk children and adolescents including young aboriginals in rural and remote regions. For a good overview document, read Parents Be Aware: Sniffing Kills, accessible through both the CCSA website and the Canadian Health Network (www.canadianhealthnetwork.ca). The Youth Solvent Addiction Committee (www.members.shaw.ca/ysac) is a network of 10 First Nations youth residential treatment centres. See documents such as Resiliency and Holistic Inhalant Abuse Treatment. Although this site could do with some updating, it provides a good focal point for learning about solvent abuse treatment services in Canadian aboriginal communities.

The Far North
For an in-depth look at addiction-related issues in each of Canada’s three territories, the Northwest Territories, Nunavut and Yukon, visit CCSA’s Territorial Resource Partnership, (www.ccsa.ca/CCSA/EN/Partnerships/Territories). The partnership also facilitates communication and networking and offers tools and resources for those working in these isolated northern communities.

BEYOND CANADA

United States
The National Center for the American Indian and Alaska Native Mental Health Research (NCAIANMHR), University of Colorado at Denver, publishes the peer reviewed journal American Indian and Alaska Native Mental Health Research: The Journal of the National Center (www.uchsc.edu/a/ncaianmhr/journal_online.htm), as well as a monograph series. Current and archival issues are available online. It is a good source of scholarly research on issues such as suicide, trauma, violence, substance abuse and alcohol policy.

The U.S.-based NativeWeb: Resources for Indigenous Cultures Around the World (www.nativeweb.org) provides a useful link to the UN Permanent Forum on Indigenous Issues. In addition, under Resources, Health and Elder Resources there are sub-categories, Mental Health and Substance Use. Understandably, not all link to aboriginal-specific resources.

Australia
Social anthropologist Maggie Brady, author of the well-known The Grog Book, has put Australia on the map for the study of culturally sensitive approaches to indigenous substance use issues, from alcohol (grog) to petrol sniffing. She is a Fellow at the Centre for Aboriginal Economic Policy Research, CAEPR, www.anu.edu.au/caepr/info.php, which provides discussions and working papers online, some of which are relevant to drug and alcohol misuse. Also, check out the Australian National Council on Drugs publication: ANCD Research Paper B: Indigenous Drug and Alcohol Projects: Elements of Best Practice – best to “Google” to find this, as well as the Aboriginal Drug and Alcohol Council (www.adac.org.au), for a range of full-text publications on a variety of topics – e.g., gambling, injection drug use, solvent use.
Why is progress so slow on supportive housing?

A consumer perspective

There are perhaps thousands of fine people who have lent their time and goodwill advocating for more housing. Service providers in the housing business spend countless hours lobbying for more units, writing proposals and developing properties. Hospitals, mental health workers, anti-poverty activists, consumer activists, psychiatric survivor activists, disability advocates, academics, faith groups - all have supported the fight for more housing for mental health consumers and psychiatric survivors. Housing, we say, is a right. Imagine, we say, in a country like ours...

Yes. Imagine in a country like ours that your neighbours, your local city councillor, your mayor talk about the need for "consultation" before more of "your kind" move into a community. Imagine demonstrations against you, appeals to municipal processes to keep you out. Imagine having to stand up in your local community centre and having to argue for your right to move. But righteousness prevails and supportive housing is built.

Imagine now that people who have the knowledge and the power to have you detained and medicated hold the keys to the door of that elusive rent-g geared-to-income apartment. Where documents like "support service agreements," "support plans" and "licensing agreements" are common trade. You read sentences in them like, "I agree that this agreement supercedes the Tenant Protection Act." Or, "I agree to accept the services of XYZ agency as a condition of my tenancy."

Imagine that your interview for your new apartment requires questions about your relationship to your family, your sexual orientation and your medical history. Have you ever been arrested, by the way? Did you think you had served your sentence? Well the onus is on you, my friend, to prove that you’re safe enough to house.

Imagine that your housing support worker, half your age, offers you a referral to a harm reduction program one day. You are confused. You rarely even drink. But you are informed that you smelled like alcohol the other day when you came to drop off your rent cheque. A free ticket to an afternoon baseball game received at a drop-in and a bottle of beer to celebrate a warm summer day, you explain sheepishly. Because you have to. Don't you?

Imagine monthly inspections of your home. Surprise visits from support workers, just trying to be helpful. Or, letters from your landlord diagnosing your request for necessary repairs as a symptom of your mental illness. Imagine being told during your lease negotiation that your apartment was a privilege afforded to you by the taxpayers of your province - not a right.

Imagine all of these things and more. Bed bug infestations. Broken locks and peeling paint. Imagine that your landlord phones your doctor to recommend a medication increase.

It is given that within the mental health system there will always be those who feel they are in a better position to make decisions on our behalf than we are. Both those with honourable intentions and not-so-honourable ones. There are also people working in the system - driven by competitive proposal calls, municipal by-laws, unrealistic expectations on behalf of funders - who find themselves co-opted into out-of-control situations. What do you do when a building is falling apart and full of tenants? When workers of all manner of competency and service models are in and out of a building interacting with tenants? When contracts with private landlords go haywire? When tenants are demanding repairs while funding falls behind?

It is incumbent on those responsible for providing housing, both funding and service, to ensure sustainability. To ensure that rights are not violated out of desperation to control unmanageable financial issues. Or that lack of management, training and supervision in legal issues results in bigotry and rights violations.

The range of housing options must be expanded to allow consumers and survivors to choose both their housing and their supports. The power of that choice backed up by having control of dedicated funds. We don't need web sites with referrals to more waiting lists.

Agencies must develop a capacity to work from an anti-oppression framework and an analysis of the historical oppression of those who have used the mental health system. Finally, affirmative action strategies directed to hiring consumers and survivors in mental health services will both improve access to peer advocacy and enrich traditional service provider practice.

While we celebrate each project funded, and each tenant housed, where does the shift from the right to housing to housing rights take place? We cannot continue to mortgage people's dignity for shelter.

Lana Frado is executive director of Sound Times, a member-driven consumer/survivor initiative that provides support, education and recreation for people who use or have used the mental health system.