Bringing Home Payahtakenemowin (Peace of Mind): Creating self-governing community services

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Abstract

The decade from 1985 to 1995 saw rapid social and economic change in the 27 remote hunting and trapping First Nations of Northwestern Ontario. The area also saw an eightfold increase in the suicide rate despite the introduction of a multi-million dollar system of outside helping services. By assuming control of health services, the First Nations have increased the ability to address health and social service problems locally.

Introduction

When you have a polluted lake, the fish is sick. The fish is taken out for treatment but when it is returned the fish is sick again. The lake must be treated first in order for the fish to be well.

- Eddie Angees
Wunnumin Lake First Nation

Historical Background

The Nishnawbe-aski Nation (NAN) were a people who lived off the lands the creator had given them. Small family groups moved with the seasons and availability of game. In the summers several extended families gathered in settlements for traditional celebrations and to harvest the land and lakes. A complex clan system ensured survival and protection. Each person was required to make a contribution: to gather food, nurture the young or administer medicines to name a few. The system was its own social support network.

In Northwestern Ontario, Big Trout Lake became a gathering place for aboriginal people from the surrounding area after the establishment of a Hudson's Bay Company trading post. After the trading post was stocked for another year, the families would then move back to the wilderness to hunt and trap. The Hudson's Bay post would outfit aboriginal families with food and other necessary items, to assist them in trapping. In turn, the trappers would return to the post with their furs to erase the debt recorded in the company ledger. This reciprocity meant that the Bay benefited from cheap labour while the First Nations purchased goods that would make gaining their livelihood easier. Despite the hardships and the minimal goods given in exchange for their labour, elders with pride in their voices, recount these events through oral stories. They speak of great hunters and trappers and the enormous amounts of beaver that were abundant in the past.

In 1929 the aboriginal people signed a treaty with the federal government. However, the full understanding of the contents of the treaty and its impact were not realized by the people until the late 1950s and 1960s. They understood that the white people had asked if they could share their land. In return, the white people's government would provide for the Indians' needs in perpetuity. About $4 per person was promised as well as services such as education and medical care. The $4 payment is still dispensed and the promised services is now interpreted to mean the full range of medical and health services. The people did not understand that they would lose their rights to the land and would live on reserves. To them a reserve was a place to meet the government officials for the annual treaty payment and deal with other treaty considerations. To this day, they reject the government's assumption that title to their land, rests with the government. This on-going conflict is shared with other aboriginal people across Canada.

From the time of contact with European settlers, new diseases ravaged the north. By the middle of the 20th century, tuberculosis had caused hundreds of people to be relocated for years to distant hospitals in Thunder Bay and, after 1950, to a new federal hospital in Sioux Lookout. Years away from one's family and community caused loneliness and alienation. The bodies of those who died were not returned home, but, were placed in crowded, untended graves. Sometimes relatives were not notified of the death. Many childern lost parents with no opportunity to properly grieve the loss. Recently, a number of adults have successfully located these graves after considerable searching of records and there is no evidence to demonstrate that proper burials were given. (Sanders 1996)

The systemic persecution of the Jews during the second World War by Nazi Germany prompted Canada's elimination of racially based policies after 1945. The ideology that the same laws and services for all would lead to equality influenced post war Indian policy (Archives of Ontario 1951). Education, as the means to equality, was a popular ideology. However, equal education was not provided and equal results not obtained. Residential schools, many operated by churches, was the predominant means of education and assimilation . The shameful legacy of these schools has received increased attention through the public media.

When education for Indian children became compulsory in 1951, early school aged children were forcibly removed from their parents to attend these schools. The government grossly underfunded the schools: until 1957, schools were funded on annual per capita grants that were a fraction of the rates for similar provincial institutions. Working with inadequate funds to meet the children's needs and with the incentives of a per capita funding system, the churches overcrowded the schools and solicited enrolment to increase revenue. Schools were crowded, undersupervised and breeding grounds for tuberculosis. The children were undernourished, emotionally neglected and punished unmercifully for minor offences. Many were subjected to sexual abuse by clergy and institution staff. The implications are obvious for the mental health and well-being, not only of the suvivors of the schools, but for future generations. (Royal Commission on Aboriginal People 1996)

Children in the Sioux Lookout area of NAN left their families for ten months every year until the age of 15 or 16, usually to attend Pelican School in Sioux Lookout or Cecilia Jeffreys School in Kenora. The priority of the government was assimilation through education, while the churches promoted Christianity. The churches neither educated well nor fully Christianized native people (Gibbons and Ponting 1986, Vecsey 1983) and left children emotionally and culturally damaged. An estimated 80% of the First Nations population of the area, almost the entire 30-60 year age group, attended residential schools. At Pelican School, girls and boys were separated by physical barriers. If they spoke Ojibwa or Cree or talked across the barriers to siblings, they were strapped. One particular minister, warned children that there was no salvation for them if their parents abused alcohol. Staff faced dismissal for not attending church several times a day. Children went home only in summer months; and visitations from parents or relatives was possible for only a fortunate few. Disclosures about sexual abuse at Pelican School have emerged in recent years and a former staff member has been convicted (Wawatay News 1993).

The children returned home from the schools unfamiliar with the culture, language and the families they had left. Many were robbed of the self-discipline needed for bush survival. The decreased use of the language by the young and increased adherence to Christian

beliefs by the elders limited the transmission of native traditional practices.

The move to assigned permanent communities hastened the demise of the traditional livelihood. Moving to permanent settlements was tantamount to forced relocation. Forced relocation causes multi-dimensional stress, which is characterized by the destruction of kinship groupings, the demise of spiritual rituals tied to the locality, the loss of leadership roles and disputes over land.

Until the middle of the 1980s, most communities lacked modern amenities. Indoor plumbing, electricity and telephones were available only on government properties. Television and radio communications were relatively unavailable. The impact of the changes in recent years is captured in this quote from hearings concerning health care in the area:

> In 1975, people in the north were listening to the radio at night and talking on radio telephones. In 1985, they were watching twenty-four hour multiple station uncensored satellited link-up television and using direct dialling satellite telephones. The metal star and the microchip had come to the north. Women found that they could not cook bannock in a microwave oven. Children found computer keyboards in their school classrooms. Video cassette recorders and video games showed up everywhere. The community halls were empty. The community health was in jeopardy. (Scott-McKay-Bain 1989)

The Setting

The western portion of NAN consists of 27 small First Nations spread over 300,000 square kilometres of boreal forest, waterways and hinterland in remote Northwestern Ontario. The entire alliance encompasses 45 First Nations across most of Northwestern Ontario. The origin of this organization is found in the geographic area covered by Treaty Number 9, signed with the Dominion of Canada, first in 1905, with a later adhesion in 1929.

The populations of the First Nation communities of NAN west range from 40 to 2,000, with 400 a typical size. The people are of Ojibwa and Cree descent, and speak a language known as Oji-Cree. The communities are virtually inaccessible other than by small aircraft. The closest town, Sioux Lookout, is one to two hours away by plane, and the closest cities, Thunder Bay and Winnipeg, are yet another hour by plane.

The Shibogama tribal area, which is the focus of this paper, is comprised of the communities of Wunnumin Lake, Kingfisher Lake, Wapekeka, and Wawakapewin. The combined population of these communities is 1,200, and each community is accessible only be air.

Social and Family Services

In the mid-1970s, social services were limited and largely delivered by agencies located outside the communities. There were two mental health counsellors from the federal hospital, and a few child welfare workers whose main task was adoption work. An estimated cost for all such programming was $200,000. Community services and other resources were largely comprised of Community Health Representatives, nurses, physicians, police officers and ministers who provided counselling and family support as part of their general duties. There were no treatment facilities closer than Winnipeg or Thunder Bay, and no programs specifically developed for First Nations people.

A myriad of programs both at the community level and delivered from outside First Nations organizations had been introduced. Most were controlled by First Nations organizations from outside the community and employed First Nation staff. These authorities were, The Sioux Lookout First Nations Health Authority's regional mental health counselling service, The Native child and family services organization and the communities' respective band councils. In addition, First Nations in the area began to operate in-patient facilities including a Family Addictions Treatment Centre, A Children's home and a secure facility for young offenders. In addition, new treatment facilities outside the area, some of which were First Nations run, were now in use. A conservative estimate of $20,000,000 is poured into programs designed to heal social problems.

These services were introduced unilaterally by the outside agencies over a 10 year period with no coordinated plan to address community problems

THE PROBLEM

Endemic Suicide and the Response

Before 1978, confirmed suicides were infrequent in the area. From 1978 to 1987 there were 29 suicides, an annual rate of 24 per 100,000 based on a population of 12,000. While double the 1986 Canadian rate of 12 per 100,000 it was lower that the all Canadian First Nations rarte of 36 per 100,000 (Canada 1991). The decade 1985-1995 saw an increase in the overall NAN rate to 85 per 100,000. From 1993-1996, there was an average of 23 completed suicides per year. There were suicide attempts and related behaviour in virtually every community.

In addtion to suicide and parasuicide, other social indicators revealed distress. While previously child welfare apprehension wre rare, over 4% of the areas' children were in foster care at the end of 1992. At the time, this equalled the national rate for Native childern in care, which is ten times the national Canadian rate (Indian and Northern Affairs Canada 1993). In addition, the regional Women's Shelter housed over 400 abused women since 1985.

By the time the annual number of suicides peaked at 23, a wealth of uncoordinated services existed that had little ability to work together, or, to address the suicide crisis.

The Shibogama Situation

As a group, the communities in Shibogama had one of the highest youth suicide rates in NAN over a ten year period. One community had four suicides in a four-month period.

With less than 8% of the NAN West population, Shibogama had 28% of the suicides, and the victims tended to be younger than in other communities. The small, interrelated populations of the Shibogama communities increased the impact of the suicides. For example, the community of Wapekeka, with a population of 275, had

eleven adolescent suicides between 1985 and 1995. In such a small community, no family escaped the loss of a young relative.

After three consecutive suicides in 1993, Wunnumin Lake hired outside professional help to assist its resource workers to deal with the crisis (Timpson and Johnson, 1994). Significant problems were identified with regard to the provision of services. Resource workers were operating independent of one another, and case information was not being shared. In one extreme example, the Mental Health Worker was making plans for family counselling, unaware that the Band Family Services Worker had arranged foster placement for the children outside the community.

In another case example, when investigations were held after two suicides, it was discovered that service providers were unaware who had the responsibility for the case. People would self-refer to a worker they knew and trusted, whether or not their problem fit the worker's mandated job description. Clients experienced duplication of services, conflicting services, or no services at all. At-risk community members were falling through the cracks despite the social service system that was in place.

Barriers to effective service provision and coordination revealed several areas that impede accessibility, information exchange and case management.

> •Accountability: Workers were employed and supervised by outside agencies, and were given separate case directions regarding clients.

> •Confidentiality: Workers from one agency could not freely share information about their clients with other workers, even when working with the same family.

> •Agency mandates: Strict adherence to agency man-dates prevented holistic and family approaches to multi-level problems. For example, a family counsellor from the child welfare agency could not work with a family if it had no children under sixteen; addictions workers dealt with the substance abuse only, not with underlying mental health problems.

•Salaries: Separate salary scales created the potential
for resentment if salaries were different, but responsibilities
the same.

•Travel demands of outside agencies: Workers were
often required to be out of the community for several days,
with no accountability to the community; this interfered with
provision of activities, and teamwork goals.

•Training: Inservice training provided by agencies for
their workers differed widely in amount and type of training.

Inevitably, service providers with experience and community
knowledge, received the most difficult cases, and the after-hours calls.
Often, this was the mental health worker, since this service had been
the first implemented in the area, and was backed up by a large
medical system (Timpson, 1984). In one community, the mental
health worker brought to the position twenty-five years experience as
a Community Health Representative, and as such was the worker most
often utilized in the community.

With no mechanism for team work in place, clients needing
multiple sevices were often unnecessarily referred to agencies outside
the community. Similarly, in the child welfare area, the resource
workers' expertise was either underdeveloped or underutilized. Not
surprisingly, staff turnover was high as workers either burned out or
resigned due to dissatisfaction with the job. One community worker
stated that the stress and trauma in the community, combined with the
barriers to working with other service systems created inner doubt as
to whether the community could cope with another crisis.

In addition, suicides seemed to set off other attempts within
the close-knit communities. After a suicide, volunteer crisis teams
from other communities would give support to the grieving families
and provide security patrols. This was a positive response, as it built
on the traditional practice of helpers travelling to communities during
a crisis, and it acted as a bonding experience among the communities.
It would not be unusual for over a hundred volunteers to be in a
community.

There were, however, negative aspects to this practice, as it left, at times, a community's resource workers with limited roles. Since volunteers changed every few days, services were not consistent.

The Shibogama Response

As the number of crises increased, the four communities realized that dependence on solutions from outside the community was not working. They began to examine their own situation. In March of 1993, a conference for Shibogama front line workers brought to light the need for full community participation, training, control, and co-ordination if the problems were to be solved. A program strategy titled Tasekaywin Menoiawin (Community Wellness) was initiated.

Positive things began to happen. As the people talked about the situations which plagued them, healing came into their lives, enabling those on the front line of the new initiative to face their problems. The next step was to plan how to take control of their lives and promote solutions at the community level.

This did not take place overnight; but was hastened by the devolution of health services to the First Nations in January of 1994. There were four significant milestones in this process: health transfer, community control of centralized services, team building, and co-ordination of mental health, family and health services.

In the mid-1980s, the federal government had created a policy to transfer direct administrative control for First Nations' medical services to First Nations. In January, 1994, Shibogama communities were one of the first First Nations groups in Ontario (and the only one in the western part of NAN) to sign a transfer agreement with Medical Services Branch (MSB), Health Canada.

The health transfer process provided a forum and resources for program planning to address some of the communitys' problems. Transfer of funding provided flexibility to the First Nations. Under the previous MSB funding there was limited community input regarding the allocation of funds to specific programming needs. The negotiations for the transfer were conducted with the idea that the communities would control the funds and the Tribal Council would

act in an advisory role. Accountability of all programs to the First
Nation is key to the notion of self-governing programs.

The communities combined a portion of their federal
Building Healthy Communities monies with funding resources
received from the provincial Aboriginal Healing and Wellness
Strategy to support a centralized mental health support service.

Formation of Resource Teams

Utilizing other funding sources allowed each community to
create service positions designed to act as Resource Team Co-
ordinators. These positions were to provide case management for all
family and mental health services. The following positions comprised
the Core Resource Teams:

- •Mental Health worker
- •NAADAP workers
- •Band Family Service workers
- •Child Welfare Agency Family Counsellors

In order to implement the recommendations for improving
service provision the following areas were identified as critical for
increasing effective services:

- •workers' contracts contained, as a condition of employ-
  ment, the need to adhere to teamwork principles;

- •a Confidentiality Code approved by the Band was insti-
  tuted to allow team members to share information of a
  general nature on the progress of a case, to obtain suggestions
  for helping the client or to report incidents of violent or
  suicidal behaviour;

- •regular case management meetings, and meetings to
  co-ordinate outside travel, were held to improve
  communication;

- •an On-Call system was developed to be used by
  the community and health professionals after hours;

•the Resource Team Co-ordinator was designated to repre-
sent the team to outside agencies with respect to referrals and
case management decisions.

During the first year of transfer, the system was tenuous. Old
habits were hard to break, and accountability to outside agencies
hindered teamwork. Some of these obstacles were overcome in March,
1995, when the Building Healthy Communities program transferred
mental health funds, including planning monies, to the individual
communities. This enabled Health Councils to meet together, share
and plan mental health services, as well as to bring the crucial mental
health positions under Band control.
       As further planning occurred, the need for the health service
to work together with family and mental health services became
obvious. After a year, the mandate of the Health Councils evolved to
include an integrated approach to delivering health and social services.
All social and health employees, although paid and supervised by
outside agencies, were consolidated under a scheme of accountability
to the community.

Conclusion

Progress 1993 - 1996

In a planning meeting, an advising elder named the
Shibogama program "Payahtakenemowin", meaning Peace of Mind.

At the community level, the successes of working together are
as follows:

       •All staff assume responsibility for cases regardless of
        their title or agency mandate.
       •On-call systems for after-hours emergencies have
        been developed.
       •There has been an identification of broader com-
        munity needs, such as the need for parenting courses and
        marital counselling, and the implementation of co-ordinated
        prevention initiatives, such as wilderness based treatment
        programs.

- •Individual training programs have been designed
  for communities' particular needs: counselling skills for all
  workers, including school personnel, and elders; parenting
  skills training, spiritual and grief work.
- •A community-based approach to treating solvent abusers
  has been developed.
- •There has been a proposal to develop the land of the small-
  est community into an aftercare treatment centre which
  emphasizes family care.
- •It is accepted that the line of accountability is to the Re-
  source Coordinator and the Health Director, not to an outside
  agency.
- •At the tribal council level, centralization, co-ordination and
  pooling of budgets has created new programs and services in
  a cost-efficient manner.
- •Outside community resources are used less and when
  they are, they work under the direction of the Community
  Resource Team.

The centralized services of Shibogama have developed programs which are unavailable in other communities. These programs include: a college-accredited community-driven training program which will produce its first graduates in January, 1998; the development of culturally-appropriate training aids in the Oji-Cree language; and an Employee Assistance Program for service providers and support for the leadership in the communities.

Looking back on what Shibogama has accomplished through the community development process in the health and mental health fields, the Shibogama people cannot help but feel a sense of *deja vu* . Remembering the elders' stories of days gone by -- of the hard work, the co-operation, and how they overcame their difficulties not by outside intervention, but by using indigenous resources, it is evident that the process was one of returning to traditional ways, with a modern face. Shibogama people are regaining the personal spirit of the days when they were self-sufficient and in control of their lives.

Through their own efforts and by looking inward for solutions, the people of Shibogama are clearly on the road to once again becoming the self-sufficient people they once were.

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