Social Support and Self-Determination: Protective Factors for Aboriginal Mental Health and the Effects of Post-Colonialism
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Abstract
Mental health issues have become a prominent problem for Aboriginal Canadians. Current research has shown that Aboriginal Canadians have a higher prevalence of mental illness, especially depression, suicide, and drug addiction than non-Aboriginal Canadians (Maar et al., 2009). Social support and self-mastery are determinants of mental health, and they are influenced by several historical, cultural, social, and political factors (Menzies, 2007). These factors have contributed to the high prevalence of mental illness among Aboriginal Canadians. Marginalization and government assimilation practices have been detrimental to individual and collective Aboriginal empowerment, eroding social support and self-mastery. This paper argues that the trauma from colonialism has lead to large mental health disparities, and that protective factors such as social support and self-mastery can ameliorate Aboriginal mental health. This paper will examine how self-determination and community support are implemented in mental health services available to Aboriginal Canadians. A discussion on more culturally-relevant services for the future will complete this paper.

The state of mental health for Aboriginal Canadians is dire and requires immediate attention. Research has shown that in comparison to non-Aboriginal Canadians, Aboriginal Canadians have a higher prevalence of mental illness, particularly depression, suicide and drug addiction (Maar et al., 2009). Aboriginal cultural understandings of mental health are distinctly different than that of the Western worldview, which emphasizes scientific medicine and clinical care (Wingert, 2011). Aboriginal people view health in a holistic manner and in connection to the community, requiring a balance between four dimensions of health: mental, physical, emotional, and spiritual (Wingert, 2011).

This paper argues that post-colonial trauma faced by Aboriginal Canadians has caused these large mental health disparities and that social support, as well as self-mastery, can serve as protective factors that will help Aboriginal people on their path to healing. This paper will investigate the mental health services that Canada currently offers to Aboriginal people. An examination of how self-determination, the freedom to determine one's own fate, and community support have been implemented in these services will be provided, ending with a discussion on future implications for improvements on more culturally-relevant services.

Mental health for Aboriginal Canadians has been affected by various historical, cultural, social, and political factors. These factors have a dramatic impact on social support and a sense of mastery (Wingert, 2011). A history of marginalization and government assimilation practices has led to increased mental illnesses through eroding relationships and through creating individual and collective disempowerment (Marr et al., 2009). The Indian Act of 1976 reflects a form of paternalism, establishing the federal government as the ‘guardian’ for Aboriginal Canadians. It also enabled
non-Aboriginals to determine Aboriginal identity status and allowed non-Aboriginals to control Aboriginal people’s health in ways that do not reflect their cultural conceptualizations of health (Menzies, 2007). The residential school system as well as child welfare legislation separated Aboriginal children from their families in order to assimilate them into mainstream society, leading to a loss of community and identity (Menzies, 2007). Previous studies have found that many adults who had attended residential schools had experienced psychological abuse during attendance and now experience symptoms of alcohol and substance abuse, depression, and suicide (Beisner & Atneave, 1982; Gagne, 1998; Hodgson, 1990; Mussel, Nicholls, & Adler, 1991; cited in Menzies, 2007). Many children from the welfare program that were removed from their birth families were forced between two cultures (Menzies, 2007). This may have created divergent cultural views so that they were unable to relate to either culture with little community support or guidance for managing cross-cultural differences. In addition, a loss of identity and culture leads to decreased measures of self-determination (Wingert, 2011). From these detrimental historical events, Aboriginal people may experience a sense of learned helplessness from the loss of cultural continuity and social disintegration. This cultural oppression and loss may be a source of the socioeconomic and health disadvantages Aboriginal people experience (Wingert, 2011).

Healthy populations can be created by fostering positive social environments. Aboriginal people emphasize that the community plays a role in producing health or illness and that community support, as well as self-determination, is recognized in aiding individual development (First Nations Inuit Health Branch, 2009). This creates a collective responsibility for the community’s state of wellness (Menzies, 2007). Given the Aboriginal holistic view of community, it is not surprising that there is a growing body of evidence which suggests that social support influences Aboriginal mental health (Richmond, Elliott, Matthews, & Elliott, 2007; Yen et al., 2006; Wingert, 2011). For instance, a study on the Cree of James Bay found distress was inversely correlated with social support (Kirmayer, Boothroyd, Tanner, Adelson, & Robinson, 2000). The focus groups in Richie’s (2010) study emphasized that independence and effective relationships were necessary for good mental health. Previous research also suggests mastery as a determinant of mental health (Wingert, 2011). Mastery has been defined as the ability to control the forces that affect one’s life, which includes one’s health (Wingert, 2011). The RHS National Team (2007) noticed that suicidal thoughts are higher among those receiving government transfers. Thus, government dependency, in addition to the loss of cultural continuity and social disintegration, can increase mental illness by creating a sense of learned helplessness and loss of control. The RHS National Team also found less depression if one had more mastery, while Chandler and Lalonde (1998) found decreased suicide rates if there was self-government and community control.

It is clear that the effects of colonization on community and self-determination have affected Aboriginal mental health and that support and self-mastery are important mental wellness determinants. However, dominant Western mental health models are biomedically based and thus may not acknowledge culture and the historical influences of colonization. This results in Western mental health models being culturally inappropriate for the care of Aboriginal people’s mental health. Culturally competent care involves three attributes: cultural appropriateness, cultural accessibility, and cultural acceptability (Petrucka, Bassendowski, & Bourassa, 2007). Culturally appropriate care must be able to meet the cultural, social, linguistic, and spiritual needs of the client (Petrucka et al., 2007). In addition, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), which is typically used as a diagnostic and assessment tool, does not account for the historical and cultural context of Aboriginal mental health such as the historical trauma that Aboriginal people have faced (Maar et al., 2009). This can lead to misdiagnosis and inappropriate treatments seeing as the symptoms of trauma are parallel to symptoms of several mental health disorders such as
anxiety and depression.

There is a great need for more culturally-relevant mental health services. Health Canada does not have a national Aboriginal mental health strategy, even though in Canada rates of Aboriginal mental illnesses are astounding high. For example, a 2001 survey found that 13% of Aboriginal people on reserve were classified as distressed compared to 8% of non-Aboriginal Canadians, and 12% of Aboriginal people on reserve had suffered an episode of major depression compared to 7% of non-Aboriginal Canadians (Marr et al., 2009). The available services are fragmented and contain serious gaps, as they are only provided to a small number of the Aboriginal population and depend on legal status and place of residence (Marr et al., 2009). Although there are effective therapies for depression, they lack the cultural relevance to make them useful for Aboriginal Canadians (MacMillan et al., 2008). For example, the Inuit in Nunavik do not have a word for mental illness in their language, but instead reference thinking too much or not thinking at all (Wingert, 2011). There is also no Aboriginal concept similar to the Western one for substance dependence or addiction as a disease-like condition (Munro & Allan, 2011). Western therapies and treatments emphasize the individual, but in Aboriginal culture, family and the community can sometimes take primacy over the self as Aboriginal sense of self is seen collectively. In Western clinical care an individual seeking health services is regarded as a client or a patient, and thus a passive receiver, whereas Aboriginal culture views the individual as an equal partner in a healing relationship (Maar & Shawande, 2010). Culturally-relevant services will serve to increase a sense of identity and cultural belonging, as well as make mental health treatments more efficacious.

In recent years, several prominent organizations have expressed the need for improving cultural competence in mental healthcare and have advocated for appropriate adjustments to our healthcare system. For example, the World Health Organization has advocated for the recognition of traditional healers (Maar & Shawande, 2010). This has resulted in the acknowledgement of traditional healers in Ontario’s Regulated Health Professions Act, as well as the development of an Ontario strategy, which funds various traditional Aboriginal healing programs and services (Maar & Shawande, 2010). Although the mental health services for Aboriginal people in Canada is lacking, a number of mental health programs and services are available. An example of this is the Knaw Chi Ge Win, a collaborative community-based Aboriginal mental health service model in the Manitoulin District in Northern Ontario (Marr et al., 2009). This model integrates psychiatric clinical care with traditional Aboriginal healing within a holistic framework, and with extensive education and capacity building (so that the client can manage themselves) has led to improved quality of care, as well as cultural safety (Canadian Institutes for Health Research, 2007). For example, providers explained that care for the clients were more stable and handled locally with this model approach, which may have attributed to the found reduction in acute care readmissions (Marr et al., 2009). In addition, the clients reported feeling more safe and comfortable expressing their mental health needs in this environment (Marr et al., 2009). By providing both clinical and traditional mental health care with traditional services was helpful because some clients did not regard traditional practices as their way of life (Maar & Shawande, 2010). The team strives to always have a fluent speaker available so that the clients can be comfortable speaking in their own language if they chose to do so (Marr et al., 2009). The Knaw Chi Ge Win team has also attempted to create a mental health care system by creating formal networks that gather mental health providers together for referral connections (Health Canada, 2011). Although some Aboriginal people have stated that they prefer a mental health service provider of Aboriginal ethnicity, others have claimed that as long as the provider is informed of local values and practices and they remain respectful,
Aboriginals living in both rural and urban areas (Marr et al., 2009). Over half of the Canadian population that identifies themselves as Aboriginal reside in urban areas (Walker, 2008). In addition to difficulty accessing care, these Aboriginal Canadians may experience a loss of a sense of community and confusion in cultural identity. Opportunities for meaningful social interaction are required. The creations of urban reserves and friendship centres have helped to improve the social presence of urban Aboriginal Canadians (Walker, 2008). However, the mobility among Aboriginal Canadians between rural areas to cities and within cities makes it difficult to develop effective community interventions for mental service delivery (Walker, 2008). Little will change without the adequate funding for appropriate healthcare delivery, as well as more education to recruit Aboriginal healthcare workers and increase cultural understanding for non-Aboriginals. Stigmatization and discrimination is difficult to correct without knowledge and awareness. There is little Aboriginal people can do without a national strategy and the necessary funds.

The Health Canada Transfer Initiative enables Aboriginal people to pursue their right to self-determination by allowing them to take control of federally funded health programs (Minore, Boone, Katt, Kinch, & Birch, 2004). Aboriginal communities have used this transfer initiative “to design and manage the delivery of services, and allocate funds according to their own health priorities” (Minore et al., 2004, p. 362). Several nations have taken advantage of the Health Transfer Initiative to provide holistic mental health services (Lemchuk-Favel, 2004). For example, the Kahnawake nation have used health transfers in order to build a community health unit that offers public health services (hospital care), specialty services (dental care and a diabetes education program), and social services (alcohol and drug abuse treatment) to reduce inefficient programming previously in place (Lemchuk-Favel, 2004). While the transfer initiative has provided mental health care services to Canadian Aboriginals with increased community involvement, it does not provide the full
range of services needed (Adelson, 2005). There is also a serious lack of funding, it does not acknowledge Aboriginal people living off-reserve, and it still produces dependency of Aboriginal people on the government because the government essentially decides what is ‘fundable’ (Adelson, 2005). Aboriginal control over mental health services can be a confusing affair due to the split responsibilities of the federal, provincial, and municipal governments. The relationship between local government and treaties is indirect because the federal government exercises treaty rights and municipalities are governed by the provincial statutes (Walker, 2008). Canada will need to develop formal processes to provide services that transcend neighbourhood boundaries (Walker, 2008). In addition, a visible presence of Aboriginal people in municipal affairs is lacking and this needs to be changed in order to encourage collaborative decision-making for culturally appropriate care. This paper proposes that provincial and municipal governments should not wait on the federal government for action, but should begin acknowledging the Aboriginal population and collaborating with Aboriginal health systems in order to allow the Aboriginal population to perform their right to self-determination, and consequently, lead to better mental health outcomes for the Aboriginal population.

It is clear from this research that the implementation of empirically informed services that focus on these protective factors should be encouraged in order to improve the efficacy and quality of care. Such interventions should aim to increase social inclusion and the quality of Aboriginal social environments. Interventions should be delivered not only at an individual level, but also at a community level. Although there are services available, they are not meeting the needs of Aboriginal Canadians. Culturally appropriate assessment tools are required to rectify this deficit of culturally-inappropriate mental healthcare. Sensitivity training to non-Aboriginal staff is needed along with encouragement for Aboriginal workers to enter the mental healthcare field. Without better cultural understanding, successful interventions cannot be implemented. Effective interventions require knowledge of the protective factors for mental illnesses that affect the health of individuals and communities. With more knowledge, mental health service providers, both Aboriginal and non-Aboriginal, will be able to produce effective health interventions that will increase Aboriginal life expectancy and ultimately improve the health status of Aboriginal people.

Just providing mental health services is not enough to improve the mental health status of Aboriginal Canadians. Aboriginal people continue to be controlled through the Indian Act. The government needs to grant the Aboriginal population more control over their health through locally-funded services and allow communities to grow and flourish. Enabling Aboriginal Canadians to control and improve their health will require policy innovations, as well as funding that is sustainable and appropriate. Understanding and addressing the root causes and broad societal factors that have led to the mental health status disparities between Aboriginal and non-Aboriginal Canadians is crucial. A history of discrimination and racism has caused difficulty for Aboriginal people to establish trust in the Western healthcare system, which may lead to decreased utilization and effectiveness of mental healthcare services. In addition, as westernized and Aboriginal mental health care models are so distinct, more research is required in order to determine how the two systems will be able to integrate successfully. Detrimental colonial effects may have diminished, but colonization has not ended and the collective trauma it has caused continues to impact and affect the mental health of Aboriginal Canadians today. When this trauma is experienced by more than one generation it can become institutionalized within the community and pass on to future generations, creating a continual cycle of intergenerational trauma (Menzies, 2007). Aboriginal mental health interventions will need to account and change these historical influences in order to provide strength to the Aboriginal community. Aboriginal populations will need to break this si-
lence and allow grief to be shared within the community; traumatic effects cannot be eliminated by short-term interventions. Only with time, support, and empowerment will Aboriginal people begin to heal.

References


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