Mental Health Issues in an Urban Aboriginal Population:
Focus on Substance Abuse

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Abstract

The aims of the study were to examine substance abuse and physical and mental health in an urban Aboriginal population. Data was collected through structured interviews (n=202) with Aboriginals in the greater Montreal area. The majority were single, unemployed, and lived in the urban area for a long time (mean of 9.96 ± .76 years). One third reported having a current substance abuse problem. Results indicated high levels of psychological distress augmented by substance abuse. Substance abusers were also more likely to have been the victims of abuse.

Ethnographic interviews with urban Aboriginals and community workers were also conducted (n=30). One third were victims of abuse and 6 reported having a current substance abuse problem. Psychological and biological understructures were used in defining addiction and explaining substance use among Aboriginal peoples. Cultural traditions were viewed as integral components of substance abuse treatment and the need for outpatient treatment facilities and aftercare programs were indicated.
Résumé

Les buts de cette étude étaient d'examiner l'abus des substances intoxicantes et ainsi que la santé physique et mentale dans une communauté urbaine autochtone. L'information fut obtenue par entretiens (n=202) avec des Autochtones du grand Montréal. Les informateurs, en majorité, étaient célibataires, sans emploi, et résidents de la région de Montréal pour une période plus ou moins prolongée (moyenne 9.96 ± .76 année). Le tiers a admis avoir présentement un problème d'intoxication. Les résultats ont indiqué un niveau élevé de détresse psychologique accrue par l'abus des substances intoxicantes. De plus, ceux qui ont tendance à abuser sont ceux qui, en grande partie, ont été victimes d’abus physique et mental.

D’autres entretiens ethnographiques furent conduits avec des Autochtones urbains locaux et les assistants sociaux (n=30). Le tiers de ces Autochtones a été victime d’abus et 6 ont rapporté avoir présentement un problème d’intoxication. Des facteurs psychologiques et biologiques ont été mentionnés pour expliquer la dépendance et l'utilisation de substances intoxicantes parmi les Autochtones. Les traditions culturelles autochtones ont été considérées partie intégrante du traitement contre la dépendance de ces substances intoxicantes. Le besoin d’aménagement pour traitements externe et suivi, fut aussi indiqué.
Acknowledgements

This research was made possible by a CQRS (Conseil Quebecois de la Recherche Sociale) team grant to the Native Mental Health Research Team at McGill University. It is the result of a research program developed from a partnership with the Native Friendship Centre of Montreal, a Native-run urban community-based service organization.

I wish to acknowledge my indebtedness to the individuals who assisted me throughout this study. A thank you goes out to Dr. Kathryn Gill, for her guidance and supervision in data collection, analysis and editing of this thesis, her assistance has been invaluable. I also want to thank Ms. Natalie Lloyd and Ms. Darlene Wapachee for their significant contribution to this study via data collection. I want to thank Lynn Marchand for helping me transcribe the interviews. A thank you goes to Mary Ellen Macdonald for her counsel in the art of qualitative analysis. I also want to thank Jody Tinkham for proofreading my final draft and Micheline Parent for translating my abstract into French. A thank you goes to Mrs. Ida Billois-Montour, Executive Director, Native Friendship Centre of Montreal for her ongoing support of the project. And my love and thanks goes to Marc Lambert for his faith and never ending support of my endeavours.

To the individuals who participated in this study, I offer my sincerest appreciation for sharing their experiences with me. Without their trust and cooperation, this study would not have been possible.
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Introduction

Aboriginal Peoples in Canada

Statistics Canada census data reports that the Canadian Aboriginal population (comprising North American Indians, Métis and Inuit) numbers 799,010 (Statistics Canada, 1996a). The Aboriginal population was identified by membership in one or more Aboriginal groups and being a Registered/Treaty Indian or Band/First Nation member without identification with any specific Aboriginal groups. Canadian census data further report that the total number of Indians registered under the Indian Act is 488,040 with 227,285 living on reserve and 260,755 living off reserve (Statistics Canada, 1996b).

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 live off-reserve, increasingly 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 is some evidence 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; Secretariat aux Affaires Autochtones, 1989). Many Aboriginal people have difficulty obtaining services on first arriving in urban areas. They may be uncertain where to find them and may lack healthcare 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).
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; Petawabano et al., 1994). However, there is little systemic data on the pattern and severity of substance abuse in urban populations. Gathering such data was the objective of the current thesis.

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 of approximately 38,635 Amerindians, 5,820 Métis and 775 Inuit (Statistics Canada, 1994). No effort was made in the census to survey homeless or transient individuals (Peters, 1995). However, the 1996 census reported Montreal's Aboriginal population numbering 9,965. The Aboriginal population consisted of North American Indians (6,285), Métis (3,485), and Inuit (365) (Statistics Canada, 1996c). The disparity between these two size estimates of the urban Aboriginal population has not been explained.

The Aboriginal population of Montreal includes individuals of many nations (Inuit, Mohawk, Atikamekw, Métis, Cree, Naskapi, Montagnais, Micmac, Ojibway, Malecite and Algonquin), as well as other Canadian and American and non-status Indians. To speak of "the Aboriginal population" in this context is to overlook considerable ethnic diversity. These nations differ from the larger non-Aboriginal groups and from each other in culturally fundamental ways. They are diverse in terms of languages of origin, traditional ceremonies,
social customs and historical and political backgrounds (Dickason, 1992; Frideres, 1993).

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, could not take advantage of social, educational and legal services available to them.

The First People's Urban Circle (FPUC, 1993) surveyed urban Aboriginals in nine Canadian cities, identifying needs and comparing urban experiences. The survey found that Aboriginal people in Montreal had an unemployment rate of 19% and 34% of the sample had an average income of $10,000. The study also found that Native peoples in Montreal were more likely than other urban Aboriginals to find the relationship between Natives and non-Natives unfavorable and 54% of the sample reported experiences of racial discrimination (FPUC, 1993). When compared to urban Aboriginals in other Canadian cities, Native peoples living in Montreal were less likely to say that recreational, policing, health and social services were made available for them (FPUC, 1993).

Mental Health and Social Problems

Suicide

Suicide has been consistently identified as a major problem for Aboriginal peoples
(Aboriginal Health in Canada, 1992; MacMillan, 1996; Petawabano et al., 1994; Secretariat aux Affaires Autochtones, 1989). In a research review Kirmayer (1994) reports that Canadian Aboriginal peoples have three times the suicide rate of the general population, a rate that is one of the highest worldwide. In addition, when compared to the general Canadian population, Native males are 5 times and Native females 3.6 times more likely to commit suicide (Kirmayer, 1994). In addition, suicide risk is higher for peoples residing in Northern communities and substance use is a major contributing factor in Native suicides, with solvent users 8 times more likely to attempt suicide then non-users (Kirmayer, 1994).

Data from a study of Aboriginal suicide rates in British Columbia from 1984-1989 indicated that on-reserve populations had higher rates of suicide than did Aboriginals off-reserve. (Cooper et al., 1992). The same study found that the rate of suicide for off-reserve Aboriginal peoples was similar to that of the general Canadian population. It was suggested that the lower rates of suicide found among Aboriginal peoples living off-reserve in British Columbia may be attributable to higher degrees of acculturation compared to those living on-reserve (Lester, 1996). Suicides occurred most often among young Aboriginal males with personal and familial histories of alcohol abuse and violence (Cooper et al., 1992). In addition, more Aboriginal suicides involved alcohol intoxication than those of non-Aboriginals (Cooper et al., 1992).

A youth health survey for American Indian and Alaska Native youth identified risk and protective factors for suicide (Borowsky et al., 1999). Risk factors included alcohol, marijuana and other drug use, past sexual and physical abuse and somatic symptoms such as headaches, stomach problems, nerves and being concerned with one’s health (Borowsky et al., 1999). Protective factors for suicide were identified as discussing problems with friends
or family, emotional health and family connectedness (Borowsky et al., 1999). The authors report that increasing protective factors was more effective in reducing suicide attempts among youth than decreasing risk factors such as alcohol and drug use.

Chandler and Lalonde (1998) identified cultural continuity as a protective factor against suicide among Aboriginal adolescents. They maintain that sense of identity can protect these individuals from harm during periods of individual and cultural change when they are most likely to commit self-destructive acts. While they lack data to support a direct causal link between cultural continuity and a reduction in rates of suicide among Aboriginal communities, they maintain that the communities who endeavoured to recapture their cultural traditions experienced much less youth suicide.

Violence and Abuse

There are no previous epidemiologic studies of physical, sexual or emotional abuse among Aboriginal peoples. Existing data reveals that in many cases of physical abuse the offenders and the victims of abuse are family members (Moyer, 1992; Petawabano, 1994; Dumont-Smith, 1995). Sûreté du Québec data from 14 Inuit communities reveals that 24% of the reported cases of sexual assaults reported to the police occurred between family members (Petawabano, 1994). Of those cases, 7 occurred between spouses and ex-spouses, 15 between a parent and a child, and the remaining 25 were between members of immediate family. Data from 20 Amerindian communities in Quebec has also revealed that from 1981 to 1992, 28% of sexual abuse cases were incest offences and 36% of reported cases involved a rape (Petawabano, 1994). It is unknown how many of these cases involved drug or alcohol intoxication. In addition, family violence was reported in 80% of the active cases at a Native
Child and Family Services agency in Toronto (Dumont-Smith, 1995). According to a study of homicide among Aboriginal peoples, more Aboriginals are beaten to death (31%) than are non-Aboriginals (19%) and Aboriginal women are especially likely to be beaten (40% versus 17% of other women) (Moyer, 1992).

Those findings are echoed in the report produced by Le Comité de la Santé Mentale du Québec (Petawabano et al., 1994). Through a review of available statistics (on reserve populations) and individual and group interviews with Aboriginal peoples, the report indicated that conjugal violence has increased in Aboriginal communities (by 83% between the years 1987 and 1992). It was also 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).

Legal Problems

A study entitled "Seen But Not Heard: Native People in the City" explored the lives of inner-city Natives in Regina, Edmonton, Vancouver and Montreal, seeking to understand their "over involvement in the criminal justice system" (LaPrairie, 1994). This study is exceptional for comparing across different social classes within the Aboriginal population. The study demonstrated that urban Aboriginals are not a homogeneous group and that some individuals have more skills, resources and options than others. LaPrairie (1994) found that Aboriginals living in the inner city were prone to feelings of hopelessness, and many had hard-core alcohol problems. The study also found that urban Aboriginal peoples had low levels of education, employment, and were highly likely to be childhood victims of abuse.
A number of reports indicate that alcohol is highly related to criminal offences among Aboriginal peoples (National Association of Friendship Centres, 1985; LaPrairie, 1994; Weekes et al., 1995; Duclos, 1998). Interviewees in the east (Toronto and Montreal) emphasized lack of employment and quitting alcohol and drugs as their biggest problems (LaPrairie, 1994). Respondents from Montreal and Edmonton also reported the most alcohol related crime (LaPrairie, 1994). Generally half of the criminal offenses by urban Native people are alcohol-related (National Association of Friendship Centres, 1985). One study that compared Aboriginal and non-Aboriginal offender profiles for homicide cases in Canada reported that 70% homicides among Aboriginal peoples allegedly involved the use of alcohol, compared to 25% for non-Aboriginals (Moyer, 1992). Compared to non-Aboriginal homicide victims, Aboriginal victims were more likely killed by family members (Moyer, 1992). LaPrairie hypothesizes that there is a strong connection between idleness, lack of opportunities and criminal offences among Aboriginal peoples. In general, there is a lack of investigation into the causes of increasing levels of crime within Aboriginal communities (LaPrairie, 1992).

Substance Abuse

Alcohol and drugs have been related to many other problems among Aboriginal peoples (suicide, family violence, legal problems) as discussed above. Indeed, the use of alcohol and other drugs 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 comite interministeriel sur l'abus des drogues et de l'alcool" identified alcohol and drug abuse as a serious problem for Quebec Aboriginals (Secretariat 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).

In 1991, Santé Québec conducted a random survey of 400 households in nine Cree communities around James Bay. Overall, 22.2% of the population reported occasional drinking, and 26.7% reported habitual drinking (defined as drinking at least once per month) (Santé Québec, 1994). There was considerable variation among different age groups, with those in the 15-24 year range showing the highest prevalence of occasional or habitual drinking. The majority of respondents in the survey identified excessive and abusive consumption of alcohol as the major social problem in their communities. This
may be related to the consequences of "binge" drinking in the population. A large proportion of occasional and habitual drinkers reported that although they tended to drink infrequently, their consumption on drinking days was very high--typically five drinks or more--to the point of inebriation (Santé Québec, 1994).

Data from the Aboriginal Peoples Survey conducted in 1991 by Statistics Canada points to severe social problems due to drugs and alcohol (Statistics Canada, 1993). For Quebec, 13% of the adult Aboriginals stated that they did not drink any alcohol during the past twelve months (compared to 19% of general Canadian population). Of those who did drink during the past year 54% were occasional drinkers who drank twice per month or less. Of the remainder, 18% drank once per week, 10% drank 2-3 times per week, 5% drank 4-7 times per week. 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 Aboriginals in the perceptions of their own social problems (Santé Québec, 1994; Statistics Canada, 1993). Studies of drinking practices among Aboriginals have identified a pattern typified by sporadic, high dose binge drinking accompanied by blackouts, family violence and physical fights (Alcohol in Canada, 1989; Manson et al., 1992).

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. Little information 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). Much of any prior research
on substance use among Aboriginals has been conducted among reserve-based populations. The aims of the present study were to examine substance abuse, and physical and mental health in the urban Aboriginal population of Montreal. The pathways and barriers to accessing medical and social services were explored as well as the nature and severity of drug or alcohol problems.
PART I

A Survey of the Physical and Mental Health of an Aboriginal Population

This work is the result of a research program developed from a partnership between the Native Mental Health Research Team of McGill University and the Native Friendship Centre of Montreal, 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 an urban Aboriginal population. The nature and severity of drug or alcohol problems in this population were explored. Data was collected through structured interviews with urban Aboriginal people in the greater Montreal area (n=202).

Methods and Procedures

Structured interviews were conducted using the Addiction Severity Index (ASI) (McLellan, 1995) in both English and French versions. The ASI collected a wide range of information, including socio demographics (age, gender, education, income, employment status), legal status, family and social relationships, psychological status, medical status and drug and alcohol use. Respondents were asked to identify any problems they were experiencing in each of these domains, the number of days they had those problems and to rate how troubled or bothered they were by those 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 (heroin, amphetamine, cocaine etc.) and alcohol use during the past 30
days, the number of days of drug abstinence as well as the severity of problems engendered
by drug 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’évaluation de la clientele, Quebec (see Boivin, 1990).

This survey was administered to 202 status and non-status Native, Métis and Inuit
people. Respondents were required to be residents of the city or its surrounding areas at the
time of the study. Efforts were made to interview individuals from many different
socioeconomic strata and included individuals from Native-run businesses and organizations,
educational institutions, drop in centres, and from the streets of Montreal. Participant
recruitment was made via personal visits to the targeted areas and organizations,
announcements on a Native radio station, and through printed advertisements in a number of
local papers. Informed consent was obtained and respondents were remunerated for their
participation with gift certificates redeemable for public transportation, food, and movies.

**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 8.0 of the Statistical Package for the Social Sciences (SPSS, [SPSS, 1997]). 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.

Results

Sample Characteristics

As illustrated in Table 1, the mean age of the sample was 32 years, and the gender distribution revealed a higher proportion of females. Inuit and Cree peoples predominated and they spoke primarily their languages of origin, closely followed by English. The majority of the respondents were unemployed and living with their family. The population shows considerable variability in the duration of residence in Montreal (from 2 weeks to 48 years, with a mean length of 9.9 years).

Substance Use and Abuse

Overall, 64.2% of the sample reported that they were current alcohol drinkers and 67.2% were cigarette smokers. The rate of smoking in this sample was considerably higher than the national average of 27% (Statistics Canada, 1994a). When stratified for the presence of a substance abuse problem, the analysis revealed that there were more smokers among substance abusers (substance abusers 80.6%, non-abusers 60.3%; p<0.05). Substance abusers also smoked more cigarettes per day (substance abusers 16.46 ± 1.38, non-abusers 11.76 ± 1.02; p<0.05).
Table 1

<table>
<thead>
<tr>
<th>Demographic Characteristics (n=202)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Age (± SEM)</strong></td>
<td>32.6 ± .69</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>34.5%</td>
</tr>
<tr>
<td>Female</td>
<td>64.5%</td>
</tr>
<tr>
<td><strong>Nation</strong></td>
<td></td>
</tr>
<tr>
<td>Inuit</td>
<td>26.1%</td>
</tr>
<tr>
<td>Cree</td>
<td>17.2%</td>
</tr>
<tr>
<td>Mohawk</td>
<td>12.3%</td>
</tr>
<tr>
<td>Micmac</td>
<td>11.8%</td>
</tr>
<tr>
<td><strong>Mother Tongue</strong></td>
<td></td>
</tr>
<tr>
<td>Indigenous Language</td>
<td>48.8%</td>
</tr>
<tr>
<td>English</td>
<td>43.8%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>57.6%</td>
</tr>
<tr>
<td>Married</td>
<td>27.1%</td>
</tr>
<tr>
<td>Divorced</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>36.8%</td>
</tr>
<tr>
<td>Full Time</td>
<td>25.4%</td>
</tr>
<tr>
<td>Student</td>
<td>22.4%</td>
</tr>
<tr>
<td><strong>Years of Education (± SEM)</strong></td>
<td>11.7 ± .26</td>
</tr>
<tr>
<td><strong>Years Living in Montreal (± SEM)</strong></td>
<td>9.96 ± .76 *</td>
</tr>
</tbody>
</table>

* 19% of the sample <1 year residence
The characteristics of drug and alcohol abuse in the sample are presented in Table 2. When the sample was stratified by gender, it was shown that males had used alcohol for a longer period of time than women (women 7.4 ± 0.77 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 $25.28 ± 5.47, males $108.89 ± 20.34; p<0.05). In addition, males used cannabis for more years than females (females 3.1 ± 0.56 years, males 8.0 ± 1.1 years, p<0.05). Overall 31.7% of substance abusers reported being extremely bothered by their alcohol problem and 40% were extremely bothered by their drug problem. Many substance abusers also reported that treatment for their drug problem and their alcohol problem was extremely important (41.9% and 46.5% respectively).

**Comparisons of Substance Abusers Versus Non-Abusers**

**Family and Social Relationships**

Characteristics of family and social relationships when stratified by substance abuse are reported in Table 3. 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 entire sample showed that 6.5% were on probation or parole at the time of the interview, and 8.5% were awaiting charges. The relatively high rate of legal
### Table 2

<table>
<thead>
<tr>
<th>Characteristics of Drug and Alcohol Use</th>
<th>Non-Abusers (n = 135)</th>
<th>Abusers (n = 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Drug or Alcohol Problem</td>
<td>66.6%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Mean Days Used Past 30 (± SEM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>3.20 ± .43</td>
<td>8.37 ± 1.22**</td>
</tr>
<tr>
<td>Cannabis</td>
<td>1.18 ± .39</td>
<td>3.64 ± .95</td>
</tr>
<tr>
<td>Polydrug</td>
<td>0.28 ± .15</td>
<td>3.71 ± .95**</td>
</tr>
<tr>
<td>Mean Years Used (± SEM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>6.68 ± .76</td>
<td>13.3 ± 1.02**</td>
</tr>
<tr>
<td>Cannabis</td>
<td>3.06 ± .56</td>
<td>7.90 ± 1.15**</td>
</tr>
<tr>
<td>Polydrug</td>
<td>1.54 ± .35</td>
<td>6.54 ± 1.02**</td>
</tr>
<tr>
<td>Mean Number of Days Experienced Alcohol/Drug Problems (Past 30) (± SEM)</td>
<td>.25 ± .21</td>
<td>13.27 ± 2.25**</td>
</tr>
<tr>
<td>Mean Amount of Money Spent on Alcohol or Drugs (Past 30 Days) (± SEM)</td>
<td>$53.66 ± 14.86</td>
<td>$193.14 ± 42.37**</td>
</tr>
<tr>
<td>Prior Drug or Alcohol Treatment Episodes</td>
<td>.26 ± .009</td>
<td>3.13 ± .81</td>
</tr>
</tbody>
</table>

** significant differences between groups p< 0.05, corrected for multiple comparisons
Table 3

<table>
<thead>
<tr>
<th>Family and Social Relationships Stratified by Substance Abuse</th>
<th>Non-Abusers (n = 135)</th>
<th>Abusers (n = 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>55.7%</td>
<td>65.7%</td>
</tr>
<tr>
<td>Married</td>
<td>30.5%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Satisfied With Marital Status</td>
<td>77.9%</td>
<td>64.2%</td>
</tr>
<tr>
<td>Living With **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>60.3%</td>
<td>37.3%</td>
</tr>
<tr>
<td>Alone</td>
<td>25.2%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Friends</td>
<td>6.9%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Satisfied With Living Arrangements</td>
<td>71.8%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Living With Someone With an Alcohol or Drug Problem</td>
<td>9.9%</td>
<td>30.0%**</td>
</tr>
<tr>
<td>Family History of Alcohol or Drug Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>36.7%</td>
<td>73.7%**</td>
</tr>
<tr>
<td>Father</td>
<td>60.0%</td>
<td>68.8%</td>
</tr>
<tr>
<td>Brother(s)</td>
<td>59.7%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Sister(s)</td>
<td>40.0%</td>
<td>79.4%**</td>
</tr>
<tr>
<td>Have Had a Close Relationship With</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>70.3%</td>
<td>48.4%**</td>
</tr>
<tr>
<td>Father</td>
<td>46.3%</td>
<td>39.0%</td>
</tr>
<tr>
<td>Spouse</td>
<td>78.2%</td>
<td>79.0%</td>
</tr>
<tr>
<td>Friends</td>
<td>85.8%</td>
<td>76.2%</td>
</tr>
<tr>
<td>Serious Problems Getting Along With (Past 30 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>10.4%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Father</td>
<td>8.1%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Spouse</td>
<td>17.0%</td>
<td>32.8%</td>
</tr>
<tr>
<td>Friends</td>
<td>6.9%</td>
<td>27.0%**</td>
</tr>
</tbody>
</table>

** ** significant differences between groups p< 0.05, corrected for multiple comparisons
problems within the sample was also indicated by the mean number of convictions lifetime (5.06 ± .94) and total number of months spent in jail (6.43 ± 1.5). When stratified for substance abuse it was shown that abusers experienced more legal problems than non-abusers (see Table 4).

Medical History and Identification

Characteristics of medical problems and help-seeking are presented in Table 5. Within the general sample, 85.1% had a significant medical problem (past year) requiring treatment. Of these individuals 38.3% did seek treatment. The most frequent reasons for not seeking treatment were 1) thought the problem would go away by itself (83.6%), 2) wanted to solve the problem on my own (69.6%), 3) was unsure where to go for help (23.2%), 4) did not have a medicare card (23.2%). Results also indicate that substance abusers were less likely to have the identification needed to access medical and social services (see Table 6).

History of Psychological Problems and Victimization

The sample displayed a high level of psychological distress. Notably there were high rates of anxiety (54.7%), depression (51.7%), suicidal ideation (46.3%) and attempted suicide (33.0%), as well as emotional, physical and sexual abuse (see Table 7). A significant difference in the rates of attempted suicide was observed when comparing abusers and non-abusers. In the past month, substance abusers experienced significantly greater amounts of depression (28.8% vs. 7.6% for non-abusers) and trouble controlling violent behavior (22.7% vs 5.3% for non-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 differences were found in rates of victimization in the past month and over their lifetimes (see Table 7). When victimization was stratified for gender, it was revealed that females had more lifetime history of sexual abuse (males 20.0%, females 47.7%; p<0.05). Overall, 43.3% of the sample had experienced a significant emotional problem in the past 12 months requiring treatment. However, only 42.5% of these individuals sought treatment from a professional.

**Discussion**

This survey examined the physical and mental health of an urban Aboriginal population. Through reported use of alcohol or drugs, and reported history of victimization and psychological problems, a clearer picture of the well being of this population has emerged. The largest proportion of the sample had lived in the urban area for a long time (mean of 9.96 ± .76 years). Only 19% of the sample were newcomers, living in the city for one year or less. The majority of the sample consisted of single young Inuit women who were unemployed and living with members of their families. Fully one third of the sample reported having a current drug or alcohol problem, and a large proportion (85%) experienced 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.

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 problems with drugs and alcohol within the sample. The rate
Table 4

<table>
<thead>
<tr>
<th>Legal Problems Stratified by Substance Abuse</th>
<th>Non-Abusers (n = 135)</th>
<th>Abusers (n = 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Number of Charges in Lifetime (± SEM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B&amp;E</td>
<td>.16 ± .07</td>
<td>3.10 ± 1.66</td>
</tr>
<tr>
<td>Shoplifting</td>
<td>.22 ± .07</td>
<td>3.05 ± 1.59</td>
</tr>
<tr>
<td>Assault</td>
<td>.14 ± .04</td>
<td>1.75 ± .69</td>
</tr>
<tr>
<td>Disorderly Conduct</td>
<td>.28 ± .12</td>
<td>1.62 ± .44</td>
</tr>
<tr>
<td>Total Convictions (Mean ± SEM)</td>
<td>2.06 ± .71</td>
<td>7.63 ± 1.56**</td>
</tr>
<tr>
<td>Months Spent in Jail (Mean ± SEM)</td>
<td>3.0 ± 1.34</td>
<td>13.44 ± 3.56**</td>
</tr>
<tr>
<td>On Probation or Parole</td>
<td>2.3%</td>
<td>15.2%**</td>
</tr>
<tr>
<td>Awaiting Charges</td>
<td>5.3%</td>
<td>14.9%</td>
</tr>
</tbody>
</table>

** significant differences between groups p< 0.05, corrected for multiple comparisons
Table 5

Medical Problems and Help Seeking Stratified by Substance Abuse

<table>
<thead>
<tr>
<th>Medical Problems and Symptoms (Past Year)</th>
<th>Non-Abusers (n = 135)</th>
<th>Abusers (n = 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>47.3%</td>
<td>64.2%</td>
</tr>
<tr>
<td>Pain (limbs, stomach, chest)</td>
<td>48.1%</td>
<td>55.2%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>37.4%</td>
<td>41.8%</td>
</tr>
<tr>
<td><strong>Chronic Medical Problems</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma/Emphysema</td>
<td>5.4%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4.6%</td>
<td>4.5%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>0%</td>
<td>4.5%</td>
</tr>
<tr>
<td><strong>Sought Medical Help</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor/Health Professional (past year)</td>
<td>69.2%</td>
<td>57.8%</td>
</tr>
<tr>
<td>Time Since Last Checkup (Months) (± SEM)</td>
<td>14.65 ± 2.18</td>
<td>11.07 ± 2.74</td>
</tr>
<tr>
<td>Prescribed Medication on a Regular Basis for a Medical Problem</td>
<td>26.0%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Number of Days Medical Problems (Past 30) (± SEM)</td>
<td>6.0 ± .85</td>
<td>9.7 ± 1.54</td>
</tr>
<tr>
<td>Mean Number of Hospitalizations (Lifetime) (± SEM)</td>
<td>2.29 ± .30</td>
<td>3.79 ± .81</td>
</tr>
<tr>
<td>Last Hospitalization (Years) (± SEM)</td>
<td>10.53 ± .98</td>
<td>7.42 ± 1.16</td>
</tr>
<tr>
<td><strong>Been to Native Healer/Healing Ceremonies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Healer (past year)</td>
<td>16.0%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Healing Circle</td>
<td>10.7%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Sweat Lodge</td>
<td>8.4%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

* no significant group differences when corrected for multiple comparisons
Table 6

<table>
<thead>
<tr>
<th>Identification</th>
<th>Non-Abusers (n = 135)</th>
<th>Abusers (n = 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Insurance Number</td>
<td>92.4%</td>
<td>73.1%**</td>
</tr>
<tr>
<td>Birth Certificate</td>
<td>82.4%</td>
<td>68.7%</td>
</tr>
<tr>
<td>Medicare Card</td>
<td>89.3%</td>
<td>62.7%**</td>
</tr>
<tr>
<td>Baptismal Certificate</td>
<td>68.3%</td>
<td>42.4%**</td>
</tr>
<tr>
<td>Temporary Medicare Card</td>
<td>33.3%</td>
<td>25.0%</td>
</tr>
</tbody>
</table>

**p<0.05 corrected for multiple comparisons
Table 7

History of Psychological Problems and Victimization
Stratified by Substance Abuse

<table>
<thead>
<tr>
<th>Experience</th>
<th>Non-Abusers (n = 135)</th>
<th>Abusers (n = 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>49.6%</td>
<td>62.7%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>55.7%</td>
<td>55.2%</td>
</tr>
<tr>
<td>Trouble Controlling Violent Behaviour</td>
<td>20.6%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>40.5%</td>
<td>61.2%**</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>22.9%</td>
<td>50.7%**</td>
</tr>
<tr>
<td>Prescribed Medication for a Psychological Problem</td>
<td>16.8%</td>
<td>26.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience</th>
<th>Non-Abusers (n = 135)</th>
<th>Abusers (n = 67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Abuse</td>
<td>0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>3.1%</td>
<td>13.6%**</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>15.3%</td>
<td>31.8%**</td>
</tr>
</tbody>
</table>

** p<0.05 corrected for multiple comparisons
of maternal history of drug and alcohol problems 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 subjects had 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 counselling for their family and social problems as extremely important.

The results of the present study confirm the impressions of Aboriginal community workers within the Greater Montreal region that substance abuse problems are severe and chronic in the urban Aboriginal population (Petawabano et al., 1994). Data on the prevalence of substance abuse among urban Aboriginals compared to those on reserves or to the general urban population is not available. A proposed way of understanding inner-city urban Native substance abuse is in terms of a "career or lifestyle" (e.g., Bibeau, 1995; Brody, 1971). Within this paradigm, dependence rapidly becomes a lifestyle and social networks of substance abusers become part of a survival strategy for navigating life in the city. Due to the strength of these social relationships, inner-city Aboriginal substance abusers may be resistant to even culturally-relevant treatment programs. Results from a classic ethnographic study of Aboriginal men on skid row in a Western Canadian city suggested that to drink is to be part of the community and that spree drinking is a way of solidifying community participation, involving a "repayment of debts and building up credit." (Brody 1971). Those Aboriginals who have made a successful transition to city life may not be noticed as "Native" by the general population, while the most visible urban Aboriginals may be those in the inner city who conform to the "drunken Indian" stereotype (Royal Commission Report 1993).
Brody (1971) states that "Skid row life offers to the Indian the possibility of an urban milieu without the pressures of a white middle-class value system." In this context, treatment for a drug or alcohol problem entails not only the physical and emotional difficulties of detoxification but also the challenge of creating new social networks and differing survival strategies. Nonetheless, at some point in this "career", individuals may want to stop their alcohol or drug abuse. That exact point in time is unpredictable, but there are some identifiable clues. For example, women who become pregnant may contemplate the connection of their problem abuse to their future and attempt to change. One Inuit woman surveyed in the course of the present study quit drinking when she became pregnant and stayed sober for 13 months. Her child is presently being raised by a relative and she continues in her "career" of alcohol abuse but remains proud of her accomplishment. An individual may seek treatment many times throughout an alcohol/drug using career before permanent change is made. Many substance abusers in this sample 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.

Congruous with the findings of previous work among Aboriginal peoples, the overall results point to high levels of psychological distress. Rates of depression are particularly high, and it has been shown that psychological distress is augmented by substance abuse. For instance, when substance abusers and non-abusers were compared, 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.

Zambrowsky (1986) found that a large majority of Montreal Aboriginal women in conflict with the law, were migrants to 'inner city areas'. The report also demonstrated that many of these women had alcohol and drug problems, and alcohol was a significant force in difficult relationships with men (Zambrowsky, 1986). Similarly, LaPrairie (1994) found that many inner-city Aboriginals had alcohol, legal and employment problems and were more likely than others to be victimized as children. Similarly, the majority of adult Aboriginals in an urban treatment program had a reserve or rural background with recent migration to the city, low levels of education and job training, family environments involving substance abuse, and arrests involving drugs and alcohol (Guyette, 1982). In the present study substance abusers reported more legal problems than non-abusers but there were no significant differences in drug and alcohol use between newcomers (< 1 year residence) and those who had lived in the city for a longer period of time.

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, 1996). In an American study, Gutierres et al. (1994) compared male and female urban American Indian substance abusers on a number of variables. The results of their study showed that females experienced more family dysfunctions, more family histories of substances abuse, and a much higher rate of childhood emotional, physical and sexual abuse compared to males. Of the females, 84% reported emotional abuse, 74.1% physical abuse and 51.9% sexual abuse, with males much
lower in all categories (McEvoy and Daniluk, 1996). The present study had similar findings with females having experienced more emotional and physical abuse in their lifetimes than males (emotional abuse: males 51.4%, females 67.7%; physical abuse: males 47.1%, females 49.2%). A significant gender difference was found in lifetime rates of sexual abuse, with females having experienced more sexual abuse than males (males 20.0%, females 47.7%). In the present study, there was no significant gender difference found in rates of victimization within the past 30 days.

In summary, this study explored the physical and mental health of a sample of urban Aboriginal peoples in Canada. The findings have shed light on a number of severe social, legal and psychological consequences of substance abuse that should be considered in developing health care services for Aboriginal peoples in urban communities. Since the number of Aboriginals living in urban areas in North America is growing at a substantial rate (LaPrairie, 1994), these issues are likely to increase in magnitude over the coming years. Clearly, there is an issue related to the representativeness of the sample in making any conclusions from this study’s data. The urban Aboriginal population is culturally diverse and mobile from season to season. In addition, the definition of who is a Native person is often problematic, due to issues of self-identification and mixed parentage. Ascertainment of the health, psychological and social problems from an epidemiological perspective in the urban population is not feasible. However, from a descriptive perspective the data indicate that the urban Aboriginals one is likely to encounter on a day-to-day basis (at native organizations and on the street) are typified by substantial psychological, legal and substance abuse problems.

While the statistics gathered in this study have given us an idea of how common
physical and mental health problems are, they do not tell us about how people perceive these problems and what causes they attribute them to. It is generally perceived by Native peoples themselves that they have severe problems with substance abuse and other mental health problems. A qualitative study was undertaken to further explore these issues and put a face on the views and experiences of urban Aboriginals. The perspectives of Aboriginal community workers and Aboriginals who use health and social services will be discussed in the following section.
PART II

Introduction

Ethnographic methods have been used to explore a number of mental health problems among Aboriginal peoples. For example, they have been used in studies of sexual abuse (McEvoy and Daniluk, 1995), depression (O’Neill, 1996), drug and alcohol use (Spicer, 1998) and substance abuse treatment (Stahler and Cohen, 1999). According to Castillo (1997), anthropology made an impact on psychiatric theory when the ‘psychic unity of humankind’ assumption was questioned. Mental health researchers have come to understand that cognitive constructions of mental illness are the result of individual experiences and social structures, separate from biological deterministic explanations (Castillo, 1997; Kleinman 1988). Anthropological methods have been used in mental health research to go beyond diagnostic criteria established for North American and European populations to explore contextual bases of mental health.

An example of such investigations is the work of Trimble (1992) who reported a distinction between ‘Indian sicknesses’ and ‘White man’s diseases’ among American Indians and Alaska Natives. This distinction may have effects on how problems are treated by traditional healers (Trimble, 1992). Within this cultural paradigm, the healing abilities of Aboriginal traditional healers are contingent upon the perceived origin of peoples’ maladies. Trimble explained that if a sickness is thought to have originated from outside the Native community, it is considered to be a white man’s disease. Therefore, the cure for that sickness must also come from outside the community. He reported that drug and alcohol addiction fell into the category of a ‘White man’s disease’. Trimble elaborates that the rationale is that drugs and alcohol did not exist in pre-contact Native life, with the exception of South
American Indians who used psychoactive substances for ceremonial purposes. Substance abuse in this context cannot be treated by medicine men (shamans) so they must seek the services of professionals in outside health agencies (Trimble, 1992).

Results from the health survey in part I of this project indicated that among Aboriginal peoples in Montreal there were high rates of problem drug and alcohol use as well as extensive histories of sexual, physical and emotional abuse. While gathering quantitative data is necessary in the examination of substance abuse as well as physical and mental health, it is also advantageous to explore these issues qualitatively. Qualitative research methods allow researchers to explore the subjective experiences of mental health among different cultural groups. This section will discuss the personal narratives of urban Aboriginals concerning issues relating to violence and substance use and abuse.

Study Methodology

For this study, in-depth ethnographic interviews were conducted with a sample (n=20) of urban Aboriginals as well as Aboriginal community workers (n=10). The goal was to gain more insight into belief systems and attitudes towards issues related to health, mental health and well being. Study participants were recruited through printed advertisements as well as by word of mouth (the snowball sampling method). 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. Information on treatment seeking was gathered for medical problems, violence and drug and alcohol abuse. In addition, respondents were asked to elaborate on the importance of Native content in treatment settings, barriers to treatment and general beliefs regarding drug and alcohol use. See
Appendix A for the full interview guide. Individual informed consent was obtained from participants in order to tape record the interviews. Content analysis was performed on the interview data. Content analysis involves three basic steps. First, interview tapes are transcribed verbatim, second, the transcriptions are reviewed several times and third, conversations are placed into categories developed from the informants’ speech (Agar, 1996). The Microsoft Word 2000 word processing program was used for text indexing and searching. Bolded sections in the following text identify the interviewer’s speech, italics are used on words emphasized in conversation and period marks note pauses in the conversation. Interview numbers were randomly assigned in the text to differentiate citations and to protect the identities of the interview participants.

Results

Interpersonal violence

One third of the respondents indicated that they had been the victims of some form of abuse in their lifetimes. They suffered emotional, physical and sexual abuse at the hands of spouses, parents, grandparents, uncles, other children and in one case, a teacher. Of those individuals, 60% said they sought treatment from a professional to deal with those issues. When speaking of violence, there was mention of violent encounters with others in bars. One such confrontation is recounted in the following excerpt.

023 Well my friends are rarely violent. OK. You want to get into that a little bit? 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. Is there any violence directed against you? Yeah. I just got a, I almost broke my jaw here. And my tooth cap broken. What
happened? I got beat up last week. ... I was at the bar, drinking. OK, 
what was the fight about? I don't know.

Others stated that their lives were negatively affected by the physical and sexual abuse 
they experienced as children, affecting their relationships as adults. In the words of two 
individuals,

001  ... Um, yeah, um, I mean, um, my mother used to hit me... a lot. Um, 
whether or not my memory um, serves me right but I don't know, that's 
what I felt. My mother used to hit me a lot and I think that kind of affected 
me cause um, I'm afraid of people, and I went through a period of being 
afraid of my husband that he might hit me and scold me.

030  ... Yeah, um, the violence that I've been through from the age 3 to 7 has 
been through sexual abuse, has been through uh, drug and alcohol, uh, I've, 
I've been raped, uh, during that time. As a child? As a child. I don't talk 
about this part very often but um, it does make an impact on you. (exhales 
heavily) So, and then of course uh, 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...

Accounts of spousal abuse were also reported. The following excerpt is from a 
conversation with an individual who both witnessed violence in the home as a child and 
experienced spousal abuse as an adult:

007 He was abusive, my [spouse]. He was abusive? Yeah. In what way? 
Oh, physically, emotionally, mentally, Very abusive. Umhmm. And uh, I 
was very young uh, when I started going out with him. And uh, so he 
pretty much took advantage of me in every way. And I think that um, all 
fathers and mothers are extremely responsible for teaching their children is, 
what kind of um, behaviour they should expect from a potential spouse.
Umhmm. Umhmm. And they should teach them that they should be honoured and that they deserve to be treated with respect and love. Umhmm. But I wasn't taught that because the example was, was the role models were, my mom took abuse you know? So for me it was normal. OK. But of course he got so abusive and so bad that when I got older I uh, finally I left him...

While a third of the respondents indicated that they had experienced some form of abuse at some point in their lives, two respondents made a causal link between childhood sexual abuse and the development of a substance abuse problem in adulthood. In the words of one person,

029 ... 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 had... didn't give a care, my friends would go out to a bar and I would stay home, I wouldn't go out with them, I would drink juice or [soda]. 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 the second individual, seeking counseling for the sexual abuse issues superceded the need for treatment for the alcohol problem.

025 So um, so once I started dealing with the sexual abuse issues, then everything's kind of like "OK, I don't need to use this, this is not, (low voice) I don't, this is why I was using. I don't want to use it. Because it doesn't make me feel very good about myself. So yeah, it was a problem. But not on a scale where people were worried, about sending me off to treatment. ... But um, so that, that was basically it, was the... alcohol, um,
.. but, the biggest, the biggest thing for me and I guess you kinda know, was the sexual abuse issues. I, I didn't go in for drug and alcohol treatment, I went in for looking at dealing with the sexual abuse issues.

One individual who reported witnessing spousal abuse stated that problems with alcohol use and violence did not exist until people moved closer to urban areas where alcohol was available.

Well, [the abuse was] not directly to me but in my, my stepfather, you know, when I was young used to beat up my mother. You know, like before we lived in the bush and 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 and that's, and that was when I was teenager, because when, before that we lived in the bush most of the time. And that's, you know that's when I noticed that people were very violent when they started drinking, 'cause I never saw that before when we lived in the bush but no one beaten up and you know there was no fights or nothing. And then people started drinking and then it was like, it was like automatic, women were beat up, and sometimes the women were beating up the men too.

Substance Use and Abuse

Definitions of substance use and abuse were varied. Respondents were asked whether or not they had ever had a problem with alcohol or drugs, leaving the definition of 'problem' use to their discretion. From the sample of 20 urban Aboriginals 6 stated that they had a current drug or alcohol problem and 14 said they had problems in the past. For instance, one individual indicated that they had "heavily" used alcohol for 12 years but did not characterize it as a problem. It was not considered a problem because,
"... it didn't affect my life. Like I was able to like function very well. Like I never lost my apartment or I never ended up in jail, or I never... we always had food and all that so I don't think it was a problem, it was just like excessive use at times. It wasn't every day either.

In contrast, the accounts one individual describe how drinking habits had progressed over the years, becoming problematic.

Um... first it started like on weekends, and then when I got older I started drinking like every weekend, like 3, every 3 days in a row every weekend until Sunday. Umhmm. And then it started like, I was drinking like every day mostly I would stop only 2 days, 3 days then I started again. Umhmm. Drinking to one week, then started drinking every day. ... I liked it drinking, I liked it drinking, and then um, after many years that I couldn't stop drinking at it was uh, I couldn't handle it anymore and uh, I tried to stop many times but I couldn't. Ok. I used to, I used to drink because uh, of the problems I had, to uh, forget about my problems, and the hard ti..., the hard life I was living.

What is Addiction?

Interviewees were directly asked how they defined addiction. Peoples’ definitions included references to using drugs or alcohol as well as other activities such as smoking cigarettes, having sex, gambling and shopping. Themes of loss permeated conversations about addiction. Loss was used to describe the failure to maintain personal relationships, losing the ability to care for children, and losing one’s house or job. Some also believed that abusing drugs or alcohol caused you to lose your sense of self. As one person put it,

I mean you lose your um, who you really are as a person, you forget who you are. You just um, you're lost and you just, the only thing that you
can do now you've like drink, take drugs and you totally lose like reality. You know you forget about reality, you forget about how nice life can be when you end up in the streets and then you don't care about nothing. You don't care about your, you forget about your family, you forget about your kids, you forget about yourself and you don't care no more. You just wanna drink or you just wanna do drugs. That's what addiction is for me.

Many individuals interviewed alluded to issues of control when explaining what it meant to be addicted. They described addiction as a gradual loss of control with the transfer of "power" over to the addiction while being unaware of the transition. In the words of two individuals,

027 Well, I guess it's you know, when you depend on substance, you know. After a while it takes control of your life. Basically that's what addiction really is. How does it take over your life? You know, like eh, you start abusing drugs and alcohol, and you just want more and more and more. And you have to spend money with it, to get it. You don't do things like you normally would do, you know, buy food, and support your family and stuff like that.

002 [You] just can't get enough. You can't stop. It rules you instead of you ruling it, ruling it. It sort of takes over everything... and you don't really don't really notice it at first, you know? And then it's like when you're, when you know you're running out of money, you're running out of whatever it is you're taking, and right away you start thinking where am I getting my next one? Umhmm. That's to me is when I know that I get addicted. Is when I start looking... like if I have a case of 24 and I'm down to 12 and I say "Oh no, where am I getting the next case?" then it's obvious that there's an addiction.
Others referred to “needing” the substance they were addicted to, having “an overpowering desire of a substance, of a person, or a behaviour that you go back to even if you have negative consequences” and addiction being “something that you always want, and sometimes I think if you can’t have it, you do whatever it takes to get it”. As one person lightheartedly put it,

017 Oh, I find addiction is something that you really need, you know, like you can’t cope without it. If you’re addicted to, you know, cigarettes or something, you know, you have to have a cigarette. Like me I think I’m addicted to cigarettes, I feel like having a cigarette now. (Laughter) And the thing is, the thing is, one time, you know like, we talk about addictions all the time, you know, like people are addicted to the drugs, alcohol, and uh, and I said well I think I’m really really addicted, I said, you know, because you know why I say that is because, I said if there was a storm, I said, and if we ran out of milk at home, you know, I probably wouldn’t go to the store to get the milk, I’d say, ah well, I don’t really need it, I’ll just drink my coffee black, but if I ran out of cigarettes! I’m going to go put my boots on my mitts and ---(laughter) so that’s addiction.

Psychological and behavioural causes were more prevalent than biological explanations in descriptions of addiction. For instance, people made statements such as these supporting a psychological explanation for addiction:

022 Addiction’s being dependent on whatever substance you are addicted to, depending on it, like, you need it. You think you need it, but you body doesn’t. But your body doesn’t? Is that what you said? Yea. Like your mind is telling you that you need that stuff, when your body doesn’t really need it to function.
I think that I look at addiction as more of a symptom. You see, like the disease concepts says it's a primary disease, I see it more as a underlying issues, you know a way of coping with some things that you're not able to cope with. So it's a negative coping skill. Either it's learned through your family background. I think it's a symptoms of more underlying issues. If you do go to the core issues and teach that person to cope different coping mechanisms, that you can overcome addiction.

[It’s an] obsession, an overpowering urge, craving, um, something that you, something that a person can physically or psychologically need. An addiction is, not just to alcohol or drugs, an addiction could be to anything, it can be to gambling, it can be to sex, can be to um, can't think of anything else there. Bingo. Yup, Bingo (both laugh) smoke you know, smoking, oh my gosh, yeah I do have an addiction, smoking, yeah.

When people spoke of a biological basis, they generally referred to research reports and television programs they had been exposed to. But they seemed unsure about the biological interpretation, as can be seen in the following excerpt:

I read one, one.. research that was done and they were saying in the research that Native people are more susceptible to being addicted and even uh, I think even I saw it on TV or something uh, David Suzuki was talking about it and he said that the oriental, I think he's Japanese or something, he said that he had done research and he found that there was the same people, you know, with the same kind of blood or whatever, so make the same way or something and he said that this was the same thing for his people, you know, and the Native people, he said, it, we were more susceptible to, or some kind of uh, doesn't take long for somebody to get addicted. Umhmm. So I don't really know if that’s true...
One person made a strong statement supporting both psychological and biological explanations for addiction.

... So yeah, I think it is uh, a psychological addiction, its also a physical addiction. So there's changes. So my general belief is that it's a disease. Umhmm. It's a social disease. And especially in the Native community it's a disease cause I think they've, they're dealing with.. I really strongly believe men and women pass it on to their children, the gene, the genetics. And men do pass it on to their children. I really feel that children are born that are, are uh, revealing today uh, a predisposition, genetic situation that they can't handle.

Do Native Peoples have a Problem with Drugs and Alcohol?

When conversations steered towards discussing whether or not Native people had a particular problem with alcohol or drugs, many opinions were offered. Some believed there was a problem among Aboriginal peoples and others did not. Explanations for the existence of a problem encompassed issues of biology, history, and escapism. Those who did not believe Aboriginals generally had a problem with substance use, pointed to ethnic equality, visibility, media and reporting influences to explain why. While people made vague references to Native people being biologically different from others to explain problem substance use, ...

... for example like there's research um, about Native people not having the metabolism to deal with the alcohol or having a lower metabolic, I don't know, something along those lines.

One individual made a very strong connection between biology, history and problem drug use. It was explained that Native people were vulnerable to the effects of alcohol because of their limited exposure to the intoxicant in the past. The individual began by saying
Native people had problems with alcohol and drugs "just the same as anyone else" but then recounted a conversation with a non-Native person that had convinced him of the veracity of the biological explanation. In the words of this individual,

030 Yeah, its just the same as anyone else.. Umhmm. But what somebody uh, somebody was mentioned to me one time, I was hitchhiking he goes, "You know why I think you guys are so much more susceptible, to it, rather then like Europeans, is because Europeans have been drinking for thousands of years, where we had been completely pure, so their, natural tolerance is so much natural than ours, because what, its only been in the last uh, well, 400 years that we'd been introduced to it, when they'd been drinking this stuff clear back to 2000 years ago, so yeah, they have a naturally higher tolerance. Umhmm, Umhmm. And that's why our tolerance, isn't quite, yeah, its you know, we were practically destroyed just through the use of liquor alone. Umhmm. So that's your belief too then? Because.. Well, it stands to reason. Because, you started out by saying someone else was telling you this but.. Well, it makes sense, yeah. it's what you believe too. Because our bodies have been pure for all these thousands of years, and then, yeah, of course, we're not going to have that naturally high tolerance to it. You know, it makes sense doesn't it?

Escapism was a strong theme proffered as an explanation for problem drug use among Native peoples. The premise was drugs and alcohol were used to escape personal pains. The following excerpts illustrate this theme.

003 Yeah, it's because people are still trying to, to find out who they are. So, as long as there's having emotional pain I think they're gonna try to take a break from their emotional pain once in a while with a drink.

024 Yeah, they're a big problem. And again I said, to me it stems from
them not uh, feeling functional and accepted and valued in the society. That's a big, big part of it. Umhmm. And also, uh, all the same issues of dysfunctional backgrounds. I mean don't forget too like the, well I'm sure you're aware of this, like our, a lot of our ancestors were abused in residential homes and the damage that was done there was so severe and so that carried on again. That carried on through generations until people had the strength to break the pattern. Umhmm. So, yeah I think that, that all that brings people to drink and, and take drugs. Again like I said, I keep saying it, but I really believe it's a way of avoiding our pain and it's a very negative way of avoiding our pain.

Not everyone believed Native people in general had a problem with drug and alcohol use. Some maintained that every individual was equally likely to develop a drug or alcohol problem irrespective of ethnicultural background, as can be seen in the following excerpts.

005 I don't know. I don't know what it's like in a Jewish community, or the Greek or the Italians or ... Like I know that Irish people have a reputation but I don't know cause I'm not them. But I think that we do have a problem with it. It's very obvious. But we also can't say that every person does, cause there are people who don't, and they're doing quite well.

013 Hard to say, you know that? Cause the statistics say that yes, but I don't know because uh, sure its easy to point to uh, one group of people and say "Oh yeah, look at them uh, they're a bunch of drunks" and things like that. But you know, if you look across history, look at the Irish... a lot of Irish people were oppressed and had big alcohol problems so see, I find that its tied in again, oppression and alcoholism, oppression and depression and all of that... ... And so to say that, that its just Natives, that's a really hard question.. Umhmm. and a lot of people would tend to say yes, more Natives drink but I don't think so. I think pretty much that's the disease of
the society all over. Umhmm. Drugs and alcohol... and lack of beliefs and values and all that. Umhmm. Umhmm. And unresolved, all that garbage. All those issues.

Visibility was used to explain for the widely held belief that Native peoples in general have a problem with substance use. Individuals referred to the visibility of drunken Indians in western Canada as an example. According to one individual,

022 All you see is the reserves that have the problem are very well known or the villages are very well known, but they never say, O.K., these villages or reserves have no drinking problems, all you hear about is the ones who do or you go out West and all the reserves are on the highway or right close to the city, so the only people that come into the city are the alcoholics. The Indians that stay on the reserve, you never hear from them. So all you see if you’re out West is drunken alcoholics, drunken Indians in your city. You don’t see the other Indians on the reserve that are doing good and own businesses and everything else. Because they stay on their own reserve and do their own business.

Others pointed to the media’s influence on the perception of drug and alcohol use among Aboriginal peoples. It was posited that reports on Native peoples on television and in newspapers are negative, concerning only criminal or deviant acts. One individual gave this impassioned statement about the labelling of Aboriginal peoples as drunks:

009 Oh God, This, I’ll be honest with you, it's the White people seeing that way. I don't see our, our old people being an alcoholic and drug addict. I don't judge the Native, you know, it's the White people judging us that way. Not, I don't know, I don't judge my own people, no way. I don't judge Native and Inuit. The only way I know that it's those White people doing that, they’re calling us the alcohol and that hurts you know. It hurts, ..
(begins to cry) hurt our feelings. Calling us an alcohol, they should talk about themselves too. ...

When asked if there was a perspective particular to Native peoples concerning the use of drugs and alcohol, one individual stated that Native people themselves buy into the drunken Indian stereotype. In that person's words,

030 Um, yeah, there is this, this, I think um, Native people themselves have.. well I grew up with this drunken Indian syndrome right? Things change. There are a lot of stereotypes. I think that Native people themselves have this drunken Indian stereotype of themselves. I think they have uh, um, the attitude that if you're Indian, you're out of control. They don't see someone who is maybe perhaps um, an occasional drinker, they just see a Native person drinking. ...

It was also an opinion that among other things, getting together to use drugs and drink alcohol was a social experience. This opinion was described well in the following excerpt:

004 Um, having been in the drinking circle, um, its very much,.. um, a way to be together. I think its been replaced, it replaced the community gatherings. I think it replaced community suppers. Um, I think um, its just a way to connect in a big urban setting. I think um, for myself it was a sense of identity and that went along with being Native even though I didn't know of this. So, it was really a part of being Native. Umhmm. Um, I think drugs and alcohol are in, especially I mean in the younger generation, ... it's a way just to deal with everything that, that uh, has happened to us. And um, I think Native people see drinking um, as just a part of our communities right now.
The Importance of Culture in Treatment

A number of opinions were offered on the importance of culture in treatment. For instance, it was thought that having a focus on Aboriginal identity put people at ease, affecting their level of disclosure and it lent a sense of community. A connection between the notion of selfhood as it related to cultural awareness, or rather the lack thereof, and the significance of culture in treatment settings was also made. It was proposed by some that people abused drugs or alcohol because they did not know who they were as Native people. Practising cultural traditions like sweat lodges and healing circles in treatment settings were said to provide people with the means to reconstruct their Native identity. One community worker explained it this way:

028 ... what I find is cultural and spirituality are linked a lot together, and that's what's missing in the other treatment centres. I think that in Native treatment centres we have that component of spirituality and cultural that just brings the home to the person and we're not talking only emotional, but it's emotional, physical, spiritual and social. You know all those areas of your life that you need to take into account and I think that the culture brings you that sense of identity of who you are, where you're from. ... I think that once you feel proud of who you are and once that you realize that you're a valuable human being, that abuse is harming you. Well once you start loving yourself as an individual as a Native person, you're less likely to use I think. To self abuse.

It was also maintained by respondents that these teachings helped build the self-esteem needed to combat self-defeating behaviours such as substance abuse. One individual in particular thought that the focus on culture in the treatment process was very helpful when they entered a Native treatment program for a cocaine addiction. In the words of that
individual they are essential,

013 Cause it can remind you exactly who you were before you start your drinking. And it shows you everything that you have to be proud of and in a way it helps you to build your, builds up your self esteem. Cause it makes you .. proud. You know, it makes you feel good about yourself. Umhmm. That's what it did for me anyways.

Based in a collective notion of identity, cultural traditions in treatment were also thought important because they taught people about their common historical background as Native peoples. One person said that you needed to know where you came from to understand where you were in the present.

012 Because me, like the way I see it, because I always look at things holistically, and I find that if you go through, if, if you really want to understand yourself as an individual, you have to look at your whole historical history, you have to understand your people what they went through, your ancestors what they went through and then where you are now, like your whole history, you know, in order to feel that uh, you know, to understand yourself as a person, as an individual. Because that's, you know, your whole, like, even your family history to be able to be understand you family history, why things happened the way they did, you know? Why did my father beat up my mother, you know? What happened in his life that made him do things like that, you know?... I think that, that holistic healing is very important to Native people in order for them to be able to deal with some issues.

Perceptions of the Problems and the Solutions for Treatment

A great number of barriers to drug and alcohol treatment were indicated by the men and women interviewed for this study. Barriers concerned the difficulty of entering treatment,
drawbacks of available programs and motivation for treatment in light of those difficulties. Problems encountered in the entry process included distances needed to travel to treatment centres, transportation costs, lack of identification for Medicare coverage, cohort entry protocols and lack of knowledge of the resources available. People also indicated that programs available in Quebec do not accommodate pregnant women or people with health problems, and they do not provide counselling services for families or lodge young children when parents are in treatment. Interviewees suggested that motivation for treatment was affected by the length of time spent on waiting lists, concerns for employment and income security while in treatment and fear of being labelled an alcoholic or a drug addict in the community. Respondents also indicated that the lack of pretreatment care and aftercare programs was problematic for urban Aboriginals.

The need for more services for Aboriginals in the Montreal area were indicated by Aboriginal community workers. Among those suggestions were outpatient treatment programming and outreach workers in the streets of the city. It was also suggested that there was a need for a Native run social service centre. It was explained that such a centre was essential,

014 ... because you need that, you need a, you know a place where they can go, get some help with the UIC, Welfare. They get some of that at the Friendship Centre, but you know, you need like a Social Service Centre. Where people can go, get some help.

The establishment of a boarding house for Native youth was also recommended. It was proposed that the issues of substance abuse and violence could be addressed in such a long term boarding facility. In that individual's words,
018 OK, we have the Native Friendship Centre, we have the Native Women's Shelter, uh, but the Native Friendship Centre is, you can't live there. Umhmm. And then you have the local uh, um, uh, Salvation Army um, that are catering to old dirty men (laughs), but where's our youth, our Native youth to go? To heal?...

The development of a treatment program designed with the needs of pregnant women in mind was also suggested. Pregnancy was flagged as a barrier to treatment because of the need for regular visits to a doctor, which may be distract one's attention from the treatment program. It was further stated that existing treatment programs only admit women after they've given birth to their infants. According to this individual, this is problematic because for most women the desire to care for newborns takes precedence over entrance into a treatment program.

It was also recommended that modifications be made to existing drug and alcohol treatment programs. For instance it was suggested that treatment centres have onsite detoxification units.

007 ...I think treatment centres should have on sight detox, so the first thing they do is go into the detox for a week, and then after that then they're ready to go into treatment. So, it's like, they're not going there coming back here, going there. ...

Other suggestions offered were to increase the number of beds available in treatment centres, to include patients' families in counselling sessions and to follow up on the community to '... make sure that the support system is there, whether it be an urban or a non-urban centre.' Aftercare programs were viewed as integral components of that support
system. The development of an aftercare program was deemed important because in such a program people could be taught skills needed to make an easier reintroduction into society.

024 [People need to] develop a follow-up plan of action after they leave the treatment centre. What uh, what resources, what options or alternatives are there for them realistically to avoid getting back into the cycle of addiction again? If they are on welfare, you know, um, .. you know when they've had difficulty maintaining a fixed address and uh, you know, they're, they're not, they don't have resources to introduce them to new, new environment, like give them life skills.
**General Discussion**

Little information 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). Much of the prior research on substance use among Aboriginals has been conducted among reserve-based populations. Therefore this research project was aimed at examining substance abuse, and physical and mental health in the urban Aboriginal population of Montreal. The pathways and barriers to accessing medical and social services were also explored, in addition to information on the nature and severity of drug or alcohol problems. This latter issue was examined using qualitative ethnographic methods in order to explore the subjective experiences of mental health among urban Aboriginal peoples. Personal narratives shed light on issues related to violence and substance use and abuse.

**Characteristics of Substance Use and Abuse**

In the first part of this study, 33% of the survey respondents reported having a current drug or alcohol problem. Among the 20 urban Aboriginals who used health and social services in Part II of the study, 6 reported having a current substance abuse problem and the remaining 14 stated they had similar problems in the past. Interviewees were given the opportunity to define problem use as it was reflected in their own life experiences. In their descriptions, reasons for drinking alcohol ranged from the desire to socialize with others and have fun, to drinking alcohol to escape problems (including unresolved issues with childhood physical and sexual abuse) and to self-medicate oneself for loneliness or depression. The use of substances to self-medicate has been largely discussed in the literature (see Langeland and Hartgers, 1998). It is important to note here that the overall results in the first part of this
study pointed to high levels of psychological distress in the study sample. In particular, there were high rates of depression that were augmented by substance abuse. A study by LaPrairie (1994) also found that Aboriginals living in the inner city were prone to feelings of hopelessness, and many had hard-core alcohol problems.

Native Perspectives on Substance Use

The belief that Aboriginal peoples in general have a problem with the use of alcohol and drugs is not universally accepted. In the present study, ethnic equality, visibility and media and reporting influences were used to explain why interviewees did not believe Native peoples had a problem with substance use. The explanations offered by those who did believe it was a problem, were biological, historical and psychological in nature. For decades researchers have been examining the rate that alcohol is metabolised in both Natives and Caucasians. Since the results of early studies were methodologically weak, it is difficult to interpret their findings (Griffiths et al., 1990; Gill et al., 1999; Smart and Ogborne, 1996). A recent study did not find any metabolic differences between Native Americans and others (Gill et al., 1999). Despite the varied results of early studies, this explanation is still wide-spread, and is common among Substance abuse treatment personnel. (Griffiths et al., 1990).

The literature shows that there is considerable variability in the prevalence of substance use and abuse among differing First Nations communities. These differences are influenced by the historic, social and cultural factors particular to each Nation and community. These explanations were also used to explain drug and alcohol use among Aboriginal peoples. Clearly it should not be assumed that all Native peoples drink or that all Native communities have problems with the abuse of alcohol or drugs to degrees that warrant intervention.
Saggers et al. (1998) noted that during colonisation, Native people had to be 'taught' how to drink by the settlers, since the taste for alcohol did not come naturally. With the use of alcohol as a means of exchange, it was in the vested economic interests of the colonists to encourage the consumption of alcohol among Native peoples (Saggers et al., 1998). Over the years, Native peoples endured increasing levels of subjugation with the loss of land bases through forced relocation, forced entry into residential schools and increasing dependence on social welfare systems. Aboriginal peoples came to use alcohol as a means of escape from their changed social world (Saggers et al., 1998). Drug and alcohol addiction has been conceived of as a symptom of a larger 'social pain' suffered by Aboriginal peoples (Duran, 1995). Theoretically, causal links have been made between the objectionable nature of colonialisit experiences and socio-psychological distress experienced by Native peoples (Duran, 1995; Trimble, 1992; York 1990).

**Violence and Victimization**

When the sample was stratified for substance abuse in Part I of this study, the results showed that when compared to non-abusers, substance abusers reported higher rates of physical abuse in their lifetimes (65.7% versus 40.5%) and more physical and emotional abuse in the preceding 30 days (physical abuse: 13.6% versus 3.1%; emotional abuse: 31.8% versus 15.3%). Similarly, results from Part II of the study revealed that one third of the respondents were victims of abuse. The findings were corroborated in a study by LaPrairie (1994) which reported that Aboriginal peoples living in Canadian cities were highly likely to be childhood victims of abuse.

When people were interviewed with regards to their personal experiences with
violence, a relationship between childhood physical and sexual abuse and the development of a substance abuse problem in adulthood was hypothesized. The relationship between violence and substance abuse is also seen in the literature. In one review, it was shown that rates of childhood sexual abuse were highest among females seeking treatment for alcoholism (Miller et al., 1993). Included in that study was an outpatient alcoholism treatment group. Results from another study also indicated that exposure to trauma may increase the likelihood of developing an alcohol problem (Stewart, 1996). The relationship between childhood physical and sexual abuse and the development of a substance abuse problem later in life was found to be particular among women (Langeland and Hartgers, 1998; Spak et al., 1998). Results from recent studies also corroborate the relationship between psychological distress and substance abuse. In one study of clients at an at an outpatient substance abuse treatment facility, relatively high rates of family history of physical violence (37%), physical violence victimization in adulthood (22%) and childhood abuse (14%) were found (Easton et al., 2000). High prevalence of family history of alcoholism were also found among Native Americans with substance abuse problems (Gill et al., 1997; Wall et al., 2000).

Another study on the effects of childhood abuse among Navajos seeking treatment for alcohol abuse also supports the link between trauma and the development of a psychological problem later in life. Physical and sexual abuse before the age of 15 were risk factors for conduct disorder (Kunitz et al., 1998). In this study, respondents defined physical abuse in terms of beatings by parents and whippings. It also included being forced to fight other children with punishment upon refusal (Kunitz et al., 1998). Untreated abuse has been associated with both an increased risk for suicide and drug and alcohol use/abuse (Dumont-Smith, 1995).
Studies have indicated that violence and abuse are consequences of a disadvantaged economic positioning in society, inadequate housing conditions, lack of or poor quality of services available, loss of traditional culture and government initiatives to eradicate Native cultures (Pressman, 1994; McEvoy & Daniluk, 1995). It appears that there is a strong correlation between family violence (emotional, physical and sexual abuse) and alcohol/drug abuse in Aboriginal communities. 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). Successful treatment of addiction, therefore, could be a point which interrupts this intergenerational transmission of abuse.

Native Appropriate Treatment Issues

Cultural traditions such as healing circles, sweat lodges and consultation with elders were considered integral components of drug and alcohol treatment programs for native peoples. It was suggested that the inclusion of cultural elements gives clients the ability to reconstruct their Aboriginal identities. Selfhood, self-esteem and cultural awareness were hypothetically linked by interviewees. It was suggested that building up self-esteem and pride in oneself would help individuals to combat their tendency to self-defeating behaviours.

According to the literature, Native peoples have defined mental health in terms of balance and harmony within the mental, physical, emotional and spiritual aspects of human nature (Mussell et al., 1993). An increasing number of health service programs have strived to offer services that acknowledge the special cultural needs of Aboriginal peoples. Kral (1998) describes the medicine wheel as a tool for relieving psychological distress in an article
on Aboriginal suicide. Kral (1998) writes that in focussing on the physical, mental, emotional and spiritual domains of well-being using the medicine wheel, people can explore personal pains that have been externalized through drug and alcohol problems. In addition, traditional healing practices can give order and meaning to otherwise tumultuous and emotion filled experiences that are encountered in the processes of healing (Kral, 1998).

Traditional ceremonies have served to supplement drug and alcohol addiction treatment programs and they have also been used as integral components of rehabilitation programs among incarcerated criminal offenders (Waldram, 1993). According to Waldram (1993), ceremonies lower the stress levels of Aboriginal inmates, decrease the rates of illegal activity within the prison and enhance the inmates’ abilities to cope with prison life (Waldram, 1993).

Trimble (1992) discusses the culture-boundedness of counselling and therapeutic approaches that have been used to prevent and intervene drug use among American Indian youth. He relates that these methods are culture-bound, having been created from Western medical theories that are individualistic in nature. As a consequence, their formulae may be inappropriate for addressing the problems experienced by Indian peoples. According to Trimble (1992), since conventional therapeutic techniques lack a due regard for the worldviews of Aboriginal peoples, problems may ensue when they are applied to Native groups.

A number of barriers to substance abuse treatment were offered by interviewees. Structural barriers dominated the list, with references to the disadvantages of available treatment programs. Problems flagged by interviewees included the distance someone seeking treatment needs to travel to get to treatment centres outside the greater Montreal area,
securing funding to cover transportation costs and lack of accommodation for pregnant women in treatment.

A number of suggestions to improve services for urban Aboriginals were offered by community workers interviewed for this study. Among the suggestions were the development of outpatient treatment programming, a Native run social service centre, a boarding house for Native youth and a treatment program designed with the needs of pregnant women in mind. It was also recommended that existing treatment facilities develop onsite detoxification units to curtail problems incurred with traveling between facilities. It was also strongly suggested that aftercare programming be made available for Aboriginal peoples in urban centres. These are concerns that need to be addressed since urban Aboriginal populations are growing throughout North America. In the words of one individual, "...I don't think the question is whether or not we're ever gonna all be sober, I don't think that's attainable cause that's not the reality of it and there's even in the non-Native world, not everyone's sober and straight and, you know?..."
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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.

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APPENDIX A

Interview guide for “Wellness Study” Qualitative Project

IDENTIFICATION

Nation
Status
Community
Age/Date of Birth
Education
Employment/Assistance
Children/Dependants
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?