Building Bridges Symposium Report

November 2007

Background

Over the past several years leaders from the Native Mental Health Association and the Mood Disorders Society of Canada identified many similarities between the history and experiences of mental health consumers and Aboriginal people. These included social marginalization, stigma and discrimination, and a higher prevalence of traumatic experiences. It was recognized that these issues were related in turn to higher rates of poverty, unemployment, homelessness, overrepresentation in the criminal justice system, suicide and poor health outcomes. As a result there were a number of common themes which emerged including racism in all its forms, social exclusion along with historic geographic and financial barriers to accessing services.

Subsequently, a collective vision emerged to draw leaders together to share information on priorities within the two cultures and convey a shared understanding of benefits associated with joint planning and action. The following report provides an overview of the results of that collective planning and action.

Introduction

On October 3rd and 4th, 2007, the Native Mental Health Association of Canada and the Mood Disorders Society of Canada, with the support of the First Nations and Inuit Health Branch of Health Canada, co-sponsored a National Symposium in Ottawa. The Symposium brought Board members together with invited “thought leaders” along with Executive Directors of leading national and provincial mental health NGO’s to discuss common issues facing indigenous and non-indigenous communities, identify mutual priorities, and agree on key messages to convey to the recently formed Mental Health Commission of Canada. Leaders at the symposium were joined by representatives from key federal government departments. Symposium organizers recognized that a silo approach existed to program planning and service delivery and that there was a need to ensure that a series of consistent messages was delivered at this historical event.

This Report highlights and summarizes the “best thinking” of plenary and small group discussions, and provides recommendations for follow-up actions which could be considered.

Affixed to this Report as “Appendix A” is a discussion paper distributed to delegates prior to the meeting entitled “Mental Health Consumers and Aboriginal People: Similar Experiences, Shared Outcomes”, prepared by Bev Bourget. In “Appendix B” is the compelling and inspirational keynote address by Dr. Lorna Williams entitled “Building Bridges; Hearts, Minds and Spirits Together” which was a catalyst for the meaningful discussions that followed.

> *The metaphor of the bridge reflects the need to bring resources together in a collective effort. Bridges need to be built between levels of government, between the mental health consumers, their families, professionals, and the public. It is an inclusive metaphor, which extends beyond professionals and consumers to engage as many people as possible, to enlarge the communities of those working for change. To build bridges, we need to know what it is we share in common, what brings us together, not what separates us. For the survival of the planet and humankind, we need to adopt as a core value that all life is equal; none is greater or lesser than another.*

Following the keynote address and panel presentation, the Honourable Michael Kirby brought greetings from the Mental Health Commission of Canada. Mr. Kirby noted the historical significance of the symposium and challenged delegates to collaboratively identify key systemic issues and bring forward creative recommendations to the Commission.

Systemic Issues

The symposium focused on identifying common systemic issues facing indigenous and non-indigenous communities in Canada along with identifying those common factors preventing access to Canada's health care system with particular emphasis on diagnosis and treatment of mental illness and/or access to mental wellness support.

Participants identified four major common systemic issues:

- Labeling and discrimination
- Colonialism
- Racism
- Stigma and discrimination

Stigma and discrimination are not unique to those suffering from mental illnesses, their families and caregivers. However, stigma and discrimination are widespread and persistent toward them. Stigma causes serious economic, health and social consequences to consumers, patients, families and caregivers as well as to society at large. The experience of stigma, and its resultant discrimination, is a profoundly personal one and is best understood by those who have experienced its effects.

From early childhood, there is little or no discussion of lived life experiences, including those of discrimination and segregation. Nothing is done to help children name what they are living and seeing. This is why segregation persists and is echoed in bureaucratic silos. When you are not taught to question, you do not become a critical thinker and unthinkingly take your place in the institutional bureaucracy. Education prepares you to take your place in the system but not to question the legitimacy of the system or the status quo.

Labels stigmatize and marginalize. The power of the label is shown in the stigmatization not only of the consumer but also of the worker delivering the service, and in the fact that mental health services are not funded to the same extent as other health care services. Without adequate services, the mentally ill become more of a burden on other social systems, such as addictions and corrections.

The lack of a level playing field also applies to First Nations people who aren't eligible for or in receipt of the same quality of services as other Canadians; because their needs are often not adequately met, problems compound.

The training of professionals needs to include study of the use of labels and the intent of such, as a way for them to get in touch with barriers to equitable services, like discrimination and racism. Labels are designed to focus on deficits, not strengths.

What is the function of the DMS4? It is to label people so they are eligible for service, and so the service provider can bill for payment. This is the only service system in the country based on needs of the provider to be compensated rather than needs of the consumer. Labels affect the consumer life-long.

Who defines "normal"? It is people who conform to society, the dominant culture, who obey the laws and norms. This draws attention to culture; it must be considered as a vital health determinant. Furthermore, relationships between cultural groups greatly affect the well-being of group members, especially when a dominant group devalues and oppresses a minority group.

The Western worldview dichotomizes and fragments. The medical model of Western society is not holistic; its primary strategy is pharmacological, which ignores or minimizes the importance of the emotional, spiritual, and environmental realms. What is needed is human intervention in a holistic way, not just drugs.

Labeling creates walls, keeps people segregated, apart from, when they need to be actively engaged in the community.

Chances of creating integrated services are remote if you have stratification amongst service providers, which is an integral part of the bureaucratic structures of the Western world.

It is important to confront and challenge the tyranny of the "medical model" and the tyranny of "normal", which continues to support the system of providers, not the consumers and imposes a template which obstructs multi-modal approaches and alternatives. This results in a loss of individuality and self-determination. To address this, we need to build social relationships and collective determination.

The loss of land, language, life and community, and the trauma connected with these affects the lives of all aboriginal people. These historical realities and the negative labels associated with them, continue to oppress the aboriginal population.

Elders are products of these traumatic forces. They have lived with stigma their whole lives and most have not dealt with it because they do not feel they have a voice or are important. Connected with this is the deprivation of their language. They do not have literacy, which would help them transmit to others the knowledge they have acquired through living. As well as lacking their own language, they may not have mastery of English or French. They have no voice, yet are the parents and grandparents of the present generations. To understand their lives, is truly to understand stigma.

Similarly, the mentally ill may have contributions to make but are segregated, medicalized, their potential contributions blocked. They, too, are challenged to find voice.

Many First Nations and people with mental illness have retreated from any behaviour that has high cost and little return, and as a result, no longer use their voice. Based on what they have learned, the risks involved are too great, the forces arrayed against them too powerful, to risk challenging.

That is why the Symposium is so important. It is a gathering of people who have voice, both First Nations and mental health advocates who have experiences that can help them begin to understand what needs to be done, and the willingness to do it. From the Symposium can come practical suggestions on actions we can take on to change attitudes of people, and to engage the support and involvement of community members.

Barriers to Access

> *Access can be thought of in terms of accessing both external resources and ones inner resources; for both kinds of access, you need acceptance, safety, and trusting relationships. When you are oppressed and stigmatized, you are not in touch with or do not value your inner resources enough to act on them, and you may not have any confidence in external resources either, if you have any.*

Trauma is so pervasive in First Nations communities that ordinary people need to be mobilized to help, not just professionals. They need to understand what families go through in a process of grief and loss when a member is diagnosed with a mental illness. The family's initial rejection of the diagnosis may be a form of denial in the face of the loss of their family member, as they have known him or her. Stigma is complex and needs to be carefully analyzed in context in order to be understood and addressed properly.

Aboriginal people and mental health consumers in correctional and other institutions may not reach out for help because they do not believe that help would be forthcoming.

Their experiences prior to institutionalization were likely also of isolation, disconnection and absence of inclusion in their communities.

Sometimes help is not forthcoming because service providers are unsure of what is culturally appropriate and so do not take any action.

It is important to remember that self-stigma, family stigma, and community stigma are barriers to accessing the system, which can be overcome only through education and awareness, and family and peer support.

A major barrier to access is families' fear of the negative impact on their lives of engaging with mental health services. It is not unusual for parents of a child with a mental illness to choose not to pursue recommended treatment because of stigma, lack of education, and fear. Sometimes, the consequence of this is the early entry of the child to the corrections system.

For children, labeling, the bed in which the seeds of stigma are sown, can begin early in life, especially when parents or foster parents do not have the literacy to understand the implications of the medications or the skills to deal otherwise with the child's behaviour. The label shapes the child their entire life and results in a "non-person".

There are many people for whom the issue is not their diagnosis and labeling; it is how to live with their woundedness. We need to learn from them and to assist them in finding meaning, purpose, and belonging in their lives.

Another barrier to access can be language itself when the provider is trained in the Western paradigm of regarding mental illness as a disruption of cognitive functioning requiring pharmacological intervention, with all the associated terminology. This is counter to the indigenous paradigm, which is holistic and looks at relationships and context, and seeks cultural interventions meaningful to the person.

Existing mental health services are based on Western values, worldviews and practices, manifested in structures and systems that hold a lot of bureaucratic power. These must be critiqued and evaluated. Concurrently, indigenous paradigms, values, perceptions of mental illness, and cultural interventions need to be acknowledged and assessed. In a true democracy, through such a process, a balance can be found between the two that will serve the best interests of the people.

A major issue for indigenous people is not lack of access to services, but rather access to the holistic paradigm, which offers good cultural ways to reestablish balance in life, guided by reconnection to ones personal and cultural identity. The Maori of New Zealand address this through the inclusion of the concept of cultural safety in the professional training of all health care providers.

We should also give priority to teaching our own community leaders, managers, and workers what we choose to teach non-aboriginal health practitioners about First Nations, Inuit, and Métis people. The teaching must not be confined to book learning; it has to be experiential, and thus reach into other realms of a complete person-physical, emotional, spiritual- as well as cognitive. Cultural safety is more a process than a “content” or “curriculum”. In true dialogue, people can discover the cultural knowledge they carry and appreciate the cultural knowledge of others with which they may not have been familiar.

Through the exchange of information and experiences, participants in such a process begin to integrate and take ownership of what is learned. They begin to see through other “lenses”, perspectives other than their own. They also begin to get in touch with emotional and spiritual sources of information, in addition to cognitive, that enrich their learning.

The dominant cultural perspective has invaded the minds, lives, and practices of indigenous people. Most seniors in indigenous communities are not in touch with what they know. When they do know a great deal about healing, they are not eligible for compensation for their work, because their knowledge and associated competencies are not acknowledged and validated by the mainstream.

As indigenous people decolonize themselves, they begin to discover that contrary to their colonization, they do have valuable history and culture to transmit and to use in the design and delivery of services. Belief of indigenous people in their own ways has been undermined and must be rebuilt. With the growing recognition of indigenous knowledge and the owning of it by indigenous people comes a resumption of responsibility for their own health and wellness, instead of dependence on external or mainstream systems that foster abandonment of self-responsibility.

Because mainstream society lacks a commitment to holistic strategies, there is a lack of readiness on its part to learn from indigenous people. To the degree that colonization still shapes indigenous peoples’ thinking, they may be constrained in their readiness to teach. As well, their isolation from mainstream creates challenges to relationship building and mutual understanding. We are at a pivotal point where we have to address the absence of readiness on the part of indigenous people to teach and of mainstream society to learn.

Unstructured public consultations are vital in order for all parties to share insights and build bridges of understanding; between professionals, consumers, peer supporters, family members, different cultural groups, and other stakeholders. The needs are so great; we can no longer continue to invest power and responsibility in the hands of experts only. Community members must re-empower themselves and we have to be part of that empowerment. It is a process of discovering what people already know and how to build on it. People do not have to concede their power and knowledge to the professional. People themselves can teach each other, and the professionals, what works. They can become empowered to take responsibility back for their own health and well-being.

> *Traditional knowledge is what is transmitted generation to generation and practiced: it is another name for indigenous knowledge and ways of knowing. Indigenous knowledge is "tacit" knowledge, knowledge about "right relationships", "right conduct" in all ones interactions with people, creatures, the land and its resources. It is vital that it not be seen as lesser than mainstream, or co-opted into mainstream. It is a rich resource from which important answers can be found to dilemmas in mental health.*
>
> *Elders who carry traditional knowledge can be identified and validated by their own community.*

Recommendations

As a result of the Symposium the following seventeen (17) recommendations have been formulated:

- That elders be selected and honored for their gifts as educators and healers by their communities, in reshaping mental health services in this country.

- That Mental Health Resource Teams be promoted and established, particularly in the North, where there are clusters of communities that can be served by a team. Include selected elders in such teams. The potential of the Truth and Reconciliation Commission to re-stimulate trauma, makes these teams particularly important. Members of such teams are to be equally valued; their value is not to be based on their credentials. Mental Health Teams are not to be seen as emergency response teams but as resources for building mental wellness. Consumers are to be included in such teams.

- That funding be provided for Participatory Action Research concurrent with the activities of Mental Health Resource Teams to demonstrate that what is done is effective. PAR is the desired type of research because when it is designed with the input of the people for whom it is done, then it is of benefit to them and knowledge is transferred.

- That a "College of Elders" be established to investigate how traditional knowledge can be a resource for problem solving in the field of mental health and addictions.

- That peers and families be respected as important advocates and resources to the mentally ill person and their service providers, and be included in the mental health team.

- That a process for accreditation of peer support workers be established.

- That systems be developed which allow the consumer and their family support system to guide and be in control of their own care. Promote collective consumer self-determination from the ground up.

- That small mutual support groups be established in which people can help themselves, gain self-respect, and learn how to navigate systems and clinical situations.

- That a new system be created not dominated by psychiatry rather than repair the old system, after first analyzing carefully the value base and deficits of the medical model. It is important to base strategies on a thorough understanding of the problem.

- That strategies and solutions be community generated, otherwise they won't be embedded.

- That mental health services be established which are equal in quality and funded as generously as physical health services for all Canadians, including those incarcerated.

- That the Mental Health Commission of Canada's meetings be dialogical processes in which sufficient time is devoted to problem analysis and practical understanding of the issues.

- That it is understood that unstructured public consultations are vital for all parties to share insights, to build bridges of understanding between professionals, consumers, peer supporters, family members, and cultural groups. The needs are too great to be addressed solely by experts; community members must be empowered.

- That the Mental Health Commission of Canada gives careful consideration to the Mental Health Wellness Plan.

- That it is formally recognized that quality mental health systems and services are a human right. The federal government should affirm the rights of the mentally ill and provincial/territorial governments should be required to meet a minimum standard of service.

- That government supports multi ministry approaches to achieve seamless integration of services that will adequately address health determinants (e.g. shelter, food security).

- That a National Steering Committee be established to develop a comprehensive five-year action planned aimed at collectively dealing with the systemic issues and recommendations emanating from the national symposium.

The National Symposium in Perspective

The Symposium represented a very successful and unique national experiment in health and social policy. The following overall objectives as established at the outset of this historic event were met:

- To articulate the importance of applying population health determinants and spirituality as keys for making meaning of life in Indigenous families/communities as it was, is, and could become;

- To show that holistic concepts of mental health and well-being are fine working concepts to employ while doing developmental work with Indigenous communities; namely, as (a) tools to promote understanding "what"; (b) tools to explain "how"; (c) tools to explain "why";

- To show that definitions of mental health are changing and, in fact, are shifting towards a more holistic approach to mental health which affirms Indigenous cultural perceptions of wellness. Balance between the physical, emotional, intellectual and spiritual dimensions of life is a sign of health and wellness and may also be viewed as an indicator of a healthy lifestyle;

- To show the importance of "walking with our ancestors", knowing their teachings, and living by those teachings as we live today for tomorrow while at the same time living within a framework guided by core values that feature 'community' and the need for 'community of care' where there is safety and feelings of security, nurturance, stimulation, and belief in an optimistic future.

- To demonstrate how the mood disorders movement in Canada can work with Indigenous communities to identify priorities and promote appropriate training for professionals, especially culturally relevant training;
- To explore how Indigenous ways and best/promising practices can be shared with under-serviced communities in rural and remote areas of Canada. People are connected to their communities, but resources are inadequate to support their needs.
- To challenge funding practices and traditions that encourage the creation and maintenance of silos;

- To promote the importance of spirituality and connectedness (belief and belonging) as key factors in prevention, recovery and mental health.

The Next Steps – An Agenda for Action

The Symposium has resulted in the development of a concrete framework for planning and future action. Major systemic issues and barriers have been identified and a series of recommendations have been formulated. The Symposium has clearly demonstrated that cross cultural planning and service delivery along with resource sharing and sharing of best/promising practices will benefit all communities.

New paradigms, new ways of thinking are needed because what actually works doesn’t always fit the existing models. New ways of solving problems may not be understood because of the persistence of previous paradigms and bureaucracy. A new system is called for. Additional resources will be required to serve as a catalyst for change in the way in which programs and services are delivered in both urban and rural settings.

The restorative justice model holds promise to address on reserve and off reserve realities and challenges in which traditional community systems of support may be broken. These must be rebuilt because they are key vehicles for mental health and wellness, and restorative justice offers potential for community rebuilding, reducing suicide, incarceration rates of youth, family violence, and abuse of elders. Instead of top-down priorities, there must be community driven action plans and solutions.

The trust, cooperation, transparency and success of the Symposium will serve as the cornerstones and catalyst for the development of a national strategy and a series of strategic initiatives in 2007 and beyond.

APPENDIX “A”

MENTAL HEALTH CONSUMERS AND ABORIGINAL PEOPLE: SIMILAR EXPERIENCES, SHARED OUTCOMES

Discussion Paper for the MDSC/NMHAC Symposium
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> “What you see in every group the law has ever disenfranchised, whether it be First Nations people, Chinese Canadians, women, people labelled disabled (including people with mental illness or kids who were deaf)—anybody for whom we had created a law making them second-class citizens—is that we create a subcategory of people, and they are the ones that are abused. So, because we take away all their rights, including their right to be safe from harm, those are the people that get hurt.”
>
> Dulcie McCallum, 2006

INTRODUCTION

A scan of the research literature and relevant policy documents reveals many similarities between the history and experiences of mental health consumers and Aboriginal people. These include social marginalization, stigma and discrimination, and a higher prevalence of traumatic experiences. These are related in turn to higher rates of poverty, unemployment, homelessness, overrepresentation in the criminal justice system, suicide and poor health outcomes.

SOCIAL OPPRESSION, HUMAN RIGHTS ABUSES, AND DISCRIMINATION

History

Aboriginal people and mental health consumers share a long history of social marginalization, discrimination, oppression and human rights abuses. In the case of Aboriginal people, first contact with European colonists brought into opposition two very different worldviews. Aboriginal people had a deep respect for the natural environment, and they did not view humans and human culture as separate from or above the natural world. Nature, humans, and human culture were inter-connected (Wesley-Esquimaux and Smolewski, 2004). Europeans arrived in the Americas with tendency to view the world as being made up of two categories: spirit and nature. Nature was seen as inferior to spirit and therefore subject to domination and control (Metzner, 1993). Typical examples of these categories would be heaven/earth, humans/animals, mind/body, male/female, and civilized/primitive. It is this world view that has driven policy and practice toward Aboriginal people, people with mental illness, and other vulnerable groups.

In the European view, Aboriginal fell into the primitive category and they were therefore inferior. The devastating effects of the resulting persecution and oppression of Aboriginal people have been well-documented. They include the catastrophic collapse of as much as 90% of the original Aboriginal population in North America between 1500 and 1900 (Thornton, 1997), waves of epidemic disease, famine, and the destruction of social relationships and social support (Wesley-Esquimaux and Smolewski, 2004). This was followed by a process of forced assimilation to the European way of life, including changes to traditional diets, the introduction of alcohol, and the promotion of male control and domination of women and children (Hanki, 1994; Wesley-Esquimaux and Smolewski, 2004). To make way for the newcomers' cities and farms, large numbers of Aboriginal people were displaced from their traditional lands and moved to settlements and reserves in locations not of their choice (RCAP, 1995; Kirmayer *et al*, 2000).

From the 1880s to the 1970's, First Nations children were sent to residential schools, operated first by missionaries and then by the Government of Canada, where abuse was rampant, a policy designed to complete the destruction of Aboriginal social and cultural identity (RCAP, 1995; Wesley-Esquimaux and Smolewski, 2004). The typical residential school experience is well documented and often involved multiple forms of abuse (Chrisjohn *et a*l, 1997; Kirmayer *et al*, 2000). Children were used as unpaid day labourers and were punished for a variety of rule infractions including speaking their language and engaging in traditional spiritual practices. Punishments were often extremely brutal and involved physical, sexual, emotional and verbal abuse. Historical documents show that as many as half of the children who attended the schools died of tuberculosis, even though the federal government was repeatedly warned that "overcrowding, poor sanitation and a lack of medical care were creating a breeding ground for the rapid spread of the disease" (Curry and Howlett, 2007)

The child welfare practice of apprehension with no access to family reunification services was another feature of ongoing oppressive practices of assimilation. By the late 1960's, so many children had been taken from their families that 30-40% of the children in care were Aboriginal (Kirby *et al*, 1993; Kirmayer *et al,* 2000; Kelm, 1998 in Hanki, 2003).

Two Canadian provinces, Alberta (1928) and British Columbia (1933) instituted Eugenics Programs involving the forced sterilization of "unfit" individuals Towards the end of Alberta's sterilization program, which went on until 1972, Aboriginals and Métis made up 25% of the sterilizations performed, although they were less than 3% of the population. Many of these were women, especially young women and teenagers (Dyer, 1996). The convergence of all of these policies came near to causing complete cultural genocide of Aboriginal people (Chrisjohn *et al*, 1997).

The history of the treatment of people with mental illness in Western society is similar in nature if not in scope. The mentally ill were perceived as brutes, and like all wild beasts, they needed to be confined and controlled (Whitaker, 2002). The long and well-documented series of cruel interventions imposed on people included forced confinement in appalling conditions, beatings, cold baths, starving, electric shock, induction of insulin coma, and surgical removal of various body parts (Whitaker, 2002; Szasz, 2003). Between 1935 and 1950, more than 20,000 people in the United States were subjected to psychosurgeries like frontal lobotomy. This practice ended with the introduction of the first psychiatric medications in the 1950's (Eisenberg, 2000). As late as the 1960's, however, researchers were still debating the merits of sterilization of people with mental illness, and twenty-two states had laws on the books permitting compulsory eugenic sterilization without patient consent (Birnbaum, 1961).

Aboriginal people and mental health consumers have also been denied full citizenship and participation in democracy. It was 1960 before all Aboriginal people qualified to vote, when the franchise was extended to all women and men ordinarily resident on a reserve (Tremblay, 2003). And it was only in 1993 that the Canadian Elections Act was amended to allow citizens being treated in mental health facilities the right to vote. Canada is now one of only four democracies that have no restrictions on voting by people with mental illness (CBC Archives, 2004). In the U.S. for example, as of 1997, forty-four states barred voting by some subgroups of persons with mental illness or mental retardation, with fifteen using terminology that restricted voting by "idiots," the "insane," or "lunatics" (Applebaum, 2000).

Discriminatory Treatment and Human Rights Abuses Today

Aboriginal people and mental health consumers continue to face discriminatory treatment and human rights abuses today. Despite a persistent culture of denial in Canada about racism and its effects, Aboriginal people are exposed to racism and discrimination in many aspects of their lives, (St. Denis and Hampton, 2002). They are often subjected to verbal abuse in the form of racial slurs and bigoted comments, to psychological abuse through discriminatory treatment (e.g. people walking across the street to avoid them; being served last in restaurants or shops), and to social marginalization and rejection (St. Denis and Hampton, 2002).

Stigma and discrimination are the terms commonly used for similar treatment of mental health consumers. The word stigma means a mark of disgrace or defectiveness (Gray, 2002). Stigma can be felt internally or enacted (acted out by others) (Scrambler, 1998). When enacted, stigma is experienced as social rejection and discrimination, frequently encountered by people with mental illness from landlords, employers, physicians and other mental health professionals (McNair *et al*, 2002; Corrigan *et al*, 2003; Stuart, 2005). Felt stigma is an internalization of negative stereotypes, causing a sense of shame which can lead to social withdrawal, loss of social support, and reluctance to seek help for people with mental illness (Priest *et al*, 1996; Watson and Corrigan, 2001; McNair *et al*, 2002; Gray, 2002; Stuart, 2005). Aboriginal people can similarly internalize racist attitudes, resulting in a low sense of self-worth and self-esteem (St. Denis and Hampton, 2002).

At a systemic level, Canada has been repeatedly criticized by UN treaty bodies for its failure to implement the reforms proposed by the Royal Commission on Aboriginal

Peoples (AI, 2004). In January 2007, the Canadian Human Rights Commission submitted a report to the United Nations Committee on the Elimination of Racial Discrimination, which specifically referenced racist policies and practices that affect Aboriginal people, including under-representation of Aboriginal people in federally regulated workplaces, and limitations on Aboriginal rights to the human rights redress process under the Canadian Human Rights Act (CHRC, 2007). Amnesty International, along with other human rights bodies, has called on government authorities to address discrimination against Indigenous women, which has contributed to a heightened and “unacceptable” level of violence (AI, 2004)

Human Rights Abuse in Mental Health Facilities

Human rights abuses are still occurring in psychiatric institutions around the world (Katz, 2006). This includes mental health facilities in North America, where cases have been reported of the use of seclusion and restraint leading to death (Katz, 2006; Curie, 2005). It has been estimated that these practices may result in as many as many as 50-150 deaths each year in the United States (Weiss, 1998). There is little published research on other types of traumatic abuse in mental health facilities, especially from a consumer perspective (Cusack *et al*, 2003). However, one study found that 86% of participants had experienced intrusive institutional procedures such as restraint; 44% had experienced physical or sexual assault; 39% had experienced coercive measures, such as being forced to take medication or threatened with involuntary commitment; 26% had witnessed abuse; and 23% had experienced verbal intimidation or verbal abuse. Few had ever been asked about such events by mental health staff (Cusack *et al*, 2003).

In the U.S., investigative reporting has uncovered patterns of neglect, abuse and lack of accountability in mental health facilities in many states. One investigative series of reports revealed that 115 patients died under suspicious circumstances while in the care of mental health facilities in the state of Georgia over a five year period (Miller and Judd, 2007). Another such story was recently reported about widespread mistreatment and suspicious deaths in mental health facilities in Missouri, hidden from the public and with few mechanisms in place to ensure accountability (Tuft and Mahr, 2006). Several studies have been compiled with regard to abuse and neglect in mental health facilities in New York State by the Commission on the Quality of Care and Advocacy for Persons with Disabilities (NYSCQCAPD, 1979-1992). Cases of physical and sexual abuse of patients in mental health facilities have been reported in many other states as well, including Nebraska, where a class action suit has been launched against the Director of Nebraska Health and Human Services on behalf of a number of women patients for failing to protect them from repeated incidents of physical abuse, sexual harassment, sexual abuse and rape by male staff members and other residents (Nebraska Advocacy Services, July 2004).

The literature scan found no evidence specific to the abuse of adults in mental heath facilities in Canada. However, abuse in institutions in Canada is known to occur (PHAC, 2005b,c,d). A study in Quebec surveyed 140 professionals who identified 974 acts of abuse they had witnessed or knew about. Of these, 35.5% were observed in residential centres and hospitals, and more than half of the acts were committed by facility personnel or other persons in authority (PHAC, 2005c). In another study done on behalf of the Ontario College of Nurses, 804 registered nurses and 804 registered nursing assistants were asked about abusive incidents committed by nursing staff against clients of any age. Nearly one half of the respondents reported witnessing one or more incidents of abuse in hospitals (85%), nursing homes (29%) and homes for the aged (7%) (PHAC, 2005c). There have also been a number of criminal cases in Canada resulting from the abuse of children in institutional care, including Aboriginal children in Residential schools (Shea, 1999). Institutional abuse has also been suffered by children with disabilities (including mental health issues), orphans, and young offenders or troubled youths imprisoned in facilities (Wolfe *et al*, 2002; PHAC, 2005d).

EFFECTS OF TRAUMATIC EXPERIENCE

Historical Trauma and the Residential School Experience

The high incidence of health and social problems experienced by Aboriginal communities in Canada today cannot be understood without an appreciation of the ongoing effects of historical trauma resulting from colonization. Traditional Aboriginal societies were generally peaceful. They were not entirely crime-free, but the extent of problems existing in these communities today far exceeds any abuses that occurred within traditional Aboriginal communities (Department of Justice Canada, 2006). The Royal Commission on Aboriginal Peoples has indicated that the high rate of crime in Aboriginal communities is directly related to the history of colonization and its continuing effects. Many Indigenous cultures around the world have been subjected to similar processes, the effects of which are akin to the disruptions and collective trauma experienced by victims of war and natural disasters (RCAP, 1995).

In addition to the collective trauma of violence, disease, cultural destruction and forced relocation experienced by Aboriginal people, many Aboriginal children experienced traumatic abuse in church and government run residential schools. The first schools were established in the mid-1800's and by 1920 attendance was compulsory for all children aged seven to fifteen (AFN). Because of this and a per capita grant arrangement that put a premium on each student taken from a community, many children were forcibly removed from their families by priests, Indian agents and police (AFN; RCAP, 1991). It is estimated that approximately 100,000 children attended these schools over the years in which they were in operation (INAC, 2004a). Overcrowding and under-funding led to many health problems such as tuberculosis; neglect was endemic and many children were emotionally, physically and sexually abused; including being beaten for speaking their language (RCAP, 1991). In some schools, death rates approached fifty per cent (RCAP, 1991).

Several researchers and thinkers have pointed out that trauma, particularly collective trauma, is inter-generational in its effects, as the experiences associated with the trauma are passed on to the next generation (Yehuda *et al,* 1998; Wesley-Esquimaux and Smolewski, 2004; Adler, 2005; Barron, 2004; White, 2005; Daud et al, 2005*)*. The various sources of trauma to which Aboriginal people were subjected have resulted in the transmission of inter-generational trauma within communities, including an increased prevalence of physical and sexual abuse (Department of Justice Canada, 2006).

Rates of Traumatic Victimization

Studies show that as many as 98% of people with severe mental illness have a history of trauma victimization (Cusack *et a*l, 2003). Indeed, most people receiving mental health/addiction services have a history of traumatic events in childhood and/or adolescence: 90% of public mental health clients have been exposed to (and most of these have experienced) multiple traumatic events; 75% of people in substance abuse programs and the vast majority of homeless people report abuse and trauma histories;

and many people with mental illness report having been physically abused by a family member or partner (Jennings, 2004; Burich *et al*, 2000; Cascardi *et al*, 1996). These individuals may carry any psychiatric diagnosis, and many of them have been assigned various diagnoses in their lifetimes, including PTSD, borderline personality disorder, schizophrenia, various mood disorders, anxiety disorders, eating disorders, etc. – all of these diagnoses have been linked to a history of trauma (Jennings, 2004). Few of these persons have ever been screened or treated for trauma by mental health providers (Jennings, 2004; Cusack *et al*, 2003). In fact, individual histories of violence and trauma are rarely taken into account in treatment planning and few clinicians have adequate training to attend to these issues effectively.

Several studies have shown that rates of criminal victimization in the community are also higher for people with mental illness, especially those who are most vulnerable such as people with severe mental illness and/or who are homeless (Walsh *et al*, 2003; Levin, 2005).

Aboriginal People are more likely to experience violence than other people living in Canada, both at home and in the community. They are at least three times more vulnerable to family violence compared to non-Aboriginals and the violence they experience is often more severe (Statscan, 2005). The Public Health Agency of Canada cites several studies showing high rates of domestic violence, with up to 80-90% of Aboriginal women having personally experienced family violence and up to 40% of children in some communities having been physically abused by a family member (PHAC, 2005a). Aboriginal children are removed from their homes and placed in the care of child welfare authorities at much higher rates than non-Aboriginal children (AI, 2004). Rates of criminal victimization in the community are also higher for Aboriginal people, with about 40% reporting having been victimized in a 12 month period compared to 28% of non-Aboriginal people. They are also twice as likely to be repeat victims of crime and three times more likely than non-Aboriginal people to be victims of violent crime, specifically sexual assault, robbery and physical assault (Statscan, 2006).

Patterns of violence in Aboriginal families and communities are considered a direct result of colonization, cultural destruction, and historical trauma (Department of Justice Canada, 2006a).

Effects of Traumatic Stress in Childhood

Exposure to traumatic stressors in childhood has been labelled Adverse Childhood Experience (ACE); this includes abuse (sexual, physical, emotional), neglect, exposure to domestic violence, and growing up in a home with significant dysfunction such as substance abusing or mentally ill parents, parental discord, domestic violence, or crime in the home (CDC, 2006). A large scale study of ACE involving 17,000 participants shows that it is highly prevalent in society (CDE, 2006). Rates of sexual victimization in the general population for example are very high: one in two females and one in three males has been sexually abused, most often in childhood (Badgley, 1984). ACE is associated with a multitude of long-term negative health and social outcomes and the risk of these problems increases along with the total amount of stress in childhood (CDC, 2006)

Outcomes associated with ACE are: alcoholism and alcohol abuse, chronic obstructive pulmonary disease (COPD), ischemic heart disease (IHD), depression, illicit drug use, liver disease, risk for intimate partner violence, multiple sexual partners and sexually transmitted diseases, smoking, severe obesity, suicide attempts, and unintended pregnancies (CDC, 2006). A history of abuse also appears to be related to other health problems such as chronic fatigue (Taylor and Jason, 2002), gastrointestinal disorders, chronic pelvic pain, and number of lifetime surgeries (Drossman *et al*, 1990). A recent study shows a strong relationship between the ACE score and utilization of psychotropic medications, demonstrating the contribution of childhood experience to adult mental illness (Anda *et al*, 2007).

Evidence from neuroscience indicates that ACE evokes a stress response which affects the developing brain and disrupts a number of brain functions such as the ability to regulate the stress response and immune system activity (Sapolosky, 1992; Sternberg and Gold, 1997; Perry, 1997; Schore, 2001; Anda *et al*, 2006). These disruptions persist into adulthood, affecting many functions including the individual's ability to regulate emotions, body sensations, substance abuse, sexuality, memory, arousal and aggression (Anda *et al*, 2006). The negative long-term effects sustain the cycle of abuse, neglect, violence, substance abuse, and mental illness. For example, problems regulating emotions and emotional unavailability due to psychic numbing from trauma impair the capacity of parents to respond their children in a sensitive and nurturing way, especially during times of stress (Schore, 2001; DeOliveira, *et al, 2004*). Similar disruptions in functioning may be related to the well-documented increased risk of re-victimization of trauma victims as well as the increased likelihood of criminal behaviour (Greenwald, 2002; Gladstone *et al*, 2004; Sandoff, 2004; Department of Justice, 2006a,b; Smith *et al*, 2006). Indeed, ACE may represent a key underlying cause of many of the seemingly unrelated health and social problems discussed below.

CURRENT ECONOMIC, SOCIAL AND HEALTH STATUS

Education, Unemployment and Poverty

Aboriginal students are half as likely as other students to complete high school (Centre for Social Justice, 2007), and fewer go on to post-secondary education: only 26% have some post-secondary education, compared to 43% of the general population (Mendelson, 2006). Aboriginal students report being subjected to racism and discrimination and often feeing isolated and marginalized in educational settings (St. Denis and Hampton, 2002), a likely contributor to lower levels of academic achievement.

It is estimated that one in five children in Canada has a mental health problem and these children are much more likely to drop out of school compared to their peers (Paediatrics and Child Health, 2004). In the United States, 50% of young people with mental health problems do not complete high school, about half the rate of other youth (NAMI, June 2006).

Both Aboriginal people and mental health consumers are more likely to be poor and to be unemployed compared with other Canadians. Unemployment and poverty rates among people living on reserve are three times those in non-Aboriginal communities, and almost half of people on reserve live in poverty, often in Third World conditions (INAC, 2006). Close to 50% of Aboriginal people now live off-reserve, but they are still twice as likely as other Canadians to live in poverty (CCSD, 2003). Overall, the unemployment rate for people with Registered Indian Status is significantly higher than that of other Canadians – 23.3% versus 7.2% (Statscan, 2001).

People diagnosed with a mental illness are more likely to experience long term unemployment, underemployment and dependency on social assistance (Mechanic, 2003; Stuart, 2005; CPA, 2007). The unemployment rate is three to five times higher among persons with any mental disorders than among those with no disorder (Sturm *et al,* 1999). It is estimated that between 75-85% of people with severe mental illness are unemployed in the United States and the rates are thought to be similar in Canada, although surveys consistently show that most of these people are willing and able to work (Crowther *et al*, 2001; Stuart, 2005; The Standing Senate Committee on Social Affairs, Science and Technology, 2006; CMHA; 2007). Studies show that many employers are reluctant to hire people with a history of mental illness and that some would dismiss a worker for not disclosing a history of mental illness. This places mental health consumers in a very difficult position with regard to disclosing a disorder to a prospective employer (Stuart, 2005).

Homelessness

Aboriginal people are over-represented in the homeless population in every major city where statistics are available (Treasury Board of Canada Secretariat, 2005). For example, in Hamilton Aboriginal people represent 2.0 per cent of the population but 20.0 per cent of the homeless population; in Edmonton, Aboriginal people represent 43.0 per cent of the homeless population while accounting for only about 6 per cent of the overall population (Statistics Canada, 2001). In addition, a disproportionate number of homeless people who sleep on the street rather than in shelters are of Aboriginal origin (Hwang, 2001).

People with serious mental illness are also disproportionately affected by homelessness. Between 30 and 35 percent of the homeless in general, and up to 75 percent of homeless women specifically, have a mental illness (City of Toronto, 1999). Twenty to forty per cent of homeless people are estimated to have affective disorders, six per cent have schizophrenia, and 60% have alcohol use disorders; dual diagnosis is also common. Homeless single women are more likely than men to have mental illness alone, without any substance use disorder (Hwang, 2001). Homelessness itself can precipitate mental illness and substance abuse disorders (CPHA, 1997).

Incarceration Rates

In the U.S. and Canada, people with mental illness are vastly over-represented in the prison system, and this appears to be attributable in large part to under-funding of mental health care systems (Kanapaux, 2004; Arboleda-Florez, 2005). While lifetime prevalence of mental disorders in the general population is about 21%, it is much higher for people in prison. Lifetime prevalence for males in prison is about 84% and 41% for females, and it has often been pointed out that in many ways prisons have become the new mental institutions (Arboleda-Florez, 2005). Few people with mental illness are in prison for violent offences (about 3% in one study), most are there for misdemeanours and crimes of survival (Kanapaux, 2004; Stuart and Arboleda-Florez, 2001). Once in prison, many cannot access mental health services, are victimized and exploited, and are punished for showing symptoms of their illness. (Schizophrenia Society of Canada, 2005).

Aboriginal people are similarly very much over-represented in the prison system in Canada. And the numbers are growing at a staggering rate: Between 1996 and 2004, while the overall federal prison population was declining, the number of male Aboriginals in jail increased by almost 22% and the number of women in prison increased by 74%. Furthermore, younger and younger Aboriginal people are being imprisoned – by 2000 41% of the prison population was Aboriginal people aged 25 or under (NWAC, 2006).

Aboriginal people also face discrimination within the prison system. They are routinely treated as higher security risks than non-native inmates, are released later in their sentences than other inmates, and are more likely to have their conditional release revoked for technical reasons than other offenders. Aboriginal inmates often do not receive timely access to rehabilitative programming and services that would help them return to their communities (The Correctional Investigator of Canada, 2006)

Suicide Rates

Suicide is one of the leading causes of death for people in Canada between adolescence and middle age (Langlois and Morrision, 2002). Suicide rates here consistently exceed those of many countries, including the United States (Leenaars, 2000), and the risk of suicide is higher yet for both Aboriginal people and mental health consumers.

In many parts of the world, Indigenous people have extremely high rates of suicide compared to the general population (UNICEF, 2004). This is the case in Canada as well, where statistics show an Aboriginal suicide rate two to three times greater than the non-Aboriginal rate (Health Canada, 2003). In some areas, Aboriginal suicide rates are even higher, for example Inuit peoples living in the Arctic register a suicide rate between 60 and 75 per 100,000 people, with rates among young males as high as 175 per 100,000 (WHO, 2002). Overall, the Aboriginal youth suicide rate is significantly greater than that of non-Aboriginal youth, by as much as five to six times (Health Canada, 2003).

In recent years, there have been trends toward dramatic and increasing levels of suicide in some communities. Among Nishnawbe-Aski youth in northern Ontario, for example, there was a 400 per cent increase between 1986 and 1995 (Health Canada, 2003), and this trend shows no sign of abating. A recent Globe and Mail article on the deplorable living conditions in Native communities in Northwestern Ontario reported that the recent suicide of one youth in a remote community was the 24th in two decades in a community of 700 people. An equivalent rate for Toronto would have been 4,520 individuals, more than annual suicide rate for the entire country (Philp, 2007).

It is important to note that national data likely underestimate the number of Aboriginal suicides, as they exclude non-status Natives and Métis people along with Inuit people residing outside the Northwest Territories, and they do not include accidental deaths that are possible suicides (Chandler and Lalonde, 1998; RCAP, 1995).

Having a mental health disorder also places people at higher risk for suicide. As noted by the Standing Committee on Social Affairs, Science and Technology in its interim report on mental health, mental illness and addiction, more than 90% of suicide victims have a diagnosable mental illness or substance use disorder. Suicide is the most common cause of death of individuals with schizophrenia and it also accounts for 15% to 25% of all deaths among individuals with severe mood disorders. Addiction can predispose people to suicidal behaviour by intensifying depression and reducing self-control (SCSST, 2004/2005)

Health Outcomes

It has long been known that people with mental illness are less physically healthy than others. People with all types of mental disorders, regardless of severity, have poorer health than the general population, although health status is especially poor for people with serious mental illness (Adler *et al*, 2000; Phelan, 2001; Sanderson and Andrews, 2002; Jones *et al*, 2004; Foti *et al*, 2005). Psychiatric patients have higher mortality rates from all causes compared to the general population, and much of the physical illness of psychiatric patients goes undetected (Felker *et al*, 1996; Phelan, 2001; Foti *et al*, 2005). Rates of obesity, cardiovascular disease, gastrointestinal disorders, diabetes, HIV, and both chronic and acute pulmonary disease are all higher among mental health consumers (Jones *et al*, 2004). The high incidence of substance abuse disorders among people with mental illness contributes to overall poorer health, along with poor eating habits, higher rates of tobacco use and lower rates of physical exercise compared to the general population (Phelan *et al*, 2001; Jones *et al*, 2004).

The health status of Aboriginal people is also poor compared to other Canadians. Aboriginal people are at higher risk for illness and earlier death than the Canadian population as a whole (PHAC, 2002). The infant mortality rate is higher among Aboriginal people (INAC, 2005) and there are higher rates of respiratory problems and other infectious diseases among Aboriginal children, compared with non-Aboriginal children, mostly due to poor living conditions and inadequate housing (PHAC, 2002).

The gap in life expectancy between First Nations and other Canadians is approximately seven years, and life expectancy is lowest for people living on reserves (INAC, 2004b). Aboriginal people are more likely than other Canadians to have disabilities involving hearing, sight and speech (INAC, 2004b). Chronic disease rates, particularly diabetes, but also cancer, heart disease, and arthritis, and rates of infectious disease, including tuberculosis and HIV/AIDS, are higher among Aboriginal people (SOGC, 2001).

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APPENDIX "B"

KEYNOTE ADDRESS

Dr. Lorna Williams: Building Bridges: Hearts, Minds, Spirits. Together

Thank you for having the courage to invite me to open these days of meetings you are having, especially Bill, Phil and Mike. I'd like to thank the ancestors who used this as a meeting place to solve mutual problems, and to spend time together. I want to acknowledge them because their wisdom is on this land. I want to ask them for guidance because of the work we are collectively to do during these two days.

The work we do is never just about us but the people who came before us and those who will come after. We must come up with the best ideas we can for those who have been voiceless, invisible and without champions in our communities. Because of this we need powerful allies and I ask for their help this day.

The title I chose reflects that unless we can bring out resources together collectively we can't build those bridges. I have been working in Aboriginal education for many years and much of it has been about creating opportunities and making space within educational institutions and other services for Aboriginal people.

My presentation is in 3 parts: 1) Stigma as we know it and have experienced it as Indigenous people in Canada; we need to understand how it enacts itself in daily life because it is very deep within society and affects daily relationships; 2) How we have approached counteracting stigma, and 3) What I have learned over the years.

1) Stigma

For about 200 years at the beginning of the exploration period when explorers from Europe were going out into the world and came upon Indigenous peoples' land, it was questionable as to whether the Indigenous people of Canada were human.

This is really important to consider because this question about our humanity continues to play itself out in our lives today and is part of the stigma we experience. It wasn't until 1763 that it was decided that we were human. This affects every aspect of our lives in this country today.

In 1976 farmers burned Indigenous people because they wanted their land. They were not charged with a crime because they were able to prove that the Indigenous people were not human.

This manifests in the way language is used, and the way we are treated daily as substandard human beings with something defective and irregular about us because of our Indigenousness. It was thought that we are primitive people. Our primitiveness plays out in thinking that our languages are not as sophisticated, rich, and descriptive as European languages. Most of our languages were oral until the last 30 years and because of this, people think that our languages are primitive.

I attended a lecture by a renowned linguist. She described some research into an Indigenous tribe in California and their understanding of time. This example points out the care we need to take in research because the language used as a base for the study was English. She used the English language and concept of time in order to look at the Indigenous language. Because people all over the world live time and understand time in very unique ways the very concept of time is different across cultures and all are valid but different. When the researcher’s base is understanding from an English perspective, the conclusion is always that there is something wrong with the Indigenous world because there is no understanding of the Indigenous world by the researcher.

The understanding of the world as experienced by people with mental challenges is also different.

So our relationships with people are guided by our understandings. Primitiveness in the modern world means something is not as sophisticated, doesn’t serve people well, and so we can get rid of it.

Our work to maintain and revitalize our languages suffers because of the idea that our languages are valueless to Canadians. Canadians forget that in adopting this land as theirs they also adopted the ways of living on this land which can only be understood through languages.

Our being ‘uncivilized’ plays out in the mistaken idea that we don’t have governance structures that allow us to care for our land, our communities, ourselves. Our social governance was seen as valueless. But each nation had social governance systems built on generations of stories, ceremony, protocol and practice that were carefully protected.

From the beginning of our relationship with colonizers, our intelligence was questioned. It was thought that our intellectual capacity was less than white peoples. This idea that we had less intellectual intelligence plays itself out in the assessment tools we use, the interpretations we make, and the programs we design for children.

For example, when residential schools were being closed and Aboriginal children were being moved from federal to public schools in the 1960’s, they did assessments to prepare us to move over. Most of the children of our class of 45 students were deemed to be mentally retarded. The tests used were language based tests of verbal skills and comprehension. The children of my community tested very low on verbal scores and high on comprehension.

The children from the neighbouring white community had reverse scores. So the public school placed all the Aboriginal children in a separate modified class, ignoring the high comprehension scores which really meant that the children understood language on a very sophisticated level. Ten (10) years later the scores reversed. So the school system reversed any advantage the children had to be able to decode and use their intelligence to figure things out.

It was always thought, and you could see this in the relationship between the Federal government and those who lived on reserve, that we lacked the ability to set goals and the strategies to attain these goals. Thus, every aspect or our lives is controlled because the belief is that we can’t figure things out on our own.

The belief is that we are not normal. “Normal” is an important idea to keep in mind because everything in our world today revolves around the myth of normality. Every tool created revolves around the myth of a standard of normality which is used by every service for people.

Our people have never been seen as normal – there are normal and Aboriginal programs. In everything created we are always set apart. I would say that is what you are facing in your work with the mentally ill - they are not normal, not human because the highest capacity is considered to be the intellectual capacity which is connected to the myth of normal.

We continue to be wards of the state. We are immature and childlike and there is a need to fix and repair us. Because we are wards, our “parent” has to fix us, repair us, so we can stand shoulder to shoulder with other Canadians.

How to do this was the challenge. In the residential schools we had unlearn our language; we had to be removed from the land, our families, and especially from the older generation, the Elders of our community.

Traditionally, the Elders and children spend the most time together, especially in the most formative years.

So we had to be removed from the land, the community, and the older generation to another place. In the residential schools actually, instead of fixing and repairing, children existed between the layers, in limbo, removed from our foundation. What was created in the schools also was not of this world, it was an “unworld”, a manufactured world. When spit back out, to make in the ‘real world’ we neither fit in our communities or families or in the world outside our families and communities. This “fix” and “repair” took away the foundation and fabric of what makes a person.

In the school system, Aboriginal children have been categorized and labeled and I know it is the same with the mentally ill children when they enter the school system with a label, “inhuman”.

In order to fix and repair we have to categorize. Aboriginal children in BC were over represented in every special education category, every single one.

The government decided they were going to remove some of the categories but to this day Aboriginal children are over represented in the category of “behaviour disordered”. Because we don’t behave in the same way as normal regular children, we are labeled “disordered” and get access to funding and programs.

But those programs and that funding are not designed to meet the needs of the population because the templates that people have in their heads have not taken into account cultural differences and the effects of colonization. We are probably the most labeled and mislabeled group in Canada.

I was trying to develop some social service resources for the public schools in Vancouver where we have First Nations from every First Nation across Canada. Twenty years ago, our highest speaker group was Cree, with Indigenous groups from Central America, U.S.A, and around the world.

I wanted children to understand the richness and diversity of our cultures around the world. We couldn’t complete the project because we could not agree on a name that would describe who we are as a collective. We came up with 35 labels, the majority of which are adjectives; Aboriginal is an adjective, Indigenous is an adjective. You see this in the media when these words are written in lower case. So we can’t even in this country honour the people on whose land we coexist.

The way that the notion of stigma plays itself out is through blame. Parents of Aboriginal children are usually blamed; for not reading to child in the evening, for homework not being done, for not having lunch, for not understanding Canadian history. The community is blamed for not supporting whatever the school is trying to do. The children are blamed because they don’t engage, pay attention, use language the way other children do.

Rejection of the knowledge of Indigenous people was evident in every social service agency until about ten (10) years ago. Indigenous knowledge has been devalued in society. This plays itself out in the exclusion of Aboriginal children during the natural course of going to school. Their stories are excluded from history books, from dramas, from performances in theatre. Why– because they are not the right colour; the darker they are the more we know they could never play a prominent role in a school drama because they aren’t quite the right colour.

They are excluded in the life that makes school a place of belonging; excluded throughout the entire extra curricular activities.

For many decades, Aboriginal children were secluded, separated from others. Mentally ill children also become separated from the ordinary course of life. Yet they need to be part of the community in order for them to be accepted.

Closeting means invisibility. In order to exist you deny who you are to the rest of society. If aboriginal children were fair enough they could deny their heritage. So children who were accepted in schools denied their identity. At some point, this catches up with them. Invisibility in plain sight; Aboriginal children became invisible in plain sight.

At some point during the 12 weeks we spend together in my course at U. Vic, the students tell me that they have never been on a reserve. Even when they lived across the street from one, they never visited it. Parents encouraged their kids to avoid the reserve, so children growing up nearby never met an Aboriginal child.

Until very recently, most Canadians would say the same.

During the constitutional talks, when we were trying to educate Canadians, this is probably what we heard most “why don’t I know this history?”

It plays itself out in daily life for Aboriginal people in this country. If I go to a store nobody sees me unless they think I’m going to steal something. If a white person comes to stand next to me, they see that person.

You can imagine what this does to young people who are not quite sure yet who they are. A parent who just moved to Victoria was telling me about the experiences her children were having in stores. It’s a good thing the mother was able to mediate to her children that it had nothing to do with them.

There was a sense of loss of “who I am” when children were sent from home to residential school where there was no confirmation of who they were. In order to be successful in school, many children have to reject their identity as an Indigenous person, lose their values, worldview, and the philosophy that makes them who they are.

In schools there are two types of Aboriginal children who make it: 1) those who have rejected their identity and have adopted a middle class identity; 2) children who have a powerful sense of their Aboriginal identity. They can exist knowing that they are negotiating always two worlds. Because of their strength and knowledge they can do this.

The children who struggle are children who have neither, and lack role models they can adopt. This results in loss of self-care and self-love. In my language this called “usantsut” which means to throw oneself away, to separate oneself from the community. In my community, people watch for those who separate themselves from others, from the natural flow of the community. When this happens, a person or group intervenes.

There is a loss of a stabilizing centre – the self-knowledge, the self connection to the land, because it is the land that defines who we are, our responsibility to ourselves, our family, the earth, and to the Creator. The loss of purpose and meaning to life results in loss of self care, hope, and optimism.

Luckily there are many people who have been able to withstand this because of the care, love, and continued support of the Ancestors, Elders, and community members.

2) Indigenous Knowledge and Wisdom

To overcome this we need to understand Indigenous knowledge and wisdom. This is important because it was devalued and it is a lived experience that comes from a shared experience in communities, not codified in texts but in ceremonies and in the knowledge that is passed down from generation to generation.

Because it isn't codified in the same way as mainstream, people think it does not exist. To reclaim it we need to share it with others and talk about it ourselves.

I see this in communities across this country; when they focus their attention on restoring, reclaiming the Indigenous knowledge they have, it provides them with direction, meaning, and purpose.

We need to understand the effects of colonization, oppression, and suppression. In order for us to build bridges so we can work with existing institutions, we need to teach these sources of knowledge to service providers.

Because people with mental illness have been oppressed, suppressed, depressed, colonized and devalued, you need to understand what that experience is like so a bridge can be built from that to the wider community.

For us to self determine, we need to understand the contradictions that exist in our lives, who we are today in the modern world and the traditional world. Those two worlds must be clear to us in every waking moment, in every decision we make. It is very difficult to define what is western and what is Indigenous. There is a value system that has evolved that informs the institutions we have created and our relationships that are based on a western worldview – that of consumerism. In contrast, there is an Indigenous worldview.

We also need to understand the oppressor/oppressed relationship in order to build bridges. It isn't only that the oppressor is the colonizer and the Indigenous are the oppressed, because when people are oppressed they become oppressors themselves because that is what they have lived, that is their model.

If we are not brave enough to understand and consider this in the work we do, we run the risk of becoming the oppressor.

We need to create processes of acknowledging the losses we have experienced, the anger, the shame, the guilt that result from historic and inter-generational trauma. Unless we find ways of resolving these in our relationships, our work places and our bridges will be rickety. At the same time we need to find ways of celebrating, in the ways they exist in our lives today, our strengths, resilience, giftedness, sense of self hood, feelings of competence and community belonging.

It is the same for people who have mental illnesses. They are resilient, they have created ways of living life in the ways they can live life.

If we don't do this, we are not valuing people. We need to see that each person comes into our midst and into the world with gifts for the world. It is not only Aboriginal people who need to celebrate these, we all do.

I was reading an article on people missing work because of their sense of being devalued in the work place and feeling hurt, loss, and pain.

Both of these processes involve the individual, the family, and the community. You need to mobilize everybody to do this work.

In your work with people with mental illness you are building bridges between two worlds. This must be done shoulder to shoulder; one group cannot do this for the other group. When someone builds our bridges they collapse. It is only when we are all part of the building process that we can cross in both directions; walking equally, shoulder to shoulder, hand to hand. This requires introducing one world to the other.

We try to do this through learning, through doing – when people are doing something purposeful and meaningful together. Learning through service - all people need to feel they make a difference on this planet and we do this by being in service to one another.

Ceremonies are extremely important, not only in Indigenous communities but in every community, because ceremonies acknowledge our meaningful existence with one another. They are an acknowledgement that we are part of a larger whole, a world beyond our immediate world. They are an acknowledgement of our world as a whole world, physical cognitive, spiritual, and emotional; in ceremony all of those are unified.

All prayer is - is an ability to open one's self to openness and communion with others. We all need this to feel a connectedness to one another.

It is extremely important that we learn from each other, from each generation; generations need to be connected, parents need children, and aunts need nieces etc. The more we can create opportunities to reconnect generations, it leads to wellness. We learned when they forcibly abducted children what happens to communities when they become generation-less. We can do this by sharing knowledge, humour, fun, play and food together and making group decisions.

3) What I Have Learned

Lil'wat principles of teaching/learning are important for forging a way of working together, building community.

What I have learned about making space is that for people with mental illness to have a place in our communities', space for them needs to be created in service provider institutions. My sense is that many of you support people with mental illness outside the service providers. People with mental illness need to participate in general society; so space needs to be made for them.

Aboriginal people also need space made for them in law, medicine and social services.

When we are trying to bring a defined group into a service institution, the expectation always is that the money has to come from somewhere else otherwise we can't offer service.

So you need to imbed services in the normal course of doing things.

People say it isn't moral or ethical to provide special funds for special interest groups because there are other groups. Targeted programs may have money to serve a group because of the underlying belief that they are not normal. When they offer money for that group, what often happens is that the group doesn't get served because the program is under staffed and doesn't really meet the needs of the people. Targeted services remove people from the course of life and the focus is on accountability, not on the purpose of the funding and the person who needs the service gets lost.

To deal with this you need inclusive planning and decision-making.

There has been lots of research about us and why we don't make it in school and most of it is useless because we haven't been involved. The methods used don't tell our stories; the ethics don't really protect our knowledge; the protocols used confound doing research; the questions asked also block knowledge acquisition; and finally, the knowledge gathered is available only to a select few. To create change you need real information exchange.

For example, we weren't taken seriously until we showed the numbers of Aboriginal youth graduating from high school. But when you examine the stats of those grads, the percentage able to go from high school is still the same, 5%, even though there has been an increase in the number of grads.

Leadership needs to be able to affect the kind and quality of decisions to be made. Leaders must understand the stories of the people to be served. The middle management and the support staff are probably the most powerful people in organizations because they make a difference. Advocates are people who work on behalf of Aboriginal children in schools. I have learned that you need both internal and external advocates as your primary bridge builders. You need people to create change from within and pressure for change from without. External advocates are not as vulnerable in their jobs. So there has to be a partnership between the two and both must be aware of their roles.

Institutional advocates, usually white, belong to the organization but when working in cooperation with external advocates they build relationships, trust and respect by both groups on both sides of the bridge. They are the knowledge sources, the on the spot teachers and it is on the spot teaching that makes a huge difference.

It is important to remember that those advocates need to be protected and the leadership needs to be protected. When you are working a change you have to vent on somebody and often it is the change agents that are vented on and need to be protected both inside and outside.

They need to be part of a larger group and to share their unique stories and have these stories appreciated. Advocates need to be at every level.

Glossary of Terms – Dr. Williams Keynote Address

NMHAC	Native Mental Health Association of Canada
MDSC	Mood Disorders Society of Canada
CAMIMH	Canadian Alliance of Mental Illness and Mental Health
Usantsut	to throw oneself away, to separate oneself from the community

NOTE: THESE COMMENTS WERE BASED ON RECORDED NOTES AT THE SYMPOSIUM