

Early death among members of Toronto's Aboriginal Community: Walking in their shoes



Anishnawbe Health Toronto

Dr. C.P. Shah, Dr. R. Klair, Dr. A. Reeves

Synopsis

Toronto is a city that offers world-class health services to its Aboriginal and non-Aboriginal citizens alike. Yet, our clinical observations at Anishnawbe Health Toronto suggest that there are a large number of Aboriginal individuals in Toronto dying prematurely—meaning, they are passing away long before would be expected for the average Canadian citizen. This report details a mixed methods research study undertaken at Anishnawbe Health Toronto to explore this phenomenon, in order to determine the root causes of this apparent trend.

Overview

Background

The study, conducted at Anishnawbe Health Toronto, looks at premature deaths in the Aboriginal community through a quantitative medical chart review and a narrative analysis of qualitative interviews. Interviews carried out with Aboriginal community members who were close to the deceased offer insight into the social determinants of health for the deceased throughout their life course. The aim of our study was to identify the root causes of premature death rates among Aboriginal service users at two large urban health centres in Toronto.


Historical Context

According to data from the National Household Survey in 2011, there were 1,400,685 Aboriginal people in Canada, comprising 4.3% of the Canadian population.¹ The province with the highest Aboriginal population was Ontario, at 301,425.¹ In spite of the popular misconception that Canada's Aboriginal communities live, for the most part, in First Nations communities, here in Ontario only 37% of First Nations people with registered Indian Status live in a First Nations community.¹ This is the second lowest total among all the provinces behind Newfoundland and Labrador.¹ Research suggests that such migration occurs primarily as a response to the deplorable economic and social conditions characteristic of many First Nations communities.² In both developing and developed countries alike, Indigenous peoples face some of the heaviest burdens of ill health.³ Age-standardized, all-cause mortality for the Aboriginal population is

¹ Statistics Canada. National Household Survey 2011. *Aboriginal Peoples in Canada: First Nations People, Métis and Inuit*. <http://www.statcan.gc.ca/daily-quotidien/130508/dq130508a-eng.htm>.

² Cooke, M., & Belanger, D. (2006). Migration theories and First Nations mobility: Towards a systems perspective. *Canadian Review of Sociology and Anthropology*, 43(2), 141–164.

³ Marmot et. al. Closing the Gap in a Generation Health Equity Through Action on the Social Determinants on Health. *A Report of the WHO on Social Determinants of Health* (CSDH, 2008).



almost twice that of the whole population of Canada, for men (561 v. 340 per 100,000) and women (335 v. 172 per 100,000) alike.⁴ Consequently, census data demonstrates a clear disparity of average ages between Aboriginal peoples in Canada and the population at large. The mean age of all Canadians is 41 currently and growing, while the Aboriginal mean sits at a striking 28 years old.⁵

This present disparity is repeated in projected life expectancy rates for 2017, where Canadian men are estimated to live to age 79, and women to 83.⁶ Lowest expectancy rates in the country are projected for Inuit men at 64 years of age, and Inuit women at 73.⁶ The Métis and First Nations populations have similar life expectancies, at 73-74 years for men and 78-80 years for women.⁶ Life expectancy projections show an average increase of one to two years from the life expectancy that was recorded for the Aboriginal population in 2001.

As grave as these statistics are, there is reason to believe the reality is, in fact, significantly worse. The numbers are likely distorted by non-participation in the Census by First Nations on reserve communities and, the urban population of Aboriginal peoples is often transient and subject to extended periods of unstable housing and homelessness.⁷ Due to these factors, it is very difficult to estimate what actual numbers might be if better census data was available.

Numerous studies have documented the health disparities that produce these unequal outcomes. Rates of infectious diseases, including tuberculosis, pertussis, rubella, shigellosis, and chlamydia, are significantly higher among Aboriginal peoples than other Canadians.⁸ Further studies have also shown the prevalence of chronic diseases including arthritis/rheumatism, hypertension, asthma, and diabetes to be higher among First Nations and Métis populations than the national average.⁹

In a large urban center like downtown Toronto, which boasts the highest concentration of health care centers in Canada, it is easy to assume these problems would be less prevalent for urban Aboriginal populations as compared to Aboriginal peoples who reside on the reserve. Many Aboriginal peoples leave their homes and come to urban centers across Canada with this hope in mind. Their goals typify those of young Canadians: they are looking to further their education and employment opportunities and, generally, are seeking to create better lives for themselves. Unfortunately, due to multifactorial issues, such as marginalization, lack of social supports, unstable housing or homelessness, and a lack of education or stable jobs, the reality is quite different. In a study conducted by researchers in Saskatchewan, for

⁴ Young, T. K. Review of research on aboriginal population in Canada: relevance to their health needs. *BMJ* (2003); 327:419-22.

⁵ Statistics Canada. National Household Survey 2011. *Aboriginal Peoples in Canada: First Nations People, Métis and Inuit*. <http://www.statcan.gc.ca/daily-quotidien/130508/dq130508a-eng.htm>.

⁶ Statistics Canada. *Aboriginal Statistics at a Glance*. Ottawa, 2010. Catalogue no. 89-645-XWE.

⁷ Adelson N. The Embodiment of Inequity: Health Disparities in Aboriginal Canada. *Canadian Journal of Public Health* (2005);96 Suppl 2: S45-S61

⁸ Health Canada. *A Statistical Profile on the Health of First Nations in Canada: Self-rated Health and Selected Conditions, 2002 to 2005*. Ottawa, 2009. Cat.: H34-193/2-2008E-PDF.

⁹ First Nations Information Governance Committee. *First Nations Regional Longitudinal Health Survey, 2002-2003; Results for adults, youth and children living in First Nations communities*. *Assembly of First Nations*, (2005, November).



instance, it was found that urban Aboriginal people lag behind their rural counterparts in terms of education, income and general well-being.¹⁰

Research Focus

In order to understand why death is premature among Aboriginal people using Aboriginal health services in Toronto, we set out to investigate the experiences of these deceased individuals while they were alive. We conducted what Guirguis-Younger et al. have referred to as a “social autopsy”: an in-depth inquiry into the psychosocial circumstances of an individual’s death.¹¹ While Aboriginal peoples living on-reserve may experience negative health outcomes in part due to a lack of accessible health services in rural and remote areas, this is not the case in the urban centre of Toronto. Through an investigation of life-course trajectories shaped by historical and social determinants of health, we sought to ascertain the root causes of premature deaths among this population of Aboriginal peoples in Toronto.

Research Methods

This project respected Aboriginal community protocol since its inception and has progressed through engagement with the OCAP Principles of research ethics with Aboriginal populations, wherein Ownership, Control, Access, and Possession over research projects and data rest within Aboriginal control.¹²

Quantitative methods. The research team examined medical charts of Anishnawbe Health Toronto patients for the years 2008 to 2010, in order to search for known deaths among Aboriginal people in Toronto who use health and social service agencies in the city’s Aboriginal circle of care. Specifically, our medical chart review looked at data from four large urban Aboriginal health and social service centres in Toronto. Primary data for this study was provided by Anishnawbe Health Toronto, which has been providing primary health care and traditional healing services to this community since 1984. The patient population consists of Status and non-Status Indians, Métis and Inuit peoples. A total of 43 charts, 28 belonging to male patients and 15 to females, were reviewed. The data reviewed included whether the patient had a history of substance abuse, any chronic medical conditions, any experience of unstable housing or

¹⁰ Mohammed, D., & Kulshreshtha, S. (2003). The labour market and rural-urban differences among First Nations: The case of Saskatchewan. *Journal of Socio-Economics*, 32(2),147–159.

¹¹Guirguis-Younger, M., Runnels, V., Aubry, T., Turnbull, J. (2006). Carrying out a social autopsy of deaths of persons who are homeless. *Evaluation and Program Planning*, 29, 44–54.

¹² National Aboriginal Health Organization. (2005). Ownership, Control, Access, and Possession (OCAP), or Self-Determination Applied to Research. Ottawa, ON: Author. Retrieved from: http://www.naho.ca/documents/fnc/english/FNC_OCAPCriticalAnalysis.pdf



homelessness, and the presence or absence of documented mental illness. Data was provided either at initial intake or from their cumulative patient profile.

Three other Aboriginal health and social service centres provided additional data on clients who had been under their care over the past 5 years who are now deceased. Only files for individuals known to these agencies who passed away during this time period were provided. There were likely other deaths in the community during this time period not included in this sample; our sample simply drew from a public domain list. A total of eighty-two client charts from these other service centres were included, and of these, fourteen were excluded from the sample due to unknown age at time of death, and two were excluded for having already been included in the AHT data set.

The accumulated data was analyzed by examining age at death. The data sample from Anishnawbe Health Toronto was additionally examined for biomedical causes of death, as well as any additional information provided in charts pertaining to other biopsychosocial illnesses and challenges for these individuals.

Qualitative methods. In-depth interviews were then conducted with surviving family members and friends of the deceased individuals. These were individuals with close relationships to the deceased, who were able to provide in-depth knowledge of the personal and social challenges of the deceased, as well as their life experiences, perspectives and lifestyles. Recruitment was based on word of mouth in the community. Twenty in-depth qualitative interviews were conducted by a staff member at Anishnawbe Health Toronto. This staff member is currently very active in the Aboriginal community with close ties dating back several decades.

Interviews were transcribed verbatim and a modified grounded theory and narrative analysis considered common themes related to root-causes of premature death. The methods for analysis were adapted from grounded theory,¹³ which details a systematic approach to qualitative analysis that seeks to generate a new theory or model, in order to explain a phenomenon of concern.¹⁴ First, open coding allowed the information to be categorized by theme, and captured the detail and diversity of the content.^{15,16} Codes were derived from the data inductively, and emerged through the interpretation of the raw transcript data by the research team.¹⁷ Later, connections between categories and themes were made for

¹³ Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Co.

¹⁴ Cresswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications Inc.

¹⁵ Burnell, K.J., Hunt, N., & Coleman, P.G. (2009). Developing a model of narrative analysis to investigate the role of social support in coping with traumatic war memories. *Narrative Inquiry*, 19(1), 91-105.

¹⁶ Henwood, K., & Pidgeon, N. (2003). Using grounded theory in psychological research. In P.M. Camic, J.E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp.245-273). Washington, DC: American Psychological Association.

¹⁷ Thomas, D.R. (2003). A general inductive approach for qualitative data analysis. Auckland, NZ: University of Auckland. Retrieved from http://www.fmhs.auckland.ac.nz/soph/centres/hrmas/_docs/Inductive2003.pdf



conceptual similarities and differences. A total of 130 codes emerged through the coding process across all transcripts. Salient themes that were identified in the analysis were then placed into a ‘root cause analysis’ schemata. The root cause schema consists of a figure displaying major emerging themes across all interviews within a narrative story timeline, dating back to original causes (past) that affect contemporary health outcomes (present) and impact health outcomes to come (future). This narrative portrayal of the data offers a ‘life-space’ for detailing health outcomes along a life course trajectory is included in the Discussion section below as Figure 5.

Chart Review: Age and sex at time of death

In total, one hundred and twenty-three charts were reviewed. From our sample of medical charts belonging to Anishnawbe Health Toronto, the average age at time of death was 49 years old. The data provided by the other three service agencies indicates that the average age at time of death for these clients was 29 years old. Combining all sets of data, the average age of death was 37 years of age for this sample of Aboriginal community members using these health and social services in the Greater Toronto Area. This number is far below the average age of death for Torontonians, currently calculated to be 75 years of age by Toronto Public Health.¹⁸ The following figures indicate the number of deaths in various sex and age categories for this sample.

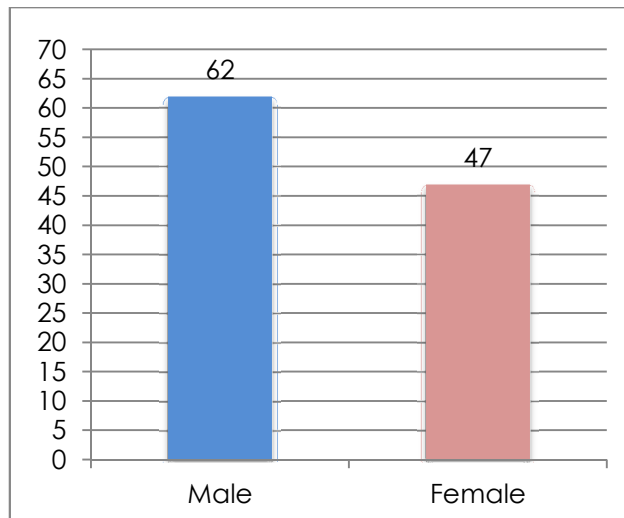


Figure 1. Number of deceased by sex

¹⁸ Toronto Public Health. Personal communication with Public Health Department, 2013.

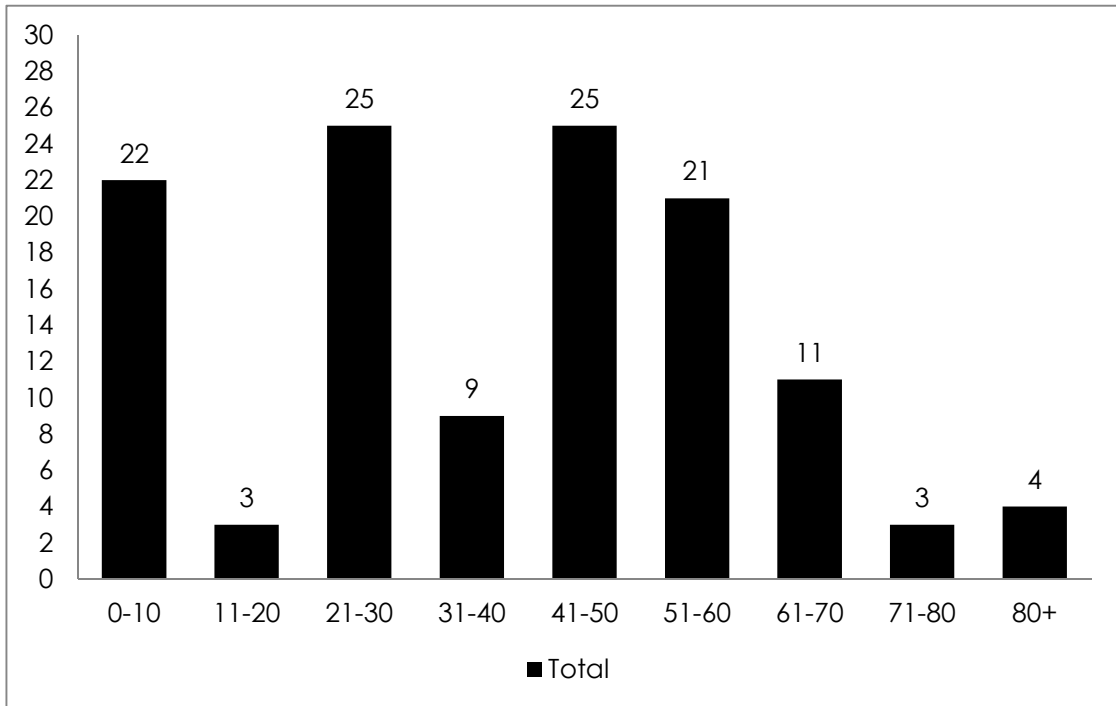


Figure 2. Number of deceased by age range

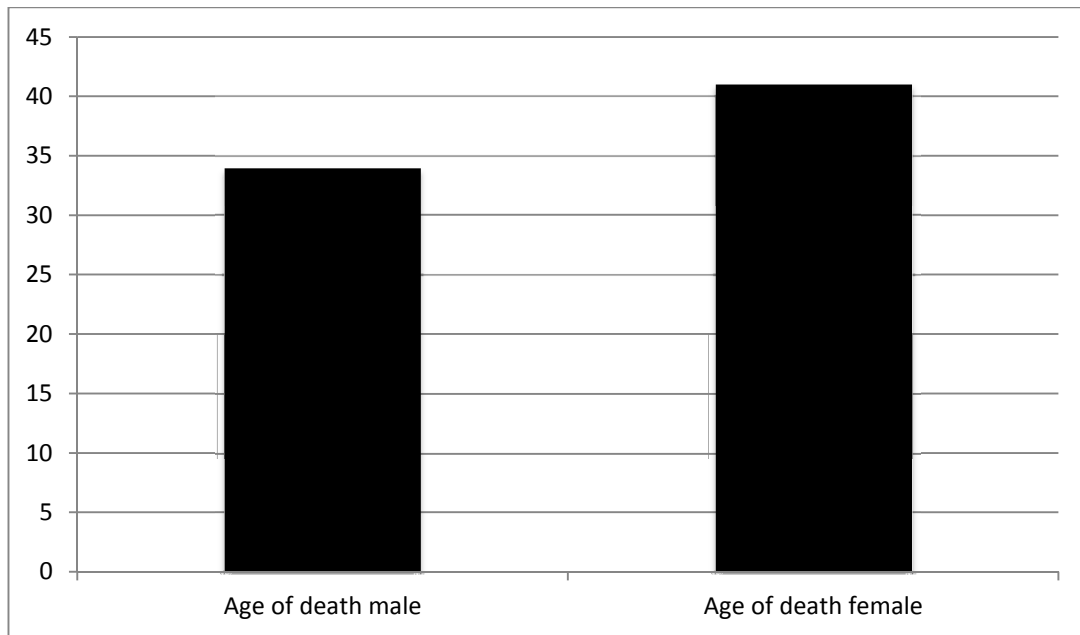



Figure 3. Average age of death by sex



Looking at data from 109 reported deaths during this time period, the average age of death among our Aboriginal sample was 37 years, compared to 75 years for the average Torontonians. It was found that the cause of death was commonly tied directly to issues arising from homelessness, physical abuse, and/or substance use, which compounded chronic conditions. This trend revealing premature death among Aboriginal clients and health service users is alarming in view of the available health and social services in the city of Toronto. This area requires additional investigation in order to understand the nature of these premature deaths among Aboriginal community members.

Interview Results

In total, twenty qualitative interviews were conducted and analyzed. The results presented here are organized around two overarching themes related to this root cause analysis: 1) *Impact of colonial & postcolonial policies on social determinants of health* and 2) *Chronic stress as a result of these historical policies*. These overarching themes will be discussed in detail below and the sub-themes that fall within each of these larger categories will be expanded on. Emerging from these qualitative interviews were also narratives on historical resilience and recovery, indicating areas of strength and well-being for participants and their loved ones. These areas of strength will be touched on as well at the conclusion of this results section.


The primary findings from this root-cause analysis will be presented below in two parts: the first examines the historical impacts of colonization on Aboriginal peoples; the second considers traumas and significant stressors that were experienced by the deceased and common across interviews. These life-course traumas had a significant impact in contributing to the physical ailment(s) or violent episode(s) in the lives of the deceased, which ultimately led to premature death.

Part 1. Impact of colonial & postcolonial policies on social determinants of health.

Across all interviews, participants offered detailed descriptions of the lives of the deceased, including their joys, strengths, triumphs, losses and stressors. What became clear from these interviews was a clear message that life for individuals of Aboriginal ancestry is quite unique to life for other Canadians. Embedded within the interviews was a description of these structural differences, rooted in a history of governmental policies that have shaped the lives of all Aboriginal peoples.

Within this overarching theme of *Colonial policies* are emerging sub-themes related to:

- Assimilation policies
- Systemic discrimination
- Cultural disruption.



Assimilation policies.

Almost all participants related stories of residential school attendance or adoption through what is now referred to as the ‘60’s Scoop’. Once the state closed its doors to residential schools, the welfare policy shifted to one of adoption into non-Indigenous families. The ‘60’s Scoop’ refers to the time period in the 1960’s when as many as 40% of all children in foster care in Canada were Indigenous¹⁹. Unfortunately, various forms of abuse were also widespread within these new contexts.

Participants spoke of the individual, family, and community impacts of these assimilationist policies. One participant described the family impacts of losing children to the residential school system:

[The deceased] remembered as each of the older children were taken away from the mother—the parents—going to residential school, until it came down to [the deceased] and [brother]. And him and [brother] got taken together at the same time and they were the last two kids that the mother had in her care. So it was really hard on his mother, he remembers, as she watched each of her children get taken away. (Participant 162)

This quote depicts how parents were grief-stricken as children were picked up by the Indian Agent and taken to residential school, one by one. Because families were separated through these policies, some children grew up not knowing their siblings:


I don’t remember [the deceased] a lot growing up, ‘cause of the age difference. ‘Cause he was already in [residential] school before I could remember him. So he was kind of like a stranger who came home and I didn’t know him. (P.121)

What was also common across interviews was the theme of pain and abuse experienced by individuals who attended residential schools. One participant discussed the degree to which entire generations were wounded by attendance at the schools:

I know that there was a lot of suffering. ‘Cause I know a lot of those ones went to residential school. Those generations went to residential school. (P.121)

Another participant discussed how parenting was affected by traumas incurred through residential school attendance:

¹⁹ Kirmayer, L., Brass, G., Holton, T., Paul, K., Simpson, C., & Tait, C. (2007). *Suicide Among Aboriginal People in Canada*. Ottawa, ON: The Aboriginal Healing Foundation.



[The deceased told me], “I went to residential school and the things that happened there—I can’t even talk about...that’s why I drank so much. I just couldn’t be a father.” (P.193)

In fact, most participants in this study referred to abuses inflicted on loved ones in residential schools.

[The deceased] had bent over to do up her shoe, and because she was showing so much leg, a nun beat her with a yardstick. She was just a little girl. And that’s one example of many, many others. (P.212)

[The deceased’s] brother was [raped] by the priest there. And her other sister just talks about it but they don’t—they lost the family bond. And, uh, so they don’t really talk to each other, even to this day. (P.141)

Disclosures in the research data related to violence and abuse at residential schools were so numerous that not all could be included in this report. However, the quotes above highlight the pervasive sense of loss and family breakdown stemming from residential school attendance.

Individuals in the study also discussed the impacts of having family members adopted out of home communities during the 60’s Scoop. One participant described a feeling of rejection experienced by one of the deceased due to having been adopted out of the community:

What [the deceased] never came to terms with, what she would never speak about [...] was the fact alone that she was an adopted person. And not knowing her biological family, or fearing rejection from her biological family...She had huge issues about...over rejection. (P.212)

This quote highlights some of the psychological and family impacts of these policies over the life course of individuals. Taken together, these quotes represent the various ways in which these assimilationist policies negatively impacted the physical, mental, emotional and physical well-being of individuals, families, and communities.

Systemic discrimination.

A related factor associated with colonization that the participants in the study described in detail, was the ongoing discrimination that those who died prematurely and other community members experienced as ethnic minorities. Participants spoke of having to manage stereotypes related to being seen as the ‘*drunken Indian*’ or the ‘*aggressive Indian*’ (P.116) in mainstream culture. In fact, there was often silence and shame within the family associated with having an Aboriginal heritage due to these damaging social norms:

My grandfather would say to my mom, “Don’t forget your Native heritage”. My grandmother would say, “Shut your mouth. Shut your mouth about that!” (P.159)



This quote highlights the fact that families were often silent about their identities when interacting with the larger society as a form of self-protection. Likewise, another participant describes the same silence and denial in the family associated with having an Aboriginal identity:

[The deceased] denied that he was the ‘dirty little Indian’ in the family...When you hear the comments that went before...(sighs)...some people think they’re funny. I never felt that was funny; I think it’s just ignorant. (P.133)

Here, this participant describes how racist slurs were often used as ‘jokes’ against family members, and the fact that this type of commentary was damaging.

Discrimination heavily affected social interactions outside of the culture and success in education. One participant spoke of how her loved one would fight with non-Aboriginal people in reaction to discriminatory remarks:

[The deceased] fought a lot because—you know...he never picked a fight but never backed down from one. And it was all really racist stuff that went on. (P.121)


The same participant describes how overt oppression also affected school performance within the family:

Our parents didn’t put a lot on us as far as going to school, and we actually missed so much school. And then school being so traumatic—going to a non-Native school and being the only Natives...we were, we had suffered so much racism, discrimination, oppression, that we just began to really hate who we were...and that’s just in the school setting! (P.121)

This quote identifies that when social spaces are physically, mentally and emotionally unsafe, individuals are not able to thrive within these contexts and conditions of chronic stress are imposed on individuals. This type of oppression can also cause individuals to experience shame associated with their identity and to subsequently hide their identities, as touched upon above. In terms of other social contexts, such as the health care system, other participants described experiencing systemic discrimination within these spaces also:

When you go to [name of hospital] they assume that...(pause)...you could be suffering from an epileptic fit and they assume it’s because of alcohol. And you go to different agencies, and because you’re Native, they assume it’s because of alcohol. (P.141)

This statement suggests that some participants feel that Aboriginal community members continue to experience systemic racism when accessing social services. Likewise, another participant describes the hardships that community members who are living on the street face on a daily basis. This participant notes that street-involved Aboriginal people experience additional discrimination due to the perception by others that they represent an underclass of people:



... 'Cause if you were on the streets, you already had all the things used against you: 'you're less than', 'you don't deserve the quality of care we're offering to community members'. (P.193)

Finally, one participant acknowledged the discrimination and internalized oppression that continues to take place within Aboriginal contexts:

...And even within our own family, the oppression and the internalized oppression within our own family. ... I can see three generations even within our own family where they're carrying that internalized oppression. (P.121)

This participant relates how the experience of racism and stigma from the mainstream culture also trickles down into the psyche of those who have membership to the marginalized group. To summarize this sub-theme, many participants discussed the generalized experience of oppression due to being a part of a visible minority population. Participants described families having to withstand discriminatory behaviours and comments from those outside of the culture. Due to this pervasive shaming, many families would hide their identity as Aboriginal peoples.

Cultural disruption.

As a result of assimilationist policies and systemic discrimination, the transmission of traditional culture was disrupted for individuals, families and communities. Individuals were separated from family, language and culture through attendance in residential schools and through adoption out of communities. Racism and shame around having an Aboriginal identity also impacted families' ability to share their culture freely. Participants discussed the fact that their deceased loved ones had been *'robbed of the culture'* (P.108) and individuals shared that they *'didn't really grow up with a culture'* (P.177). The notion of being *'culturally homeless'* was raised across several interviews.

So many Native people in the city are not connected to their traditional roots, to their traditional ceremonies, traditional ways of healing, sweat lodge, medicines, working with healers that work on every-- ...working on the reason why you're actually drinking in the first place, as opposed to the alcohol itself. (P.212)

This quote suggests that many individuals who live in urban areas are cut off from their culture and as a result lack healing tools for meaningful recovery. The following quote summarizes this section with an overview of the impacts of the colonial history on Aboriginal peoples:

It wasn't [the deceased] fault...because the history of colonialism, and the historic trauma transmission delivered over the last 500 years has impacted Aboriginal people in many different ways. And I think it's caused a lot of different levels of posttraumatic stress disorder, and it's caused Aboriginal people to suffer spiritually, mentally emotionally, physically. So when you take them from their land, their spirit becomes damaged. (P.201)



This summary quote captures this historical context of present-day traumas among Aboriginal community members. Participants described being cut off from family members, having to hide their culture and identity, and having to overcome systemic barriers, such as discrimination, in their everyday lives. Other participants described families having to relocate and hide children in the bush when Indian Agents came to collect children for residential school, and of having an ongoing fear of the state. Participants described losing their culture when residential schools ‘*abolished our teachings*’ (P.193) and made generations of Aboriginal people feel as though they ‘*grew up non-Native*’ (P.121).

Discrimination within social contexts, such as education and health care settings, was also discussed within interviews. This type of systemic oppression, coupled with assimilationist policies, led many to feel disenfranchised from the state and disinclined to participate in mainstream communities as an active member of society.

Finally, participants described observing their deceased loved ones manage lateral violence within their communities. However, the type of overt discrimination Aboriginal peoples experienced from non-Aboriginal peoples represents another form of lateral violence—in this case, the lateral violence occurs between citizen groups of a country (i.e., Aboriginal vs. non-Aboriginal peoples), whose political system creates a power differential through separatist policies, such as residential schooling. This sense of belonging to two ‘different’ groups within the country encourages an insider/outsider mentality among citizens, promotes discrimination, and prohibits cross-cultural understanding.

The following section considers the impacts of these colonial policies on an individual’s life course.

Part 2. Chronic stress as a result of these historical policies.

Participants in these interviews described the lives of their deceased loved ones in detail. The deceased were parents, siblings, children and friends to many, and these individuals were well-loved within their communities. The results below offer an explanation of why these individuals suffered and how their life course led to an early death.

Within the overarching theme of *Chronic stress* are emerging themes related to:

- Violence
- Identity issues
- Mental health challenges
- Addictions
- Social isolation.

Participant interviews described many instances of trauma, abuse and violence in the lives of the deceased. In fact, one participant reported that ‘*You didn’t really know anybody who didn’t have trauma*’ (P.121) in the community. Other participants likewise described their loved one as having grown up in families where chronic stress and trauma prevailed, including those with ‘*violent, drunk, and abused family backgrounds*’ (P.193).



Violence.

Participants described the lives of the deceased as being ones replete with violence. They described individuals witnessing domestic violence in the home as children, and they spoke of children suffering from sexual, physical and emotional violence. Some participants described these occurrences in detail.

Oh my god! That man was the most violent man I could ever imagine! As little kids he would beat [the deceased and I] up! [...] He was a horrible, horrible violent man. He was also a sexual predator. [...] My mom, I guess she tried to protect us and he beat the crap out of her. [...] She said she was leaving and she told us to stay 'cause she was so scared he was going to kill us all. (P.193)

This detailed description of horrific violence endured within families was discussed within a number of interviews. One participant describes all of the siblings witnessing violence between family members:

But my dad would beat my mom bad in front of us. Like, we'd watch it. (P.103)

Another participant describes the sexual abuse family members endured in foster care:

...And [the deceased] was placed in a foster family with his sister. And the man—the foster dad—was raping his sister all along. (P.133)

It must be stressed that these types of disclosures were not unique to one or two interviews of this study; nearly all interviews include accounts of physical and sexual abuse in the lives of the deceased. Participants also described abuse in terms of the silence that followed:


[The deceased] was abused in residential school. He didn't like to talk about it too much 'cause it was too painful. [...] So something happened there but he didn't want to tell me—he'd just stop himself. Yeah. He didn't give me the fine details of it. But I know it was really hard. (P.162)

I know something really bad has happened to [the deceased]. He left home at 15 and it was like he was an instant drunk. (P.121)

For many, the stigma and shame associated with being victimized impacted their ability to relate their pain to others. Instead, some turned to other coping mechanisms to manage the trauma that one participant describes as having started 'in the crib' (P.193).

Addictions.

Many participants discussed issues of alcoholism within families and communities, which many acknowledged was, and continues to be, pervasive in many contexts:



Where [the deceased and I] grew up in northern Ontario, we grew up in a home with alcoholism—not just in our home, but in our community. (P.116)

[The deceased] grew up in a family that had addictions. His father was a heavy drinker and he was abusive. And he also—the kids went to residential school, all the kids. (P.162)

One participant described that this is ‘*just the dynamics now*’ (P.141) in many contexts. Participants acknowledged that substances were likely used as a coping mechanism among their deceased loved ones ‘*because of the trauma*’ (P.147):

So, [the deceased] was very sad. And you what? That sadness—we understand now—it affects the spirit and the emotions like that. Her mind...she turned to trying to escape it by partying and having a good time. (P.147)

I don’t think [the deceased] could let himself go to that painful place inside himself that would have helped him. In this life. Some people can’t do that—they can’t never go there. It’s like he trained himself at a young age somehow to never go to that place. And he’d rather block it with the drugs and alcohol or just keep doing what he’s doing. (P.162)

Another participant summarizes the inherent challenge of overcoming addictions for individuals who grow up in unhealthy environments:

Imagine being born into a family of alcoholism and you become alcoholic. It’s your whole life! You have to undo those teachings and you have to re-learn something different!’ (P.193)

Indeed, this is a considerable difficulty with overcoming a troubled childhood, and this quote details how cycles of addiction can occur within families. Overall, it seems that the participants in this study acknowledged that many families experienced struggles with addiction and that this had a profoundly negative effect on the life course of individuals. In fact, in some instances, the cycles of addiction were linked to the cycles of violence and trauma, as noted by one participant:

That’s why I’m really against alcohol. ‘Cause it broke up our families to begin with. And if our people really knew what was happening to their Native families, maybe they can have that sense of understanding. It’s tearing apart our families! It’s allowing our children to be raped, our children to be hungry, our children to go without all of those things because that addiction is there! (P.174)

According to this participant, alcoholism is linked to ongoing violence and trauma with families—in fact, the one often begets the other.



Mental health challenges.

Cycles of violence, abuse and addiction also relate to challenges with mental health and identity, according to participants in this study. Participants described how the deceased had experienced mental health issues throughout their lives, often using the term ‘stuck’ to refer to these kinds of difficulties:

[People with trauma] are stuck and really can't see clearly how their life is going and how poor their health is becoming. [...] 'Cause if you're stuck in the past and blaming, blaming, and you're on your healing journey and still on that level where you're stuck, you can't move forward. (P.299)

This participant describes the painful experiences of being caught in a trap of living with past grief in the present. Likewise, another participant relates how one of the deceased was never able to cope with traumas incurred in early childhood:

Well, [the deceased] was shy, you know? Wouldn't ask anybody for help. [...] I think that [because of] residential schools or whatever, things that she had that she was dealing with...she couldn't really go out and try to get therapy or try to rise above and better herself. She was just stuck. (P.282)


Finally, this participant shares how one of the deceased tried to heal himself through treatment programs; however, his grief was too painful to examine completely and as a result he was ‘blocked’ from fully engaging in the healing process:

'Cause he was in a healing lodge when I met him, back in the 80's. And he did go to treatment. But he couldn't—he would only last a few months or whatever. But would always walk out the door. He just couldn't seem to get down—there was something blocking him, truly letting himself really go deeper. (P.162)

Feeling trapped in grief and unable to move forward on the healing journey was a common theme described by participants in this study. Experiences of trauma and addiction also undermined the self-esteem of many of the deceased. One participant uses the term ‘defeathering’ (P.138) to refer to the experience of his loved one after his loved one endured abuse as a child and felt rejected by his community. Another participant describes how the loved one that she lost also struggled to find self-worth and the motivation to recover from trauma:

He just wouldn't even try to recover at that point. 'Cause he said it was too late. There was no point anymore. [...] And I think that you kinda reach a point where...to me, he was just tired. He was tired of trying. Tired of trying to be sober. Tired of trying to live a healthy life. (P.121)

This same participant goes on to explain that when considering healing from trauma, it is not enough to understand the steps involved in recovery. In order to fully engage in the process, one must feel that they are important enough to heal:



It's not just having knowledge: "Okay these are new coping skills! Start using these!" It's not that. It's having to recover from the trauma enough to believe that you're worth something. (P.121)

Of course, many who fail to engage fully on their healing journeys often turn to substance use as a coping mechanism and subsequently suffer from physical health ailments that would have led to premature death, as many participants in the study explained (P.121, P.159, P.201, P.299).

Identity.

Another aspect of mental health challenges relates to issues of identity. Due to policies of assimilation described earlier, the loss of traditional cultures was widespread in many Aboriginal communities. Participants in the study shared that their deceased loved ones often struggled with truly understanding themselves and their Aboriginal identities, and that they often felt like lost souls.

[The deceased] really wanted to be back home. He would have liked to have known the rest of his family, but he was so displaced that he had no connection back to the reserve. So, even where he died... that wasn't even on his reserve, right? (P.201)

Another participant describes the impacts of cultural loss on mental health:

And their mental and emotional state become wrecked because they're no longer hunting and fishing and living off the land. (P.136)

Likewise, this participant suggests that high rates of suicide and mental health issues in communities relate to cultural loss:

Parents haven't taken the time to give [children] the teachings. That's why a lot of them suicide—is because they don't know the teachings. (P.138)

In this case, this participant feels that traditional teachings offer guidance and direction for life, as well as health promotion strategies that prevent the kind of widespread social and health issues that many communities see today.

Another participant highlights the identity issues inherent to internalized oppression:

That's intergenerational—you know, internalized oppression is always intergenerational. It's all from colonial crap, that everyone wants to be White and rich. And we're never going to be White enough or rich enough. (P.121)

This statement suggests that colonial messages that have permeated Aboriginal communities dictate that Aboriginal people strive to be less 'Aboriginal' and more 'White'. Moreover, they are tasked with having to be wealthy and



competing in the capitalist economy. Overall, the following quote summarizes the kind of identity loss that many of the deceased experienced in their lives as a result of not being connected to their culture:

I really think it's like a broken heart syndrome. It was [the deceased's] loneliness for his true identity, like not knowing anything about who his people really are because his family and his parents and his traditions were all lost. (P.108)

Indeed, it seems that the 'broken heart syndrome' that stems from cultural loss and chronic stress throughout the life course is related to mental health issues, low self-esteem and issues with addiction for many of the individuals associated with this project who died prematurely.

Social isolation.

The final sub-theme to consider within the meta-theme of *Chronic stress* relates to the social isolation that many of the deceased experienced as a result of the other challenges described in this section. For instance, in some Aboriginal community circles, it is forbidden to participate in sacred ceremonies without a grace period following the use of substances. Some participants described the inherent challenges related to this social norm, as it at times prevented their loved ones from accessing much-needed cultural supports, as they were unable to quit their addictions:

[They said], 'How can [the deceased] come to these ceremonies and do these things?' [...] You're already saying he's no good because he can't go over there because he's drunk. [...] And you're calling him worthless, so you're making him probably worse. (P.108)

This participant was concerned with the difficulties in accessing cultural services due to cycles of addiction. Another participant described the lack of anonymity when seeking services within the Aboriginal community:

And if you go to the Native community, the chances of you knowing that person are so large—it's such a small community here. It makes it hard to—and if you're someone who is part of the community who people look to, where do you go? [...] You're isolated that way. (P.141)

This individual felt that his loved one at times had to hide mental health and physical health issues within the community due to being perceived as a community leader. Both of these experiences ultimately relate to experiences of isolation for their loved ones. Unfortunately, these experiences of isolation come at a time when social supports are most needed.

Another participant explains the need for social support and empathy during these dark times:



‘Cause all you see is the diagnoses. You don’t see the person. I think we have to remember that these guys are not just drunks; they are not just addicts; they are not just homeless people; this is actually a man. This is a woman.
(P.193)

These quotes suggest that a confounding factor in issues related to ongoing trauma and addictions, relates to social isolation and a lack of social supports due to stigma when individuals require support the most.

To summarize this section on *Chronic stress*, one participant describes the cycle of trauma, as she sees it, within the contemporary Aboriginal community. This quote summarizes many of the findings of this study that are touched upon in the earlier sections.

If you think about trauma, it usually happens physically first, whether it’s sexual abuse, physical abuse. It’s usually a physical thing. It’s almost like we’ve been traumatized physically, and what it does to us mentally, especially when we’re being called names and whatnot. And then emotionally, where that takes us. And then spiritually. And really it’s the spirit that carries the scars. The body heals and so when we have to start recovering from trauma, we start with the spirit. And then we bring that through the voice—those emotions. And then mentally we start to understand what we’ve been through. And so physical usually always comes last. So if you think about it in that circular, moving through the medicine wheel, it’s usually: physical, mental, emotional, spiritual. So when we heal, we go backwards. Spiritual, emotional, mental, physical. But in our case, with Native people, by the time we reach the physical part we’re freakin dead!! (P.141)

The series of traumatic events in the lives of the deceased ultimately led to significantly higher states of stress for these individuals throughout the life course. To summarize these concepts, the following figure indicates the results of colonial policies and historical traumas on health outcomes for the individuals discussed in this study.

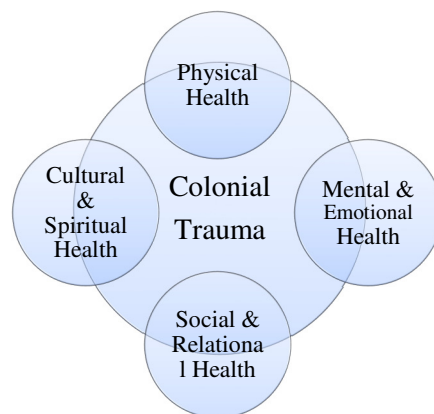



Figure 4. Impacts of trauma on all aspects of the medicine wheel of well-being.



Colonial traumas at a policy level, such as forced attendance at residential schools, which sought to break down community and family ties, affected the social well-being of the entire community and relationships between community members. Residential schooling also introduced Eurocentric Christianity to communities and interrupted the transmission of traditional spirituality, as did governmental policies that made Indigenous spiritual practices outlaw until the 1970's. Intergenerational traumas within families stemming from this colonial history affected the mental and emotional health of individuals and greatly impacted their physical health, ultimately leading to premature death.

Part 3. Strengths

It would do a disservice to the participants in this study, as well as their deceased loved ones, if this report were to overlook the many strengths and resiliency factors that were described in the interviews and that are alive and well within Aboriginal communities.

For instance, participants spoke of the many talents of their loved ones:

[The deceased] learned to play the guitar. [...] He was very talented. He had a lot of talent. And he was an artist. He could do things and create things with his hands. So he was very gifted. He could make crafts. I seen him make crafts before. He was a good man. (P.201)


[The deceased] was very powerful. His paintings were visions. The animals would talk to him and everything. He was really gifted. (P.138)

We knew [the deceased] had to be special cause of all of the gifts he got. (P.236)

Participants also spoke of the efforts their loved ones made to reconnecting with their Aboriginal communities and embarking on their healing journeys:

In the last years, [the deceased] came to ceremony all the time. He would make the meals for ceremony. And he would always make sure he didn't drink and he would be sober for making that feast food. And he would just wait for the next ceremony. Somebody passed him a drum and began to pass him pieces. So he would come out to ceremony and bring his bundle. And he had his [traditional] name. [...] He made sure that he started to make those cultural connections for himself. (P.121)

A good guy. I mean, [the deceased] went to school, he did all he needed to do. Still crazy as ever! But he found his path in the drum. So he followed that. I was happy for him cause he was finding himself. He was also a good singer, caught onto the songs really good. Fast. (P.274)



This is part of who [the deceased], it's part of her life. It's thanks to this community that she adopted a child through this community. (P.133)

Participants discussed the willingness of their loved ones to help others in the community:

[The deceased] was very special in talking to people. And helping them if they were having problems. Help them with their problems. He knew how to speak to them. (P.274)

'Cause [the deceased] knew [teachings on healing] so well—cause he could teach it to other people. And that helped some people, but you know, 'cause people liked to talk to him. Some of the brothers liked to talk to him, so to speak. [...] And plus he was a very spiritual person. (P.162)

That really made [the deceased] happy—talking about [family]. And it made him happy working in his community. (P.108)

[The deceased] cared so much about people! And it wasn't even just his own family! He'd take strangers food and call people in off the street! If he thought they were hungry. He was always feeding the neighbour's kids. I think it has a lot to do with us growing up in poverty. That he didn't ever want another kid to know what it was like to go hungry. (P.121)

[The deceased] saved his younger sister and brother, and then they, throughout the years, tried to stick together, and live as much as possible around each other, and try to take care of each other. (P.147)

Perhaps the following quote best summarizes the perspective of interviewees on the lives of their loved ones:

[The deceased] did the best she could. (P.212)

The following section offers a brief discussion on these findings and summarizes this root cause analysis through an exploration of a unified root-cause model which represents emerging themes.

Discussion

The results of this qualitative analysis indicate that the individuals and families who made up the participant sample for this study continue to face tremendous health challenges. For this sample of Aboriginal people in the city of Toronto, social determinants of health continue to be affected by family histories of residential schooling and intergenerational traumas, poverty, addictions and mental health issues, under the backdrop of systemic discrimination. The medical chart review indicates that the average age of death among our sample was 37 years, compared to 75 years for the average



Torontonian. While this sample represents a small number of Aboriginal health service users in the city, the figure is disturbingly low as compared to the average Torontonians.

One of the major emerging themes from this study relates to chronic stress experienced by these individuals throughout the life course. The biomedical and psychological literature offers clear ties between early and chronic stress in an individual's life and adverse neurobiological changes in the brain.²⁰ This relates to the role of the hypothalamic-pituitary-adrenal (HPA) in the brain and the stress response, as ongoing exposure to stress can alter the release of cortisol in the brain, resulting in dysregulation of hormonal release in the HPA axis. Research has indicated that these issues are linked to vulnerabilities later in life for mental health issues, such as depression and anxiety, posttraumatic stress disorder, and substance use disorders.²⁰ Early childhood trauma can also contribute to other developmental issues through the life course. Individuals who experience adverse childhood experiences and chronic stress early in life may go on to struggle in relationships and with intimacy, have difficulty controlling impulses, have a disrupted sense of identity and adopt health-risk behaviours.^{21, 22} Research also indicates a dose-response relationship between the presence of childhood traumas and future risk factors for serious health issues in adulthood (i.e., heart disease, cancer, lung and liver disease, etc.).²³

Chronic stress is also worsened by experiences of discrimination and racism. Racism is emerging as an important social determinant of health in the medical and psychological literature.²⁴ Racism, discrimination and social inequalities are being explored to ascertain an understanding of these forces on health outcomes through economic, environmental, and psychosocial pathways. In focus is an examination of socially inflicted trauma through overt or covert threats, violence, economic and social deprivation and other examples of 'everyday racism'.²² Racism and discrimination are tools used by a dominant group to maintain social power through oppressive systems that marginalize non-dominant groups. This increases the everyday experience of chronic stress by individuals who are targeted as visible ethnic minorities.

This discussion on the impact of trauma and discrimination on chronic stress throughout the lifespan echoes results presented in this report related to the use of substances as coping tools, mental health issues, and the experience of having a damaged sense of self.

²⁰ Brady, K., & Back, S. (2012). Childhood trauma, posttraumatic stress disorder, and alcohol dependence. *Alcohol Research: Current reviews*, 34(4), 408-413.

²¹Gold, S.N. (2000). *Not trauma alone: Therapy for child abuse survivors in family and social context*. Brunner/Routledge: Philadelphia, P.A.

²² Herman, J. (2001). *Trauma and Recovery*. New York, NY: Pandora-Basic Books.

²³ Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V.,...Marks, J. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4), 245-258.

²⁴ Krieger, N. (2003). Does Racism Harm Health? Did Child Abuse Exist Before 1962? On Explicit Questions, Critical Science, and Current Controversies: An Ecosocial Perspective. *American Journal of Public Health*, 93, 194-199.



Root cause analysis traces these contemporary social issues to the forced assimilation of Aboriginal peoples through the residential school system and ongoing intergenerational health issues rooted in Canada’s colonial legacy. Further, interviews revealed inequities related to poverty, under and unemployment, racial discrimination, lack of housing, and inadequate access to resources, among other disadvantages with respect to social determinants of health.

The following figure offers a visual representation of the findings of this root causes analysis. The very centre of the figure shows the point at which physical ailments result in death for our group of participants. Moving outward from the inner circle, one is able to see potential physical causes of death for a given individual, such as violence or illness. Moving outward from “physical trauma”, the mental, spiritual and emotional traumas are included in the next wave, suggesting that these factors are the cause behind some of the physical traumas experienced by individuals. For instance, mental health issues and trauma can lead to addiction as a coping mechanism. Moving outward from this point, we see that social and interpersonal traumas, such as experiences of racism and poverty, represent broader community-level factors that impact the health of individuals. At the most broad levels, cultural traumas due to colonial policies are at the root cause of premature death.

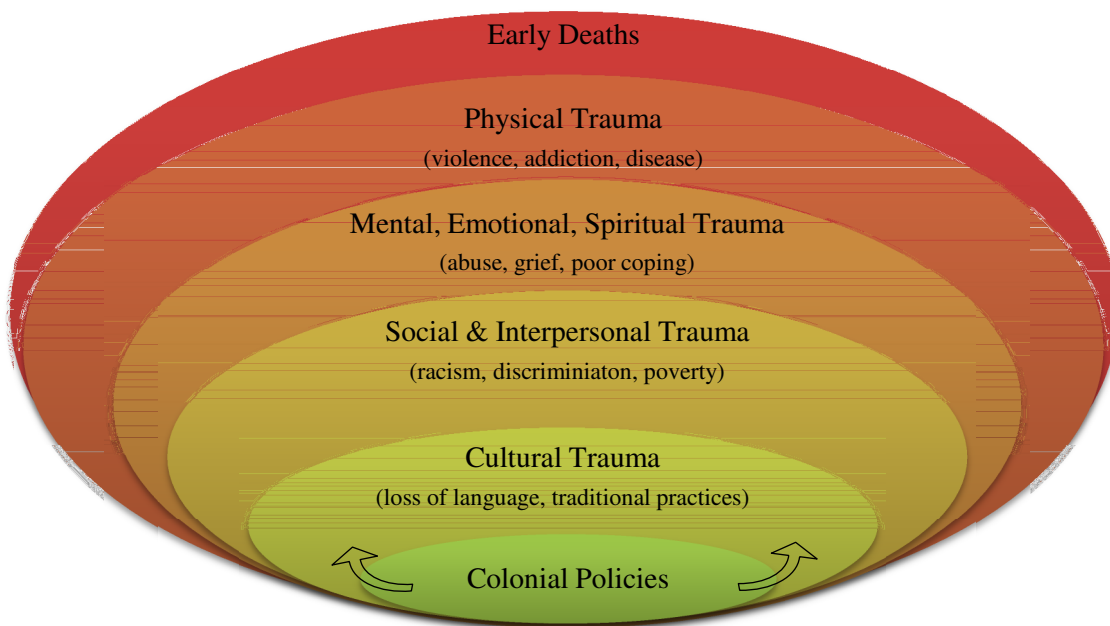


Figure 5. Root cause of premature death through a ripple effect.

As described above, one can start in the centre of this figure and move outward, to see the “ripple effect” of a series of personal, interpersonal, community-level and cultural-level traumas of the individual life course. Included within each “ripple” is a list of examples of each of these traumas seen on the bottom half of the figure. According to our analysis, the root causes of premature death is shown in the outermost ripple, representing the overarching impact of colonial traumas inflicted on Aboriginal peoples over the course of the past few centuries.



There are a few limitations to this study. One of the limitations of this study is the small sample size that was available. The other limitation is that Aboriginal peoples under the care of these agencies may over-represent a transitional population or those who are most marginalized within the Aboriginal community.

Recommendations

We have deliberately refrained from the recommendations; we intend to have a discussion among all Aboriginal and non-Aboriginal stakeholders in order to develop realistic and implementable policies and services.

About the authors

Dr. Chandrakant Shah, M.D., O.Ont. is a Staff Physician at Anishnawbe Health Toronto and provides primary healthcare to Aboriginal peoples. He is also a Professor Emeritus at the Dalla Lana School of Public Health at the University of Toronto, and is an advocate for improving the health and well-being of marginalized groups in Canadian society. Dr. Shah recently secured \$212,000 for training Aboriginal preceptors to teach Aboriginal cultural sensitivity across Health Sciences programs in Ontario Colleges and Universities. He had also secured nearly \$2 million in endowments to establish an Endowed Chair in Aboriginal Health and Wellbeing at the University of Toronto in 2000, the first of its kind in Canada. For his advocacy work with Aboriginal Community, he has received several awards, including the Order of Ontario and the Eagle Feather, presented by First Nations House at the University of Toronto.

Dr. Rajbir Klair, B.A., M.D., C.C.F.P. is a family physician and Adjunct Lecturer in the Department of Family and Community Medicine at the University of Toronto.

Dr. Allison Reeves coordinates the Aboriginal Cultural Safety Initiative at Anishnawbe Health Toronto and is currently a Postdoctoral Fellow in the Department of Applied Psychology & Human Development at the University of Toronto.

Acknowledgement:

We wish to thank Mr. Joe Hester, Executive Director, Anishnawbe Health Toronto for his encouragement and support throughout the project, Mr. Harvey Manning for conducting interviews and family members and friends of deceased to agree with interview and provide us with valuable insight.