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Three of the Four Corners: The Physical, Mental and Emotional Health of Aboriginal Peoples in Montreal

Volume 1: Health, Mental Health and Substance Abuse

Volume 2: Barriers to Treatment

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Note: This project was funded by a CQRS (Conseil Quebecois de la Recherche Sociale) team grant to the National Network for Aboriginal Mental Health Research Team (NAMHR) at McGill University. The research program was developed in partnership between the NAMHR and the Native Friendship Centre of Montreal.

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Citation: Gill K, Jacobs K (2001) Three of the Four Corners: The Physical, Mental and Emotional Health of Aboriginal Peoples in Montreal. Report prepared for the Native Friendship Centre of Montreal and the National Network for Aboriginal Mental Health Research. http://muhc.ca/addictions_unit/page/research-program

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Acknowledgements

This project was funded by a team grant from the Conseil Quebecois de la Recherche Sociale (CQRS) to the National Network for Aboriginal Mental Health Research (AMHRT) at McGill University. The research questions, methodology and focus were developed in partnership with Ms. Ida LaBillois-Montour at the Native Friendship Center of Montreal (NFCM).

We would like to thank the individuals who contributed their time, ideas and dedication to this project. The following research assistants (listed in alphabetical order) participated in various capacities such as the literature review, the survey design, as well as the data collection and analysis:

Ms. Natalie Lloyd
Ms. Lana Pratt
Mr. Delbert Sampson
Ms. Lisa Schurman
Ms. Darlene Wapachee

We would also like to sincerely thank Mrs. Ida LaBillois-Montour, who was the Executive Director of the NFCM during the period that this study was designed and conducted. She provided space at the NFCM as well as encouragement throughout the data collection and analysis phases of this work.

To the individuals who participated in this study, we offer our sincerest appreciation for sharing their experiences with us. Without their trust and cooperation this study would not have been possible.

Thank you.
Niawen.

Kathryn Gill Ph.D.
Kahá:wi Jacobs M.Sc.

November, 2001

Overview

Description of the Project

The first phase of this project **(Volume 1)** examined the physical and mental health of Aboriginal peoples living in the greater Montreal area. Data was collected through interviews with 245 status and non- status Native, Inuit and Métis residents of the city and its surrounding areas. Interviews were conducted in the context of a general health survey, in both English and French. The sample includes individuals from Native-run businesses and organizations such as Makivik, Air Inuit, the NFCM, and Native Women's Shelter as well as from educational institutions including Dawson College, Concordia University, McGill University, University of Montreal and the University of Quebec in Montreal (UQAM). Study participants were also contacted through visits to Atwater Park and the area surrounding St. Laurent Street and to drop in centres such as Chez Doris, the Open Door and the Salvation Army Men's Shelter. Announcements for the study were aired on the CKRK radio station in Kahnawake, and were printed in The Mirror, The Nation and Kahnawake's local paper The Eastern Door.

The interviews collected information on sociodemographics (age, gender, education, income, employment status), medical problems, legal status, family and social relationships, psychological problems, and drug and alcohol use. Participants were asked to identify any problems they were experiencing, the number of days they had problems and to rate how troubled or bothered they were by these problems in the past 30 days on a scale of 0 (not at all) to 4 (extremely). In addition, they were asked to indicate their perceived need for treatment or counselling using the same rating scale.

In addition, a number of special in-depth interviews were conducted with Aboriginal frontline workers and Aboriginal people who used their services. An interview guide was developed to explore support networks, health problems, attitudes toward health and social services, interpersonal violence and problem drug or alcohol use. Informed consent was obtained from all the study participants. They received tickets for public transportation and gift certificates redeemable for food and movies as partial compensation for their time and effort in continuing the study.

The second phase of this project **(Volume 2)** explored the barriers to treatment entry for a sample of urban First Nations and Inuit peoples seeking treatment for substance abuse [1]

[1] The term "substance" refers to alcohol and/or other drugs such as cannabis, cocaine, heroin, benzodiazepines, narcotic analgesics as well as inhalants.

problems. The aims of this phase of the project were:

1) to determine the severity and pattern of substance abuse (drug type, frequency and quantity of drug intake) among individuals seeking treatment for substance abuse

2) to collect information on barriers to accessing treatment.

During the study period treatment seeking clients approaching a drug/alcohol referral service at the NFCM were asked to participate in the study—which involved initial assessment, referral to treatment and ongoing follow-up. Clients received an extensive initial assessment and information in a number of areas was collected including sociodemographics, psychological status as well as the severity and consequences of the presenting alcohol/drug problem using the Addiction Severity Index (ASI). Referrals for treatment were made to one of five treatment centres for Aboriginals in Quebec. These treatment centres, funded by the Addictions and Community Funded Programs, Health and Welfare Canada included the Waniki Treatment Centre in Maniwaki, Onen'to:kon Treatment Centre in Kanesatake, Mawiomi Treatment Centre in Maria, and two centres with French-only services (Centre KA Uauitshiakanit in Maliotenam and Centre de Readaptation Wapan in La Tuque). All the available treatment centers were located outside the Greater Montreal region. Entry into treatment as well as completion was examined for all clients.

Summary Findings and Conclusions

As shown in **Volume 1** of this report, analysis revealed that among the 245 individuals interviewed, the majority were single unemployed females that had lived in the urban area for an average of 9.9 years. Inuit peoples predominated, followed by Cree, Mohawk and Mi'kmaq peoples. A large proportion of the sample had moved to Montreal to live with their families. According to those interviewed, there were both positive and negative aspects to living in the city. Positive aspects of life in the city included the abundance of activities (e.g. movie theatres) and services (e.g. public transportation). Negative aspects included concerns about safety and drug and alcohol use.

Fully one-third of the sample reported a current substance abuse problem. In addition, there were high levels of psychological distress (e.g. depression, anxiety, suicidal ideation and attempted suicide) as well as sexual, physical and emotional abuse in the general sample. Further analysis indicated that there were particularly high levels of psychosocial problems among both substance abusers and victims of physical and sexual abuse. For instance, substance abusers had a history of more suicide attempts, and were more likely to have been the victims of physical/sexual abuse. In addition, while a large proportion of the sample had significant medical

problems that required treatment, substance abusers were less likely to have identification needed to access medical services.

As shown in **Volume 2** of this report, of the 80 individuals who made contact with the drug/alcohol referral program during the study period the majority were unemployed (53.5%), Inuit (44.2%) and female (60.5%). There were a number of barriers that prevented completion of the referral process. Only 34 (42.5%) completed all stages of the referral process—and were accepted for treatment. However, few actually completed a detoxification or treatment program (12.5%).

Barriers to completing the referral process were related to individual client characteristics (e.g. lack of motivation), as well as lack of adequate identification and/or medicare coverage, lack of a fixed address, or an inability to leave the city for inpatient treatment (i.e. due to child-care duties). Barriers to treatment entry were identified including inadmissability due to health problems or pregnancy, difficulties completing the required documentation for treatment entry, problems obtaining transport to the treatment centres, as well as long waiting lists. The most significant barrier to treatment was the lack of Aboriginal or culturally-sensitive treatment centres within the urban milieu, necessitating referral to rural centres far from the city.

Overall, this research project demonstrated that there are substantial numbers of untreated substance abusers in the Aboriginal population of Greater Montreal, and marked barriers to treatment entry and completion. This project, as well as other studies (Aboriginal Health in Canada, 1992; Canadian Profile, 1994; Health Canada, 19999a,b; Petawabano et al., 1994) have shown that substance abuse is associated with deteriorated health as well as increased suicide, family violence and disruption, and legal problems. Several years ago, Peters (1987) noted that "Canadian Indians [in urban communities] under-utilize [mental health] services in relation to their numbers in the population, and [there is] an over-representation of substance abuse problems among those who seek treatment." Based on the results of the current project, this still appears to be the case in the region of Greater Montreal today. It is known that treatment of substance abuse reduces the demand for medical, legal, financial and social services. Thus, sufficient access to effective treatment for mental health and substance abuse problems among urban Aboriginal peoples is likely to have far reaching positive effects in the community--improving the quality of life for individuals, children and families. Mental health and social service providers will be challenged to find suitable, cost-effective means of meeting the needs of this population.

Future research should examine a number of inter-related issues including substance

dependence, physical/sexual abuse, family functioning, and mental health in relation to need for treatment, access to services, utilization of and satisfaction with services and outcome. The development of appropriate referral and treatment for those with multiple social problems, chronic mental illness and substance abuse requires more detailed studies of local Aboriginal populations in a number of major Canadian cities. It will be important to further analyze the barriers to treatment access for recent migrants to the inner-city, the difficulties inherent in the urbanization process (including socioeconomic factors as well as cultural adaptation), as well as the specific cultural factors which confer risk and protection for substance abuse and other mental health problems.

Volume 1: Health, Mental Health and Substance Abuse

SECTION 1.1 - Introduction

The number of Aboriginal peoples living in urban areas in North America is growing at a substantial rate. It has been estimated that 40-50% of Aboriginals currently live off-reserve, in large urban areas (e.g., LaPrairie 1994). Based on data from the Aboriginal Peoples Survey, women were shown to outnumber men in off-reserve populations (men 44.2% and women 55.8%) (Gill 1995).

There have been some suggestions that urban Aboriginals have severe problems in areas related to alcohol/drug abuse, health and mental health issues, education, employment and housing (Clatworthy et al. 1987; Gill 1995; Kastes 1993; LaPrairie 1994; Petawabano et al. 1994; Secrétariat aux Affaires Autochthones 1989). However to date, there has been no systematic study of the urban Aboriginal population and there is no reliable information on the extent and severity of these problems.

The Aboriginal Population of Montreal

Based on a 1991 Census, individuals residing in Greater Montreal who were registered under the Indian Act or reported Aboriginal origin numbered 45,230 (Statistics Canada 1991). This figure comprised approximately 38,635 Amerindians; 5,820 Métis and 775 Inuit (Statistics Canada 1994). In the census no effort was made to survey homeless or transient individuals (Peters 1995). It should be noted however, that the 1996 census reported Montreal's Aboriginal population at only 9,965. The Aboriginal population consisted of North American Indians (6,285), Métis (3,485), and Inuit (365) (Statistics Canada 1996). The disparity between these two size estimates of the urban Aboriginal population has not been explained.

Montreal's urban Aboriginal community includes people from many nations (Inuit, Mohawk, Atikamekw, Métis, Cree, Naskapi, Montagnais, Mi'kmaq, Ojibway, Malecite and Algonquin), as well as other North American and non-status Indians. To speak of "the Aboriginal population" in this report overlooks considerable diversity. The people in this community differ from non-Aboriginal groups and from each other in culturally fundamental ways. They are diverse in terms of languages of origin, traditions, social customs and historical and political backgrounds.

Little of the available literature relates specifically to urban Aboriginals. It is of some importance that Aboriginals in Montreal include English-speaking groups (e.g., Mohawks) and French-speaking groups (e.g., Montagnais). Accordingly, Aboriginals arriving in Montreal may

face problems not reflected in research done elsewhere, since appropriate health and social services are needed in both languages. A 1986 needs assessment of Montreal Aboriginal women in conflict with the law indicated that the majority of migrants to 'inner city areas' of Montreal were female Inuit who came from remote communities (Zambrowsky 1986). Zambrowsky found that these women, including those who had been in the city for up to ten years, had "been unable to take advantage of even the presently existing social, educational and legal services available to [them]." Many Aboriginal people have difficulty obtaining services on first arriving in urban areas. They may be uncertain where to find them and may lack health care cards, transportation and adequate language skills (Peters 1987). Peters also points out that "Canadian Indians [in urban communities] under-utilize [mental health] services in relation to their numbers in the population, and [there is] an over-representation of substance abuse problems among those who seek treatment" (Peters 1987).

Migration to Urban Areas

The increase in Canada's urban Aboriginal populations since the 1960s has been attributed largely to off-reserve migration. LaPrairie (1994) noted that in the mid 1960's only 20% of the Aboriginal population lived off-reserve, and that by the mid 1990's this figure had doubled to approximately 40%. Off-reserve migration is generally attributed to lack of adequate housing, isolation, lack of educational and employment opportunities and a low standard of living on reserves (LaPrairie 1994; McCaskill 1981; Morinis 1982; Yerbury 1980; David 1993; Kastes 1993).

There is little research on why particular Native people migrate to cities; however, La Prairie suggests that "powerless people, without access to land or group resources [on their reserves], may be more inclined than those with a sense of access to resources, to take up permanent residency in cities" (LaPrairie 1994). In addition to off-reserve migration, some portion of urban Aboriginal populations consists of second- and third-generation urban dwellers (Royal Commission 1993; Dagenbach and Simpson 1992). The Royal Commission Report (1993) describes Aboriginal peoples in urban centres:

> "Some are born in the city, others choose to locate there, seeking a better life for themselves and their children. Still others end up in cities, unable or unwilling to find their way back to their home communities after release from prison, TB hospital or foster care...Aboriginal people who find steady employment and social acceptance in the city blend into the increasingly multicultural city scene, while those who

> encounter difficulties retain high visibility and reinforce the stereotype of urban Aboriginal people as poor, marginal and problem-ridden."

Two comparative studies of urban Aboriginals included samples from Montreal. The First People's Urban Circle (FPUC 1993) interviewed urban Aboriginals in nine Canadian cities in order to identify needs and compare urban experiences. The FPUC found that Aboriginal people in Montreal had a high unemployment rate (19%) and an average income of less than $10,000. Montreal Natives were far more likely than other urban Aboriginals "to perceive that relations have worsened ...between Aboriginal people and non-Aboriginal people" and 54% of respondents experienced racial discrimination (FPUC 1993). The study also found that

> "Compared to Aboriginal people in other urban areas, Aboriginal people from Montreal are less likely to say that services such as subsidized housing, health care, child welfare and other welfare services, sports and recreation, youth services, seniors' services, family counselling and police services are available." (FPUC 1993)

The second study entitled "Seen But Not Heard: Native People in the City: explored the lives of inner-city Natives in Regina, Edmonton, Vancouver and Montreal, in order to understand their "over-involvement in the criminal justice system" (LaPrairie 1994). This study was exceptional for attempting to compare different social classes, demonstrating that the urban Aboriginal population is not homogeneous and that some individuals have more skills, resources and options than others. LaPrairie (1994) found that Aboriginals living in the inner city were "characterized by despondency and hopelessness, and many have hard-core alcohol problems. They are the least well-educated, [least] employed and employable, and most victimized as children." In addition, interviewees in the east (Toronto and Montreal) emphasized jobs and quitting alcohol and drugs as their biggest problems (LaPrairie 1994). "Involvement of alcohol [in offenses] 'most or all of the time' was highest in Montreal and Edmonton." (LaPrairie 1994). It has been previously documented that generally half of the offenses by urban Native people are alcohol-related (National Association of Friendship Centres 1985).

Substance Abuse

Among other health issues, the use of alcohol has been identified as one of the major problems facing Aboriginal people. However, accurate prevalence data based on clear diagnostic criteria are not available. Prevalence has thus been based on indirect estimates, for example, from mortality rates due to causes that are known to be alcohol or drug related. In Canada, injury and poisoning are the leading causes of death among status Indians and Inuit, followed by heart

disease and cancer (Aboriginal Health in Canada 1992). Alcohol and other substances of abuse are considered to be major contributing factors to the high death rate due to injuries (both intentional and unintentional). Compared to the general population, Aboriginal peoples are at higher risk of death from alcoholism, homicide, suicide, and pneumonia (MacMillan 1996).

The "Rapport du comité interministeriel sur l'abus des drogues et de l'alcool" identified alcohol and drug abuse as a serious problem for Quebec Aboriginals (Secrétariat aux Affaires Autochthones 1989). This survey gathered information from regional organizations (social service agencies, school boards, local police, hospitals, health clinics, mayors and band chiefs) from numerous villages across Quebec. The report summarized information on the extent of abuse, causes of abuse and the concrete steps taken by the organizations to combat drug and alcohol abuse in these communities. The summary findings suggest that alcohol and drugs (primarily cannabis) constitute the most serious problems in Aboriginal communities, the use of which is related to family violence, suicide, violent crime, accidents and accidental deaths. Other cited problems included fetal alcohol effects (FAE) and poor school performance (thought to be primarily due to the use of inhalants).

Data from the Aboriginal Peoples Survey conducted in 1991 by Statistics Canada also points to severe social problems due to drugs and alcohol (Statistics Canada 1993). When respondents rated the social problems facing Aboriginals, unemployment was viewed as the most serious problem (by 62%) closely followed by alcohol abuse (60%) and drug abuse (49%). It would appear that alcohol and drug issues rank consistently high among Aboriginal peoples in the perceptions of their own social problems (Santé Quebec 1994; Statistics Canada 1993).

Canadian sources have observed that high-volume binge drinking is the most prevalent drinking pattern (accompanied by legal problems, fighting and family violence) for adults (Alcohol in Canada 1989). However, the Aboriginal population is remarkably heterogenous and there have not been any studies on patterns of alcohol and drug use or the prevalence of heavy binge alcohol use in different regions or various Aboriginal groups of Canada.

Overall, it has been suggested that the medical, psychiatric and social complications resulting from substance abuse among Aboriginals are extensive, exacting an enormous toll in terms of deteriorated health as well as greater frequency of suicide, family violence and disruption, accidents and legal problems (Aboriginal Health in Canada 1992; Health Canada, 19999a,b; Petawabano et al. 1994). It should be noted that little is known about the pattern and severity of drug and alcohol abuse or other health problems in Aboriginals living in metropolitan

areas (McClure et al. 1992; Wigmore and McCue 1991). Much of the prior research on substance use among Aboriginal peoples has been conducted among reserve-based populations.

Family Violence

Through a review of available statistics (based largely on reserve populations) and individual and group interviews with Aboriginals, a report produced by Le Comité de la Santé Mentale du Quebec (Petawabano et al. 1994) indicated that conjugal violence has increased in Aboriginal communities (by 83% between the years 1987 and 1992). It was revealed that 90% of the situations that required police intervention in one community involved physical assaults and aggression, and the large majority (90%) involved the use of alcohol (Petawabano et al. 1994). It has been widely acknowledged in writings by Aboriginal peoples (e.g., Brant, 1992; Fox and Long, 2000; ONWA, 1989; Pimadiziwin, 1998) and others (Frohlich et al., 1992; LaPrairie, 1994; Larocque, 1994; Pelletier and Laurin, 1993; RCAP, 1997) that there are high levels of sexual abuse and family violence among First Nations peoples. The most prominent victims of family violence are women, teenagers, children and the elderly in Aboriginal and non-Aboriginal communities alike (Health Canada, 1994; LaRocque, 1994; RCAP, 1997).

According to a Statistics Canada study (n=12,300), 30% of married and previously married women in the ten provinces had been physically or sexually abused by their partners. In addition, 50% of women experienced some form of physical or sexual violence since the age of 16 (Statistics Canada, 1994). Results of a family violence study conducted by the Ontario Native Women's Association (n=104) indicated that 84% of the Aboriginal women surveyed considered family violence to be a problem in their communities and 80% reported that they had been abused themselves (ONWA, 1989). In addition, 89% of the women considered mental and emotional abuse to be a characteristic of family violence in their communities alongside physical abuse (87%) and sexual abuse (57%). Furthermore the report stated that Aboriginal women were more likely to be abused than non-Aboriginal women (1 in 10 non-Aboriginal women, compared to 8 in 10 Aboriginal women) (ONWA, 1989).

Section 1.2 - Methods and Analysis

Description of the Study

The study is the result of a partnership between the Aboriginal Mental Health Research Team of McGill University and Ms. Ida LaBillois-Montour, who was the Executive Director of the Native Friendship Centre of Montreal (NFCM) at the time the study was conducted. The

NFCM is a Native-run urban community-based service organization. The aims of the study were to examine substance abuse as well as physical and mental health among the urban Aboriginal population of Greater Montreal. The severity of drug/alcohol problems were determined, and particular attention was paid to the relationships between current substance abuse, a history of physical and sexual abuse and psychological distress as described in the following section detailing the sample and methodology.

Data were collected through health interviews with 245 status and non-status Native, Inuit and Métis residents of the city and its surrounding areas. Efforts were made to interview people from many different socioeconomic backgrounds. The sample includes individuals from Native-run businesses and organizations such as Makivik, Air Inuit, the NFCM, and Native Women's Shelter as well as from educational institutions including Dawson College, Concordia University, McGill University, University of Montreal and the University of Quebec in Montreal (UQAM). Study participants were also contacted through visits to Atwater Park and the area surrounding St. Laurent Street and to drop in centres such as Chez Doris, the Open Door and the Salvation Army Men's Shelter. Announcements for the study were aired on the CKRK radio station in Kahnawake, and were printed in The Mirror, The Nation and Kahnawake's local paper The Eastern Door.

In addition, a number of special in-depth interviews were conducted with Aboriginal frontline workers and Aboriginal people who used their services. An interview guide was developed to explore support networks, health problems, attitudes toward health and social services, interpersonal violence and problem drug or alcohol use.

Informed consent was obtained from all the study participants. They received tickets for public transportation and gift certificates redeemable for food and movies as partial compensation for their time and effort while participating in the study.

Structured Interviews

Structured interviews were conducted using a health questionnaire that incorporated all the questions from the Addiction Severity Index (ASI) in both English (McLennan, 1995) and French (add reference to authors of French version here). The ASI collected a wide range of information, including socio-demographics (age, gender, education), employment, legal status, family and social relationships, psychological status, medical problems as well as information on drug and alcohol use.

Study participants were asked to identify the number of days they had experienced

problems in each of these areas (employment, health, family relations etc), and to rate how troubled or bothered they were by these problems in the past 30 days on a scale of 0 (not at all) to 4 (extremely). Subjects were also asked to indicate their perceived need for treatment or counselling using the same rating scale.

For each domain the severity of problems and the need for treatment was measured in terms of the number, duration, frequency and intensity of symptoms experienced during the past 30 days (McLennan et al., 1990). The drug/alcohol subscale assesses the number of days of specific drug (marijuana, cocaine, etc.) and alcohol use during the past 30 days, the number of days of abstinence as well as the severity of problems engendered by substance use.

The ASI can be administered by a trained interviewer in approximately 30-40 minutes. The psychometric properties of the ASI have been found to be excellent with high interrater reliabilities for all scores (Alterman et al., 1994). The drug and alcohol subscales have been shown to have interrater reliability ranging from 0.86 - 0.96 and test-retest reliabilities of 0.92. Concurrent validity has been shown to be the strongest for the measure of drug use severity with correlations ranging up to 0.60 (McLellan et al., 1990). The ASI has been widely employed in Quebec, and had been recommended by the Le Comite-Conjoint MSSS-Reseau sur la selection d'instruments d'evaluation de la clientele, Quebec (see Boivin, 1990).

All information collected during the interviews was entered into a database using the scientific software program RS/1 (version 4.3.1 [RS/1, 1991]). All subsequent statistical analyses were conducted using the microcomputer version 10.0 of the Statistical Package for the Social Sciences (SPSS, [SPSS, 1999]). Analysis of data from the entire sample was conducted using Analysis of variance ANOVA for continuous variables and Chi-square tests for categorical variables. Post-hoc tests were performed using t-tests with a Bonferroni correction. In the case where multiple comparisons were conducted on the same set of data, corrections for Type I error were made using a Bonferroni correction.

Open-ended Interviews (Tape Recorded)

Tape recorded, open-ended, in-depth interviews were also conducted with a smaller sample of urban Aboriginals (n=30). The goal was to gain more insight into the belief systems and attitudes regarding living in the city, health, mental health and well-being. Interviews followed an interview guide developed to explore support networks, health problems, attitudes toward health and social services, interpersonal violence and problem drug or alcohol use (see Appendix A). Respondents were also asked to elaborate on their general beliefs regarding drug

and alcohol use.

Individual informed consent was obtained from participants to tape record the interviews. The tape recordings were transcribed verbatim and entered into a word-processing program. Content analysis was performed on the interview data. Content analysis involved review of the transcripts in order to place the dialog into categories and themes developed from the informants' speech (Agar, 1996). The Microsoft Word 2000 word processing program was used for text indexing and searching. Note that bolded sections in excerpts from these interviews identify the interviewer's questions, and comments and period marks represent pauses in the conversation.

Section 1.3 - Study Findings

Sample Characteristics

As illustrated in Table 1, the average age of the sample was 32 years. Inuit and Cree peoples predominated and they mainly spoke their indigenous languages, closely followed by English. There was considerable variability in the duration of residence in Montreal (from 2 weeks to 48 years), with an average of 9.9 years. The average length of stay at the same address was 31 months. When asked about their reasons for moving to Montreal, most stated that they came to live with their families or spouses (35%) or to obtain a higher education (28%). Approximately 20% of the sample moved to Montreal seeking better employment opportunities, and another 17% in order to escape family/social problems on the reserve. Half of those interviewed were living with family, while others lived alone (26%) or with friends (10%). As shown in Table 2, most participants had good family and social relationships with little conflict in the past 30 days. There was a wide range in the number of children participants had (from 0 to 7), with an average of 1.4. Note that for most variables the overall group mean (average) values are provided ± the standard error of the mean (± SEM).

Employment Status

As shown in Table 3, the majority of those surveyed were unemployed (36.8%). This percentage is much higher than the unemployment rate previously reported by The First People's Urban Circle (FPUC, 1993). The FPUC surveyed urban Aboriginals in nine Canadian cities to identify needs and compare urban experiences. According to their findings, 19% of Aboriginal people in Montreal were unemployed. Income varied widely, with an overall average monthly income of $996.3 ± 56.7 when considering all sources of income (employment, welfare, pensions, UIC) and money obtained from illegal activity. The most significant problem

Table 1: Demographic Characteristics of the General Sample	
Average Age (years)	32.6 ± 0.70
Gender	
Male	34.8%
Female	65.2%
Nation	
Inuit	26.4%
Cree	17.4%
Mohawk	12.4%
Mi'kmaq	11.9%
Percent with Native Status	87.6%
Mother Tongue	
Indigenous Language	48.8%
English	43.8%
French	7.0%
Religion	
Protestant	21.9%
Catholic	16.9%
Native Spirituality	12.9%
Average # Years Living in Montreal	9.9 ± 0.80 *
Values are presented as % of the sample * 19% of the sample had been living in Montreal for less than one year	

experienced in the past year (by 44% of the sample) was "not having enough money," followed by illness or death in the family (39%) and troubles with housing (35%)(see Table 4). The average (mean) values are provided on the tables ± the standard error of the mean (± SEM).

Medical Status

Within the general sample, 35.3% had a significant medical problem in the past year that required treatment. Chronic medical problems included asthma or other lung problems (8.5%), diabetes (4.5%), ulcers and other stomach problems (3.5%), HIV or AIDS (1.5%) and heart problems (1.5%). Further information on medical status is provided in Table 5. One-third of those individuals with a serious health problem failed to obtain medical treatment. The two most frequent reasons for not seeking treatment were 1) thought the problem would go away by itself and 2) wanted to solve the problem on their own. The reasons for not seeking treatment for a medical problem are outlined in Table 6. The average (mean) values are provided on the tables ± the standard error of the mean (± SEM).

Table 2: Family and Social Relationships of the General Sample	
Marital Status	
Single	58.2%
Married	26.9%
Divorced	14.9%
Average # of Children	1.4 ± 0.1
Average # of Family Members in Montreal	3.0 ± 0.3
Currently Living With	
Family	52.7%
Alone	26.4%
Friends	10.0%
Reported a Close Relationship With (Over lifetime)	
Mother	62.9%
Father	44.0%
Siblings	74.3%
Spouse	78.7%
Reported Problems Getting Along With (Past 30 days)	
Mother	10.8%
Father	8.8%
Siblings	14.4%
Spouse	22.3%
Values are presented as % of the sample, or group mean with the standard error (± SEM).	

Table 3: Employment/Financial Characteristics of the General Sample	
Average # Years of Education	11.7 ± 0.3
Average Months of Training/Technical School	9.6 ± 2.2
Employment Status	
Unemployed	36.8%
Full Time Job	25.4%
Student	22.4%
Part Time Job	6.5%
Average Income (Past 30 days) For Those Employed	
Full-Time	$1944.6 ± 242.4
Part-Time	$493.8 ± 111.7
Average Income (Past 30 days) For Those Receiving	
Welfare	$564.5 ± 20.8
Pension	$631.6 ± 72.4
Average # Days Paid for Working (Past 30 days)	8.1 ± 0.7
Have a Driver's License	31.8%
Have a Car to Drive	27.4%
Values are presented as % of the sample, or group mean with the standard error (± SEM).	

Table 4: Recent Events (Past Year) for the General Sample	
Troubles due to lack of money	43.8%
Illness or death in the family	39.3%
Troubles with housing	34.8%
Troubles with prejudice or discrimination	32.8%
Difficulties at work or school	30.3%
Problems with government agencies	24.4%
Troubles due to language differences	17.4%
Troubles with the police or law	16.9%
Victim of a crime or assault	15.9%
Values are presented as % of the sample	

Table 5: Medical Status of the General Sample	
Have a Current Serious Medical Problem (Asthma, Diabetes etc)	35.3%
Currently Taking Medication for a Medical Problem	22.9%
Average # Days Medical Problems (Past 30 days)	7.3 ± 0.8
Other Reported Health Problems (Past Year)	
Fatigue	52.7%
Pains in Legs/Arms/Stomach	41.3%
Insomnia/Sleeping Problems	39.3%
Chest Pains	18.9%
Failed to Seek Treatment for a Medical Problem (Past Year)	33.9%
Mean Time Since Last Checkup (Months)	13.4 ± 1.7
Average # Hospitalizations (Lifetime)	2.8 ± 0.3
Time Since Last Hospitalization (Years)	10.5 ± 1.4
Been to a Native Healer (Past Year)	17.4%
Been to a Native Healing Ceremony (e.g. sweat lodge) (Past Year)	33.8%
Values are presented as % of the sample, or group mean with the standard error (± SEM).	

Table 6: Reasons For Not Seeking Medical Treatment	
Thought the problem would get better by itself	24.4%
Wanted to solve the problem on own	20.4%
Help probably would not do any good	9.0%
Did not have a medicare card	8.0%
Was unsure about where to go for help	7.0%
There was a language problem	5.5%
Went in the past but it did not help	5.5%
Felt that culture or ethnic background would not be understood	4.0%
Had distance or transportation problems	3.5%
Felt there would be prejudice or racism against me	2.5%
Values are presented as % of the sample	

Psychological Status and Substance Use/Abuse

There were high rates of lifetime psychological distress in the sample (see Table 7), with 45% experiencing at least one serious symptom (anxiety, depression, suicidal ideation) over the past month. Only 18.4% of individuals with a current psychological problem sought treatment from a professional over the past year, and a small percentage (4.5%) were taking any prescribed medications. Results also showed high lifetime rates of sexual, physical and emotional abuse (see Table 7).

Overall, 64.2% of those interviewed were current alcohol drinkers and 67.2% were cigarette smokers. The rate of smoking in the sample is considerably higher than the national Canadian average of 27% (Statistics Canada, 1994a). When the entire sample was stratified by gender, it was apparent that males had used alcohol for a significantly longer period of time than women (women 7.4 ± 0.8 years, males 12.1 ± 1.1 years; $p<0.05$). Significant gender differences were found in the amount of money spent on alcohol in the preceding 30 days, with males spending more than females (females \$25.3 ± 5.5, males \$108.9 ± 20.3; $p<0.05$). In addition, males used cannabis for more years than females (females 3.1 ± 0.5 years, males+ 8.0 ± 1.1 years, $p<0.05$). The average (mean) values are provided on the tables ± the standard error of the mean (± SEM). A more detailed comparison of substance abusers vs non-abusers is provided in the following section.

Table 7: Psychological Status of the General Sample	
Experienced One or More Psychological Problems (Past 30 days)	44.6%
Experienced in Past 30 Days	
Anxiety	28.9%
Depression	14.4%
Suicidal Ideation	8.0%
Trouble Concentrating	27.4%
Attempted Suicide	0.5%
Trouble Controlling Violent Behaviour	10.9%
Currently Taking Medication for a Psychological Problem	4.5%
Average # Days Psychological Problems (Past 30 days)	12.2 ± 0.98
Sought Help for a Psychological Problem (Past year)	18.4%
Experienced in Lifetime	
Anxiety	55.2%
Depression	54.2%
Suicidal Ideation	47.8%
Trouble Concentrating	39.8%
Attempted Suicide	32.3%
Trouble Controlling Violent Behaviour	25.9%
Experienced Abuse in Lifetime	
Sexual	37.8%
Physical	48.3%
Emotional	61.7%
Values are presented as % of the sample, or group mean with the standard error (± SEM).	

Problems Associated with Substance Abuse

Note that for comparisons of drug/alcohol use and abuse, the sample size was reduced to n=206. A complete set of information was available on this sample, and results are presented in tables 8 through 13. Comparisons of drug/alcohol use between substance abusers and non-abusers are presented in Table 8. Analysis showed that there were significantly more smokers among substance abusers than non-abusers (substance abusers 80.6%, non-abusers 60.3%). Substance abusers also smoked more cigarettes per day (substance abusers 16.5 ± 1.4, non-

abusers 11.8 ± 1.02; $p<0.05$).

Overall 31.7% of substance abusers were extremely bothered by their alcohol problem and 40% were extremely bothered by their drug problem. Treatment for those problems were extremely important for many substance abusers (for a drug problem: 41.9% and for an alcohol problem: 46.5%). The average (mean) values are provided on the tables ± the standard error of the mean (± SEM).

Table 8: Comparison of Substance Abusers and Non-Abusers

	Non-Abusers	**Abusers**
Current Drug or Alcohol Problem (% of sample)	66.6%	33.3%
Average # Days Used (Past 30 days)		
Alcohol	3.2 ± .43	8.4 ± 1.20 **
Cannabis	1.2 ± .39	3.6 ± .0.95
Polydrug	0.3 ± .15	3.7 ± .0.95 **
Average # of Years Used		
Alcohol	6.68 ± .76	13.3 ± 1.02 **
Cannabis	3.06 ± .56	7.90 ± 1.15 **
Polydrug	1.54 ± .35	6.54 ± 1.02 **
Average # Days Alcohol/Drug Problems (Past 30 days)	.25 ± .21	13.3 ± 2.2 **
Average $ Spent on Alcohol or Drugs (Past 30 Days)	$53.6 ± 14.8	$193.1 ± 42.4 ****
# Prior Drug or Alcohol Treatments	.26 ± .009	3.1 ± 0.8

Values are presented as % of the sample, or group mean with the standard error (± SEM).

** significant differences between groups $p< 0.05$, corrected for multiple comparisons

Family and Social Relationships

The family and social relationships of substance abusers and non-abusers is reported in Table 9. Substance abusers appeared to be more likely to have a poor relationship with their mothers, and reported more serious problems getting along with friends (6.9% of non-abusers vs 27% of substance abusers) over the past 30 days. When asked how troubled or bothered they were by their family and social problems, many substance abusers reported being extremely bothered by their family problems (abusers 44.4%, non-abusers 22.6%). A large percentage of

both substance abusers and non-abusers rated counselling for these problems as extremely important (substance abusers 47.4%, non-abusers 32.3%).

Legal Status

Analysis of the data showed that 6.5% of the sample was on probation or parole at the time of the interview, and 8.5% were awaiting charges. As well, a relatively high rate of legal problems was indicated by the mean number of convictions in lifetime (5 times) and total number of months spent in jail (6.4 months). As shown in Table 10, substance abusers reported more legal problems than non-abusers.

Table 9: Family and Social Relationships Stratified by Substance Abuse

	Non-Abusers	Abusers
Marital Status		
Single	55.7%	65.7%
Married	30.5%	19.4%
Living With		
Family **	60.3%	37.3%
Alone	25.2%	29.9%
Friends	6.9%	16.4%
Satisfied With Living Arrangements	71.8%	56.0%
Living with Alcohol/Drug Abuser	9.9%	30.0% **
Family History of Alcohol/Drug Problems		
Mother	36.7%	73.7% **
Father	60.0%	68.8%
Have Had a Close Relationship With		
Mother	70.3%	48.4%**
Father	46.3%	39.0%

Values are presented as % of the sample, or group mean with the standard error (± SEM).

** significant differences between groups $p<0.05$, corrected for multiple comparisons

Medical History and Identification

Characteristics of medical problems and help-seeking are presented in Table 11. Non-substance abusers were just as likely as abusers to suffer from physical ailments. However, substance abusers were disadvantaged since they were less likely to have the identification

needed to access medical and social services (see Table 12). The average (mean) values are provided on the tables ± the standard error of the mean (± SEM).

Table 10: Legal Problems Stratified by Substance Abuse

	Non-Abusers	Abusers
Mean Number of Charges in Lifetime		
B&E	.16 ± .07	3.1 ± 1.6
Shoplifting	.22 ± .07	3.0 ± 1.6
Assault	.14 ± .04	1.7 ± 0.7
Disorderly Conduct	.28 ± .12	1.6 ± 0.4
Total Convictions (Lifetime)	2.06 ± .71	7.6 ± 1.5 **
Months Spent in Jail (Lifetime)	3.0 ± 1.34	13.4 ± 3.5 **
On Probation or Parole	2.3%	15.2% **
Awaiting Charges	5.3%	14.9%

Values are presented as % of the sample, or group mean with the standard error (± SEM).

** significant differences between groups $p < 0.05$, corrected for multiple comparisons

History of Psychological Problems and Victimization

Overall, 43.3% of those interviewed experienced a significant emotional problem in the past 12 months that required treatment. However, only 42.5% of these individuals sought treatment from a professional. In the past month substance abusers experienced significantly greater amounts of depression (28.8% vs. 7.6% for non-abusers) and trouble controlling violent behaviour (22.7% vs 5.3% for non-abusers) than non-substance abusers. Substance abusers were also more likely to be extremely bothered by the presence of a psychological problem than non-abusers (substance abusers 39.0%, non-substance abusers 25.9%). Significant between group differences were found in rates of victimization in the past month and over their lifetimes (see Table 13).

Table 11: Medical Problems and Help Seeking Stratified by Substance Abuse		
	Non-Abusers	**Abusers**
Chronic Medical Problems		
Asthma/Emphysema	5.4%	14.9%
Diabetes	4.6%	4.5%
HIV/AIDS	0%	4.5%
Saw Doctor/Health Professional (Past Year)	69.2%	57.8%
Average Time Since Last Checkup (Months)	14.6 ± 2.2	11.1 ± 2.7
Prescribed Medication on a Regular Basis for a Medical Problem	26.0%	17.9%
Average # Days Medical Problems (Past 30 Days)	6.0 ± 0.8	9.7 ± 1.5
Average # Hospitalizations (Lifetime)	2.3 ± 0.3	3.8 ± 0.8
Last Hospitalization (Years Ago)	10.5 ± 0.98	7.4 ± 1.2
Values are presented as % of the sample, or group mean with the standard error (± SEM).		
* note that there were no significant differences between abusers and non-abusers		

Table 12:Possession of Personal Identification Stratified by Substance Abuse		
Identification	**Non-Abusers**	**Abusers**
Social Insurance Number	92.4%	73.1%**
Birth Certificate	82.4%	68.7%
Medicare Card	89.3%	62.7%**
Baptismal Certificate	68.3%	42.4%**
Temporary Medicare Card	33.3%	25.0%
Values are presented as % of the sample.		
** significant differences between groups $p<0.05$, corrected for multiple comparisons		

Further analysis revealed that females had more lifetime history of sexual abuse than males (males 20.0%, females 47.7%). There is some literature to suggest that female Aboriginal substance abusers who have migrated to urban centres are the victims of multiple forms of trauma including sexual and physical abuse, social deprivation and poverty (McEvoy and Daniluk, 1995). In this latter study 84% of the females reported emotional abuse, 74.1% physical abuse and 51.9% sexual abuse, with males much lower in all categories (McEvoy and Daniluk 1995).

Gutierres et al. (1994) also found that compared to males, female substance abusers suffered more hardships. The results of their study showed that females experienced more family dysfunction, more family history of substance abuse, and a much higher rate of childhood emotional, physical and sexual abuse than males.

Table 13: History of Psychological Problems/Abuse Stratified by Substance Abuse

	Non-Abusers	Abusers
Experienced in Lifetime		
Depression	49.6%	62.7%
Anxiety	55.7%	55.2%
Trouble Controlling Violent Behaviour	20.6%	35.8%
Suicidal Ideation	40.5%	61.2% **
Attempted Suicide	22.9%	50.7% **
Prescribed Medication for a Psychological Problem	16.8%	26.9%
Experienced Past 30 Days		
Sexual Abuse	0%	3.0%
Physical Abuse	3.1%	13.6% **
Emotional Abuse	15.3%	31.8% **
Experienced In Lifetime		
Sexual Abuse	32.8%	49.3%
Physical Abuse	40.5%	65.7% **
Emotional Abuse	57.3%	71.6%

Values are presented as % of the sample.

** significant differences between groups $p<0.05$, corrected for multiple comparisons.

In summary, comparisons between substance abusers and non-abusers revealed that abusers were more likely to live with someone who had a drug or alcohol problem. More substance abusers also reported having had problems getting along with their friends than non-abusers. There were very high levels of parental histories of drug/alcohol problems within the sample. The rate of maternal history of drug/alcohol abuse among substance abusers was significantly higher (73.7%) than non-abusers (36.7%). No data were collected in the present study to address the issue of whether participants were likely to have been exposed to alcohol in utero, potentially resulting in FAS (fetal alcohol syndrome) or FAE (fetal alcohol effects). The

history of maternal substance use may be related to the low rate of close relationships with mothers reported by substance abusers. In general, substance abusers rated counseling for their family and social problems as extremely important.

Problems Related to a History of Physical/Sexual Abuse

Questions in the structured ASI interviews were used to stratify the sample into groups of individuals with and without lifetime histories of physical and/or sexual abuse. The groups comprised those who never experienced any abuse (no abuse - NA group), those who had a past history of physical abuse (PA) only, and those who had a history of physical + sexual abuse, or sexual abuse alone (PSA). Compared to males, females were more likely to have been abused (males: NA 43.0%, PA 31.4%, PSA 25.6%; females: NA 35.5%, PA 16.1%, PSA 48.4%).

Characteristics of Substance Use

Table 14 outlines the characteristics of drug and alcohol use among the physical/sexual abuse groups. Over half of all individuals with a history of physical/sexual abuse (~56%) reported a current substance abuse problem, compared to 25.6% of those without an abuse history. In addition, those in the PA and PSA groups experienced more days of drug or alcohol problems and spent more money on alcohol or drugs in the past 30 days, compared to the NA group.

Table 14: Characteristics of Drug and Alcohol Use Stratified by Physical/Sexual Abuse

	NA	PA	PSA
Current Drug or Alcohol Problem	25.6%	55.8%	55.7%**
Average Years Used			
Alcohol	9.2	11.3	9.4
Cannabis	4.6	6.4	6.2
Cocaine	1.5	1.9	2.1
Average # Days Drug/Alcohol Problems (Past 30 days)	4.6	11	10.3**
Average $ Spent on Alcohol/Drugs (past 30 days)	$98.8	$241.9	$125.9**

Values are presented as % of the sample, or group mean.

** significant differences between groups $p<0.05$, corrected for multiple comparisons

History of Psychological Problems

There were significantly higher rates of lifetime psychological distress among those with histories of physical and sexual abuse compared to those without (see Table 15). Psychological problems included anxiety, depression, trouble controlling violent behaviour, suicidal ideation and attempted suicide. Rates generally increased with increasing severity of the abuse history, with the lowest levels among people in the NA group, and increases among those who experienced physical abuse (PA) and dual abuse (PSA). One exception was in rates of trouble controlling violent behaviour, where individuals in the PA group rated highest, followed by those in the PSA and NA groups.

Table 15: Psychological Problems Stratified by Physical/Sexual Abuse

	NA	PA	PSA
Experienced in Lifetime			
Trouble Concentrating	29.3%	48.1%	56.7%**
Anxiety	42.4%	48.1%	71.9%**
Depression	37.0%	59.6%	75.3%**
Trouble Controlling Violent Behaviour	17.4%	42.3%**	37.1%
Suicidal Ideation	30.4%	56.9%	71.1%**
Attempted Suicide	18.5%	46.2%	54.6%**
Taking Medication for a Psychological Problem	10.9%	25%	26.8%
Experienced in Past 30 Days			
Trouble Concentrating	16.3%	38.5%	45.8%**
Anxiety	20.7%	32.7%	44.2%**
Depression	6.5%	34.6%**	26.0%
Trouble Controlling Violent Behaviour	6.5%	25.0%**	16.7%
Suicidal Ideation	5.4%	11.5%	19.8%**
Average # Times Treated for a Psychological Problem (Lifetime)	0.3 ± .07	0.3 ± .07	1.0 ± 0.3**
Average # Days Psychological Problems (past 30 days)	9.8 ± 1.9	11.3 ± 1.9	14.2 ± 1.4

Values are presented as % of the sample, or group mean with the standard error (± SEM).

** significant differences between groups $p<0.05$, corrected for multiple comparisons

Table 15 also shows that there were significant differences in rates of recent (past 30 days) psychological distress between abuse groups. Trouble concentrating, anxiety, depression, trouble controlling violent behaviour and suicidal ideation in the past 30 days were all significantly associated with abuse history. Overall, the levels of current psychological distress (past 30 days) were higher in both the PA and PSA groups compared to the NA group. The average (mean) values are provided on the tables ± the standard error of the mean (± SEM).

Family and Social Relationships

During the interview the respondents were asked if their parents had a significant drinking, drug use or psychological problem at some point in their lives that did or should have led to treatment. Based on these questions, groups with and without a family history (either mother or father) of drug/alcohol or psychological problems were formed and compared. Subjects were also asked whether or not they felt they had ever had a close, long lasting, personal relationship with their mothers or fathers. For male and female respondents combined, analysis demonstrated that there was a strong association between physical/sexual abuse history and having a close relationship with mothers. As shown in Table 16, the rate of close relationships with mothers decreased across the abuse groups, with the lowest level found in the PSA group ($\chi 2$ (2), 10.41, $p<0.005$). For females in particular, those in the PSA group were least likely to report having a close relationship with their mothers (NA 77.8%, PA 54.2%, PSA 45.2%) (2 (2), 13.74, $p<0.001$), and significantly more likely to report having serious problems with their mothers (NA 25%, PSA 17.0%, PSA 58%) ($\chi 2$ (2), 12.22, $p<0.002$) (data not shown on table).

There were significant ($p<0.05$) differences in reporting lifetime problems with spouses between abuse groups for both genders, with the highest rates of problems found among the PA and PSA groups (males: NA 31.3%, PA 66.7%, PSA 73.7% and females: NA 41.7%, PA 72%, PSA 70.4%). As shown in Figure 1, there were significant differences in rates of family history of psychological problems among the three physical/sexual abuse groups ($\chi 2$ (2), 12.56, $p<0.002$). Those in the PSA group were most likely to report a family history of psychological problems, followed by the PA and NA groups. Poor family attachment has been linked with a number of problems such as anxiety, insecurity, problems developing friendships and close relationships, violence and aggression and substance use among Aboriginal and non-Aboriginal peoples alike (De Wit et al., 1999).

Figure 1: Family History of Psychological Problems by Physical/Sexual Abuse Group

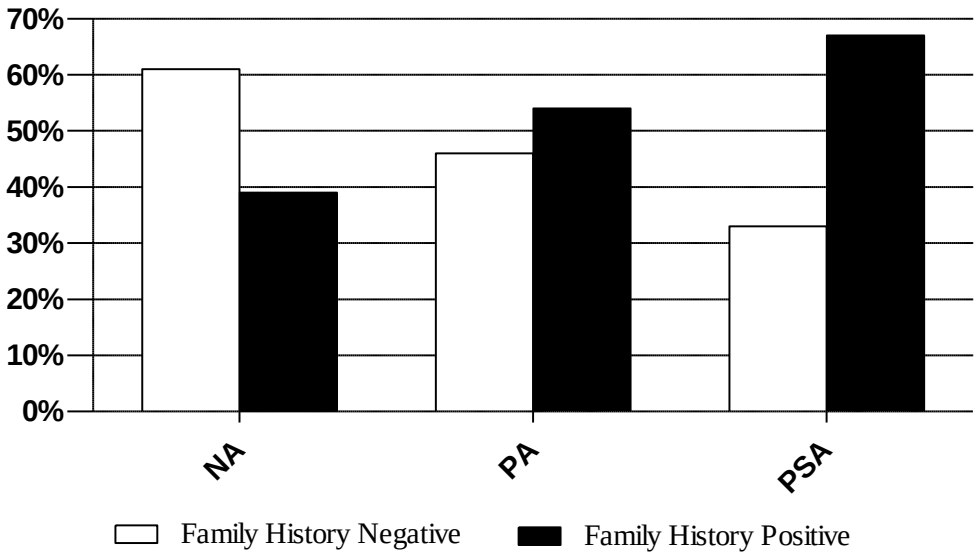

Table 16: Family and Social Relationships Stratified by Physical/Sexual Abuse			
	NA	**PA**	**PSA**
Marital Status			
Single	57.6%	75.0%	55.2%
Married	31.5%	11.5%	26.0%
Currently Living With Someone With an Alcohol/Drug problem	10.6%	29.4%	20.7%
Had a Close Relationship With (In Lifetime)			
Mother	71.6%	62.7%	48.4%**
Father	45.8%	42.6%	46.0%
Had Serious Problems Getting Along With (In Lifetime)			
Mother	41.8%	48.0%	66.0%**
Father	38.1%	41.7%	48.9%
Spouse	37.5%	69.4%	71.1%**
Friends	22.0%	26.5%	44.8%**
Values are presented as % of the sample.			
** significant differences between groups $p<0.05$, corrected for multiple comparisons			

Analysis of the In-Depth Ethnographic Interviews

The in-depth ethnographic interviews provided complementary data to the structured interviews. The majority of those interviewed were female (77%) from the following Nations: Inuit (26.7%), Cree (20%), Mohawk (16.7%) and Montagnais (13.3%). The mean age of the group was 34.4 ± 1.9 years. Forty percent of the subjects reported they had experienced some form of abuse in their lifetimes. They reported emotional, physical and sexual abuse by family members, spouses/partners, other children and a grade school teacher. Sixty percent of those abused sought professional help to deal with issues related to abuse.

Content analysis of transcribed audiotapes revealed common experiences and themes surrounding interpersonal violence. Shared experiences included family dysfunction characterized by male dominance, harsh discipline and anger mismanagement. Many reported they had witnessed violence in the home. Subjects also reported experiencing multiple abuses as children and adults, including physical, emotional and sexual assaults. Discourse on the consequences of abuse histories included negative repercussions such as difficulty in interpersonal relationships in adulthood (in particular problems with closeness and intimacy), the loss of personal identity and loss of control in one's life. In the words of two individuals,

> "...My mother used to hit me a lot and I think that kind of affected me cause... I'm afraid of people, and I went through a period of being afraid of my husband that me might hit me and scold me..."

> "...the violence that I've been through from the age 3 to 7 has been through sexual abuse... I've been raped during that time. **As a child?** As a child. I don't talk about this part very often but... it does make an impact on you. So, and then of course... as you grow older, you're really put into a victim stance, you're not really living life, you're walking around like some sort of zombie..."

For others, the sense of loss teamed with the normalization of violence seemed to establish a pattern for their relationships later in life. Normalization and revictimization were issues for a number of the respondents. In the words of a few individuals,

> "...myself being abused and going into patterns of relationships, thinking that I was only lovable when I was sexual. There was self-abuse in that sense... promiscuity and stuff like that. Letting people just do whatever they want with me... doing things that I didn't wanna do..."

> "...He was abusive, my [spouse]. **He was abusive?** Yeah. **In what way?** Oh, physically, emotionally, mentally. Very abusive. And I was very young when I started going out with him. And so he pretty much took advantage of me in every way. And I think that fathers and mothers are extremely responsible for teaching their children what kind of behaviour they should expect from a potential spouse. And they should teach them that they should be honored and that they deserve to be treated with respect and love. But I wasn't taught that because the example was... my mom took abuse you know? So for me it was normal..."

> "...my two oldest [children], they're very angry because I went through a lot, they seen me go through a lot. Being um, physically abused by their father, and then the break up [with] their father, and then me remarrying somebody else, and seeing me go through it again. And they became very angry. They're angry with me, also, which I don't blame them..."

Subjects also linked physical and sexual violence with the consumption of alcohol. Under certain circumstances, aggression was considered an expected and somewhat acceptable consequence of inebriation. In particular, a number of people were indifferent to violence in bars, as can be seen in the following excerpts.

> "...Well I've seen especially in the city...I have seen quite a bit of violence in the bars between First Nations people and White people. That's about it, you know. Nothing really serious. Maybe just punches you know, people throwing punches..."

> "...Well my friends are rarely violent. Well, just when they're drinking you get into a fight with your friends but that's about it. That's the only violence but when I'm sober I don't see no violence..."

> "...just mostly just bar room fights... just stupid, just little skirmishes, yeah. ... [It's] only drinking, it's not real. I don't think so. Well yea, it is real when you get beaten up but when you're sober you forget about it, you know, it's your friend [who you fought with]..."

The link between interpersonal violence and substance use under other conditions however were not treated with the same indifference. Two subjects made direct causal links between childhood sexual abuse experiences and the development of a substance abuse problem

later in life. Alcohol use was used as a coping mechanism, to quell the psychological distress associated with painful memories of abuse. In the words of one individual,

> "... being sexually assaulted in high school is the only reason I started drinking as far as I'm concerned. Because before I went to that school, I was only there a year and a half, before I went to that school, nobody in my family drank or take drugs. ... I mean, none of it entered my mind until I had left school due to the reason being sexually assaulted by the teacher and the other students..."

For one individual the cyclical nature of physical and sexual abuse and the pain associated with those experiences were clearly illustrated. The individual was abused as a child and later became a violent adult. The topic was discussed at length. The following are excerpts from that conversation.

> "...Uh, when I was growing up as a teenager I was violent. I went through a very difficult time as a child. I was abused mentally, physically and sexually as a child and um, ..when I got to be a teenager I started beating up my sisters and brother... [I've] been trying to work on this for 8 [or so] years, on child abuse. And the ideas are still there. And I say no, it's not right. I'm OK and I don't need to do it. If I do, I'm hurting myself..."

Analysis of the in-depth interview transcripts showed that a large number of the subjects (40%) had experienced varying levels of abuse and high degrees of psychological and emotional distress in their lifetimes. They made strong associations between the incidence of interpersonal violence and the use of substances (primarily alcohol). As well, numerous psychological and social problems were identified as sequelae to histories of physical, sexual and emotional abuse, including problems with intimacy and sexual relations, psychological problems, as well as difficulty controlling violent behaviour.

In this context, it should be noted that there is an over-representation of both male and female Aboriginals among the Canadian prison population (Solicitor General Canada (1998a). Compared to non-aboriginals, Aboriginal offenders were more likely to be convicted of violent offenses including manslaughter (5.6% vs 9.7%), assault causing injury (20% vs 28%) and sexual assault (19.7% vs 26.2%). A recent review on Women Offenders (Solicitor General Canada, 1998) notes that the high prevalence of childhood abuse and violence in the lives of incarcerated women has only very recently been acknowledged. In surveys of federally incarcerated women

the overall rates of physical or sexual abuse ranged from 72-82%, with the highest rates physical abuse (90%) and sexual abuse (61%) reported by Aboriginal women. In addition to issues of abuse/trauma, the Solicitor General's (1998) report noted other inter-related problems among incarcerated women including low employment skills, poor parenting skills and substance abuse.

Section 1.4 - Discussion

This study explored the physical, mental and emotional health of Aboriginal peoples in Montreal using both structured and unstructured (in-depth) interviews. The majority of the sample was single young Inuit women who were unemployed and living with members of their families. The largest proportion of those interviewed had lived in the urban area for a long time (approximately 10 years). Only 19% of the sample were newcomers, living in the city for one year or less. Generally, the participants reported that they enjoyed living in Montreal. Positive aspects of living in the city included cultural diversity, recreational activities (e.g. movie theatres) and the public transit system. Educational and employment opportunities were considered favourable by some. Having family members living in the city and the relatively low cost of essentials like food, lodging and transportation were also considered to be positive aspects of urban living. Services provided by organizations such as the Native Friendship Centre of Montreal and Chez Doris were held in high regard, and considered to be essential.

However, some individuals voiced dislike for the fast-paced character of the city as well as poverty (the overall unemployment rate was 36.8%), crime, and poor environmental conditions such as noise and air pollution. The relatively easy access to alcohol and drugs was considered to be a negative aspect of urban life. Fully one third of the people interviewed reported having a current drug or alcohol problem, and a large proportion (35.3%) experienced serious medical problems in the past year. Most notably they reported problems with fatigue, pains in the chest or limbs and insomnia. The data also show that substance abusers were less likely than non-abusers to have the identification needed to access medical and social services.

Congruous with the findings of previous work among Aboriginal peoples, the study results point to high levels of psychological distress. Comparisons between substance abusers and non-abusers revealed that abusers had been experiencing a number of mental health problems. For instance, substance abusers reported significantly more attempted suicides (50.7% of the sample). Substance abusers also experienced significantly more physical abuse in their lifetimes and more physical and emotional abuse in the preceding 30 days. Despite the severity of these

psychological problems the rates of help-seeking were low.

Nationally, informal surveys and governmental reports suggest that alcohol and drug abuse continues to be a major health concern among First Nations (Health Canada, 1999a,b). The results of the present study confirm the impressions of Aboriginal community workers within the Greater Montreal region (e.g. Petawabano et al. 1994) that substance abuse problems are severe and chronic in the urban Aboriginal population as well. A recent evaluation of the National Native Alcohol and Drug Abuse Program (NNADAP) suggested that there is no well defined national or regional strategies for dealing with addictions among Aboriginals (Health Canada, 1999a). NNADAP funds and coordinates prevention and treatment programs among First Nations and Inuit living on-reserve in Canada. This program has an annual budget of $23.8 million which supports 53 treatment centres with approximately 700 inpatient treatment beds. Of importance, the authors of the NNADAP evaluation report indicated that there was a serious lack of programming for youth and female clients (Health Canada, 1999a,b). NNADAP does not provide services for urban Aboriginals.

In this context it should be noted that a large proportion of the substance abusers identified in this study reported that treatment for their drug or alcohol problem was extremely important (41.9% and 46.5% respectively). Thus, in the long-term it is important that information, health care and treatment options for drug and alcohol abuse be available for Aboriginal substance abusers within the urban environment. At the present time, there are no specialized social or medical services available to urban Aboriginals in Quebec. While this was not firmly established in the present study, it has been reported that lack of treatment seeking may be related to the difficulty Aboriginals have in dealing with non-Native health care personnel. In one study conducted in Vancouver, 92.5% of inner city Aboriginals interviewed stated that "fear/ lack of trust/ shyness/ embarrassment" were the main reasons why Aboriginals are hesitant about seeking care (Mears et al., 1981). The National Association of Friendship Centres (1985) suggested some time ago that present services for drug/alcohol abuse were inadequate due to a lack of Native awareness and sensitivity and a lack of financial, human and physical resources. Some researchers have called for Native-run health care facilities in urban centres to combat personal (lack of trust) and institutional (lack of awareness and sensitivity) barriers to treatment (Mears et al., 1981; National Association of Friendship Centres 1985; Kramer 1992; Farkas et al., 1986). However, cultural sensitivity combined with a positive local reputation at a walk-in clinic in Saskatoon (which was neither Native-run nor exclusively for Native clients) suggested that

accessibility may be improved within existing facilities (Waldram 1990a).

Physical/Sexual Abuse and Psychological Well-Being

Physical and sexual abuse and interpersonal violence have also been identified as major problems among on and off-reserve communities (e.g. Pimadiziwin, 1998). The findings of the present study support this impression. There were high rates of physical/sexual abuse in the general sample and comparisons between the NA, PA and PSA groups indicated that drug and alcohol abuse, psychological problems and family/social conflict were heightened among those who had been physically or sexually abused. In particular, abused females reported significantly more lifetime psychological problems such as depression, anxiety, trouble concentrating, trouble controlling violent behaviour and suicidal ideation. The only exception was that abused males were more likely to have attempted suicide in their lifetimes compared to females. It is notable that those who had experienced physical/sexual abuse during their lifetimes were significantly more likely to report having current problems with substance abuse.

The relationship between childhood physical/sexual abuse and increased vulnerability for the development of a substance abuse problem later in life is reasonably well established for the non-Aboriginal population, particularly among women (Langeland and Hartgers, 1998; Miller et al., 1993; Moncrieff et al., 1996; Spak et al., 1998). Most recently, Easton et al. (2000) found that clients in an outpatient substance abuse treatment facility reported high rates of family history of physical violence (37%), physical abuse (22%) and childhood abuse (14%). In one review, it was shown that compared to people seeking treatment for various medical and social problems, rates of childhood sexual abuse were highest among females seeking treatment for alcoholism (Miller et al., 1993). A study by Robin et al. (1997) demonstrated that there is also a strong relationship between childhood physical/sexual abuse and psychological problems among American Indians. In a sample of 583 Southwestern American Indian tribal members, child sexual abuse and psychiatric disorders were assessed using a semi-structured psychiatric interview. Females were more likely than males to be sexually abused (49% versus 14%) and in 78% of the cases family members perpetrated the abuse. Sexually abused males and females alike were more likely to report alcohol dependence and behavioural problems. They were also more likely to be diagnosed with three or more psychiatric disorders (Robin et al., 1997). In a later publication, Robin et al. (1998) reported that the majority of both First Nations men and women in their study were victims of interpersonal violence (91%). Of those individuals, 75% reported that they had been verbally and physically abused. Alcohol was involved in the majority of the violent incidents

among males (62%) and females (74%) (Robin et al., 1998).

In the U.S., Norton and Manson (1995) conducted secondary analysis of a mental health needs assessment conducted with Aboriginal women (n=198) seeking care at an Indian health centre. Overall, 45.9% of the women had a history of spousal abuse. Women who reported current spousal assault were significantly more likely to have problems with alcohol (64.8% versus 39.2% of women without a history of spousal abuse, $p<0.001$), and alcohol intoxication was associated with the most violent incidents of assault (Norton and Manson, 1995).

It is well acknowledged that a common feature of family violence, crime, and physical/sexual abuse is anger, and the widespread abuse of alcohol and other drugs (Griffiths et al., 1990; Health Canada, 1997). For example, remarking upon the high rates of spousal assault in native communities as well as the disproportionate number of Aboriginals in federal and provincial prisons, Brant (1992) notes that "under the lubricating influence of alcohol...repressed hostility breaks out into the open and is visited upon innocent bystanders including the spouse, children and neighbours." Brant (1992) also stated that family violence made inroads into Native communities only after the onset of residential schooling, where children were subjected to separation and loss from parents, intimidation, physical beatings and sexual abuse. The linkage between the onset of family violence and alcohol use in the community was made by a respondent in this study. The individual stated that:

> "[when] we lived in the bush it never happened. It's when they started coming more to the urban areas like closer to the city where they had access to alcohol. I never saw that before when we lived in the bush. And then people started drinking and then it was like... automatic, women were beat up, and sometimes the women were beating up the men too".

Results from this study are concordant with others indicating that dysfunctional relationships within the family is characteristic of abuse victims. For instance, victims of abuse in this study were significantly more likely than others to report a family history of psychological problems. As well, those in the PSA group were the least likely to report having close relationships with their mothers. High rates of family history of substance abuse problems were found for all groups. A high rate of family history of alcoholism was also found among Native Americans with substance abuse problems (Gill et al., 1997; Wall et al., 2000). This is an important issue since untreated abuse has been associated with both an increase in risk for suicide as well as drug and alcohol problems (Dumont-Smith, 1995). The relationship between parental

history of substance abuse, family violence including physical/sexual abuse and the development of a substance abuse problem later in life deserves more exploration in future studies of urban Aboriginal peoples.

The Intergenerational Transmission of Abuse

According to a study by Dumont-Smith and Sioui-Labelle (1991), the three main contributing factors for domestic violence in Aboriginal communities are alcohol/substance abuse, economic problems and the intergenerational transmission of abuse. It has been suggested that there are a number of barriers to seeking help from available non-Native social service agencies including fear of racism and fear of children being apprehended by family services. In addition, some women may not seek help in cases of sexual assault because of bias among authorities in reserve communities, defending the perpetrator (i.e. knowing the perpetrators and disbelieving the women) (e.g. Frank, 1992; LaRocque, 1994; RCAP, 1997).

Based on the literature outlined in the sections above, as well as the results of the present study, it appears likely that there is a strong correlation between family violence (emotional, physical and sexual abuse), and depression, anxiety, suicide and other psychological problems including alcohol/drug abuse in Aboriginals. The pathological environment of a violent home or childhood abuse foster fundamental problems for adults in terms of establishing trust and forming stable relationships, developing autonomy and initiative as well as self-care (Herman, 1992). Issues of traumatic life experiences among alcohol and/or drug dependent populations have become a recent focus in addiction research. For example, Gray (1998) outlined the harmful effects that intergenerationally transmitted trauma can have on the health and well-being of Native peoples. He suggested that early life traumatic events lead to alcohol/drug use as a means of coping and escapism. The substance use and dependence in turn lead to an increased likelihood of experiencing trauma (e.g. interpersonal violence, poor health, poverty, injury) and revictimization (e.g. abusive relationships, prostitution), thus maintaining the cycle.

Research has shown that the family plays a key role in transmitting and perpetuating child physical and sexual abuse. It has been estimated that about one third of children who are abused or exposed to violence as children become violent themselves in later life (Wisdom, 1989). Furthermore, sexual abuse revictimization has been associated with a higher likelihood of engaging in a number of sexual activities and unintended or aborted pregnancies (Wyatt et al., 1992). One author equates growing up in a violent home to living in a residential school where Aboriginal children suffered years of emotional deprivation and abuse (Dumont-Smith, 1995).

Successful treatment of addiction within programs addressing trauma (physical/sexual abuse, anger management), as well as the family, therefore, could be a point which interrupts this intergenerational transmission of abuse.

Summary and Future Research Directions

In summary, this study explored the physical and mental health of a sample of urban Aboriginal people in Montreal. Due to the small sample size (n=245) and the fact that individuals were not randomly selected for interviewing, these findings cannot be generalized to the entire urban Montreal population, or to Aboriginals in other cities. Despite limitations in sampling however, the data shed light on a number of severe health and mental health issues that should be considered in future research, and in developing health care services for people in the urban Aboriginal community. The number of Aboriginal peoples living in urban areas in North America is growing at a substantial rate (LaPrairie 1994), thus the issues raised in this report are likely to increase in magnitude over the coming years. There is an obvious need for further research in order to continue to explore aspects of the urban experience, and factors which impact on wellness.

The correlation between physical/sexual abuse and substance abuse requires careful scrutiny to determine primacy, mediating variables and causal relationships. We should endeavour to refine our understanding of the circumstances surrounding physical and sexual abuse. For instance, further exploration into variables such as the victim's relationship with the perpetrator, the use of force, and the timing and context of violence against women, particularly in relation to pregnancy (Ballard et al., 1998; Burnam et al., 1988; Ratican, 1992). Physical/sexual abuse is both an index of family dysfunction and a predictor of future behavioural problems and psychopathology. This makes it an important focus for improving mental and social functioning, and reducing the intergenerational transmission of trauma among urban Aboriginal peoples.

Volume 2: Barriers to Treatment

SECTION 2.1 - Review of the Literature

Introduction

More than 25 years ago Westermeyer (1976) described the typical environment for Aboriginal people living in large American cities. He found that there were overwhelming social-environmental issues such as child abuse, marital breakdown, and alcohol and drug abuse as well as a high degree of delinquency, school drop-out and unplanned pregnancy. It appears that some of Westermeyer's findings may apply to Canadian cities today. For example, a report produced by the Native Friendship Centre of Montreal entitled “Aboriginal Women in Conflict with the Law” indicated that the majority of Aboriginal migrants to 'inner city areas' of Montreal were Inuit females with alcohol and drug problems (Zambrowsky, 1986). In addition, many of the women surveyed, including those who had been in the city up to ten years, had "been unable to take advantage of even the presently existing social, educational and legal services available to [them]."

A more recent study explored the lives of inner-city Natives in Regina, Edmonton, Vancouver and Montreal (LaPrairie 1994). The study compared different socio-economic classes within the Aboriginal population demonstrating that urban populations were not homogeneous, and that some individuals had more skills, resources and options than others. LaPrairie (1994) found however that many Aboriginals living in the inner city led difficult lives, characterized by hopelessness, hard-core alcohol problems, and unemployment.

To date little is still known about the pattern and severity of drug and alcohol abuse within urban Aboriginal communities (McClure et al., 1992). As discussed above in Volume 1, (published in Jacobs and Gill (2001)) one-third of a sample of urban Aboriginals interviewed within the context of a general health survey reported serious problems with alcohol or drugs. Efforts were made to interview individuals from many different socioeconomic strata—including individuals from Native-run businesses and organizations, educational institutions and drop in centres—however it should be noted that sampling was not random. Compared to non-abusers, substance-abusers were more likely to have a history of legal problems with more convictions (7.6 vs 2.0 for non-abusers), time spent in jail lifetime (13.4 vs 3 months for non-abusers), and they were more likely to currently be on probation or parole (15.2 vs 2.3% for non-abusers). In general, there were high levels of psychological distress in the sample such as depression and

anxiety, as well as suicidal ideation and attempted suicide. However, these phenomena were augmented among substance abusers. In particular, substance abusers had a greater rate of attempted suicide (50.7vs 22.9% for non-abusers), and they were more likely to have been the victims of physical abuse (65.7 vs 40.5% for non-abusers)(Jacobs and Gill, 2001).

Treatment of Substance Abuse

In general, treatment of substance abusers has been shown reduce their subsequent usage of medical, legal, financial and social services (Holder and Blose, 1986; Smart et al., 1993). Thus, treatment for substance abuse (and mental health) problems is likely to have far reaching effects on the economy as well as the Aboriginal community--improving the quality of life for individuals, children and families. There is no information on the availability of treatment, or rate of entry into treatment for urban Aboriginals. As discussed in Volume 1 above, it is interesting to note that while a large proportion of the substance abusers in the sample considered treatment to be important and desirable, they were more likely than non-abusers to lack the identification needed to access medical and social services. In a review of alcohol and substance abuse programs for urban Aboriginals, Griffiths et al. (1990) reported a lack of evaluative materials on treatment programs and services for Aboriginals. They found that the existing literature was characterized by small sample sizes and little attention was paid to the abuse of non-alcohol substances among urban aboriginals (Griffiths et al., 1990).

In addition, it is important to note that there is some literature to suggest that Aboriginals who have migrated to urban centres (especially females) are the victims of multiple forms of trauma including social deprivation and poverty as well as sexual and physical abuse (McEvoy & Daniluk, 1996). Gutierres et al. (1994) compared male and female American Indian substance abusers on a number of variables. The results showed that females experienced more family dysfunction, more family history of substances abuse, and a much higher rate of childhood emotional, physical and sexual abuse compared to males. In the sample described in Volume 1, females had a significantly higher lifetime rate of sexual abuse (47.7%) than the males (20.0%).

The present study was conducted 1) to determine the severity and pattern of substance abuse (drug type, frequency and quantity of drug intake) as well as the physical and mental health of an urban Aboriginal sample seeking treatment for substance abuse and 2) to collect information on barriers to accessing treatment.

Section 2.2 - Methods and Analysis

Participants included status and non-status First Nations, Métis and Inuit people who sought referrals to treatment through the Drug and Alcohol Referral Program (DARP) at the Native Friendship Centre of Montreal (NFCM). The NFCM is a non-profit service organization located in downtown Montreal providing information and support regarding employment, financial and legal problems, housing etc, as well as place to socialize for urban Aboriginals. Data collected during the study period indicated that the NFCM served individuals from a large number of different First Nations (Cree, MicMac, Mohawk, Algonquin, Montagnais) as well as Inuit. The DARP referral workers were of Aboriginal ancestry, bilingual (French, English) and familiar with the Montreal Aboriginal community. In addition, they had appropriate training in psychology/social work and were trained to administer the assessment instruments described below in special sessions using videotapes and individual instruction.

Informed consent for assessment and follow-up was obtained, and individuals were informed that all information gathered during the interviews and self-reports would be confidential. All individuals were assessed in a standardized manner using a structured interview and the Addiction Severity Index (ASI) (McLellan, 1995) in both English and French versions. The ASI was used to assess problem severity in seven areas: drug and alcohol use, family/social functioning, medical status, employment/support, legal status and psychological status. For each domain the severity of problems and the need for treatment was determined. Severity was measured in terms of the number, duration, frequency and intensity of symptoms experienced during the past 30 days (McLellan et al., 1990). Respondents were asked to identify any problems they were experiencing, the number of days they had problems and to rate how troubled or bothered they were by these problems in the past 30 days on a scale of 0 (not at all) to 4 (extremely). In addition, they were asked to rate their need for treatment or counselling using the same rating scale.

Self-report questionnaires included the Beck Depression Inventory (BDI), the Symptom Checklist -90 (SCL-90) and the Child Abuse and Trauma Scale (CATS). The BDI is a widely used 21-item self-report questionnaire that rates cognitive, affective, somatic and vegetative symptoms of depression on a four-point scale, with the total score reflecting the overall level of depression experienced in the week prior to the test (Beck & Steer, 1987). The SCL-90 is a standardized self-report inventory covering nine specific areas of psychological distress (e.g. hostility, somatization, depression, anxiety) experienced in the past week. Each item is rated on a

five-point scale (0 to 4) and the entire checklist is scored yielding 9 primary symptom dimensions as well as a global severity index (GSI) indicating the overall level of symptomatic distress (Derogatis, 1983). The CATS is a 38-item self-report questionnaire that yields a quantitative index of the frequency and extent of various types of negative experiences in childhood and adolescence (Sanders & Becker-Lausen, 1995). Each item is rated on a five-point scale (0-4) yielding an overall index of childhood trauma as well as a three subscales (negative home environment/neglect, sexual abuse and punishment).

Referrals to Native and Non-Native Treatment Centres

The DARP was specifically designed to make referrals based on each client's needs and preferences. In the majority of cases this involved arranging treatment at one of the five Native-run treatment centres for Aboriginals in Quebec funded by the National Native Alcohol and Drug Abuse Program (NNADAP, Health Canada). The Wanaki Treatment Centre in Maniwaki provided bilingual (English/ French) services, while two centres provided English-only services (Onen'to:kon Treatment Centre in Kanesatake and Mawiomi Treatment Centre in Maria). Additional centres offered French-only services (Centre KA Uauitshiakanit in Malioténam and Centre de Réadaptation Wapan in La Tuque). All of the NNADAP-funded programs were located outside the Greater Montreal region, some at a considerable distance. NNADAP works with native and Inuit communities to establish and operate prevention and treatment programs among First Nations and Inuit living on-reserve. Within the context of this program, NNADAP coordinates a network of 53 treatment centers offering approximately 700 beds for inpatient treatment (Health Canada, 1999). There are no specific NNADAP-sponsored treatment programs available within cities.

All referrals were extensively documented and referral workers provided a summary assessment of each case listing reasons for non-completion, and or failure of treatment entry. All files were independently assessed and outcomes rated according to stage of the referral process completed as well as reasons for non-completion. The stages of the referral process were as follows: Stage 1 involved initial contact with the DARP program personnel and assessment of the client's substance abuse problem; Stage 2 involved identifying and contacting an appropriate treatment centre, completing the required documentation for treatment entry (specific to each treatment centre), and arranging transport to the treatment centre.

Statistical Analysis

All information collected during the interviews was entered into a database using the scientific software program RS/1 (version 4.3.1 [RS/1, 1991]). All subsequent statistical analyses were conducted using the microcomputer version 10.0 of the Statistical Package for the Social Sciences (SPSS, [SPSS, 1999]). Analysis of data from the entire sample was conducted using Analysis of Variance (ANOVA and MANOVA) techniques for continuous variables and Chi-square tests for categorical variables. Post-hoc tests were performed using t-tests with a Bonferroni correction.

Section 2.3 - Study Findings

Individuals contacted the DARP for a variety of reasons and requested information broadly categorized as follows: information on the referral program (64.3%), requests for individual psychological or drug counseling (57.1%), requests for referral to native-run treatment centres (34.6%) and information on AA meetings (32.7%) (categories were not mutually exclusive and individual contacts may have been counted in more than one category where appropriate). It should be noted that although the DARP was offering referral—the largest majority of requests were for individual on-site counselling for both psychological and substance abuse problems.

Eighty Inuit and First Nations peoples initiated the referral process during the study period. Outcomes were independently rated (as described above) with Stage 1 comprising initial contact and assessment and Stage 2 involving completing the necessary documentation for treatment entry. Of the 80 contacts, 43 individuals (53.7%) completed stage 1 of the referral process (initial assessment). There were a variety of reasons that individuals initiated assessment, but failed to complete the process as described in Table 1. Sample demographics and substance abuse information listed below do not include those individuals that failed to complete the assessment process in Stage 1, due to missing or incomplete data.

Table 17: Stage 1 Barriers —Failure to Complete Assessment
Failure to make/keep appointments
Lack of motivation/Indecision about quitting substance use or entering treatment
Lengthy assessment process requiring reading and writing skills
Refusal/Inability to leave city for residential treatment at Native-run centres
Desire for individual counselling on an outpatient basis

Of the 43 individuals who completed Stage 1, analysis revealed that the majority (76%) of failed to enter treatment. Failure to enter treatment occurred for many reasons including long waiting lists, cohort entry and restricted access for urban Aboriginal peoples. Barriers to treatment entry are listed in Table 2 and discussed extensively below.

Table 18: Stage 2 Barriers —Failure to Enter Treatment
Lengthy application forms for some specific treatment centres
Lack of identification for Medicare coverage
Lack of a fixed address (required before release from an inpatient treatment program)
Difficulty obtaining/securing funding for transport
Preference given to specific Nations at some treatment centres -- restricted access for urban Aboriginals
Inadmissibility of individuals who had received treatment elsewhere in the past year.
Some treatment centres required sobriety prior to treatment entry
Cohort entry into treatment and/or long waiting lists
Refusal of patients with other mental health problems (e.g. schizophrenia)
Refusal of patients with other health problems (e.g. tuberculosis, AIDS) or those with physical disabilities
Pregnancy/ Lack of child care facilities

Sample Characteristics

The following analyses illustrate the characteristics of the sample. The mean age of the Stage 2 sample was 30.3 years (±1.3) and women outnumbered men (females 60.5%, males 39.5%). Inuit and Cree peoples predominated (Inuit 44.2%, Cree 20.9%) and the majority were single (69%) and unemployed (53.5%). At the time of referral, many of these women were living with a sexual partner and their children (32.6%). As illustrated in Table 3, alcohol constituted the

primary drug of abuse followed by cannabis and polydrug use among this group of treatment-seekers. A large percentage of the group reported being extremely bothered by their drug (40%) and alcohol (50%) problems. In addition, the majority of the group considered treatment for their drug or alcohol problem as extremely important (66.7% and 70.3% respectively). A large percentage had consulted a health professional during the past year, and they experienced on average 6.0 days of medical problems in the past month (see Table 4).

The group showed a high rate of legal issues, as revealed by the mean number of convictions in lifetime (6.4 ± 1.5), and the percentages on parole and awaiting charges (22.7%) at the time of the interview. In addition, the group displayed high levels of psychological distress, most notably suicidal ideation, depression and attempted suicide (see Table 5) over their lifetimes.

Analyses showed no significant differences between different Nations across any of the study's domains (legal, family/social relationships, psychological and substance abuse). Similarly, there were no significant differences between males and females, those with alcohol problems versus those with dual addiction, and those who did and did not enter treatment. Therefore it was not possible to determine predictors of failure to enter treatment based on client characteristics. Those who failed to complete were evenly distributed across genders, Nations, and drugs of abuse.

Self-Reports

Analysis of the self-reports revealed that the Stage 2 group had a mean Beck score of 22.6 ± 2.5, indicating moderate to severe depression, a mean CATS score of 50.4 ± 5.8 and a mean SCL-90 Global Severity Index score of 1.32 ± .16. No significant differences were found in these self-reports when stratified by gender, Nation, substance of abuse (alcohol versus polydrug abuse), and those who did and did not enter treatment.

Section 2.4 - Discussion

The purpose of this study was to examine the physical and mental health status, the pattern and severity of addiction and barriers to treatment among a treatment seeking urban Aboriginal population. The entire sample population was largely comprised of unemployed Inuit females with an average age of 30.3 years. This group experienced high rates of psychological distress as shown by rates of suicidal ideation, depression and attempted suicides. The primary substance abuse problems among this group were alcohol use (37.2%), dual addiction (alcohol

and cannabis) and polydrug use (alcohol, cannabis and cocaine). Study results also indicate that of the 80 individuals who sought treatment referral from the DARP, 37 did not complete the Stage 1 assessment procedures. In addition, of the remaining 43 individuals in Stage 2 the majority failed to enter treatment.

While barriers in Stage 1 of this study were largely attributed to clients' actions and ambivalence concerning treatment (e.g. not showing up for appointments), the barriers faced in Stage 2 were largely structural and political. For instance, jurisdictional issues interfered with securing the funding and transportation to send individuals to treatment. The agencies involved in providing funding depend upon the individual's Nation, home community and status. For instance, in one case an individual wanted to attend Wanaki Center and required travel arrangements to be made from Montreal. Health and Welfare Canada required proof of Indian status before starting the process. Once this was accomplished a letter from the treatment center was required confirming their acceptance. However, the treatment center would not confirm acceptance until final travel arrangements were made. Eventually, the arrangements were made after negotiating extensively with all parties, requiring a great deal of effort on the part of the DARP worker, and patience on the part of the client.

At this time, there are no treatment facilities targeted specifically for the Montreal urban Aboriginal population. As mentioned above, there are five treatment centers for Aboriginals in Quebec (funded by the Addictions and Community Funded Programs, Health and Welfare Canada) located outside the Greater Montreal region. Results from this study indicate that while treatment is available at a number of Native and non-Native run treatment centers, barriers to treatment for urban Aboriginals are considerable. There is restricted access for urban Aboriginals in some native-run treatment centers, and considerable delay in obtaining a placement (in part due to long waiting lists or cohort entry. It is important to note that some treatment centers will not take individuals with any medical or psychiatric problems, or those with physical disabilities. A significant disadvantage for female clients is that most treatment centers lack child care facilities, thus those individuals with children are not able to obtain treatment. Many of the treatment centers required applicants to read and complete long application forms that entail literacy in French or English.

Table 19: Characteristics of Drug and Alcohol Use	
Mean Days Used (Past 30 days) (± SEM)	
Alcohol	11.2 ± 1.6
Cannabis	6.9 ± 1.6
Polydrug	5.7 ± 1.3
Mean Years Used (± SEM)	
Alcohol	13.5 ± 1.3
Cannabis	9.3 ± 1.2
Polydrug	7.1 ± 0.9
Mean # Days Alcohol/Drug Problems (Past 30 days) (± SEM)	26.4 ± 3.2
Mean $ Spent on Alcohol/Drugs (Past 30 Days) (± SEM)	$350.9 ± 72.8
# Prior Drug or Alcohol Treatments	1.9 ± .4
Living With Someone With an Alcohol or Drug Problem	29.3%
Family History of Alcohol or Drug Problems	
Mother	52.9%
Father	65.5%
Brother(s)	80.0%
Sister(s)	76.2%
Values are presented as % of the sample, or group mean with the standard error (± SEM).	

Table 20: Medical Problems and Help Seeking	
Visited Doctor/Health Professional (past year)	69.2%
Time Since Last Checkup (Months) (± SEM)	14.6 ± 2.2
Prescribed Medication on a Regular Basis for a Medical Problem	26.0%
# Days Medical Problems (Past 30 days) (± SEM)	6.0 ± .85
Mean # Hospitalizations (Lifetime) (± SEM)	2.3 ± .30
Mean # Years Since Last Hospitalization (± SEM)	10.5 ± .98
Values are presented as % of the sample, or group mean with the standard error (± SEM).	

In addition, there are no aftercare programs for urban Aboriginals returning to Montreal following treatment in residential settings. Long-term aftercare of patients following detoxification or other inpatient treatment is a standard, well-recognized practice in addiction

treatment (Addiction Research Foundation 1989). The existence of an aftercare program was considered a critical component of healing and maintenance of sobriety in the Alkali Lake Band in British Columbia (Johnson and Johnson 1993). However, this component of treatment is lacking in many Aboriginal treatment centers (Addiction Research Foundation 1989). While residential treatment programs remove clients from their potentially "unhealthy" environments for periods up to six weeks, the absence of effective aftercare requires the client to return to that same environment without a support system in place. As found by the Addiction Research Foundation in its review of NNADAP treatment centers, there is a high rate of readmission to Aboriginal residential treatment centers, indicating the likely effects of poor aftercare and follow-up.

Table 21: History of Psychological Problems and Victimization

	Past 30 Days	Lifetime
Psychological Problems		
Depression	46.5%	72.1%
Anxiety	47.6%	54.8%
Trouble Controlling Violent Behaviour	32.6%	55.8%
Suicidal Ideation	32.6%	76.2%
Attempted Suicide	7.0%	69.8%
Prescribed Medication for a Psychological Problem	9.3%	20.9%
History of Abuse		
Sexual Abuse	7.3%	51.2%
Physical Abuse	19.5%	73.2%
Emotional Abuse	39.0%	65.9%

Values are presented as % of the sample, or group mean with the standard error (± SEM).

One of the most pressing health-care problems in urban areas therefore is access. Many Aboriginal people on first arriving in urban areas may be uncertain where to find services and ill-prepared to access them, not having health cards, transportation, or adequate language skills (Peters 1987). Those who are less able to adapt to the majority culture(s) or have pre-existing mental health problems may be unable to find and use existing services even years after their arrival (Zambrowsky 1986).

Gutierres et al. (1994) noted that among American Indian women entering treatment for

substance abuse, sexual issues were important elements related to long-term recovery, but this aspect of client's lives were often overlooked in treatment programs. The researchers concluded the family dysfunction (substance use combined with physical/sexual abuse) reduced responses to treatment. The importance of dealing with abuse issues in treatment is underscored by the fact that abused women carry the scars of personal violence experiences well into adulthood (Russell and Wilsnack, 1991), and may be related to the intergenerational transmission of sexual and physical abuse as well as revictimization (Ouimette et al., 1996). In fact may abused women are unaware of the relationship between their current problems, and their early life experiences with violence (Segal, Foote and Trojan, 1995). While there is widespread recognition of the high degree of physical/sexual abuse among Aboriginal women, few programs are specifically directed towards treating the combined problems, in the context of family functioning and child welfare. One program (Women and Children's Residential Program in Fairbanks, Alaska) was devoted to treating Native women, and their children (Segal et al., 1995). Components of the program included assessment of risk factors in children, parenting and family classes, problem/conflict resolution, parent-child relationships and participation in culturally-related activities. It is very likely that models for treating mental health and substance abuse among Aboriginals will need to incorporate the family as the central focus of healing, rather than individuals. For a given individual experiencing serious problems with addiction, it is quite likely that parents, spouses and children are also at high risk, and involvement of the family system is likely to be beneficial (Hill, 1989). There are models for this type of approach for family violence, as well described by Pennell (1998). Hill (1989) makes a strong argument in favour of a family systems approach to the treatment and prevention of alcoholism (and other trauma) among Aboriginals. She notes that individual focused treatments (i.e. detoxification) have not been shown to be effective treatments for Aboriginals, and that in fact Native people themselves view alcoholism as a community based problem that requires broader solutions. In addition, treating an individual, and then returning him/her to the same dysfunctional family or social environment is only likely to result in relapse and perpetuation of the process.

Conclusions and Recommendations

In summary, the behavioural manifestations of substance use and barriers in accessing treatment are worthy of further examination. These findings shed light on a number of severe, medical and psychological consequences of substance abuse that should be considered in developing health care services for the urban Aboriginal population. The number of Aboriginal

peoples living in urban areas in North America is growing at a substantial rate (LaPrairie, 1994), thus these issues are likely to increase in magnitude over the coming years. There is an clear need to address the effects of physical and psychiatric comorbidities that co-occur with substance abuse, examine methods of facilitating entry into treatment, and to improve access to aftercare programs that are sensitive to the needs of urban Aboriginals. Future quantitative and qualitative research should continue to explore aspects of the urban experience, and factors which impact on wellness.

References Cited

Aboriginal Health in Canada. (1992). Ottawa: Health and Welfare Canada.

Addiction Research Foundation (1989) Final report of the evaluation of selected NNADAP projects. Report prepared for the Medical Services Branch, Health and Welfare Canada, Ottawa.

Agar MH. (1996). The Professional Stranger: An Informal Introduction to Ethnography. Academic Press Inc., San Diego, California.

Alcohol in Canada. (1989).Ottawa: Health and Welfare Canada.

Ballard TJ, Saltzman LE, Gazmaraian JA, Spitz AM, Lazorick S, Marks JS. (1998). Violence during pregnancy: Measurement issues. American Journal of Public Health 88 (2): 274-276.

Beck AT, Beamesderfer A (1974) Assessment of depression: the depression inventory. In P. Pichot (Ed.) Psychological Measurements in Psychopharmacology, Basel: S. Karger: 151-169.

Beck AT, Steer RA (1987) Beck Depression Inventory. Harcourt Brace, New York.

Beck AT, Weissman A, Lester D, Trexler L (1974) The measure of pessimism: The Hopelessness Scale. Journal of Consulting and Clinical Psychology, 42: 861-865.

Bibeau G, Perreault M (1995). Dérive montréalaises. Montréal: Boréal.

Boivin MD (1990). Evaluation des personnes ayant des problems de drogues et d'alcool: Compte rendu des demarches et du choix d'un outil d'evaluation clientele en toxicomanie, Rapport final, Quebec.

Brant C. (1992). Spousal Assault - Anger Management. Healing the Wounds of the Native Family, Highlights of the Conference of the Native Mental Health Association of Canada, September, 1992.

Brave Heart MYH, DeBruyn LM. (1998). The American Indian holocaust: Healing historical unresolved grief. American Indian and Alaskan Native Mental Health Research, 8: 56-78.

Breton R, Akian G (1978) Urban Institutions and People of Indian Ancestry: Suggestions for Research. Montreal: Institute for Research on Public Policy, Occasional Paper No. 5.

Brody H (1971. Indians on skid row. Northern Science Research Group. Ottawa: Department of Indian and Northern Affairs.

Burnam MA, Stein JA, Golding JM, Siegel JM, Sorenson SB, Forsythe AB, Telles CA. (1988). Sexual assault and mental disorders in a community population. Journal of Consulting and

Clinical Psychology, 56 (6): 843-850.

Clatworthy S, Stevens H. (1987). An overview of the housing conditions of registered Indians in Canada. Ottawa: Indian and Northern Affairs Canada.

Dagenback JR, Simpson A (1992) Needs assessment study of the urban aboriginal population in Montreal. Study conducted by the NFCM.

Derogatis L (1983) SCL-90-R: Administration, Scoring and Procedures Manual II. Clinical Psychometrics Research, Maryland.

De Wit ML, Embree BG, De Wit D (1999). Determinants of the risk and timing of alcohol and illicit drug use onset among Natives and non-Natives: Similarities and differences in family attachment processes. Social Biology 46 (1-2): 100-121.

Dumont-Smith C. (1995). Aboriginal Canadian children who witness and live with violence. In Peled E, Jaffe PG Ending the Cycle of Violence: Community Responses to Children of Battered Women. Thousand Oaks, CA, USA: Sage Publications, pp. 275-283.

Dumont-Smith C, Sioui-Labelle P. (1991). National Family Violence Survey: Phase 1. Aboriginal Nurses Association of Canada.

Easton CJ, Swan S, Sinha R. (2000). Prevalence of family violence in clients entering substance abuse treatment. Journal of Substance Abuse Treatment, 18: 23-28.

Farkas CS. et al. (1986) Public Health Departments and Native Health Care in Urban Centres. Canadian Journal of Public Health 77(July/August):274-276.

Fox T, Long D. (2000). Struggles within the Circle: Violence, healing and health on a First Nations reserve. In: DA Long, OP Dickason (eds.), Visions of the Heart: Canadian Aboriginal Issues. pp. 271-301. Toronto: Harcourt Brace Canada.

Frank S. (1992). Family Violence in Aboriginal Communities: A First Nations Report. Victoria, B.C., Minister of Women's Equality.

Frohlich K, Scott R, Takeda V. (1992). Creating the Montreal Native Family Services for Spousal Assault. Report prepared for the Native Women's Shelter of Montreal.

[FPUC] First People's Urban Circle (1993) Choices for self-determination. Ottawa: Native Council of Canada.

Gill, K, Eagle Elk, M, Deitrich RA. (1997). A description of alcohol/drug use and family history of alcoholism among urban American Indians. American Indian and Alaska Native Mental Health Research, 8: 41-52.

Gill K (1998). Overview of research on substance abuse and Native communities. In Widening

the Circle: Collaborative Research for Mental Health Promotion in Native Communities. Conference proceedings. Oblin C, Kirmayer L, Gill K and Robinson E (Eds.). Montreal: Institute of Community and Family Psychiatry, Sir Mortimer B Davis-Jewish General Hospital & Division of Social & Transcultural Psychiatry, Department of Psychiatry, McGill University. pp. 49-57.

Gill L. (1995). From the reserve to the city: Amerindian women in Quebec urban centres. Ottawa: Canadian Advisory Council on the Status of Women.

Gray, N. (1998). Addressing trauma in substance abuse treatment with American Indian adolescents. Journal of Substance Abuse Treatment 15 (5): 393-399.

Griffiths CT, Glackman W, Esperson T, Davies G. (1990). Programs and Services for Urban Native Indian Alcoholic and Substance Abusers: Initiatives, Outcomes and Issues. British Columbia: Ministry of Labour.

Griffiths CT, Yerbury JC, Weafer LF. (1987). Canadian Natives: victims of socio-structural deprivation? Human Organization 46 (3): 277-282.

Groeneveld J, Shain M. (1989). Drug Use Among Victims of Physical and Sexual Abuse - A Preliminary Report. Addiction Research Foundation, Toronto.

Gutierres SE, Rousseau NF, Urbanski, L. (1994). Sociocultural and psychological factors in American Indian drug use: Implications for treatment. International Journal of the Addictions, 29: 1761-1786.

Guyette S (1982). Selected characteristics of American Indian substance abusers. The International Journal of the Addictions 17:1001-1014.

Health Canada. (1994). Family Violence and Substance Abuse. The National Clearing House on Family Violence. www.hc-sc.gc.ca/hppb/familyviolence/fvsubab.pdf

Health Canada. (1997). Family violence in Aboriginal Communities: An Aboriginal Perspective. National Clearinghouse on Family Violence, Ottawa, Ontario. http://www.hwc.ca/datahpsb/ncfv/nc-cn.htm

Health Canada (1999a). National Native Alcohol and Drug Abuse Program General Review 1998 - Final Report. Ottawa, Ontario. http://www.hc-sc.gc.ca/msb/pdf/final_e.pdf

Health Canada (1999b). First Nations and Inuit Health Programs, Community Based Programs 1998-99 Review. Ottawa, Ontario. http://www.hc-sc.gc.ca/msb/fnihp/comm_e99.htm

Health Canada (1999c). Evaluation Strategies in Aboriginal Substance Abuse Programs: A discussion. Ottawa, Ontario. http://www.hc-sc.gc.ca/msb/pdf/litrev_e.pdf

Holder HD, Blose JO (1986) Alcoholism treatment and total health care utiliztion and costs. JAMA, 256, 1456-1460.

Jacobs K, Gill K. (2001). Substance abuse in an urban Aboriginal population: Social, legal and psychological consequences. Journal of Ethnicity in Substance Abuse, 1(1): 7-25.

Johnson J, Johson F (1993) Community development, sobriety and after-care at Alkali Lake Band. In: The Path to Healing, Report of the National Round Table on Aboriginal Health and Social Issues, Royal Commission on Aboriginal Peoples, Ottawa, Canada.

Kastes WG. (1993). The future of Aboriginal urbanization in prairie cities: selected annotated bibliography and literature review on urban Aboriginal issues in the prairie provinces. Winnipeg: Institute for Urban Studies.

Kramer BJ (1992) Health and Aging of Urban American Indians IN Cross-Cultural Medicine - A Decade Later [Special lssue]. Western Journal of Medicine 157:281- 285.

Kunitz SJ, Levy JE, McCloskey J, Gabriel KR. (1998). Alcohol dependence and domestic violence as sequelae of abuse and conduct disorder in childhood. Child Abuse & Neglect 22 (11): 1079-1091.

LaPrairie C. (1994). Seen But Not Heard: Native People in the Inner City. Ottawa: Department of Justice, Canada.

LaRocque ED. (1994). Violence in Aboriginal Communities. Reprinted from the book "The Path to Healing" with permission from the Royal Commission on Aboriginal Peoples, Ottawa, Ontario. http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/vac.pdf

Langeland W, Hartgers C. (1998). Child sexual and physical abuse and alcoholism: A review. Journal of Studies on Alcohol, 59:336-348.

Manson SM, Shore JH, Baron AE, Ackerson L, Neligh G (1992) Alcohol abuse and dependence among American Indians. In: Alcoholism in North America, Europe, and Asia. JE Helzer, GJ Canino (eds), Oxford University Press:New York.

MacMillan HL, MacMillan AB, Offord DR, Dingle JL. (1996). Aboriginal health. Canadian Medical Association Journal 155 (11): 1560-1578.

McClure L, Boulanger M, Kaufert J, Forsyth S (1992). First nations urban health bibliography: A review of the literature and exploration of strategies. Published by the Northern Health Research Unit, University of Manitoba.

McEvoy M, Daniluk J. (1995). Wounds to the soul: the experiences of Aboriginal women survivors of sexual abuse. Canadian Psychology, 36: 221-235.

McLellan AT, Parikh G, Braff A et al. (1990) Addiction Severity Index, Administration Manual, 5th ed. Pennsylvania Veteran's Administration Center for Studies on Addiction, Pennsylvania.

Mears B, Pals K, Kuczerpa K, Tallio M, Morinis EA (1981) Illness and Treatment Strategies of Native Indians in Downtown Vancouver: A Study of the Skid Row Population. Government of Canada: Health and Welfare Canada.

Miller BA, Downs WR and Testa M. (1993). Interrelationships between victimization experiences and women's alcohol use. Journal of Studies on Alcohol 11: 109-117.

Moncrieff J, Drummond DC, Checinski K, Farmer R. (1996). Sexual abuse in people with alcohol problems. A study of the prevalence of sexual abuse and its relationship to drinking behaviour. British Journal of Psychiatry, 169:35-360.

National Association of Friendship Centres (1985) Urban Research Project; Phase I and II; Alcohol, Drug and Solvent Abuse, Executive Summary. Ottawa: National Association of Friendship Centres.

Norton IM, Manson SM. (1995). A silent minority: Battered American Indian women. Journal of Family Violence, 10: 307-318.

ONWA (Ontario Native Women's Association). (1989. Breaking Free: A Proposal for Change to Aboriginal Family Violence. Thunder Bay, Ontario.

Pelletier C, Laurin C. (1993). Assessment of violence and mental health conditions among Native peoples in Quebec. Report prepared for the Quebec Native Women's Association, Centre de recherche et d'analyses en sciences humaines (ssDcc Inc.).

Petawabano BH, Gourdeau E, Jourdain F, Palliser-Tulugak A, Cossette J. (1994). Mental Health and Aboriginal People of Quebec, Le Comité de la Santé Mentale du Quebec, Gaetan Morin, Quebec.

Peters E. (1995). Demographics of Aboriginal People in Urban Areas. In: Aboriginal Self-Government in Urban Areas, p.3-23, Evelyn Peters, ed. Kingston, Ont.:Institute of Intergovernmental Relations, Queen's University.

Peters R. (1987). Urban Indian psychiatric patients in community care. American Indian and Alaska Native Mental Health Research 1 (2):16-31.

Pimadiziwin. (1998). Highlights of the Pimadiziwin Conference sponsored by the Quebec Native Women Inc., Montreal. See: Healing from a wounded sexuality, pp 83-85.

Pressman B. (1994). Violence against women: ramifications of gender, class, and race inequality.

In Mirjin MP (ed.) Women in Context: Toward a Feminist Reconstruction of Psychotherapy. New York, NY, USA, Guilford Press.

Ratican KL. (1992). Sexual abuse survivors: Identifying symptoms and special treatment considerations. Journal of Counseling and Development, 71: 33-38.

Robin RW, Chester B, Rasmussen JK, Jaranson JM, Goldman D. (1997). Prevalence, characteristics, and impact of childhood sexual abuse in an Southwestern American Indian tribe. Child Abuse and Neglect, 21:769-787.

Robin RW, Chester B, Rasmussen JK. (1998). Intimate violence in a Southwestern American Indian tribal community. Cultural Diversity and Mental Health 4 (4): 335-344.

RCAP (Royal Commission on Aboriginal Peoples) (1993). Minister of Supply and Services, Canada. Ottawa, Ontario

RCAP (Royal Commission on Aboriginal Peoples). (1997). Minister of Supply and Services, Canada. Ottawa, Ontario

Santé Québec. (1994). A health profile of the Cree. C Daveluy, C Lavallee, M Clarkson, E Robinson (eds). Published by Le Ministère de la Santé et des Services sociaux, Québec.

Secrétariat aux Affaires Autochthones. (1989). L'abus des drogues et de l'alcool chez les cris, les inuit et les naskapis. Rapport du comité interministériel sur l'abus des drogues et de l'alcool. Gouvernement du Québec.

Smart RG, Mann RE, Adrain M (1993) Health and productivity savings from increased alcoholism treatment in Ontario. Can J Pub Health, 84, 62-63.

SPSS Release 10.0 [Computer software]. 1999. Statistical Package for the Social Sciences (SPSS Inc.). Chicago, Il.

Spak L, Spak F, Alleback P. (1998). Sexual abuse and alcoholism in a female population. Addiction 93 (9): 1365-1373.

Statistics Canada.(1991). Census Canada's Aboriginal population by census sub-divisions and census metropolitan areas. Catalogue 94-326. Ottawa: Statistics Canada.

Statistics Canada. (1993). Language, tradition, health, lifestyle and social issues, 1991 Aboriginal Peoples Survey.

Statistics Canada. (1994). Canada's Aboriginal population by census subdivisions and census metropolitan areas.

Statistics Canada. (1994a). Canada's alcohol and other drugs survey, 1994.

Statistics Canada. (1994b). Wife Assault: The Findings of a National Survey. Juristat Service

Bulletin, Canadian Centre for Justice Statistics. Minister of Industry, Science and Technology. Catalogue 85-002.

Statistics Canada. (1996). Population by Aboriginal group, 1996 census, census metropolitan areas. Source: Statistics Canada's Internet Site, http://www.statcan.ca /english/reference/copyright.htm, 01/09/99.

Taylor T (1988) Health problems and use of services at two urban American Indian Clinics. Public Health Reports 103(1): 88-95.

Trimble JE (1990-1) Ethnic Specification, Validation Prospects and the Future of Drug Use Research. The International Journal of the Addictions 25(2A):149-17o.

Waldram JB (1990a) Physician Utilization and Urban Native People in Saskatoon, Canada. Social Science and Medicine 30(5):579-589.

Wall TL, Garcia-Andrade C, Wong V, Lau P, Ehlers CL. (2000). Parental history of alcoholism and problem behaviours in Native American children and adolescents. Alcoholism: Clinical and Experimental Research, 24:30-34.

Westermeyer J, Neider J (1986) Cultural Affiliation among Indian Alcoholics: Correlations and Change over a Ten Year Period. In Alcohol and Culture: Comparative Perspectives From Europe and America, T. Babor, ed. New York, New York: Annals of the New York Academy of Sciences, p. 179-188.

Wigmore M, McCue D. (1991). No information on a forgotten people: how healthy are Native people in Canada when they live off reserve. Circumpolar Health, 90-93.

Wingert J & Fifield M (1985) Characteristics of Native American Users of Inhalants. The International Journal of the Addictions, 20(10): 1575-1582. 1-47.

Wisdom C. (1989). Does violence beget violence? A critical examination of the literature Psychological Bulletin. 106: 3-28.

Wyatt GE, Guthrie D, Notgrass CM. (1992). Differential effects of women's child sexual abuse and subsequent sexual revictimization. Journal of Consulting and Clinical Psychology 60 (2): 167-173.

Zambrowsky SC. (1986). Native women who are or may be in conflict with the law in the region of Montreal. Study conducted in collaboration with the NFCM and funded by the Solicitor General, Canada.

APPENDIX A

Interview guide for "Wellness Study" Qualitative Project

IDENTIFICATION

Nation

Status

Community

Age/Date of Birth

Education

Employment/Assistance

Children/Dependents

Living Arrangements

How did you come to the city? (Why Montreal, reasons, length, why stay, pos/neg. experiences living in the city)

Who can you rely on here in the city? (Family, friends, service providers)

HEALTH PROBLEMS/ HELP-SEEKING

What was the most important thing you went/want to get help for here in the city? (Circumstances)

What were your experiences like with those services? (Pos./neg. Aspects)

What are you attitudes towards those and any other health/social services? Particulars: Hospitalizations, time, duration, problems, circumstances - where went for services

INTERPERSONAL VIOLENCE

Has there been any violence in your life? Against you or around you? (Circumstances)

Did you go/Have you gone to anyone for help or support?

DRUG/ALCOHOL PROBLEMS

Have you ever had a problem with alcohol or drugs?

If so, what were the circumstances? (Drank/used how much, how long at the peak of the problem)

At that time, why did you drink?

Did you get help for those problems? (Where treated, experiences, pos./neg.)

Was/Is Native content important in treatment settings? Why or why not?

Have you had/Do you know of any barriers to treatment?

GENERAL BELIEFS

What is addiction? (Definition of alcoholism, drug abuse)

What meaning/effects of drug or alcohol use have on the well-being of people?

Is there a particular Native perspective on (way of understanding) the use/abuse of alcohol or drugs?

Do you think that the use of alcohol or drugs is a problem for Native people?

Do you think that Native people have more of a problem with alcohol or drugs than others?

Is there anyone else you can think of who could give me more insight into these issues?