COMMISSION ROYALE SUR LES PEUPLES AUTOCHTONES

ROYAL COMMISSION ON ABORIGINAL PEOPLES

NATIONAL ROUND TABLE ON ABORIGINAL HEALTH AND SOCIAL ISSUES

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Vancouver, British Columbia

--- Upon commencing on Wednesday, March 10, 1993 at 8:40 a.m.

DR. LOUIS T. MONTOUR, ROUND TABLE

CHAIRMAN: My name is Dr. Louis T. Montour. I am a family physician at Kateri Memorial Hospital Centre in Kahnawake, Quebec. I am also Director of Professional Services and Chairman of the Council of Physicians, Dentists and Pharmacists.

I would like to open this meeting by inviting Mr. Glen Douglas.

Glen Douglas was born in Penticton and raised in the Similkameen Valley. Glen Douglas is a member of the Lower Similkameen Indian Band. Glen has seven children from his previous marriage. He and his wife, Leslie, are now raising four nieces and nephews.

Mr. Douglas speaks a number of languages, including his first, Okanagan, which is an Interior Salish dialect, English, German, Kootenay and Shuswap. He served in the U.S. military for 22 years, receiving numerous purple hearts, three silver stars, four bronze stars, and was nominated for the Medal of Honour twice. Mr. Douglas was in World War II, the Korean and Vietnam wars.

His formal education includes two Associate degrees from the Fort Stilacum College and two Bachelor's degrees from St. Martin's College in Olympia.

He is a past director for an alcohol and drug treatment centre.

Glen Douglas is currently the resident Elder at the En'owkin Centre in Penticton. His primary non-work-related activity is the sweat lodge. His hobbies are hunting and fishing.

Mr. Douglas, please.

ELDER GLEN DOUGLAS: Good morning. If there are any local Chiefs or local leaders of the Squamish and the Musqueam here, we thank you for allowing us to be in your territory. If there are any Elders from this area, we thank you for being here, and any Elders from anywhere across this great Turtle Island, we thank you for being here. It is an honour and a privilege to stand here before you at this time to give you the opening prayer.

I will introduce myself in a formal way. I will do it in my language and translate it to you. (Native language) My name is Nilkolcheen (PH) which means a tree bent across a stream or a ravine or a chasm as a bridging or a communicating.

I am from a long line of hereditary

leaders from the Siwhilakin (PH) side and from the Spokane which is in the United States, from Alakumulow (PH). I was born in Penticton, British Columbia. I was raised in the Similkameen and in the Nicola Valley and in the United States. This is my territory.

The map that you see behind me, which is very hard to see, includes below the 49th parallel through part of Montana down to the tip of Wyoming. That is the extent of my nation's territory. Thank you.

--- Opening Prayer

DR. LOUIS T. MONTOUR: Thank you, Mr. Douglas. Mr. Douglas has left some tobacco for the other Elders who have come here to share.

I would now like to call upon Mr. Georges Erasmus, Co-Chair of the Royal Commission on Aboriginal Peoples and a former National Chief of the Assembly of First Nations.

CO-CHAIR GEORGES ERASMUS: I would like to thank Elder Glen Douglas for that wonderful opening. It certainly has set the tone, I think, for our next three days.

The Royal Commission was created in August 1991. It was given a very, very large mandate. The mandate of this Commission covers all major issues

that Aboriginal people in Canada have been concerned about for many decades -- all the political issues, all the economic issues, including the Constitution, the Indian Act, Indian Affairs, self-government questions, all the social and health issues which we are going to be dealing with here today, the questions of land treaties, Métis issues, urban Aboriginal issues.

We are also to make sure that all of the different perspectives -- women, youth, Elders -- are taken into consideration. We are to look at things like justice, education, language, culture.

Since we are dealing with Aboriginal people and Aboriginal people like to deal with things in a holistic way, it makes our work that much easier. Because of the time frame that we have as an overall Commission, we believe we are working in a time when we should be moving very quickly. Even though we have a mandate that might take us a full decade if we wanted it to, we are trying to do the work in as short a period as possible. We hope that we will be concluding our work sometime next year and that the report will be submitted to the Prime Minister sometime in late 1994.

We are dealing here with health, social issues and healing. Five hundred years ago, when Columbus

first discovered this part of the world, Aboriginal people were in a completely different situation than they are today. It is probably safe to say that we were more healthy. We had a completely different paradigm or way of approaching health than what has been brought to us since that time. We lived in societies that were different, but there were many similarities. Generally, the nations we were living in tried to approach life in a holistic way.

If one were to be treated for a particular thing, it was not only a treatment, obviously, of the physical self but the emotional self, the spiritual self; all aspects of what it means to be a human being on Earth were being treated.

We were living in societies that believed this really was a schoolhouse Earth, generally believed in reincarnation, believed that what we were doing was that we were involved in a journey to learn, to acquire as many credits as possible, as close to perfection as possible. So our societies had the values and the norms that encouraged that.

We didn't have the norms that encouraged us to create personal greatness, great wealth and capital; it was a different kind of emphasis altogether.

We have gone through a period of time when we have lost a lot of control over our lives. Over the last three, four or five decades, there has been a re-emergence amongst Aboriginal people to once again reassume control over their lives. There has been continuing resistance for the 500 years, but in the last number of decades the re-emergence of the strength of Aboriginal people is becoming more and more obvious everywhere.

As I said, we have a very large mandate. We can deal with many, many things. We have a number of Round Tables -- 10 or a dozen before we have concluded. This is our third.

We are dealing with a subject that may be one of the most important, if not "the" most important. We are going to be dealing with the question of the pain that Aboriginal people are experiencing, the health and the social symptoms that are evident amongst Aboriginal people.

We have held many hearings in this country. We have done two very major tours across the country, and everywhere we have been we have been told by people that there needs to be a process where people once again become healthy. We need healthy individuals;

we need healthy families; we need healthy communities. I quote someone speaking in Canim Lake just yesterday, but what that person said was what we have heard everywhere.

We have heard many of the problems many times across the country, and we are beginning to hear stronger and stronger the beginnings of solutions. What is inspiring to people like myself and Aboriginal people is that the answers are coming from Aboriginal people themselves. There is assistance from outside, but it is very, very obvious that, if there is going to be genuine change and movement, the direction has to come from Aboriginal people themselves. They must know very clearly what they believe and understand as the source of their problems, and they must have the recipes, the remedies, the solutions and the process which they must move through to eradicate the problems they have.

We are beginning to hear the experiments, the work that is being done in different parts of the country. Four Commissioners were in Canim Lake for a couple of days -- we returned late last night -- where we heard about communities that had been dealing with, first, sobriety and then, once they had dealt with that, they started finding that there were other problems, that all the problems of the community hadn't gone away

just because they had sobered up. In fact, this gave them the strength now to tackle more issues.

Issues like sexual abuse started to surface, and the community started to address that, as a community, with very strong leadership from the women of that community and from the surrounding communities, as we will hear from Alkali Lake later in our conference.

What we are hoping in the next three days here is that, while we have brought together experts and people who have worked in this area for many years -- we have brought together both representatives of government, representatives of the medical profession and other areas of expertise that we need, the humanities, et cetera -- we have also brought people here who are working in their communities, either in hospitals or in other projects, which is once again reasserting indigenous control.

We have some very important subjects to discuss here. I wish you all good success. The Commissioners will be listening very intently. We will be participating from time to time, but primarily we have brought people together so that we can learn from you.

The Commission has been approaching our work on the basis that the lessons are out there to be

learned. We think the majority of the lessons are in the Aboriginal communities, but there will be, as in all human experience and growth, ideas coming from many quarters.

Thank you for being here. Enjoy yourself, and have a good conference.

DR. LOUIS T. MONTOUR: Thank you, Mr. Erasmus.

I would now like to call on Judge René Dussault, Co-Chair of the Royal Commission on Aboriginal Peoples. Judge Dussault is a justice of the Quebec Court of Appeal.

COPRÉSIDENT RENÉ DUSSAULT: Je voudrais d'abord souhaiter la bienvenue à tous les participants de tous les horizons. Ces tables rondes nationales sont pour nous un instrument de travail extrêmement important.

I would like, first of all, to welcome all the participants and to say that these national Round Tables are very important work instruments for the Commission. They are bridges between the stream of information coming from the public participation process -- we have had two rounds of hearings so far -- and also with the information coming from the research side.

These Round Tables, we hope, will give us clues as to policies. They have to be policy-oriented.

I wanted to share with you this morning very, very briefly the thrust of what we heard about health and social issues in the last two rounds of hearings.

When Aboriginal people talk about health, they mean something more than the absence of disease and the presence of adequate sanitary conditions, as important as those are. They mean something more than adequate social service provision, as important as that is. They are referring to the core of well-being that must lie at the centre of each healthy person and to the vitality that must animate healthy communities and cultures.

Where there is good health in this sense, it reverberates through every strand of life -- education, employment, language, justice, family relations, spiritual values.

The key to this perspective is the idea embodied in the term "holistic". In the view of many Aboriginal people, the causes and effects of the high rate of individual illness, high risk and self-destructive behaviour, alcoholism and drug abuse, family violence and suicide are interrelated.

Many of the insights that were given to the Commission by Aboriginal people about directions for

change start from a critical analysis of the basic medical and social services available to Aboriginal people. It has been put to us, and it has been put to investigative panels before us, that Aboriginal people have a right to receive the same quality of health care that is available to others in Canada. Access to services is especially problematic in northern regions and in communities at a distance from urban centres.

Rapid turnover of nursing personnel creates continuing distress in communities where nursing stations are the only source of medical care. It has been argued that accessible, culturally-sensitive treatment services are a fundamental necessity to deal with the high levels of illness which plague Aboriginal people.

In a nutshell, the elements of solutions that we are hearing from the hearing trail turns around things like comparable standards of medical and social services, focus on self-esteem, recognition of traditional healing and traditional culture, holistic approaches to critical symptoms like alcohol, drug abuse, suicide and violence, and Aboriginal and community control of programs. The lack of health personnel is pointed out to us as a major problem.

I know that the Round Table will address

many of those issues, and we hope that the Commission will receive ideas as to policies. We want to come up with sound policies for Aboriginal peoples, but also we feel that there would be lessons to be learned by the non-Aboriginal world. This is particularly true in health and social services. So it is for the betterment of the whole community that we hope this Round Table will work and give its best effort.

Thank you very much. We are hoping for a very successful meeting for all and each of you. Thank you.

DR. LOUIS T. MONTOUR: Thank you, Judge Dussault.

I would like to call on Mr. Frank Rivers on behalf of the Squamish Nation Elected Council. He would like to say a few words to welcome us to Squamish territory, and we have tobacco for Mr. Rivers.

FRANK RIVERS: Thank you. I was asked to do a welcoming address, and I would like to keep it short. I was a little late here. Speaking of health, my sister who was supposed to give me a ride over was sick this morning, and I had to rearrange my travel to get over here.

I would just like to welcome in three

ways. One, I would like to welcome our delegates and representatives of the various First Nations on behalf of the Squamish Nation Council. I welcome you to the territory and hope your stay on our lands here is safe, and I let you know that you are welcome here.

Also, I pray that everyone returns home safely to your various homes and back to your families.

I would also like to welcome the work of the Commission. I know they have a wide mandate, and I welcome them in their endeavours here in this consultation process. I know in my travels that consultation is a very important aspect in First Nations country. In all the various First Nations consultation is very important, and I know the Commission here is doing it on a step-by-step basis and are going to do a thorough job.

I welcome the Commissioners, especially George, who I worked under and worked with in his previous capacity as National Chief. I would like to especially welcome George to our territories here and welcome him in his work here.

As the third part of my welcome, I would like to welcome the representatives and the submissions that will be presented here over the next few days. I

would like to welcome everyone in terms of their submissions and welcome the information that is going to be put across the table to the Commission. I know there are going to be various solutions presented, and I know there are going to be various answers to many of our questions put forward. I welcome that information.

Again, I would like to welcome everyone. Feel safe here, feel welcome, and I hope you have a very productive next few days. Again, I say this with all my relations.

Thank you.

DR. LOUIS T. MONTOUR: Thank you very much, Mr. Rivers.

Kwe Kwe, Wa'tkwanonweraton, Sewakwekon, Bonjour. Bienvenue à tout le monde. Greetings, welcome to all.

Elders, participants, Commissioners and observers, greetings and welcome to the National Round Table on Health and Social Issues. It is a great pleasure for me to be here today and to have the honour and privilege of serving as Round Table Chairman. I am thankful for the opportunity to contribute in any way I can to the historic work of this Royal Commission, and I look forward to working with all of you. Together, with good minds,

we can all assist the Commission in completing its important work.

Over the next few days we will be focusing our undivided attention on a number of important themes relating to health and social issues in Aboriginal communities, issues that have received much press coverage in recent days but little action over the years. By reviewing your agenda, you will see that our task is significant in terms of our making a major contribution to the work of the Royal Commission on Aboriginal Peoples.

This National Round Table is the third of eight-to-nine major focus sessions of the Royal Commission. As part of the Commission's public consultation and education process, we have an opportunity to make a historic impact on changing the reality of health and social conditions in Aboriginal communities today. We have an obligation to our future generations yet unborn to do our very best.

It is important, therefore, for us to understand, acknowledge and consider the testimony already provided to the Commissioners by individuals and organizations, Aboriginal and non-Aboriginal, right across the country. Although I personally have not

previously been involved with the Commission, I am informed of two documents soon to be published by the Commission: one document provides an overview of what was heard during the second round of public hearings; the other document synthesizes those views into a discussion paper.

There have been numerous reports, studies and surveys completed over the last 20 years, each with their own set of relevant recommendations. To what degree or extent have such recommendations been implemented? And what are the obstacles that must still be tackled? Presenters have referred Commissioners to examples that demand answers. Why must so many studies be undertaken and what is preventing the implementation of their recommendations?

To cite a few examples:

In Lac La Biche, Alberta, in June 1992 the Alberta Mental Health Association referred to a community that had 26 private consultants coming in, doing work and leaving -- 26 people at one time. They wondered why efforts had not been taken instead to co-ordinate the expertise needed and to focus on preventive measures.

The Swampy Cree Tribal Council and Health Centre in The Pas, Manitoba, in May 1992 described to Commissioners the obstacles they have been encountering

for almost 30 years regarding health transfer.

A study examining the extent and degree of alcohol and drug abuse in urban communities completed by the National Association of Friendship Centres in 1985 is "still being considered."

Recently, we have seen the pain and suffering endured by the Innu children of Davis Inlet, and what we know about Davis Inlet continues in every Aboriginal community across the country.

Many presenters noted that, although a major impediment is a lack of resources -- financial, human and physical -- there are other barriers. Aboriginal women appearing before the Commission spoke strongly about family violence issues and about the need for healing the individual, the family, the community and, ultimately, the nation. But what is preventing the application of these Aboriginal-designed strategies from being implemented? Aboriginal youth have expressed in very clear terms their concerns about the future.

Dennis Peters, a student at the Crocus Plains Secondary School in Brandon, Manitoba, said: "You should provide children with examples of the right things to do: teach kids how to live, not how to die."

The Commission was also told that there

will be no fundamental change unless, and until, cultural identity and cultural wholeness is restored. The further message that comes through is that no health or social issue can be "cured" if the problems are approached in a piecemeal fashion. Health and social issues must all be addressed as part of a systematic understanding of the links between oppression and self-destruction, and they must lead to culturally-appropriate means and sites for change and recovery.

Over the next three days we will hear from First Nations, Inuit and Métis peoples sharing descriptions of their initiatives in changing things in their communities. By understanding more about these initiatives and other models, we will have an opportunity to further the dialogue on content and priorities that will shape the recommendations of the Royal Commission.

The Commission is about to publish its second discussion document: a major focus is on healing. Based on what the Commission has heard to date, there appear to be five recurring themes among the approaches to healing:

1. Parity in Medical and Social Service Standards.

The Yukon Medical Association, when

appearing in Teslin, Yukon, said: "The average Canadian is unaware of the degree of ill health in the Aboriginal population in Canada. It is a fact that in many areas of this country the health of Aboriginal peoples is equivalent to poor third world standards."

2. Focus on Self-Esteem.

Violet Mundy of the Ucluelet Health Committee in Port Alberni, B.C. said that "modern medicine (needs to learn) that self-esteem is an important part of being a healthy human being. By feeling good about yourself, by knowing that you have value, that your life means something, you will have the confidence to lead a healthy life."

3. Recognition of Traditional Healing and Traditional Culture.

The vision statement of the Native Child and Family Services of Toronto speaks to "providing for a life of quality, well-being, caring and healing for our children and families ... it does this by creating a service model that is culture-based respecting the supreme values of Native people, the extended family and the right to self-determination.

4. Holistic Approaches to Critical Symptoms.

Sophie Pierre, administrator of the Ktunaxa/Kinbasket Tribal Council said in Cranbrook, B.C.: "wellness encompasses all areas of human development ... if any of the facets is in need of healing, a complete range of related solutions is necessary."

5. Aboriginal and Community Control of Programming.

Henoch Obed, an Addictions Counsellor with the Labrador Inuit and Drug Abuse Program told Commissioners in Nain that "there must be a full recognition of (Inuit) Aboriginal rights and promotion of cultural health and pride, and that a strong Inuit identity must be a pre-condition to good effective emotional, spiritual, physical and mental health upon which all services must be provided."

The above references are just a sampling of what the Commission has heard.

And so we come back to our task, why we are here.

Although health and social issues are the topic of this Round Table, you must always bear in mind that health problems and social problems in Native communities are not end points in and of themselves but, rather, are symptoms of a larger ill. The approach to

a community with symptoms is no different from the approach to an individual with symptoms: identify and treat the cause, and the symptoms will go away.

What is this illness? To quote Dr. Clare Brant, quoting George Bernard Shaw in 1907: "Every disease has two causes. The first is pathophysiological; the second, political." As all of you know, Indian medicine is political.

It would do us all well to recall that our work and our recommendations, to quote Alma Favel-King from the "Treaty Right to Health" position paper, will be achievable only if the federal government is serious in addressing the health and social needs of Aboriginal people.

What is the illness?

Loss. Multiple losses. To quote Bea Shawanda, "Multigenerational trauma and grief." Loss of ways of life. Loss of language. Loss of ceremonies and traditions. Loss of a land base. Loss of meaningful control over day-to-day life.

Despite this picture of multiple loss, there are reservoirs of strength and pockets of traditionalism still present in Native communities right across the country. There is mention by several of the

presenters of a renaissance of traditionalism burning across the land. It remains for us to nurture and fan this flame.

I was trying hard to avoid the word "culture." That, too, is one of our losses. As a simple, practical measure, we must remember that language is culture, and we should repeat here and from all the rooftops to all Native communities everywhere: Use your language; learn your language; save your language.

Canada must renegotiate a new social contract with its Aboriginal peoples, including a land base, economic autonomy and political self-control. Health improvements and social improvements will assuredly follow.

I hope over the next three days we can draw on our strengths and develop ideas and that these deliberations can be directly and practically applied to the benefit of all Aboriginal people.

With your knowledge, expertise and wisdom, we have an opportunity here to address the fundamental questions facing us today. We are at a historic crossroad. Over the next three days we have an obligation to our children to find and follow the pathway to reconciliation in this country.

I would like to proceed on to our Day 1 Agenda and Objectives and Introduction of Panel. If you would consult your program, our first order of business -- and we are a half-hour behind; we hope to catch up as the day goes on -- will be a panel presentation of discussion papers. We will have a break probably a bit later than what is scheduled here. We will announce that as we go along.

Dr. Jay Wortman will be moderating the panel discussion of the first two papers. Dr. Marlene Brant-Castellano will be moderating the Panel of Elders, from 10:15 to 12:00 on your program.

We will break for a luncheon keynote speaker in the Plaza Ballroom at the Plaza level. We will return here at 13:30 for a panel presentation of discussion papers moderated by Mr. Peter Ernerk.

We will have an afternoon break. Then we will have our first Round Table of the day. This will be moderated by Dr. Jay Wortman. That will be followed by a Plenary Session which I will chair, followed by a closing prayer from Mr. Glen Douglas.

This evening, from 6:00 to 8:00 in the Plaza Ballroom at the Plaza level will be a reception featuring a cash bar, cheese and crackers, and a

presentation by the Squamish Nation, drummers and singers. It will be a short performance. After that, you are free for supper on your own.

I would like to call on Dr. Jay Wortman. Dr. Wortman is a consultant, Community Health Services, AIDS & STD, Health & Welfare Canada, Medical Services Branch. He graduated with a Bachelor of Science from the University of Alberta -- and I won't say the year, Jay -- and Medical Doctor from the University of Calgary. He was awarded certification by the College of Family Physicians of Canada in 1988.

Ladies and gentlemen, Dr. Jay Wortman.

DR. JAY WORTMAN: Thank you very much, Dr. Montour.

We are running a little bit behind time, so the five-page speech that I wrote last night I will discard in the interests of preserving time for the discussion.

The one thing Dr. Montour didn't mention about my curriculum vitae is that, for 10 years before I went to university, I worked in construction in northern Alberta, from where I come. In the course of my duties with Health & Welfare, I travel extensively and speak to many, many Aboriginal audiences, and I usually introduce

myself by saying, "Before I became a doctor, I was a normal person for 10 years."

I do this because it breaks the ice and also because I have become very sensitive to the fact that we all bring very diverse experience, education and expertise to the discussion of health. I think we also bring very diverse beliefs and very diverse understandings of what we mean when we talk about health.

It was a great honour for me and I was very pleased to be asked to participate in this very important Round Table of the Royal Commission. I think the question of the status of health among Aboriginal peoples is a very important question. I think it is something that will require fresh approaches, new ideas, lateral thinking, and I think this opportunity here in this Round Table will be an excellent time to entertain new thinking, new ideas, lateral thinking, fresh approaches.

It is with great pleasure that I introduce the first panel. I will ask Dr. John O'Neil and Karen Ginsberg to come and join me at the table here now.

We will start with the presentation from Dr. John O'Neil who, I think, is known to many of you for

his work as a scholar and a professor at the University of Manitoba. Dr. O'Neil is a medical anthropologist, and he has done extensive work in the north, particularly with the Inuit. In the past he has done work that you may be familiar with in terms of perinatal, transportation of women from the north for birth in the south and the ramifications of that. Lately he has been working on the issue of environmental health and the threat of environmental toxins and the perceptions of Aboriginal people related to environmental health.

Dr. O'Neil will present to us a paper that gives us an overview of health issues and discusses some of the policy ramifications of those health issues for Aboriginal peoples.

Please welcome Dr. John O'Neil.

DR. JOHN O'NEIL: Thank you very much, Jay.

I would like to thank the Commission for inviting me to participate in this forum. This is certainly an honour to participate here. It is also a very humbling experience. With the collective expertise in this room, I feel quite challenged as well as being a rare opportunity to be able to lead off the discussion with the paper I have prepared for this Commission, which

I hope most people have had an opportunity to read. I am also very honoured to be here to talk to you today and, hopefully, contribute to these discussions.

I have the further honour, I think, and challenge of serving as your rapporteur for this Round Table. My task will be to sit quietly, I guess, although I was told this morning that everyone has an opportunity to talk so perhaps I won't be as quiet as some rapporteurs. But it is my task to listen to the discussions, take notes, and on the last day of this Round Table to try to provide you with some synthesis of what has transpired.

Today what I would like to do is just pull out some of the key themes that I tried to address in my paper, which I think are issues which surround the topic of Aboriginal health and need to be taken into account in framing these issues, thinking about them, and in thinking about policy development change in this area and resolutions for improvement of Aboriginal health status across the country. In the interests of trying to bring the agenda back on time, I will abbreviate my comments. I anticipate that most people have had an opportunity to look through the paper and, if you haven't, you will over the course of the meeting.

One very important theme that Mr.

Erasmus mentioned in his opening remarks this morning, which I tried to deal with in the opening of my paper, is the issue of paradigms and perspectives in the field of Aboriginal health and in the field of Aboriginal issues in general. Mr. Erasmus pointed to the different paradigms that Aboriginal people and non-Aboriginal people have about health and healing, what constitutes health.

By nature, paradigms are not easily melded or brought together. Paradigms, by definition, are the way in which people organize their worlds, think about their worlds, give meaning to their worlds. These different paradigms, I think, will underlie our discussions over the next several days.

Within the non-Aboriginal health and social service communities, I have also tried to point out that there are different paradigms that underlie our discussions. There are biomedical paradigms, public health paradigms, social science paradigms, all of which create conflicting perspectives which, again, in terms of the research that goes on, in terms of the interpretation of the data that is available to scholars and academics, is an issue which I think will be evident in some of our discussions.

A second important theme that I have

pointed out in the paper, which has struck me most dramatically in the last several years -- and I mention an experience I had in Australia last year where consultants from Poundmaker's Lodge and the Nechi Institute in Alberta were speaking at the Australian Public Health Conference and then at the Healing the Spirit worldwide conference that was held in Edmonton this past summer, to bring into the public arena the incredible development that is going on globally in the area of Aboriginal health and the exchange of ideas and strength and potential for very innovative approaches to some of these problems that are occurring through the cross-fertilization that is going on globally among indigenous peoples. Again, I think this is something we must keep in perspective.

I also in my paper tried to describe what I have referred to as truncated historical descriptions of Aboriginal history. I use the example from epidemiological discussions of falling infant mortality rates. Infant mortality rates, of course, are always used to reflect underlying socio-economic conditions, and the standard picture of Aboriginal health using infant mortality rates is to show, beginning in about 1925, very high infant mortality rates in the Aboriginal community,

falling to a point where they are still very much of a problem but closer to the national standards today. I think this is one example of the way in which our efforts to represent conditions in a particular population truncate the historical reality.

I mention in my paper that over the last several hundred years the impact of infectious disease on population decline, really a demographic disaster that occurred in North America, is a reflection of contact with Europeans, contact with European-introduced disease. As Mr. Erasmus mentioned this morning, the best understanding we have of Aboriginal health conditions in the pre-Columbian era is that, in fact, these were well-integrated and very healthy societies.

Another theme that I think is very important is what I would refer to as fourth world health conditions. The epidemiological evidence we have indicates that not only are rates of infectious disease continuing to remain high in Aboriginal communities, but that we are seeing a dramatic increase in chronic illness conditions. Diabetes is a very serious problem; cardiovascular disease is increasing; and, until recently, Aboriginal communities were reasonably well-off in terms of cancer, but there is disturbing evidence to suggest

that cancer, as well, is beginning to increase.

By fourth world health conditions, I mean that epidemiologists are fond of describing the epidemiological transition that has occurred in the developed world. In the third world or developing world infectious disease is still the primary problem and, as societies industrialize and develop, infectious disease disappears and the problem becomes one of chronic health conditions

-- cardiovascular disease and other conditions.

In fourth world health conditions, Aboriginal people suffer, in a sense, the worst of the developed, under-developed and urban modernizing kinds of condition. Infectious disease remains high; chronic health conditions are increasingly a problem; and the kinds of social problems that are of concern to all of us

-- domestic violence, violence in communities, anomie, suicide that is alluded to in many of the papers -- characterize a health picture that is not found except in indigenous societies globally. You find the same kinds of health conditions in Australia with Aboriginal people; you find the same kinds of health conditions in northern parts of the Soviet Union with indigenous people; you find the same kinds of health conditions throughout the

Americas.

I have also tried to discuss in the paper what I would refer to here as the theme of colonial surveillance systems. Scholars have begun with some of the work done in France with people like Michel Foucault, a social philosopher, who have looked at the human disciplines -- that is, the social sciences, public health, criminology, et cetera -- as regulatory mechanisms that provide a picture of society and control the operations of different segments of society in ways which are perhaps not transparent and which perhaps we don't fully understand. The way in which data is collected on health conditions in Aboriginal people, I would suggest, reflects this kind of colonial history which we talk about in various other areas, but which I think we need to address very seriously in the area of public health surveillance in Aboriginal communities.

We are aware at this conference, and I am sure we will talk about the issue of status or reserve Indians and Inuit. The statistics reflecting their health conditions are well-developed and, hopefully, fairly accurate, but for urban Aboriginal people, Métis, et cetera, we lack information in this area. This is an important issue, but the way in which we approach the

collection of that information and the way we approach the interpretation of it and the way we approach the dissemination of it are critical issues that are surrounded by important political concerns. I think we need to develop new approaches to public health surveillance which reflect Aboriginal concerns.

I have also raised the theme of community portraits in the paper. I first had this really brought home to me several years ago by some of the graduates from medical school, Aboriginal physicians in Manitoba, who had during their student days sat in lectures that I and some of my colleagues had given, where we had spent an hour flashing blue slides of health conditions on a screen before the medical students, indicating the various rates of health problems in Aboriginal communities, all of which were anywhere from two to ten times as high as the Canadian national population. One of these graduates, who is here today, was asked to participate in these first-year medical lectures. She made the very important point that, when she was an undergraduate and sitting in the audience, the impression she was given of Aboriginal communities was one of a sick, disorganized society. This overwhelming evidence, obviously, is important in order to redirect our energies in developing and improving availability of

resources and programs for Aboriginal communities.

As an exercise, it presents an image that we need to be concerned about. This medical graduate, young physician, talked to the first-year medical class about Native communities as healthy places, as places where family was important, as places where people enjoyed their lives, and tried to, in a sense, counter this somewhat stereotypic picture of sick, disorganized communities that public health epidemiology can't avoid.

Another important theme I have tried to address in the paper is what I refer to as the culture of science. Science is often assumed to be value-free or apolitical, that we collect information and the facts speak for themselves. This is clearly not the case. Science is very much a western enlightenment in the history of European cultural development, embedded in the enlightenment period, and the values of science reflect that culture history. We need to reflect on that as we think about science and its relationship to resolving the problems we are talking about.

I talk about what I refer to as medical monopolism versus medical pluralism. I think Canada is a rare society where medical pluralism is not reasonably widely accepted. In Britain, for example, homeopathic

medicine is state-supported. The state insurance system supports people. In Canada we are only recently beginning to look at the licensing of midwives as alternative practitioners in an otherwise medically dominated field. I think the important contribution that traditional medicine is making, not just to Aboriginal societies but in some areas there are efforts to make traditional medicine available to non-Aboriginal communities and individuals, is a change in Canadian society which we need to address, to embrace traditional medicine and the contribution it can make to society widely, not just to Aboriginal communities.

As to diversity in traditional medicine, clearly there are commonalities across the Aboriginal world, in the Americas, in the kinds of principles that the Elders speak of and that the various healers in different communities talk of, but there is tremendous diversity. With the people that I work most closely with, the Inuit, their history of traditional medicine is quite different from other parts of Canada. Other communities in Canada, as all of us are aware, for reasons associated with colonialism but nonetheless clearly embrace Christianity and the values implicit in Christianity. So we have to be sensitive to this diversity and how we

address changes in this area.

Traditional medicine has cultural foundation. Traditional medicine is not the parallel institutional complex to western medicine that we think about in academic terms. Traditional medicine is the foundation of Aboriginal culture. Issues of social justice are embedded in the concepts of medicine. As one of the speakers this morning mentioned, medicine is politics. That is true, I think, fairly generally, but particularly in Aboriginal communities.

I also would point out, in looking at the history of development of services in this area, that this is a very brief historical period. In titling my paper, I made the somewhat grandiose choice of "Health Policy for the Next Century", and I expect some people may challenge that, wondering why it is not for the next year. In reviewing the history of development of services in this area and in looking at the Indian health policy in 1979, the tremendous growth and development that has occurred in the last decade

-- the involvement of Aboriginal communities, the kinds of innovative programs that we are going to hear about over the next several days -- has all come into place in the last couple of years.

I think we need to be very positive and optimistic about what is happening. We need to focus on the incredible development that has occurred. Although people are suffering and are in pain and the kinds of solutions that, hopefully, we will contribute to over the next couple of days are very necessary, I think the history of damage has been several hundred years, and the resolutions to these problems are not going to occur overnight.

I also mention the difference between what I refer to as official versus grassroots development. The transfer initiative, which other speakers will address in detail, is one of a government-mandated directive where change is part of a federal program of transferring administrative responsibility and all the issues surrounding that, of treaty rights, resources, et cetera.

I tried to focus in the paper a bit on the grassroots or non-official development that has occurred. In urban areas particularly, in areas where this kind of transfer and devolution is not occurring, Aboriginal communities have taken control over the community health system and have developed initiatives that I think are embedded in broader principles and give

us a clear picture of the way in which this kind of development can occur.

Finally, as Jay is getting nervous here and pointing to "15 minutes" on his paper, I would like to mention three final themes which I think are very important to guide us in our discussion.

One is not something that I mention in my paper but, in reading the other papers, I think it is critically important, and that is the issue of jurisdictional conflict. The issues around the provision of services and the development of the infrastructure, the provision of quality lifestyles in Aboriginal communities and the jurisdictional problems between federal, provincial and municipal governments, I think, is one that really requires concentrated attention. Until there is some resolution in this area, I don't think we will move very far forward.

The second-last theme is sustainable economic development. We are going to focus over the next several days -- and I was struck by the variety of papers -- on services, on solutions to problems. The problems will not go away until underlying economic infrastructural community development occurs. The Davis Inlet situation was mentioned this morning, and I mention in my paper that

in the 1970s children were sent to a Philadelphia treatment centre from Shamattawa in Manitoba. The problem is still occurring despite the development of services. That underlying development, obviously, is important.

Finally, I think the most important theme that emerges in this area and which will really be the focus of our discussions is the community healing that is going on. Broad discussions are beginning to occur across the nation in Aboriginal communities, bringing together people at the community level, to begin to address the kinds of problems and concerns that we are going to be talking about. The power in that movement and the need for those of us who are in the establishment, in the public health field, in the academic field, in the service field and in government to support both in terms of resources and in terms of our energies and research, et cetera, that community healing process, I think, is a key to changes in this area.

Thank you very much. I look forward to trying to summarize our discussions over the next couple of days.

DR. JAY WORTMAN: Thank you very much, Dr. O'Neil.

Our next speaker will be Karen Ginsberg

who will present Discussion Paper B in your program. I will just point out, before I introduce Karen, that Discussion Paper B was written by Rosemary Proctor who could not be with us today. Rosemary Proctor was a Policy Advisor in the Ontario Ministry of Health and is now the Deputy Minister of Community and Social Services, so her duties have precluded her ability to attend here.

However, Karen Ginsberg is eminently qualified to present this paper and knows Rosemary Proctor quite well and shares her views. Karen Ginsberg is an Assistant Director of the Information Management Unit for the Royal Commission. She was educated in political science from which she holds a Master's Degree.

Her thesis explored the relationship between health and economic development for Aboriginal people in northern Manitoba, and she followed that thesis work with additional training in the Liverpool School of Tropical Medicine where she participated in an experimental approach aimed at seeing what perspective social scientists and other non-medically qualified health professionals could bring to the study of medicine.

I think it is entirely appropriate that Karen is presenting a very important paper for our discussion, one that challenges our definitions of what

health is and asks us to expand our consideration to what we have, in the past, looked at in terms of how we view health and the paradigms that we have brought to bear on health issues. I think this is a critically important issue, so please welcome Karen Ginsberg.

KAREN GINSBERG: Thank you very much, Jay.

As Dr. Wortman has explained, I am not Rosemary Proctor. I do, however, bring her very profound regrets that she couldn't be here personally and her hopes that her ideas can in some way contribute to the discussion of how to overcome barriers to substantive change in achieving health in its broadest sense for Aboriginal people.

Given that her topic, "Changing the Way We Think About Health", is so key to being able to act on the lessons learned that Georges was referring to in his opening remarks, I would like to deliver her remarks, albeit in a somewhat abridged fashion, as Rosemary herself has conceptualized them.

She begins by noting that on January 10 of this year the New York Times contained an article announcing that the prestigious National Institute of Health was establishing a new Office of Alternative

Medicine. According to the article, this new office will "begin seeking proposals from researchers who want to explore the merits of therapies outside mainstream healing." The Times noted that "some researchers hail the initiative as visionary, but others liken it to governance by horoscope." The first director of the office is a paediatrician who is familiar with American Aboriginal medicine through his Mohawk mother and through work on the Navajo Reservation.

She says: When I saw this article, it seemed to me a very significant step on an important debate about understanding health and health policy.

Our society is really actively engaged right now, and has been for some years, in changing the way we think about health, illness, caring and curing. What we are doing is changing the paradigm which defines health and disease, how we think about health and what we do about illness.

I have chosen to use the idea of a paradigm in this discussion because I think it is useful in analyzing and understanding the subject. I think it is useful to help us understand the changes in our approach to health and medicine if we cast it in the language of paradigmatic thinking.

In this sense, a paradigm is a shared body of theory and practice that defines a certain science. This means that the people who operate in the particular science agree upon what are the important theories, experiments, bodies of facts, for that science. They also agree about what are the outstanding issues they need to investigate. The paradigm defines their intellectual world.

Occasionally, scientists operating in one paradigm change the dominant way of thinking and replace it with a new framework. The process of changing from one dominant body of theory to another has been likened to a revolution. An example is the change Galileo precipitated for western thinking when he "discovered" that the earth revolves around the sun, rather than the sun around the earth. It certainly took a while for people to accept and digest that change. It meant looking at the world and describing things people observed in completely different ways.

About 30 years ago, Thomas Kuhn wrote a very influential book called "The Structure of Scientific Revolutions." While Kuhn's book is about the history of science, it provides a useful way to think about human health.

What Kuhn says is that a revolution in scientific thinking occurs when the theories scientists use to explain reality and the ways they practise their science become unable to deal with critical questions or issues relevant to that science. The existing ways of thinking and working do not explain things that happen and do not explain observations that scientists make. The results of experiments don't somehow fit the expected pattern.

When this begins to happen frequently, scientists start to reformulate their theories to try to get more accurate or complete answers to their questions. They also go back over other contradictory evidence that has accumulated over the years but has been neglected. They reassess it. But they don't abandon the existing paradigm -- the body of theory and practice -- until a new one emerges to replace it.

This process of developing a new paradigm takes time. And since it is essentially a process of redefining how one sees the world, it is often resisted by people who prefer the old definitions. Adopting a new paradigm is a sort of conversion to a different way of thinking.

What happens when we apply this

framework to the issue of human health?

In the western world -- that is, the white western world -- starting in the early 1800s, scientists began developing what we call the "germ" theory of disease. This theory explained that illnesses are caused by specific germs and other causal agents.

This theoretical framework or way of defining and explaining disease was successful in many different ways. It fostered rigorous training of physicians, objective interpretation of symptoms, and extensive research into the causes and cures of disease. Over many years the causation paradigm has been able to deal with ever more challenging questions or demands, including organ transplants and in vitro fertilization as just a few examples.

A really important aspect of the causation paradigm is the way it defines disease. In this framework disease has tended to be defined as a dysfunction or an inability to function, the cause of which originates outside the individual. In short, it's not your fault that you're sick. The sickness comes from outside you. Health is then defined as the absence of disease, a relatively neutral state.

Over time, these definitions have also

resulted in the tendency to identify everything that is not health as disease. Addictions have become illness, bizarre behaviour has become illness, disability and aging have become illnesses. All these conditions are then supposed to be treated by the medicine or intervention prescribed by the dominant paradigm.

For nearly two centuries this paradigm has developed and has increasingly influenced the way people throughout much of the world think about health and disease. It fundamentally influences what we call health care, or what we call something else, such as social services or religion.

However, the paradigm has not been without challenges. In fact, over the past 30 years or more, people have been criticizing many aspects of the causation paradigm, suggesting that it is not necessarily or always valid or that it is too narrowly conceived. It is not able to deal adequately with the experiences of illness in contemporary society.

For example, at one time the development of scientific medicine was generally credited with a substantial improvement in life expectancy. More recent studies suggest that the decline in the mortality rates actually started before the rise of modern medicine.

Increases in life expectancy can be more accurately explained by improvements in nutrition, housing, contraception or sanitation. Other population studies indicate that patterns of illness and morbidity are more successfully explained by environmental factors such as occupation, socio-economic status, and gender than by access to health care or treatment of a disease.

In several areas recent studies have identified trends toward greater disparity in mortality and morbidity rates within societies. That is, there is a trend toward reduced mortality in the higher socio-economic classes and increasing mortality in the lower socio-economic or occupational groups.

In the mental health field, critics question the utility of the causation paradigm in understanding behaviour or in prescribing effective treatment. Including so-called mental illness in the purview of the paradigm is seen as misrepresenting the nature of human experience and problems of living.

The causation paradigm was never situated in a social or economic context. It is generally seen as being timeless and without boundaries because it is rooted in proven scientific evidence, physiological facts. It does not acknowledge that, as modern medicine

has spread around the world and has become the dominant paradigm, it has engulfed and in many cases discredited and eliminated traditional forms of thinking about health and health care in different parts of the world. Much as dominant western, industrialized culture has spread its hegemony, the subculture of health care and thinking about individual and community health has also spread.

Dr. David Skinner of the Yukon Medical Association, who made a presentation to the Royal Commission in Whitehorse some months back, articulated this view very clearly. Dr. Skinner says:

"What we have to remember here is, we have a white ethnocentric health care system which we have brought to the native people, and we are asking them to see it and do it our way. ... It is our belief, though, that because our white man's medicine is very technical-oriented, very symptom-oriented, very drugs- and surgery-oriented, it lacks something that native medicine has and which we desperately need but don't practise: spirituality, or

a spiritual component."

One criticism of the paradigm is its narrowness: human experience is being fit into too tight a mould. The paradigm began to be constructed at a time when European living standards were improving dramatically. The newly developing paradigm was not necessarily aware or conscious of the significance of these improvements. Nor did the causation paradigm confront the problems associated with efforts to eradicate a culture. It can explain little about the associated problems of family breakdown, violence, suicide, alcohol and drug use. It does not embrace the compounding problems of poverty, lack of employment or powerlessness.

Gradually, a new or modified paradigm is emerging to challenge the firm premises of specific causation. I tend to think of this emerging body of work as an environmental paradigm because it explains illness and disease in terms of all aspects of our world environment and of our bodies themselves. In this environmental paradigm, health and illness are no longer opposites, but more points along a continuum.

The environmental framework sees human beings as adapting to their environment in effective and ineffective ways, and simultaneously altering their

environment in beneficial or harmful ways. The environmental framework includes the psychology of humans and society, the vulnerability of individuals to specific diseases, the interaction of people and their environment. Health has become a goal statement: the presence of physical, social and mental well-being. The question has become not what is the cause of disease but what are the determinants of health.

Disease is less frequently seen as being caused by specific agents and more identified as emerging from the interaction of the individual and the social environment.

In turn, the mediating forces, those which promote health and prevent illness, include social supports, employment, reduced environmental pollution, and so on. These, as well as health care, are seen as legitimate subjects for research in the areas of health and illness. The individual's social and physical environment may be more appropriate for intervention than the nature of the specific illness.

The process of reconsidering an old paradigm, rejecting it, and developing a new one is filled with conflict. There is a strong tendency for people working in one paradigm to ignore evidence that contradicts

their version of reality. One obvious example is the well-documented iatrogenic effects of medical treatment -- that is, the fact that drugs and treatments can, and do, cause illness. There is a tendency for the medical treatment system to adopt medical procedures and continue to use them despite documentation that they are ineffective or even harmful.

Conflict over public policy occurs as practitioners or proponents of the two paradigms compete for support and resources. This is a paradigm shift which is not limited to scientists and laboratories. It engages the public individually and collectively. It engages us in our communities, in our particular historical and social consciousness. Consider the strength of the causation paradigm and the professions and institutions it has engendered. Consider the importance of health to people generally. The struggle for power, for the influence to define the meaningful questions, methods and theories is understandable.

However, this may sound too much like a conflict between two quite opposite ways of viewing reality. Rather, the situation is probably closer to creating a new paradigm by incorporating aspects of the specific causation framework and aspects of the new

insights into a larger whole. This process enables us to test what more effectively answers the perplexing questions of our time and our communities. Hopefully, it will also enable us to add a sense of cultural and historical reality to our so-called scientific knowledge.

Health promotion and prevention have become key concepts in the new paradigm. Initially, the definitions of prevention were highly individualistic. They reflected a linear relationship between, for example, lifestyle and a person's risk for illness -- that is, the relationship between cigarette smoking and lung cancer, for example. Over time, health promotion and prevention are becoming more social in nature. They are seen as community, group and collective efforts.

In the new paradigm there is scope for individual responsibility for health, both in terms of personal health and also more generally. For example, when the occurrence of disease is correlated with lack of exercise, the individual is seen to bear some responsibility for this behaviour and, to some extent, for the presence or duration of the disease. In the more general case of morbidity that is correlated with environmental factors, such as poverty or lack of nutrition, the paradigm suggests that society as a whole

is able to affect health. Collectively, we have a responsibility to prevent disease or improve the chances of achieving health.

Efforts to recover or rediscover aspects of traditional healing and bring these to bear on modern afflictions are also expanding the new framework. Healing circles, for example, may illustrate the more effective linkage of people's spiritual and social well-being with the physical and emotional problems they experience.

In efforts to develop a new paradigm, the dominant culture is searching for new ideas. People may well be too conditioned by the dominant mode of analyzing and explaining reality, and this itself may be a barrier to thinking creatively about alternatives. Nevertheless, this creative work is going on in communities in Canada and elsewhere. The work of the Aboriginal communities in finding ways of integrating traditional understanding and healing with modern medicine may assist not only the people in these communities, but also help further the development of new ways of understanding human health and the challenges of caring and curing.

Which brings me back to the New York Times article. To me it represents a successful challenge to the power of the established paradigm because it

recognizes there are other questions to pursue. It helps bring mainstream resources to answering questions that are important to the new paradigm. It illustrates the importance of the bridge between traditional understandings and approaches to health and those which are embodied in the dominant culture. While it certainly may threaten the firm views of some researchers, to others it represents the creative challenge of addressing questions that are important to our communities. It shows that the definition of health and illness is an open question, one in which many of us may usefully and creatively engage.

Thank you very much.

DR. JAY WORTMAN: Thank you very much for your presentation.

We will have a period of discussion now. I will take some direction from our esteemed Chair in terms of timing. Dr. Montour tells me that we will have 10 or 15 minutes for discussion.

I will just briefly explain the rules of the game for you. Some of you have white badges on. That means that you are an invited participant, which means that you are invited to participate in the discussion. The discussion will go on for 10 or 15 minutes

from this point onward, and you will have access to three microphones in the room.

If I see no white badge, unfortunately I will not recognize you and your input. If you feel that you should have a white badge, please contact the people at the desk outside and make your case there; I am afraid that I can't help you in the context of this discussion.

I would at this point invite you to come to the microphones and direct questions or make points to the speakers and to the issues that have been presented to you just now. I will exercise some discretion from the podium here if I feel that you are making a longwinded political speech or if your questions or comments are not germane to the discussion at hand. I will try to do this in a respectful way because I think we all have important contributions to make to this discussion.

While you are collecting your thoughts, I, in particular, have some ideas about what has been presented and the importance of this as a foundation for the discussions that go on. I will just briefly direct a comment to the speakers about that.

What I heard here and what fits quite well with my perceptions is that we have two issues. We have one issue of the treatment of injury or illness, and

the other issue is the prevention of injury and illness. I think there are two quite clearcut problems that we have to grapple with. On the one hand, a lot of resources, control of resources, access to resources, and so on, and a very big discussion takes place in terms of what we do about treatment.

In the past and up until now, I think we have tended to neglect, probably for want of ideas or courses of action, what we do about prevention and health promotion.

I will recognize the speaker at microphone No. 1.

KEITH LECLAIRE: Thank you, Jay.

I am Keith LeClaire from Kateri Memorial Hospital in Kahnawake. I just want to thank both the presenters.

I think the main thought that was coming out -- and maybe John can reply. I am hearing the fact that, when we are talking holistic health, what we are actually saying is that, in fact, Indian health is more political and social issues than actual medical issues. That is the first point that I captured from a policy aspect.

Also from the community aspect, what I

am also gathering is the idea that, when you go into community healing, what you are looking at is developing the self-esteem of an individual to make that person better. Is that the way I have understood it up to now?

DR. JOHN O'NEIL: First of all, it's nice to see you again, Keith.

The point I was trying to make in the paper about the way in which health in Aboriginal communities is embedded in broader social, political, economic contexts is that in western society we tend to specialize and isolate issues. There has been a real trend in that direction over the last couple of decades, although there are some interesting changes toward things like healthy public policy and that kind of thing more recently, but we do isolate.

As Dr. Wortman has just said, we focus in on -- we call it health, but we really are talking about illness all the time. We focus in on illness and the treatment of illness, as separate from everything else that is going on -- separate from education, separate from social development, separate from economic development -- and our institutions reflect that -- Indian and Northern Affairs, Health and Welfare, Social Services, et cetera.

As I understand the principles of

traditional medicine, for example -- which is a very limited understanding; I by no means consider myself an expert. My understanding is that it is very much embedded in a way of life -- that is, the way in which communities are organized, the expectations around appropriate behaviour, the way in which one conducts oneself, the way one lives one's life. Health is reflected in that way of life.

That is an approach, I think, which is encompassed within the politics -- not the politics in terms of the kind of political battles that go on, but the organization of a community, the way in which communities regulate themselves, the kinds of justice system they have, et cetera. That was the point about politics.

KEITH LECLAIRE: Thank you.

DR. JAY WORTMAN: The speaker at microphone 3.

ELDER GLEN DOUGLAS: About the political aspect of medical treatment, I see it as political because, if I was to make a triangle and it starts from the top with the monarchy and the Prime Minister and on down to the Minister of Indian Affairs, as it dribbles down to us, what we receive at the bottom is what I call

the dribble-down disease.

Further to that, I understand there is a bill that is in the hopper or has had its first reading already. I think it has something to do with medicine patent law. The pharmaceuticals are introducing it into the house of Parliament to prevent the use of Native traditional medicine.

That is very ominous to us. This, I believe, is the result of the North American Free Trade Act which was passed while they were arguing over the referendum last fall. No one hardly knew that it was passed. I just happened to get a copy of it.

Because of this, the pharmaceutical companies of the United States may have influenced our Parliament to start passing this bill. This is very ominous to us.

What do you have to respond to that, as a political aspect?

DR. JAY WORTMAN: I will just interject here. For the record, Mr. Glen Douglas was the speaker at microphone 3. It was my error not to ask each speaker to identify themselves for the record.

Did you have a particular speaker you wanted to address your comment to?

ELDER GLEN DOUGLAS: To either one.

DR. JAY WORTMAN: Do either one of you have a comment about the drug patent law and its influence on traditional medicine?

KAREN GINSBERG: I am sorry, Elder Douglas, I am not familiar with the aspect of the bill that you are talking about. Is it intended to prohibit the use of traditional medicines in your own homes or in your own communities?

ELDER GLEN DOUGLAS: That is correct.

KAREN GINSBERG: How could that possibly be policed?

ELDER GLEN DOUGLAS: I don't know. If it is passed, it is legislation. Of course, if it is legislation and you violate that, that's a legislative crime.

DR. JAY WORTMAN: I see that we have another speaker at microphone 2 who may be able to shed some light on the issue that you have raised. I will recognize the speaker at microphone 2. Please identify yourself for the audience.

MARIE FORTIER: Thank you, Jay. My name is Marie Fortier. I am Acting Assistant Deputy Minister for Medical Services Branch in Health and Welfare.

I am, by far, not an expert on pharmaceutical policy, but I think I may be able to shed some light on Bill C-91 which, indeed, has been passed and has received royal assent, just before Christmas or right after; I am not certain.

I would like to reassure you that it will not do what you are afraid it might do. All Bill C-91 does is extend patent protection for drugs that require that level of approval by government for a longer period than was the case earlier. That is the only effect it will have. It doesn't change the scope. It doesn't cover new drugs; it just extends the period during which certain drugs are protected by patent. Therefore, during that period generic manufacturers cannot be licensed to produce cheaper versions.

DR. JAY WORTMAN: Thank you for that clarification.

I would like to bring the discussion a little bit back toward the issues that were raised in the papers just now. If anyone has comments directed at those issues, please step forward.

I think what we have heard in the first two presentations will form a very important basis for the discussions later on. What we have heard, I hope,

has challenged what we might be thinking in terms of definition of health and health issues, and challenged it in such way that we have broadened our thinking.

The participant at microphone 2 has the floor.

ELDER GLEN DOUGLAS: Thank you for that reassurance.

DR. JAY WORTMAN: Thank you. We will now go to microphone 2. Please identify yourself for the audience.

DAVID NEWHOUSE: My name is David Newhouse. I am a Professor at Trent University in the Department of Native Studies and the Chair of the Joint National Committee on Aboriginal AIDS Education & Prevention.

I have a question about the change in paradigm. It seems to me that, if we are going to make any headway in beginning to deal with health within our own communities, we need to accept the new definition of health that you have prescribed here.

I was quite amazed, in reading the paper and in listening to what people are describing now as the environmental paradigm and the description of health as being not necessarily the absence of disease but the

presence of physical, social and mental well-being, that we seem to have changed the definition. To me, the fundamental question is: Are we willing, as policy-makers, to accept this definition of health as the basis for future policy work instead of the old paradigm, considering that most of the work in this field is dominated by physicians who are, in most cases, very unwilling to accept this definition of paradigm?

KAREN GINSBERG: Professor Newhouse, it seems to me that, in many respects, it is maybe not a new definition; in fact, it is the definition of health that has been in operational use by the World Health Organization for many, many years.

I think what is happening is that, with the spiralling financial costs of running the health care system as we presently know it, there is a confrontation that is just unavoidable at this time which forces a reflection on making that definition really operational. We have had the definition in place before, but we have never acted on it. We have always looked at the health care system in terms of illness.

We can no longer neglect the body of scientific evidence and the body of other evidence that has been accumulating which would suggest that the broader

definition is really what will make the difference. By broadening the definition, we are not necessarily adding to the cost of the health care system, but in many ways are probably going to be able to reduce some of the cost.

DR. JAY WORTMAN: Thank you. We have a participant at microphone 3. Please identify yourself.

ANNIE TULUGUK: I am Annie Tuluguk. I am the General Manager of the Innuulitsivik Hospital in Povungnituk in northern Quebec. I am an Inuit.

I would just like to say, concerning policy on health, that we have been governed in northern Quebec by the James Bay Agreement. We have all the institutions that are financed and given to us that were agreed upon by the James Bay Agreement between the provincial government, the federal government, Quebec Hydro and the Inuit and the Cree.

We have the highest rate of youth suicide. We have the highest rate of STD. Family violence and alcohol abuse is very rampant in our communities.

We were given a hospital under the James Bay Agreement, and we have a large budget for health services. However, under the James Bay Agreement we were not given any kind of community activities, no recreation

for youth. No programs were given under the James Bay Agreement to help the community to live a healthier life.

I feel that all the problems that we are having in our communities with the youth, with the women, with the alcoholism, are due, in part, to the lack of activities which were not provided for by the James Bay Agreement. We have to scrimp and scramble to get money to operate these youth centres or to send women to programs where they can get help.

DR. JAY WORTMAN: I think the point you raise very clearly illustrates the issues that are being presented here. There has been a tendency in the past, and a continuing tendency, to focus on the treatment and the delivery of services for injuries and illnesses that are occurring and have already occurred, and we tend to neglect the whole, much broader and, I think, more important issue of prevention and health promotion, the things that go on in the community that give rise to these things.

Thank you very much for making that comment.

Dr. Montour is cutting off the discussion right now -- and it is a cowardly thing for me to blame him, but he is responsible for keeping us on

time. I am sorry, I should have pointed out that that would be our last participant for this part of the discussion. Please bear in mind that this program goes on for the next two days and that there will be plenty of time for you to bring your questions and concerns forward.

Thank you very much for this portion of the discussion.

DR. LOUIS T. MONTOUR: I would like to thank Dr. Wortman, Dr. John O'Neil and Karen Ginsberg for their presentations, and thank the questioners.

We are doing not too badly. It is 10:29. I would like to call for a 10-minute recess and to reconvene here at 20 minutes to eleven.

--- Short Recess at 10:29 a.m.

--- Upon resuming at 10:49 a.m.

DR. LOUIS T. MONTOUR: I will call the meeting back to order, please.

The next order of business will be a panel of Elders. Our moderator for this is Dr. Marlene Brant-Castellano. Dr. Brant-Castellano is a Co-Director of Research of the Royal Commission on Aboriginal Peoples. She will introduce our Elders.

DR. MARLENE BRANT-CASTELLANO: Good

morning. It is my pleasure and honour to introduce and moderate the session with Elders.

What we have described in the program is that this session is about traditional understanding of Indian, Métis, Inuit health and healing, the understandings which are held by Aboriginal peoples.

We have heard in the papers already presented this morning that health practitioners, theorists, thinkers, from the floor community people, a suggestion that there is within our traditional knowledge the key to health, not separate or independent from the good things which technology has brought, but very certainly the key to the healing of spirit which is the foundation of health.

Just by way of introducing the subject, I would like to tell you a couple of short, short stories.

One is from a recent conference that I was involved in where someone was describing her own journey through residential school and separation from family and loss of self-esteem and suicide and despair. When she heard the drum and when she began to hear teachings, she began to believe that for her, perhaps, there was a life for her to return to, that there was a reason for her to turn her back on the despair and death

that she had been seeking. She said, "The Elders told me, 'Go back to your mother. You need to go home.'" She said, "I tried to figure out what that meant, and I thought they meant I should go back to Witwemakan (PH), but my mother was dead already. My mother had suffered premature death." So she couldn't understand what the instruction for her own health was all about.

She gradually found what the meaning of going home was. It was going home to her traditions, her culture, and she found that she had not one mother but many mothers, including Mother Earth and other Elders.

The other story is from my career as a teacher at Trent University. We had invited Elders to an Elders' Conference. There was a woman who was quite young then, Rose Layman, from Saskatchewan, who was fluent in Cree. Because we didn't have an interpreter, we asked her to interpret in the presentation of one of the Cree Elders from Alberta.

The session proceeded, and Rose was starting to interpret. At a certain point she broke down and cried. She was just sobbing. She said, "It is so beautiful what I am hearing, and I don't have the words to explain it."

That is the situation of so many of our

young people today. They are looking for their mother; they are looking for wisdom. They have an idea where it is, and they may even hear the glimmers of it in the words of Elders. They break down and cry and say, "I don't have the words. I don't know how to translate this."

What we are going to try to do this morning is to invite four Elders from different traditions to speak from the heart about health and healing and how they talk about that in their own languages, in their own communities, in their own world. What we will invite the audience to do at the end of the presentations is to engage with the Elders, picking up and speaking to one another but also speaking to you, to try to bridge that gap between the knowledge which resides in people whose feet are still firmly planted in knowledge and wisdom that is our heritage. We will try during this session to make some of those bridges so that both other generations and other peoples can understand what is being said.

Our first speaker -- and I will just go in the order that they appear in the program -- is Jean Aquash. Jean is an Anishnawbekwee. She has worked in partnership with Peter O'Chiese, and together they have been not only in Alberta but throughout Canada mentors and guides and teachers to people of many nations.

Jean and Peter make their home in Anawe, Alberta. Jean is recognized as being very knowledgeable about traditional ways and healthy lifestyles. She also works in Edmonton with the Bear Women and Associate firm.

I will call first on Jean.

JEAN AQUASH: I am excited. I was told that excitement and fear have the same body reactions, so I just prefer to say I am excited.

My Indian name is Kishabakumagakwee (PH). It means the beginning and the end of time woman. I come from Walpole Island in Ontario, and I have been living in Alberta since 1985.

My mom and dad were under arranged marriages, and I used to wonder why. My dad was Thunderbird Clan and my mother was Turtle. So in our people I take the paternal; that means I am of the Thunderbird Clan.

I didn't get to understand about this clanship until I began to look for the answers to my traditional past. I have been doing that in the last 20 years.

First, I want to thank the Creator for bringing us together, and I want to thank the spirits of the people that live in this part of the land for welcoming

us in and for the welcome that was extended to us earlier. I really give thanks to the spirits of the people here.

I want to thank the Royal Commission on Aboriginal Peoples for the invitation, and I especially want to thank Karen for making it possible for me to be here.

This is a very strong issue that we are about to talk about this morning on the concerns of child sexual abuse and the family violence and suicide. In my work, as I have gone to reach out for healing -- I come from a family of 18 people. Before most of the kids became five, there was death. Eleven people died before they were five, so that left us to about seven people. Right now there are only three women and three men left of the 18 people. There are many relatives that collected through that time.

I was one of the residential school children, and there is a lot of loss in that time of my life. As I look out for the answers to my life, I have never been one to stay with my family. I have always had to do things by myself and alone. But, being that way, I have come to a lot of answers, a lot of truth to what I understand today.

Because of traumatic experiences

throughout my life -- and I have had many -- my shift to a different way of living or a different way of thinking came through a sweat lodge and became a spiritual awakening for me in 1975. Since that time my life hasn't been the same.

I have been led to many coaches and teachers through traditional paths, ceremony after ceremony. Since that time, too, I have made a lot of spiritual commitments in fasting and sundancing, and I go to all the ceremonies every year since that time. I have never stopped, and I probably never will because that is my practice and my connection to a power greater than myself, and I believe it for me that way. It has given me a lot of truth in my life and led me to many, many good teachers and opening to many ways of thinking in my learning.

In my search for this life, as I came into my partner back in 1981, I knew he was a teacher that had handed down teachings from generation after generation. Those are the teachings that I was looking for and prayed for so that I could understand what life is all about. I know that the god of our understanding, no matter what name you put him by, gives to all his four colours of children. For me, to find my identity, I had

to look for whatever gift there was for me to receive, and I found it through the ceremonial circles and through the teachers in that ceremony to teach me what life is all about, the spirituality of living.

I am not the only spiritual person. Because I am two-legged, it doesn't mean I am the only one with spirit. It's the trees, the animals, the birds, the air, the waters -- everything about us is a spirit, and we are just evolved within each other.

I have come to understand that with a lot of coaching and with a lot of enlightenment through my teachers.

It's the old people that I believe in and their way of teaching. They have helped me to understand the value of living.

By going back into a relationship -- I was 17 years single. I had been married to a man before and through that marriage I have four kids, and I am a grandmother of 14 grandchildren and I am raising one. He is three and a half years old. I have had him since he was a month old. He is giving me a lot of ways of looking at my life, even up to today.

What was happening to me in the past while, maybe about four years ago I started coming down

a downshift into being negative again. By going down into a downshift, I knew that there was something I had to do. I have a really close friend who saw the change I was making from the positive back to negative again. Even through my spiritual practice I still couldn't help myself to bring myself up.

I went to a training program, Nechi Training it is called, and it has helped me to understand what a human being is through past dysfunctions. I finished that program, and it has really helped me to look at a deeper aspect of us.

What I really want to share with you today is that we are a walking medicine wheel. We are made of four parts. We are made of the mental, the physical, the spiritual and the emotions, the feelings. Inside of that component is the real self, the spirit self. It's only a vehicle of the spirit that is within us.

In order to get the holistic healing that we are needing, we need to look at our past, our traumatic experiences, in order that we can clean up and step forward. To do that, for me, I have understood it to have to be on a spiritual base. In the past, as I look at my healing journey, my first step was to think about my mind, go

amongst people who can project positive thoughts for me. I have tried the AA movement and the ACOA movement to help me project a better way of thinking.

From that point on, because I destroyed my body with many things, like drugs and alcohol, I went into a lot of other fasting, into vegetarian -- not so much vegetarian as the power of foods, how to cleanse your body of toxic poisons and mucous and a lot of stuff. But the hardest to flush out of the system is the drugs that I placed in it. So I went into a lot of fasting to cleanse that part of my body.

It also helped me to energize and rejuvenate the sluggishness that I have placed in my body at that time. I have learned to give a lot of energy and a lot of youthful agility to my body, and it also opened my brain. I have come to have more of a photographic mind by cleansing all the garbage out of my system. I wasn't as forgetful as I was when I was abusing my body. I came to have a very photographic mind, and I still have to this day. From time to time I still cleanse.

The last part of my healing journey is the emotions. That is the part that I act upon now and believe in. Through this training that I took in Nechi it has helped me to look at myself in a different way.

There is a personal growth program that they had that opened my eyes to the in-depth of me, what caused me to be more on the negative side.

It had a lot to do with the beginning of my life where I had to look back and felt that I was less then, not good enough, not lovable, and that nobody could be close to me and I couldn't be close to anybody -- a lot of things I had told myself in the beginning where I felt I was rejected through my parents by taking me to a residential school, for one thing. I had to deal with abandonment and rejection. I had to deal with just being alone, with nobody being there for me. My mother and dad weren't there for me when I was hurting. Nobody was there for me, to hold me or to cuddle me when I needed cuddling -- a lot of things like that that I didn't have in my first years of my life.

That really marked my path for who I became and what I became, and the traumatic experiences that I experienced throughout my life. It really marked that path for me.

Since my spiritual awakening, I have been open and willing to learn different ways of healing. For me, I came to this emotional part of my healing where I work with Bear Women and Associates. Through this

program of Nechi, I have gone into group therapies and I have even taken a psychotherapy, a weekly visit with a psychologist, just to be able to talk.

All of these things that I have reached out for, to get the help that I needed, have helped me to understand how important that emotional healing is for all life, for all of us.

My world vision would be that I see all mankind to find their original purpose and that they walk in the integrity of their truth, and find a balance in all living things. To me, that speaks for a lot of my healing.

When I am looking at this part that I drew here in the four directions or the four parts of us, in the emotions we have to first learn what kindness is and unconditional love, to really exercise that to ourselves and to people around us. That is also the path of sweetgrass. The emotions part of us is that we need to really exercise -- I am sorry, I got sidetracked; my time is running out.

Where I am working right now, we do a lot of emotional healing work. We go to the core of the people, but the base of that work is that we use the pipe. Every day of our sessions it leads our path. There are

about 10 of us in that program, Bear Women and Associates, and we continue to make our commitments with our spiritual practices. But the work that we do on a daily basis is on spirituality. We know that there is a power greater than ours and that the help from the spirit world is there to help to clean out the past, what we have walked in, our traumatic experiences, and to be able to have enough people. I can't do it by myself, but as a team we can help one another go back to that traumatic time and walk through to the light. We let them see how much power they have.

We are bigger than what we see. We are bigger than we see ourselves being. The only thing that holds us back is those past experiences. When we walk past those experiences through the help of a group of people, we walk into the light of the god of our understanding, the light of unconditional love.

We, as coaches or facilitators in this work, figure ourselves to be just mirrors, mirrors of one another. Each one of us here is a mirror of each other. If you see something you don't like about me, it is something that you don't like about yourself. If you see something that is powerful about me, that is a power that you have within yourself. All of us were given the same

gifts from the god of our understanding. He didn't make anything puny; he made us all equal. All we have to do is exercise and bring that out to each other as working together.

I wanted to share with you this one world vision that we have, and it is given through my friend and partner where I work. It says here: "We, the caretakers of Mother Earth, share our vision of the future for all humankind and all other forms of life made by the Creator. We envision a world in which people recognize that they are spiritual beings first and foremost. It is time for us to realize that we are all evolving mentally, physically, emotionally and spiritually with our supreme purpose being to co-exist in harmony with all creation. Just as the Creator continues to renew the Earth -- the plants, the animals and all living things -- we call upon all people to renew their commitment to a world made whole through the sharing of age-old teachings and through co-operative action. We recognize that the traditional way of life of the indigenous peoples of North America was one of harmony with Mother Earth and one that today serves as a model for re-creating a new world of balance and harmony.

Our mission is to build upon the

teachings of North American Indians, to incorporate in our daily lives the spiritual power of the Earth and the ancient wisdom of all cultures which are great gifts of the Creator."

Based on the need to honour and nurture this vision, we are, in the Centre that I am working at, in the making of a new Wellness Centre. It is going to be a multicultural one, and it is Native spiritually based. To me, it is like when you go to a conference, when you ask the Elders to protect that conference, when they use the pipes, no matter what kind of practice you have, the spiritual protection around that Wellness Centre will be based on Native spirituality.

Through the participation of individuals, groups and whole communities, new knowledge and new ways of being are being shared. Our commitment is to carry the vision to others and to create a network of people devoted to individuals and planetary healing, growth and development, a network which will encompass all caretakers on Mother Earth.

These are the things that I believe in. For those who are wanting to know about our program, I brought some pamphlets. If I have permission, I will lay them out wherever is available.

I thank you for asking me to speak. As you gather, I am not used to speaking, but I believe in a power greater than ourselves, and I know the healing journey I have gone through. I thank all of you very much. Meegwitch.

DR. MARLENE BRANT-CASTELLANO: One of the recurring problems of translating traditional teaching into a modern environment is that we try to talk to 200 people instead of three or four around our fire. That creates time constraints.

I would like next to call on Norman Chartrand. Mr. Norman Chartrand is the provincial Elder for the Manitoba Métis Federation. His involvement in the Métis movement goes back many years and spans from the Community Council level to the provincial Métis Federation activities.

Mr. Chartrand makes his home in Camperville/Duck Bay where he is a former operator of the General Store in Duck Bay. He is fluent in both Saulteaux and Cree. He is a father and a grandfather and, having been raised in a northern Métis community, Norman is also a hunter, a fisherman and a trapper.

Mr. Chartrand, please.

NORMAN CHARTRAND: Thank you.

Good morning. Honoured guests, dignitaries, Elders, ladies and gentlemen, my name is Norman Chartrand.

I won't make this very long because we were already told to try to make our speeches short. I wish to thank the Commission for inviting me to be able to participate in this conference.

My presentation will not be a long one. In order for you to understand how I prepared my thoughts on health and social issues, it will be necessary for you to understand the nature of the service that an Elder provides to his or her people.

Today I will depend on my ability to provide communication and search for a practical solution to the problems identified for our consideration.

I am a Métis Elder. My life has always been closely knit to a lifestyle that is much different from the society that we now live in. I was fearful after reading the material prepared for today's meeting. I found it very academic. I was unsure of how to prepare myself, and then decided to just be myself and take it from there.

During my life I learned by listening, watching and by doing. Written material was not a part

of the learning or teaching process. It is very difficult to come to grips with the problems identified. For example, the preparation materials referred to health studies that paint a grim picture of the state of well-being in Aboriginal communities.

Health and well-being in Aboriginal communities are closely related to poor environmental and economic conditions, inadequate housing and sanitary facilities, and the social dislocation occasioned by the disruption of support networks, such as the expanded family through divorce, the birth of children outside marriage, child wardship, and the adoption of Aboriginal children outside their cultural milieu.

If we are to overcome the difficulties we face, we must be able to communicate. Therefore, I will use my own English to tell you a story.

When I was young, my community survived by caring, sharing and hard work. Our health and medical needs were met by the members of the community we lived in. Medicine was gathered from the forest, or we got it from other places and things we knew about. This knowledge was passed on from generation to generation.

Midwives delivered babies. In fact, the small community that I come from, Camperville,

Manitoba, is 438 kilometres north of Winnipeg. We named our school there the Philimand Chartrand School because this lady -- and I knew her quite well. It is said that she had delivered over 1,000 babies in that area between Camperville/Duck Bay and Pine Creek Reserve beside us, and the surrounding area of farmers all came to her. So she was a well-known lady in our community.

People died at home, and the community members buried them.

Almost every family raised children who were not born into the family. Grandparents many times raised two generations of children. That was one reason our people died young, and still do.

Like other people, we had hard times and good times. Fish was the main part of our diet, and so was wild meat and vegetables from the garden and berries from the bush. Most of the Métis families had their own gardens. There were no fridges at that time, so we had to preserve our potatoes and corn and the rest of the vegetables to have enough for the winter.

Much of this way of life is lost. Our housing is not the same. We no longer use wood for heat. Today that is a luxury for the rich -- "fireplace" is the word I am looking for. Many Métis people don't have

the money to live the new way. Many of the customs of our people are not understood by others, and there is a lot of interference.

We are being taught to be different. Once again, the Métis must have the strength to hold on to old ways that were good and dependable and be careful not to make big changes just to please someone else.

Many people in our communities have no desire to leave them. Many young people are wanting to return, including children taken by the Child Welfare system. One of our own studies showed that 50 children were missing from the area of my own community of Camperville alone. Other communities suffered also.

Some of us have to remain in the old ways if our people are to survive. The basic necessities of life -- love, food, clothing, and shelter -- must be guarded and replaced where they were lost. Our customs of child-raising must be protected from the law also. Our old people must not live in fear of dying an unnatural death far beyond their time.

It is not a matter of providing solutions that are beyond the ability of our people to live by and pay for. It is a matter of stopping, taking a breath and putting back that which was taken.

Many solutions can be found in just not doing things. Stop taking our children. Stop taking our land and fish, our means of making a living. Only then we have food for our children that will protect our children.

One thing the Métis are famous for is our humour, our music and our dance. We must hang on to this. We must teach our children to enjoy it and live it. It is one of the ways we have survived against great odds. Other people do not understand our gift for laughter; we must teach them also.

The Red River jig is our national anthem for the Métis people. The Red River jig is the main dance in many Métis communities. It is the dance of the Métis, but it seems to have been known from Alaska to James Bay from the mid-1800s. The Red River jig is unique. It is a special piece of fiddle music that is played and danced in two sections. When the fiddler plays the high section, the dancer does a basic jig step. When the fiddler changes to the low section, the dancer does a fancy jig step. Métis dancers take very seriously the knowledge of many different fancy steps. Fifty different fancy steps are known to exist -- 48 of them I know. Just kidding.

With this I will finish my talk. If

there are any questions to be asked later, I still have some of the things that we do in our organization, in the Manitoba Métis Federation, like housing and different things. I will be able to answer some of these things.

Thank you very much.

DR. MARLENE BRANT-CASTELLANO: Our next speaker is Mr. Glen Douglas who has already been introduced to you as an Elder from the Similkameen Valley, who opened our Round Table this morning with a very dramatic and, I think, moving statement of how his people understand the world.

We will call on Mr. Douglas now.

ELDER GLEN DOUGLAS: Good morning again. My name is Nutukoshin(PH) from the Similkameen Band of the Okanagan dialect, the interior Salish people.

I am here to tell you in 15 minutes what took me a lifetime to learn: traditional understanding of Native health and healing held by Aboriginal peoples, including the community health approaches.

To begin with, we must have balance and harmony. The balance and harmony are contained within the medicine wheel which is round. That is our teaching tool. It contains the features from which we get our knowledge -- the physical, the emotional, the mental and

the spiritual. It also contains the four seasons of spring, summer, fall and winter; also the infant, the youth, the adult and the elder.

So we talk about the physical, the emotional, the mental or intellectual and the spiritual.

For example, a child who is not very well balanced goes to school, having experienced abuse or watched the abuse of his mother. He becomes emotionally unsettled when he gets to the school. He may not have been fed, so he is mentally incapable of comprehending what is taught in school and, therefore, cannot make spiritual progress. So he is unbalanced. It's like having a flat tire on your car when you are going down the freeway; it could kill you.

We have to balance these four things: the physical, the emotional, the mental and the spiritual aspects.

Our Elders' part in these areas is very, very important. They teach us about the mind and that we are to keep it clean, to keep intrusive thoughts out of it, such as suicide, violence and other things. The body, we are to build it. They used to train us. We would take a stick and wrap something around it and walk toward a mountain. Of course, where I come from we have so much

land that we have to stack it. We call it mountains.

We carry this stick and walk as rapidly as we can up that mountain until we get tired, and we lay it down, drop it and go back. We go back again and keep doing that. Then we run, to build up our bodies. We continue to run because, once we have built up that stamina, we must continue to do so in order to maintain it and retain it.

We build up the heart so that it is good. There is a great distance between the heart and the mind; it's a great journey. When you see things, your perception of what you see, immediately the western thought goes to the mind and then it goes to here and then you speak out. To us, we are taught that, when we see something, we bring it to our heart and then back out and speak. We speak with a good heart and a good mind.

The spiritual aspects come naturally -- and I will cover that a little later.

The emotional -- we have the tempers. As you will notice, this is progressive. The child is very emotional and cries. It is the only way it can communicate. Sometimes we cry when we are emotional. Sometimes we are taught that it is not good to cry because we are a big baby, but that is not true. If I have learned

to cry, then I have begun the healing process.

There are the acts and omissions, my actions, what I do, and things I don't do. They are all part of the instructions of the Elders. They also teach me patience by telling me to sit down and listen.

The mental by which we take in the comprehension through oral tradition -- we plug our mouth and unplug our ears and sit down and listen. While we are listening, we hear what the Elders are saying and we learn. We learn by example.

I used to ask my father, when he would be doing something -- I would walk up to him, watch him a little bit, and then say, "Father, what are you doing?" He would say, "If you watch me long enough until I am finished, you will learn to do the same thing as I am doing."

So, from this our children learn because we are all role models. We are either a good role model or a bad role model; there is no halfway in between. If we hit our wives, then our sons and our daughters see this, and they will follow that example. That chain will start growing, and we have to break that.

From the mental we also have the comprehension. We understand. We are taught to understand things, taught to think for ourselves, like

when he told me, "Watch what I am doing and you will learn." From that we have retention and recall. These are all part of the teachings.

From this we learn the universal laws and also language. The universal laws, as I mentioned this morning, are honour, respect, caring and sharing. We honour everything the Creator has created. We respect what the Creator has created. In doing so, we also honour Mother Earth by caring for her and caring for our families and loving our families.

Also, in doing so, we share what Mother Earth has shared with us and what our parents and our Elders have shared with us. They share with us their time; they share with us their knowledge; they share with us their wisdom and their skills, and they pass that on to us.

From this comes the impact of the family because they also teach us, first of all, in the "must know", "should know", "well to know" reference, that we must know who we are and who our families are. We must know our territory and its resources, when to harvest and when not to harvest, because our forests are our ranches and also our pharmacies. From there we get our medicines from all these plants that are growing out there.

The father and mother are our candy and

sugar people; they are our sanctuary whenever we get punished by other members of the family and those who are in roles of discipline. We run up to them and say, "Mom, so-and-so spanked me," and she will say, "Well, did you learn anything from that?" Or I fell down and got hurt and I ran to them, "Mom, I fell off that tree 15 feet up in the air." "Well, did you learn something?"

Our grandparents were our teachers. Our other Elders -- in my society, all my grandparents' cohorts are my grandparents, too. All my mother's sisters or their age group are my aunts. Everyone older than I was my Elder, and I had to listen to them.

Other things missing from this are the rites of passage or the rites that we go through -- the coming of age in which we make a transition from the teenage years into young adulthood, in which they sent us out in isolation to cleanse ourselves, to cleanse our bodies and our minds in the sweat lodge. I am so proud to see Russel Willier here, who has something to say about that later. The sweat lodge, to me, is one of the most important places, where we cleanse ourselves physically, emotionally, mentally and spiritually. We can also pray there.

Our grandparents and extended family and

relatives and other people had a great influence. In these rites of passage, the isolation and fasting and cleansing were necessary. It was a time for the vision quests, vision and dream quests, for the powers that we were seeking, that we all have. I received mine when I was eight years old. I didn't understand it, but I was told that, when the sun starts dropping like that, you will start understanding it.

I didn't know what that meant, until 1986 when I heard another Elder tell his story. He was told the same thing except that he asked a question -- he was smart enough to ask a question. He said, "What do you mean?" They said, "When your hair starts to turn grey." That is when I understood what my role was and why I stayed alive through three major wars and survived.

I had a guardian spirit. I had eight of them that followed me the rest of my life and are with me today.

From this we were told we had responsibilities. Those responsibilities were that I would do nothing that is harmful to me, to you, other people, races and things. That was part of the honour, the respect, the caring and the sharing. Part of these responsibilities is that this gift came from the Creator,

from our government as my Elders tell me. The Creator is our government; it never changes. It is based on continuity and consensus and longevity, while the western government is based on dollars, power and authority.

These gifts are from the Creator. They are not to be used for bad or evil. I am not to refuse help to anyone because one day I might want to ask for help and someone will refuse me, or no one will be there to help me.

And it is not to be sold. We do have some people who go to Europe and sell our ceremonies. Those are the people who don't practise what they preach. They talk the talk, but they don't walk it.

Our cleansing times are in the spring, March 21; in the summer during the summer equinox, June 21; in the fall, September 21; in the winter, December 21, at which time I am instructed by my Elders to go and have a four-day sweat.

So all these things were taught to me and passed on by my Elders. Yet, I broke their word. I learned to use alcohol. I drank for a number of years. That intruded into my life. I didn't know why, but the reason for it, I found out later on, was the influence of the residential schools and my war experiences. Just

last summer I learned what that was, really.

All my external wounds that you can see -- I can walk now. I almost lost both legs the last time I got wounded, the eighth time I got wounded in Korea. While I was wounded and recovering, I learned to drink because alcohol helped me relieve the pain.

I drank for a number of years. I became an alcoholic and almost drank myself to death. Then I had to recover from that. This is called post-traumatic stress disorder.

While I was recovering, these were some of my thoughts that I had written down. I call it "The Drunkard's Lament."

"I drank for happiness and became unhappy.

I drank for joy and became miserable.

I drank to be outgoing and became self-centred.

I drank for sociability and became argumentative.

I drank for sophistication and became crude and obnoxious.

I drank for friendship and made enemies instead.

I drank to soften my sorrow and wallowed in self-pity.

I drank for sleep and awakened without rest.

I drank for strength and became weak and a slave of alcohol instead.

I drank for sex drive and lost my potency.

I drank medicinally and acquired health problems.

I drank because my job called for it and then lost that job.

I drank for relaxation and got the shakes.

I drank for confidence and became uncertain.

I drank for bravery and became afraid.

I drank for certainty and became doubtful.

I drank to stimulate thought and blacked out.

I drank to make talk easier and slurred my speech.

I drank for warmth and lost my cool.

I drank for coolness and lost my warmth.

I drank for a heavenly feeling and found hell instead.

I drank to forget and became haunted by blackouts.

I drank for freedom and became a slave of alcohol.

I drank for power and became powerless over alcohol.

I drank to erase my problems and watched them multiply.

I drank to cope with life and invited death, or worse.

I could have gone to prison for life.

Then I learned that my behaviour determines what happens to me, and what happens to me is determined by my behaviour.

This all came along in my road and my path to healing -- all the things I have experienced through my lifetime.

Some of the things I have lived through took away all of those teachings and made it illegal for my Elders to continue to practise the things they taught.

It was contained in 1927, Chapter 98, section 140, which is the Indian Act

-- one of the most repugnant pieces of genocidal

legislation that prevented us from the use and practice of all the teachings and our ways of health and medicine.

Those are the things that I wish to share with you.

For those whose ears these are going to, I hope they open their minds. The human mind is like a parachute. It must be opened before it can work. I hope that, after today, they will start listening and hearing what we are saying.

I find it peculiar that part of the Commission is Native. Sometimes I look upon those things as just tokenism. But I hope that today's presentations will waken them up, and I hope they will listen.

Those are the words of my Elders that have been passed on to me, and those others whom I consulted before I came here. I am their working Elder. I am their eyes and ears. I circulate amongst the people for those who are unable to travel.

With that, I thank you and the Commission for inviting me here to participate at this time. Thank you very much.

DR. MARLENE BRANT-CASTELLANO: Our final speaker is Daisy Watts. Daisy is an Inuk from Kuujjuaq in northern Quebec. She is a mother of three

and a grandmother. Her eldest son is Senator Charlie Watt.

In the 1950s and 1960s, when the hospital ship, C.D. Howe, visited the eastern Arctic communities, Daisy was their interpreter, and she reports that she made many good friends as well as broadening her experience of what was happening among her people in the north.

More recently, Daisy has been the interpreter at a hospital. People look to Daisy for guidance. She is a very respected woman in the community of Kuujjuaq.

Daisy will speak to us in Inuktitut. She has a younger apprentice here to help with interpretation.

DAISY WATTS: (Through an Interpreter) Thank you for inviting me. Thank you for being given the chance to see a few people that I know.

I would like to first speak about the traditional medicine that our people used in our land. I will speak about plants.

I will first speak about plants. The older people, the Inuit, are still using plants. These have been used for many centuries in our land by our people. Right now we have modern ways of preserving the freshness of these plants, so we can gather them any time now and

freeze them or keep them in a cool place, in a refrigerator. We boil them until they are ready for use. We use a drainer, and then we drink the juice of the plant.

There are many older people who are doing this, and there are more and more younger people who are using these plants now under Daisy's advice and supervision.

When I was younger, I had heard from an older person of a young woman who had delivered a child and had not stopped bleeding, who was bleeding and could not stop. Nobody could stop that bleeding. So the older woman, the midwife, served her the juice of this plant little by little, and she started to stop bleeding. As she was able to drink more of the juice, she became fully recovered.

The older people are especially worried about our young people. We hear about the kinds of things the young people are doing these days, which are not good. They do not help the person to survive. They do not help the person to thrive as a person. It helps them to die, and that is what our young people are going through now. Every time we hear of an untimely death, a suicide or an accident, we are saddened by this. We hear of every death that happens in any community within the Inuit

nation. We all know each other; we all know each other's families. So this worries us a lot.

Fifteen years ago Daisy would have died if not for modern medication. With the help of God, the doctors and nurses were able to help Daisy to survive through heart surgery. A vein was taken from one of her legs and put into her heart -- sorry, three vessels were added to her heart to help her heart, and this is how she is able to stand before you today, before the Royal Commission.

Daisy would like to finish her presentation by thanking the Royal Commission for inviting her and everyone who is here.

DR. MARLENE BRANT-CASTELLANO: Thank you, Daisy and all of our guests who have shared. I would like to say that Jean's brochures will be displayed on the table just outside the meeting room here.

We have delayed lunch for a quarter of an hour, so we have a few minutes to raise some questions or comments if people would like to come to the microphones.

Microphone 3.

DAVID YOUNG: My name is David Young. I am Director of the Centre for the Cross-cultural Study of Health and Healing at the University of Alberta.

First of all, I would like to thank the Elders for sharing their experiences with us today. As usual, I find that very helpful.

I would just like to comment on something that we hear quite a bit, which I take exception to a little bit. We often hear the idea that we have an obligation to help raise the quality of health care for Aboriginal people to the same level that the rest of us experience. I find that a little bit misstated, a little bit misleading.

True, there are certain areas where western bio-medicine is very effective and could be very useful and is needed in remote areas, on Native reserves, and so forth. But the point I would like to make is that there are many types of illness where I think Native medicine does a better job than western bio-medicine.

Some people have told me that up to 80 per cent of our illnesses are chronic, stress-related diseases. If this is true, I think it is in this area that Native healers oftentimes do a better job.

I am not speaking just academically here, because I have had firsthand experience of this myself and in my family. I am sitting beside one of my Native healer friends here, Russel Willier, who I think

wants to say something a bit later. I have also had the privilege of working with other Native healers, and I know from firsthand experience that this is true.

If this is true, then I think it is paternalistic to keep using the phrase that we need to bring the quality of health care up to the standards of the rest of society. I think, traditionally, Native healers already did a better job.

You might ask: If that is true, why are there so many problems on Native reserves? That is a complex problem. I understand that I will have a chance in the third Round Table to talk a bit more about that, so I am not going to say anything about that today. There are many reasons why Native healers have lost some of the power, prestige and some of the knowledge that they had in the old days.

The issue I would like to see people address themselves to here this week is: What can we do, as a society, to help re-empower Native healers, to give back some of that power to Native healers that made them so effective in their traditional communities? I think there are some things that can be done along that line.

DR. MARLENE BRANT-CASTELLANO: Thank you. Microphone No. 2.

GLEN WILLIAMS: First of all, I would like to thank the Elders for their words. My name is Glen Williams. My Indian name is Seis'Lom.

I wanted to share a few things with you in regard to dealing with health and social issues.

First of all, I would like to offer this tobacco to my Elder so that I can share these words with the people.

As you can see, I am just a young man. My Indian name is Seis'Lom and I come from Slatleen(PH) country. I do not propose to be Canadian or to be an Indian. I am (native language).

The things that come to mind with regard to dealing with some of the issues that affect us directly -- I know that some of you people were up north at Canim Lake talking about residential schools. I think it would be very important that some kind of a letter or notification be sent to all churches to notify them that I think there needs to be a moratorium in regard to setting up this healing process. I think that basically should come from our leadership in the Native community.

The reason I bring that up is that I believe that our leadership needs to caucus to look at what kind of a vision and what different kinds of things

we need to work on.

Number two, we need to do something with regard to the protection of all traditional Indian medicines. I thank my grandmother for what she shared in regard to the preservation of medicine. What we need to look at there is dealing with the medical and pharmaceutical bureaucracies who are basically trying to put a stop to the use of Indian medicine by -- and I just heard this from a brother who is one of the senior herbalogists of my people. The medical profession and the pharmaceutical people are trying to take down 26 different herbs that were used traditionally by our people. I think we need to acknowledge that.

There is a great need to set up training programs for young men and women who are committed to the traditional way of life. We also need to put a stop to non-Native people who are setting up businesses to sell Indian medicine. There has to be some kind of law that protects the exploitation of Aboriginal medicines -- and this is happening right here in this fair city of Vancouver.

There needs to be a formalization of an association to address the identification of Elders and spiritual leaders who are recognized by their respective communities to be medicine people; also to work on an

international policy. I know for a fact that the Asian people and the African people have associations in which they have a very strong voice to deal with environmental issues, and I believe that needs to take place here in the Americas.

I was kind of surprised to hear about this Royal Commission. As a member of the Haowhin(PH) Healing Circle for Addiction Society, I thought it would be very important that all the organizations that are involved in healing be notified to be here at this Royal Commission. The Haowhin(PH) Healing Circle is an Indian name that has magic in terms of healing. It comes from the Musqueam people. We work on the healing of our families -- from the destruction cycle of addictions from alcohol or drugs, pharmaceuticals, and also healing from sexual abuse.

There needs to be a new vision in regard to the healing process. We need to look at the healing of our family units, especially in regard to dealing with residential schools. We need to look at making the church accountable for that healing process, because nobody is going to pay for it. We need to look at the fact that we, as young people who have gone through those residential schools, are now paying for our own therapy.

In terms of the holistic model, we need to look at what our relationship is with the other disciplines that are involved in healing, in terms of our journey of healing, such as naturopathic medicine, homeopathy, the martial arts.

Just over this past year I was asked by people from palliative care and hospice work that we need to start looking at what kind of relationship we want to build with the hospitals and with the medical profession. Our people are going there and they are dying, and they are dying of loneliness. We need to find out how we can become involved in regard to being better caretakers and caregivers with our people.

We need to look at what kind of relationship we have with other institutions -- education, health, social services, the justice system, the trap door of the correction system. We also need to look at the court system and policing. All of these things are basically relevant in terms of our own healing.

Healing, as I look at it, involves justice for our people and purification.

DR. MARLENE BRANT-CASTELLANO: I am going to have to interrupt you. We have one more question, and we need to adjourn soon.

GLEN WILLIAMS: That is all I had to say. Thank you.

DR. MARLENE BRANT-CASTELLANO: Thank you. We will have one more brief question or comment and look forward to having an opportunity, as the days progress, to discuss these issues more fully in terms of their application to changing the way we live and our health.

RUSSEL WILLIER: I appreciate you listening here today. I have to thank everybody.

I also sincerely want you to use your five gifts God gave you -- the mind, the heart, the eyes, the ears and the mouth -- today and in the two days that are going to come. They are God's gifts. They are the only ones that are going to break this monster that is killing our society every day -- the booze and suicidal things.

If we don't work together sincerely from our hearts and our minds, we are not going to get anything done. People are still going to be dying.

Those are God's gifts, five of them. On top of those five gifts, we use them to write down things that we are going to do today or in the future. It should be expressed across the nation what we are saying today

and what is going to take place, how we are going to work this. We need everyone's ears; we need everybody's eyes on how we are going to solve our problems where we come from.

If we don't do that, it's no use. Medicare can turn the other way. We also have to pull as a group. We talked about that today. I heard them mention things.

What we have to recognize is some of the medicine people that are on the committees. They have to prove what they can do; they have to be recorded what they can do, if it's mental problems that they can cure, or whatever it is. A lot of this has to be documented, and they have to be recognized in the medicare. If we can't do that, we are wasting our time.

My name is Russel Willier. I forgot to introduce myself a minute ago.

DR. MARLENE BRANT-CASTELLANO: That brings to a close our morning session, and I will call on Louis Montour.

DR. LOUIS T. MONTOUR: I would like to thank Dr. Marlene Brant-Castellano, Jean Aquash, Norman Chartrand, Glen Douglas and Daisy Watts for their participation this morning. Thank you very much.

I have an announcement on behalf of Inuit Broadcasting Corporation. They have brought a number of videos for our viewing pleasure. There is a VCR available out in the hallway. I will just give you a few of the titles.

One is called "Straight Shooting." It's a drama featuring Cape Dorset students where youth has to decide between the cool life of sniffing cocaine or the straight life of a non-addicted teenager.

We have "Sivamut PSAs", "A Bite Out of Life"; "Putting the Pieces Together", which is a sensitive look at how the community of Pangurtung(PH) copes with the lasting effects of child sexual abuse and what they are doing to prevent it.

"Ikajurte" -- excuse me if the pronunciation is not correct. "Midwifery in the Canadian Arctic"; "AIDS, PSAs, Solvent Abuse: A Matter of Life and Death." "A Summer in the Life of Louisa", a touching drama on the effects of spousal assault; and "The Homecoming", an insightful drama on alcohol abuse.

We will now be breaking for a luncheon which will be in the Plaza Ballroom on the Plaza level, which is the floor just below us. We will have a keynote speaker, Dr. Harriet Kuhnlein whom I will introduce later

downstairs.

Lunch is open to all invited participants with the white tags, all our speakers, our moderators, and the Royal Commission staff.

I now invite you to please make your way down to the Plaza Ballroom. Thank you.

--- Luncheon Recess at 12:20 p.m.

LUNCHEON ADDRESS

Dr. Harriet Kuhnlein

DR. LOUIS T. MONTOUR: In the interests of keeping this meeting moving smoothly, we will now proceed to our luncheon speaker. I encourage all of you to continue eating and enjoy because she will be speaking on food, which is something close to all our hearts.

Our speaker is Dr. Harriet Kuhnlein who is a Professor of Human Nutrition and is the Director of the new Centre for Nutrition and the Environment of Indigenous Peoples at McGill University. Dr. Kuhnlein has worked extensively with indigenous peoples in Canada, United States and Guatemala.

In Canada she has worked extensively with the Nuxalk Nation at Bella Coola here in B.C., with the Baffin Inuit and the Dene-Métis of Mackenzie Delta. In the U.S. she has worked with the Hopi, and in Guatemala she has worked with the (native language) people.

Ladies and gentlemen, Dr. Harriet Kuhnlein.

DR. HARRIET KUHNLEIN: Thanks so much, Dr. Montour.

I certainly also want to thank the Royal

Commission for letting me speak to you today. It is certainly an honour for me to be here, and it is also a good learning experience for me to hear so many perspectives from so many good minds.

Dr. Montour mentioned our new Centre. For those who haven't heard about it, I left some informational materials outside the Royal Commission meeting room upstairs. If you want to pick one of those up, that will be fine.

I do feel that a talk about nutrition at lunch time is a stroke of genius. I couldn't have planned that better myself. I hope that you don't mind hearing about other kinds of food while you are eating foods from Mexico and an Italian pasta dish, and I understand we are going to have some kind of an English trifle for dessert.

What I want to talk with you about is indigenous foods. I am going to start with a series of slides that will set the stage for you to remember the richness and beauty of traditional food systems of indigenous peoples.

I am going to turn the lights down, and the focus, of course, will be the screen. I don't know how easy that is going to be for some of you with your

focus on your plate and looking over your shoulder, but I hope it will be okay.

During the series of slides, I will explain what you are seeing and what areas the foods are from. It is going to take about 10 minutes or so, and I would like you to focus on four major functions of Aboriginal foods and total diets and what they contribute to Aboriginal peoples. I will just name them off quickly.

First of all, food is an anchor to culture and to personal well-being. Second, food is the direct link between the environment and human health, and it is the avenue by which a healthy environment can provide complete nutrition and a sense of integration and wellness. Three, food is an important indicator of cultural expression. Finally, food is an essential agent to promote holistic health and culture.

I am going to move quickly through these slides because I have about 30 of them or so in these 10 minutes. I just want you to think about those four important elements.

This is close to the community of Broughton Island, looking toward Baffin Island, somewhere around midnight on a July night, jigging for cod -- an important traditional food at that time of the year for

the Inuit.

The next important traditional food resource for the Inuit is narwhal meat. Here you see it drying on the side of a house in the sunshine on a July day.

Many of you know about caribou and how it is so important for so many Aboriginal peoples in Canada. Here you see that there is a lot of caribou-eating going on in this community.

Maluga, muktuk, is important for a lot of people, not only in Baffin but across the Arctic. This slide happened to have been taken in Tuktoyaktuk last summer.

Plant foods are also important in the Arctic. Here you see some children who have just come back from an excursion of berry-picking over on the main island of Baffin.

Hunting seal is an important cultural activity and social activity as well as extremely important nutritionally. Seal hunting during May on Baffin. One of those seals -- and I show this slide just to remind you that there is a lot of fat in seal, and we recognize this fat as being very important for a lot of essential fatty acids and good nutrition of Inuit, as it has been

over thousands of years.

Seaweed is another important food. Usually, it is not taken from the beach like this, but directly from the water. It is just another example that plant foods are important for the Inuit.

Moving over to the Interior of B.C., here a friend, Hilda Austen, is showing how to prepare pine mushrooms which are one of the few examples of the traditional use of mushrooms by Aboriginal people in British Columbia. There are really quite a lot of mushrooms here, but not too many of them are used. This is one, the pine mushroom.

Also from the Lillooet area, salmon oil is used for a variety of cooking. A very delicious thing it is. And salmon wind-drying in a house protecting it from not only insects but also ground animals of various kinds.

I have done quite a lot of work with the Nuxalk of Bella Coola, so I would like to show you some of my favourite slides from that area.

This is in about March, the time of the harvest of the oolakan. People learned that the oolakan comes into the Bella Coola River, and they can recognize this when they see the seagulls hovering over the oolakan

run. This is happening along about now, and people are thinking about making that favourite Nuxalk food, oolakan grease. To make oolakan grease, you have to start by harvesting and netting the oolakans, which you can see people doing here. The oolakans are put into bins to ripen for a couple of weeks, depending on what the temperature is like. You see the bin in the back behind, and in the foreground you see the tub of hot water that the ripened oolakans are put into to make oolakan grease, panning off the grease after it boils to the top. All of those foods that oolakan grease is used with -- everything from bread to potatoes to herring roe, with seaweed, bannock, salmon roe, herring roe, dried fish and a couple of kinds of berries, traditionally all eaten with oolakan grease.

You can't deny that sockeye salmon from the west coast is probably one of the most delicious fish in the world. Here you see Alice Tallyoe and her grandson barbecuing quite a lot of sockeye, which is then put away in cans and also in the freezer for use during the year.

Fish roe are used in many different kinds of ways. Here you see a picture of steelhead roe that is cooked at camp. This camp was close to an oolakan bin during the month of March. It is being cooked with seaweed that comes in from Bella Billa, and the oolakan grease

is added to this. I think it is fair to say that it's my most favourite Nuxalk dish. It is really quite delicious.

There are at least 20 different species known to the Nuxalk people, species of berries that are harvested any time from May into October. This is an example of berries that are harvested in late July or early August.

Soap berries made into what we call Indian ice cream, whipped in with some raspberries at the end. Probably many of you here have had soap berries.

Clover roots, an important Aboriginal root food up and down the coast of B.C. where the freshwater rivers meet the salt water tide flats. Clover roots and silverweed roots grow together. They are not so often used today, but they are still remembered by a great many people as being quite a taste treat. They taste a little bit like fresh uncooked peas. They have a nut-like flavour to them.

Labrador tea, used across Canada by Aboriginal people to make tea.

Moving up now to the western Arctic into the Mackenzie area, we see the teepee where people do a lot of smoking of fish. This is the community of Fort

Good Hope. I have just a few slides from this area.

The banks of the Mackenzie River, or Dai-cho I should say. You see this gentleman with a burbitt. Unfortunately, burbitt has been targeted as a contaminated fish because the liver of burbitt contains quite a lot of toxaphene as has been documented by several researchers over the last couple of years. But it is still a favourite food for the Dene-Métis people of this area.

Drying whitefish on the banks of Colville Lake -- again quite late at night on a summer evening. Children and all members of the family are involved in netting the fish and drying it.

We are going to move now to some other cultures. This is the community of First Mesa in Hopi land in Arizona. One of the most important Hopi foods is maize. They have many different kinds of maize. Here you see sweet corn being dried. It's actually pit-roasted fresh and then hung to dry, and then it is taken home, traditionally, and then made into several different kinds of sweet corn dishes.

The making of piki, blue corn mixed with the ash of the fourwing saltbush and water and spread on a hot stone to make these very thin, flaky sheets that are then rolled up -- traditional Hopi food, piki bread,

and really quite nutritious by way of minerals and energy and carbohydrates, and so forth.

Going to real Indian country, this is northern India where they are growing rice. They also have their spice. I am going to show you just a few shots of Aboriginal foods from other parts of the world.

In Guatemala people are still buying their foods in the market, in addition to growing their own foods. They have outdoor markets regularly; in that climate it is easy to do. Green leafy vegetables are still very important, especially in the Patin area of Guatemala.

Over to Laos where they also have pasta. There is actually quite a controversy about where pasta really comes from. People sometimes say it comes from Asia and it went back to Italy after Marco Polo discovered it in China, or maybe it was in Laos. They make both wheat and rice noodles here in Laos. Again, the open-air markets where they buy lots of their fruits and vegetables in the city of Vientiane.

The Arab Emirates, the big desert country on the Persian Gulf. People there are still harvesting and have an important resource in the traditional fisheries. Surprisingly, I learned that the pollen from the palm tree is an important accompaniment

to some of these fish that people are harvesting.

Another big jump across the Atlantic Ocean to the Andes. You see the city of La Paz in Bolivia. Bolivia is one of those countries that has a great proportion of Aboriginal people, and they are still harvesting and using a lot of their traditional food resources.

This happens to have been taken in Peru, but these are traditional potatoes that are freeze-dried in the natural atmosphere, with the altitude and climate they have, and then they are reconstituted and used throughout the year.

What you can see on this slide is that there are all sorts of industrialized foods making their way even to these highland Andean communities. They are making their way all over into Aboriginal areas, industrialized foods from the mega corporations around the world that produce them.

I want to close this series with a shot that I clipped out of the Otimahora, the newspaper of La Paz. When I was there last October, they were having a conference, the International Congress of South American Indigenous Peoples. They were protesting the coming of Columbus, and this imperialistic Pepsi Cola was a big

target for what they felt was wrong with the world today.

This whole concept of Coca-colonization or Pepsi-colonization has been used quite a lot in the literature, particularly in the scientific literature around diabetes.

It is becoming more and more clear that traditional food systems derived from the local natural environments of indigenous peoples are on decline throughout the planet. For a variety of reasons and external pressures, foods made available through industrialization and market economies are replacing traditional foods in the diets of Aboriginal peoples.

Here you see one small, but significant, example of this phenomenon. This is the cow parsnip, or in scientific terminology Heracleum lanatum, or Kwiche in the language of the Nuxalk, Solo in one of the Interior languages. There may be 20 different names for cow parsnip amongst the west coast Aboriginal peoples.

This is a traditional green vegetable harvested in the spring, with care to remove the caustic outer peels of the stalk that you see in the bucket. Cow parsnip provided a welcome treat from winter diets, both with respect to taste and nutrients. It is kind of akin to celery in its taste, and it is remembered by Nuxalk

Elders as a nice thing to harvest in the spring.

However, during this century the use of cow parsnip has been slowly declining, to such a point that it is rarely used today by Nuxalk women. The Elders still remember it, but younger women often don't even recognize the plant or know how to prepare it.

In this slide I show you some of the work that Nancy Turner and I did to document the change in use of the different foods of the Nuxalk food system during the decades of this century. We interviewed about 60 women, grandmothers, mothers and daughters, amongst the Nuxalk Nation. You see the number of women at the bottom in each of those categories in brackets, and then the use scores at the top. It is about once a week in season that the fresh foods were used. This food was never really preserved for use at later times; it was always used fresh.

During the decades of this century, women clearly showed that there was a gradual decline in the use of cow parsnip, so that today it is used hardly at all.

Another example of the declining use of traditional foods in favour of foods from markets is taken from the work I contributed to with the community of Broughton Island, which is really in our work a community

representative in many ways of Baffin Island in the eastern Canadian Arctic. The Baffin Inuit have a rich and varied traditional food system, as I showed you earlier, but today the use of foods provided through commercial outlets, such as this Bay store in Broughton Island, provide the majority of daily calories to people of all ages.

In this figure you can see that for the seasonal average market foods contribute a total of about 70 per cent of calories of adult women in this remote community of Broughton Island. In November, when we see the maximum use of market foods, it jumps up to 86 per cent of calories and, when traditional foods are being harvested in earnest in July, the number of calories is still about 65 per cent coming from market food.

Moving over to the western Arctic community of Colville Lake, which the Sahtú people consider as their most traditional community -- and you can see the households there along the lake. This is a community of about 60 people. It is more remote than Broughton Island. It has less access to food resources coming in by air.

What I have presented here are summer, winter and spring differential use of market and traditional foods. In the summer and winter it was still

about 30 per cent of their total energy coming from market foods, and in the spring, when traditional foods were harder to get, market food calories jumped up to 56 per cent.

It needs to be emphasized that, even though a large percentage of people's calories are coming from these market foods, the people in these communities are still deriving a major portion of their nutrition, such as protein, essential fatty acids, iron, zinc and other essential nutrients, from the traditional food resources. It is not too difficult to understand why this is the case when we look at a list of the most frequently used market foods in communities such as Colville Lake, Fort Good Hope and Broughton Island.

The list of the most often used foods is really quite similar across the Arctic. What we see are low-cost, quick-energy and low-nutrient quality foods, so it is not too surprising to realize that nutritional status of indigenous peoples is rapidly declining when they stop using their traditional foods from the natural environment and replace them with foods such as these.

This is especially evident when there is a circumstance of poverty and low expendable income to drive the supply/demand market equation to provide

higher-cost, more nutritious foods to remote communities, such as fresh meats, vegetables and fruits, if that is what people need to replace their traditional food system nutritionally.

Considering the reasons for this unfortunate nutritional health circumstance in the broadest global view, there is really a complex, but recurring, rationale. What I have shown you here is just to keep in your mind that the total diet and the total nutrition of people is coming from two sources: indigenous food and nutrients and market food and nutrients.

Most importantly, the rationale emphasizes industrialization, market economies and colonization in one form or another, so that indigenous foods are no longer used. There are population pressures on the land and sea resources; education in its broadest sense and exposure to others; media and private enterprise advertising -- just think of all those reasons why people are not using these foods any longer; certainly, lack of access to traditional food resources because of limited time, energy or equipment for hunting, fishing or harvesting.

Other reasons are migration from rural

to urban areas; changing food preferences and health beliefs, in part because there is an imperfect transfer of the wisdom of the Elders to younger generations. We also have health personnel -- and here we have some of the people from Fort Good Hope who are helping us with our work. Health personnel on reserves are not regularly trained in the good use of market foods or in the values of the traditional culture, which include the environment-wellness dyad. I certainly feel these women were well-versed in the environment-wellness dyad, as traditional Dene women. Nevertheless, we are all aware that health personnel on reserves are not always traditional people or people from the community.

All of these reasons are part of the problem, and each community and individual has differential impacts from these various components of the rationale.

My friend and colleague, Laurie Montour from Kahnawake and also from Walpole Island, wrote in her description of the knowledge of traditional foods in Native communities, and I quote:

"Sadly, though, there is the realization that the foods themselves, and the skills and practices in using them, are slowly

dying. There is a triple threat: the loss of knowledgeable elders, leaving no one to teach; the loss of culture, leaving little incentive to learn; and the loss of healthy ecosystems, leaving no foods available to take even if one wanted to."

Following on this, the more recent knowledge and publicity about environmental contamination has placed another serious, if not critical wound to the use of traditional food systems. At a time when our knowledge of the human health effects of specific contaminants is eons away from being complete, people in communities are being frightened away from the use of their traditionally-known, culturally-relevant food resources. Concerns for mercury, PCBs, cadmium, toxaphene and other organochlorine contaminants are under intensive review in this country because of the impact these contaminants may have on the health of Aboriginal peoples who still take some of their food resources from the natural environment.

As one example, again using the hamlet of Broughton Island as an example of Baffin communities,

we did a review of the extent of traditional food use across seasons. It is demonstrated here in the variety of foods used and how, from season to season, things really do vary quite a bit. The total grams of food that are used on the average can vary anywhere from 200 to 400 grams at any one time.

When we did the analysis, with the help of the Department of Fisheries and Oceans, for the PCBs contained in those foods, we also saw a differential spread across the seasons and the different food resources that contained PCBs. We saw anywhere from six to twenty micrograms per day being consumed, in this case by women 20 to 40 years of age.

This project demonstrated that, while the use of traditional foods is substantial and critically important for nutrition, the intake of PCBs is certainly worrisome but, in this case, still within accepted guidelines on a population basis.

Clearly, research of this kind is needed, not only to identify severe ecosystem illness and to prevent human health effects, but also to stimulate national and international action and political will for stopping pollution. It is unfortunate, but a reality, that the food systems of Aboriginal peoples happen to be

best sentinels for this kind of inquiry and will be a most effective stimulant for political action. The attention to Aboriginal food systems and contaminants is not going to go away for a while.

What I want to emphasize here is that traditional food resources of Aboriginal peoples and the use of these foods are important for so very many reasons. The declining use of these foods is not just a symptom of a larger system that is failing, but it really is a major organ in the system of environment and cultural well-being that needs immediate and vital attention. This is so for indigenous peoples globally, not just in Canada, wherever the forces of de-culturalization and environmental destruction are powerful. Finding the solution to return traditional food systems to the control and benefit of local indigenous peoples would contribute greatly to the prognosis for the health of the entire planet, and all of us now and in the future.

When we think about the loss in use of traditional food systems and the simultaneous increase in the use of high-energy, low-nutrient-density, industrialized foods that are available in market networks, there are really well-documented changes in disease patterns of indigenous peoples. This is true for

rural and remote communities, but also for people close to and in urban environments. The rich and the lucky and the well-educated may be able to find a healthy diet among the foods of well-stocked urban markets and in wonderful hotels, such as we had today, but that is not to say that it always happens.

The diseases of the so-called western diet and lifestyle are striking rural, urban, rich and poor alike. Chronic diseases that were unknown among tribal peoples and those of non-western cultures but are now among the increase amongst them are building into an impressive list. You have all heard these diseases named before. Obesity, diabetes, the cardiovascular diseases and cancer, infant morbidity and mortality in high frequencies, alcoholism, loss of teeth and clear eyesight, and rampant infections are all part of this diet and health picture that has emerged for indigenous peoples in the last 100 years.

In the non-industrialized world, such as India, China and Guatemala, where indigenous peoples are still fighting the battle of getting enough food energy and protein, these chronic diseases are not of the same magnitude, of course. However, the wealthier segments of those societies are finding themselves afflicted with

western lifestyle diseases and realizing that these are certain to follow upon development or migration to find the so-called better way of life.

Is there something that can be accomplished for better health of Aboriginal peoples by paying greater attention to the benefits of traditional food systems? Surely, we realize that it is not reasonable to expect a return to the past, to the way people were living and eating 100 or more years ago. But, in my view, to answer this question, the best approach is to take a cold, hard look at what is going on and to try to reverse the trends or, at least, to try to steer the ship.

I feel that it is time for action and leadership to stop this tremendous loss of traditional food system knowledge and the loss of the tangible and meaningful links to the environment and to human health and social well-being that is really unique to Aboriginal peoples living on their traditional lands. It is time for Aboriginal peoples to take back the traditional food systems in one form or another and to use them to their best advantage, as decided by each community.

At this time, traditional foods are just slip-sliding away with every passing generation and with the loss of every Elder who has lived close to the land.

I feel it is also time to take back traditional knowledge of the environment and how it gives health to people in their food. This is really teachable information for the schools. It could be insisted upon in the information in health centres and in the training curricula of health professionals serving Aboriginal peoples.

When it comes to issues of health, traditional food systems and food contaminants, I think it is time to strike a balance between loss, demoralization and scare tactics on the one hand and, on the other, assuming the collective and personal knowledge and control needed to make a difference for confidence in the total food system, thinking about both traditional and market foods that people in reality are using today, and to foster community health promotion.

One of the suggested topics for this keynote address was the demedicalization of health. In my view, there is no better place for demedicalization than in the area of nutrition. The medical networks of academics, policy-makers and practitioners, as we know them internationally, focus on disease -- and we have heard a lot about that this morning and about the paradigms: how to find what's wrong and how to fix it; how to make

the human body well again after it gets sick.

A tiny fraction of the financial and personnel resources for medical teaching, research and practice goes for finding what is right in an individual or community and keeping it that way. I am speaking here beyond health promotion. As we think of health promotion, we think of getting people out to exercise, getting people to do things differently. What I am speaking about is looking closer at the Aboriginal culture and finding those good things and building on them.

Indigenous cultures have always held a holistic view on the intertwining of environment, culture and health through the traditional food system and all it offers, the emphasis being on what is right and healthy and how to get people to take better advantage of it.

Two examples of this concept of the need for the demedicalization of nutrition are offered for your consideration -- and I won't dwell on them, but just mention them. The first goes back to my days as a nutrition graduate student, when I was doing my dissertation research with the Hopi. At that time there was very little scientific documentation on the nutritional value of the traditional Hopi foods. In fact, that was partly why I was there.

At the same time -- and this was in the mid-1979s -- there was an increasing and alarming rate of diabetes on the reservation. Because the traditional Hopi foods were often made of corn, especially blue corn, and because there was no documentation on the carbohydrate, protein, fat and calorie content of foods such as piki and nokviki, the physicians in the Indian Health Service were admonishing the Hopi to completely avoid all traditional Hopi foods -- "they are just starch, and they're dirty," they would be told. "Take your insulin and eat a carefully prescribed diet of imported foods."

What was happening was that people who fell into diabetes at that time because of lifestyle changes were driven even farther away from the diet and lifestyle that could make them well again. Fortunately, with increased knowledge and improved methods of dietary counselling on diabetes, this isn't any longer the blanket recommendation on that reservation.

The second example concerns childhood blindness in developing countries, particularly in tribal communities, which is caused by Vitamin A deficiency. Every year half a million new cases of childhood blindness are caused in large part by too little vegetables, fruit and animal foods in children's diets because of lack of

access to land to grow foods, environmental destruction and poverty so severe that there is not enough food to eat.

The solution to this problem that is now promoted by the World Health Organization is to give capsules of Vitamin A at the time of immunizations. There is only passing mention that Vitamin A capsules are not a sustainable solution to this severe nutritional problem affecting the whole community and that the real answer lies within the traditional food system in each local environment, knowledge of how to use it and access to it. The medical band-aid is not solving the real problem. In fact, it is probably impeding the real solution to the problem of an unhealthy ecosystem by instilling a complacency that at least something is being done.

In both of these examples, the medical solution is not what is going to make the difference for sustainable nutrition and environment. The difference will be made in finding what is right in the traditional knowledge of the environment and the foods it provides, putting that knowledge forward, and implementing it for the health of the people.

What about a strategy for promoting traditional food systems?

The Aboriginal leadership in Canada, we know, are highly regarded internationally for their success in promoting and protecting the cultural traditions, the rights and responsibilities of Canadian Aboriginal peoples. For the situation of declining use of traditional foods to be turned around, it will take strong leadership at both the national and the local community levels. It will take commitment on the part of entire families within communities. In some places it won't be possible at all.

This kind of grassroots movement for community recognition and documentation of traditional knowledge has already been taking place in several areas of Canada. I am aware of only a few, I am sure. Fort Simpson, for example, and their curriculum on traditional foods, the Nuxalk Nation, the Shuswap Nation and the Mohawks of Kahnawake, among others, have begun to implement traditional knowledge of food, environment, culture and lifestyle into the elementary school curriculum.

If we still have time before you are finished with dessert, I can also share with you some ideas from a health promotion program with the Nuxalk Nation that stressed traditional foods.

The knowledge and wisdom of the Elders

regarding the environment and its integration with food, culture and self-identity is the important concept. It needs to be put to use with the best communication techniques available within communities, and for sharing among communities, and sharing success stories to stimulate change. An essential aspect in the training of young people is the knowledge and respect for an environmentally-sustainable food system, from both traditional and market foods. This kind of training comes best from the home and the community as well as the school system, and the subject matter is suitable for curriculum in the elementary through the secondary schools.

At the professional level, health careers programs for Aboriginal people should clearly include the professions of nutrition and dietetics. Training within these programs could include substantial information on the integration of environmental integrity with culture and nutritional health and on how Aboriginal foods promote health in the local environment.

At this moment, there are less than a half-dozen practising Aboriginal dietitians in Canada -- and you have one of them in this room today. Improving this statistic will greatly assist the solution to the problem of nutrition education in a sustainable

environment for Aboriginal peoples.

Finally, in my view, it is critically important that health professionals who seek employment in health services for Aboriginal clients be informed on the contributions and values that the local environment and culture and the traditional food system offer to the community and to the individual. This holistic approach includes the best of Aboriginal values, and it is a real service to communities for health professionals working there to be informed of these issues.

The integration of knowledge on environmental quality and cultural identity to promote the understanding and the reasonable use of traditional food systems will greatly enhance quality of life and self-care for indigenous peoples.

Thank you.

DR. LOUIS T. MONTOUR: We have time for one or two questions.

By the way, the Native dietitian in the room is the quiet and unassuming Rhea Joseph.

COMMISSIONER ALAN BLAKENEY: In the Inuit communities, do you feel that the limiting factor in the use of the traditional foods is because of a change in lifestyle or because of a lack of resources? Is there

enough caribou and seal now, or whatever the case may be, to have all the people in the community use it to approximately the same extent as was previously done?

DR. HARRIET KUHNLEIN: It's a complicated question. Changing lifestyle goes with changing resources.

Because of the settlement patterns that have taken place, it is my view that it is sometimes harder to get far enough away to harvest foods. But, on the other hand, in the areas where I have been -- and I think maybe somebody from the Inuit association can speak better to this than I can. In the areas where I have been, there is enough food for the Inuit, at least in Canada. Maybe someone from an Inuit organization would like to comment further on that.

ANNIE TULUGUK: At the hospital where I work, we are teaching people that the best food for them is traditional food. But it is very hard to get the men to go and get the food. They work during the week, and they can only go out to get food during the weekends. There may be something that prevents them from going, and they have their extended family to feed.

We are doing work to inform the people that traditional food is better for them, no matter what

they say about PCBs and all those toxic things. People still have to go out and get it.

RUSSEL WILLIER: Unfortunately, I can't say that for Alberta. Native people over there have a hard time with the fish and game because of the animals declining very fast and timber being logged out. We have to try to live both ways. If we don't, we are going to be enemies of the law and stuff like that. That's what I can say about Alberta.

DR. LOUIS T. MONTOUR: Thank you for those comments. I would like to close now and thank Dr. Kuhnlein for her excellent presentation.

It is now a quarter to two, by my reckoning. I would like to suggest that we reconvene at ten minutes to two, in five minutes, in the main ballroom upstairs. Thank you.

--- Upon resuming at 2:00 p.m.

DR. LOUIS T. MONTOUR: Good afternoon, ladies and gentlemen. I would like to call the afternoon session to order, please.

We are half an hour behind. We will keep to the same schedule except that we will just put everything half an hour later.

Our first order of business is a panel presentation of discussion papers. Our moderator will be Mr. Peter Ernerk. Peter is the Executive Director of the Inuit Cultural Institute. Peter has lobbied actively in the areas of suicide prevention programs, women's issues, daycare programs and funding. He has maintained good relationships with regional governments and has supported regional programs in all areas.

Ladies and gentlemen, Mr. Peter Ernerk.

PETER ERNERK: Thank you very much, Mr. Chairperson.

I am going to speak in two languages.

(Native language) I am pleased to be part of this meeting on the invitation of the Royal Commission on Aboriginal Peoples. I am extremely pleased to be here.

(Native language) So it is nice to recognize a number of people. Some of the people I have worked with for a long time, and I would like to work with them for many years to come.

(Native language) The discussion paper this afternoon is on the issue of suicide. It continues to be a major issue in the Northwest Territories, especially in the Northwest Territories. Yet, it is the concern and responsibility of every individual that lives in the Northwest Territories, among our own people.

One of the things that we did several years ago, when I was still with the Legislative Assembly of the Northwest Territories, was that, politically speaking, we decided to take this issue -- I don't like to use the word "seriously" because we have always been serious about it. We decided to talk about it at the Legislative Assembly level as well as with all of the people in the Northwest Territories. We didn't see it as only the government's responsibility, but the responsibility of all the people that live in the Northwest Territories, the people at the community level, the regional government, territorial government, as well as the general public.

Among the Inuit population itself, many years ago, it used to be the older people, the Elders

themselves, who decided to commit suicide. Today it is the young people, the future of our communities, the very people who are the future of our territory, who decide to commit suicide. (Native language)

First of all, I would like to introduce, to talk about this issue this afternoon, with the presentation of Discussion Paper C as well as D, Dr. Clare Brant. In 1984 Dr. Clare Brant returned to his home reserve where he is presently practising psychiatry. He is Assistant Professor of Psychiatry at the University of Western Ontario's off-campus program, guest lecturer in psychiatry and social work at Dalhousie University, and program consultant at Trent University's recently established training program for indigenous mental health workers.

Please welcome Dr. Brant.

DR. CLARE BRANT: Thank you very much. Thank you for the invitation to come and speak to the Royal Commission.

This is a gruesome topic that you have assigned me. I think my sister, Marlene Brant-Castellano, had something to do with it -- not that it's nepotism. I think she asked me to do it because it is the grim subject.

People have a tendency to think that

because Clare is a doctor and because Clare is a psychiatrist, he is tough and can handle these things without too much sweat. I will tell you that that is not the case at all. I am as alarmed at the trend in the suicide rate as all of you. My personal life has not been affected by suicide, as I know many of yours have been -- a very distressing trend among our young people.

I want to call attention to the statement at the beginning of my written paper as distributed. Ramon Cajal was an early pathologist. He brought the first microscope into Spain. He went to some lectures in Italy and bought a microscope and brought it back to Spain, and he worked out some very basic pathological disorders. He made the statement in 1899, which is 74 years ago, that every disease has two causes. The first is pathophysiological, and the second is political.

What we are dealing mainly with is social and political causes of a psychological and biological disorder.

The Aboriginal suicide rate is three and a half times what it is in the general population. In the general population, it remains fairly constant at 14 per 100,000 per year. However, it occurs in clusters.

Dr. Jack Ward, in his suicide study of

the Wikwemikon epidemic in 1975, reported a rate of 267 per 100,000, which is astronomical when you compare it to an average, usually steady suicide rate of 14 per 100,000 in Canada. However, it is zero per cent in many communities, but it averages out to about 43 or 44 per 100,000 population.

There are some difficulties in demographics, in that it is difficult to identify all Native suicides. Probably some of the death by misadventure, such as motorcycle accidents and car accidents are not car accidents at all, but probably suicides or death as the result of suicidal behaviour.

It is highest in young people aged 15 to 24. There is a transparency over there with some demographic characteristics. This is an old study, in 1979-80. I have to apologize for the quality of my transparencies. My secretary broke her ankle and couldn't get into the office for the last week as I was preparing to come out here.

These are the demographic characteristics which are fairly constant through other studies. There was a study done by Dr. Ward and also by Philip May in the States, but this is the largest one that was available. It was retrieved for a meeting on suicide

of the Canadian Psychiatric Section on Native Mental Health.

There is an average age of about 22-23; a slightly better than average Indian education, but a slightly worse than white education, which indicates that suicides may have had aspirations to higher education which failed. They at least had some high school. They were mostly unemployed, mostly never married. Most had no occupation, were unemployed, poor and alcohol abusers.

I think if that study were done again, you would have whether or not there was sexual abuse. In the males you would probably have a 50 to 60 per cent incidence of sexual abuse, and in the females 75 to 90 per cent sexual abuse, if that were to be studied again.

What do these demographic characteristics tell us?

I want to digress for a moment and tell you, if you don't already know, of a new study which is not very well accepted and certainly not respected because it is very cynical. It's a discipline called psycho-biology, and it is the psychological explanations of biological outcome. I will give you an example.

The psycho-biological -- and this is a new theory -- explanation for homosexuality is that that

phenomenon gives extra hunters to the tribe. If some are lost through warfare or misadventure, there are replacement hunters and the tribe will survive. So, in that aspect, homosexuality has a survival aspect to it, and it keeps the tribe going because there is a replacement hunter.

Whether or not replacement hunters are needed, they will either despise homosexuality or they will glorify it, so that the attitude toward homosexuality changes over different generations and ages and times of history.

If I can just give you another explanation, after the preying mantis female is fertilized, the male becomes expendable, disposable and redundant and is eaten for a bridal breakfast. If you again look at these demographic characteristics, "never married" did not include common law relationships. I heard a statistic a few years back that 46 per cent of the Indian children in Ontario were born out of wedlock. When I heard that, I really flashed on it. Being a psychiatrist, I said, "These children are doomed. How can they be so irresponsible? These children are doomed to being improperly parented; they are doomed to a life of poverty, powerlessness and anomie," until it was brought

to my attention that these children born out of wedlock were actually born to young women in common law relationships and that they would not marry their boyfriends because they would then have to give up the security of the mother's allowance pension.

Can you imagine the humiliation? Place yourself in that situation. Imagine the shame, the degradation and the humiliation of having your girlfriend refuse to marry you because you couldn't afford to support her and she would do better unmarried and living on a mother's allowance pension. Just imagine what that would be like for you as a young man, and then wonder how they survive at all.

These young men who kill themselves often have two or three children from one or two common law relationships, and their common law wives have refused to marry them, further eroding what little self-esteem they had.

They are poor. They don't contribute. Their substance abuse probably depletes the liquid and financial assets of the family and of the community. So they feel, and perhaps are seen, even by their own community, as the male preying mantis. After the fertilization process, they are redundant, expendable and

superfluous.

That is the psycho-biological explanation, and please don't go around telling people that I espouse psycho-biology, because I find it offensive. But the young men may be getting this message: What place do they have in our society?

They are certainly not wanted in the white work population because they are unskilled, they are untrained, they don't have the high technical ability. So they would be competing for jobs in labour and industry at the factory unskilled labour level with the white people, and that certainly isn't welcome in this day and age, is it?

Once the fertilization process has taken over, they are no longer needed to hunt and support the family. So, in fact, in their own minds and perhaps in the minds of the rest of the community and of the rest of the country, even in the dominant culture, they are then redundant and disposable.

At that meeting in St. Foy, Quebec in 1985, we established a paradigm which suggested that the triad of poverty, powerlessness and anomie, mixed with a history and the memories of disturbing childhood experiences, peppered with a recent separation, loss,

disappointment or letdown, would result in alcohol abuse, depression and suicide. Had that occurred on a chronic basis, it would be a chronic depression, alcohol abuse and chronic suicide. Freud saw alcoholism as chronic suicide. If it happened on an acute basis, then you would get the acute suicide and you would get a completed suicide.

In that paper, which I am not going to allude to, Dr. Fred Wien drew a parallel to the Micmac economic development and history from the Aboriginal subsistence patterns and community production and consumption to the present system of centralization, welfare and government dependency.

Dr. Marlene Brant-Castellano talked about the three dimensions of power -- personal power, interpersonal power and functional power.

Poverty is a contributing factor, and it is a contributing factor in every culture. It has never been clear to me why poverty should be a contributing factor to suicide, but it is, not only in our group of Native people and Inuit people but in every other group. The suicide rate is highest in the lowest and fifth socio-economic group and is next highest in the first socio-economic group where it occurs at a lower rate than in the fifth.

It isn't clear. Is it greed and envy turned into a rage, turned on the self, or is it a subtle and gradual persistent erosion of the self-esteem? When satellite television invaded the north, it is possible to look at the grandeur of the South Forks residence in Dallas and then look at the poorly-heated hovel in which you are living, and this can only have a deleterious effect on the self-esteem. Those of us who live in the south realize that the Brady Bunch is not the typical family. We do not live in architecturally-designed homes and have a live-in maid but, if you are living in the north, this may be held up as the norm to which you can never, under any circumstances, aspire.

Because we live in a meritocracy, where everybody is supposed to be able to become Prime Minister, then it is very easy to internalize the causes as being one's own. One's own unworthiness is the cause of the situation in which one is born.

I heard a joke the other day which said that George Bush was born on third base and thought he had hit a triple. We were born at home plate, I guess, never having got there and having no hope to get around the bases.

Some general causes of psycho-social

stresses, added to the psychological stresses -- may I have the next transparency, please. This was a government study which I don't think was ever published. What were the concerns as the result of 600 non-directed interviews of people? What kind of chronic frustration do they live under?

Inadequate housing -- sometimes two or three families are jammed into a house that is designed for one family.

Lack of employment and other income supports, which just means poverty.

No recreation facilities or programs. The recreational facilities which do exist on reserves are few and far between, and the ones that are there are poorly equipped and maintained. The young people are standing around idle, and the devil finds work for idle hands in the form of thrill-seeking behaviour, substance abuse, gas-sniffing, sexual promiscuity, et cetera.

Poor access to education and health resources. If you could possibly apply for a job, get the job interview, and muster the fluency of English to get hired, you would be faced with the unhappy choice of setting up two residences. Very few reserves have a resident physician and rely on nursing staff. Some

reserves are even too small for a nursing station.

Disorganized Band administration, patterned on the bureaucracy of the Department of Indian Affairs, is a favourite hobby horse of mine -- and not because I am an Indian living on an Indian reserve. The Band office staff, who are inadequately trained, have no job description, no sense of empowerment or responsibility and little opportunity to learn, terrorize the reserve residents with their oppositional behaviour. Frequent appeals are made to the Chief and Councillors who intervene in ordinary day-to-day decisions of the Band administration, further eroding and undermining their confidence and ability to make useful decisions. The Chiefs and Councillors are distracted from important issues by wasting their time on minor administrative matters.

When we set up our own system of government, we patterned it on the Department of Indian Affairs where you have to fill out the right form. I could tell you horror stories about what happens in the Band Office. But, of course, what goes around comes around. I had to have very expensive dental work, and I was too ashamed to go down and ask them for a form to fill out. I had been so rude to everybody for so many years, I was

embarrassed to go down and ask them to pay my dentist.

Let's go on to the prevention strategies.

These can be divided into primary, secondary and tertiary. The tertiary prevention of suicide consists of treating the people who have attempted suicide by emergency medical treatment, evacuation, psychotherapy, drug therapy, et cetera, and that usually happens. There is a bottomless pit to mop up blood -- and that's a sarcastic remark. We always seem to save, rescue, get the helicopters out, do whatever is necessary, evacuate for treatment.

I was saying to Marlene -- we had a nice visit. We live a couple of hundred yards apart, but we see each other infrequently and hardly ever sit down to have a visit. I was just reflecting that in my own personal career, I work about 20 days a month, and 16 or 17 of those days are spent in treatment, in psychotherapy in my office, and only two or three days are spent doing this kind of work, which is prevention, which is getting at the core issues, talking about the core difficulties. Why?

You could say that I am a pig feeding at the trough of treatment because there is money through the provincial ministries to pay doctors to do clinical

work; whereas, prevention programs are a pit into which you drop your time and with no apparent result for 15 or 20 years down the road.

The problem I am raising is: How can we shift our priorities from treatment to prevention? How can I ask the government, you people, to shift your priorities when I am still stingy about doing it myself? I don't know the answer to that question.

There has to be funding for prevention programs, and we are repeatedly told by government that there is not enough to do both, that we have to be parsimonious and careful with the funding. How can we maintain the current level of treatment, which the population demands and which will vote you the hell out of office if you don't give it to them, and also implement prevention programs?

What are the prevention programs? To deal with the secondary prevention, that would be education and the early recognition of suicidal risk in the community by the general population of the reserves -- that is to say, education workshops, if you can get the people out, the blitz. The typical Native at risk is those demographic characteristics which I alluded to before.

One of the questions I was asked to

address is: What is the resistance to this? Native people expect to be self-reliant in their internal emotional world. If one of these people were identified as being at high risk and if they were approached with the offer of assistance, they probably would say something like, "There's nothing wrong with me that I can't manage or handle myself." Therefore, they give you a straight-arm. So it has to be done somewhat indirectly.

Bea Shawanda, who used to work at Rainbow Lodge and was connected with the Manitoulin Island suicide epidemic, set up the Rainbow Lodge as an alcohol treatment and rehabilitation centre. She involved almost the entire community in recreational activities. Feasts were held to honour prominent citizens in the community, cooking and washing-up was done by volunteers who were invited from the community to do so, so most of the people on that reserve were included in one way or another. They even went so far as to have a dog show and award prizes and have a banquet.

The socialization assisted in developing a sense of community purpose, direction and belonging. Other gatherings, such as political or religious affiliations, tend to split the communities. However, any congregation of people will develop into a

community with a sense of purpose, direction and belonging.

Primary prevention, of course, deals with getting at the root causes of poverty. I am not an economist, and I don't feel competent to comment on that.

Prevention of powerlessness -- Mr. Bill Mussell is already on this program. It is really a point of talking to each other about our sadness, giving voice to our negative feelings. There is a common superstition among Native people that, if you talk about suicide, the people will then go out and do it. Nothing could be farther from the truth. You can help people to change the balance between the will to live and the wish to die. That is what they are juggling when they talk about suicide -- the will to live and the wish to die. It is very easy to tip it over into the will to live. Sometimes it's as simple as asking them, "Who would look after your dog if you killed yourself?" That has happened to me. I asked a person, "Whoever would look after that mangy old dog of yours?"

To talk about things is to give evil space in one's mind and in the community -- and we are not the only people who have that superstition. The Catholics are very, very touchy about giving their children information about birth control because they feel that,

if they tell them how to do it safely, they will go out and do it wantonly and promiscuously.

I have just been notified that I have just a couple of minutes left.

Indigenous helpers are not funded, trained or supported by the dominant culture. There is a denial process in the community in that there are problems until there is an explosion, and then there is a desperate cry for help in the form of tertiary treatment.

Jake Thomas has told us through Marlene -- I didn't hear this directly -- that we all have the power to give medicine to each other. I have a very fancy education and some very fancy credentials, but I think it is my humanity that actually gets through to people and is the healing aspect of what I do in my interactions with the patients in my office. The only difference between me now and me 30 years ago is that I say things with great conviction because I know them to be true in a theoretical and academic sense.

A therapy is essentially a learning process. I am suggesting that everyone read, as I will in the next couple of weeks, "The Pedagogy of the Oppressed" by Paulo Freire.

Thank you very much.

PETER ERNERK: Thank you very much, Dr. Brant.

The next speaker, Jo-Ann Daniels, will present Discussion Paper D in place of Emma LaRocque. Jo-Ann is an Executive Trustee - Committee. Otipemisiwak. She has been actively involved in the Métis community for 20 years. She is co-founder of Women of the Métis Nation and is the only Métis woman to sit at the Constitutional Table.

Please welcome Madame Daniels.

JO-ANN DANIELS: Good afternoon. I was told that I couldn't read out Professor LaRocque's 30-page paper, but that I had to present it in an engaging manner.

Professor LaRocque sends her regrets. She really wanted to be here, and she is hoping that people will read her paper. I will try to base my discussion -- I will try to condense it as much as I possibly can. The opinions and views that I made are not necessarily my own, although I agree a lot with Professor LaRocque.

Her paper is "Violence in Native Communities," and it specifically deals with sexual assault.

Some statistics behind it are that in 1989 a study by the Ontario Native Women's Association

cited that eight out of ten Aboriginal women across Canada suffer from sexual assault, have experienced sexual assault sometime in their lives. Also in 1987 the Child Protection Centre of Winnipeg cited that child abuse was epidemic in Aboriginal communities. Then on one reserve in Manitoba 30 adults were charged for abusing 50 persons, women and children; that was on one reserve. Also in November 1992, just this past November, I developed and co-ordinated a conference on violence and abuse against Métis women. It was the first-ever discussion that Métis were able to be engaged in, discussing their own issues on violence and sexual abuse.

We had a circle of about 150 women, and the question that was asked was: Those women who have not experienced abuse and violence in their lives take a step forward. Of the 150 women who attended that conference, seven women stepped forward.

This paper deals with the women's perspective on the factors causing sexual violence and on some strategies. Some of the factors Professor LaRocque goes into are: Colonialization, which was the subjugation of Aboriginal peoples and refers to loss of lands, resources, self-direction and severe disturbances of cultural ways and values. It has also

diminished the status of women. Where a lot of Aboriginal cultures were a matriarchy or semi-matriarchy, it was changed to a European patriarchy. It was imposed by the fur trade, missionaries, Christianity and government policies.

Also contributing are racism and sexism and the problems of internalization. Colonialism and racism go together. Racism justifies the subjugating of Natives, and women have yet to deal with the kind of sexism that came from that. Racism bred the hatred of Natives and sexism breeds the hatred of Native women.

Sexual violence is related to racism in that racism sets up the objectification of women as sex objects -- such things, as I am sure a lot of Aboriginal women are familiar with, as the term "squaw". It renders all Native females vulnerable to physical, verbal and sexual abuse and violence.

The long-term effects of colonialization and internalization is that Native people judge themselves in white terms or by white standards. They often became ashamed and they rejected themselves and other Native people around them.

We know a lot about the violence of white men against Native women, but what she wanted to explore

was the violence of Native men against Native women and children. Some of the reasons that were given why Native men abuse is because they, themselves, were abused.

Professor LaRocque thinks this is certainly not the final answer. In fact, she says that there were many indications of abuse before Europeans but only it was individuals against what were the best ideals in a lot of Aboriginal cultures. There was every indication, as well, that, when the Europeans came, it exacerbated the situation and it certainly built up a situation for the potential for violence in the original cultures.

Native men internalized these white male evaluations of women. Some examples that she cited are pornography, sexism and racism, the racist macho image of Indian men as the violent, crazed savage and the lengthy and unrestricted mass media projection and objectification of Indians as violent people.

Another topic that she goes on to is defence of offenders which serves to perpetuate violence.

Sexual assault is prevalent in all cultures and economies, but there is an apathy by Native leaders and governments, and it cannot rest on Aboriginal

shoulders. It seems to have come out with the discussion of residential schools, and that opened up the book for Aboriginal people to start talking about the epidemic sexual violence that is happening in all Aboriginal communities.

Because we are the people to be opening up our books and to talk about it, it doesn't mean that the responsibility of dealing with sexual abuse is ours alone.

To cite some of the reasons for the perpetuating of violence, she believes that the cultural differences is a myth, that it typecasts people. When people talk about social conditions, societal neglect and the policies explained as cultural, she believes these are also a myth. She believes that it is a gross distortion of the notion of Aboriginal peoples. Men assault; cultures do not.

Rape and violence met with quick justice in original cultures. Sexual violence simply was not tolerated in the original cultures, and any culture which advocates the oppression of women should be confronted by governments to change their cultures.

Sexual violence should never be associated with Native culture. Offenders defended in

the name of culture avoid personal responsibility, and offenders as victims -- the ramification is that they do not become personally responsible for their actions. There is a belief that they should not be punished because they, too, were victims.

Rehabilitation and victimization should not take precedence in the way in which inmates are dealt with which is devastating to the real victims, to the women and to the children. Political oppression does not preclude the mandate to live with personal and moral responsibility within communities.

Some obstacles facing real victims include the lack of privacy. Community gossip, fear of ostracization, intimidation from supporters of the perpetrators, and then there is the lack of belief. Often victims are met with disbelief, anger, denial and betrayal. Secrecy is expected and enforced and, therefore, censorship against reporting incidents.

Reporting of community -- the victim is often met with racism, sexism and often indifference. Non-Native handle the case and are ignorant about Native culture and sexual violence. For instance, you have your social workers, you have your police, you have your lawyers -- most of these people are non-Native. A lot of them

are not trained to deal specifically with sexual violence, and a lot of them don't have the kind of cultural sensitivity that the victims need.

A lot of Native women do not trust policemen. Professor LaRocque specifically says that the police, too, attack Native women.

If a Native woman does get to a court, she is also a victim of the courts. Only 10 per cent of non-Native women get to the court, and they have told the tales of what it is like to be a rape victim or a victim of sexual assault inside a court room. There are even fewer Aboriginal women who would take their cases to court.

Next there is the lenient sentencing. Thieves and minor drug dealer receive stiffer sentences than perpetrators of sexual violence. There is a society depriorization. The parole system, as well, is lenient. I know in some cases you will have a sexual offender who is out in three weeks and back into the community, and often there is retaliation against the victim.

What about the victim and where is the help and the rehabilitation for the victim? There seems to be a persistent sympathy for the offender and little for the real victim.

She wants to discuss the causes of sexual

violence. One would be going back to the rapist as victim. It doesn't resolve any problems to see rapists as victims, and it may perpetrate violence. Being a so-called victim causes one to be a victimizer. If it is true that victims do victimize, then what about the millions of women who have been victimized and do not become offenders of sexual violence?

What about the poor and abused men who do not victimize? There are many men who are sexually abused and raped who do not victimize? So how true can it be or how big a factor can it be that victims victimize?

She suggests that, because sexual violence is a universal problem, perhaps the reasons for sexual violence are far more complex and disturbing than we would like to sometimes explore; that adults violate from a place of awareness and choice. Offenders know that they are doing wrong. She then suggests that sexism and misogyny are nurtured in society, that women become playthings of men. We are objectified and degraded.

There is a male maintenance of power. It is a deliberate form of power not caused by trauma or abuse, and it is in the interests of men to keep women down. Society supports this with its tolerance of sexual violence.

The criminal justice system is seen as a white, upper middle class, male system, a system that does not take sexual violence toward women and children seriously. Rape is a warfare against women. There is no absolution for the offender, and society should never tolerate sexual violence. This should be very visible in our criminal justice system.

The duty of the criminal justice system is to serve justice first. It is absolutely essential to the victim healing that the message is that violence is simply not tolerated in this society. The criminal justice system should turn its attention to the real victim -- that is, the women, the children and the teens. Left to their own devices, they have to deal with these sexual problems, and the sexual problems then become recycled.

Some of the prevention steps she would like to see are, first of all, the Native youth. We have to reach the Native youth, as some of the people before have said. Some of the things that have to happen are, one, the socio-economic revitalization of all Aboriginal communities. This gives meaning to people's lives. When people become the masters of their own economics, when they get to say where they want to develop, this gives meaning to their lives. There should be avenues for

economic bases and activities, and vocational opportunities. These all open up that area.

Two, there is miseducation in schools. Schools have to stop presenting Native histories and cultures in biased and ethnocentric ways. Schools have to stop talking about Native cultures as being in the past.

There has to be a role in clarifying cultures. Native youth need to know what their role is in clarifying Native culture. They need some reassurance of their heritage. There has to be some real dialogue in the schools about their role in their communities and their role in their own heritage.

Recreation development -- there should be no boredom in Aboriginal communities. There should be massive efforts to develop recreation in all Aboriginal communities.

There should be sex education, specifically about sexual abuse. In fact, education is seen as the best hope for the future. Sex education especially to teens, specifically in respect to women -- all teenagers should be taught that there should be respect for themselves and respect for women. They should be taught about birth control, safe sex, reproductive choices, sexual responsibility. It should be noted that

teenage girls specifically in alcoholic or drug abuse environments are specifically susceptible to sexual violence.

Rape devastates, and they often, in turn, turn to substance abuse, prostitution, self-mutilation and/or suicide, pregnancy, sexually-transmitted diseases. All of these affect the sexual violence victim.

The suicide rate is five times higher than the national average for young people between 15 and 24 years of age. Among Native females, sexual assault is specifically linked to suicides of Native females.

There should be full disclosure, exposure and open discussion between victims and youth. There should be access to counselling; there should be safe houses in all Aboriginal communities. The largest migrating population to urban centres is that of single Aboriginal women.

Their spiritual needs have to be attended to. Their hopes and dreams should be nurtured. All teenagers, all children, should have their hopes and dreams, and those should be nurtured. Take someone like Richard Cardinal who, in 1983 or 1984, committed suicide. He had been to a number of foster homes. One of the

reasons that he committed suicide, one of the reasons that he hanged himself in the bushes of his last foster parental home, was because he could not see a future. I don't think it was so much that he wanted to die; he just simply didn't want to live any more. It was preferable because he just simply could not see a future.

Some of the considerations toward better responses are support systems: as I said before, safe houses, rape crisis centres, counselling and therapy. The laws have to be changed and enforced. There has to be an effective kind of priorization for the victim, to keep their dignity and for the victims themselves to be rehabilitated.

Some of the effects on Native women is that they make up 40 per cent of the prison population. Seventy per cent of that prison population are Métis.

The Native leadership and the government must take a leadership role in dealing with sexual violence. Aboriginal women cannot have political equality, they cannot be partners in self-government if they have no personal power. It should be alarming to Aboriginal men to sit in a room of leaders and have them all men. They should know there is something wrong in that system, which does not allow their women to be their

equals so that they can make their own decisions on their own behalf.

Those are some of the devastating results of sexual violence.

All Native and non-Native agencies should be involved with dealing with Native family problems when it comes to sexual violence. The emphasis on equality is even in the language. You have a Native offender, and that offender could be put in the same pot -- when you use the word "offender", it could mean B&E, some kind of theft, some kind of minor thing, and it could be a rapist. If an offender is a child molester, say he is a child molester. If he is a rapist, say he is a rapist.

In the corrections system, there should be a bilateral structure set up to accommodate the types of crimes and criminals being addressed. There should be a differentiation between non-violent and violent offences.

I am afraid I am not going to be able to get through all of Emma LaRocque's paper. Toward the end she makes some very good recommendations on the kinds of things and how the criminal justice system can change and how communities themselves can begin dialogue, how the communities themselves have the power to change the

kind of social ills that exist in our communities; how we can change the laws so that they do priorize sexual violence in the Aboriginal communities for the victims; how we can change the Young Offenders Act. There is a difference between people knowing what they are doing and just being young. There should be long-term rehabilitation programs for victims and their families and the communities.

I am going to wrap this up by reading Professor LaRocque's final words:

"As most of us know, violence has long been rampant in many Native communities. I know too that we have shied away from dealing with the issue partly because we have had to fend off racism and stereotypes. But given the seriousness of the situation we must confront the problem(s). If we do not, there will be 'self-governments' without selves to govern for people are leaving their places of birth to escape the violence. And it is possible to deal with these issues in an intelligent manner, without having to resort to racist stereotypes.

Finally, lest I be misunderstood, I must emphasize that I am painfully aware of the Criminal Justice System's dismal record re Native peoples! I grew up

watching police abuse my parents' generation. I saw police rough-up and/or pick up my aunts, uncles and my mother for no reason whatsoever. This generation could not defend itself in the courts due to language, discrimination and/or poverty. But I also saw or heard of police/courts neglect Native victims of Native violence. This is the ultimate form of racism. It is this latter fact that must be addressed as much as the former. Is it not time for us to make a stand against violence in our midst?

In my community, we were all victims of colonization but we did not all turn to violence. Further, why should Native victims of Native violence bear the ultimate brunt of colonization/racism and negligence of the Criminal Justice System?

My hope, of course, is that our communities will be renewed, persons will find support and restoration.

Thank you for this opportunity; I trust it can have some influence towards finding protection and justice for victims, and hopefully, toward some understanding of the issue."

Thank you very much for your attention this afternoon.

PETER ERNERK: Thank you, Jo-Ann. I will allow 12 minutes for questions.

We have had two important discussion papers this afternoon. Microphone No. 3.

PATRICK JOHNSTON: Thank you, Mr. Chairman. My name is Patrick Johnston.

I have a fairly specific question of Dr. Brant, in the first instance, but if anybody else would like to respond, I would appreciate hearing from them as well. It was reinforced, in a sense, by something that Jo-Ann made reference to, Richard Cardinal.

I was struck, Dr. Brant, by a number of references in your paper. One, in particular, was to a study you cited which I think is about 20 years old now -- Dizmang, I think, was the name of the fellow -- which made the link between the likelihood of suicide and placement in caregivers' homes outside the community or outside the family -- foster homes, adoption, and that kind of thing.

From your personal experience, are you aware of any more recent studies that may reinforce that? Two, from your own personal experience, do you believe that there is some kind of causal link? Are children who have been placed in foster care or adoption homes for even

a short period of time more likely to end up committing suicide?

Three, if you think there is some sort of causal link, do you think it is more the case today or less so than 10 or 20 years ago?

DR. CLARE BRANT: I alluded to that under the rubric of disturbing childhood experiences. The most disturbing childhood experience is separation from and loss of the primary caretaker.

Somebody has estimated -- and I don't know if they have actually done a study -- that children can stand about four separations and losses in their early childhood, which is in the first five years. Thereafter, they become disturbed adults or are on their way to becoming disturbed adults.

If something has been proved, you don't have to reinvent the wheel by doing further and further studies. So the answer is that disturbing childhood experiences, the most devastating one being separation from parental caretakers early in life, will damage you not only as a child, make you depressed as a child, but it will produce a skew in your personality as an adult.

What was the other part of your question?

PATRICK JOHNSTON: It was really

whether or not your sense is that it is less a factor today than it was 10, 15, or 20 years ago.

DR. CLARE BRANT: We are still seeing the fallout from people who were raised under the old system of the Children Aid Societies, being autocratic and based outside the reserve. It is only in the last five, ten or twelve years that reserves have established their own child and family services and ' (had control over prevention and little bit of influence over the protection needs.

However, we are not going to see the outcome for another 10 or 12 years. This is a very healthy trend, our being the directors of our children's lives and even the children who require protection and apprehension, that we have some say in it. If I saw any trend at all, I don't think it would have any significance in terms of that changeover to Native family and children's services.

PETER ERNERK: Thank you. Microphone No. 2, please.

ELDER GLEN DOUGLAS: Glen Douglas here, directing a question to Dr. Brant.

I draw your attention to page 4 of your presentation. Dizmang in 1971 found that suicides tended

to have caretakers -- and I emphasize "caretakers" -- who had troubled personal situations as well.

Many of the suicides were students of residential schools. Have any studies been done with the people of the cloth who were supposed to be the caretakers in addition to some of these studies that you quote here?

DR. CLARE BRANT: There is a typographical error. That should be Dizmang, 1974, rather than 1971.

You will be getting information on the residential schools from, I believe, Roland Chrisjohn. I know of no direct link between suicide rate and residential school experience. My opinion would be that there would be a higher incidence of suicide in people who had the residential school experience. That would be my guess, but I have no statistical back-up to prove that to you. That is an impression I have been left with over the years.

It would also depend on what age they went to the residential school. There is a book by Basil Johnson called "Indian School Days" in which he chronicles his experience in a school near Spanish, Ontario. If you have the heart to read it, the kids who were placed in

those residential settings at the age of three, four and five years old and looked after by one of the priests -- he describes this heart-wrenching scene of these little children clutching these stuffed animals as their only source of nurturing and love. He himself was not placed in a residential school until he was 13, and it was not a particularly devastating experience for him because he had 13 years with his primary caretakers, and his personality was well-established. He had a well-balanced kind of personality. They were secondary caretakers, and he survived it.

Those people, in my experience, who have consulted me in my office and who have an early residential school experience in their childhood are ruined. Their lives are ruined. They have no chance of happiness. They very rarely come for treatment themselves; they bring their children and they say, "I don't know what to do for my child because I wasn't parented myself. Help me parent my child."

ELDER GLEN DOUGLAS: Thank you, Doctor. Is it possible that sometime there could be studies made of these people who have made an oath of celibacy and then reverted to this type of activity that is unacceptable to society?

DR. CLARE BRANT: I think the study would be in the form of a police report and crown attorneys' charges. I think studying these people should be interesting and entertaining even, but I think they need to be punished so that this stops.

ELDER GLEN DOUGLAS: Thank you.

I have something to share with Jo-Ann at the next break. Thank you.

PETER ERNERK: Thank you. Microphone No. 3, please.

DR. MICHAEL MONTOUR: My question is directed to Dr. Brant. It is in relation to the comments you made regarding unwed pregnancies.

I had the opportunity to present some statistics to a community in northwestern Ontario. One of the comments that was made was that this isn't surprising because the young girls see pregnancy as an opportunity to get out of oppressive situations, whether in the home or in a foster situation.

My question relates to whether you envision a possibility in the short term to restructure the social care system, the social assistance system, in order to allow these women to develop some autonomy without the requirement of becoming pregnant.

DR. CLARE BRANT: Some prevention of the family violence, alcoholism, et cetera, yes. You would have to go back, and the results would not be forthcoming for 13, 14, 15 years. You would have to grit your teeth until the outcome came.

I served on a committee of the Ontario Community and Social Services Ministry. We were looking at all the children's services in Ontario, and it was the consensus of the committee members, after interviewing literally hundreds of people, that we should shift from treatment to prevention. Then all the treatment people showed up and said, "How can you even consider doing this? Are you going to let two or three generations of children perish because you are going to shift the funds from treatment to prevention?"

I think that is a factor, that young girls do escape school which they find unrewarding, home which they find brutalizing, and the demands of a career, and retreat. It is a kind of withdrawal into a nuclear family or to establishing their own family unit, which is them and a child, which they think is going to provide them with the love, nurturing, et cetera, which they didn't get themselves. Of course, it is a horrifying disappointment to have this noisy, smelly, little creature

around which doesn't love you at all and is not grateful for what you do. They are disappointed in their enterprise.

PETER ERNERK: Thank you. Microphone No. 2.

WOODY MORRIS: Thank you. My name is Woody Morris, and I am Haida.

Dr. Brant, in listening to your presentation, I sort of got the feeling that everything would be okay if our people just assimilated a little faster, that we are susceptible to that 1950s theory about rising expectations.

I grew up in a village where there were sometimes as many as 20 kids sleeping in a house, but there was never a feeling of being overcrowded. I also started my career in residential schools at age 13 and left when I was 21 years old. So, when you talk about it really having very little impact, I don't know how anyone can imagine that it would have no impact when I had no access to my parents; all I had was rules.

I think we spend too much time looking at what are the characteristics of the ones they call the victims, when we should take a look at the characteristics of who is providing the violence. In every case they are

Christians. If we take a look at what is happening over in Bosnia or Hercogovina, we talk about the Moslems being slaughtered, but we don't talk about who is doing it.

When we take a look at what happened to us, this was done by Christians. We always call them Catholics; that way we don't have to say Christian. In my case, I was in a Presbyterian school.

Then we talk about sexual abuse. I think maybe we should take the word "sex" out of it because it has nothing to do with sex. It's power and abuse.

In the United States, when you talk about assault, we are talking about an offensive, unconsented-to touching. That is what, to me, sexual abuse is. It is violence; it has nothing to do with sex. Sex is something normal. What these people did in residential schools to us and others had nothing to do with sex; it was violence pure and simple, power.

One of the things that Jo-Ann mentioned I think is something we should really take a look at. One, culture must be spoken of in the present tense. It is not something that happened in the past. This is our history. It is still happening, but we are in a terrible time of confusion. When we talk about seven out of ten Native women experiencing sexual assault at some time in

their lives, are we going to look at trying to stop that or are we going to take a look at our societies and say maybe what we need to do is to realign our societies. Maybe our Band Councils should stop acting like the provincial or the federal government. That is who they are modelled after, not Indian Affairs. Orders in Council are the order of the day.

I think we better start taking a look at where we are trying to go. Do we sober people up simply so that they can really be miserable; take them off drugs so they know how bad things really are? Or do we take a look at the society and say, "Hey, wait a minute, matrilineage is natural." I follow my mother's clan; I follow my grandmother's clan. My father happened to sire me, but he is not the boss.

When we look at spirituality, we are talking about a way of life, not something we simply believe.

I am sick and tired of all this stuff. One bishop said, "We couldn't possibly have hurt those kids too much because it was done in love." My god, what kind of people are they? They talk about, on the one hand, the model of perfection; yet, it is the same thing that victimizes us.

Women are put on a pedestal like the Virgin Mary, something they can never achieve. They took the epitome of the male and nailed him on a cross. So what the hell is there in it for me to be a good guy if I am only going to get crucified?

All these contradictions are in there. My kids suffer the same rage that I did. Their kids are going to suffer it, too, but they don't know why. It has nothing to do with the Brady Bunch. It has to do with what happened to us. It happened to you, too. We have to talk about ourselves in the first person singular, not "they", the third person. It is us.

PETER ERNERK: Could you go on to your question, please.

WOODY MORRISON: My question is this: Dr. Brant, if you don't think any more studies are necessary to find out if there is a connection between what happened in the residential schools and what is happening now, then what do you think is significant that we should look at?

PETER ERNERK: Just before you answer, I am going to entertain two more questions.

DR. CLARE BRANT: I would like to correct some of your misunderstandings of my statements.

First of all, I do not hold that acculturation should be speeded up. As a matter of fact, at page 19 of my presentation I said: "Previously, one's self-esteem depended on the degree to which one could acculturate one's self and give up the old Indian ways in favour of an allegedly more progressive culture."

I am not advocating acculturation as a means of solving our difficulties.

The second misunderstanding that you have taken from what I said was that it was not painful for Basil Johnson at the age of 13. If you read his book, I think you will understand the pain in it, as you understand your own.

I think perhaps more studies, that disturbing childhood experiences cause damaged children, might be helpful, but I can't see that as a priority. We know it was helpful. If I hit you over the head with a sledgehammer, it is going to break your skull. Do I have to prove that to you again and again? No, because it is established truth.

WOODY MORRISON: Why don't we look at the people who did the abuse?

DR. CLARE BRANT: If you are looking for revenge, then find it another way rather than wasting money

on further studies.

WOODY MORRISON: Revenge won't take it away. We would know what to exploit, if we know who these people are. They hide behind that cross; they hide behind the courts; they hide behind everything. Yet, we are supposed to go to their churches.

PETER ERNERK: I will go to Microphone 1.

RUSSEL WILLIER: Thank you. I was beginning to feel kind of rejected over here.

First of all, I believe I stand in honour of a young brother who gave his life for my people. He put himself up on the mountain to fast for four days, and he didn't make it.

I seem to hear this time and time again, coming from our young people, that our young brothers and sisters do believe they have a message, but then we are not listening.

When I hear all this talk about suicide, I work with teenagers on the street and know what kind of impact the media and the medium has had on our young people for generations, including our parents. I do believe that one of the things that has to stop happening in regards to dealing with residential schools is that

we have to stop dealing with it from the puritan ethic and from the position of guilt, which creates fear and anger.

I believe that the symptoms with regard to suicide go a lot deeper than basically what we see, hear and feel. For me, as a young man in this generation, having had parents and grandparents who had gone through the residential school system and learning what kind of impact that has had on my own personal life, I always say this and I will say it again: We need to look at making the churches accountable for all the stupid, bloody things they have done -- that it was ignorant, that it was cheap. We can go on and on in terms of all the different kinds of beautiful words we can think of in a very negative way.

When we look at the history of family violence, when we grew up, segregated from our own sisters, not even being able to go over and shake their hands across that line because the women were all the way over at the other side of the territory, what kind of impact do you think that had on the male ego? What kind of impact do you think that had in regards to our growing up without any kind of contact with the women whatsoever?

I look at one of the great needs that our people need to take a look at today, and that is that

we need to train men to be counsellors and therapists, to touch base with men's needs in regard to sexuality, in regard to manhood issues, in regard to not having fathers or brothers or uncles around to be able to give us nurturance and guidance.

I have to pay for my own therapy today. I look at that with resentment, and I say to myself, "One of these days these sons of bitches are going to pay."

Yes, we need to be angry. I think we are through talking too nice to these people. The law system isn't going to help us. They don't care. They can't. They're not in a position to. But we have to find different and creative ways in order to help ourselves. The government sure as hell isn't going to do it. They were in bed with the church when this happened.

I think housing, both on reservations and in urban centres -- we need to take a look at the policies with regard to the size of houses and the size of families. We can no longer be plugged into ghetto systems and think that family violence and abuse of any kind is not going to happen. Physical violence, dammit, is learned when we see it from our mothers and our own fathers.

We also need to take a look at positive

Aboriginal male role models -- not TV and film heros, not Olympic heros. We need to take a look at our own role models in our own communities and we need to address that. Everything in this day and age basically boils down to entertainment, and we need to address the entertainment system, which basically does condone suicide. We need to take a look at that realistically. In the next two to five years, the days of our youth and also the days of our Elders are pretty well numbered. My god, we have people like Michael Jackson who are doing wonderful things for people all over the world, but what about the people here in Canada and the United States, the indigenous people of this nation, of this island, that at one time was the strongest nation in the world?

Could I ask you a question, please. I need to find out, basically, what is being done for parents, for parents to be able to touch base with themselves, to educate and re-educate them, that spiritual therapy and not purely academic therapy is available. When is this intervention going to take place, because it has to stop in this generation?

I went through a Healing Workshop just down the street on February 26. We were told that by the year 2000 we want this issue addressed and we need to take

a look at a goal to do that. Yes, I believe that a lot of work needs to be done with parents. It is not the youth that are causing all these problems; it's the adults, the parents. We need to take a look at it. We need to take a look at ourselves. The mirror has to shift from here to here, and not out there.

I do believe that a lot of work has been done in regard to women's issues, and I really want to acknowledge my sisters for the good hard work they are doing. But there needs to be something that has to happen for men, for single men.

I work in a pre-employment training program for Native men, and the services are very limited in regards to young single males, and they are high in suicide.

PETER ERNERK: Thank you very much.

I would like to thank our two speakers this afternoon on behalf of the meeting. Thank you very much.

DR. LOUIS T. MONTOUR: I would like to thank Peter Ernerk, Dr. Clare Brant and Jo-Ann Daniels for their presentations. Thank you very much.

We will break for 10 minutes. We will be following this with our first Round Table. I will ask

all of the Round Table participants to please bring themselves to have a seat around the table after the break. Thank you.

--- Short Recess at 3:12 p.m.

--- Upon resuming at 3:30 p.m.

DR. LOUIS T. MONTOUR: I would like to call the next session to order.

This next session will go from 3:30 to 5:00 p.m. We will have a round table discussion from 3:30 to 4:30, followed by questions from the general audience from 4:30 to 5:00. We will then have a closing Plenary from 5:00 to 5:30 on the issues of the day.

This round table will be chaired by Dr. Jay Wortman. The question Dr. Wortman and his panel have been charged with discussing is: What is preventing the application of holistic community health strategies to deal with critical situations such as youth suicide, family violence, addiction and other serious ills? How can we support holistic community health strategies to deal with critical situations? Why has this not been done? Who should take these steps?

I would now like to call on Dr. Wortman and the panel to take over.

DR. JAY WORTMAN: Thank you, Dr.

Montour.

Welcome again to this final session of the day. It has been a very interesting day so far, and I think this session is going to be a fitting way to end the day or to wrap up what has happened up until now. I sense that there is a lot of pent-up desire in the room to speak and to have your concerns and your questions heard.

The structure of this session is set up to allow that to happen. First, there will be a discussion among the people seated around this table. That discussion will go on for approximately an hour. Following that time we will open up the floor mikes and everyone to participate further in the discussion around the question we are dealing with here.

I will begin by reading the question but, before I do that, I would like the participants seated at the round table to please tell us who you are and just very briefly -- and I know it is going to be hard for you, Alwyn, to be very brief, considering all your accomplishments. I will ask you to start by very briefly telling us who you are and what you are about.

ALWYN MORRIS: I am Alwyn Morris. My Mohawk name Onatakowa (PH). I have been working in the Aboriginal community with young people for approximately

the last eight years, through a program out of Medical Services Branch, Health and Welfare, called the NNADAP program. It is part of a role model program, where we visit different communities and try to work as effectively as we can with young people, to try to give them a spirit of what can be done in their lives with a lot of hard work and a lot of dreaming.

I would just like to say that.

KATIE RICH: Hi. My name is Katie Rich. I am the Chief of the Mushuau Band of Davis Inlet. I was elected over a year ago, on March 31, so it has been a year since I have been the Chief. Thank you.

DR. YVON ALLARD: Hello. My name is Yvon Allard. I am a Métis from Manitoba. My home village is St. Laurent. We were very happy last Friday to have somebody from our village become the new Lieutenant Governor of Manitoba, Yvon Dumont.

I am presently a medical researcher at the St. Boniface Hospital Research Centre. Thank you.

JEAN GOODWILL: Good afternoon. My name is Jean Goodwill. I am a Cree from Saskatchewan. After 20 years as a civil servant in Ottawa, I am finally home living on Standing Buffalo Reserve in Fort Qu'Appelle. I have had firsthand experience in the realities of life

there, in a small Indian community, which is only a microcosm of the many things that were talked about today.

DR. IRWIN ANTONE: My name is Irwin Antone. I am an Oneida from southern Ontario. I am a family physician, and I have been practising in my community for the last 13-14 years.

DR. ED CONNORS: Good afternoon. I am Ed Connors. I am of Mohawk and Irish ancestry. My Band is Kahnawake. I have an Ojibway name (native language). I work amongst the Ojibway people in northwestern Ontario, in the area of Treaty 3. I work with Ojibway Tribal Family Services Sacred Circle; it is one of my consultation services that I provide.

I also work with Ma Mawi Wi Chi Itata in Winnipeg, and consult with other organizations across the country.

I am a psychologist by training. I also am studying the traditional ways of healing. The Elder who is my teacher is Elder Alex Skead. My work is centred out of the (native language) First Nation in the upper half of Treaty 3.

MAGGIE HODGSON: My name is Maggie Hodgson. I am the Director of Nechi Institute. Nechi is a training and research centre in the area of alcohol

and drugs and family violence and management. We also co-ordinate National Addictions Awareness Week.

MADELINE DION-STOUT: My name is Madeline Dion-Stout. I am a Cree from Alberta originally. I do live and work in Ottawa now.

I am presently the Director of the Aboriginal Centre for Aboriginal Education, Research and Culture at Carleton University.

I am a nurse in my first incarnation and am presently a student of human development.

MARTHA MONTOUR: My name is Martha Montour, and I am here representing the Native Women's Association of Canada.

I am a former, and still, registered nurse and also a lawyer.

RODA GREY: My name is Roda Grey. I am originally from Kanuktuk, northern Quebec, but I work in Ottawa for the Inuit Women's Association as a national health co-ordinator.

We deal with a lot of issues, health and social issues. This is my opportunity to talk about social issues.

ANNIE TULUGUK: My name is Annie Tuluguk. I am from Povungnituk in northern Quebec. I

am Inuit. I am the Director General of the hospital in Povungnituk. I am also the President of the local Women's Group.

DR. JAY WORTMAN: Thank you. I am Dr. Jay Wortman, as you know, born into a Métis family many years ago in northern Alberta. It was interesting to hear the Métis Elder this morning explain why Métis have these three qualities of dance, music and humour. Now you will understand why I make such a clumsy attempt at humour, because I can't play the fiddle and I can't dance.

The question that this panel is going to grapple with, bringing to bear issues that have been presented today and the information that we have had presented to us in their own experience and expertise, I will read to you now:

What is preventing the application of holistic community health strategies to deal with critical situations such as youth suicide, family violence, addiction and other serious ills? How can we support holistic community health strategies to deal with critical situations? Why has this not been done? Who should take these steps?

To provoke you a little bit, to get you started in this discussion, I am going to put to you a

thesis that I have formed here, that the reason holistic community health strategies -- and when I read that, I think traditional healing methods, traditional health strategies, the kinds of things we have heard the Elders and many other people here speak of. When we say "community health strategies", I propose to you that those things are not the tools that you use to deal with crises like suicide and family violence and addiction. Those crises have emerged out of the turmoil that destroyed the culture that gave rise to community health strategies.

Holistic community health strategies are strategies of prevention and health promotion. We are left again with the dichotomy which we heard addressed earlier in the day of treatment and all the resources that go into treatment versus the tendency to neglect the other side of the equation, the prevention and health promotion.

I am not going to try to defend that thesis, but I just throw that out as a provocative notion that may help you get the discussion started. I am not going to point to anyone to start the discussion unless there is a long period of silence when I ask for the discussion to begin. In that case, I have somebody in mind.

I invite your participation. I will

keep track of your interjections and, if you have been silent, I will at some point ask you to participate.

The floor is open.

MARTHA MONTOUR: I would like to make a comment. One thing I would like to say about this Round Table is that I am glad to see that there is a majority of women sitting here. I think that is lacking across the country, that women are sitting at tables like this, having input and making political statements, and also having some real say over what goes on in the community.

In listening to what went on this morning, I can see that the traditional practices, although it was tried very hard to do away with them and legislate them out of existence, are still there. They are still being practised.

In order to implement holistic community health strategies, these things have to be thought of by the community and have to be supported by the community, and there has to be funding put into the things that the community feels will help them achieve health and a healthy community and help them deal with the problems.

We can't do away with what happened in the past, but we have to learn how to deal with it and continue living on in the society that we have to live

in.

I think one of the keys is that the government has to quit saying, "We are only going to fund mainstream medical models, only if you have M.D. degrees, or you to follow a set medical protocol." They went professionals into the community who have absolutely no knowledge of the culture, no knowledge of the traditional healing practices, no knowledge of traditional foods because of their medical background. That has to be one of the criteria for funding.

The community has to support whatever the health professionals bring into the communities and have the resources to incorporate all types of practices that the community will follow and support.

I just wanted to start off with that.

A lot of the traditional healing practices and the traditional foods were cultivated by the women. That is why women have to have at least half the say and they have to have half the funds going to them, and there has to be women sitting at the table, not just mostly the male side. This is good, and I think it is a good example of how it can work really well. There has to be the women's input as well as the men's input on an

equal basis so that they work together for the good of the community.

DR. ED CONNORS: I agree, in part, with your theory. I think it is partly true that the approaches that are holistic and that have come from our communities that are considered to be traditional are, by and large, health promotion approaches.

I work primarily in the area of suicide prevention with youth in our area. When we started our work, we were directed by our Elders to go around to our communities and to speak with the Elders and the youth in the communities and ask them why the rate of suicide is so high within our communities and what can we do about it.

The Elders primarily directed us to strategies and approaches that could be characterized, if we were to call them traditional, as prevention approaches. However, that is not the whole explanation for why holistic approaches are not used.

I think one of the more all-encompassing explanations is simply -- and our Elders continuously direct us to understand things in the simplest form and to understand what is the basis for things. I think the simplest explanation is simply that people are not trained

in thinking holistically, the people who are making the decisions about funding most of our community projects. That is, non-Native people as well as, by and large, many of our people within our communities today have lost contact with holistic thinking. The kind of education and training they have received, as they have been raised by various different caretakers many of whom were non-Native people, taught them to think in ways that were not holistic.

Many times, I think what happens is that people just do not see the holistic solutions and, therefore, are not able to implement them. Many of our Elders who have been raised in traditional ways very clearly see the solutions and give us the solutions, but then are frustrated by the fact that younger people are not able to comprehend what they are trying to tell us and are frustrated by the fact that they cannot receive the kind of support, either financially or physically, from the community members to implement these strategies.

I will give you one example of that. Our Elders in our community had envisioned for a long time the need for an Elders/Youth Learning Centre. The concept of that was, very simply, to provide a place where Elders could once again teach the young people to think

holistically.

That came about. It actually was supported by a couple of small groups within the community, and they actually built a facility. Now they are having a very difficult time getting the funding to actually implement the approach to teaching, training and healing that they have envisioned. The support is not coming, not only from government, but also, to a large extent, not coming from Chief and Councils a lot of time because they perhaps can't see the vision that the Elders have shared with them.

DR. YVON ALLARD: I agree with you, Dr. Wortman, with your assessment about community health strategies. First, there must be a collective sense of a cohesive community; there must be a common bond, a sense of commonality among individuals in that community.

Individualism seems to be adversarial to this collective idea of community. First, you must have in individuals a sense of who they are, their place in the community.

In a lot of Aboriginal communities, there is a great loss of this individualism -- the word for it is "anomie" -- where individuals feel disconnected from their surroundings, disconnected from this thing

called community.

Before you can have a community health strategy, you must deal with the individuals having a strong sense of who they are and then having a collective sense of the community. In a lot of communities, I guess most appropriately, places are not communities because there is not this common sense of belonging to a place and of a common history.

That is why community health strategies, when they go in, assume that there is a community there, and there isn't. It's a place, a collection of people, not a community of individuals working together.

MADELINE DION-STOUT: I believe that, just by using the word "community", we are focusing our energies in the right direction.

I believe there are some very real barriers to implementing community health strategies. If you don't mind, I have listed them so I don't go talking for hours -- I am known to talk a lot. I will be very brief.

Going back to Rosemary Proctor's paper this morning, where she talked about the shift from disease causation to determinants of health, I believe we have to take a critical look at what the bio-medical model says

are our determinants of health. Normally, it is infant mortality rates, morbidity rates, life expectancy rates, and mortality rates.

I believe that, as people who are being exercised in our own communities about our own health problems and concerns, we have to roll in there what my community would call (native language). Those are poverties, all our poverties, not just our socio-economic poverties but the poverties that translate into all our basic, unmet human needs. If it is discrimination, that is what it is. If it is inability to get into a school, then we are made poor by that.

Because we suffer poverties, we then suffer pathologies, and those I don't have to list out.

I really believe, too, that a new and emerging health determinant for us is what I would term the information standard. We saw in minutes the situation of the Innu community, and it was flashed around the world about the injustices that have been committed against the Innu people. That is what I mean when I say "information standard." I believe this is the very exercise we are going through here today -- that health determinants are going to be very much determined by what information exists in society about our situation.

I also think that one of the barriers to community health strategies is, of course, the over-emphasis on the bio-medical model. I speak probably as a heretic, because I am a nurse. But I believe that has to be said because some of the bio-medical health strategies have not worked, particularly when you consider that some of the interventions that medical health professionals -- in fact, all health professionals -- do is counsel one-to-one. I believe that is very detrimental to having good outcomes for families, good outcomes for a sense of self to begin with and good outcomes for communities.

I also believe that we are all our own health development. I really shudder to think that we are shifting some of our health dependency on to our overworked Elders. If there would be some way that we could help one another to be about our own health development, I believe it would have far more reaching consequences.

Loss of mediating structures, I believe, is something that is at work in our communities. Here I refer to our families. Our families aren't even forming any more; we heard that during the discussions today.

I also feel that we enshrine phenomena

like extended families. I, too, believe in extended families, but we have had some research done by the Nechi Institute where, in fact, extended families have been instrumental in hiding sexual abuse and sexual abusers. I think we have to take a very hard look at some of our own social institutions.

I also believe that there is some abuse and unuse of our traditions. I take a real strong position here for women. I believe that there is some consideration to be made for people who have different belief systems, that it is not just traditional practices and traditional beliefs that are at work in our communities. There are many, many belief systems in our communities.

Sometimes I feel that there is no other way but to follow traditional practices -- and I am not knocking them down. I am just saying that we have to respect one another's belief systems.

I also feel that it is to our detriment that there is such poor integration of scientific medicine and traditional medicine. Some of our traditional health practices have stood us in good stead for thousands of years, and we have to recognize those at the same time as we recognize some of the scientific developments that

have worked in our favour. I believe Daisy talked about that this morning, where she had helpful heart surgery 15 years ago.

I believe, too, that we have to name our situation. We cannot normalize our situation and say that, if we are in crisis, we are not calling it a crisis. In order for us to make movement, we have to recognize that there are some real problems in our communities and that these problems have to be rectified.

I don't believe that the community is the only group that the responsibility falls on. By the very fact that we say "grassroots", "bottom up", "on the ground," suggests to me that there are other players besides communities here and that a lot of responsibility falls on the governments at all levels.

I worry about the overall oppression of all men and women in our communities. I believe it is because of that that oppression of women exists. I agree with some of the men here who are saying: Involve us in improving the lot of all our men and women.

I also think that there are some theories that keep coming back to us, such as colonization and things like that. They are helpful, but I like the focus of community here where we are getting away from blaming

others and seeing ourselves as being protagonists in making changes for ourselves.

Thank you.

DR. JAY WORTMAN: Thank you, Madeline. Alwyn has a comment.

ALWYN MORRIS: I would just like to pick up where Madeline left off. She talked about community and basically taking control of our own destiny.

When I think of holistic and I think of community and I think of what we are facing in our communities, there may be policies in governments that say that line funding has to come down this way. But, ultimately, the moneys that come down for programs and health services and whatnot have to come on the discretion of our own people, and that is our own leadership.

I find it sometimes very difficult to understand that we are faced with a number of ills, which I think we can control, but often we look at following a line department criterion for spending as opposed to saying, "What does our community need?" From what I understand of traditional beliefs, our communities worked in a holistic manner from the beginning. If we try to take an example from the Mohawk society, it is that each clan had a responsibility.

We are not necessarily going to be able to go back to that tradition, for a lot of different reasons. However, there are practitioners in our communities who have those responsibilities and who have to work together.

One of the examples I would like to bring to the table is that we talk about our young people and we talk about education; yet, when we look at education, we look at them and we say, "What do you want to give us, provincial government? What do we have to follow?" We take their whole curriculum and we say, "Okay. Now we have to make sure that these kids have math and they have to have a history and they have to have a science. And they have to complete high school in five years."

Why do we keep taking those things and saying we have to apply them to ourselves? Why aren't we saying, "Fine. What's the big rush for our kids to get out in the world anyway? We are saying there are a lot of ills out there. Let's try to make sure they are well-prepared." Why don't we take control of education and say, "The heck with trying to finish high school in five years. Let's get our kids to stay a year and a half longer. Maybe then we can prepare them properly."

That is going to take the community and

the community leaders. It doesn't take the government policy in the end; it takes us.

Sometimes I struggle with that. We are sitting there in those communities. We are the ones who are supposed to be in control, but sometimes we are so out of control. Why?

This document here and every one that is sitting in my bedroom upstairs talks about mobilizing the need for certain things for young people. The focus is directly on young people.

The media certainly brought that to us. We know it is out there. Yet, when we plan for infrastructure in our communities, be it schools, be it recreation centres or whatever the case, nobody works together. Somebody is building this over here because that is a project they find their criteria will only spend on. Somebody else is building something over there, and they are going to take care of that.

When I go back to the question which is what is preventing the application, I am not sure what is preventing it. I think we can control that. We are the ones to control our own destiny. If we start to take on a governmental attitude, which is basically, "We will take care of you," -- we have all come through the day

and everybody understood that they are not taking care of us. We're the ones who have to do it. We're the ones who have to implement, if you will, our expanding cultural revival. We are the ones who need to be able to control those things. So why aren't we doing it?

Has it come down to a basic premise that says, "Well, our Chief and Council and our political leaders are saying, 'We can't do this because it puts us in jeopardy on a constitutional basis. We can't do this because then we jeopardize the jurisdictional battle.'?" In the meantime, our kids are dropping off left and right, and we are all saying the kids are our future and, without them, we have no future.

I think it is time to start to look at some realities here. They are going awfully quick. Somewhere along the line we have to make sure that -- yes, there are going to be political battles in this country and in the United States and everywhere else in the world for indigenous people. Yes, there are going to have to be some leaders who are going to have to take that role on and not give up. But there are other realities which our communities are facing which have to be taken care of right up front.

Maybe sometimes it is going to be very

hard to say -- and probably this happens in the Council chambers, at a table very much like this one, when they say, "All right, we have X amount of dollars for housing. Who gets one?" Does your family get one, or does your cousin get one down the road or does your best friend get one? Who gets it? If that is what we are faced with, no wonder we are having problems.

I go back to that young group of kids who are sitting there, who are supposed to be our future. Do we let go one house for the sake of providing a program for young kids to be active?

We have to somehow set our priorities, and we have to start to mobilize. Rather than becoming line departments with criteria that is faced with government, we have to expand our own horizons. In many cases, I guess we all have to become visionary. It may be critical.

I am talking from that point of view, but I think the Chief sitting next to me is probably feeling very similar. She feels it is out of hand; it is out of control. What are we going to do about it? It's back in our court.

Maybe that's my mentality as a former athlete; I don't know. Maybe that is something that I

have seen happen when I have met young kids who came and gave you a hug and never wanted to let go because they were afraid to let go, because they had to go home to something that was less. Maybe those things have impacted on me for eight years, and that is why I am trying to figure out why we aren't doing it for ourselves as opposed to looking on the outside all the time.

Thank you.

DR. JAY WORTMAN: Thank you, Alwyn. You have done a good job of tweaking the sensitivities of the group. Everyone now wants to speak.

Jean, I think you are next; then Irwin; then Annie; then Roda.

JEAN GOODWILL: My background is also nursing, so I am glad we have three nurses here in this crowd -- my only bias.

Just to follow up on what Alwyn said, I thought maybe I should throw this in for further discussion. I think one of the reasons that it has been very difficult for communities now and in the past to try to accomplish something, despite the millions of dollars that politicians usually throw around during election time and how much they spend on indigenous people across this country, is that we have always had to grapple with two

government departments, and never the two shall meet. One is looking after social services, and one is looking after health services. Even to this day, at this point in time, I don't know -- maybe a few of them are talking to each other.

I think that's one of our biggest problems. We have always had to rely on government funding for anything and everything we have done, and I guess we will be doing so for quite some time. Maybe if we could bang their heads together and get them to get at it and grapple with some of the issues we are talking about, we might get some place.

The second point I would like to make is that we have buildings -- buildings and buildings. I remember some years ago, when the Native Alcoholic and Drug Abuse Program was first established in Ottawa, the treatment centres cropped up across this country. There was very little preparation. There was a lot of minimal para-professional training that was taking place.

Treatment centres are great and wonderful, and I am sure Maggie can vouch for that, from the Nechi Institute. But I am talking about many others. These people get terrific treatment, but they are there for two or three weeks or a month at a time. They come

home, and there is no support system. Again, we are back at the same old problem. Again, we are back to dealing with two government departments. There is no support system, and within two weeks they are back to where they started from.

In the small community where I am living now -- I have been there close to three years. In the first three years I have been there, there have been two suicides. I am sure it is not as many as some other communities, but we have a small community of approximately 400 people. This last week there were two attempted ones. This happens all the time, and we are still facing the same problem of two government departments and who is going to do what. This is an election year, and you can almost hear them standing at the podium telling us how many millions of dollars they are going to spend on us in the coming year.

DR. IRWIN ANTONE: To begin with, in answering the question that is presented before us, I first of all want to say that I am fully supportive of the holistic approach to medicine. The other thing is that I want to compliment the discussion that has been going on already. In fact, I consider the women to be the prime backbone of most organizations and communities.

With some of the comments I am going to make, I am going to be a devil's advocate and make them a bit inflammatory just to see what happens.

In response to the question, one of the things that I jotted down here was, in fact, that the involvement in answering the question of what is preventing the functioning of the holistic approach is that the involvement should be by the community and of the community. I think that has been stated several times already around the table.

The second item is ignorance. My comment on ignorance is that, in fact, I think a lot of the Native communities do not know the traditional ways. There are pockets that know traditional ways, and there is young development of traditional ways. But I think a lot of the traditional ways are, unfortunately, gone and may be lost forever.

This was followed up by the fact that I think there is a lack of sincerity. A lack of sincerity is on the health providers and the people in the communities, who can talk and talk and talk and say what we should do for young people, what we should do with Elders, what we should do with abuse, what we should do with a whole number of issues, but it never goes beyond

talking.

The traditional way was that people worked together. I think lack of unity was one of the comments mentioned. Communities are not working together as a unit. People are going here, going there. I think that is one of the traditions that Native people have lost.

I think some of that sincerity of support is also lack of government. I know that funding is needed for lots of organizations but, if you go back to truly traditional, there was no funding, and people made it. They struggled and they worked hard and had new ideas. They had to make new ideas and followed old ideas that worked for hundreds and hundreds of years. But no one came along and gave them money and said, "This is what you need, and you need this amount of money."

True, it is a different society now than years ago, but, if we are going to talk tradition, this is my comment.

This morning and this afternoon there was already mention of innovative ideas. Again, that is something that we should try to further support. One of the things that sticks in my mind is the comment on making other people accountable. I suppose that will scare the heck out of some people, and maybe that's good because

it will get a response.

There are a number of other different ways of innovative ideas. I think we really just have to put our heads together and, working as a sincere unified group, come up with those ideas.

Another comment is the individuality of different areas of Native people. What works in one place may not work in another. For a provincial or a national body to say this is how it should work in B.C., this is how it should work in northern Ontario, this is how it should work among the Micmacs, I think is going to fail. Each group of Indians, whether out of pride or individuality, are going to say it may not work and, in fact, it may not work.

I think we have to be careful that there is enough individuality in our approaches.

The last thing I want to mention is that I think western medicine and traditional medicine as is can be interwoven. They can go hand in hand. There was mention this morning already of the lady who does traditional medicine; yet, she benefited from cardiac surgery. So the two can work together.

Prevention is not new to Native people. It has been recorded in history, and things have been

done in terms of medicines, child-bearing, birth control -- and that is not new.

Thank you.

ANNIE TULUGUK: When we received the fundamental questions, we found those questions so important that we decided to ask not only one group of people but the community as well.

I asked the professional staff at the hospital -- the doctors, the midwives, the social workers: What is preventing the application of holistic community health strategies to deal with all those social ills that we have? Their answers were: funding; lack of personnel and training; and the absence of treatment centres at Povungnituk, up north.

When I asked the Inuit, the community, what was preventing us, they said: There are too few of us working who understand what we are doing, why we are working in that area, in healing. There are too few of us who have completed the circle of healing and are doing something about the pain that is existing in the community. There are not enough of us, and there is too much pain in the community. We are burning out our people. There is a lack of resources. We have no treatment centres up north, not one.

When someone wants to go for treatment for alcohol addiction or any kind of treatment, they have to go down to Montreal, where it's a totally different environment, different language. There is a big language barrier, so lots of people come back discouraged.

There is the other thing that I was talking about earlier this morning. There is no program, there is nothing for young people in the Inuit communities in northern Quebec. Nothing was provided for the young people, the women or the children under the James Bay Agreement, which is where we get all our money from, all our programs. Nobody foresaw that there would be any need for youth programs or for women's programs or for children. There is not one daycare centre being funded up north. If we want one, we have to work hard and long to get one.

There are no recreation facilities. There are a few, but you the community really had to work hard for that, too.

How can we support the holistic community health strategies? It is by training people, by having more people complete the Healing Circle -- and I mean looking at their childhood traumas, their childhood pain, the violence they have experienced, and by healing from those experiences, the loss and the separation. By

understanding those experiences and going through a healing process, that was the only way we could improve the statistics on youth suicide.

We have had many suicides in our community in Povungnituk. We went to speak with one family who experienced a suicide a year and a half ago. The answer from the family was: "No, we don't want to talk about it. We want to forget about the suicide. Don't talk to us; let us forget it." That was the answer we got from the family.

There has to be education in the Circle of Healing -- the spiritual, the emotional, all the four factors that people were talking about this morning. There are too few of us who understand that as yet.

There has to be funds, and people have to take responsibility for their own health. It is by taking the responsibility to look at their own pain, their childhood pain.

That is what I wanted to say.

DR. JAY WORTMAN: Just before you speak, Roda, I will just remind you that at 4:30, which is seven minutes from now, Dr. Louis Montour is going to interrupt us and open up the discussion to the rest of the group.

I notice that Roda is going to speak

next. Two other members of the group haven't spoken yet, and I would like to give you the opportunity to do that before we open up the discussion. Please keep your remarks focused and to the point.

Thank you.

RODA GREY: That's not fair.

DR. JAY WORTMAN: That is Dr. Montour's rule, not mine.

RODA GREY: What I want to say is that communities have their own problems. We know that. But, as Annie says, there is no funding, there are no resources. Even though there is funding from the government, it is always at the end of March. Everything happens at the end of March.

It is really, really difficult. If we want to solve our problems, we all have barriers because we don't have resources. I get so frustrated. Almost every day my community says that we have volunteer workers, and we need funding, and I say, "Well, I don't have the resources."

They are out there in the communities ready for training, but there is no resources for the Inuit communities. It is very, very frustrating.

It is very nice to see in the papers that

there is some possibility for solutions for strategies from the national level to the communities, but if we don't have all the resources, I don't know what we can do.

Yesterday I was asking somebody on the plane, I wondered if this meeting was worth it because it costs a lot of money. That money could be used in communities for prevention or to help the children who need it.

Thank you.

KATIE RICH: My name is Katie Rich, from Davis Inlet, Labrador.

February 14, as you all know, is a day when you give gifts to your loved ones. February 14 was a sad day for Davis. That was the day ---

DR. JAY WORTMAN: I think we all appreciate the difficulties that have occurred in Davis Inlet, the community that Chief Katie Rich comes from. If you like, we can proceed with the rest of the discussion, and you can give us your input later. We understand why you feel very strongly about this.

MAGGIE HODGSON: When I listened to Alwyn talk about education and the need to re-look at what we are doing and our responsibility and our decision-making, there was this white guy who was doing

research on transfer of control of education to an Indian Band. He asked the white community which was transferring authority what the Indian people would be getting, and they said they were going to have control of education. He asked the Indian people who were receiving the transfer, and they said, "We're going to have strength."

I think what you are talking about is strength, a new way of creating strength when we get that control.

I think one way we get strength and one of the things that stands in our road is our own mythology, mythology that you talk about, about how we have all this culture. Yes, I think we do have a lot of culture in terms of traditional ways, but I think we have to be aware of what kind of new culture we are creating in our community through our own policy-makers and our own decision-makers. The policy I am talking about is the policy of gambling.

The same people who brought us the residential school brought us gambling into our churches, and that was bingo. We did a study where 62 per cent of our students and adult counsellors have from five to twenty years' sobriety. That is exciting, wonderful, right on!

What I wonder is what percentage of those parents go to bingo. We know what their average take-home

income is, about $24,000 gross. They have an average of four children apiece. If they spend $300 or $400 a month on bingo, that $300 or $400 is not going into their kids' education, it's not going into their children's recreation, and it's not going into their children's well-being. That is our culture. That is our mythology, and that is our denial.

The issue of gambling, for me, is a manifestation of our need for the collective -- who am I in this new society? If I go to a bingo hall, everybody knows me there -- my god, that sense of collective. I can be in the city, and I can be with other Aboriginal people and I can belong. So we recreate culture to our own detriment sometimes, in terms of what kinds of choices we are making as parents.

It has to do with the issue of abandonment. If I look at suicide, if I look at violence and if I look at pain of children, in a study that we did, the people who developed a drinking problem developed a full-blown problem at age 13. If they develop a full-blown problem by age 13 if they are going to develop that problem, when they are left home babysitting, their parents meet them at the door and they go to bingo, and those kids take care of the younger kids.

The same rationalization, the same excuses are made about bingo as were made about booze: "I deserve it. I work hard." The kids are left to feel guilty because they complain.

The issue of abandonment is historical. It starts with residential school and the kids being forced out of their homes. Then it moves to alcoholism, and then we have abandonment again -- not physical abandonment, but emotional abandonment. Now we just create a new opportunity for abandonment of our children.

The whole issue of abandonment, I think, ties right into the issue of violence and kids being abandoned emotionally when there is violence in the home and people don't talk about it. That is one of my big concerns as a mother.

Working in the field, I want to do what is right. But we are missing the mark somehow. We are missing the bloody mark. If we can create sobriety and we don't create addressing the issue of addiction, we are missing the mark.

One of the other things is training. When I look at social policy, Health and Welfare Canada, Department of Indian Affairs and Canada Employment and Immigration need to look at how they can more effectively

collaborate in the area of training. I work in the area of training. You have NNADAP funding for training. Health and Welfare are kind of slow. They don't know how to reach into other people's pockets. We have to learn how to be more effective at that.

I listened to these other women talk about the need for training. I think CEC and the other departments need to get together.

I think we have to stop blaming. We have to accept the responsibility and continue to accept responsibility.

DR. JAY WORTMAN: Thank you, Maggie, for those remarks.

Each of our panelists have spoken to us. I personally feel that, although Katie didn't share many words with us, she probably spoke the loudest in terms of feeling her pain and the pain of her community. I am appreciative of her contribution, as I know you are.

We will now open up the discussion to the other audience. Dr. Louis Montour will kick that portion of this discussion off now.

DR. LOUIS T. MONTOUR: I would like to invite participants from the audience to please address questions to any of the members of the Round Table, or

please feel free to make comments. I would like to request that those individuals who had a great opportunity to discuss in group allow other individuals to have a chance to address us. I would like those other individuals to please come forward now. Jay will continue to moderate.

Thank you.

DR. JAY WORTMAN: I always end up doing the hard work, in case you haven't noticed.

We will conduct this portion of the discussion in the way we have earlier discussions. I will just remind you that for the next half-hour I want you to direct your comments to the question that the panelists have been speaking to. After that time, there will be a Plenary Session during which you can direct your comments to anything that has been discussed today.

We will begin with the person at Microphone 2, and please start by telling us your name.

LYNNE JORGESEN: My name is Lynne Jorgesen. I am a member of the Okanagan Nation in British Columbia.

First, I would like to say I am really proud to see so many health care professionals in the room today.

Second, I would like to address my

comment or my concern to something that Dr. Irwin Antone said, although other people touched on it. He made a comment that western and traditional medicine should be interwoven and that they can go hand in hand.

I would like to comment that I think they already have been interwoven to a great extent, but it is just not acknowledged. To cite a historical example, I think it was the Huron people who showed Jacques Cartier a simple cure for scurvy that had plagued his crew. They took it and were cured, but the information was lost to history for another 200 or 300 years.

Aspirin is a synthesis of another Native medicine that is found in my area. It is found in red willow bark. Today cancer researchers are very excited about a substance that is found in the bark of the Pacific yew, a remedy that was already in use by Native healers for hundreds, if not thousands, of years.

I really think it is about time that the western medical establishment paid tribute to the enormous debt that they owe Native healers with their centuries of wisdom. I think that awareness is really important to deal with the question which the Round Table has been dealing with today, and I would just like to hear a comment from anybody about that.

Thank you.

DR. JAY WORTMAN: Thank you. Irwin looks like he is poised to respond, but I would invite other panelists as well to make a comment if the wish.

DR. IRWIN ANTONE: I would like to compliment her. She is making a very excellent point. In fact, Native heritage and tradition has led North America through a large number of things, including the United States Constitution. So I agree completely.

DR. JAY WORTMAN: I would just add that I think the traditional holistic community health strategies, to use the words in our question -- I think the traditional Native community health approach has much to teach us, not necessarily about particular bio-medical interventions where we boil the heck out of some tree bark and find out what works, but in the continuity of spiritual and emotional and physical health that western science is now discovering, which has been part of traditional healing forever.

DR. IRWIN ANTONE: If it's any consolation, at the University of Western Ontario Medical School, one of the requirements of getting into medicine is, in fact, that people have the ability to communicate. So medicine is slowly developing some of the holistic

approach.

DR. JAY WORTMAN: Before the next question at the mike, Dr. Ed Connors wants to make a comment.

DR. ED CONNORS: I just wanted to add to that comment and something Irwin said in his comments -- and I acknowledge that he was wanting to be controversial, so I am not sure whether it was really his position.

The comment you did make was that traditional healers have found a way to survive for hundreds and thousands of years and, therefore, it should be still be possible today, and that method of survival should perhaps be something other than dependent upon the economic system that we have established and developed in this country.

I would like to say that our Elders are not able to live today on simply the gifts of tobacco and the other contributions that our people make. They are making a tremendous contribution to the healing in this country today, much of which is not even present here in this forum. We are not aware of it, and it is going on and has been going on and will continue to go on, despite whatever we talk about here and whatever recognition or

lack of recognition we give them.

It used to be, traditionally, that our Elders were supported by our people and by our communities. Their needs were met. Currently, we don't do that, and they can't survive in the way in which they used to. But they continue to do what they used to do.

Somebody said just recently to me that our Elders certainly cannot pay for their gasoline with tobacco and they can't buy airline tickets to go to the places we are asking them to go on tobacco. We have to support our Elders and we have to do that financially today. That is traditional, I would argue. It's the traditional way, and it is consistent with traditional values and beliefs.

DR. JAY WORTMAN: The speaker at Microphone 2, please.

KEITH LECLAIRE: Keith LeClaire from Kateri Memorial Hospital in the territory of Kahnawake.

I just want to share -- and maybe I can bounce it off all the participants. What I have heard, in fact, are three levels of discussion today. The first one we are really talking about is at a personal level; the second one was at a community level; and the third one was at a federal level.

In fact, at the personal level, I think what we are really saying is that we have to communicate. I think Maggie brought it out very clearly. Is it not true that, in fact, part of our problem, in terms of our own support mechanisms, is the fact that we can't talk to each other, that we can't feel what each other is feeling and, because of that, basically we can't trust.

What I am hearing right now is that there is a lot of pain, a lot of anger. In fact, how do we generate it to make that something very, very useful? I think that is where the whole issue of the denial is coming through. There is a lot of pain that every one of us has, and maybe there is a need to make sure that we, as individuals, try and work that out for ourselves, to be able to help other people from our own communities.

At the community level -- and I think it was Irwin who brought out the point that it appears that what you really have to look at is your own community. Maybe that is one of the things we can look at in terms of our recommendation. What do we have right now in our communities and how can we use what is there? A lot of times, instead of running and asking for more money, we should check and see what we can do within those programs of capability.

The other one is more at the government level. The problem is that the government pigeonholes all of the funds through the different programs, with no flexibility. Working at a hospital, I would really like to recommend that, instead of dealing with two types of funding agency, being the federal government and the provinces, perhaps we should be looking at Indian health as an improvement to go to perhaps 100 per cent federally-funded programming. I know this can cause a lot of differences in terms of legislation, but the reality is that we are losing a lot of our own people. Maybe that is one thing we can be looking at.

It is very hard, especially if you started off trying to develop a program. What happens? You start off talking with, say, the province; two or three meetings later, "Oh, you better go check with Medical Services," or vice versa. Sometimes you are bounced around like a ping pong ball.

In terms of trying to look at something that is more objective and might be workable, maybe that is one of the things we can look at. Maybe I could have some comments from some of the Native people who worked in the federal government, i.e. both Madeline and Jean. They would probably be able to give us some comments on

this from their own perspectives.

Those are my comments. Thank you.

DR. JAY WORTMAN: Thank you for your comments. Yvon indicates that he would like to respond to part of your question, I believe.

DR. YVON ALLARD: I would like to give you a history lesson about a Métis community health strategy.

Back in the 1840s in the Red River, the first western hospital was initiated by the Métis communities of St. Boniface, St. Vital and St. Robert at the meeting of the Red River and the Assiniboine River. In the last 150 years that hospital has been funded by the Métis communities and the francophone communities as well.

Last year the provincial government put their new health strategy in plan. They are taking away the paediatric ward, obstetrics and gynaecology, and the geriatric ward. That is a hospital that was built by the Métis community, and now the provincial government is essentially dismantling that Métis health institution that was initiated and supported for the last 150 years.

One of the greatest fears for the Métis people is not the federal level; Métis communities get

no federal health services or social services at all. Our problem is health institutions that we have initiated and supported which are now being destroyed by provincial health plans in Manitoba. Saskatchewan just announced their provincial health reform.

The Métis people in St. Boniface, in St. Vital and in St. Robert and in the Red River, such as in St. Laurent, feel powerless to stop this provincial health reform, essentially to take something which they have built and now are dismantling.

DR. JAY WORTMAN: Perhaps in the interests of keeping the discussion going along, I will take the prerogative, as someone who is Métis and works for the federal government, to make a comment.

It is really an acknowledgement that I understand, I have heard the message quite clearly, that people in all Aboriginal communities find it confusing in terms of where funding originates, who is responsible, where the responsibilities are changing, whether they have control over those changes.

I am not advocating on either side of the question, but I think it is important to acknowledge that that occurs and that maybe within government there is a need to look at this issue. If we focus back on the

question we are presented with here, I think one of the problems for motivated people in communities to do things is figuring out that maze of how to get the resources to do things.

Having said that, Alwyn will make a comment. After Alwyn speaks, we will go to Microphone 3 and then to Microphone 2.

ALWYN MORRIS: I hate to interject, but I am trying to figure this out. There are some realities that seem to come and haunt us all the time. If we are trying to figure out the system, to go in there, to make the changes, to be involved politically in the mainstream political world, when we go home, we don't go home. So how can we go back home when we are ostracized because we joined this other mainstream system? We're dead.

People who want to see change try to get involved somehow without showing their colours -- because that is what you have to do if you get involved with political life in the mainstream. Once you have done that, what are you going to do?

Ultimately, if you ever think that you can go and run for politics on the outside, become a member of Parliament, and then go home and become Chief of Council,

it's not going to happen because you're tainted right away. They say, "You were part of that non-Native system and you cannot, by any stretch of the imagination, come back and tell us how we should be living as Indian people because you have lost your Indian ways."

So we're caught in that dichotomy. What are we going to do? Sure, we will send our best warriors off to go and become political leaders in the mainstream, and the rest of us will stay there and we will all wait for them to go and figure it out for us. But, if they happen to come back home, I can't be their friend -- never mind being their friend; they will never be able to lead in our own communities. So, we're stuck again.

If we are trying to say that we need to look at our communities and help our own communities grow holistically, and that is based on our traditions, we have to somehow influence government to start thinking holistically. They are always saying to us, "You have to do more with less." Maybe what we should be telling them is, "Fine, we'll do more with less, but that means you guys have to come together to make sure that we can do more with less; you guys have to arrange yourselves appropriately as well."

Unfortunately, the question that comes

to hand is: If you are a minister of the crown and you have a constituency, you are always going to be responsible and react to that constituency. What happens to us, again?

MAGGIE HODGSON: Alwyn, you wouldn't be hinting that you are running for Brian Mulroney's job, are you?

ALWYN MORRIS: Not on your life!

DR. JAY WORTMAN: Without jumping into that one, I think we'll move along and invite the speaker at Microphone 3 to make a comment.

DR. ISAAC SOBOL: I am Isaac Sobol. I am a non-Native physician working in a Native-run health organization in northern British Columbia.

As the speakers made their comments, I made a few notes, and I have some questions and comments, hopefully directly related to the topic of what is preventing the use or introduction or promotion of holistic health care services in Native communities.

There was a comment made that not all of the knowledge base of traditional medicine remains in Native communities. It may be that I am an outsider and so I haven't been made privy to the knowledge that remains, but it is my sense that that is true in some cases, that there isn't the complete body of knowledge left, at least

in individual communities, that there used to be.

I am wondering if anyone has done a real investigation of how much traditional medicine knowledge remains. Is anyone doing any research at a local level, at a provincial level, at a national level? Is anyone interested in that? Is there an inventory of such practices?

If practices have been lost in certain communities, can they be re-introduced? Is there anyone interested in doing that? Is there community interest in re-introducing these practices if and when they have been lost? Is there the local political will to re-introduce these practices?

I think a lot of the impediment to this has to do with acculturation and the pressures of acculturation. People watch television. Kids and adults watch TV, and they see that doctors give out Robitussin DM, for example, for coughs. They come in to see me as a doctor, and they want Robitussin DM.

I am very interested in holistic medicine and traditional medicine. I would like to be able to weave the two brands of medicine together, western and holistic. There has to be a movement toward the medical community, the so-called western medical

community. It has to be really strong, and there has to be some pressure placed on it.

There are a lot of moves in the medical community to increase the number of Aboriginal students getting medical degrees. But, at the same time, are those universities thinking of incorporating traditional medicine into the curriculum? Are Native medical students in those universities demanding that in the curriculum, or are they satisfied just to learn western medicine and go back to their communities?

Has anybody approached the Canadian Medical Association, for example, or the provincial Royal College of Medicine to push for traditional medicine information and research? Is anybody doing that?

Another impediment to holistic and traditional medicine is the fact that doctors are part of a system which is tied heavily into the multinational pharmaceutical industry. A comment was made earlier today about Bill C-91. Medicine is a business. Doctors are the end salesmen of drugs which are made for profit. So a lot of medicine doesn't have anything to do with health or caring for people; unfortunately, it has to do with people making a living and companies making a profit.

That's a big social issue which is an

impediment to holistic and traditional medicine. That has to be addressed at some level. It is not just a Native problem; it's a society problem, and that is the society we are working in.

In terms of acculturation, I see in Native communities role models. Unfortunately, Alwyn is here, and I see calendars with Natives on them providing role models -- the Olympic athlete, the conductor, the actor. I don't see any calendars being made with role models of the Elder giving advice on the reserve, the woman getting involved in local politics. There is always this pressure to join the mainstream system or to have role models appear to be in that mainstream system, and I think that inhibits the introduction or the promotion of holistic care.

Thank you.

DR. JAY WORTMAN: Thank you for your comments, Isaac. I know those questions weren't intended as rhetorical. You asked some very good questions, and quite a few.

In the interests of making sure that we move the discussion along, I have one panelist who wants to make a comment. We will have two comments, I am told, and then we will take the last question from Microphone

2.

Roda, and then Jean.

RODA GREY: I just want to make a comment on this, because we didn't really touch on it. Youth suicide, what are we going to do about that? I am sure a lot of you have a lot of good ideas. I don't have any answers. Do the communities have answers? I don't know.

What are we going to do about youth who are suiciding? It is a big problem for the communities. Maybe they don't know how to start. Maybe we have to strategize what should be done. Maybe we have to do something. It's a real, real problem in communities. Maybe we should address the political leaders or professionals -- doctors, local nurses, social workers.

I think agencies and communities should be involved in how to strategize and in how to deal with our youth suicide, because it is very, very painful.

Thank you.

JEAN GOODWILL: I just wanted to comment on Dr. Sobol's questions. When he asks how much traditional knowledge exists, I think it exists in most communities, but it is still very well hidden. There are many traditional people, both young and old, who are still very reluctant to come out and express the fact that they

do have that knowledge and they do have expertise in the area of healing practices. It is slowly coming around.

The area of training I think we are going to be discussing on the last day again. I just wanted to say that the Saskatchewan Indian Federated College and the University of Regina, where I teach part-time, we do have an Indian Health Studies program, and part of that course does teach traditional health, and we bring in different speakers.

I just wanted to make a brief comment. I will be talking about it more later.

DR. JAY WORTMAN: Thank you. I will just remind you that we will take the last question from Microphone 2, and then this portion of the session will end. There will be a continuing opportunity because a Plenary Session follows this. For those of you who have other questions, your opportunity to ask those questions will be in the next portion which follows immediately afterward.

LOU DEMERAIS: Mr. Chairman, in view of the fact that I will be speaking tomorrow -- by the way, my name is Lou Demerais, and I am with the Vancouver Native Health Society. In view of the fact that I will be participating in the Round Table tomorrow, perhaps I will

yield to the person behind me who wants to make a statement.

If anyone wants to hear about the Vancouver Native Health Society, they are going to have to come back tomorrow. I did have a question and a statement, but I will defer.

DR. JAY WORTMAN: We are at the end of the period for this. This will be the last question for this segment. We will wrap this segment up after this question and then move into the Plenary.

JEAN AQUASH: I was interested in the one that was talking about traditional medicines.

I do know of some traditional people who know of traditional medicines. Whatever they know they don't give out to the public. It is really kept to themselves because of scientific patenting and stuff like that. They prefer to use it for their own.

It is hard to come by those who do hold those medicines. They are few and far between who do know the real traditional way of healing.

DR. JAY WORTMAN: Thank you.

We will bring this Round Table discussion to a close now. I will just say that we have had some very meaningful input from all the participants

and from the floor. I don't know if we have answered the question satisfactorily, but I think we have had some good discussion around the question.

I think the thing that has come through most clearly to me in the discussion is that it is a little bit of a vicious circle. The question seems to be how can we improve the health of the community, to create a holistic community health strategy, when the individuals who make up that community are suffering, and how can we address the suffering of those individuals so that they can form a healthy community when they don't have a healthy community to help them with their suffering? It's a circular problem, and I think it's one that is a very essential problem that needs to be solved.

We are asking people to lift themselves up by their own boot straps, essentially. It is a question which I hope we will revisit again and again during this discussion as it goes on and into the future.

Thank you very much for your participation. I will turn you over now to our Chairman, Dr. Louis Montour.

DR. LOUIS T. MONTOUR: I would like to thank, on behalf of the panel, Dr. Yvon Allard, Dr. Irwin Antone, Jean Goodwill, Dr. Ed Connors, Madeline

Dion-Stout, Maggie Hodgson, Martha Montour, Chief Katie Rich, Alwyn Morris, Roda Grey and Annie Tuluguk for their excellent participation and input, and our hardworking moderator, Dr. Jay Wortman.

We are now going to have a half-hour Plenary Session about any questions you wish to raise about any of the issues, basically anything. We will go to 5:30. If we see that we are petering out with questions or audience, we will then invite Glen Douglas for the closing.

I, myself, would like to start off this session with a little bit of my own comments on many of the issues that were addressed.

I have often been asked, as a Native physician, what is my view on traditional medicine and what do people get out of traditional medicine, do I believe in it. It is usually non-Native people who ask me that. I usually ask them first what is their concept of traditional medicine, what is to them.

People have very funny ideas about what traditional medicine is. They think you shake a few beads or burn some grass or do some mumbo-jumbo, and this is traditional medicine. That's obviously a caricature, but just to make a point.

Traditional medicine is part and parcel

of a traditional lifestyle. One must be filled with the culture; one must have a background and must have knowledge of the traditions and customs and ceremonies. If you are such an individual, then, of course, traditional medicine is part and parcel of your lifestyle, and it works.

To contemplate traditional medicine as an entity unto itself and totally separate from the rest of Native culture is false and erroneous and should not continue.

I was struck very much by many of the speakers, especially this morning. I was thinking of all these ailing and hurting people out there in Indian country who need acute care and need intervention. This is necessary to permit people to survive long enough to be able to succeed in the healing journey.

This is where we are today. We have to commence a healing journey in ourselves; we have to commence a healing journey in our communities; and we have to commence a healing journey in our nations.

We have Daisy Watts who exemplifies the blend of traditional and western medicine. She is here today to talk to us because of western medicine and western intervention. But that is not what is important. What is important is the traditional element.

We heard Glen Douglas speak of honour, respect, caring and sharing. I would submit to you that that is the essence of traditional life and lifestyle and the essence of traditional medicine.

I would now like to open the floor to questions and comments.

TUMA YOUNG: My name is Tuma, and I am from the Mi'Kmaq Nation.

I heard all these people talk about what they do, and I am just a thorn in the side for many people.

I am so glad to be here, and I would like to thank the Royal Commission first and foremost. I am also glad that I heard the term Micmac come up many times. Dr. Clare Brant mentioned it in his report and Dr. Antone said it. Just a little clarification: it's not Micmac; it's Mi'Kmaq. I just wanted to clarify that.

I was going to get up and make a comment, and Jay Wortman is gone. He mentioned about our holistic methods being more geared toward prevention, not crisis-oriented.

I don't necessarily agree with that. Our history and our culture and our traditions teach that our holistic methods were primarily geared toward prevention, but that they were also quite able to cope

with crises. We also had crises in our lives. I was sitting next to Keith, and he mentioned that he was from the Mohawk Nation, and I said, "Oh, our traditional enemies." That would have been a crisis a long time ago.

DR. LOUIS T. MONTOUR: Fortunately, that doesn't happen today.

TUMA YOUNG: No. He married a Micmac. It wasn't me, though.

I think what is hindering us -- I agree with Maggie. One of the things that is hindering us is that we refuse to take responsibility for our own actions. We heard of violence against women. Who is doing it? It is men. Why aren't men getting up and saying, "What can we do?" It's not a woman's issue; it's a man's issue. It is up to us, as men, to deal with that. It's not up to women.

That was very clear to me when they opened a treatment centre, a family healing treatment centre, in Waicugmah (PH). They said: Isn't that a wonderful program, a transition house for where women and children can go and help start the healing. I said that was a pretty dark day for Micmacs, that we actually needed a program like that. Why aren't the men being counselled?

I think about what I do as an AIDS

educator. Mostly, I hold up a mirror to people. Many times we hear about Micmacs and Native people as a whole that we respect our Elders, we respect our women, we respect our children. When I am in the communities, I will be the first to say that's bullshit; that is not true. We may have a long time ago, but let us look at ourselves. Why are these things happening? Because we don't respect ourselves.

I also try to get AIDS education to be more personal and responsible. One of the first questions I ask -- and I am going to ask this crowd of people here, not necessarily to the Royal Commission because I already asked them one time: How many of you here use condoms when you are having sex? How many of you give AIDS education, talk about AIDS in your communities? Not that many.

It's more a personal responsibility. You know that famous saying: Practise what you preach. That's what the kids told me one time. They said, "Do you have sex?" Here I was trying to tell them about abstinence, and they were saying, "It's like smoking. You tell me not to smoke, and here you are smoking." And I am honest about that, too. It's now changing; it's called postponing.

It is really taking personal responsibility. This is what is happening, and we are doing it.

Thank you.

DR. LOUIS T. MONTOUR: Thank you. Microphone No. 3.

DR. CLARE BRANT: You have heard quite a lot from me today, but I just wanted to tell you a favourite story of mine and one of my experiences with traditional medicine.

I would like to compliment the last speaker on her candour.

When I was working in London, there were three reserves within about 20 miles of London. I had a patient who was referred to me and who had a great deal of transportation difficulties getting into town. He used to have to take the school bus in and then hitchhike back. He came every week for two years, and sometimes he came twice a week.

His situation was that he was the youngest child living with his aged mother who was in her middle-eighties and very cranky and mean, under circumstances which were impoverished. There was no plumbing or electricity in the old shack they were living

in.

All of her other children had done well, and she reminded him on a daily basis of what a failure he was and what a burden he was to her, living off her old age pension and welfare, so she denigrated him.

It was a simple case of self-esteem-building, and I was trained to do that. I saw him every week for two years and nothing happened. We whined and commiserated about his situation, but no progress was made. Then he suddenly disappeared. He just stopped coming in.

I saw him at a social event on that same reserve about 18 months later, and he looked great. He had lost weight. He had a girl with him. He was nicely dressed, and he was having a good time at the social event.

I had an opportunity that evening to speak to him and I said, "What is going on with you?" I was waiting for congratulations on my successful treatment. But he had, in fact, consulted a medicine person near Syracuse, New York, named Standing Arrow, who, in one session, told him that he was the subject of a curse by people who had been envious of his good looks, good fortune, good family, fine connections, et cetera, and that the treatment to have the curse removed was for him

to have a feast for his entire clan. He was given a menu which was moose meat and wild rice, and he had to have a live band at this feast for about 90 people, which was going to cost him three or four thousand dollars.

In order to do that, he had to get off welfare and go to work at the Band Office cutting brush. Then he started going out with the maid at the Band Office. They were going to pay him $2 extra if he brought his own truck and, if he had his own truck, he could also take his girlfriend to the show in town.

This went on and on and on. He never did save up the money for the $2,000 feast, but he was looking forward to doing that in maybe the next 10 or 15 years to get this curse removed.

What happened in that situation is that the medicine man cured him in one session, which I could not do in 100.

DR. LOUIS T. MONTOUR: Microphone No. 1.

ELDER GLEN DOUGLAS: It has been said that some of the Elders could not live on tobacco. That's right. You can't put tobacco in a gas tank. I used to chew tobacco, and it don't taste so good. But I had an advantage. For those who blew smoke on me, I could spit

on them.

It goes without saying that in our communities there is much denial. Denial is what perpetuates any kind of illness, social illness, be it abuse or whatever it is, alcohol, drugs, whatever it is.

You see, I like to think of myself as being three people. I am who I think I am; I am as you see me; I am who I really am when I am in a dark room or in my sweat lodge where I don't role play for anyone. Therefore, I am the best role model because I am humble and I am asking the Creator for help.

Too often our leaders talk and talk and collect reams of studies. Our people are the most studied people on the face of this earth. In the United States, they are going through the forty-second President. Each administration studied the people down there. We have something like 18, going on 19, Prime Ministers that are going to study our situation. We have had some 34 Premiers doing the same thing. Now we have this Royal Commission. That's another study. I don't know how many times this Royal Commission has been through.

I have discovered, because I have several contacts in town here that have called for various

reasons and they ask me what I am doing here, and I tell them I am here with the Royal Commission. "Oh, the Royal Commission is here for the Aboriginal Peoples?" "Yes." They didn't know about it. They still don't know about it, until I told them. There is a lack of communication.

One of the things my Elders taught me also was: Don't always believe what people say. Watch what they do, and therein lies the truth. I hope this Commission here comes up with something which we can work with, so that we can do it ourselves.

Long before the Europeans came, it didn't cost us a dime to teach language or culture or customs or traditions. We did it on our own. But, we were interfered with because we were savages. In the French language, we are still called savages. I get copies of the Minutes of Parliament, and in French we are still savages.

There is a lot of these things we have to get hold of and pull our own boots on. We have to take action ourselves.

There are many people who know the practices, know the way, who still have some of these healing powers with their hands and so forth, but who will

not do it except on referral through special friends. It is because they can get charged with practising medicine without a licence.

When I returned in 1983, I couldn't hardly walk. I started going back to the sweat lodge. I almost lost both my legs in Korea. I still carry a bullet in my back. I couldn't hardly walk; I couldn't hardly move my arms. I started going back to the sweat lodge and using the various medicines in there. Today you see me walking as though nothing is wrong. I have a piece of metal from here down to my knee.

When I still had that on, I went back and fought one more war because of my cultural practices.

I am going to tell you a story about what happened in 1938. I was a young boy then, but it actually happened in a court room in Kelowna, B.C. An Elder tells me this, who is my mentor and also my hereditary Chief.

A young man went to the hospital for a ruptured appendix. The doctor was to cut on him the next morning. He says, "I don't want to be cut on," and he asked his friend to go and get this Indian doctor, as he is called, in Vernon which is about 25 miles away. The man went on his saddle horse and brought this medicine

man down.

He looked at him, put a bandana around his eyes, worked on him and, when he finished with him, that young man got up and walked out. He couldn't hardly stand up before it happened.

When the doctor came in at six o'clock to operate on him, he was gone, and he was very angry. "What happened?" They said, "Some old man came and talked to the young man, and he left." He said, "Where are they?" He said, "I don't know. Downtown."

He went and found him in a pool hall. There was this young man playing pool. He said, "I am supposed to cut on you. You had better get back to the hospital." He said, "I'm well." He said, "What happened?" He said, "That old man over there worked on me."

He walked over there and said, "What did you do to him?" He said, "Well, I fixed him up."

This doctor went downtown and got the RCMP, brought them back and said, "Arrest this man for practising medicine without a licence."

They tried him and had him in court. They asked him, "How did you do this?" He asked for a pitcher of water to be placed about 10 or 12 feet in front

of the witness stand and an empty glass. He said, "I'll show you."

He put his bandana on, and he went like this, and he inhaled. The contents of the pitcher went down. Then he said, "Now watch this. Watch that glass." He blew, and that glass filled up. He says, "That's what did. First I looked at that young man. By blindfolding myself, I could tell what was the matter with him, and I withdrew the poison from him. Now you have arrested me and now you put me in jail. Why? It was our way." He said, "Now I want that doctor to do what I did."

The doctor sat there and never said nothing. The old man said again, "I want that doctor to do exactly what I did." The doctor raised his hands and said, "How can I?"

Case dismissed.

As for suicide prevention, I have had two in my own family -- three -- two nephews and a daughter. I worked as crisis intervention worker; yet, I couldn't help them. It is something that is very difficult, very difficult to stop. I have had suicide ideations myself, and I think I did when I was in combat because of some of the things that I have seen.

Judging from my military record, the

awards and decorations I received on the battlefield, that made me very suicidal because it didn't matter what I did. I don't remember that I did those things, but I did them and I was recognized for them.

I am working on my healing. I am working on it because I am aware. Awareness is a great tool. I have to risk like I risked in combat, risk telling about what happened to me, why it happened to me, and who did it, and then work on it some more, and then to determination.

I have learned in my counselling career that the key words. The first one is subjective: listen to what the person has to say about himself. The second is observation of the person's mannerisms. While all this is happening, you make an assessment of what is going on. Concurrently, you are making plans for that person, what to do with him -- to refer him to some Elder, to a psychologist or whatever.

Thank god I still had Elders left that I could go to. I can count them on one hand now in my whole Okanagan territory -- on one hand. Right now my aunt is dying. I told my brother who called me -- "Where are you going to be?" I said, "I am going to Vancouver." He said, "Are you going to go and visit her?" I said,

"She will understand that I am fighting a different war."

If I get a call and I suddenly have to leave, you will know why. It will be three days or longer after she passes before she is buried, so I can make it back in time.

Meanwhile, next week I have to spend a week at the Veterans' Hospital taking care of my own needs.

So we have to think about priorities, about the new church that our people have found, that bingo hall, which reminds me of a story which happened. It is supposed to have originated from one of these sounds here in Vancouver, between Vancouver Island.

These people were out fishing in a boat. A storm started blowing. The wind was really blowing and was rocking them all over the place. The skipper says, "Any of you guys know how to pray?" One guy says, "No." He asked the next guy, "Do you know how to pray?" He says, "Well, I don't know. You people will laugh at me." He said, "Go ahead, pray."

So he kind of paused and everybody stopped, and they were trying to keep the little boat upright. They were flowing with the waves. This guy got started and he said, "Under the B, 6."

Thank you.

DR. LOUIS T. MONTOUR: Thank you. Microphone No. 2, please.

DR. ED CONNORS: I think what we have just heard is an eloquent presentation by Dr. Brant, a psychiatrist, Elder Douglas, an Elder, testifying, telling us of the existence of that other paradigm that was referred to by Rosemary Proctor.

She refers to it as a paradigm shift. She tells us that currently there is a paradigm shift occurring. But I submit that that shift is really an observation, in a sense, from outside of First Nations and Inuit communities. It's an observation of a shift that is going on in western medicine, a shift in paradigm, and a movement toward thinking holistically.

That holistic thinking has existed in our communities and continues to exist. It has suffered. It has gone underground, but it has never died. There are many, many Elders that I know of in our area who are healers and who have knowledge about healing, various degrees of healing, and many who have always throughout their life practised.

In our area I think what we need to have happen, when we talk about what needs to happen, is that there needs to be -- as that paradigm shift occurs in

western medicine, western medicine people have to begin to acknowledge and recognize the validity and the effectiveness of the holistic way of healing. They have to come to respect that, and it is only when that happens that truly we will have a sharing of the knowledge.

It is not until people in western medicine begin to say to our people and to show, as Elder Douglas describes, that they have respect for that healing that our people will come forward and share that knowledge. It is when they feel that and see that that they begin to share.

That has happened in our area. The Kenora/Lake of the Woods Hospital, for over 10 years, has had a healers' program within the hospital. It wasn't because the healers came to the hospital and said, "We want to share our healing with you or our healing knowledge." It was because the physicians there said, "There's a knowledge here that we don't have," just like Clare said, "and we need it here. It would make our healing much more powerful and much more effective if it is here."

So they initiated the development of a healing program, and that healers' program goes on today and has facilitated all kinds of other healing experiences,

not only in the hospital but in the surrounding communities.

It is when our people who are western physicians, western-trained psychologists, psychiatrists, are able to say and to accept that those people who are trained in traditional ways are equal brothers and sisters in healing, when they can say and not put forward ideas that suggest that those people should do their practices on the side as an extra activity and that physicians, psychiatrists and other healers should be paid for what they do.

When the thinking comes about where we can that all those healers are legitimate and that they should be equally supported, in whatever ways that support comes about, that is when the true coming together of the knowledge will happen. Then we will really see tremendous healing happening in this country.

I have experienced some of that happening already. Many of our people who are teachers or Elders tell us that we are in a very powerful time of healing, a time when that knowledge is coming together. Many of us who are working in the community see that happening already and have experienced it.

I just wanted to add that.

DR. LOUIS T. MONTOUR: Thank you. We have time for two more comments, both at Microphone 3.

DAVID NEWHOUSE: I just wanted to add to the debate. I think one of the factors that was not considered in the discussion this afternoon was a general discussion on the system of human knowledge. We fail to realize that all human knowledge is constructed and there is a very definite hierarchy of knowledge that exists, with western knowledge based upon rationale through logic and reason at the top and everyone else somewhere down at the bottom. Traditional practices tend to fall somewhere down at the bottom and, therefore, are not considered valid forms of knowledge.

As a result, when people in positions of authority begin to consider the approaches that we would like to take in health, they don't consider the approaches valid because they are not based upon a valid set of knowledge.

I want to recount an experience which I have had recently. I sat as a member of a new board of Ontario, called the Ontario Health Professions Regulatory Advisory Council. It was created by the NDP government, and its purpose is to regulate the health professions in Ontario. There are now 24 self-governing

health professions composed of doctors, dentists, denturists, midwives, and a whole series of groups. The purpose of the board is to consider a series of regulations concerning things like entry to practice and training and development of members of the profession.

The Traditional Chinese Healers Association have asked to be regulated. If you want to be regulated, then you have to go through a fairly rigorous process.

The College of Physicians and Surgeons of Ontario have said to us that they do not consider there to be a body of knowledge that the Traditional Chinese Healers can draw upon, which is codified, which is written down, which meets the standards of western science. Therefore, they are not eligible for regulation and, therefore, not eligible for funding from the government through the OHIP program.

That is one of the barriers that we face. The Aboriginal traditional healers and Aboriginal midwives are currently exempt from the legislation but, undoubtedly, there will be pressure in the future for other Aboriginal healers to come forward so that the Ontario medical plan can continue to pay for them. So one has to begin to talk about questions of standards and questions

of body of knowledge.

I don't know how one begins to deal with that whole question and how one culture begins to judge the validity of a body of knowledge of another. That is a very large problem. The Chinese Traditional Healers Association responded by saying to the College, "We have been practising medicine for 5,000 years. You have been practising modern medicine for about 200. Who has the valid body of knowledge?" The discussion so sits at this point.

So we should be very careful in the future in ensuring that we do things that do not continue to reinforce the current structure of knowledge. We will have to somehow begin to consider this whole question of validity and how to begin to address that question so that we can begin to ensure that our practices are considered valid. There are even people within our own communities who don't consider traditional practices valid.

It is a large question, and I felt that it was omitted from the debate this afternoon.

DR. LOUIS T. MONTOUR: That is an excellent point. The last comment will be from Peter.

PETER ERNERK: Thank you, Mr. Chair.

If I am completely out of line, just feel

free to kick me away from the microphone.

DR. LOUIS T. MONTOUR: I would never do that.

PETER ERNERK: I want to talk about two issues that were touched upon at the Round Table this afternoon. They include family violence as well as the issue of suicide.

I really think it is about time that we take control of our own lives as we take a look at our future. On the issue of family violence, I have always seen this as a very serious issue and we need to deal with it. We men must get involved now to make some changes as to how we take a look at this serious matter in our own communities.

I think what needs to be done is that we must have more educational programs as well as information provided to all people who live at the community level. I think it's about time that we take it as a serious matter.

Secondly, Mr. Chairman, the issue of suicide we also have to take under control. I talked briefly about what we have been doing in the Northwest Territories, especially in the last three to four years. It is a painful issue and, since it is a painful issue,

we have to try to find some answers to it; we have to try to find some solutions to it. We have to able to take some preventive programs.

Let me share with some of the things we have done in the past 10 years or so in the Northwest Territories.

Ten years ago a man by the name of Jack Kenouac who is our Member of Parliament now for Nunachuk riding, did a study of suicide in the Keewatin Region in particular as it relates to the Nunawit Region of the Northwest Territories. We found that there were a lot of problems with this.

One day we decided that we had to take some measures to try to find some solutions to it. In the Legislative Assembly of the Northwest Territories, four years ago, we decided to talk about this situation in terms of trying to find some solutions to it among our own people. We have taken action in terms of preventive measures.

In the Northwest Territories I believe we now have 10 suicide prevention specialists across the Northwest Territories. In the Keewatin Region, where I live, we have one suicide prevention specialist who has the responsibility of visiting the communities, getting

the people involved at the community level -- that is to say, the Mayors, the Hamlet Councils, as well as the general public itself.

The other situation that we have in the Keewatin Region in the Eastern Arctic is that we have volunteers who man crisis lines, the telephones in place, where people can phone in. I, myself, have been involved in Rankin Inlet, looking after the crisis line, along with other volunteers who receive calls from the various individuals from the Keewatin as well as many other communities in the region.

I think we have taken some fairly constructive programs.

DR. LOUIS T. MONTOUR: I would like to ask you to make your most important point now.

PETER ERNERK: I was just about to make that.

DR. LOUIS T. MONTOUR: I am glad you are not an Elder, so that I can interrupt this way.

PETER ERNERK: I think we have taken some very positive steps in terms of providing preventive programs in regard to the issue of suicide prevention program, and I think it is quite positive.

Thank you very much.

DR. LOUIS T. MONTOUR: Thank you very much, Peter.

I am just judging if I should try the patience of the group further. I would like to make one comment.

We have heard a lot of discussion about western medicine and traditional medicine and the term "western medicine" bandied about. The gentleman here who commented about knowledge and bases -- I think we should remember that western medicine and western culture are young. We are suffering from a societal clash of western culture and Native culture.

We have a western culture based on materialism, based on profit, based on imperialism, colonialism -- all the "isms" that we have been subjected to over the last many years. I think what we need, before we are going to get healing and before we are going to get a renaissance of traditionalism, is a reconciliation of the knowledge that western culture has really done a disservice to other cultures that are here today.

I would like to ask Elder Glen Douglas to please come forward and give the closing prayer.

--- Closing Prayer

--- Whereupon the Hearing was adjourned at 5:45 p.m. to resume on Thursday, March 11, 1993, at 8:30 a.m.