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# Health in the Communities of Duck Lake and Beardy's and Okemasis First Nation

## An Exploratory Study

Julia Bidonde, Mark Brown,  
Catherine Leviten-Reid, and Erin Nicolas

**A research report prepared for the Northern Ontario, Manitoba,  
and Saskatchewan Regional Node of the Social Economy Suite**

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Entreprises sociales  
économies intelligentes  
et communautés durables

HEALTH IN THE COMMUNITIES OF DUCK LAKE  
AND BEARDY'S AND OKEMASIS FIRST NATION

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JULIA BIDONDE, MARK BROWN,  
CATHERINE LEVITEN-REID, AND ERIN NICOLAS



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## INTRODUCTION

THIS RESEARCH PROJECT was conducted at the request of the Duck Lake Primary Health Team (DLPHT). DLPHT's vision is "to improve the overall health and well-being of children, families, and individuals in our schools and community through access to primary health services" (DLPHT 2009). It works to accomplish this by "working in partnership to build a healthier community" (DLPHT 2009).

In December 2009, the DLPHT partnered with the Community-University Institute for Social Research (CUISR) at the University of Saskatchewan to conduct an exploratory study of health care in the communities of Duck Lake and Beardy's and Okemasis First Nation. Using a qualitative approach, the research project investigated community health as perceived by those who live in the communities. More specifically, this project explored the following:

- perceptions of the health of the communities
- thoughts about, and experiences with, access to programs and services
- suggestions on how to improve health in Duck Lake and Beardy's and Okemasis First Nation

## BACKGROUND ON THE COMMUNITY

DUCK LAKE IS A RURAL MUNICIPALITY, with the municipal seat being the town of Duck Lake. Beardy's and Okemasis First Nation is adjacent to this municipality.

According to the 2011 census, the municipality of Duck Lake has a population of 867 individuals (Statistics Canada 2012). A more comprehensive statistical profile of the



municipality is available only from the 2006 census. This profile shows that the median age of Duck Lake residents is 44.8 years. Thirty (or 13 percent) of the 230 census families in the community are headed by single parents. The median household income is \$42,668, and for single-parent families, this figure drops to \$12,343. Thirty percent of community residents identify themselves as Aboriginal. The unemployment rate in the community is 4.5 percent (Statistics Canada 2007).

According to 2011 census information (Statistics Canada 2012), Beardy's and Okemasis First Nation has a population of 1,322 people. Information from the 2006 census shows that the median age on the reserve is 20.9 years. One hundred and thirty (or 44.8 percent) of the 290 census families on the reserve are headed by single parents. At Beardy's, the median household income is \$19,776 and the median income for single-parent families is \$13,867. The unemployment rate is 28.3 percent (Statistics Canada 2007).

Duck Lake is situated on the northern fringe of the Saskatoon Health Region. Health services at Duck Lake are administered by the Province of Saskatchewan. At Beardy's and Okemasis, they are administered by the federal government. A letter from the DLPHT to CUISR commented that "[c]omplications arise around residence, ancestry, and boundaries in relation to responsibility of service. People tend to fall between the cracks" (2009, 1).

## BACKGROUND INFORMATION: RURAL AND ABORIGINAL HEALTH

### Rural Health

THERE ARE KNOWN BARRIERS to good quality health care in rural communities in Canada for both Aboriginal and non-Aboriginal populations. In general, the health of people living in rural and Aboriginal communities is poorer than that of their urban counterparts. Rural communities face a number of issues:

- underdeveloped health promotion programs
- a lack of diagnostic services
- poor access to emergency and acute care services
- a lack of non-acute health-care services
- underservicing of special needs groups, such as seniors and people with disabilities (Ministerial Advisory Council on Rural Health 2002)

Compared with urban residents, people living in rural communities have higher rates of long-term disability and chronic illness as well as infant mortality rates (Laurent 2002). Poor health status in rural areas is linked not only to a lack of services but to a broad range of socio-economic and environmental factors and conditions that influence health, such as income, opportunities for employment, and working conditions (Laurent 2002).

Studies that explore health-care services from the perspectives of rural stakeholders (including users, agencies, and administrators) document deficits with the health-care system in rural areas (Skinner et al. 2008; Ramsey and Beesley 2006; Wong and Regan 2009). Focus groups with residents living in six rural communities in British Columbia (N=50), for example, revealed concerns over the continuity of care. Participants noted the turnover of health-care providers in their communities and the concomitant problems in how their health conditions were managed. They also noted that while they could travel to access health-care services, this resulted in out-of-pocket expenses and often had to be done on dangerous roads (Wong and Regan 2009). Interviews with individuals representing health-care agencies, the social services sector, and local government in nine rural communities across the country (N=55) revealed similar opinions about access to health services for seniors (Skinner et al. 2008). Access to health-care services was perceived as limited in rural areas due to minimal public transit, bad roads, a lack of specialists, and limited professional services, such as those for mental health. Interview participants also noted that seniors are not necessarily aware of the different services that exist in their communities, and that agencies lack the staff and resources to play a co-ordinating role in the delivery of health care. Finally, surveys done with health-district managers in rural Manitoba (N=20) revealed an interest in having more services available for local residents, including fitness facilities, better mental health services, as well as dental and elder-care services (Ramsey and Beesley 2006).

Two studies that more objectively measure the availability of health-care services also point to gaps in delivery. A longitudinal study examining nineteen rural and small towns across Canada in 1998 and 2005 found a noticeable decline in the availability of professionals such as nurses and social workers in these locales, and small reductions in the presence of physicians, dentists, and dental surgeons (Halseth and Ryser 2006). A second article offers a comparative analysis of different types of urban and rural regions in Canada (Sibley and Weiner 2011). Here, urban areas are divided into census metropolitan areas (CMAs) and census agglomerations, while rural communities are divided into three categories, all of which consist of populations less than ten thousand but vary in how they are “influenced”

by urban areas. In strong metropolitan influenced zones (MIZs), at least 30 percent of the population commutes to an urban centre for work; in moderate MIZs, 5–30 percent of residents commute to urban centres; and in weak or no MIZs, 0–5 percent of people drive to urban areas for work. Interestingly, this study finds that Canadians living in both CMAs and weak or no MIZs were less likely to report having a doctor after taking into account factors including perceived health status, age, education, and occupation. This study also finds that individuals from all three rural categories were less likely to indicate unmet health-care needs. The authors interpret this finding not as an indication that a full range of health-care services is actually available in these communities, but that individuals living in rural areas have “... different expectations of the health-care system, leading to rural residents having a different threshold at which they report their needs being unmet.” (Sibley and Weiner 2011, 7)

### **Aboriginal Health**

There are significant health disparities between Aboriginal and non-Aboriginal people in Canada. Diabetes, for example, is prevalent among Aboriginal people (Barton et al. 2005), with rates from three to five times the national average and highest among First Nations people living on reserve (Frohlich 2006). Obesity rates in First Nations communities are also twice as high as the rest of Canada (Frohlich 2006). Although national data on infant mortality rates are not available (Health Canada 2011), regional studies have found that the First Nations rate is double that of non-First Nations people in Canada (Luo et al. 2004 and 2007, cited in Health Canada 2011). Disparities also exist among many other indicators of health, including self-reports of chronic illness (Frohlich 2006), suicide rates, and life expectancy (Health Canada 2011).

Researchers have proposed several frameworks in an attempt to explain these disparities (Adelson 2005). One is colonization, which refers to the loss of lands, resources, and self-direction as well as the uprooting of culture and values (Adelson 2005). The social determinants of health is another; some Aboriginal people experience inequities in the conditions that determine health (Reading and Wein 2009) — lower quality housing and levels of income as well as fewer employment opportunities. Many Aboriginal people live in small communities located in rural and remote areas of the country, where access to health-care services is limited (Health Canada 2011; Frohlich 2006). An additional barrier is that many

Aboriginal communities do not have the infrastructure to promote healthy lifestyle choices and behaviour (Health Council of Canada 2005). A recent survey of First Nations communities in Saskatchewan, for example, found that the majority of respondents indicated they desired infrastructure such as a swimming pool, park, playground, gym, or indoor rink (NAHO 2004).

## METHODS

THIS PROJECT USED A FLEXIBLE RESEARCH DESIGN (Robson 2011). A student from Beardy's and Okemasis First Nation who was doing an internship with CUISR conducted interviews during the summer of 2010 with nineteen participants living in Duck Lake and Beardy's and Okemasis First Nation. Individual interviews lasted approximately forty-five minutes. CUISR staff and a representative from the DLPHT jointly developed the open-ended interview questions.

A student transcribed the interviews, which were then coded thematically by a CUISR staff member, who then met with the DLPHT to inform them of preliminary findings.

A doctoral student with a background in community health as well as the faculty lead for the project re-read and re-coded the transcriptions. They re-did the coding to ensure that the categories that emerged from the data reflected what the interviewees said as closely as possible. Researchers grouped the codes into categories, which are presented in the results section of this report. The results section includes many excerpts taken directly from interview transcripts so that readers of this report can hear the voices of research participants. Including the excerpts is also a way to address the internal validity of this report, allowing readers to judge for themselves whether the chosen categories accurately reflect what was communicated during interviews.

This study was approved by the Behavioural Research Ethics Board at the University of Saskatchewan.

## FINDINGS

Three major themes emerged from the transcripts during the data analysis:

- perceptions of health in the communities of Duck Lake and Beardy's and Okemasis First Nation
- access to programs, services, and infrastructure
- Aboriginal health

These themes are presented in detail below and also summarized in Appendix 1.

### Findings — Theme One

#### PERCEPTIONS OF HEALTH IN THE COMMUNITIES OF DUCK LAKE AND BEARDY'S AND OKEMASIS FIRST NATION

THIS THEME FOCUSSES on how participants view the health of the communities. The researcher mentioned six dimensions of this theme during interviews. The first was specific health problems felt to be prevalent, such as obesity, substance abuse, and mental illness. Second, changes in lifestyle, such as a shift to convenience foods and more technology in the home, which participants felt were detrimental to health. Third, poor parenting skills and the role participants felt parents play in fostering health. Fourth, the importance of youth, i.e., healthy children and teenagers are central to the well-being of the community. Fifth, the legacy of residential schools and their impact on the social, emotional, and physical health of local people. And sixth, improvements in health that participants saw in the communities.

### Health Problems

#### *Obesity*

Participants mentioned specific health problems within the community during the interviews. One was obesity, which participants linked to lack of physical activity, current dietary

practices, fast foods, and diabetes. One person commented, “I think ... a lot of people are overweight and not very active,” while another observed, “People don’t do anything active so it leads to obesity and diabetes.”

### *Substance Abuse*

Participants felt substance abuse was an issue affecting both youth in the community and the community at large, and that the drugs being used were “harder” and of more serious consequence than before. One participant stated that “...our biggest problem in the reserve is drugs; we’re talking crystal meth and crack. Marijuana days are long gone.”

### *Mental Health*

Participants discussed the mental health issues in the community. While they spoke of the stigma and the reticence to disclose mental illness, they also recognized the pressing need for access to services in the community, as illustrated by the following excerpt:

I think there’s a lot of depression and a lot of mental things that affect physical health. But I think depression, people that feel very alone, just everything that surrounds depression. Just everything, depression makes people feel just awful. How do you pull yourself out of that? You can go to the doctor and get all kinds of pills, but I think mental health is just a big issue here. More and more I am seeing mental health issues bringing people down physically. I really believe that. I do think that if a person can deal with their mental issues, drugs aren’t always the answer. Talking to someone would probably help more.

## **Changing Lifestyles**

Participants felt that changing lifestyles were detrimental to health. This included the fast pace of life, the reliance on ready-made foods, and new technologies in the home. As one participant observed: “One blessing in our community is that we don’t have any of the McDonalds and A&W places, but I’m sure we sell a lot of convenience-type foods like cutlets and nuggets, stuff you can warm up in the oven.”

### **Parenting Skills and the Role of Parents in Promoting Health**

Participants also commented on how poor parenting skills affected the health of the community. One person noted that “we need a paradigm shift in mentality. Health is whole health; we have kids having kids, with no parenting skills; they were not taught parenting skills. [This] evolves into discipline and the whole issues of parents.” A second participant spoke about the current strengths and weaknesses of family life in the community: “Socially there are a lot of problems — family problems at home, parents that are drinking or negligent ... but there are some [good] things too, like good family bonds, extended family, aunts, and grandparents. Some components are healthy and some aren’t.” A third participant, speaking of obesity among youth, thought that a solution was to start with parents: “Teach parents. If you see the kids after school, the parents buy it.”

### **Youth**

Interestingly, the experiences and state of young people in the community were often discussed during the interviews with no prompting from the interviewer and with no specific questions pertaining to youth in the interview guide. This suggests the centrality of youth in participants’ understanding of the health of the community; it also suggests that interventions designed to improve community health should incorporate and/or target young people.

#### *Lack of Infrastructure*

Several participants spoke of the lack of infrastructure and activities for youth, which affected their health and well-being. Comments included:

The youth have nowhere to go, so they tend to hang out in the streets and end up fighting among themselves, forming gangs. That is definitely not a healthy choice; youth need a place to go.

There are so many kids that I know that don’t do anything — stay in their

house, play video games, go to the store. In a way there is not enough activities in town for kids to stay active.

There is no real place for kids to go. Kids used to practically live at the pool-room. They have no place to visit and socialize. This is a problem. Now they drive around and drink in cars.

There's nothing for the kids to do around town. Shutting down that poolroom was the worst thing that could have happened. That was the hangout from when I was a kid. It closed at 11 o'clock, but it didn't matter, we all still met there. With that closed, the kids have nothing to do, so they wander around town breaking lights.... They have to have something for the kids. It's just ridiculous.

### *Unhealthy Behaviours*

Youth were also emphasized when participants discussed poor nutrition, obesity, and the use of drugs in the community. A focus on youth was seen as central to improving people's diets and the general health of the community:

I believe parents have to take care of their children from the get go — no alcohol, no chips...

One of my big things is nutrition for kids. People get kids too much junk food, so we need to mould these little kids to know what is good for them to eat, and how to stay physically fit is important.... Just starting with the basics when you are young ... you end up having a healthy community.

Obesity, those severely overweight, especially kids. You go to school and all is junk, drinks, chocolate bars. People go and get pizza and chips; pizza is not bad but if they get it every day....

Regarding lack of physical activity and obesity, participants observed the following: "I think technology like video games and computers are adding to the problem, especially for kids. And the youth are the ones we should really be trying to keep active." Another individual commented, "[There is] ... too much screen time, too much TV time ... our kids do little activity. There is a lack of activity that is affecting our health."



Regarding drugs and young people, one person noted:

I think there is beginning to be quite the drug problem with the kids. I think more drug awareness in the school is needed. And not pot, hard drugs like coke and crack. So, more drug and alcohol awareness in the schools. The three young people that drown in that accident, I think that led to more problems. That girl that hung herself, those kids were her friends. People have always drunk and [done] drugs, but now it seems like things are more extreme.

### **Residential Schools Legacy**

Participants spoke of the difficult legacy left by the residential school system, which was devastating not only for those forced to attend but also for the communities themselves. Interviewees discussed how the residential schools contributed to alcoholism, the dismantling of families, the underdevelopment of parenting skills, to stigma, and to mental illness. One person said, “A lot of people do not talk about their residential school experience; still there is shame and stigma and stuff like that.” Another participant added:

I think in this community in particular there is a lot of fallout due to residential schools. The residential schools caused a lot of generational dysfunction in families and it’s going to be there for a long time because there is so much work to do.... People my age are just starting to be able to talk about it, where they couldn’t before. People are more willing to talk about the things that happened there and how it made them dysfunctional as parents and just as people.

### **Improvements in Community Health**

Although numerous problems and deficits came to light during the interviews, many respondents saw positive dimensions of health in the community as well. One participant, for example, commented, “I think our community is getting healthier, but not 100 percent, not that any place is,” while another noted, “There are sectors of our community [that] are [more] health conscious and exercise and eating right than other sectors.”

Although this will be described in greater detail in theme two (under Current Services

Available, page 12), participants mentioned the positive effects of a number of programs:

- counselling offered by the local school
- the creation of vegetable gardens
- the initiation of a youth centre by members of the community
- access to a variety of professionals working at school, in Duck Lake, Beardy's, or surrounding communities

Interviewees commented further:

You drive around town and you see lots of gardens and you think, wow, that's good to see. And we are fortunate now that we have noticed in the past twenty-five years, more health-related programs have come into the community and I think they're having an impact.... My personal opinion is that [health] is getting better.

It's not all doom and gloom, though. We've made good progress, especially in the past couple months with education and the health region coming together on some of these things.

## **Findings — Theme Two**

### **ACCESS TO PROGRAMS, SERVICES, AND INFRASTRUCTURE**

#### **Access to Health-Care Services**

Access to health-care services emerged as a main theme in the transcripts. Subthemes in this section include transportation and cost as barriers to accessing health services, the availability of health-care services in the community, and suggestions on how to improve access.

#### *Transportation*

Although a medical taxi is available to individuals living at Beardy's, transportation was still identified as a barrier for people living on reserve, particularly regarding access to specialized services. As one participant observed,

I think as far as First Nations people go, I think that probably the toughest part of getting health care in the community is access to services. They won't bring the speech and language people to Duck Lake. The First Nations people have to go to Rosthern to get it. A lot of the time, we are talking about single moms with no vehicle. People don't always have access to the medical taxi to go to Rosthern, so don't you think it would be easier for the speech therapist to come to Duck Lake versus sending the thirteen pre-kindergarteners to Rosthern?

Participants also stated that many individuals in Duck Lake either do not own their own vehicles, are not able to drive, or do not have funds to pay for transportation. These situations create further barriers to health-care services. As one individual commented "... a problem is transportation for a lot of people." Another asked, "How do people get their kids to medical appointments if they have no vehicle? They're not. And they're not going to walk to the clinic with their three kids when it's minus thirty outside either."

One participant felt that driving to appointments was just part of living in rural Saskatchewan:

In Saskatchewan you'll always have to deal with distance ... no matter where you are. We have good roads that go to Saskatoon and Prince Albert. Bring it closer to home? Actually Rosthern has lots of doctors, it's actually quiet good, better than most areas. We can't expect any more. How much do you want this to cost?... I've never had a problem. [It's] also a matter of attitude and how you look after yourself. I'm tired of blaming yourself or the health system.

### *Cost of Service*

Participants noted that certain health-care services were accessible if you had a health-care plan through your place of work. One person, for example, said he/she experienced no barriers because of the comprehensive benefit package at the office, while another commented that access to services was "... probably an issue for low-income people." Another participant commented on the high cost of living in the local nursing home, indicating that the monthly cost was \$1,600, and that "...you need money..." in order to stay there.

### *Current Services Available*

Participants noted a number of services available in the community during the interview process. Beady's has a new health clinic, a nutritionist, as well as a doctor who practises

there two afternoons. Duck Lake has a doctor offering services two afternoons a week, as well as the health station, which provides nursing, nutrition, and dental services. In addition, there is a counsellor and a nurse practitioner at the local school and a nursing home in the community. Participants also commented on services available to them in Rosthern and Prince Albert.

Interviewees noted positive aspects of the health-care services available, as well as synergies that have occurred in health programming. As one person commented, “We are fortunate now that we have noticed in the past twenty-five years more health-related programs have come into the community and I think they’re having an impact.... With the cooking and garden projects we run, a lot more health-related services have come into the community.” This person also described the development of additional programming in the community, facilitated through the local primary health team:

Through the Duck Lake primary health team, I was able to meet the nurse practitioner at the school. She came in for a few hours and spoke to our moms.... Through [this nurse practitioner], I learned that we can access all types of services. We just ran a program that was called Healthy Families, Happy Homes and we ran it for eight weeks. Each week we had a new speaker. [An individual from the health region] came in and did simple first aid and CPR. We had an addictions counsellor from Wakaw and [an individual from the health region] came in and talked to them about budgeting. The parents really enjoyed it. It was Tuesdays for two hours and we had snacks and a question-and-answer period after.

Another participant described programming provided by the nutritionist working at the health station in Duck Lake: “There is a nutritionist at the health station. She runs programs like Biggest Loser and sends out information and stuff. They have the Hundred Mile Club, where you keep track of how far you walk. When you reach a hundred miles, you can win prizes.”

### *Limitations in Service Delivery*

Despite the availability of the health-care services mentioned above, participants also identified limitations in the kinds of services available and made suggestions for improvement. First, the amount of time the doctor spends in Duck Lake was described as too limited. As

one participant noted, “If you can’t get into the clinic in Duck Lake when the doctor is here for those two afternoons, then you have to get to Rosthern. The doctor is also at the nursing home on Thursdays, so sometimes the doctor doesn’t get to the clinic until two.” Another person stated, “One of the half days that the doctor is here, he is also at the nursing home for that half day.... The nursing home will have a list of people they need seen.” This individual suggested that a doctor could spend one half of every week day in the community instead.

Participants noted that the limits to the services available in Beardy’s and Duck Lake were not always acknowledged by other health-care providers. One person, for example, described being asked, “ ‘... don’t you guys have your own clinic on your reserve?’ But it is not like the doctor is here every day.” Another participant commented:

If you are trying to go to the doctor in Rosthern, it’s hard to get in, especially if you are from Duck Lake. They will say “The doctor goes to Duck Lake twice a week,” but still, if you need blood work you need to go to Rosthern anyway.... If you phone there and say you are from Duck Lake ... they’re kind of.... Well that’s how they make me feel and other people I know.

Second, elder care is an issue in the community. Although there is a nursing home, it has a long waiting list. Further, many seniors would like to stay in their own homes for as long as possible. Those who currently require assistance in order to maintain their independence receive it from family and neighbours. Participants observed the need for assisted-living services in the community to help with personal care and to provide services such as laundry and meal preparation. They also explained that seniors who do not have access to the services they need in the community have to move away: “Lots of people move away because they can’t take care of themselves.”

Third, transcripts revealed that there is some lack of information regarding the kinds of services available in the communities, as well as nearby, and who is able to access them. One individual spoke about discovering that the nurse practitioner located at the school was available to provide services to the wider community: “I thought she was just there for the school, but she told me she was there for the whole community.” Another person was unaware of the full extent of counselling services available in Rosthern: “As far as I know, they do have counsellors in Rosthern, but I am not that familiar. Is it for people with addictions? Is it for other issues like stress or abuse? I’m not really sure.” And another participant spoke

about the lack of advertising of services in general: “[Information about health services] doesn’t seem to be advertised here. I see them in Rosthern but not here. It just seems we don’t know about the programs. It is not advertised; it seems they don’t want everyone to be there.”

Participants made a wide range of suggestions regarding how to improve health-care services and programming. One person recommended that more mental health services should be available in the community, while many recommended additional programming in the school. Specific suggestions included drug awareness programming and classes based on nutrition and healthy lifestyles for children from grades one to ten, as well as classes on how to hunt and skin deer. Participants recognized that parents had to be involved in order to ensure a positive effect on children: “We really need to start teaching a nutrition program at school, health programs, lunch programs throughout the school ... and lifestyles. Elementary is when the teachers are a real focal point in the [children’s] lives. It can be strong, but again, [you] have to work with the parents.”

One participant also noted that children needed to be more physically active at school: “Our kids do little activity; there is a lack of activity that is affecting our health.... I feel it is really important and I’d like to see it at school.”

## **Access to Community Activities**

### *Activities for Youth*

As stated above in the section titled Lack of Infrastructure (page 8), participants spoke overwhelmingly about the lack of activities for young people in the community, observing the need for more infrastructure for youth. One participant went into considerable detail:

We should have some kind of gym with a weight room that they can use every day or every other day. Mainly, we need stuff for the youth. Video games, TV, computers, watching movies, that’s all they do. A lot of these kids don’t even go and play outside anymore. So I think we need more all-year-around activities.... Some kind of pool room or something would be good. The kids have nothing to do and it leads to them getting into trouble.

Participants expressed great support for a youth centre in the early phases of develop-

ment in Duck Lake. It was described as a place for young people to hang out, a place where they will take ownership and be involved in making decisions about how the centre is run. One interviewee noted the need for more volunteers to help get the centre off the ground: “I feel we need to get more people involved ... we need more people, more community members to volunteer, and not only parents but grandparents.”

Participants agreed that there were some existing activities available for youth in the community, citing hockey and soccer specifically: “Lots of people are still into hockey and soccer. We actually have ... five boys from Beardy’s leaving to play soccer in Europe on Thursday with the Native Sons Team.” It was noted, however, that both were seasonal and that hockey was an expensive sport.

#### *Activities for the Population in General*

Participants also noted a lack of infrastructure for people of all ages, suggesting the need for a swimming pool and tennis courts in Duck Lake. One person commented that there should be more recreational opportunities for seniors as well.

### **Findings — Theme Three** ABORIGINAL HEALTH

Health as it relates specifically to Aboriginal people emerged as a theme in the interview transcripts. Subthemes included experiences with discrimination in the health-care system, the legacy of the residential school system, specific health-related problems of the Aboriginal population, and the potential role of Elders in building community health.

#### **Experiences of Discrimination**

Participants spoke of the discrimination they have encountered in the health-care system. One participant shared the following story:

I’ve seen discrimination in the health system. I have spent a lot of time in the hospital. The nurses may not realize I am Aboriginal and that I see all of this. They talk down to Natives and it’s upsetting. Look at my daughter, she’s mar-

ried to a Native and her kids don't look Native whatsoever. Then when she goes, their medicine is free and they look at her like, you know. Her kids are really white, but their dad is Native so the kids are registered. This one cream that my daughter needed, Indian Affairs didn't pay for it and the pharmacist said, "Oh, I didn't fill it because I didn't think you would want it because you have to pay for it." My daughter said, "Well, we need it." The pharmacist said again, "Well, Indian Affairs doesn't pay for it." My daughter said, "It doesn't matter, we need it." And my daughter goes to school with another girl and the same thing happened to her. The pharmacist assumed she wouldn't want the medication because she had to pay for it. They just assume right away because you're Native, you won't take the medicine. Stuff like that just drives you crazy.

A second issue focussed on the willingness of non-Aboriginal health-care professionals to work with the Aboriginal population. As one participant commented,

Sometimes, I think it is the people in place.... I think some [health-care workers] aren't comfortable around Aboriginal people, and those aren't the people you need working in a community that is all or at least 90 percent Aboriginal.... It's true, but people don't say it.

Participants have also experienced discrimination via the framework through which health care is delivered in the community, i.e., it may not be provided in a manner that encompasses Aboriginal perspectives on health and well-being. As one participant stated, "[I'm] not sure if people will be receptive to [counselling] ... I don't want to say white people, white way of thinking. Maybe some are. I know that what happens to us is through culture. My mom is a pipe carrier. [They are] not aware of healing circles and things like that." Another person commented, "The Saskatoon Health Region, I do not see any Aboriginal influence in it, not within our community. When you hear Saskatoon Health Region, [it] doesn't bring relief or any positiveness to me as an Aboriginal woman."

### **Residential Schools and Health**

Participants spoke earlier in this report about the impact of the residential school system on the Aboriginal community. The experience has undermined the trust Aboriginal people are able to instill in different institutions, including the health-care sector.



As one participant noted,

I think Aboriginal people, maybe First Nations people even more than Métis, are leery of the education system, the justice system, and the health system because they believe they haven't been treated fairly by all three. And those are the three major social safety blankets that we are supposed to have in society. This makes it difficult for Aboriginal people to be healthy because they don't have trust in those systems.

Another individual, in the context of the residential school system, commented, "There's just so much hurting out there," while a third observed, "A lot of people do not talk about their residential school experience; still there is shame and stigma and stuff like that."

### **The Role of Elders in the Community**

Elders were noted as playing an important role in the well-being of the Aboriginal population. One participant, providing an example of how to strengthen connections between Elders and youth, commented:

British Columbia has done a phenomenal job at combining day-care centres and Elder centres; it is amazing. Elders come and plan their week, month events, kids come after school, and they get the language at the same time. They have so much positive feedback building strong leadership, because I think Elders have all this knowledge, but sometimes they don't know where to go, so where are they going to put it, who are they going to send it to, pass that knowledge down? This is a way to bring them together, so it is amazing, having a building where the Elder and youth are together. There will be some bonding happening there.

## **DISCUSSION**

**T**HIS STUDY EXPLORES community health in Duck Lake and Beardy's and Okemasis First Nation, Saskatchewan. Specific research questions include perceptions of the health of the community, thoughts about and experiences with

access to programs and services, and suggestions on how to improve community health. Researchers interviewed nineteen local residents and analyzed the results thematically.

Findings reveal many dimensions of health in the communities that are consistent with the literature on both Aboriginal and rural health. These include problems identified by the participants such as obesity, substance abuse, and mental illness. As the literature notes, the prevalence of these health problems is higher in rural as well as in Aboriginal populations (Health Canada 2003; Laurent 2002). The challenges participants mentioned in accessing services are also consistent: the need to travel outside of the community to see specialists, the lack of elder-care services in the community, and the limited availability of doctors (Halseth and Ryser 2006; Ramsey and Beesley 2006; Skinner et al. 2008; Wong and Regan 2009).

Three findings that diverged from initial expectations regarding what would be found in the data include the participants' focus on young people, the statements regarding both health-care workers' attitudes toward Aboriginal people and the Western paradigm through which services are delivered, and the positive statements made about existing and evolving services in Duck Lake and Beardy's and Okemasis First Nation.

Regarding the emphasis on youth, the subject came up throughout the interviews, even though none of the questions or probes addressed this target group. At early meetings between members of the DLPHT and the research team, in fact, DLPHT people felt that access to health-care services might be the major issue identified by participants. And while access emerged as a definite theme, participants frequently noted the state of health among young people and the lack of community infrastructure available to them.

A small amount of research is available on the health of young Canadians living in rural areas. It does suggest a prevalence of unhealthy behaviours and eating habits among rural youth, although it is worth noting that the extent to which these differ from urban youth seems minimal. For example, in a study of the dietary patterns of grade nine and ten students in Ontario (N=2,621), young people from both urban and rural districts were consuming inadequate amounts of fruits and vegetables, and were reporting levels of fibre and calcium intake that were below recommended amounts (Minaker et al. 2006). In a noncomparative survey of high school students in rural Alberta (N=288), the data on eating habits were mixed (Groft et al. 2005). While approximately 60 percent of respondents stated that they felt they ate healthy meals, 50 percent indicated that they also ate considerable amounts of "junk food" and 25 percent said they frequently skipped meals.

Regarding physical activity and body weight, Plotnikoff et al. (2006) compared high school students in urban Ontario to those in rural Alberta (N=2,697) and found no differences in self-evaluations of physical activity. Overall, 26 percent of rural and urban youth reported they were sedentary, 24 percent indicated they were somewhat active, and 50 percent indicated they were very active. This study did find that male rural youth were more likely to be overweight than their urban counterparts, while female rural youth were more likely to be obese than their urban counterparts.

The literature affirms research participants' observations regarding the use of alcohol, drugs, and tobacco among rural youth, although the extent to which this differs from the behaviours of urban youth is again unclear. Groft et al. (2005) found that half of their sample (144 youth) reported having used marijuana at least once, and 20 percent reported using drugs at least ten times in the year preceding the survey. Moreover, 27 percent indicated that they had been intoxicated at least ten times in the past year. A national study looking at the use of alcohol among urban and rural youth ages eleven to fifteen (N=7,031) found that youth who reported having been intoxicated at least once in their lifetime ranged from 28 percent to approximately 40 percent of respondents, depending on geographic location (Jiang et al. 2008). The lowest percentage was found among youth living in large urban centres, followed by youth in small urban centres (28.2 percent), medium-sized urban centres (32.9 percent), rural centres not adjacent to a CMA (census metropolitan area) and with a population less than 50,000 (33.6 percent) and, finally, rural centres adjacent to a CMA (33.9 percent). With regard to teen smoking, Plotnikoff et al. (2006) found that although more rural than urban youth had experimented with tobacco, no differences were found in the percentage of rural and urban youth who were currently smoking, and approximately one-quarter of youth in the study were found to smoke.

Studies on the health of rural youth reviewed above do not disaggregate by Aboriginal identification; however, researchers located a small amount of research that focussed specifically on the health of Aboriginal youth. A health survey of on-reserve communities asked parents or guardians to report on the well-being on one child or adolescent living in their home (MacMillan et al. 2010). Eighty-four percent of caregivers reported that the health of the young person on whom they focussed was either excellent or very good. Ten percent of the youth aged twelve to eighteen were assessed as overweight, and 23 percent of young people in this same age group were considered to have experienced greater emotional or behavioural problems in the past six months than their peers.

Teen suicide is a problem that disproportionately affects Aboriginal youth. While the rate of teen suicide varies significantly among Aboriginal communities across the country, 31 percent of deaths among all Aboriginal youth aged ten to fourteen can be attributed to suicide, while for youth aged fifteen to nineteen, the amount is 25 percent (Health Canada 2011).

Researchers located only a handful of studies on the role of youth infrastructure in rural communities in Canada, and the role of this infrastructure in supporting health. An ethnographic study of a rural community in British Columbia found that young people felt that the lack of activities in their town helped explain why youth drink or get involved in risky sexual behaviour (Shoveller et al. 2007). However, Groft et al. (2005) found that only a small number of students in a rural high school (11 percent) perceived that a lack of facilities or equipment was a barrier to healthy living. The top three reasons these youth reported not focussing on their health was that they didn't feel it was important to do so (45 percent of respondents), they lacked time (29 percent), and they lacked motivation (28 percent). With regard to Aboriginal youth specifically, studies have found that having a supportive person in their lives significantly influenced their ability to withstand unhealthy behaviours and suicide. This person was defined as someone youth can confide in, a person to go to during a crisis situation or to talk through big decisions with, and an individual who "... makes [youth] feel loved and cared for" (Andersson and Ledogar 2008, n.p.). Not surprisingly, the behaviour of peers was also found to be associated with the likelihood that Aboriginal youth would engage in unhealthy behaviour. Young people were less likely to smoke or do drugs, for example, if their friends didn't either (Andersson and Ledogar 2008). Interestingly, in their study of a rural Alberta high school, Groft et al. (2005) also found that peers seemed important in health promotion and prevention. Forty-three percent of high school students felt that their school could support their health by facilitating the sharing of advice among students.

Research participants noted a second unexpected finding — discrimination toward Aboriginal people. This included the perceived unwillingness of health-care professionals to work in Aboriginal communities and the treatment of Aboriginal people by health-care workers and allied professionals. Participants noted further that the medical framework through which health care is delivered does not encompass Aboriginal cultures. And similar to the youth-related theme discussed above, these findings were unexpected because they were not discussed or anticipated by members of the DLPHT in their conversations with the research team about the project. It is noteworthy that this theme also emerged in 2009 con-

sultations with Aboriginal people in the Saskatoon Health Region during the development of the Aboriginal Health Strategy (Strengthening the Circle Partnership 2010).

The cultural appropriateness of the Western medical system for Aboriginal people is certainly discussed in the literature. The Romanow Report noted the importance of making health-care services culturally relevant more than a decade ago (Romanow 2002), and targeted studies on health-care interventions have drawn similar conclusions. A study of mental health services in Mi'kmaq communities in Nova Scotia, for example, concluded that services needed to be made more culturally appropriate and that health-care workers who were not Aboriginal required training so that they would be more knowledgeable about, and sensitive to, local culture and history (Vukic et al. 2009). This study interviewed health-care providers, individuals with mental health issues, and family members of individuals with mental illness (N=53). Bartlett (2005) conducted in-depth interviews with Métis women (N=17) in order to conceptualize their understanding of health and well-being, and concluded that it is different from the bio-medical understanding of health typically used in the health-care system. Participants from rural areas aged twenty-five to forty-five, for example, spoke of well-being as encompassing emotional, physical, intellectual, and spiritual dimensions. They understood health as having a collective dimension. In other words, while it involved taking care of yourself through a nutritious diet and physical activity, it also involved responsibility for the health of others. Varcao et al. (2010) went a step further and explored a First Nation community's interest in incorporating Elders in an initiative to reduce smoking among pregnant women and the parents of young children. In individual and group interviews with stakeholders (N=66), they found a great willingness to involve Elders, also noting that participants felt Elders played a central role in helping youth. Finally, research has also found that Aboriginal people do wish to receive health-care services that are culturally appropriate. A national survey (N=1,209) of First Nations adults living on or near a reserve found that 80 percent of respondents indicated that this strategy would serve to improve Aboriginal health (National Aboriginal Health Organization 2003).

There was a third unexpected finding in this study — research participants acknowledged the positive initiatives and aspects of health in the community. The literature on rural health is overwhelmingly focussed on deficits — the lack of health-care services in rural areas and health disparities between rural and urban residents. While these are important areas of concern, the literature's strong focus on problems may have the same affect on rural communities as a deficit-based approach to community development, ignoring existing strengths

and leading communities to look to and depend upon individuals and organizations outside themselves to solve their problems (Kretzmann and McKnight 1993). While participants in the current study noted specific health-related problems in the community related to population health, access, and programming, they also observed improvements, including better collaboration among service providers, new programs, and, importantly, grassroots initiatives — community gardens and the development of a youth centre.

## CONCLUSIONS

THE PURPOSE OF THIS STUDY was to explore community health in Duck Lake and Beardy's and Okemasis First Nation. Researchers conducted nineteen in-depth interviews with members of these communities, with questions focussing on perceptions of the health of the community, thoughts about, and experiences with, access to programs and services, and suggestions on how to improve community health. Interviews were transcribed and coded thematically.

The first major theme, perceptions of community health, included dimensions pertaining to specific problems such as obesity, mental illness and substance abuse, changing lifestyles in the communities, and poor parenting skills and the role of parents in promoting health. An additional dimension under this theme concerned youth, including the lack of infrastructure for this target group, and the specific health problems they face such as obesity, inactivity, substance abuse, and poor nutrition. The last two dimensions focussed on the legacy of residential schools and improvements in the health of the communities.

The second major theme related to barriers to access, with participants mentioning transportation problems and the cost of services. However, participants were also aware of a number of services currently available in the communities, including dental, nutrition, and nursing services offered at clinics, as well as counselling and a nurse practitioner located at the local school. Shortcomings with current service delivery included limited physician hours, a lack of information regarding what services are available and for whom, lack of awareness among health-care workers outside of Duck Lake and Beardy's and Okemasis First Nation regarding what is available to local residents, and inadequate elder care. Finally, participants spoke of access to community activities, and emphasized a lack of infrastructure and programming for youth.

The third major theme in this study related to discrimination, including the experiences of Aboriginal people with discrimination in the health-care system, the legacy of the residential school system, specific health-related problems of the Aboriginal population in the community, and the potential role of Elders in building community health.

It is up to members of the DLPHT and people in the wider communities of Duck Lake and Beardy's and Okemasis to determine what actions to take in response to the findings presented in this report. However, the DLPHT could consider the following items as next steps in building and supporting community health in Duck Lake and Beardy's and Okemasis First Nation.

First, given the emphasis on the health of youth and the lack of infrastructure for this target group, the DLPHT may want to support the development of the community's youth centre. This could include providing or helping to locate funding for the centre through the health region or province. The funding could be used to purchase exercise equipment or to help pay for a youth worker. Because the transcripts suggest that simply having a place for youth to go would support health in the community, this funding could also be used to support the centre in other ways, such as making improvements to the space.

Second, the DLPHT may want to consider offering more health-related programming in the local school. They may want to use a participatory approach, such as that used by Groft et al. (2005), so that youth and other key stakeholders in the community such as teachers and Elders can help establish what kind of programming to offer.

Third, with regard to Aboriginal health, the DLPHT could consider training for health-care workers in the following areas:

- Aboriginal cultures
- non-Western approaches to medicine
- Aboriginal history
- racism
- the social determinants of health

Cross-cultural training was also recommended in the 2010 Strengthening the Circle report on improving the health of Aboriginal people receiving services in the Saskatoon Health Region; this means that the DLPHT need not establish training independently. If this initiative to improve Aboriginal health has not yet started, however, the DLPHT could consider becoming vocal in requesting that the training begin.

It is difficult to make recommendations regarding access to services given the financial constraints of the health region and the federal government, as well as the trend toward regional health services. One low-cost recommendation is to better promote the programs and services currently available in Duck Lake, Beardy's and Okemasis First Nation, and the surrounding communities, since some research participants spoke of not knowing what services were available and for whom. Local officials could improve access to services by increasing the availability of transportation to and from medical appointments; they could increase the hours during which a physician is available locally; and they could co-ordinate visits by specialists, such as speech therapists and mental health workers.

Finally, future research and action related to the health of the communities could focus on strengths, building on the positive elements of health-care delivery in Duck Lake and Beardy's and Okemasis First Nation. This fits with best practices in community development; it is also in keeping with what participants in this research noted is working well in the communities and with the perspective of the DLPHT. As we were told when this project began, "Despite some of the struggles, this community is very resilient. There [is] an overriding hope that things can improve." (DLPHT 2009, 1)



## APPENDIX 1: THEMES

### Perceptions of Health in Duck Lake and Beardy's and Okemasis First Nation

#### Health Problems

- Obesity
- Substance abuse
- Mental health

#### Changing Lifestyles

#### Parenting Skills and the Role of Parents in Promoting Health

#### Youth

- Lack of infrastructure
- Unhealthy behaviours

#### Residential Schools Legacy

#### Improvements in Community Health

### Access

#### Access to Health-Care Services

- Transportation
- Cost of service
- Limitations in service delivery
- Suggestions for improvement

#### Access to Community Activities

- Activities for youth
- Activities for the population  
in general

### Aboriginal Health

#### Discrimination

#### Health Problems

#### The Role of Elders in the Community

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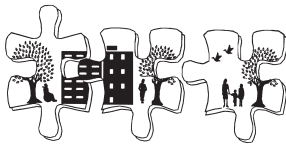


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