

# Chapter 2

## An Examination of Residential Schools and Elder Health

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TABLE OF CONTENTS

<b>List of Figures</b>	<b>29</b>
<b>List of Tables</b>	<b>29</b>
<b>Introduction and Background</b>	<b>30</b>
<b>Methods</b>	<b>31</b>
<b>Review of Literature</b>	<b>32</b>
<i>Indian and Inuit Residential Schools in Canada</i>	32
<i>Harms Caused by Residential Schooling</i>	34
<i>Physical and consequent Emotional Harm to Children</i>	34
<i>Educational Harm</i>	34
<i>Loss of Culture and Language</i>	34
<i>Harm to Family Structures</i>	34
<b>Health Conditions of Elders</b>	<b>36</b>
<i>Socio-cultural Factors</i>	36
<i>Family Support Net works</i>	37
<i>Health and Social Services</i>	37
<i>Mental Health</i>	38
<i>Elder Abuse</i>	38
<i>Poverty</i>	38
<b>Results</b>	<b>40</b>
<b>Discussion</b>	<b>48</b>
<b>References</b>	<b>52</b>



## LIST OF FIGURES

Figure 1.	<i>Age by Gender</i>	40
Figure 2.	<i>Aboriginal Language Used Daily by Age</i>	40
Figure 3.	<i>Highest level of Education</i>	41
Figure 4.	<i>Excellent / Good Self-reported Health Status By Gender and Age</i>	41
Figure 5.	<i>Poor / Fair Self-reported Health Status by Smoking Behavior and Age</i>	42
Figure 6.	<i>Asthma by Pack-Years Smoking and Age Group</i>	42
Figure 7.	<i>Breathing Problems by Pack-Years Smoking and Age Group</i>	42
Figure 8.	<i>High Blood Pressure by Pack-Years Smoking and Age Group</i>	43
Figure 9.	<i>At Least One Chronic Health Problem by Gender and Age</i>	43
Figure 10.	<i>Diabetes Alone and Cardiovascular Co-Morbidity in the Presence of Diabetes</i>	44
Figure 11.	<i>Diabetes Alone and Cardiovascular Co-Morbidity in the Presence of Diabetes by Age</i>	44
Figure 12.	<i>Rank Order of Health Services in Need of Improvement</i>	45
Figure 13.	<i>Disability and Activity Limitation</i>	45
Figure 14.	<i>Community Progress Over the Last Two Years</i>	46
Figure 15.	<i>Community Progress and Wellness</i>	46
Figure 16.	<i>More Than One Year Since Last Received Dental Care by Gender and Age</i>	47
Figure 17.	<i>Dental Treatment Needed at the Time of Survey by Gender and Age</i>	47
Figure 18.	<i>Residential School Attendance by Gender and Age</i>	47
Figure 19.	<i>Determinants of Health - Shaded Factors Theoretically Impacted by Residential School</i>	50

## LIST OF TABLES

Table 1.	<i>Estimated life expectancy at birth, total population, Inuit and Registered Indian, 1991.</i>	32
Table 2.	<i>Life expectancy at birth, age 30 and age 60, Registered Indian and Total Populations, 1978-81, 1982-85 and 1990</i>	33
Table 3.	<i>First Nation and Inuit Elder Smoking Rates versus Canadian Population</i>	41
Table 4.	<i>Chronic Conditions, First Nations and Labrador Inuit compared to the Canadian Population: Age-gender-specific and age adjusted prevalence for self-reported heart problems, hypertension (high blood pressure), diabetes, arthritis and rheumatism</i>	43

## INTRODUCTION AND BACKGROUND

Ultimately, everyone has a vested interest in maintaining optimal health and wellness particularly with advancing age. Those fortunate enough to live to an old age will likely be personally confronted with some of the health and social issues that accompany aging. Population demographic trends show that the numbers of First Nations and Inuit elder peoples are increasing. Presently, and to a greater degree in the future, aboriginal society will increasingly encounter the aging of family, friends and community members. Thus, the broad health issues associated with aging need to be addressed.

For the purposes of this report people in older adult age groups (45 years +) were defined as ‘elders’ and not ‘middle age adults’ or ‘seniors’, since elders is an acceptable term used by Aboriginal peoples. The term elders was used here to signify age only, not the spiritual definition that is usually used in Aboriginal communities to define an Elder.

Whereas an expanding body of information exists concerning the impact of residential school experiences on Aboriginal peoples in Canada, relatively little information exists regarding the current health status of elders. This report was written to investigate the health of First Nations and Labrador Inuit elders living in their home communities. In addition, the report will explore the numbers of elders who attended residential schools.

The Assembly of First Nations recognized the importance of reconciling history to make sense of current health stating that:

*“First Nations need to know their history. History provides a context for understanding individuals’ present circumstances, and is an essential part of the healing process.”*

Assembly of First Nations (1994)

A comprehensive examination of elder’s health status should begin by linking historical health determinants to social, political, environmental, economic and cultural influences. Thus, a study that proposes to examine the health status and social circumstances of elders living in their home communities in Canada cannot ignore the pervasive impact that residential schools have had on many individuals and the ripple effects felt throughout their families and communities. The reader is particularly encouraged to consider health survey indicators in a holistic context of past residential school experiences as a significant cohort-specific determinant of health.

The rationale for such an approach to understanding health is found in the ‘determinant of health’ conceptual framework that builds on the link between health status and income inequality (including poverty, lack of education and under-employment) but extends to include a shift away from ‘material constraints’ to ‘social constraints’ as the limiting condition on quality of life (Wilkinson, R., 1994). In other words, health may be viewed as a holistic balance and harmony involving body, mind, emotions and spirit. Theoretically, residential school experiences seem to have

## METHODS

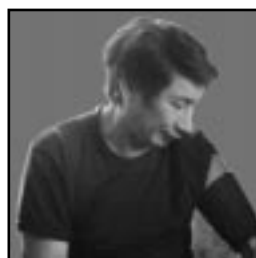
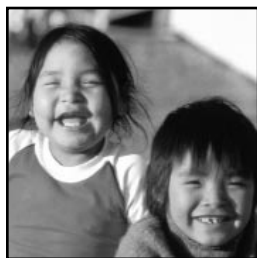
created fundamental inequalities that, in part, could have been manifest in the profound poor health of elders when compared to their non-aboriginal counterparts in Canadian society. The aim of this report is to describe the health of First Nations and Labrador Inuit elders, explore the complex multiple causative factors in the etiology of ill health and to make recommendations that fundamentally improve health. Failure to acknowledge the potential impacts of the past events and current social, political, economic and cultural circumstances in the complex etiology of poor health will likely lead to an incomplete understanding of the root causes of ill health.

In January of 1996, a national steering committee (NSC) was struck to develop the FNIRHS. The NSC included membership from First Nations political organizations drawn from nine participating regions including Labrador, New Brunswick, Nova Scotia, Quebec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia. Two ex-officio members attended, one each from the Assembly of First Nations and Medical Services Branch of Health Canada.

All decisions were reached by consensus. The NSC managed the entire survey process including the development of national core questions, a detailed code of ethics, financial and community accountability, data security, ownership, control, analysis, interpretation and dissemination of results.

The national core questions were common concerns that were developed and mutually agreed upon by all members of the NSC. The survey examined chronic medical conditions including diabetes, residential schools and elders health issues, the 'non-traditional' or recreational use of tobacco, wellness, children's health, dental health, health services, disabilities and restrictions on activities. It should be noted that regions and communities had the flexibility to develop additional regional questions that aimed to address regional and local health issues.

The nine participating regions each submitted national core data reports and electronic copies of their databases. After a series of quality checks were performed, individual records were appropriately weighted to properly represent the national population of adults living in First Nations and Labrador Inuit communities. Comparable data responses from the National Population Health Survey (1994-95), the Aboriginal Peoples Survey (1991), and community-specific ecological variables (1997) were appended to the national database. Individual, community and regional identifiers were removed from the sample of 2,663 respondents ranging in age from 45 years and older.



## REVIEW OF LITERATURE

### Indian and Inuit Residential Schools in Canada

The following review draws heavily on the Royal Commission on Aboriginal Peoples' final report (1997), which contains extensive research on Indian and Inuit residential schools. Readers are encouraged to access this important source of information for further reading and recommendations made by the commission.

Education, administered by the church became an essential tool in the assimilation of Indians. In 1879 the federal government adopted the American model of Indian residential schools with the added provision that these schools be operated by various Christian denominations. In 1920 the Indian Act was amended to make school attendance compulsory for all First Nations children between the ages of seven and fifteen.

By 1923, there were 72 Residential schools. That number grew to a high of 80 in 1931. There was then one school in Nova Scotia, 13 in Ontario, 10 in Manitoba, 14 in Saskatchewan, 20 in Alberta, 16 in British Columbia, four in the Northwest Territories, 2 in the Yukon and plans for 2 schools in Quebec. That number then gradually fell through school closures, many because of fires, to 75 in 1943. Indian and Inuit residential schools operated in Canada for nearly 150 years. The majority of them were in western Canada, and the ones in British Columbia operated until the 1970s.

	Male	Female
Total Population	75	81
Inuit	58	69
Registered Indians	62	70

*Table 1: Estimated Life Expectancy at Birth, Total Population, Inuit and Registered Indian in 1991 (years)*

*Source: M.J. Norris et al., "Projections of the Aboriginal Identity Population in Canada, 1991-2016", research study prepared by Statistics Canada for RCAP (February 1995).*

*Note: 'Total Population' refers to all Canadian citizens including Aboriginal peoples.*

The stated policy of the Canadian government was to assimilate aboriginal people into the dominant society by educating children away from their parents' control and their community's culture. By financing and regulating these residential schools, the Crown bears ultimate responsibility for this action.

Milloy, (1996) clearly states that:

*"Federal policy since Confederation, and what it would remain for many decades, was a policy of assimilation, a policy designed to move Aboriginal communities from their 'savage' state to that of 'civilization' and thus to make in Canada but one community; a non-Aboriginal one. At the core of the policy was education. In the education of the young lay the most potent power to effect cultural change - a power to be channeled through schools and, in particular, through residential schools.....Aboriginal knowledge and skills, had enabled the newcomers to find their way, to survive and to prosper. But they were now merely historic;*

they were not to be any part of the future as Canadians pictured it at the founding of their new nation in 1867. That future was one of settlement, agriculture, manufacturing, order, lawfulness and Christianity. In the view of politicians and civil servants in Ottawa whose gaze was fixed upon the horizon of national development, Aboriginal knowledge and skills were neither necessary or desirable in a land that was to be dominated by European industry and, therefore, by Europeans and their culture.”

The long term consequences of these schools, designed to ‘christianize and civilize’, have been, in sum, disastrous. For as long as five generations in some areas of Canada, children were removed from their homes, families, culture and language to be immersed far away for long periods in what has been described as a ‘cultural commando course’. At the schools children’s long hair was cut off and school uniforms issued, they were forbidden to speak their own language and forced to live by strict rules which prevented any contact with siblings or children of the opposite sex, in short, many of these children endured long years of isolation and loneliness.

To give some idea of the impact of residential school it is important to examine the context of the residential school experience. Children entered a strange new world in residential boarding schools that were run primarily by the Christian churches: Roman Catholic, Presbyterian, Anglican and what is now the United Church of Canada.

In many of the schools missionaries taught western culture to Indian children. Yet, in western society, priests, brothers and nuns were people who lived on the fringe of their own society. They deny sex, marriage and family, opting instead, to live their whole lives within a religious culture. Further, within the religious culture of priests and nuns, missionaries are a marginal group. They move away from their own cultural group and yet take their culturally-based and culturally-biased views with them. Many spent their

	At Birth		At Age 30		At Age 60	
	Registered Indians	Total Population	Registered Indians	Total Population	Registered Indians	Total Population
Male						
1978-81	61.6	71	39.5	43.4	18.4	17.5
1982-85	64	72.4	40.8	44.4	17.9	18
1990	66.9	73.9	41.1	45.7	16.9	19
Female						
1978-81	69	79.2	44.1	50.7	21.4	23.4
1982-85	72.8	80.1	46.8	51.4	22.5	23.8
1990	74	80.5	46.7	51.6	20.5	23.7

Table 2: Life Expectancy at Birth, Age 30 and Age 60, Registered Indian and Total Populations, 1978 - 1981, 1982 - 85 and 1990

Notes:

- Total population is the total population of Canada, including Aboriginal peoples.
- Life expectancies at age 30 and 60 for registered Indians in 1990 are the average life expectancies for ages 30-34 and 60-64 respectively.

Source:

Health and Welfare Canada, “Health Indicators Derived from Vital Statistics for Status Indian and Canadian Populations, 1978-1986” (September 1988); DIAND, “Life Tables for Registered Indians, 1985 and 1990”, Information Quality and Research Division, unpublished tables (May 1995); Statistics Canada, Report on the Demographic Situation in Canada, catalogue no. 91-209E (Ottawa: 1993)

lives isolated from any influence from their own culture and kind.

Scores of children died from disease; others were emotionally and spiritually destroyed by the harsh discipline and living conditions. Children were referred to as ‘inmates’. Survivors report being hungry all the time. In some cases, children were separated from their siblings, tortured for speaking their mother tongue, forbidden to honor their traditions. Grievous sexual abuse also occurred in some schools, but other outstanding issues include physical abuse and poor quality of education. Very few students graduated until education passed into the control of First Nations communities. Some communities were completely de-populated of

children from ages 5 to 20. Traditional means of educating and parenting children were lost. In many cases the extended family was destroyed.

In retrospect it seems that the effect of the Indian and Inuit residential schools could be described as an assimilation process that failed. Former students were often confused and frustrated, unable to fit back into their own families, communities and Nations, while not adequately prepared to join mainstream Canadian society.

The legacy of these schools is multi-generational, thought to be reflected in the unacceptably high rates of suicide among First Nation and Inuit peoples, as well as high incidence of substance abuse, family violence and alcoholism.

### Harms Caused by Residential Schooling

Réaume, D.G. and P. Macklem (1994), identifying the harms caused by residential schooling including four possible types of harm and potential claimants as follows:

#### Physical and Consequent Emotional Harm to Children

Most readily recognizable by the legal system are the harms caused to the individual children who were mistreated or abused within the system. These include, in addition to the obvious physical harm of physical or sexual abuse, the emotional harm consequent upon such abuse, and harm to dignity. The psychological effects of abuse, the full extent of which needs further study, have long outlasted their physical progenitors. In the category of physical harm we also include the under-nourishment suffered by some children, as well as general health problems and the exposure to disease due to unhealthy living conditions.

#### Educational Harm

Individual children within the system were given a radically inferior education, which may have had enormous consequences for the quality of their lives... No serious attempt seems ever to have been made by the Churches or the government to design an educational program for Aboriginal children that was

consistent with their own cultures. Instead, Aboriginal children received a second class education that ill equipped them to live productive lives.

### Loss of Culture and Language

Rather than making available to Aboriginal people the benefits of education in a way consistent with Aboriginal traditions, the residential school system was designed to do and did lasting damage to the culture, spiritual traditions, and languages of entire communities. This harm extended far beyond the individual children who attended; it encompassed their whole communities. Languages were nearly wiped out; traditions were lost. Generations of Aboriginal people were alienated from their past.

#### Harm to Family Structures

The last type of harm has both individual, family, and communal manifestations. In removing children from their parents for long periods of time, the system had a negative impact on the normal development of parent\child relationships.

Sivell-Ferri (1997) equates the residential schools to prisons and the educational process as a means to achieve social control:

*“Prisons are one place today in which people are obviously watched and monitored in this way. The Indian residential school system, now abolished, certainly stemmed from this same history of thought. European educational systems still follow this logic when classrooms are arranged in rows and the teacher’s desk is placed at the back or on a raised platform....European societies are based on a particular idea of order arising from the rule of reason and rationality. That which does not fit, whether an indigenous society in the Americas or the complex natural world, into a specific category within this system of order has traditionally been classified as disorder, irrational, and unreasonable and thus becomes a problem to be solved or a crisis to be averted.”*

The Government of Canada acknowledged their role in development of residential schools recently in a speech given by the Hon. Jane Stewart (1998):

*“Sadly, our history with respect to the treatment of Aboriginal people is not something in which we can take pride. Attitudes of racial and cultural superiority led to a suppression of Aboriginal culture and values. As a country,*

*we are burdened by past actions that resulted in weakening the identity of Aboriginal peoples, suppressing their languages and cultures, and outlawing spiritual practices. We must recognize the impact of these actions on the once self-sustaining nations that were disaggregated, disrupted, limited or even destroyed by the dispossession of traditional territory, by the relocation of Aboriginal people, and by some provisions of the Indian Act. We must acknowledge that the result of these actions was the erosion of the political, economic and social systems of Aboriginal people and nations....One aspect of our relationship with Aboriginal people over this period that requires particular attention is the Residential School System. This system separated many children from their families and communities and prevented them from speaking their own languages and from learning about their heritage and cultures. In the worst cases, it left legacies of personal pain and distress that continue to reverberate in Aboriginal communities to this day. Tragically, some children were the victims of physical and sexual abuse.*

*The Government of Canada acknowledges the role it played in the development and administration of these schools. Particularly to those individuals who experienced the tragedy of sexual and physical abuse at residential schools, and who have carried this burden believing that in some way they must be responsible, we wish to emphasize that what you experienced was not your fault and should never have happened. To those of you who suffered this tragedy at residential schools, we are deeply sorry.*

*In dealing with the legacies of the Residential School system, the Government of Canada proposes to work with First Nations, Inuit and Métis people, the Churches and other interested parties to resolve the long-standing issues that must be addressed. We need to work together on a healing strategy to assist individuals and communities in dealing with the consequences of this sad era of our history.”*

The Government of Canada recently allocated some \$350M to an Aboriginal Healing Strategy as part of “Gathering Strength Canada’s Aboriginal Action Plan”.



## HEALTH CONDITIONS OF ELDERS

A growing body of research examines gerontologic health issues in the general public however serious gaps exist in the published literature concerning the health status of elders. Ruiz, (1995) concludes “Epidemiological data on mental disorders among older Asian and Native American populations are virtually non-existent.”

Life expectancy rates of First Nations and Inuit peoples are profoundly lower than the rest of Canada. The Royal Commission on Aboriginal Peoples report prepared by Statistics Canada (tables 1 and 2) indicate that the life expectancy for Status Indian males and females were approximately 13 and 11 years less respectively, when compared to the Canadian population statistics. Inuit males and females were approximately 17 and 12 years less longevity respectively, when compared to the Canadian population rates. Females in all three populations lived over 6 years longer than their male counterparts. In general, life expectancy rates for the Status Indian and Inuit population resemble the rates seen in the Canadian population 40 or 50 years ago.

Table 2 estimates that the life expectancy gap is present at each ‘life-stage’. These datum were published in 1988, thus 1990 data presented are based on a theoretical improving trend for longevity for Status Indians, however examination of table 1 shows that improvements in life expectancy at birth fell short of the prediction value depicted in table 2. Even given the inherent limitations of rosy predictions that apparently suggested a narrowing of the life expectancy gap, the predicted pattern for the gap in life expectancy still appears to be increasing for Status Indians in comparison to the general population. In other words, table 2 shows that the average years of life remaining for those who reach age 60 appears to be decreasing (1985 to 1990) while longevity appears to have plateaued for the rest of Canadians, thus

increasing the life expectancy gap between First Nations peoples and the rest of Canada.

The next section of this brief review will specifically focus on studies examining aboriginal elder’s potential determinants of health and discuss a broad range of possible etiologic circumstances including social factors, family support networks, perceived advantages and disadvantages of old age, health and social services, mental health and coping with change, poverty and the potential impacts of residential schools.

### Socio-cultural Factors

Perhaps due to lower life expectancy (see tables 1 and 2) a serious paucity of empirical data exists concerning the health of aboriginal elders living in Canada. Assembling comparative evidence from research in the United States may limit its interpretation in a Canadian context however, it seems likely that aboriginal elders in Canada and America are similar in many respects and quite different from their non-native counterparts. Clearly, much more investigative work needs to be done to obtain a better understanding of this rapidly growing and changing population.

Cultural traditions reflected in values, attitudes, and behaviors clearly differ in varying degrees among ethnic ‘minority’ elders. For example, studies of Native American elders have shown a belief that healing a sick person requires a restoration of harmony, especially with the use of super-natural forces (Yee, B., et al., 1994) . M. Harris, et al., (1989) examined advantages and disadvantages of aging among 128 Native American, Hispanic, and Anglo adults aged 60-92 living in central New Mexico. Participants reported improved relationships with their

families since turning age 60. The most commonly mentioned advantage of old age was increased freedom and free time; other advantages mentioned included improved relationships with families, increased relaxation, not having to work, increased self-acceptance and self-respect, and the opportunity to engage in specific activities. Poor health and physical problems were viewed as a major disadvantage of growing old, as were limitations on activities, feelings of loneliness and isolation, and concerns about dependency.

### Family Support Networks

An examination of social integration of 101 elderly Seneca Indians aged 55 or older from the Allegany reservation in New York State, (1984) show that the overwhelming majority (83 percent) of the elders were integrated within their familial and friendship networks as well as in informal social organizations. In this study health status was the most important determinant of social integration, followed by employment and marital status. Not one of the elders who worked was socially isolated. Elderly women were more likely to be employed in old age than the elderly men. The emergence of informal age-specific social groups on the Allegany reservation after relocation was seen as an adaptive measure following the tremendous social change experienced by the Senecas since the 1960s due to building of a dam and involuntary relocation off flooded land. This involuntary relocation was thought to have had a deteriorating effect on the traditional kinship networks of the Senecas and accelerated the assimilation process. (Randy, J. 1995).

Chipperfield and Havens, (1992) assessed serial changes in older Canadians' levels of perceived respect and found there was not a uniform increase across ethnic groups; while respondents of British, French, and German descent reported significant increases in perceived respect, those of North American, Native Canadian, or other descent did not. Other evidence suggests that this finding is not consistent with traditional aboriginal values.

Among Native American families, elders are considered an integral resource and play a central role in family life by providing assistance to younger members for discipline, spiritual guidance, and

maintenance of cultural heritage. In return for meeting family responsibilities, Native American elders expect to be respected and cared for when they become too frail to care for themselves (Yee, B., 1990).

Family support networks are important in older age. Elders who live on or near the Prairie Band Potawatomi reservation in Kansas were questioned about their contact with each living child and sibling regarding nine common family activities. Results documented that the family support network functions better if it includes an adult child rather than a sibling. Females were somewhat more involved in family interactions than men, although this was not always the case when particular family activities or relationships were studied in detail. The presence of a spouse acted to insulate elders rather than increase contact within the family support network, (Robert, J., 1991).

In studies of inter-generational co-residence, pronounced differences were found in both the patterns and the trends according to race and ethnicity in both younger and older co-resident households. In 1984-1986, 30 percent of Asian American households with an older host generation were co-resident, compared with 24 percent of older African American households, 22 percent of the older Hispanic households, 21 percent of the older Native American households, and 12 percent of the older white households. The factors that determine inter-generational co-residence are consistent with the idea that economic situations, the available human resources, and housing situations act as constraints on meeting the independent living norms and the family care norms (Morris and Winter, 1995).

### Health and Social Services

Cuellar (1990), reviewed the literature on the health status and health and human service needs of elderly Native Americans, including American Indians, 'Eskimos', and Aleuts. Demographic profiles, ethnographic descriptions, needs assessments, research projects, policy analyses, and critical reassessments were reviewed. Native American elders generally lived in worse socio-economic conditions than the majority of older persons in the United States and were more

functionally dependent at a younger chronological age because of the earlier onset of “old-age” problems. Almost one of three older Native Americans lived below the poverty level. Death among Native Americans occurred an average of 9 years earlier than among the general population.

Cuellar (1990) stated:

*“Health and human service systems have failed to address the needs of older Indians because they do not integrate family generations; are not based on adequate information of older Indians; and do not include assessment of family lifestyle, institutional arrangements, cultural factors, and native languages in their service plans.”*

Gaps in the existing research literature indicated the need for much more information about aging and health among Indian, Eskimo, and Aleut populations.

Review of the extent of current knowledge about drug use among older minority women led to the conclusion that the particular problem facing Native Americans is distance from the health care system both culturally and physically. It was suggested that policy makers should consider providing adequate funding for drug regimens, make efforts to bridge the distance between minority elderly and the health care system, and encourage more extensive use of informal sources of support. (Kail, B., 1989)

## Mental Health

Narduzzi, (1994) investigated the mental health status of Native American elderly using a research model that evaluated stress and coping among a sample of Native American and Alaskan Natives. Data were used from the National Indian Council on Aging’s study of older American Indians and Alaskan Natives conducted in 1978-1980. A sub-sample of 682 persons, aged 44 to 101 years (mean age 62), was used in this study, with 75 percent reservation Native Americans and 14 percent Alaskan Natives. The median income ranged from \$4,000 to \$4,999 per year. Of the total, only 29 percent were employed either full- or part-time at the time the survey was administered. A research model was developed that equated mental health status with a combination of stressors including: physical health, income, education, social support, and coping. Social support networks and coping behavior were believed to

mediate the impact of the other variables on individual mental health. Regression analysis and analyses of variance showed that physical health and coping were consistent predictors of mental health; coping mediated the impact of physical health on mental health; and important male-female and urban-reservation differences existed within the Native American population in terms of mental health.

## Elder Abuse

Elder abuse was examined among 37 elderly Navajos aged 59-90+ from the Oljato Chapter, and from a close relative of each elderly person. Results show that neglect was the most prevalent form of abuse. Three dependency-related factors made the elderly vulnerable to abuse: suddenness of becoming dependent, mental problems, and lack of income (Brown, S., 1989).

While few studies have examined the extent of elder abuse in Australia, existing research has identified older women as the most likely victims of neglect, abuse, and exploitation. Widows, aged migrants, disabled or frail persons, the Aboriginal and Torres Strait Islander aged populations, isolates, medication users, rural and remote dwellers, and poor persons were thought to be most vulnerable to abusive situations. (Dunn, P. 1995)

## Poverty

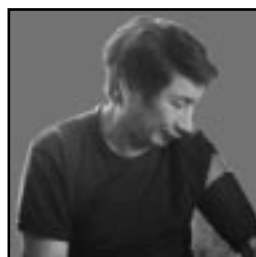
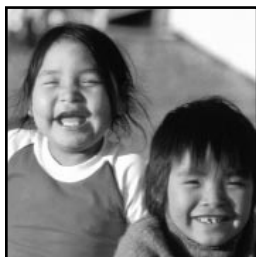
Schiefelbusch, R., and John, R. examined urban and rural/reservation American Indian elders, (1991). Their study revealed a mixed portrait of American Indian elders’ status and characteristics. Compared with their urban counterparts, rural and reservation elders experienced greater problems with social and economic resources, mental and physical health, ability to perform routine activities of daily living, and need for and use of social services. A majority of both urban and reservation elders lacked more than a grade school education.

Schiefelbusch, R., and John, R. (1991) also examined social service needs of reservation Elders living New Mexico including the Nambe, Picuris, Pojoaque, Tesuque, Isleta, Laguna, San Felipe, San Juan, Santa Clara, Taos, and Zuni; the Ponca Tribe and

Sac and Fox Nation of Oklahoma; and the Warm Springs Confederation of Oregon. The results indicated high levels of social service needs with the greatest needs reported in the areas of financial assistance (8), food assistance (6), social/recreational services (6), information and referral (5), transportation (2), housekeeping assistance (2), and regular monitoring (2). Ponca elders were the notable exception to other tribes studied; they appear to have adequate social support, with 100 percent reporting having both a confidant and a person who would care for them if they became sick or disabled. Ponca elders enjoyed substantially higher median annual income, employment-related education, medical services, housekeeping assistance, and access to health information and referral.

Earlier work conducted almost twenty years ago by John (1980), concluded that the problems of the Native American community concern the mechanics of program implementation and result from basic uncertainties of the government-native American Indian relationship including uncertainty that the

Federal Government would make a positive commitment to honor past agreements and confusion over areas of Federal-State jurisdiction. In the United States, Indians stressed the need for direct Federal funding of programs in order to eliminate intervening State government units. They also addressed the problem of conflicting regulations that Natives encounter when seeking benefits from various Federal programs. Other concerns focused on Indian problems in confronting the diverse bureaucratic structures that administer programs for the elderly. Because Indians view life holistically, comprehensive programs that reflect an understanding of Indian cultures needed to be designed. The most important service needs of the Indian elderly were thought to fall into the categories of communication and information dissemination, income maintenance, interventions that respect Indian values, and the entire spectrum of health services. Services to the Indian elderly also needed to be sensitive to the diversity of Native American cultures (John, 1980).



## RESULTS

The survey sample results include 2,663 respondents ranging in age from 45 years and older, living in 183 First Nations and 5 Labrador Inuit communities. The sample results were weighted to reflect the actual age and gender distributions in the population according to the department of Indian Affairs data appended to the national core database in electronic format. Thus, data presented are representative of a population of 51,755 elders (45 years and older) living in First Nations and Labrador Inuit communities.

Selection of age 45 years as a starting point in analysis was based on two main criteria; first, it was necessary to group respondents into categories that would span several decades to demonstrate age and gender-specific trends, if present within the cohort, and secondly, it was postulated that First Nations and Labrador Inuit peoples were more functionally dependent at a younger chronological age due to an earlier onset of chronic 'old age' health problems when compared to their Canadian counterparts.

Papers in this series deal with specific health concerns such as chronic conditions including diabetes, tobacco use, activity limitation, wellness etc. Rather

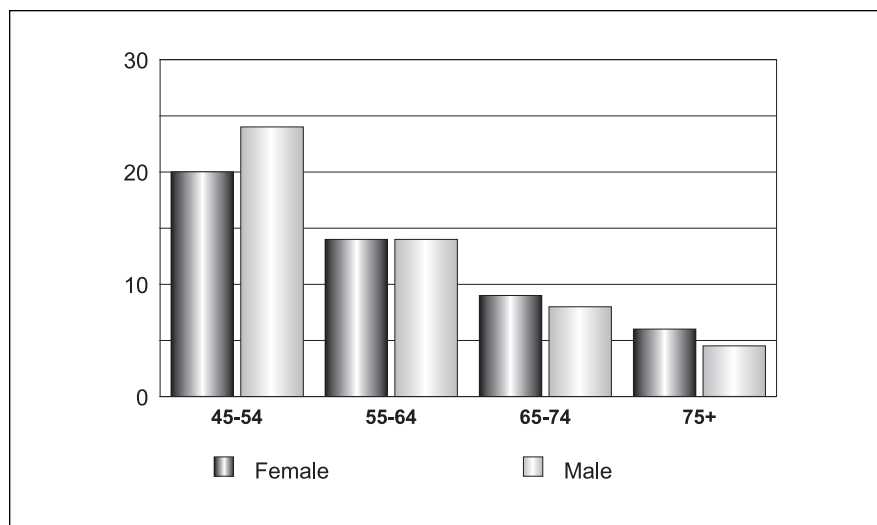


Figure 1 : Age by Gender

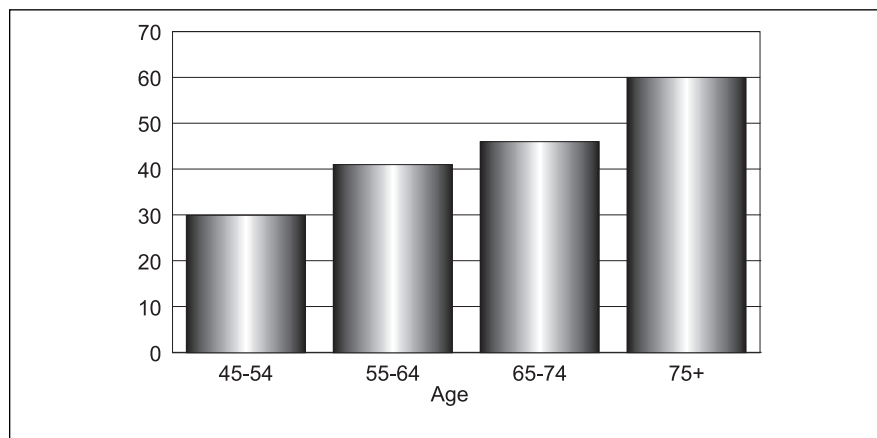


Figure 2: Aboriginal Language Used Daily by Age

than replicate all elder age group findings from other papers, data from other relevant papers will be discussed and presented with reference to the source documents. It is envisioned that the research

reports will be published and bound as a series thus the reference to other papers in the series seems an appropriate approach that aims to direct the reader toward a more in-depth

treatment of a specific area of interest.

Concerning residential schools, the scope of questions were quite limited and when cross-tabulated to specific health concerns the results did not show significant between group differences when controlled for age. Attempting to quantify the specific effects of residential schools on long-term health outcomes was not feasible since the entire community of elders experiences would have been severely confounded over time by the experience of other pressing health determinants such as inadequate education, employment and income. In other words, the residential school experience is but one early life influence along a continuum of social, economic and cultural influences that, in sum, determined health status for the entire community.

Figure 1 shows the age and gender distribution of the weighted sample. Females exceed males above age 65.

Fifty-nine percent of elders were married (legal or common-law partner), the remaining 41% were separated, divorced, widow or single. Comparing language used most often in daily life indicates that Aboriginal language is used by 39 percent of First Nations and Labrador Inuit over age 45 years. As Figure 2 shows, Aboriginal language increases in direct proportion with increasing age, with some 30% speaking their Aboriginal language daily for 45-55 years. This increases to 60% above age 75.

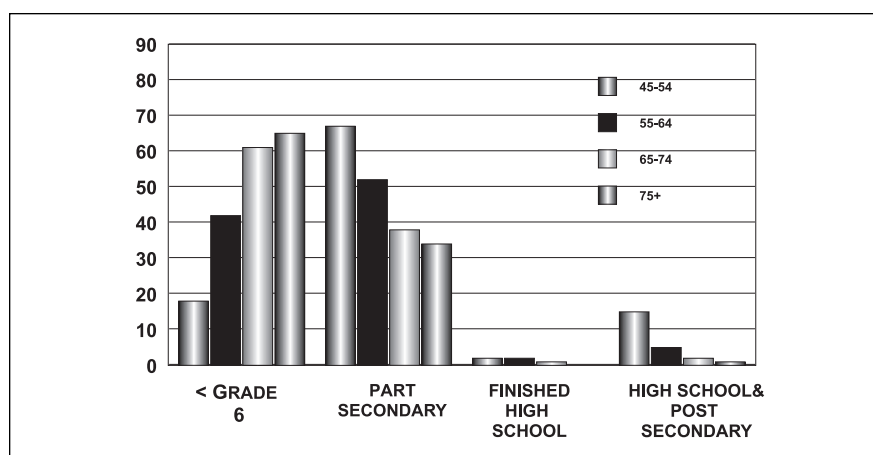


Figure 3: Highest level of Education by Age

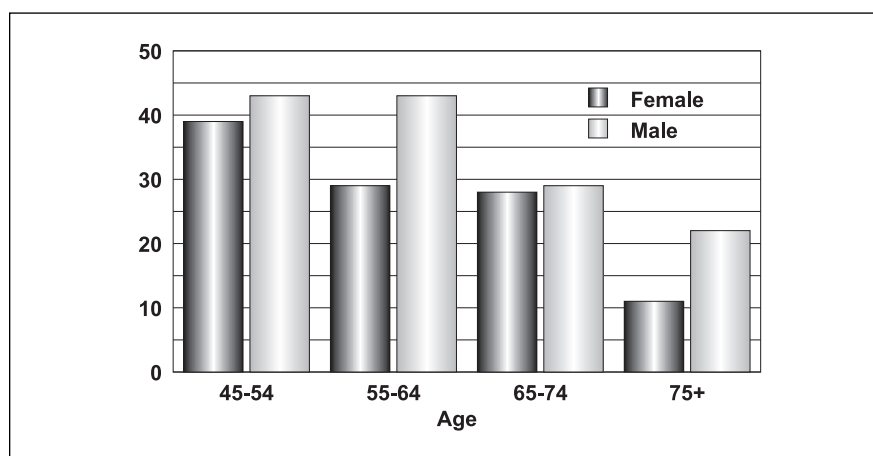


Figure 4: Excellent / Good Self-reported Health Status by Gender and Age

Age	FNIRHS*	NPHS**
45-49	59	32
50-54	54	29
55-59	48	27
60-64	37	25
65-74	35	17
75+	23	10

Table 3: First Nation and Inuit Elder Smoking Rates versus Canadian population

\* = FNIRHS weighted proportion 1997;

\*\* = National Population Health Survey, 1994

Examining the highest level of education completed shows that many First Nations and Inuit elders did not complete high school. In the youngest age group (45-54), fourteen percent completed high school and began some post-secondary education, a substantial increase over the older age groups.

Excellent/good health status self reports decrease with increasing age. Females were consistently less likely to report excellent/good health than their male counterparts.

Cigarette smoking rates were compared and reported in a companion paper of this series (Reading, 1998). The following chart compares cigarette prevalence rates and shows that First Nations and Labrador Inuit consume tobacco at a rate that is roughly twice that of their age-matched counterparts in Canada.

Smokers and former or ‘ex-smokers’ are also more likely to report poor/fair health than never smokers (Figure 5). Above age 75 years never smokers report poorer health status than ex-smokers and smokers which likely reflects a well known ‘survivor effect’ that suggests a selection or screen out of those who have succumbed to the ill effects of tobacco or those who may have moved away from the community to receive medical care.

Examination of tobacco and specific chronic health problems (Figures 6 to 11) shows that asthma rates increase with increasing total amount of tobacco smoked in all age groups studied, suggesting that tobacco smoking contributes to asthma.

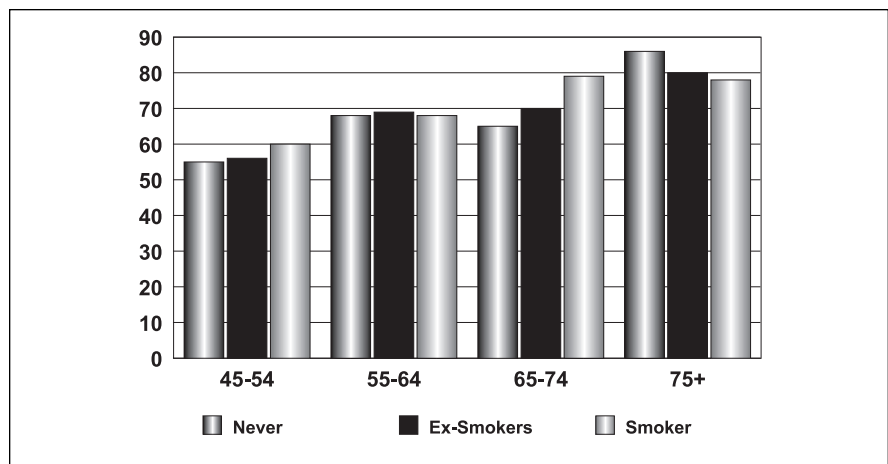


Figure 5: Poor / Fair Self reported Health Status by Smoking Behavior and Age

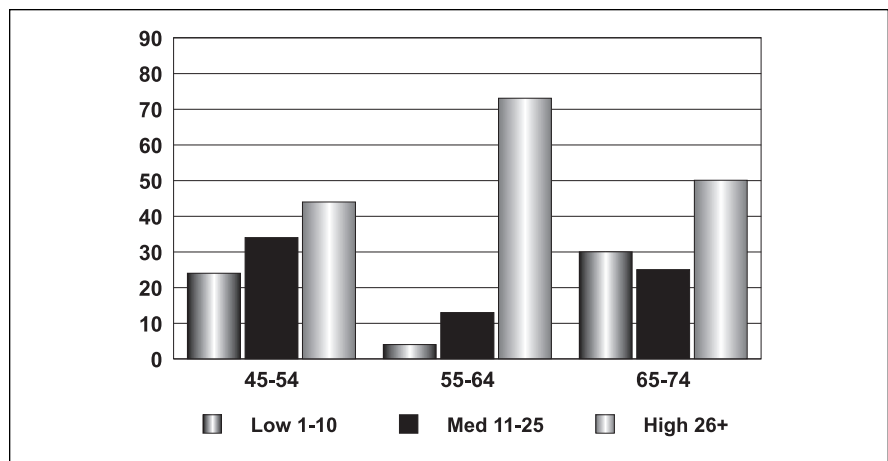


Figure 6: Asthma by Pack - Years Smoking and Age Group

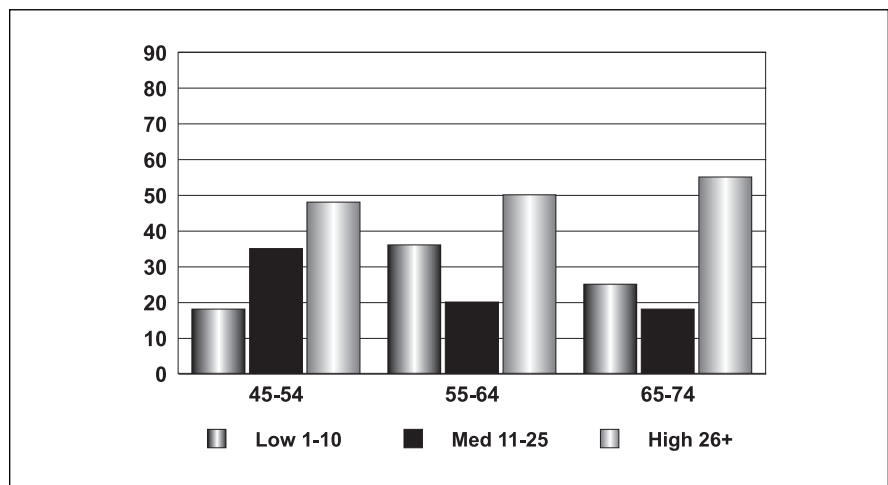


Figure 7: Breathing Problems by Pack - Years Smoking and Age Group

Breathing problems also increased with the total amount of tobacco smoked in all age groups.

High blood pressure (hypertension) increases with increasing total amount of tobacco smoked in all elder age groups studied.

Respondents were also asked to recall whether a health professional had ever diagnosed a chronic health problem. As figure 9 shows, chronic health problems are widespread among First Nations and Inuit elders. Such problems are more prevalent among women than men and increase with age.

Chronic conditions included heart problems, hypertension, diabetes, cancer, arthritis and rheumatism. Comparative results were obtained from a companion paper in this series (Young, et. al., 1998) show that the First Nations/Inuit to Canadian rate ratio for age-adjusted prevalence for diabetes is 3.3 (M) and 5.3 (F), for heart problems is 3.0 (M) and 2.9 (F), for cancer is 2.0 (M) and 1.6 (F), for hypertension is 2.8 (M) and 2.5 (F); and for arthritis/rheumatism is 1.7 (M) and 1.6 (F).

Comparison of chronic condition rates between the Canadian population and the First Nations and Labrador Inuit population (table 4) clearly show that chronic conditions are present at profoundly higher rates for First Nations and Labrador Inuit. Chronic conditions are linked to lifestyle risk factors (exercise patterns, diet, smoking habits, etc.) and changing these factors may impact the future course of these diseases or conditions. Smoking

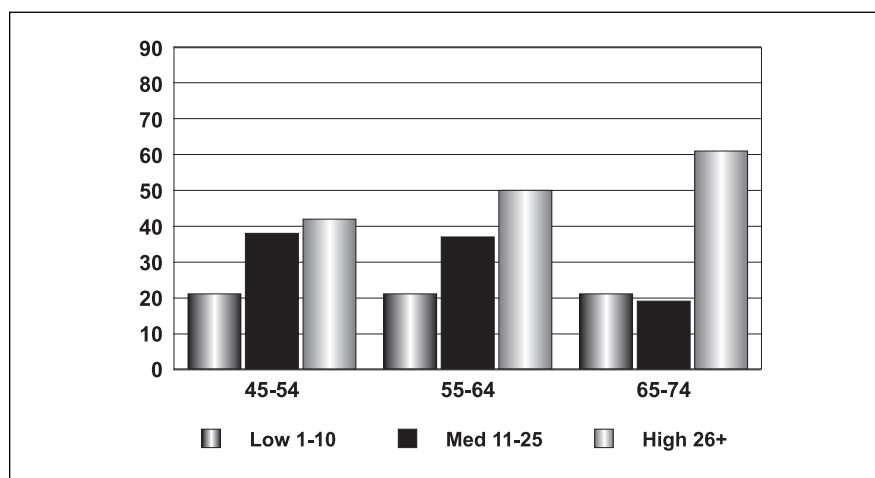


Figure 8 : High Blood Pressure by Pack - Years Smoking and Age Group

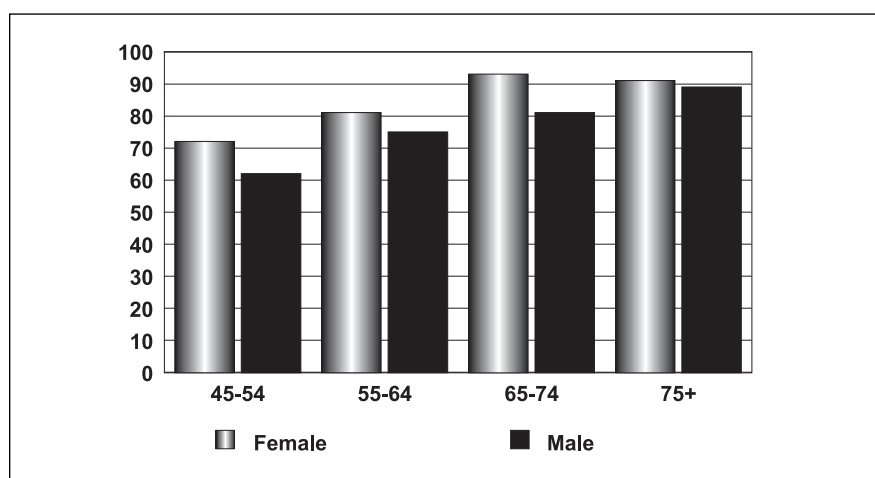


Figure 9: At Least One Chronic Health Problem by Age and Gender

Chronic Conditions	Gender	Age Adjusted		45-54 YRS		55-64 YRS		65+ YRS	
		FN/I	CDN	FN/I	CDN	FN/I	CDN	FN/I	CDN
Heart Problems	Male	13	4	14	4	24	8	44	18
	Female	10	4	10	2	24	5	30	15
Hypertension	Male	22	8	29	9	36	5	49	23
	Female	25	10	29	10	37	22	59	32
Diabetes	Male	11	3	18	3	18	7	28	11
	Female	16	3	22	3	34	5	32	9
Arthritis/Rheumatism	Male	18	10	21	10	32	21	49	33
	Female	27	18	32	18	47	33	57	47

Table 4 : Chronic conditions , First Nations and Labrador Inuit compared to the Canadian Population: Age - gender - specific and age adjusted prevalence (%) for Self-reported heart problems, hypertension ( high blood pressure), diabetes, arthritis and rheumatism

is related to respiratory conditions and lung cancer. Diabetes is also associated with higher risk for hypertension and heart disease. The following data clearly indicated that multiple interventions are needed.

Diabetes affects one in five elders from 45 to 55 years and increases to affect more than one in three elders above age 65; affecting one in three women above age 55 and one in five men above age 55. Diabetes cases include other associated illnesses or conditions known as co-morbidity in two out of three cases. Cardiovascular conditions associated with diabetes include high blood pressure and heart problems.

The pattern of diabetes related cardiovascular co-morbidity changes with increasing age. Diabetes appears to precede cardiovascular problems. As age increases, it appears that cardiovascular co-morbidity for diabetes also increases.

When respondents aged 45 years and over were asked “do First Nations and Inuit have the same level of services as other Canadians”, 48% said no while 18% didn’t know. In other words, only 34% answered that First Nations and Inuit had the same level of health services. Figure 12 shows that a great number of health services are needed urgently. Prevention, education and long-term health care services for the elderly and pediatric health services for children were identified as most in need of improvement.

Activity limitation is widespread among elders. One in

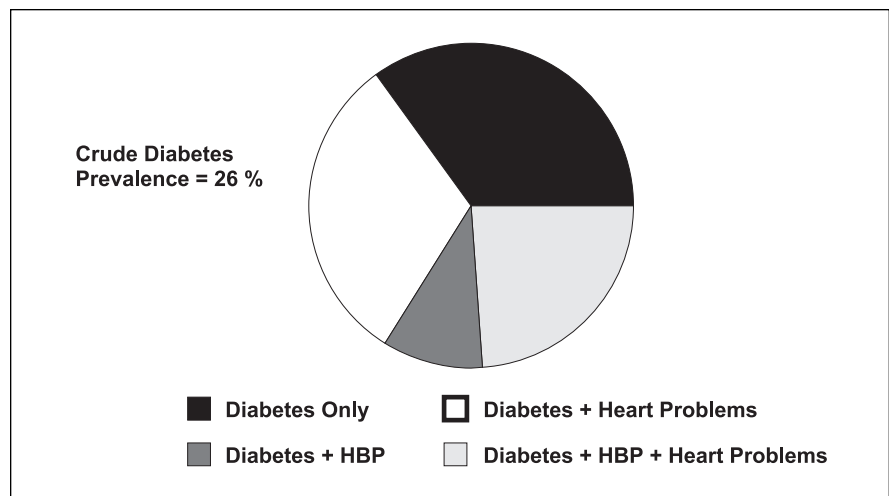


Figure 10: Diabetes Alone and Cardiovascular Co-morbidity in the Presences of Diabetes

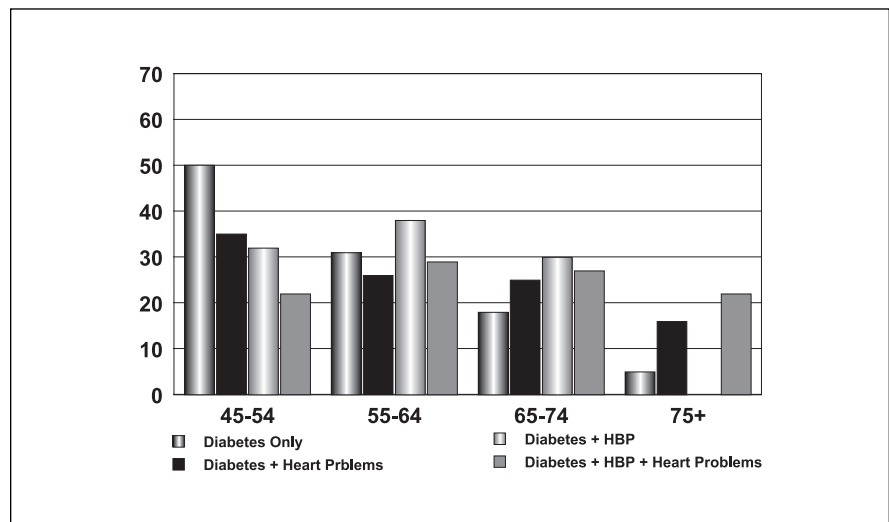


Figure 11: Diabetes Alone and Cardiovascular Co-morbidity in the Presence of Diabetes, by Age

three elders experienced problems with hearing. One in four elders experience activity limitations within the home. Elders require help leaving home for short trips. One in eight elders is unable to leave home and is in need of personal care in the home. These data suggest that activity is limited by specific health problems but questions on specific disabilities and their causes were not included

in the survey questions due to survey time constraints.

Eighty percent of respondents answered yes to the question “Do you think a return to traditional ways is a good idea for promoting community wellness?” The 80% that answered yes were asked to respond to a list of specific areas where there has been progress as depicted in Figure 14.

Figure 15 shows where respondents believe community progress has been made.

Concerning dental care, more than half of all respondents said that it has been more than one year since they last received dental care. Some 3 out of 4 elders above age 65 years had not received dental care over the past year.

Examining dental treatment needed shows that younger groups require treatment with males slightly higher than females.

Figure 18 shows that thirty-nine percent of elders attended residential schools. The mean duration was 6

years (range = 1 to 15 years).

Sixty-five percent of those who attended residential school reported fair or poor health. When the group of former residential school students were sorted into two groups according to duration of stay at residential school (less than 6 years and greater than 6 years), both groups indicated that a return to traditional ways was a good idea for promoting community wellness (< 6 years = 83%, > 6 years = 86%); and both groups responded that mental health services were in need of improvement (< 6 years = 89%, > 6 years = 87%).

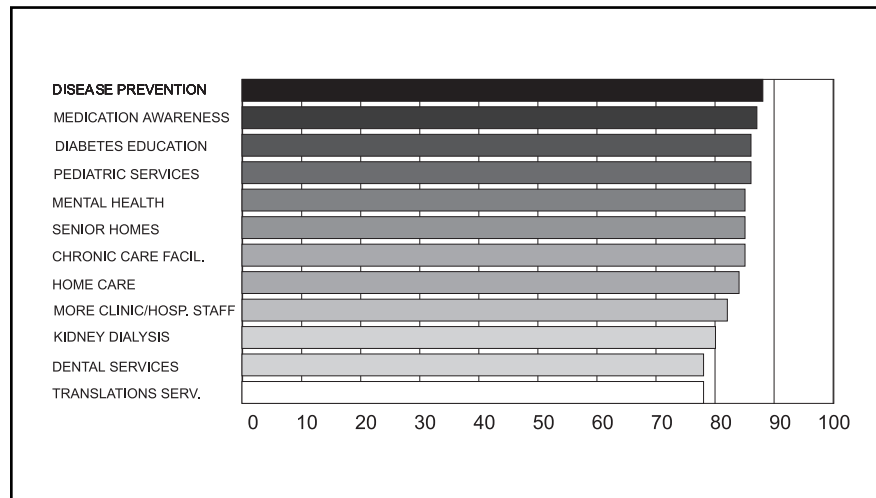


Figure12: Rank Order of Health Services in Need of Improvement

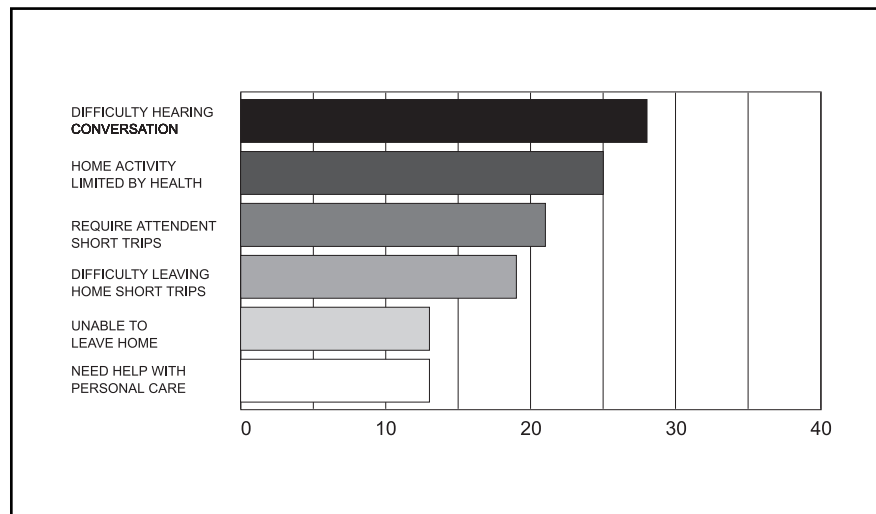


Figure 13 : Disability and Activity Limitation

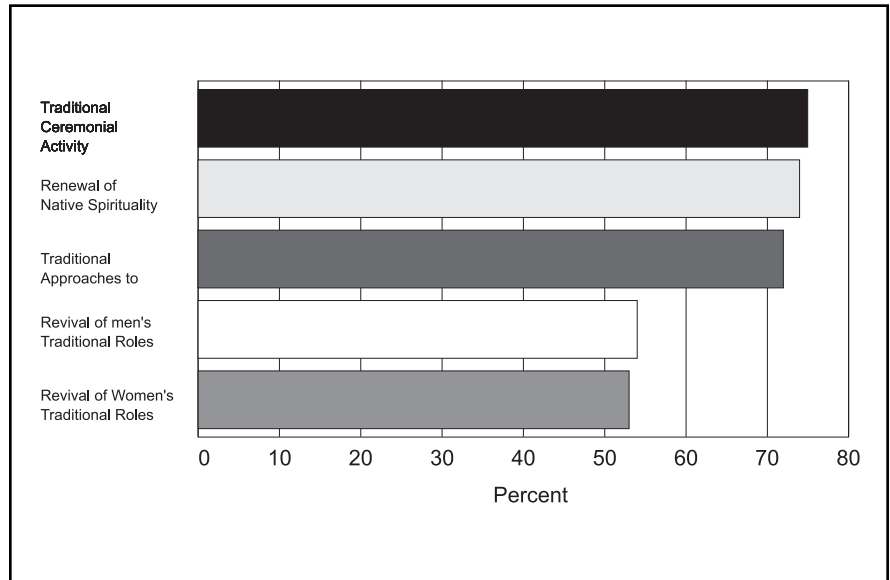


Figure 14:  
Community Progress over the Last Two years

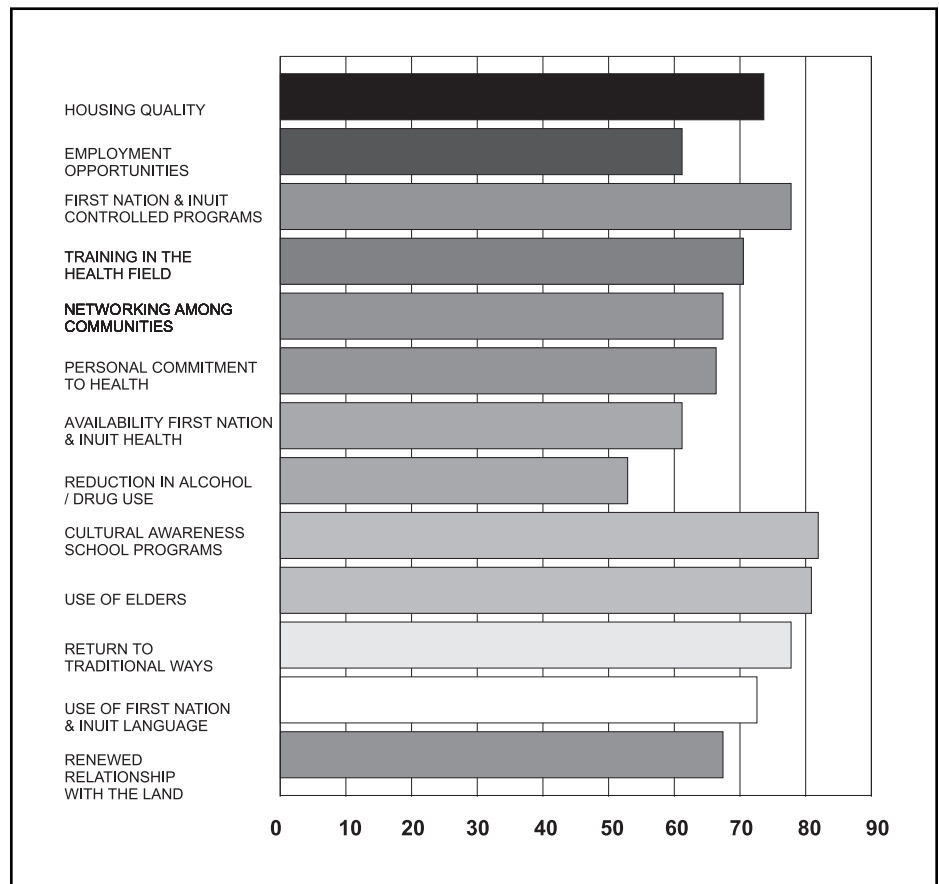


Figure 15 :  
Community Progress and Wellness

Figure 16:  
More than One Year Since Last Received Dental Care  
by Age and Gender

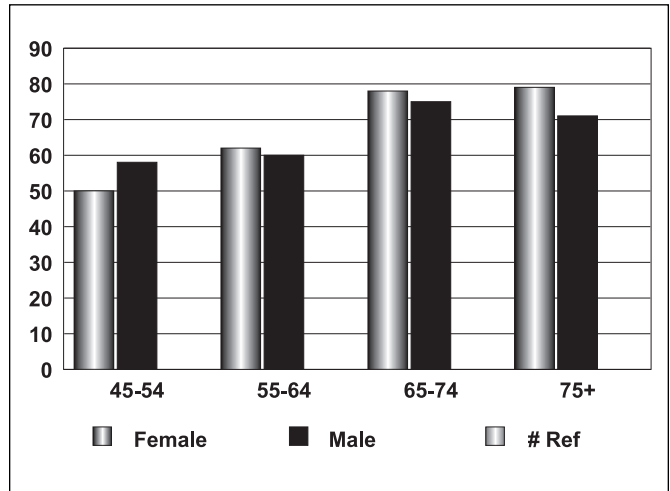


Figure 17 :  
Dental Treatment Needed at the time of Survey, by  
Age and Gender

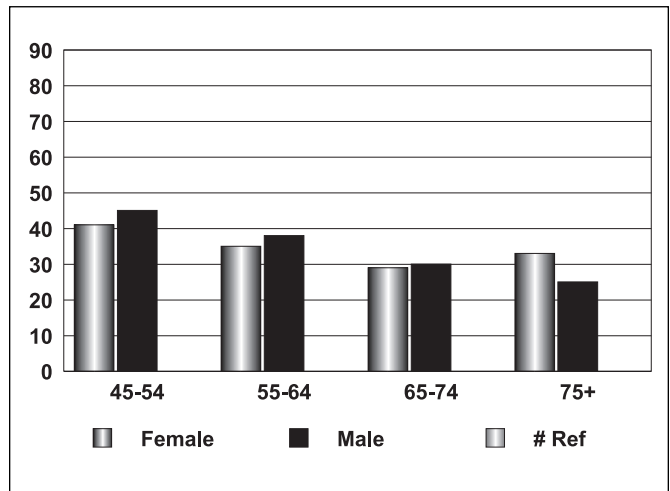
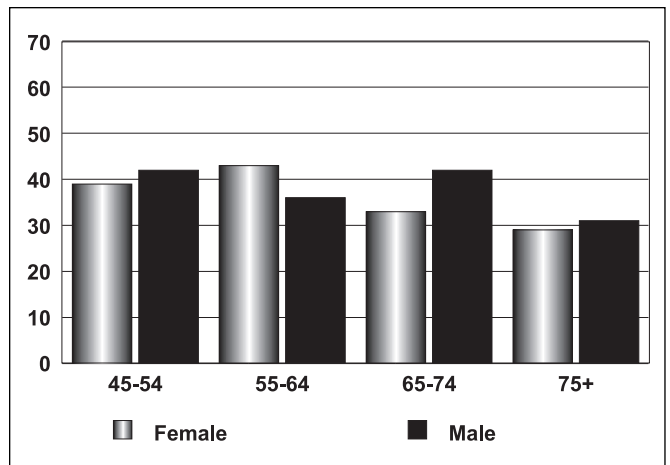


Figure 18:  
Residential School Attendance by Age and Gender





## DISCUSSION

Investigating the health status of First Nations and Inuit elders was a primary concern for the First Nations and Inuit Regional Health survey national steering committee. This study did not attempt to review the entire body of aging or gerontological literature but to review data sources that have relevance to the aboriginal elder community.

Thirty-nine percent of First Nations and Labrador Inuit over age 45 years said Aboriginal language was the most often language used in daily life. Aboriginal language is used most often as age increase; 30% spoke Aboriginal language daily in the 40-45 year olds age group compared with 60 % for age 75+. Clearly language services will continue to be an important part of medical services to the elder client group.

The large majority of First Nations and Inuit elders did not complete high school which likely had a profound impact on income and employment thereby indirectly influencing health status.

As age increases excellent/good health status self reports decrease. Women were consistently less likely to report excellent/good health than their male counterparts. Chronic health problems are widespread among First Nations and Inuit Elders. Such problems are more prevalent among women than men and increase with age.

Diabetes affects one in five elders from 45 to 55 years and increases to affect more than one in three elders above age 65; affecting one in three women above age 55 and one in five men above age 55. Diabetes cases include cardiovascular co-morbidity in two out of three cases. Cardiovascular conditions associated with diabetes include high blood pressure and other heart problems. The pattern of diabetes related cardiovascular co-morbidity changes with increasing age. Diabetes appears to precede cardiovascular problems. As age increases, it appears

that cardiovascular co-morbidity for diabetes also increases. Women experience higher rates of diagnosed diabetes.

Asthma rates, breathing problems, and high blood pressure increase with increasing total amount of tobacco smoked in all elder age groups studied. Smokers and former or 'ex-smokers' are more likely to report poor/fair health than never smokers. There were no questions concerning alcohol consumption, diet and nutrition, exercise or other behavioral factors which should be considered in a follow-up survey.

Elders identified prevention, education and long-term health care services for the elderly and pediatric health services for children as most in need of improvement in their communities. Activity limitation is widespread among elders and is likely due to disability. One in three elders experienced problems with hearing. One in four elders activity within the home is limited. Elders require help leaving home for short trips and one in eight elders is unable to leave home and is in need of personal care within the home.

Eighty percent of respondents answered yes to the question "Do you think a return to traditional ways is a good idea for promoting community wellness?" When the group of former residential school students were sorted into two groups according to duration of stay at residential school (less than 6 years and greater than 6 years), both groups indicated that a return to traditional ways was a good idea for promoting community wellness (< 6 years = 83%, > 6 years = 86%).

Concerning dental care, more than half of all respondents said that it has been more than one year since they last received dental care. Some 3 out of 4 elders above age 65 years had not received dental care over the past year. Examining dental treatment needed

shows that younger groups require treatment with males slightly higher than females. Thirty-nine percent of elders attended residential schools. The mean duration was 6 years (range = 1 to 15 years). Sixty-five percent of those who attended residential school reported fair or poor health. Almost 9 out of 10 former residential school students responded that mental health services were in need of improvement.

Residential schools were the most overt instrument used to assimilate aboriginal children and youth into mainstream Canadian culture. Removal of children from community and family to an institutional setting can create a 'cultural vacuum' whereby people may be unable to 'fit in' either in their home community or outside the community. A great number of elders experienced residential schools and the health impacts will likely never be fully understood.

Examining the link between health status and psycho-social dislocation in areas such as resilience, parenting skill, social factors, family support networks, perceived advantages and disadvantages of old age, health and social services, mental health and coping with change, poverty and other potential impacts of residential schools would seem appropriate.

Little has been done to investigate the complex context of health determinants for First Nations and Labrador Inuit elders. The following chart attempts to model the various determinants of health factors that may be linked indirectly to present health status via early residential school experiences. The model is meant as a starting point to explore various associations within the elder cohort to better understand the etiology of ill health.

Inadequate education is an independent determinant of health and this factor was shown to be very prevalent in the elder population. Education and other factors are inter-related thus early education experiences, if negative, would likely have a negative impact on future education, employment, social status, working and living conditions in the community, health practices and coping skills.

Residential schools were an ubiquitous feature of community life for the First Nations and Labrador Inuit elder cohort examined in this study. In other words, the effects of the residential school experience were so widespread within this group as to be

unavoidable - essentially everyone was affected either via their peer group or passed on through family generations impacting on fundamental family values such as child rearing (Ing, 1990).

The following theoretical model (Figure 19, Page 50) identifies sub-components that link residential schools as a predisposing factor that may determine current health status.

Economic circumstances, availability of resources and housing situations are potential additional constraints on meeting independent living and family care. Poverty among elders appears to be widespread. Overall, the poor health status and profound gaps in life expectancy must no longer be tolerated.

The health concerns uncovered in this report are limited by three major factors. First, the national core content of the survey contained too few questions to adequately address the broad range of health concerns of elders. An important aspect of the study was to reserve the majority of the survey for regional concerns as regional autonomy was an important fundamental principle for the study (O'Neil et. al., 1998) The findings presented here are an introduction to elders health concerns. Unfortunately, these data lack a context due to a paucity of literature available concerning the health of elders and the factors that affect their health. Secondly, survey data is based on self-reports of illnesses, conditions, behaviors etc., and are recognized as an under-estimate of true prevalence due to under-reporting. The reader is instructed to interpret prevalence data with caution as true prevalence is likely higher than reported here. Third, the residential school question instructed respondents to skip the question if they believed it was sensitive issue that they did not wish to discuss. Thus, the residential school attendance rate was likely underestimated and represents a conservative estimate of the true prevalence rate for attendance.

Clearly, the study raises more questions than it answers and the following are potential areas that could to be addressed:

Much more detailed research in the form of ongoing longitudinal studies need to be undertaken to obtain a comprehensive understanding of the health concerns for the elder population that will continue to grow and change in the future.

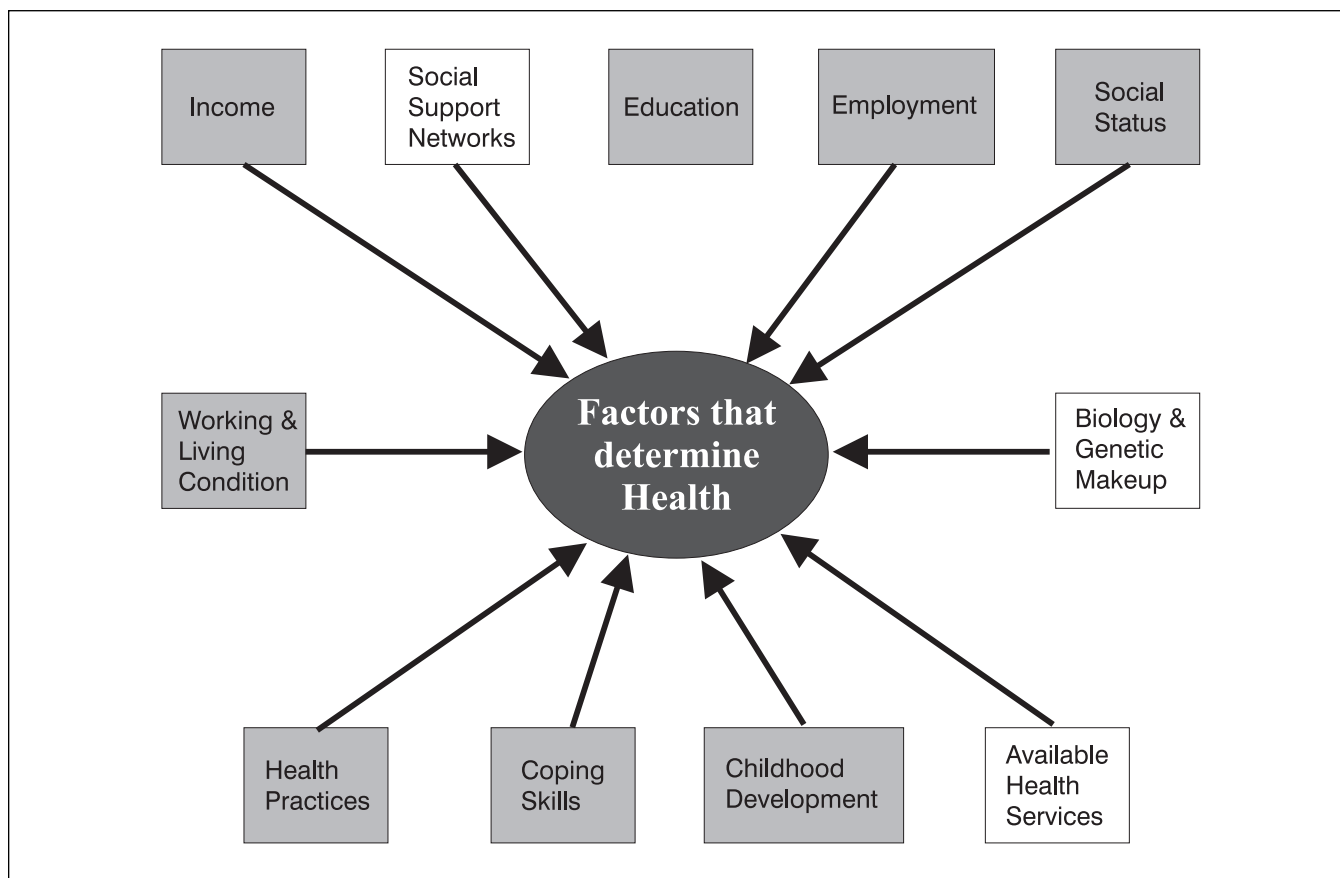


Figure 19 ;  
Determinants of Health - Shaded Factors Theoretically Impacted by Residential School

Reports state that residential schools were a state sanctioned instrument of oppression linked to the political economy of Canada (Chrisjohn, R., et al., 1997) and suggest the European doctrine of manifest destiny (RCAP, 1997) made operational by the eager cooperation of church and state. It seems reasonable that residential schools would have profound and far-reaching impact that potentially influences almost every aspect of community life and likely contributes to ill health either directly or indirectly.

Health, marital and employment status are important factors in social integration. Elders need opportunities for social interaction, exercise, recreation and leisure time activities. Gender specific health concerns, on- and off-reserve differences in health status and security issues need immediate attention.

It is critical that elders health and social service concerns be given the attention of communities, health professionals, governmental and non-governmental organizations, and leadership.

Concerning elders health status, an epidemic of chronic disease conditions indicates that elders now require intensive secondary and tertiary prevention programs and improved access to specialized acute and chronic medical care.

Elders also need home support to continue living in the community. The provision of home care services are urgently needed since a great number of elders experience severe activity limitations in their homes and community.

Community level care management, prevention, rehabilitation services and specialized services specifically targeted to the special needs of elders is an urgent need that will only become more pressing in the future.

There is a need to conduct more detailed longitudinal surveys on the health and social service needs of First Nations and Inuit elders. This survey contained no questions concerning alcohol consumption, drug use and abuse, diet and nutrition, exercise or other behavioral factors which should be considered in a follow-up survey.

Adequate and appropriate medical transportation and access to medical escort and language services are an important and critical health service needs for elders.

In conclusion, findings from the First Nations and Labrador Inuit Regional Health Survey support the notion that elders are more functionally limited at a younger chronological age due to earlier onset of so called 'old-age' or chronic health problems. Functional limitations are manifest as profoundly higher rates for chronic medical conditions compared to age and gender matched Canadian citizens.

Failure to address the legitimate health concerns of elders by tolerating inadequate social and economic circumstances (determinants of health) will likely be reflected higher costs for medical interventions. Factors that determine and improve the health and well-being of elders need urgent careful investigation and detailed longitudinal follow-up study with the aim to develop, plan and implement integrated community based interventions.

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2. Pack Years = average number of packs of 20 cigarettes smoked per year times number of years smoked.
3. Source: Table reproduced with permission from companion report, (figures 2,3,4,6):
4. Young, T.K., O'Neil, J.D., Elias, B., Leader, A., Reading, J., and McDonald, G. (1998) Chronic Diseases. Literature Review and Analysis of the First Nations and Inuit Regional Health Survey. Data sources: FN/I refers to the First Nations and Labrador Inuit data from the FNIRHS (1997), Canadian data from the NPHS, 1994-95.