URBAN INDIAN PSYCHIATRIC PATIENTS IN COMMUNITY CARE

RON PETERS, B.A.

ABSTRACT. This study examines characteristics and problems of, and services received by Indian psychiatric patients in an urban community care setting in Canada. A census of patients of a community mental health service showed 25 Canadian Indian patients out of 2,652 patients in care, or 0.9%; whereas Canadian Indians are estimated to comprise somewhere between 1.6% and 4.8% of the general population. A comparison group of 100 Anglo Canadian patients was matched four-to-one with the group of 25 Canadian Indian patients in terms of sex, age, educational level, and employment status to render the groups sociodemographically comparable. The Canadian Indian and Anglo groups are compared in terms of related socioeconomic factors, accommodations and transiency, selected clinical characteristics, social networks and social support, prior psychiatric service utilization, and psychiatric services currently received.

In 1966 less than 16% of registered Canadian Indians was living off-reserve. By 1980 this figure rose to nearly 30%, and some 80% of off-reserve Canadian Indians now live in cities. Further, of the more than 100,000 off-reserve Canadian Indians in 1978, more than one-quarter lived in the province of British Columbia. Numbers are readily available for registered Indians only; no one knows in total how many persons of Indian descent live in Canada's urban centers. Indian Affairs figures for 1980 give estimates for the city of Vancouver, British Columbia ranging between 6,500 and 20,000, or, from 1.6% to 4.8% of the general Vancouver population (Frideres, 1983).

Little is known about the utilization by Canadian Indians of urban community mental health services. Fritz & D'Arcy (1982) and Rhoades et al. (1980) find that Canadian Indians under-utilize these services in relation to their numbers in the population, and find an over-representation of substance abuse problems among those who seek treatment.

The purpose of this study was to look at characteristics and problems of, as well as patterns of service utilization among, Canadian Indian psychiatric patients in community care. The hope was that such analyses can offer a guide to the ways in which services can be made more accessible and acceptable to a major group of potential recipients of service.

The study was conducted at the Community Mental Health Teams of the Greater Vancouver Mental Health Service Society (GVMHSS). Operating under a mandate to care for the seriously and chronically mentally ill, the GVMHSS maintains an active caseload of around 3,100 patients, more than half of whom carry diagnoses involving psychotic conditions. Eight multidiscipli-

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nary community teams provide services to geographically defined catchment areas with populations ranging from 15,000 to 120,000. Each patient's principal link with a team is a mental health worker who may provide therapy, who acts as a patient advocate and community services broker, and who will attempt to tailor an individual management plan that may include elements such as housing placement and supervision, social and recreational enhancement, and programs designed to develop vocational skills. Physicians provide assessment and medical supervision. The GVMHSS also operates short-term residential services for patients in crisis, a suicide attempt counseling service, a 24-hour psychiatric emergency service, and offers consultation to various community agencies. In most regards, the GVMHSS fulfills the criteria of a model program for the chronically mentally ill (Bachrach, 1980; Cumming et al., 1976).

Methods

A questionnaire was administered to the primary therapist of every patient actively in care at a Community Mental Health Team during an index week. Of the 2,652 patients included in the study, 25 (0.9%) were identified as Canadian Indian.

To create sociodemographically equivalent groups for comparison on clinical and other characteristics, each Canadian Indian patient was matched with four Anglo patients on several characteristics. Table I first compares Canadian Indian patients with Anglo Canadian patients and all other non-Anglo patients in terms of sex, age, educational level, and employment status prior to matching, and then compares the Canadian Indian and Anglo Canadian matched samples.

There was no significant difference among these ethnic groups by sex (x^2 = 3.21, df = 2, p = .20). But since sex correlates highly with age, diagnosis, and the presence of violent versus suicidal acts in our caseload, it was thought important to control for this variable.

There were significant age differences, with other non-Anglos (mostly Asians and Central Europeans) being oldest, and Indians youngest (x^2 = 48.70, df = 6, p = .0001). Canadian Indians are a youthful population; the median age of Indians in British Columbia is sixteen. This distribution depends partly on high fertility rates and equally on a comparatively low life-expectancy. At the same time, proportionately more Indians in their twenties and thirties move to cities (often bringing young children), and Indians over 65 move to cities less often, further skewing the age distribution of urban Canadian Indians (Frideres, 1983).

As is commonly found, the educational level of the Canadian Indian group was low compared with Anglo Canadians and other non-Anglos (x^2 = 90.27, df = 2, p .001). This finding distinguishes Canadian Indians from non-Canadian In-

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TABLE I
SOCIODEMOGRAPHIC CHARACTERISTICS OF: A) INDIAN PATIENTS VERSUS ANGLO AND ALL OTHER NON-ANGLO PATIENTS PRIOR TO MATCHING, AND B) INDIAN VERSUS ANGLO PATIENTS AFTER MATCHING.

	Patients With Characteristic					
	Canadian Indian		Anglo Canadian		Other NonAnglo	
Characteristic	N	%	N	%	N	%
A. Prior to Matching						
Sex						
Male	13	52	926	43	233	48
Female	12	48	1210	57	257	52
Age (years)						
Under 30	5	20	546	25	84	17
30 - 34	5	20	311	15	63	13
35 - 39	8	32	221	10	32	7
40 and Over	7	28	1058	50	311	63
Educational Level						
Grades 0 - 8	15	60	539	25	220	45
Grades 9+	10	40	1595	75	265	55
Employment Status						
Employed	5	20	555	26	150	31
Unemployed	16	64	1257	59	285	58
Out of the Labour Force	4	16	319	15	55	11
B. After Matching						
Sex						
Male	13	52	51	51		
Female	12	48	49	49		
Age (years)						
Under 30	5	20	21	21		
30 - 34	5	20	22	22		
35 - 39	8	32	24	24		
40 and Over	7	28	33	33		
Educational Level						
Grades 0 - 8	15	60	62	62		
Grades 9+	10	40	95	75		
Employment Status						
Employed	5	20	20	20		
Unemployed	16	64	64	64		
Out of the Labour Force	4	16	16	16		

dians, but does not differentiate urban Canadian Indians from rural Canadian Indians (Stanbury & Siegel, 1975).

Finally, patients from all three groups were unemployed at levels five times higher than in the general population. With an unemployment rate of 72%, however, Canadian Indian patients had higher rates than Anglo Canadian (69%) or other non-Anglo patients (65%) ($\chi^2 = 7.83$, $df = 4$, $p = .09$).

After one-to-one matching, the differences by sex, education, and employment status between the Canadian Indian group and the Anglo comparison sample were non-significant ($p = 1.00$). The mean age (and s.d.) in the Canadian In-

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dian sample was 36.0 years (11.8), as against 36.1 years (12.3) in the Anglo sample (t, df = -0.04, p = .97).

Given this group of 25 Canadian Indians and a sociodemographically comparable sample of 100 Anglo patients, we set out to see what might be different about Canadian Indian psychiatric patients in community care. Because of the small number of patients involved and the exploratory nature of the study, no great emphasis can be placed on the statistical significance of the results. Some of the findings attain statistical significance, but most do not. Many of the comparisons would be statistically significant, with the same pattern and strength of association, given a larger sample.

Results and Discussion

Related Socioeconomic Factors

Despite matching, only 8% of the Canadian Indian patients derived their income primarily from wages or savings, in contrast to 22% of the Anglo Canadian patients (see Table II). Since the patients were matched for employment status, this indicates that more of the unemployed Anglo patients pre-

TABLE II
RELATED SOCIOECONOMIC CHARACTERISTICS OF INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS

	Patients with Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Principal Source of Income[1]				
Wages and/or Savings	2	8	21	22
Welfare	13	52	42	43
Handicapped Pension	6	24	20	21
Other	4	16	14	14
Employability Ratings[2]				
Competitive Employment	6	24	34	34
Sheltered Emplolyment	8	32	37	37
Unemployable	11	44	29	29
Recombined Employability Ratings[3]				
Part-time Competitive, Full-time Sheltered, or Vocational Training	9	36	26	26
Full-time Competitive, Part-time Sheltered	5	20	45	45
Unemployable	11	44	29	29

1. x^2 (df = 3) = 2.44, p = .49
2. x^2 (df = 2) = 2.17, p = .34
3. x^2 (df = @) =5.25, p = .07

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viously worked in jobs where they could accumulate savings. This is understandable since Canadian Indians as a group in British Columbia are over-represented in seasonal, unskilled, and low-prestige occupations (Frideres, 1983).

The combination of under-education, low participation in the work force, lower-class and less-secure jobs, and high rates of unemployment naturally means less disposable income and increased poverty. Thus, Stanbury and Siegel (1975) found that 54% of off-reserve Canadian Indians in British Columbia made less than $2,000 per year, compared with 24% of the general population.

The Canadian Indian patients were rated as unemployable more often by their therapists and were less often rated as ready for regular employment, or for work rehabilitation programs. Among the Canadian Indians who were rated as employable, the majority were deemed ready for part-time competitive employment, full-time employment under supervision, or for work rehabilitation programs. These levels denote an intermediate work readiness, and such patients could be expected to benefit from special training directed at increasing their work readiness.

Accommodations and Transiency

Roughly 55-60% of both Anglo and Canadian Indian patients were living in private independent residences, but the accommodations for the remaining 40-45% were markedly different. More than 30% of Canadian Indians as opposed to 12% of Anglos lived in residential hotels, emergency short-stay facilities, or had no fixed address. Among Anglo patients, about 32% live in some form of supervised housing, as against 9% of Canadian Indians.

Another item on the questionnaire asked, "If in your judgement the client's current housing is not appropriate, indicate which type of housing would best meet the client's needs". The results show that the therapists believed Canadian Indian patients were more often inappropriately housed. The kinds of housing that therapists thought the Canadian Indian group ought to be in were just the types they were absent from: programs for the hard-to-house, supervised group homes, family care homes, and other residential care facilities.

When combined with data, below, on substance abuse and violent acting-out, the general picture is that about two-thirds of both Canadian Indians and Anglo patients do well in unsupervised settings. But when the behavior of the Canadian Indians becomes problematic, they are much more likely to be simply cut adrift.

The data on transiency suggest that Canadian Indians in our caseload tend to stay in one general district, but are quite mobile within that district. Thus, both groups are very likely to have lived within their catchment area for at least a year, but two-thirds of the Canadian Indian group changed addresses within that time, as compared with one-third of the Anglo group.

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TABLE III.
ACCOMMODATIONS AND TRANSIENCY AMONG INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

Characteristic	Canadian Indian N	Canadian Indian %	Anglo Canadian N	Anglo Canadian %
	Patients With Characteristic			
Type of Residence[1]				
Private Independent Housing	14	61	55	56
Hotel, Transitional Housing, or No Fixed Address	7	30	12	12
Other (Supervised) Housing	2	9	31	32
Do the Current Accommodations Meet the Patient's Housing Needs?[2]				
Yes	17	68	87	87
No	8	32	13	13
Patient's Recently Moved into Team Catchment Area?[3]				
Yes	4	17	8	8
No	20	83	88	92
Changed Address in Last Year?[4]				
Yes	15	65	36	37
No	8	35	60	63

1. X^2 (df = 2) = 7.59, p = .02
2. X^2 (df = 1) = 3.90, p = .05
3. X^2 (df = 1) = 0.70, p = .40
4. X^2 (df = 1) = 4.74, p = .03

TABLE IV
SELECTED CLINICAL CHARACTERISTICS OF INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

Characteristic	Canadian Indian N	Canadian Indian %	Anglo Canadian N	Anglo Canadian %
	Patients With Characteristic			
Violent Acting-Out in Last Year[1]				
Yes	12	50	16	16
No	12	50	83	84
Suicide Attempts in Last Year[2]				
Yes	3	13	4	4
No	21	87	96	96
Primary Diagnosis[3]				
Schizophrenia, Other Psychosis	12	48	54	54
Drug and/or Alcohol Abuse	5	20	2	2
Personality Disorder	3	12	17	17
Other Psychiatric Disorder	5	20	27	27
Capable Under the Property Act[4]				
Yes	24	100	89	94
No	0	0	6	6
3-Month Hospitalization-Risk[5]				
Yes	11	44	52	53
No	14	56	47	47

1. X^2 (df = 1) = 10.80, p = .001
2. X^2 (df = 1) = 1.27, p = .26
3. X^2 (df = 3) = 12.40, p = .006
4. X^2 (df = 1) = 0.55, p = .46
5. X^2 (df = 1) = 0.29, p = .59

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These results are consonant with some data on urban Canadian Indian migration patterns, but not others. Neils (1971, p. 125), for example, comments that "one of the most visible and noted characteristics of Indians living in cities has been their mobility, in a pattern of movement that seems to be peculiarly Indian and demonstrates the ability of Indians to use the urban structure in an Indian way". However, studies of Indians in U.S. cities report that the majority of Indians move out within six months, or move back and forth between the reserve and the city (e.g., Levine, 1968). The pattern is similar to that seen among migrant workers.

Our Canadian Indian patients, though mobile within a given catchment area, do not seem to be "migrants" in the manner described by Levine, but are more like "residents", having spent considerable time in an urban setting. Davis (1968), in another Canadian study, finds a pattern similar to ours: a survey of Indian and Metis households in the Western prairies shows that, while mobile within the region, the majority of respondents had long terms of residence within the city.

Selected Clinical Characteristics

The Canadian Indians at our teams were reported to have acted in a violent fashion significantly more often than matched Anglo patients. A 50% rate of violent acting-out seems high, but in another study conducted at the GVMHSS suicide attempt counseling service, Canadian Indian suicide attempters also were found to be the only ethnic group in which family violence was reported to be present more often than not (Peters, 1982). In both of these studies, "violence" was rated in global terms by non-Canadian Indian service providers. One would feel more comfortable with the reliability of these data if specific behaviors had been rated instead.

The data on suicidal behavior in this sample are equivocal (see Table IV). While we know that the suicide death rate among registered Indians in British Columbia is typically double the general Provincial rate (Termansen & Peters, 1979), virtually nothing systematic is known about either attempted or completed suicide among Canadian Indians in urban settings (Peters, 1981). Finally, too, the importance of inter-tribal differences in suicidal behavior and the need for individualized program approaches is becoming ever clearer in this literature. Consequently, any global notion of "the suicidal Indian" is increasingly viewed as inappropriate.

About half of each group had been assigned a diagnosis of schizophrenia or of other psychoses. Though the course of schizophrenia varies somewhat cross-culturally (Sartorius et al., 1978), agreement on core signs and symptoms is high (World Health Organization, 1973). The differences tend to be related to the content, severity, or frequency of particular symptoms and signs (Jablensky & Sartorius, 1975).

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The major diagnostic difference is the high proportion of Canadian Indian patients with primary problems of drug and/or alcohol abuse. The cross-cultural validity of the diagnosis of alcoholism has been supported by Westermyer & Peake (1983), where, on 10-year follow-up, a group of Canadian Indian heavy drinkers showed outcomes similar to alcoholic rather than normal populations. The evidence therefore suggests that this is a "real" problem, rather than simply being a question of a culturally alternate style of dealing with alcohol, as some writers have suggested (cf. Kunitz & Levy, 1974).

The only other diagnosis given often enough to report separately was personality disorder, where Canadian Indians were no more likely to be assigned this diagnosis than matched Anglo patients.

Two other items included in the survey were whether or not the patient was deemed legally capable under the Property Act, and therapists' ratings of the patients' risk of hospitalization. By these measures, the need for actions that imply serious impairments in functioning was no more or less common among Canadian Indians than among the group of matched Anglo patients.

Social Networks and Social Support

Family cohesion, a strong reliance on extended social networks, and the notion of the community as family are important features of traditional Indian culture. Studies of Canadian Indian urbanization also give the overall impression of high levels of social cohesion. McCaskill (1981, p. 85), for example, reports that large households (not necessarily "families" as typically defined) were common among Canadian Indians living in Vancouver, and comments that the informal communal arrangements formed were "particularly striking considering the large number of single parent families and single, divorced, and widowed individuals seen". At the same time, much has been written in recent years about the disintegration of the family unit among Canadian Indians, and the role played by the child welfare system in its demise (Johnston, 1983).

The Canadian Indian patients in our sample were, in fact, seen to more often live alone, and this was balanced by a tendency to not be found in group living situations (see Table V). These group situations are the same supervised housing settings that Canadian Indians were noted to be relatively absent from earlier.

Though Canadian Indian patients in our sample live alone more often than both the matched Anglo group and other Canadian Indians living in Vancouver, our data show that they receive no less support from their social networks (though they also receive no more). This suggests a loose-knit network of friends or relatives that one might not live with, but who are proximate enough to be a source of support. McCaskill (1981) found that 72% of Vancouver Canadian Indians reported having friends or relatives living in the city, and that a significant

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minority of urban Indians associate almost exclusively with other Indians, suggesting an extension of the pattern of extended kinship typical of the reserve. McCaskill also reports high levels of membership in formal Canadian Indian organizations and attendance at Indian activities and ceremonies, from which additional support may be derived.

Prior Psychiatric Service Utilization

The findings for prior contacts with community psychiatric services are largely negative; however, a concentric geographic pattern is notable (see Table VI).

TABLE V
SOCIAL NETWORKS AND SOCIAL SUPPORTS AMONG INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

	Patients With Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Living Arrangements[1]				
Lives Alone	12	48	37	37
Lives With Family	6	24	20	20
Group Accomodations	2	8	22	22
Other Arrangements	5	20	21	21
Emotional Support from Family[2]				
Yes	11	44	48	48
No	14	56	52	52
Emotional Support from Spouse[3]				
Yes	5	20	2	12
No	20	80	88	88
Emotional Support from Friends[4]				
Yes	14	56	61	61
No	11	44	39	39
Patient is an Isolate[5]				
Yes	8	32	33	33
No	17	68	67	67

1. x^2 (df = 3) = 2.82, p = .42
2. x^2 (df = 1) = 0.02, p = .89
3. x^2 (df = 1) = 0.51, p = .47
4. x^2 (df = 1) = 0.05, p = .89
5. x^2 (df = 1) = 0.00, p = 1.00

Canadian Indian patients were more likely to have previously utilized community psychiatric services within their local catchment area, equally likely to have utilized these services in the city as a whole, and less likely to have used services outside of the Vancouver area. This matches the pattern of changing

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address often within a given area, but less commonly from one area to another. If one looks simply at the number of prior community psychiatric contacts, regardless of geography, the effect disappears.

Services Currently Received

Canadian Indian patients were as likely as Anglo patients to be referred into community psychiatric care by an inpatient service. They were, however, much

TABLE VI.
PRIOR PSYCHIATRIC SERVICE UTILIZATION AMONG INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

	Patients With Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Prior Psychiatric Hospitalizations[1]				
None or One	5	20	34	34
Multiple	20	80	66	66
Prior Service Within the Current GVMHSS Catchment Area[2]				
Yes	11	44	27	27
No	14	56	73	73
Prior Service In a Different GVMHSS Catchment Area[3]				
Yes	8	32	32	32
No	17	68	68	68
Prior Service Outside of the GVMHSS Catchment Region[4]				
Yes	3	12	24	24
No	22	88	76	76
Any Prior Community Psychiatric Contacts[5]				
None or One	19	76	80	80
Multiple	6	24	20	20

1. x^2 (df = 1) = 1.23, p = .27
2. x^2 (df = 1) = 1.99, p = .16
3. x^2 (df = 1) = 0.00, p = 1.00
4. x^2 (df = 1) = 1.07, p = .30
5. x^2 (df = 1) = 0.03, p = .87

less likely to be referred from another community-based psychiatric service. This matches the geographic patterns of mobility and utilization noted previously, and suggests problems in engaging these patients in ongoing outpatient

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treatment. Thus, only one Canadian Indian patient was referred to the GVMHSS by another community mental health team, one more by a general practitioner, and no referrals were received from privately practicing psychiatrists or psychiatric outpatient departments.

TABLE VII.
COMMUNITY PSYCHIATRIC SERVICES CURRENTLY RECEIVED AMONG INDIAN PATIENTS VERSUS MATCHED ANGLO PATIENTS.

	Patients With Characteristic			
	Canadian Indian		Anglo Canadian	
Characteristic	N	%	N	%
Source of Current Referral[1]				
Psychiatric Inpatient Facility	8	32	31	31
Community Psychiatric Facility	2	8	31	31
Self, Friends, Relatives	7	28	22	22
Other	8	32	16	16
Years of Case Activation to Date[2]				
Less Than One Year	9	6	33	33
One to Two Years	8	32	33	33
More Than Two Years	8	32	34	34
Services Received *				
Chemotherapy	16	64	72	72
Oral Neuroleptics	7	28	47	47
Depot Neuroleptics	6	24	19	19
Antidepressants	0	0	12	12
Anxiolytics	1	4	9	9
Sedatives	2	8	10	10
Other Medications	7	28	32	32
Individual Psychotherapy	21	84	89	89
Family Therapy	4	16	25	25
Activity Therapy	1	4	15	15
Play Therapy	1	4	3	3
Occupational Therapy	2	8	16	16
Social-Recreational Services				
GVMHSS-Funded	6	24	27	27
Ministry of Health-Funded	8	32	30	30
Community-Funded	12	48	37	37

1. x^2 (df = 3) = 6.99, p = .07
2. x^2 (df = 2) = 0/08, p = .96

* This section shows only the number and percent of patients who were receiving a given service. None of these differences are statistically significant.

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Canadian Indian patients were slightly more likely to be referred by themselves or a friend or relative, and much more likely to be referred by "other" means. This last category largely reflects referrals by various forms of community gatekeepers: landlords, operators of other residential facilities, police officers, and welfare workers. There is little to distinguish Canadian Indian from Anglo patients on the basis of length of service given in years.

In terms of the various therapies and other services currently being received, none of these differences was statistically reliable. But visual inspection of Table VII suggests that Canadian Indian patients consistently receive slightly less of virtually everything. In fact, of the fifteen services listed, Canadian Indian patients received an average of 3.8 different types per patient, compared with 4.5 services per patient among Anglos, which is marginally significant (t = -1.41, df = 123, p = .08).

The only individual differences that approached even marginal significance in this section were the low proportion of Canadian Indians on oral neuroleptics, and their under-representation in activity therapy. Diagnosis provides no basis for predicting fewer Canadian Indians on oral neuroleptics; the slightly higher share of Canadian Indians on depot neuroleptic makes up part of the difference, and suggests medication compliance problems. Under-participation in activity therapy may either be related to the high levels of violent acting-out in this group, which creates a potential for management problems in group settings, or may reflect a lack of perceived relevance of the kinds of activity offered.

Conclusion

Even when matched on sex, age, education, and employment status, Canadian Indian psychiatric patients in community care showed relatively greater socioeconomic deficits -- reflected in their higher dependence on transfer funds, unmet housing needs, and somewhat lower ratings of employability. Shore et al. (1973), studying a Pacific Northwest Indian village, found that degree of psychiatric impairment correlated highly with socioeconomic status, family income, and employment status _within_ the village population. Thus, while Canadian Indians as a group have a lower than average socioeconomic standing, Canadian Indians with psychiatric impairments fare worse than either other Canadian Indians or other non-Canadian Indian psychiatric patients.

Canadian Indian patients in community care were seen to be quite mobile within relatively restricted geographic areas, showed a somewhat greater tendency to live alone, but received levels of social support comparable to the matched controls. This, in connection with the literature reviewed, suggests a transfer to

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the city of traditional migratory patterns, and a broad but loosely-knit social network reminiscent of patterns of association seen in villages and reserves.

Canadian Indians in our sample were reported to act violently significantly more often, more commonly carry a diagnosis of substance abuse, and present greater difficulties in community placement. Possibly, they are more prone to suicidal behavior, but not markedly so, and any excess risk of this nature may be associated with the higher levels of substance abuse observed (cf. Berglund, 1984; Moore et al., 1979). We do not, for example, find a greater frequency of depressive diagnoses among Canadian Indian patients.

We do find a suggestion that Canadian Indian patients more commonly have multiple hospitalizations, but more information on the nature and duration of these inpatient stays is desirable. The prior use of community psychiatric services seems similar to that of the matched group of Anglo patients, and the differences that exist seem largely attributable to Canadian Indian mobility patterns.

Various community gatekeepers seem more important as sources of referral into care than are other community-based psychiatric services. It is possible that active public education efforts directed toward enhanced case identification, or greater consultation and liaison work with welfare workers and the police force would prove useful.

Using the best available population data (which are not good), we know that Canadian Indians are certainly not over-represented on our caseload, and may be significantly under-represented. Additional patient census studies will be conducted in the future to monitor progress in this area. For the present, however, community mental health facilities such as ours are mandated to provide accessible, acceptable, and appropriate care to all members of the community. In a strongly multicultural city such as Vancouver, this includes giving due consideration to the problems involved in meeting the mental health needs of a culturally and ethnically diverse population.

Wu & Windle (1980), studying the utilization of community mental health centers by various ethnic groups, found that the presence of minority staff members, in itself, serves to increase minority utilization. Though the relatively small numbers of Canadian Indians seen in many community services may seem too small to warrant additional staff, several points are worth bearing in mind: a) the purpose of such an exercise is, in fact, to increase the number of Canadian Indians being seen; b) Wu & Windle (1980) found that ethnic staff members did not have to be actually be seeing the minority patients themselves for utilization to increase, and c) such positions can be filled through developing employment equity programs without increasing staffing levels.

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In addition, resources for staff education in the areas of Canadian Indian cultural differences and communications styles should be explored. Workshops conducted on an annual basis would allow new employees to gain knowledge of Canadian Indian culture and interpersonal styles, and maintain an ongoing level of interest in the issues of multiculturalism. Since clerical and other support staff are often the first persons encountered by patients on arrival, such a staff should be actively encouraged to take advantage of such training opportunities.

Our data also show that Canadian Indians are: a) markedly under-represented in existing community residential programs; b) over-represented among persons of no fixed address, in residential hotels, detoxification centers and other emergency and transitional facilities, and c) more often deemed to be living in unsuitable accommodations by their therapists. The feasibility of psychiatric boarding homes for Canadian Indians, run by Canadian Indian staff, should be explored. Ideally, whole Canadian Indian families should be able to stay in such facilities.

A point that has been made repeatedly by Canadian Indian organizations in relation to residential alcohol and drug treatment programs for Canadian Indians is the direct and deleterious effect this can have on Canadian Indian families. As the Indian Homemakers' Association of British Columbia (1981, p. 1) has stated:

> While the family is said to be the base of any society, the family for Indian people is of still greater importance. It is the very foundation of our culture. In contrast to the individualistic, nuclear family concept of the non-Indian people we are culturally a communal society which functions within the framework of the extended family.

The acceptance of residential treatment programs by Canadian Indians has in the past been low, in part because such approaches are perceived to weaken Canadian Indian families, and so Canadian Indian society as a whole.

Our data also indicate that Canadian Indian patients would stand to benefit, as would non-Indian patients generally, from increased resources and facilities for vocational rehabilitation. Since the Canadian Indian patients studied here are functioning at such low socioeconomic levels, the absolute and relative gains they could accrue would be significant.

Another, more general, set of concerns lie in the area of continuity of care. In terms of both policy and program planning, Canadian Indians and psychiatric patients are best thought of as being members of largely distinct, yet somewhat overlapping populations. Logically, and for the most part appropriately, the kinds of social programs, staff, and skills that have evolved to meet the needs of these populations are equally distinct.

Problems arise when, as in the present case, the focus is on persons at the overlap between groups. Neither persons working in Canadian Indian social and support services nor the community mental health worker are equipped to deal

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optimally with persons who are at the intersect of the two populations, who need specialized psychiatric services and culturally appropriate and acceptable counseling in equal measure. Solutions to these problems seem to lie in the areas of developing formal systems-links, and boundary-spanning roles that permit good case-management practices.

Finally, no discussions in these areas should occur in a vacuum without active input from those persons most directly affected. As Shore (1974) suggests, the guiding principles in this area should stress Canadian Indian needs, such as: a) planning, implementation, and evaluation; b) taking cross-cultural differences into account when planning mental health programs and an explicit recognition of the effects of inter-tribal cultural differences on the diversity of Indian mental health care needs, and c) the necessity of matching the philosophy and methods of a treatment facility to the specific needs of the population being served.

Greater Vancouver Mental Health Service Society
#300-1070
Vancouver, B.C., Canada V6H 2R2

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