Moving Towards Cultural Safety in Mental Health and Addictions Contracting for Urban Indigenous Peoples: Lessons from British Columbia

by

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Ethics Statement

Abstract

In response to the inequities in health and health care that Indigenous communities continue to experience, governments in many countries have used contracting as a policy mechanism to improve access to culturally safe health services. Case studies from New Zealand, Australia and Canada demonstrate the equity-promoting potential of contracting-out interventions within the Indigenous primary health care (PHC) sector. At the same time, these studies have heightened concerns about the exigencies of contract reform within increasingly neo-liberal climates. To foster accountability for health equity, more needs to be known about how current contractual arrangements, intended to support Indigenous community-based systems of care, actually fit with the evolving needs, priorities and contexts of Indigenous communities in Canada.

In this project, I use a qualitative design and ethnographic methods to examine urban Indigenous Providers' experiences with contracting for culturally safe mental health and addictions care within one Canadian province, British Columbia (BC). Critical theoretical perspectives and input from Indigenous advisors informed my inquiry. In addition to a critical policy review, I conducted in-depth interviews with Indigenous and non-Indigenous people within seven Indigenous and one non-Indigenous provider organizations (n=23), including senior administrators, managers and mental health care providers. I also interviewed policy and funding decision-makers and contract managers in the area of Indigenous mental health (n=10).

Examining contracting for culturally safe mental health and addictions care from the perspective of urban Indigenous Providers in BC sheds light on the ways in which current funding structures, policies and contractual approaches mediate wider ideological constraints and impinge, often inadvertently, upon organizations' capacities to develop and effectively deliver mental health care services that safely meet the intersecting needs of their communities. Neo-liberalism, the ongoing dominance of biomedicine within the broader health care system, the legacy of colonialism, race, gender and class intersect to simultaneously reproduce, reinforce and obscure colonial and neo-colonial patterns within contractual relationships, mental health programming and care. These findings have important policy implications for funders and support the call for an alternative framework to contracting that articulates equity as an explicit dimension of accountability and Indigenous culturally safe mental health and addictions care.

Keywords: Contracting in mental health care; accountability; cultural safety; Indigenous; urban; equity; policy; structural violence

Dedication

I dedicate this dissertation to my father. Thank you for always believing in me.

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Lastly, I would like to acknowledge the generous support for this study that was provided by the Canadian Institutes of Health Research through a doctoral scholarship.

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List of Acronyms

AHIP	Aboriginal Health Initiative Program
AHS	Aboriginal Health Service
ANAC	Aboriginal Nurses Association of Canada
AFN	Assembly of First Nations
AHF	Aboriginal Healing Foundation
BC	British Columbia
BCAAF	BC Association of Aboriginal Friendship Centres
BCMOH	British Columbia Ministry of Health
BCPHO	British Columbia Provincial Health Officer
FNC	First Nations Centre
FNHA	First Nations Health Authority
IBPA	Intersectionality-Based Policy Analysis
IRS	Indian Residential School
MHCC	Mental Health Commission of Canada
MVAEC	Metro Vancouver Aboriginal Executive Council
NAFC	National Association of Friendship Centres
NCNZ	Nursing Council of New Zealand

NPM	New Public Management
NPO	Non-Profit Organization
PHC	Primary Health Care
PM	Performance Management
RCAP	Royal Commission on Aboriginal Peoples
RCHCC	Royal Commission on Health Care and Costs
RFP	Request for Proposals
RHS	Regional Health Survey
TRC	Truth and Reconciliation Commission
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
VCH	Vancouver Coastal Health

Chapter 1. Introduction

1.1. Background to the Problem

Globally and locally, Indigenous peoples continue to experience significant inequities in mental health and well-being (Anaya, 2014, 2015; First Nations Health Authority [FNHA], British Columbia Ministry of Health [BCMOH], & Health Canada, 2013; Kirmayer et al., 2007). Health inequities are defined as systemic social differences in health that are unfair, unjust and remediable (Whitehead & Dahlgren, 2006). It has become increasingly clearer that the mental health inequities affecting Indigenous populations must be understood within the context of histories of colonization and ongoing colonial policies and practices (Allan & Smylie, 2015; Czyzewski, 2011; Greenwood, De Leeuw, Lindsay, & Reading, 2015; Loppie Reading, 2013; Loppie Reading & Wien, 2009; Smye & Browne, 2002). The problem of lacking access to culturally safe mental health and additions services and supports is one manifestation of this neo-colonial[1] reality for many Indigenous people (Smye, 2004; Smye, Browne, & Josewski, 2010; Smye & Browne, 2002).

While current policy frameworks in mental health recognize the creation of culturally safe mental wellness and substance use services as a critical factor in redressing inequities in mental health (Assembly of First Nations [AFN] & Health Canada, 2015; FNHA et al., 2013; Mental Health Commission of Canada [MHCC], 2009; Smye et al., 2010), dominant public health and policy discourses in mental health, and health care more generally, remain embedded in a Western biomedical worldview, effectively marginalizing alternative, more holistic perspectives and approaches to mental health and healing that would align better with an Indigenous worldview (Browne & Smye, 2002; Josewski, 2012; Morrow, 2017; Smye, 2004; Smye & Browne, 2002). Overall, mental health services that are designed in keeping with Western Euro-centric traditions of psychiatry and biomedicine fail to take into account the unique cultural identities of Indigenous peoples and the long-term impact of a history of colonization on the mental health of Indigenous peoples, families and communities (Menzies, 2014; Mitchell & Maracle, 2005; Smye, 2004; Smye & Browne, 2002). As a result, many

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[1] Neo-colonialism refers to new forms of colonial control that shape the lives of contemporary Indigenous peoples; these forms of control are often “more insidious and more difficult to detect and resist than older forms of overt colonialism” (Browne, Smye, & Varcoe, 2005, p. 19).

Indigenous people are reluctant to seek mainstream care, and if care is accessed, often perceive that their needs are neither adequately recognized nor fully met (Kirmayer, Simpson, & Cargo, 2003; Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011; McCormick, 2009; Smye, 2004; Smye & Browne, 2002; Tait, 2008). Improved access to culturally safe mental health and addictions care, therefore, remains a pressing concern for Indigenous peoples in Canada (AFN & Health Canada, 2015; FNHA et al., 2013; Smye et al., 2010).

For Indigenous peoples, the realization of this objective is inextricably linked to Indigenous peoples' inherent right for self-determination as highlighted in the recent release of the Final Report of the Truth and Reconciliation Commission (TRC, 2015) of Canada[2] and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007), to which Canada is a signatory party. In this context, contracting in the health care sector with Indigenous organizations emerges as a potential mechanism for promoting the ideal of Indigenous self-determination and working against the paternalistic and assimilationist nature of historical Indigenous–state relations colonial health care (Dwyer, Boulton, Lavoie, Tenbensel, & Cumming, 2014; Dwyer, O'Donnell, Lavoie, Marlina, & Sullivan, 2009; Lavoie, 2004, 2005). Today, governments in Canada, Australia and New Zealand employ contracting with Indigenous Providers3 a means of supporting “by Indigenous for Indigenous” primary health care (PHC) services (Lavoie, 2004, 2005; Lavoie, Boulton, & Dwyer, 2010). In all three countries, Indigenous community-based organizations play an important role in the delivery of a broad spectrum of community-based PHC services, including mental health and addictions care (Boulton, 2007; Dwyer, Lavoie, O’Donnell, Marlina, & Sullivan, 2011; Lavoie, 2005; Lavoie et al., 2018). While contractual approaches vary, the underlying discourse is similar: contracting is expected to enhance equity in health and improve access to culturally safe health services through increased Indigenous participation in policy,

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[2] The TRC of Canada was established with the mandate to document the colonial legacy of state-sanctioned Indian Residential School system and other colonial policies and develop a framework for reconciliation between Indigenous and non-Indigenous people(s) in Canada. In 2015, the TRC released its final report which provides a principled set of recommendations to transform the historical and ongoing inequities that structure the relationship between Indigenous peoples and the state in the area of health, child welfare, language and culture, education and justice.

[3] As I explain in the terminology section of this chapter (1.4), for the purpose of this dissertation, I am using the capitalized term ‘Provider’ when referring to an organization that is contracted to provide mental health services; this to help the reader differentiate these instances from those where I use the term to refer to an actual individual providing the care, in which case lowercase (‘provider’) is being used.

programming and service delivery (Lavoie, 2004). Contractual relationships between purchasers and providers are not neutral, however: rather, they need to be “understood as extensions of social relationships” (Lavoie, Boulton, et al., 2010, p. 667). Government contracting for health and social programs, and the social dynamics that comprise and shape these relationships, are thus important areas for study, because they reflect and constitute broader socio-political and ideological relations. This claim is particularly true for governments contracting with Indigenous Providers, where the dynamics of relations between state purchasers and providers are shaped by past and ongoing (neo)colonial relations (Lavoie, Boulton, et al., 2010, p. 667).

Within the Canadian context, the legacy of colonialism in health care continues to play out in numerous ways (Browne & Smye, 2002; Menzies & Lavallee, 2014; Smye & Browne, 2002). This ongoing history of racialized oppression is illustrated by the longstanding jurisdictional struggle between the federal and provincial governments about what level of government holds responsibility for addressing the unique health care needs of Indigenous people off-reserve (Loppie Reading & Wien, 2009; Peters, 2011b; Smye, 2004). The resulting void in government policies and legislation to recognize and address the distinct health needs and rights of urban Indigenous peoples remains a major barrier for the development of equitable access to adequate and culturally safe health care services for urban Indigenous populations (Lavoie, 2013; Snyder, Wilson, & Whitford, 2015).

However, recent policy developments in British Columbia (BC) reflect a renewed commitment from the federal and provincial governments and health authorities to work together, and in partnership with BC First Nations, to address the gap in health and social disparities that exist between First Nations residents and other British Columbians (Gallagher, Mendez, & Kehoe, 2015; O’Neil et al., 2016). These developments have led to the creation of a new First Nations health governance structure unprecedented in Canadian history, as well as the release of BC’s first-ever *First Nations and Aboriginal People’s Mental Wellness and Substance Use Plan* (2013), which emphasizes the need for “partnerships within regions—collaboratively designed by First Nations and Aboriginal people with local, regional, provincial, federal partners, individuals, families, and communities” and the delivery of “culturally safe services and supports that respect [Indigenous peoples’] customs, values, and beliefs” (p. 6). BC’s story, it is hoped, will “serve as an example in other [I]ndigenous health settings both within Canada and internationally” (O’Neil et al., 2016, p. 230). To support other jurisdictions that may “contemplate undertaking similar processes of reconciliation”, O'Neil et al. (2016) have argued that it is paramount to document the evolution of this transformational process, as well as its impacts and challenges, by “initiating dialogue and telling the story from the multiple perspectives of those engaged in the process” (p. 233). The need for input includes the perspective of urban Indigenous peoples.

Given the historical marginalization and silencing of urban Indigenous voices in policy (Tomiak, 2011), the inclusion of urban Indigenous peoples’ perspectives on recent policy developments is particularly important. Lavoie et al. (2015) point out that in consideration of the historical absence of self-government pathways for Indigenous people living in urban areas, “the developments in BC are ostensibly fulfilling aspirations of First Nations while possibly side-stepping the broader discussion of how to engage First Nations and other Aboriginal peoples living off-reserve” (p. 2). Given that contracting is a potential pathway to include urban Indigenous people(s) in health policy, programming, and service delivery, this research represents a timely opportunity to add another chapter to the ‘story’—one written from the perspective of urban Indigenous Providers.

Few health researchers have examined how government contracting in Indigenous health might be shaped by, and constitutive of, the colonial project. Informed by neo-classical contract theory, contractual analyses have “generally side-stepped the context in which purchasers and providers operate,” and focused instead on examining single contracts from the perspective of funders (Lavoie, Boulton, et al., 2010, p. 667). However, over the last decade and a half, a small but burgeoning body of international research conducted within Canada, New Zealand and Australia has emerged: this work examines and compares the different types of contractual and policy environments that are in place for the delivery of Indigenous PHC services within these countries (Dwyer et al., 2014; Dwyer et al., 2009; Dwyer et al., 2011; Lavoie, 2004, 2005; Lavoie, Boulton, et al., 2010). These studies have made important contributions to the current state of knowledge concerning the strengths and challenges of different funding models from the points of view of both Indigenous Providers and funders (Dwyer et al., 2014). These researchers also highlight the need for more research investigating the relationship between different contractual arrangements and Indigenous providers’ abilities to deliver effective health services, and in particular, how different “contractual arrangements may favour or impede the implementation of Indigenous models of health service delivery” (Dwyer et al., 2014; Lavoie, 2004, p. 20; Lavoie, Boulton, et al., 2010).

The scope and focus of such systematic investigation conducted within Canada[4] has been rather limited, and for the most part it has remained confined to policy and contractual environments for First Nations on-reserve. Little is known about government contracting with urban Indigenous providers off-reserve (Dwyer et al., 2014). More work is required to engage with such questions as: what possibilities and tensions arise for Indigenous Providers because of the unique historical, economic, cultural and socio-political positioning of urban Indigenous communities? What might contractual arrangements for culturally safe mental health and addictions care look like within an urban setting? How can such arrangements be fostered?

This gap in our knowledge base continues to exist despite a growing urban Indigenous population—for example, it is estimated that more than 60% of First Nations are now living in urban centers (Peters & Andersen, 2013; Statistics Canada, 2008). Furthermore, contracting with Indigenous Providers for mental health and/or addictions programs and services is common practice among Canadian health authorities (Dinsdale, 2014). In BC, where 62% of First Nations people are living off-reserve (Statistics Canada, 2010), 85% of Aboriginal health services are contracted out to Aboriginal not-for-profit organizations, with more than 50% dealing in mental health and addictions (Vancouver Coastal Health [VCH], no date).

In part, this relative lack of attention to urban Indigenous issues can be attributed to the enduring colonial imaginary, which continues to place Indigenous peoples into rural and remote areas despite mounting evidence to the contrary (Newhouse, 2003; Peters & Andersen, 2013; Tomiak, 2011). Inadequate engagement with questions about how institutional and contextual factors, such as contracting and contractual environments, might promote and/or hinder the implementation of culturally safe mental health and addictions care and wider equity-related goals might also be perpetuated by the continued dominance of the biomedical discourse in public health and health policy. While funders frequently use the language of social determinants of health when discussing Indigenous mental health and culturally safe mental health care, an extensive body of critical literature suggests that biomedicine has remained the hegemonic model in health care, keeping a disproportionate amount of attention focused on the micro-level interactions in health care rather than the social and structural factors at the macro- and meso-level of health care that are shaping these relations (Browne, 2017; Browne et al.,

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[4] For example, Lavoie (2005) conducted an extensive examination of contracting as a mechanism for implementing the transfer of on-reserve health services from the federal government to First Nations as an extension of the federal 1998 First Nations Health Transfer Policy.

2016; Josewski, 2012; Lavoie et al., 2018; Morrow, 2013; Morrow & Weisser, 2012; Reimer-Kirkham & Browne, 2006; Smye, 2004). The additional determinants of Indigenous health, such as land, geography and self-determination (Greenwood et al., 2015), are also not necessarily considered.

This knowledge gap raises questions with respect to system accountability—questions that become more urgent still within a neo-liberal policy context. While some maintain that neo-liberalism has provided increased opportunities for Indigenous peoples to exercise their right of self-determination, others have cautioned that the goals of "neoliberal Aboriginal governance" are "not simply about meeting the demands of Indigenous peoples but also about meeting the requirements of the contemporary governmental shift towards 'privatization' within liberal democratic states" (MacDonald, 2011, p. 257). The concerns are that with an ideological commitment to individualism, managerialism[5] and free-market capitalism, neo-liberalism is fundamentally at odds with substantiating Indigenous individual and collective rights and other social justice claims. Instead, neo-liberalism, it is argued, might have promoted a "marketization of Indigenous citizenship" (Altamirano-Jiménez, 2004, p. 349), "a politics of privatization" (MacDonald, 2011, p. 258) and one "of blame … [or] responsibilization" (Orsini, 2007, p. 354). Rather than fostering true partnerships based on mutual trust, respect and accountability—and building social and structural solutions to public health issues of inequity—neo-liberal policies have been described as promoting relationships marked by principal-agency thinking (Dwyer et al., 2014; Josewski, 2012; Kornelsen, Boyer, Lavoie, & Dwyer, 2015; Tenbensel, Dwyer, & Lavoie, 2013) and individualistic (i.e. biomedical) understandings of (and responses to) complex social and health inequities (Morrow, 2013; Morrow, 2017).

Thus, as mutually-reinforcing ideological systems, neo-liberalism, biomedicalism and colonialism operate hand-in-hand, rather than in isolation from one another (Brown, McPherson, Peterson, Newman, & Cranmer, 2012; Fiske & Browne, 2008; Josewski, 2012; Morrow, 2013; Morrow, 2017). As I wrote in 2012, without strategies to dismantle the intersecting dynamics of biomedical, colonial and neo-liberal ideologies that operate in health care, policy itself might turn out to be one of the largest barriers for fostering the development of culturally safe mental health and addictions services (p. 231). Thus,

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[5] Managerialism refers to the doctrine of New Public Management (NPM), which promotes the idea that the increased use of market mechanisms, such as competitive, performance contracting, in the provision of health and social programs will promote public sector efficiency and accountability (Evans & Shields, 2000).

according to MacDonald (2011), “the coexistence of a neoliberal political context and the increasing strength of various Indigenous movements provides a crucial point of critical inquiry for those of us interested in Indigenous–state relations in Canada” (MacDonald, 2011, p. 257), in particular when analyzing contractual relations for the delivery of culturally safe mental health and addictions care between government funders and urban Indigenous Providers (Josewski, 2012). As Waldegrave (2009) argues,

> We need to deconstruct the industries of … policy making from the perspectives of culture, gender, and socioeconomic status and enquire as to the reasons for their hegemony and practice. Are they … achieving equity? Do they enable the goals of social inclusion and well-being to be reached? Do they respect the breadth of citizenship in a country, and do they enhance or hinder the inspirations of all citizens? (p. 97).

Current approaches to contracting with urban Indigenous Providers of mental health and addictions care may, unwittingly, create conditions that reinforce rather than disrupt colonial relations, thus constraining Indigenous Providers’ ability to provide culturally safe mental health and addictions care. In keeping with Waldegrave (2009), we need to ask, in which ways does contracting shape and/or distort Indigenous aspirations for self-determination and involvement in health policy, planning and delivery? Does it enable culturally safe service provision and improve access to health and social supports that are responsive to urban Indigenous peoples’ needs and rights, or is it at odds with these ends given the socio-political reality?

Significantly, I do not seek to speak for or on behalf of Indigenous peoples. Rather, as a non-Indigenous researcher, I position myself as an ally who seeks to de-centre dominant discourses to create space for those whose have been marginalized through their historical and social positioning to speak for themselves.

1.2. The Central Problem

Increasingly, governments around the world, including those of Canada and BC, endorse contracting with Indigenous Providers as a key mechanism for pursuing Indigenous self-determination and promoting equitable access to culturally safe health care services for Indigenous peoples (Baird & Hammer, 2013; Lavoie, 2004; Liu, Hotchkiss, & Bose, 2007). However, government contracting in health care with Indigenous providers unfolds against a backdrop of intersecting ideological forces. Few studies have critically examined how these contexts shape contractual relationships and arrangements and/or the ability of Indigenous Providers to delivery culturally safe care; fewer still have done so in relation to *urban* Indigenous Providers of *mental health and addictions care*. In light of these exclusions and the persistent mental health and access inequities affecting Indigenous people, the central problematic addressed in this study is the current lack of knowledge concerning government contracting with urban Indigenous Providers for the provision of culturally safe mental health and addictions care. To foster systemic accountability and the realization of the equity-related goals attached to government contracting with Indigenous Providers, more needs to be known about the challenges and opportunities that arise from current contractual arrangements from the perspective of urban Indigenous Providers. I aim to reveal and examine the ideological forces and structural factors that are shaping their work.

This research aims to create new knowledge about the potential for culturally safe and equity-promoting contractual arrangements for urban Indigenous mental health and addictions care, and to identify what is needed to support and foster these arrangements. To do so, I critically examine Indigenous perspectives on and experiences of how current contractual arrangements for the provision of urban Indigenous mental health and addictions care in BC promote and/or constrain the realization of cultural safety and broader equity-related goals.

1.3. Research Objectives

The overarching aim of this dissertation is to more fully understand the intersecting socio-political, historical and economic contexts of government contracting with urban Indigenous Providers of mental health and addictions services in BC as well as how these relations shape and are shaped by institutional funding structures, policies and practices, contractual relations and the everyday realities of mental health and addictions care. Using a cultural safety and equity lens informed by critical theoretical and decolonizing perspectives, I conducted an ethnographic study. The specific objectives of this study were to:

(1) explore Indigenous perspectives on, and experiences of, how government contracting with urban Indigenous Providers shapes access to and provision of equitable and culturally safe mental health and addictions services and programs for Indigenous peoples,

(2) analyze Indigenous experiences within the wider institutional, sociopolitical, economic and historical contexts to understand how these experiences are structurally and ideologically mediated,

(3) identify and explicate those structures, policies and practices that support and/or impede equity, access, and the provision of culturally safe mental health and addictions services and programs, and

(4) drawing on the insights from this study and the literature, generate recommendations for promoting culturally safe and equity-oriented practice in contracting with urban Indigenous Providers of mental health and additions care.

To address these objectives, I conducted in-depth individual interviews with community-based administrative leaders, clinical managers and health care administrators, as well as service providers of Indigenous mental health and addictions programs, services, and supports within the context of eight non-profit organizations (NPOs) located within three different health authorities in BC. To contextualize the interview data further, I conducted interviews with managers and senior administrative and policy leaders affiliated with different government funders to seek these participants' experiences related to contracting in mental health and addictions service delivery for urban Indigenous people. In addition, I engaged in a critical policy review of relevant funding-related material, health service contracts, and government health plans.

1.4. Organization of the Dissertation

In Chapter One I provide an introduction to the research topic. I describe the research problem and the overall purpose and specific objectives of the research. Then, in Chapter Two, I provide a synthesis of the relevant literature. My goal is to situate the research problem within the historical and contemporary sociopolitical, cultural and economic contexts and tie it into the wider conversations that are shaping government contracting in Indigenous health service within the study context. In Chapter Three, I outline the theoretical perspectives that frame the approach to inquiry and indicate my positionality as a non-Indigenous researcher who is engaging in Indigenous health research; in Chapter Four, I focus on the methodological approach guiding the research implementation process. I also discuss the relationship-building process with community partners and health authorities, the data collection methods and procedures used, the process of data analysis, measures taken to ensure scientific integrity, ethical considerations and the limitations of the study.

Chapters Five to Seven present the empirical findings of this research. The organization of the findings chapters reflects the intersectional framework that informs the study's data analysis. As the first of the findings chapters, Chapter Five presents an analysis of the perspectives and experiences of policy participants related to Indigenous health policy and funding decision-making within the historical and contemporary contexts of Indigenous-state relations and local health care reform, focusing on the macro-dynamics involved. Specifically, I use policy participants' experiences of tensions as a starting point to explore how colonial and neo-liberal ideologies shape, and in turn are shaped by, institutional inequities and disjunctures within current health policy and funding environments. In addition, I show how these ideological processes work to reproduce and perpetuate colonial and racializing assumptions and constructions of Indigeneity within policy discourses. The analytical insights generated in this chapter provide the ideological backdrop against which to examine the meso- and micro-level dynamics of relations between funders and Indigenous Providers in Chapter Six and Seven, respectively.

In Chapter Six, I draw on the experiences of both Policy and Indigenous Provider Participants to examine more extensively the relational dynamics between funders and Indigenous Providers at the meso-level. Specifically, I analyze the data with a view to issues of economic redistribution and resource allocation, cultural recognition and participation. Using examples from interviews and the document review, I examine the extent to which the ideologies identified in Chapter Five are mediated through institutional processes, policies and practices in contracting to address, reproduce and/or create inequitable relations along the lines of class, gender and race (Indigeneity).

In Chapter Seven, I shift the focus of analysis to the micro-level of mental health and addictions care. This chapter presents an analysis of Provider Participants' experiences of delivering culturally safe mental health and addictions care. These data highlight the importance of analyzing 'performance' within wider fields of ideologically and institutionally mediated power relations.

Lastly, in Chapter Eight, I conclude with a discussion on the significance and implications of the findings of this research in light of the literature and theoretical perspectives informing this study. In this process, I propose an equity framework for government contracting in Indigenous mental health as a strategy to foster capacity for equity at all levels of care. I conclude by putting forward recommendations derived from the study findings.

1.5. Terminology

In this dissertation, I follow the terminology of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007) and use the term ‘Indigenous peoples’ in its plural sense to refer collectively to the Indigenous inhabitants of Canada, or within the context of talking about Indigenous populations and cultures from other parts of the world. ‘Indigenous people’ in its singular sense is used when making reference to a group of Indigenous people that is not necessarily representative of the three recognized Indigenous groups in Canada and where it is more important and/or appropriate to foreground other shared social identities and locations, such as poverty status and/or lived experiences of substance use and mental health issues. I use the specific nomenclature—First Nations, Inuit and Métis people—when distinction between the state-recognized Indigenous cultural groups is needed. Moreover, while in the Canadian context, the term ‘Aboriginal’ is often used synonymously with ‘Indigenous,’ I am using the term Aboriginal only when referencing and/or citing concrete policies and/or other literature or data sources that explicitly use this term. I am doing so in recognition of a personal conversation that I had with Bill Mussell, a member of my Indigenous Advisory Team, who highlighted the contested nature of the term ‘Aboriginal’ as a government-imposed rather than self-declared term. Indeed, the term ‘Indigenous’ is increasingly used in place of ‘Aboriginal’ to denote the contemporary role of Indigenous peoples in Canada and their relationship to the “land,” which some observers have pointed out is implicit in the meaning of Indigenous peoples as “native to the area” (International Journal of Indigenous Health, no date, p. 5). However, I recognize Indigenous peoples’ right to define their own identity and respect that other Indigenous individuals, including participants in this study, may think differently.

Two other terms that require added clarification include (1) ‘Provider’ and (2) ‘mental health and addictions’ issues and/or care. First, for the purpose of this dissertation, the capitalized term ‘Providers’ is used to refer to community-based and -controlled provider organizations. Lowercase (‘providers’) is used to refer to the people who are working as service providers. I adopted this convention to facilitate reading.

Second, in keeping with current conceptualizations of mental health and related inequities for Indigenous peoples (Menzies & Lavallee, 2014), in this dissertation, I use the notion of mental health and addictions issues in a broad sense to include such experiences as violence, abuse, intergenerational and historic trauma, depression, unresolved grief, generalized despair, and suicide, based on an understanding that many of the mental health problems that Indigenous people experience are socially determined and can be directly traced back to Canada’s history of colonization. In line with this perspective, components of mental health and addictions care consist of mental health promotion and prevention, as well as intervention and aftercare.

On a related note, the importance of ‘culturally safe’ care arises. I discuss in Chapter Two the issue of what precisely constitutes such care in relation to mental health and addictions services within an Indigenous context. Suffice to say for now that the concept is used to signify health care that is experienced as accessible, culturally appropriate and safe by Indigenous peoples.

Chapter 2. Locating the Problem

In this chapter, I review the literature to provide a historical and present-day context in which to examine state contracting with Indigenous Providers for the delivery of culturally safe mental wellness services. The intent is not to provide an exhaustive review of all literature, but rather to a) locate and describe some of the relevant issues, challenges and opportunities related to the research problem, and b) position the research problem within the contemporary political climate, in relation to current conversations and debates in the international literature on contracting in health care with Indigenous Providers.

2.1. The Health and Social Disparities Affecting Indigenous Populations

To contextualize the need for mental health and addictions services for Indigenous peoples, I begin by providing an overview of the health and social issues and status inequalities affecting Indigenous communities compared to other Canadians, with a particular focus on the province of British Columbia (BC). Persistent inequalities in overall (mental) health status, social determinants of health, and access to health care between Indigenous and non-Indigenous populations are well documented in Canada (Adelson, 2005; Kirby & Keon, 2006; Loppie Reading & Wien, 2009; Romanow, 2002). While these inequalities cut across First Nations, Inuit, and Métis populations, and urban, rural and remote locations, serious data limitations and gaps exist that are particularly pronounced for non-status First Nations, Métis and urban Indigenous populations (Allan & Smylie, 2015). The reader is thus advised to be mindful of the limitations of the statistics presented here, as the data are not specific to urban Indigenous populations, and “most available and cited statistics actually underestimate the degree of these disparities” (Allan & Smylie, 2015, p. 9).

Compared to their non-Indigenous counterparts, Indigenous populations in Canada consistently fare worse across almost every health indicator, including life expectancy, infant mortality, suicide rates, injuries, and communicable and chronic diseases (Anaya, 2014). For example, according to aggregate regional data for 2002–2006, suicide rates for status First Nations in BC were twice as high as for other residents (British Columbia Provincial Health Officer [BCPHO], 2009). Although the percentage of First Nations youth considering suicide declined from 23% in 2003 to 17% in 2008 for those living off-reserve (no improvements were seen for First Nations youth living on-reserve), suicide has remained the fourth-highest overall cause of death for status First Nations under age 75 (FNHA et al. 2013; BCPHO, 2009). According to the same source, status First Nations individuals are also much more likely to be hospitalized due to attempted suicide, homicide and for mental health and substance use problems. Indigenous people were reported to have a rate of alcohol-related deaths almost five times that of other British Columbians (BCPHO, 2009). Across Canada, alcohol and drug addictions,[6] depression, suicidal ideation, intimate partner violence and child abuse are consistently identified as key issues plaguing many Indigenous communities (Kirmayer et al., 2007; Kirmayer et al., 2009).

Empirical evidence shows that the disproportionate burden of mental health and addictions issues affecting Indigenous people is continuous with wider systematic social and economic disparities between Indigenous and non-Indigenous populations in Canada (Adelson, 2005). Compared to the general Canadian population, Indigenous communities experience a disproportionate burden of social disadvantage across income, employment, education, housing, food security and access to health care (Loppie Reading & Wien, 2009). In BC, social status indicators demonstrate major discrepancies: Indigenous people on average experience higher levels of poverty and unemployment, poor and overcrowded housing, lower income and education compared to the rest of the BC population (BCPHO, 2002). Despite representing only 4.9% of the Canadian population (Statistics Canada, 2017), Indigenous people make up 25% of the prison population, and Indigenous women are overrepresented even further at 33% of the total female inmate population (Anaya, 2014). Indigenous women and girls also continue to be disproportionately targeted by violence, with over 660 documented cases of murdered and missing Indigenous women and girls and many more undocumented cases in the last 20 years (Anaya, 2014). The apprehension rate for Indigenous children by child welfare authorities is eight times higher than for non-Indigenous children, with First Nations children comprising 30 to 40% of all children in care in spite of representing less than 5% of the overall child population in Canada (Blackstock, 2011). According to

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[6] Although substance abuse remains a key issue for Indigenous communities, according to the 2002/03 First Nations Regional Longitudinal Health Survey (RHS), “rates for both abstinence from alcohol and the frequency of alcohol use” are higher among the general population than for First Nations (First Nations Centre [FNC], 2005, p. 113). At the same, a higher proportion of First Nations reported to engage in heavy drinking and drug use with young males in the 18–29 age group being particularly at risk (FNC, 2005a).

Cindy Blackstock (2011), a longstanding First Nations child advocate, the number of First Nations children in care today has unsurpassed any point in history.

2.2. Racism, Colonization and the Roots of Indigenous Mental Health Inequities

The above socio-economic and environmental factors represent well-known social determinants of mental health (Raphael, 2009). For Indigenous peoples, the social determinants of health approach marks an important shift in the conversation about Indigenous health (Allan & Smylie, 2015; Loppie Reading & Wien, 2009). This promising approach displays a “departure from strictly biomedical and health behaviour paradigms” (Allan & Smylie, 2015, p. 6)—paradigms which have been instrumental in shaping public images of Indigenous communities as “sick” and “disorganized” by failing to adequately conceptualize the social and structural root causes underpinning the mental health inequities experienced by Indigenous peoples (O'Neil, Reading, & Leader, 1998, p. 230).

However, while poverty, unemployment, lack of education and adequate housing, and other factors are behind much of the mental distress and social suffering experienced by Indigenous people, these elements are, as Indigenous scholars and leaders consistently point out, not the root causes of the mental health inequities that Indigenous populations face (Greenwood et al., 2015; King, Smith, & Gracey, 2009; Loppie Reading & Wien, 2009; Nelson, 2012). As Loppie Reading and Wien (2009) assert, for Indigenous peoples, “colonialism, racism and social exclusion, as well as repression of self-determination act as the distal determinants within which all other determinants are constructed” (p. 20). In order to develop effective responses to addressing the mental health inequities that Indigenous peoples face, “one must grapple with and firmly understand the workings of colonialism, both historically and into the present” (De Leeuw, Greenwood, & Cameron, 2010, p. 286).

2.2.1. Historical and Intergenerational Trauma:[7] An individual and collective legacy of trauma

According to LaRocque (1999), colonization can be described as “a pervasive structural and psychological relationship between the colonizer and the colonized” (p. 9), which “has its origins in the colonial laws and policies enacted upon Aboriginal peoples in 1876 in the Indian Act” (Smye, 2004, p. 25). Historically, the political agenda behind the colonial project was twofold: (1) assimilate Indigenous peoples into the dominant culture’s notion of civilized life; and (2) establish and maintain external colonial control over Indigenous jurisdiction and land.

Under the 1876 Indian Act, this intent was pursued through multiple measures, such as residential schooling,[8] the appropriation of Indigenous lands, the establishment of the reserve system, and the prohibition and/or criminalization of ceremonial and traditional practices that were integral to Indigenous health and ways of life—all of which have impacted the mental health and well-being of Indigenous people. The rippling and intergenerational effects of the trauma caused by these colonial policies and laws on the identities, mental health, and well-being of Indigenous people, including families, communities, and their relations to the land, have been well-documented (Bombay, Matheson, & Anisman, 2014b; BraveHeart, 2003; Gone, 2009, 2013; Kirmayer et al., 2009; TRC, 2015).

The intergenerational impact of the trauma associated with the Indian residential school (IRS) system has received particular scholarly attention. This body of research presents consistent evidence that the trauma associated with residential schooling continues to undermine the mental health and well-being of Indigenous peoples today by interfering with or impeding the intergenerational transmission of Indigenous languages,

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[7] Evans-Campbell (2008) defines historical and intergenerational trauma as “a collective complex trauma inflicted on a group of people who share a specific group identity. … It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events” (p. 320).

[8] As the Truth and Reconciliation Commission (TRC) of Canada (2015) states, “the residential school system for Aboriginal children was an education system in name only for much of its existence” (p. v). The actual intent behind residential schools was to destroy Indigenous cultures, languages, family ties and community networks. Through the schools, Indigenous children were separated from their families and communities and subjugated to an institutional Christian regime that suppressed and punished any expression of Indigenous culture, including the right to speak their native language (Kelm, 1998; TRC, 2015). Adding to the trauma of separation and forced religious indoctrination into a new culture was that many children were also abused physically and sexually, and many died while being in the ‘care’ of the schools to a large extent because of malnutrition and overcrowding (Brant Castellano, Archibald, & DeGagne, 2008).

knowledges, values, beliefs and practices, including the need for healthy parenting skills (Bombay, Matheson, & Anisman, 2009; Bombay, Matheson, & Anisman, 2014a; Bombay et al., 2014b). For example, in a recent review of research and literature on the topic, Bombay et al. (2014b) found accumulating evidence that having a familial history of IRS attendance (a) is associated with significantly poor mental health outcomes relative to those who have not attended, and (b) interacts with contemporary stressors (e.g., exposure to discrimination) to increase the risk of poorer mental health and social outcomes. Data from the 2002–2003 First Nations RHS revealed that 20.4% of adults who had grandparent(s) who attended residential school reported a history of attempted suicide, in comparison to 13.1% whose grandparents had not attended (AFN/First Nations Information Governance Committee, 2007, p. 37). Finally, "familial IRS attendance across several generations within a family appears to have cumulative effects" (Bombay et al., 2014b, p. 1). In other words, "the more generations that attended IRS, the poorer the psychological well-being of the next generation" (Bombay et al., 2014b, p. 331).

According to Brant Castellano (2006), residential school experience "is thus a collective as well as an individual legacy" of trauma (p. 147) that has affected "Aboriginal peoples at every level of experience, from individual identity and mental health, to structure and integrity of families, communities, bands and nations" (Kirmayer et al., 2003, p. S18). Understanding the past and ongoing impact of collective and intergenerational trauma in Indigenous peoples' lives is, therefore, essential for improving access to and the delivery of culturally safe health services (Allan & Smylie, 2015). With these considerations, I now turn to discuss the role of health care as a social determinant of Indigenous peoples' (mental) health.

2.2.2. The Legacy of Colonial Health Care

To understand the relationship that many Indigenous people have to the mental health care system today, it is critical to locate the analysis of mental health care for Indigenous people within the historical context of colonialism (Browne & Smye, 2002; Kelm, 1998; Smye & Browne, 2002). This is the case because colonial health care was "part and parcel of the process of colonization" by helping to lay the moral foundation for colonialism and creating and cultivating relationships of disempowerment and dependency (Smye, 2004, p. 30).

Dependency on colonial provisions of health services was constructed and perpetuated within a context of infectious disease epidemics of European origin that devastated Indigenous populations (Kelm, 1998). The displacement of Indigenous peoples from their lands, the transformation of family and community values and structures, and the subjugation of traditional economies and Indigenous knowledges and practices through colonial laws and policies all contributed to the erosion of traditional healing resources and the weakening of practices of holistic, preventative well-being (Allan & Smylie, 2015; Kelm, 1998). The pervasive poverty, undernourishment and the decline in health status that ensued—coupled with the loss of power and credibility of traditional healers (because they were unable to stop the deaths of their own people)—paved the way to dependency on colonial health care and reliance on other governmental aids, such as food rations, which were provided in exchange for agreements that Indigenous leaders negotiated with the state to ensure survival of their people (Long, 2014; Wesley-Esquimaux & Smolewski, 2004).

However, for Indigenous peoples, the provision of health services by colonial governments was, and continues to be, a double-edged sword. Under colonial governance, assimilative goals and economic interests merged with a “humanitarian” racism—the belief that “First Nations required domination to save them from their *unsanitary selves*” [emphasis original]—and welfare colonialism, which together set the parameters of colonial health care (Kelm, 1998, p. 100). In addition, the model of colonial health care was expressly paternalistic and authoritarian (Smye, 2004). Under the federal department of Indian Affairs, ‘Indians’ became “wards of the state” and were subjected to a regime of colonial medicine that was intent on establishing Euro-Canadian medical superiority while “alienat[ing] Aboriginal people from their medicine” (Kelm, 1998, p. 154). As Kelm (1998) notes, Western knowledge systems, such as the science of biomedicine, played a key role in portraying Indigenous forms of medicine as “quackery or superstition” (Kelm, 1998, p. 153) and consequently in its rejection as “unscientific” (Loppie Reading, 2003, p. 4).

While Indigenous healing knowledge and practices would prevail, so too would the paternalism and ethnocentrism[9] underpinning colonial health care (Adelson, 2005; Browne & Smye, 2002; Browne, 2007; O'Neil, 1989; Smye, 2004; Smye & Browne, 2002). Within the current mental health care system, the legacy of colonial care

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[9] The term ‘ethnocentrism’ is used to describe an ideological “belief in the [inherent] superiority of one’s own culture or ethnicity” (Loppie Reading, 2013, p. 2).

continues to play out in numerous ways, resulting in major access barriers to safe, effective and responsive mental health and addictions services (Josewski, 2012; Smye, 2004). As Browne (2017) notes, there is a considerable body of evidence-based literature showing how "racialized assumptions about Indigenous peoples actually *organize* health care providers' practices, and organizational and institutional policies, practices, discourses and norms" (p. 24) and continue to marginalize Indigenous voices and needs (Fiske & Browne, 2008; Smye, 2004). Exploring this theme in-depth, Smye (2004) concludes that an embedded assimilationist ethos and "the predominance of Western biomedical approaches to mental health (i.e. psychiatry)" within the mental health system continue to place Indigenous people at risk of not having their needs addressed (p. 258).

Repeated calls for a deliberate decentring of the dominant culture of the mental health system are based on solid evidence that mental health treatment models that draw on Western notions of mental illness create barriers to access for many Indigenous peoples: they are often ineffective and experienced as unsafe (Kirmayer et al., 2003; Kirmayer et al., 2009; Kirmayer et al., 2011; Smye, 2004; Smye & Browne, 2002). As Tait (2008) writes,

> Western medical models of diagnosis and treatment marginalize the historical and social context of their suffering, the social inequities that exacerbate their distress, and the inner strengths and resilience of Aboriginal peoples and their cultures to survive despite ongoing adversity (p. 29).

This is why as Browne (2017) argues, "responsibility for shifting these deeply engrained power relations must lie with health care institutions, and the practices and policies that sustain or disrupt discriminatory practices" (p. 24). Yet institutional racism has received only inadequate attention as a key social determinant of Indigenous peoples' mental health and well-being (Allan & Smylie, 2015; Browne, 2017). Because institutional racism is often unwittingly enacted, its workings often remain outside critical consciousness and thus accountability (Paradies, Harris, & Anderson, 2008). More research problematizing the taken-for-granted institutional policies and practices that allow racism and other forms of discrimination to be enacted within health care is thus urgently needed.

2.3. Indigenous Approaches to Mental Health Policy and Practice

In spite of the tremendous harms inflicted on Indigenous individuals, families and communities as a result of more than a century of colonial politics, the assimilationist intent failed, ultimately, to be successful. As Browne (2003) observes, “ongoing healing, revitalization of traditional knowledge and practices and gains in the area of self-determination are attestations of the strength, resiliency and the capacity for resistance” among Indigenous peoples (p. 19). While Indigenous cultures are tremendously diverse, many Indigenous people share a belief that (re)engagement with Indigenous culture is foundational to the healing process from historical trauma, and that an Indigenous worldview can be delineated based on certain core values, principles and beliefs that are common to most Indigenous peoples and distinct from those informing the dominant Western worldview (AFN & Health Canada, 2015; Menzies & Lavallee, 2014).

According to the final report of the Aboriginal Healing Foundation (AHF), promising[10] healing practices are developed in keeping within an Aboriginal worldview and include “models, approaches, techniques and initiatives that are based on Aboriginal experiences, that feel right to [Residential School] Survivors and their families, and that result in positive changes in people’s lives” (Brant Castellano, 2006, p. 113). Others have extended this definition to Indigenous mental health and addictions programming more broadly (AFN & Health Canada, 2015; Hart, 2014; Wise Practices Research Group, 2018). For example, in discussing the findings of the Aboriginal Mental Health ‘Best Practices’ Working Group, Smye and Mussel (2001) argue that “Aboriginal Mental Health ‘Best Practices’ need to reflect a worldview consistent with Aboriginal understandings of and response to mental health and illness” (p. 29).

Some of the values and principles that are consistently identified by Indigenous scholars, Elders and communities as having a central place in Indigenous ways of knowing and being include: holism and balance, respect for autonomy and self-determination, the importance of relationships with family and extended kin, community,

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[10] The language of ‘wise’ or ‘promising’ practices as opposed to ‘best practices’ is used to account for the reality that all successful interventions or practices are found to be effective only within a particular context, which makes the universal claim of ‘best practices’ untenable and potentially repressive (Brant Castellano, 2006; Wise Practices Research Group, 2018). The notion of promising or wise practices acknowledges that practices which have been shown to work well within the context of one community ‘promise’ important learning opportunities for other communities, yet create no expectations of replicability, transferability or adaptability, thus leaving space for the emergence of alternative healing models (Brant Castellano, 2006).

ancestors and the natural environment/land (Greenwood et al., 2015; Little Bear, 2000; Mussell, 2014; Smye & Mussel, 2001). From an Indigenous perspective, each of these cultural values and principles provides directions for designing and implementing culturally safe mental health and addictions programs (Smye & Mussell, 2001). In keeping with Indigenous values of holism and interconnectedness, Indigenous frameworks tend to approach mental health and addictions programming from a mental wellness perspective (FNHA et al., 2013; Mussell, 2014). In this view, “wellness is a balance of one’s spirit, heart/emotions, mind, and physical being” as well as extended relations to family, community, ancestors, future generations and the land (AFN & Health Canada, 2015, p. 4). When these relations are imbalanced or disrupted, “mental unwellness” results (Mussell, 2014, p. 190). Indigenous approaches to mental wellness support therefore the holistic models of mental health and addictions programming, which aim to address “intergenerational trauma, poverty, unemployment and lack of housing ... alongside the consequent mental health issues” (Smye & Mussell, 2001, p. 24). In line with this view, the need for comprehensive and integrated approaches to mental wellness programs and services, and an increased focus on prevention and the creation of Indigenous healing centers or Indigenous primary health care (PHC) clinics, is constantly emphasized (AFN & Health Canada, 2015; Royal Commission on Aboriginal Peoples [RCAP], 1996; TRC, 2015).

Further, because the mental health and well-being of the individual is understood to be inextricably linked to the collective health and wellness of the family and community, Indigenous healing approaches commonly extend beyond individually-focused mental health and addictions services to family- and community-centred programs that are oriented to build relational capacity within and among people, families and communities in the spirit of self-determination (AFN & Health Canada, 2015; Smye et al., 2010; Smye & Mussel, 2001; Wise Practices Research Group, 2018). This means a commitment to relational approaches that focus on promoting participatory engagement and building capacity within the contexts of both care and community development (Smye & Mussell, 2001). From an Indigenous perspective, ‘community ownership and control’ are necessary elements for the development of effective and sustainable mental wellness programming that is responsive to the needs of the community (Smye & Mussell, 2001). This is not only the case because respect for autonomy and self-determination are core values, but also because “[c]ommunities are the primary generator of ideas and innovations to meet these needs and [thus] must be recognized and supported in this role" (AFN & Health Canada, 2015, p. 38). According to the First Nations Mental Wellness Framework, "[c]ommunity ownership ensures that the continuum of mental wellness programs and services for First Nations are relevant, effective, flexible, and based on community needs and priorities" (AFN & Health Canada, 2015, p. 38).

Strength-based approaches to mental wellness are another defining feature of Indigenous healing approaches (Menzies, 2014). As Brant Castellano argues, healing and recovery from historical trauma are ultimately about "empowerment" of individuals, families and communities (Brant Castellano, 2006, p. 89). This empowerment requires an approach that shifts "the focus from an examination of deficits to a discovery of strength" (AFN & Health Canada, 2015, p. 21) and "facilitates finding solutions built on identified strengths" (Menzies, 2014, p. 67). Indigenous culture is an inherent strength (Gone, 2013; Menzies, 2014). Indigenous frameworks consistently identify Indigenous culture "as a crucial element to effective program and service delivery" (AFN & Health Canada, 2015, p. 13). The notion of "healing through culture" is reflective of an emergent approach that endorses the idea of Indigenous "culture as treatment" (AFN & Health Canada, 2015; Gone, 2013). Cultural interventions take many different forms and shapes depending on the local cultural and treatment context. They include land-based healing approaches and traditional ceremonies and practices, such as feasting, smudging, sweat lodge ceremonies and talking circles, the use of plant-based medicines, as well as story-telling and traditional teachings; these practices are performed by Elders, traditional healers, and other cultural practitioners (AFN & Health Canada, 2015; Hart, 2014).

While an evidence base is just starting to emerge, the findings from a growing body of research and literature suggest that holistic and culture-based interventions can be effective in promoting an increased sense of belonging, meaning in life, and cultural pride and identity, which have been shown to act as important sources of resilience and protective factors against suicide and the impacts of everyday racism (Brant Castellano, 2006; Greenwood et al., 2015; Kirmayer et al., 2003; Kirmayer et al., 2011).

2.3.1. Cultural Safety

While cultural safety has its origins in the Māori nursing context in Aotearoa/New Zealand, the concept has been widely taken up by health authorities as well as professional and health service organizations across Canada with the aim of enhancing access to appropriate and safe health care services for Indigenous populations (Aboriginal Nurses Association of Canada [ANAC], Canadian Association of Schools of Nursing, & Canadian Nurses Association, 2009; AFN & Health Canada, 2015; FNHA, no date; FNHA et al., 2013; Smye et al., 2010). In BC, the provision of culturally safe care for Indigenous people with mental wellness and/or substance use issues ranks among the key strategic directions identified in BC's 10-Year First Nations and Aboriginal People's Mental Wellness and Substance Use Plan 'A Path Forward' (FNHA et al., 2013). Moreover, in 2015, all health authorities in BC and the federal Ministry of Health signed a Declaration of Commitment to foster cultural safety and humility in health service delivery for First Nations and Aboriginal people in BC across all levels of the health care system (BCMOH et al., 2015). One way this commitment has been operationalized is through a unique online San'yas Indigenous Cultural Safety (ICS) training[11] program for health authority and Ministry of Health employees and staff.

Irihapeti Ramsden and other Māori nurse leaders developed cultural safety as an innovative educational framework (Ramsden, 1990, 1993, 2000; Ramsden & Spoonley, 1994) to elucidate complex "power differentials embedded inherent in health service delivery and redress[…] these inequities through educational processes" (ANAC et al., 2009, p. 2). Whereas other cross-cultural education frameworks have tended to narrowly focus on the culture of the patient and/or the knowledge and skills of the provider (ANAC et al., 2009), cultural safety "shifts the gaze onto *culture of health care"* and the self away from the cultural Other to counter and disrupt those taken-for-granted practices and processes within health care system that create situations of cultural risk (or *unsafety*) for Indigenous peoples (Browne et al., 2005, p. 32). As Browne and Varcoe (2006) explain, there is a tendency within the health care system to view culture in relatively narrow and essentializing terms. Such "a narrow understanding of culture … allows" as these authors argue "those who identify with the dominant norm to see themselves as not having 'culture,' rather than seeing themselves as embedded in dominant culture to the point that it is difficult to see that culture and their daily enactments" (p. 163).

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[11] The training program represents one of the tangible outcomes of the Transformative Change Accord First Nations Health Plan (Government of BC, & BC First Nations Leadership Council, 2006).

Cultural safety helps to counter these culturalist tendencies within health care by promoting an understanding that (a) “we are all bearers of culture” and (b) that culture is “being enacted *relationally* through history, experience, gender and social position” (ANAC et al., 2009, pp. 1-2). According to the First Nations Wellness Framework (2015), cultural safety “involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to First Nations people” and other Indigenous groups (AFN & Health Canada, 2015, p. 36). It challenges health care providers “to reconsider the realities of ‘establishing trust’” and respectful relations (Browne & Smye, 2002, p. 36) by acknowledging the inequities that exist in health care and drawing attention to the power relations embedded within health care encounters (Browne & Fiske, 2001). For example, to establish safety, providers must have an understanding of the deep-seated mistrust that many Indigenous people experience when dealing with government institutions and authority figures, such as health care providers, as a consequence of the trauma associated with residential schools, the Sixties Scoop and/or contemporary child welfare or other institutional interactions. In addition, cultural safety charges providers with the ethical responsibility to carefully examine their own culture, history, life experiences, and social and professional positioning to gain insight into the ways in which they might consciously or unconsciously contribute to inequitable relations in health care by engaging in “unsafe cultural practices”—defined as any health care action that “diminishes, demeans and disempowers the cultural identity and well being of an individual” (Nursing Council of New Zealand (NCNZ), 2011, p. 7). On the other hand, culturally safe health care results from actions that “recognize, respect, and nurture the unique cultural identity of … indigenous people … and safely meets their needs, expectations, and rights” (Spence, 2005, p. 409).

Cultural safety thus politicizes Indigenous people’s health and health care needs by placing them within the context of equity, respectful relationships and Indigenous citizenship rights. In the New Zealand colonial context, DeSouza (2008) notes that “in understanding the place of cultural safety in nursing education and practice, it is important to consider the relationship between the Treaty of Waitangi/Te Tiriti o Waitangi, Māori health and cultural safety in New Zealand” (p. 130). According to the NCNZ (2011), the principles outlined by the Treaty are foundational to the mandate of nursing and are expressed in a commitment to acknowledge and support “Māori self-determination and the right to development, autonomy and authority"[12] (De Souza, 2008, p. 130) within nursing practice. Nurses are to facilitate Māori "participation in health services and delivery at all levels" to promote access to health services that are appropriate to Māori beliefs and practices and "equality in health outcomes" between Māori and non-Māori (NCNZ, 2011, pp. 13-14).

In Canada, Indigenous peoples' inherent rights, including the right to self-government, are similarly enshrined within the Constitution Act. Additionally, Canada is a signatory to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007), which, among other things, also recognizes Indigenous peoples' inherent "right to self-determination" (article 3) including the right to:

- "be actively involved in developing and determining health … programmes" (article 23);
- "enjoy the highest attainable standard of physical and mental health" (article 24.2),
- "their traditional medicines and … healing practices" and "access, without any discrimination […] all social and health services" (article 24.1).

In addition, according to the Declaration, signatory states have an obligation to "provide effective mechanism for prevention of, and redress for … any form of forced assimilation or integration" (article 8.d). Access to culturally safe mental health and addictions care can thus be considered a collective and individual right of Indigenous peoples—a right whose realization relies on, and provides the means to, the fulfillment of other rights and equity-related goals. For example, establishing "emotional and physical safety" is widely regarded as "a prerequisite to healing" and recovering from the wounds of historic and intergenerational trauma (Brant Castellano, 2006, p. 114). As Castellano (2006) and others have pointed out, this requires relational approaches to care that emphasize collaborative decision-making as well as "a culturally welcoming, healing environment" (p. 114) that conveys respect for, and provides access to, Indigenous cultural knowledge and healing practices (AFN & Health Canada, 2015; Brant Castellano, 2006; Menzies, 2014).

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[12] In more detail, this includes facilitating "Māori ownership and control", "Māori to define knowledge and worldviews and transmit these in their own ways" as well as "Māori independence over thoughts and action, policy and delivery, and content and outcome as essential activities for self-management and self-control" (New Zealand Nursing Council, 2011, p. 13).

However, cultural safety also reminds us that it is essential for Indigenous clients and communities to define for themselves “what culturally safe services and policies entail” (AFN & Health Canada, 2015, p. 36). As Menzies (2014) points out, although “there is an increasing demand for services based on Aboriginal values and culture” (p. 67), it is important to be aware that not all Indigenous people wish to access Indigenous forms of medicine—some might feel safer accessing “treatment via mainstream services”, while many Indigenous people perceive that their needs are best met through a combination of Western and traditional medicine (Menzies & Lavallee, 2014, p. xi). Rather than thinking of cultural safety “in a realist sense”, (Reimer Kirkham, Smye, Tang, & et al., 2002, p. 228), cultural safety might be better understood as a critical “interpretive” and “ethical” lens for unmasking and countering the ways in which institutional policies, processes and practices within the health care system unwittingly create, maintain and perpetuate health inequities for Indigenous people (Smye & Browne, 2002, p. 47). It is this latter way in which I use the concept in this dissertation; for more information, see Chapter 3.

Finally, it is important to briefly mention that despite the extent to which cultural safety has been taken up, some concerns can be noted. For example, while cultural safety aims to politicize Indigenous health and provides a framework for thinking about Indigenous peoples’ rights and the need for organization-wide and systemic change (Smye & Browne, 2002) within the Canadian context, the link between cultural safety and Indigenous peoples’ rights has received rather little attention. As this dissertation reveals, this shortcoming is particularly true within the urban Indigenous context. The absence of any discussion of urban Indigenous citizenship within the ongoing dialogue about cultural safety in Canada is noticeable and inconsistent with Canada’s recognition of Indigenous peoples’ constitutional and international rights and the recent tripartite policy commitments in BC. Also problematic is that applications of cultural safety have predominantly focused on the micro-level of health care delivery. What is urgently needed is research that critically examines how cultural safety can be actualized at the organizational and systemic levels of health care. Such analyses are needed for the development and/or ongoing support of culturally safe care (Johnstone & Kanitsaki, 2007; Josewski, 2012). Without such analyses, front-line workers and recipients of care are put at risk of taking the blame when success remains elusive (Tait, 2008).

2.4. An Urban Indigenous Policy Lens

The proportion of urbanized Indigenous peoples in Canada has been rapidly growing and now exceeds those who live on-reserve, with 60% of First Nations living off-reserve as of 2006 (Statistics Canada, 2008). This trend is particularly apparent in Western Canada, where almost two-thirds of Indigenous people live in cities (Hanselmann, 2001). BC is home to one the largest and most culturally diverse[1] Indigenous populations in Canada (Statistics Canada, 2013): represented are 198 recognized First Nations and 36 Métis Chartered communities as well as more than 60% of Canada’s First Nations languages (Indigenous and Northern Affairs Canada, 2010). Available data for 2011 show that 232,290 people living in BC self-identified as Indigenous, of whom 69,475 were Métis and 155,020 First Nations; this figure includes 112,400 First Nations people with registered Indian status and 42,615 non-status First Nations (Statistics Canada, 2013, p. 10). Of the total Indigenous population base in BC, almost 80% are estimated to live in urban and off-reserve areas (Province of BC, 2018). As one of the top ten census metropolitan areas in Canada, Vancouver has the largest number of First Nations (23,515) and Métis people (15,075) in the province, but population data indicate that Indigenous communities are growing across BC in both larger and smaller urban centres, reflecting larger national trends of increasing Indigenous urbanization, migration and population growth (Statistics Canada, 2008).

Clearly, the urban experience forms an integral component of many Indigenous peoples’ lives and “part of the continuing transformation of Indigenous peoples' culture” (King et al., 2009, p. 79). Nonetheless, the mental health and mental health care needs of urban Indigenous people have only received little explicit attention by health authorities and other decision-making bodies and are thus not well-understood (Place, 2012; Tjepkema, 2002). This knowledge gap is problematic because available data and literature suggest that while urban Indigenous people experience social and health inequities similar to First Nations communities on-reserve, urban Indigenous communities face a number of unique challenges and opportunities that must be taken into account when planning for effective and culturally safe mental health and addictions care (Browne, McDonald, & Elliott, 2009; Snyder et al., 2015).

For example, while cities might offer better access to health care and economic/educational opportunities than remote and on-reserve communities, moving to the city also means losing access to the kind of supports to which community members residing on-reserve might have access, such as family and extended kinship and/or federally-funded health and social programs (Browne, McDonald, et al., 2009; Snyder et al., 2015). Tjepkema (2002) reports evidence showing that urban Indigenous people experience more unmet health care needs than their non-Indigenous counterparts, predominantly because available health care services were perceived to be unacceptable. Furthermore, there remains a high level of mobility among urban Indigenous people, with many individuals frequently moving back and forth between rural/on-reserve and urban/off-reserve areas (Snyder et al., 2015). This pattern of mobility creates specific challenges in terms of continuity of care and also makes it more difficult to develop and maintain a strong sense of community and cultural identity within the city (Norris & Clatworthy, 2003; Snyder et al., 2015). This situation is often compounded by experiences of racism and social exclusion within urban settings, which have been found to contribute to a sense of social isolation (Norris & Clatworthy, 2003).

To promote access to culturally safe mental health and addictions care—and equity in mental health for Indigenous peoples living in urban centres—more must be known about the specific contexts that shape urban Indigenous people’s mental health care needs. One important factor is the distinct relationship that urban Indigenous people(s) have with the Canadian state (Browne, McDonald, et al., 2009; Newhouse & Peters, 2003). As Loppie Reading and Wien remind us, while Indigenous peoples share the collective burden of a history of colonization, colonialism as well as its past and ongoing effects manifests differently in the lives of Indigenous peoples depending on their unique social and cultural identities, personal life circumstances and socio-political contexts. In order “to engage in any meaningful discussion about urban First Nations health,” Browne, McDonald, et al. (2009) and others thus assert that it is critical to look at the urban Indigenous experiences through a historical lens (p. 3).

2.4.1. Urban Indigenous–State Relations: Historical & Ideological Context

According to Blomley (2004), the city has been a "site of particular ideological, material, and representational investments on the part of the settler society" (p. 127). In this context, the invisibility of urban Indigenous communities is at once a product and modality of settler colonialism (Peters & Andersen, 2013; Tomiak, 2016).

Despite the fact that many Canadian cities formed in places of pre-existing Indigenous settlements (Browne, McDonald, et al., 2009), within the spatial logic of settler colonialism, the city—symbolic of Western civilization and progress—epitomized white settler space (Tomiak, 2016). In contrast, colonial images of Indigenous cultures as backwards and unfit for modern urban life constructed Indigeneity as “antithetical to urban space” and belonging to remote and ‘uncivilized’ places far away from urban centres (Czyzewski, 2011, p. 2). This mapping of space and identity “enable[d] settlers to know city space as theirs and individual settlers to know themselves as the managers and rightful inhabitants of public space” (Razack as cited in Czyzewski, 2011, p. 2). Colonial policies and legislation further reinforced and legitimized that perception, dispossessing and displacing Indigenous peoples from urban areas (King et al., 2009).

Together, the British North America Act (also known as the 1876 Constitution Act) and the Indian Act (in its various codified versions) played a central role in the colonial project of place-making and its ongoing politics of erasure of Indigenous histories, identities and bodies within city space (Alfred & Corntassel, 2005; Coulthard, 2014; Tomiak, 2016). Under the Constitution Act, responsibility for “Indians, and Lands reserved for Indians” was given to the federal government, which resulted in the passing of the Indian Act (Peters, 2011a). The Act entrenched government control over Indigenous identities by “provid[ing] the federal government of Canada with the right to determine who can and cannot be an 'Indian'” (Allan & Smylie, 2015, p. 9) and “exclud[ing] Aboriginal people who are not 'registered Indians' from access to distinctly Aboriginal services and the power of self-determination” (Bourassa & Peach, 2009, p. 1). While the Indian Act has had a profoundly negative impact on the lives of *all* Indigenous peoples in Canada and continues to do so, its divisive character has also been instrumental in creating and perpetuating horizontal inequities among Indigenous peoples (Loppie Reading & Wien, 2009).

According to Macdougall (2016), the categories established under the Indian Act “had nothing to do with who people actually were in relation to one another, but everything to do with the needs of colonial administrators to rid themselves of 'the Indian problem' by reducing the number of Indians” and asserting settler state sovereignty (p. 2). In relation to the city, this aim was pursued through an aggressive program of deterritorialization, assimilation and segregation which had devastating consequences that continue to be felt by Indigenous peoples today (Peters & Andersen, 2013). As Peters (2004) and Newhouse (2003) point out, the colonial image of Indigenous peoples and their cultures as incongruent with urban spaces continues to have an enduring presence in the settler imaginary—as evidenced in the ongoing invisibility of urban

Indigenous communities within contemporary political and policy discourse related to land-based First Nations communities on-reserve (Peters, 2011a). According to Goldie, there continues to be a tendency among non-Indigenous writers to construct "authentic Aboriginal culture" as "belong[ing] either to history or to places distant from urban centres" (as cited in Peters, 2004, p. 8). This misconception about Indigenous people in relation to the city has led many to believe that those who move to urban/off-reserve settings from rural/on-reserve Indigenous communities are "rejecting" their cultural roots (Snyder et al., 2015, p. 6) and/or "becoming acculturated and assimilated" into the dominant culture (Newhouse, 2003, p. 247). As a result, cities are often seen by "government, policy makers, and some members of the public ... [as] places of loss of culture and community for Aboriginal people" (Browne, McDonald, et al., 2009, p. 4) and incompatible with the notion of Indigenous rights (Peters, 2011a).

This discourse is also inextricable linked to the "lack of jurisdictional clarity about which level of government has jurisdiction over Aboriginal people in urban areas," (Peters, 2011a, p. 12). Pursuant to s.91(24) of the Constitution Act (1876), the provinces and territories are responsible for the provision of health care, while the federal government has jurisdictional authority over "Indians and Lands reserved for Indians." Federal provisions for health services under the Indian Act have, however, been largely confined to status First Nations residing on-reserve (Peters, 2011a). In contrast, the provinces argue that the constitutional responsibility for "Indians" assigned to the federal government applies to all Indigenous peoples who have been recognized under the Constitution Act of 1984, accusing the federal government of unfairly off-loading to the provinces the entire financial responsibility for addressing the health care needs of a growing urban Indigenous population (TRC, 2015). As a consequence of this ongoing jurisdictional struggle and the association of Indigenous culture and rights with rural and remote areas, both levels government have failed to fully address the unique health needs, expectations and rights of urban Indigenous peoples (Peters, 2004, 2011a).

Thus, while many urban Indigenous people "have expectations that their Aboriginal rights and identities will make a difference to the ways that they structure and live their lives" (Peters, 2004, p. 3). However, while the right to self-government is constitutionally recognized by the Government of Canada as an inherent right of all Aboriginal peoples, most urban Indigenous people lack political representation, and as a consequence, their voices and issues often remain invisible in the political sphere (Peters, 2011b). As Tomiak (2009) points out, "advances in the political and legal arenas have largely bypassed For Urban Indigenous peoples, who are generally forced to look to state recognized land-based communities as the source of their rights" (p. 5). The present-day "geographies of Aboriginal rights" (Senese & Wilson, 2013, p. 221) serve, therefore, as an important area of inquiry for this research.

Next, I discuss how these historically and ideologically mediated relations have structured mental health care delivery for urban Indigenous peoples and how they shape access to care. Then, I shift the focus to discuss the emergence and role of the urban Indigenous non-profit sector (i.e., the "fourth sector") in the delivery of mental health care for urban Indigenous populations before moving on to a discussion of the literature on contracting.

2.4.2. The Structure and Social Organization of Mental Health Care

Colonial discourses and policies that render urban Indigenous peoples' rights and identities largely invisible vis-à-vis an unresolved, ongoing jurisdictional wrangling have resulted in a complicated patchwork of policies and services specific to urban Indigenous peoples, creating complex barriers to culturally safe mental health and addictions care (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011a; Lavoie, 2013; Peters, 2011a, 2011b; RCAP, 1993a; Senese & Wilson, 2013; Snyder et al., 2015; Tomiak, 2009; TRC, 2015). For example, although provinces are constitutionally responsible for delivering health and social services to all of their residents, including Métis, non-status First Nations, and off-reserve status First Nations, provinces and territories (with the exception of Ontario[13]) have failed to develop comprehensive Indigenous health policy frameworks with a focus on urban Indigenous populations (Lavoie et al., 2011a; Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011b; Snyder et al., 2015). Without a presence in policy, urban Indigenous peoples' needs, rights and voices are routinely marginalized (Abele & Graham, 2011; Andersen & Strachan, 2011; Murray, 2011), in "mismatched and inadequate scales of resource allocation" (Snyder et al., 2015, p. 20), gaps and overlap in programming, as well as geographical disparities in terms of service availability and accessibility (Andersen & Strachan, 2011).

The focus of the federal "policy environment … remains [predominantly] focused on the reserve-based population" so that few federally funded mental health and/or

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[13] For more information on Ontario's Aboriginal Health and Wellness Strategy and Aboriginal Health Policy, see (Lavoie et al., 2011).

addictions services are available to registered First Nations regardless of where they live (Snyder et al., 2015, p. 3). The most notable exception is the Non-Insured Health Benefits (NIHB) program which extends access to specific benefits to status First Nations who reside off-reserve; NIHB includes short-term psychological services. Access to on-reserve mental health and addictions programming and basic community-based mental health care requires not only status recognition through the Indian Act but also on-reserve residency (Kirby and Keon, 2006; Snyder et al. 2015). A policy framework that binds access to Indigenous culturally grounded health and mental health services and Aboriginal rights to on-reserve residency "geographically discriminates against urban status Indians, as they lose most of their status rights upon leaving the reserve boundary", as well as against other Indigenous groups who are not eligible to register under the Indian Act and are thus excluded from accessing these federal programs and benefits (Snyder et al., 2015, p. 8). Instead, urban Indigenous people tend to be viewed and treated as "citizens of the province like all other citizens, without Aboriginal rights or benefits" (Peters, 2001, p. 142).

Although it is important to point out that federal arrangements for health programming on-reserve have also been criticized for "being complicated, short-term and insufficient to meet the mental health needs of the population" (Kirby & Keon, 2006, p. 292), the exclusion of urban Indigenous populations from most of these services and supports is problematic, particularly in relation to mental health and addictions services. The reasons are complex, and include, among other concerns, the ongoing marginalization and underfunding of mental health and addictions services in Canada, especially community-based resources (MHCC, Kirby & Keon, 2006; 2017).

As Kirby and Keon (2006) point out, under the Canada Health Transfer—through which provinces and territories receive federal health care funding under the conditions set out by the 1984 Canada Health Act—"there has never been any, nor is there now, an identified, specific transfer to any province or territory dedicated to mental health care and addiction treatment" (p. 201). Because under the Act, only medically necessary health services provided by physicians or in hospital must be publicly funded, psychiatric services are the default form of treatment for the majority of people in Canada (Chodos, 2017). While all jurisdictions have opted to fund some alternative mental health services, there is not a single Canadian province or territory that "provides universal insurance coverage for counselling, psychotherapy and psychological services" (Chodos, 2017, p. 8). This concentration of state resources on medical rather than community-based forms of mental health care is, as Morrow (2017) argues, largely a reflection of biomedicine's ideological embeddedness in public and policy discourse around mental health.

The dominance of biomedicine within the mental health care system has prevailed despite espoused policy objectives to enhance the capacity of community-based and culturally safe mental health and substance use services within mental health plans (Morrow, 2017), including BC's most recent 'Mental Health and Substance Use Strategy 2010–2017' (Government of BC, 2017) and its Mental Wellness and Substance Use Plan for First Nations and Aboriginal People (FNHA et al., 2013). According to Morrow (2017), this narrow focus exists at least in part due to these policy developments' coincidence with an increasingly neo-liberal political context and "an intensified governmental discourse in BC that promotes individualism and independence" (p. 45). Neo-liberal ideology seems to support rather than challenge the hegemony of biomedical models of care (Morrow, 2013; Morrow, 2017).

2.4.3. Urban Indigenous Self-Governance, Mental Health and Healing: The Fourth Sector

In spite of colonial efforts to erase Indigenous peoples and histories from cities, Indigenous peoples never ceased to have a presence in urban centers. There has been continuous engagement in "reasserting city spaces" as Indigenous spaces, as today's "thousands of community-directed Indigenous [health and social] services and programs" across Canadian cities confirm (Tomiak, 2009, p. 3). This resurgence manifests itself in the delivery of a wide variety of Indigenous community-based mental health and addictions programs and care. The organizations delivering these services constitute part of what Lavoie (2004, 2005) has named the "fourth sector." Like the third sector, the fourth sector is resourced predominantly with public funding (Lavoie, 2004). However, while fourth sector organizations may have much in common with third sector organizations, they also share a number of distinct features that set them apart from their non-Indigenous counterparts. These differences include: 1) an explicit mandate to serve the needs of urban Indigenous populations often highly marginalized by social and health inequities; 2) 'by Indigenous for Indigenous' programming models that integrate Indigenous healing approaches with Western treatment models; 3) an Indigenous community-based governance structure; and (4) an Indigenous workforce (Lavoie, 2004).

The fourth sector emerged as a “result of decades and decades of advocacy, organizing, implementation and expansion work by Indigenous leaders” (Allan & Smylie, 2015, p. 31). In Canada, the first Indian and Métis friendship centres developed in the late 1950s (Newhouse, 2003) in response to a sudden increase of urban Indigenous populations. This rise in the urbanization of Indigenous peoples occurred due to multiple factors, including the lifting of mobility restrictions (i.e., the pass system) (Snyder et al., 2015). The mission of these early organizations can be summarized as fostering a sense of community, providing a gathering place and supporting newcomers to cope with the stress of adjusting to the experience of city life (Newhouse, 2003). As the number of Indigenous people living in urban centres grew, so did the number of Indigenous organizations. For example, while there were only three friendship centres in the 1960s, in 2012 the National Association of Friendship Centres (NAFC) represented 117 Friendship Centres and seven Provincial and Territorial Associations (NAFC, 2017). BC alone is home to 25 Friendship Centers providing employment to 1,000 people and delivering 426 unique programs (BC Association of Aboriginal Friendship Centres, 2019). In addition, BC’s urban Indigenous non-profit sector encompasses a diversity of other Indigenous service agencies.[14]

Allan and Smylie (2015) explain that the fourth sector “is of fundamental importance to improving the health inequities faced by Indigenous peoples in Canada” (p. 31). Indigenous non-profit organizations (NPOs) are “closer” and “more responsive” to the needs of their communities than mainstream providers and thus more effective in delivering responsive services to Indigenous populations (Newhouse, 2003, p. 249). Over the last decades in particular, urban Indigenous organizations have thus come to fill important service gaps for Indigenous peoples who live in cities, providing vital points of access to health and social supports (Browne, Lavoie, et al., 2009; Browne, McDonald, et al., 2009; Kurtz, Nyberg, Van Den Tillaart, Mills, & The Okanagan Urban Aboriginal Health Research Collective, 2008). In addition, they function as “integral points of connection” (Browne, McDonald, et al., 2009, p. 31) and important sites of collective and individual healing and cultural renewal (Peters & Andersen, 2013; Silver, Ghorayshi, Hay, & Klyne, 2006). As Silver et al. (2006) assert, the creation of Indigenous

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[14] A quick search using www.HealthLinkBC.ca produced for instance 86 hits for the search term ‘Aboriginal organizations’. From these, 45 organizations had provided culturally-appropriate health services to urban Indigenous peoples in addition to offering a range of social supports and acting as important referral centres to other ‘mainstream’ services.

organizations is part of “the process of people rebuilding themselves” and reclaiming their identities both at the individual and collective levels (p. 48).

Furthermore, urban Indigenous organizations are fulfilling a vital leadership role in their communities by “emphasiz[ing] their right to play a substantial role in setting public policy and defining programs and services to urban populations” (Peters, 2011a, p. 17) and offering sustained advocacy in relation to the health and social needs of the communities they serve (Lavoie et al., 2015; Snyder et al., 2015; Sookraj, Hutchinson, Evans, Murphy, & The Okanagan Urban Aboriginal Health Research Collective, 2012). Urban Indigenous people make up only a relatively small proportion of the overall population, and their political visibility and representation by existing Aboriginal political bodies is limited (Abele, Lapointe, Leech, & McCrossan, 2011; Dinsdale, 2014; Hanselmann, 2001; Peters, 2011a). Thus, many urban Indigenous people—in particular those most impacted by social and structural inequities—depend on the presence and leadership of Indigenous community-based service organizations in order to have a voice in the making of public policy, and in order to have their interests represented and their citizen rights recognized (Dwyer et al., 2011; Peters, 2011b).

At least to some degree, governments contracting with Indigenous Providers acknowledge that these organizations serve a representative voices for the communities they serve and that their involvement in health policy decision-making can contribute to the development of more effective policies and health services for urban Indigenous people (Dwyer et al. 2014; Peters, 2011a). However, at least within Canada, such acknowledgement of the authority and special expertise of urban Indigenous organizations in the area of health programming and delivery has not yet extended to a recognition of urban Indigenous organizations as an expression of self-government or urban Indigenous citizenship (Lavoie et al., 2015; Snyder et al., 2015). In contrast to the self-government pathways for First Nations established under the federal 1989 Health Transfer Policy, opportunities for exercising self-determination and participation in policy decision-making for urban Indigenous communities are frequently a product of “goodwill-based initiatives and relationships” rather than being anchored in policy or legislation (Lavoie, 2013, p. 1).

This situation is problematic, because the involvement of urban Indigenous service organizations as ‘co-producers’ of healthcare policy, planning and implementation is not only important but also a necessary condition for ‘good policy’ (Abele et al., 2011; Lavoie, Forget, et al., 2010; Murray, 2011; Walker, Moore, &

Linklater, 2011). As Carlie (2012) argues, “some of the most innovative and fruitful initiatives have been, and continue to be, those that are set up and nurtured by urban Indigenous persons and groups” (p. 11). Co-production requires, as Walker et al. (2011) emphasize, the meaningful involvement of Indigenous leadership and expertise at all stages of the policy-making process. In keeping with Walker’s perspective, Young (2011b) argues that the extent to which urban Indigenous leaders and experts are engaged as co-producers in the policy-making process represents a chief criterion for evaluating Aboriginal policies. He states that while generally speaking, citizen “participation in policy making” might not always be a criterion of a good policy, in the context of “policies about Aboriginal people” this participation *is* such a criterion; here “[b]y *definition*, policies that do not rest on their full participation are sub-optimal” [emphasis original] (p. 226). Young continues,

> Aboriginal people have special rights to determine the policies that affect them, especially those that target them. They have a claim for resources to support these policies and programs, one that is based in part on the damaging and dishonourable treatment that has often been inflicted on them (2011b, p. 226).

Overall, the promotion of self-determination within the urban Indigenous context is a complex matter that remains at the heart of many discussions in the literature. While some maintain that there is reason to be optimistic—“some successful multi-level, tripartite government partnerships have emerged to support urban Aboriginal programming”—others sound notes of caution, saying for instance that “while tripartite funding and programming partnerships such as the UAS [Urban Aboriginal Strategy] are increasingly becoming the preferred mechanism to address urban Aboriginal policy gaps and jurisdictional conflicts, these agreements do not necessarily clarify federal, provincial, and municipal service responsibilities for off-reserve, non-status, and Métis peoples, nor do they support Indigenous self-determination” (Snyder et al., 2015, p. 9). This being the case, there exists a need for more nuanced analyses of how and to what degree tripartite governance structures actually support the meaningful involvement of urban Indigenous organizations as co-producers of health policy and programming.

BC's Tripartite First Nations Policy Framework:[15] A New Era?

The Tripartite First Nations Policy Framework marks the beginning of a ‘new era’ in the approach to First Nations health policy in BC and Canada more broadly (Kelly, 2001; Lavoie et al. 2015). As Kelly (2011) asserts, this is an era where policy is no longer “made *for* First Nations, but *by* First Nations” (p. 9).

The Policy Framework outlines a shared commitment between the federal and provincial governments and BC First Nations to work together to achieve three overarching objectives: “(a) close the gaps between First Nations and other British Columbians in the areas of education, health, housing and economic opportunities over the next 10 years; (b) reconcile Aboriginal and treaty rights with those of the Crown; and (c) establish a new relationship based on mutual respect and recognition” (Lavoie et al., 2015, p. 9). A central step to realizing these commitments was the creation of the First Nations Health Authority (FNHA) in 2010, which set the stage for the transfer of former federal functions (including the funding, planning, management and delivery of health services for First Nations) from Health Canada to FNHA. As the first health authority of its kind in Canada (and elsewhere), the FNHA signals a historical turn in the relationship between Canadian governments and First Nations, as well as a new community-driven, nation-based approach to Indigenous health service delivery (Gallagher et al. 2015; Johnson, Ulrich, Cross and Greenwood, 2016; Reading, Loppie & O'Neil, 2016; O'Neil et al. 2016). Some of these changes include the emergence of a new BC First Nations health governance structure,[16] the formation of new cross-jurisdictional partnerships (through, for example, partnership agreements between the FNHA and the five provincial health authorities) as well as the adoption of a First Nations *wellness* framework, which aims to ensure that cultural knowledge, values and traditional health practices and medicines are emphasized in health care planning, programming and service delivery (O'Neil, Gallagher, Wylie et al. 2016, pp. 229-230).

However, while it is important to acknowledge the significance of these developments in BC, “the language used in the First Nations Health Plan suggest[s] that at this point, only First Nations recognized by the federal government through the registry and those nations who have MHOs [mandated health organizations] are included in the new policy framework” (Lavoie et al. 2015, p. 10). This remark raises a

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[15] BC’s Tripartite First Nations Policy Framework consists of the 2005 Transformative Change Accord and the Tripartite First Nations Health Plan.

[16] BC’s new First Nations Health Governance structure is comprised of the FNHA, the First Nations Health Council and the First Nations Health Directors Association.

number of questions, particularly in relation to urban Indigenous communities. For example, are urban Indigenous peoples benefiting from the tripartite developments in BC, or does this structure deepen existing inequities by reproducing colonial relations based on problematic state-issued categories of Indigeneity? How are urban Indigenous Providers involved—and perhaps more importantly, how *should* they be involved, given that the communities they serve include many status First Nations people from BC and considering the growing number of status First Nations who are moving to urban centers?

The release of BC's First Nations and Aboriginal People's Mental Wellness and Substance Use Plan (2013), and the development of an Aboriginal Urban Health Plan for greater Vancouver by Vancouver Coastal Health (VCH) and the FNHA, suggest that these spaces of exclusion exist simultaneously alongside opportunities for more inclusive collaborations. Nevertheless, as the new partners move towards implementing these plans and policy objectives, it will be critically important to actively engage with these questions.

2.5. Contracting Health Care Involving Indigenous Peoples: Current Patterns of Tensions and Disjunctures

While contracting with Indigenous organization for the delivery of culturally appropriate health care is widely endorsed by governments in Canada, New Zealand and Australia (Lavoie, 2004, 2010), several key tensions and contradictions have emerged that inform current academic and policy debates on contracting in Indigenous health. To locate and extricate these tensions in relation to the research problematic, a more detailed exploration of how neo-liberalism has shaped both theoretical and policy approaches to contracting is necessary.

2.5.1. Neo-liberal Backdrop

In Canada, neo-liberalism has been the key driving force of economic and social policy development and the retrenchment of the Keynesian welfare state for more than three decades (Morrow, 2017), and as such, it must be recognized as a key factor shaping the policy context of contracting and social inequities in mental health. Ideologically speaking, neo-liberalism is based on a set of beliefs and values which emphasize the efficiency of the free market, individualism, free choice, autonomy and the idea of a minimalist state (Larner, 2000). As Larner (2000) writes, together, “[t]hese values compromise the intellectual basis of the neo-liberal challenge to Keynesian welfarism” (p. 7). One way in which neo-liberalism imposes itself on society is through New Public Management (NPM) (Evans, Richmond, & Shields, 2005). Translated into public policy, the NPM reforms have focused on improving public sector efficiency, cost-effectiveness and fiscal accountability (Evans et al., 2005). NPM is premised on the idea that importing market-based, entrepreneurial technologies and practices into the public sector will improve (cost) efficiency, service quality, accountability and customer choice (Evans et al., 2005; Lorenz, 2012). In addition to ‘contracting out’ formerly public goods and services to third-party actors, these techniques consist of the establishment of professional management roles, competitive environments to increase efficiencies, fiscal constraints and performance measurement frameworks along with an increased use of audits and inspection as measures of accountability (Evans et al., 2005).

According to Larner (2000), “the term 'neo-liberalism' [thus] denotes new forms of political-economic governance premised on the extension of market relationships” (p.5). Underpinning this new configuration of relations of governance is a belief that the role of government should not be that of rowing but rather that of steering (Peters, 2011c; Young, 2011b). As Larner (2000) points out, “while neoliberalism may mean less government, it does not follow that there is less governance” (p. 12). Here, she draws on Foucault 's (2000) notion of governmentality, which as she argues is useful for promoting an understanding of neo-liberalism as not only “a political discourse about the nature of rule” but also “a set of practices that facilitate the governing of individuals from a distance” by creating new identities, such as the citizen as a consumer of public services (p.6). Coached as a strategy to increase consumer choice and redress governmental inefficiencies, more than a decade of neo-liberal policies in BC has brought about massive government cuts to social services and supports and advanced an agenda of de-unionization, privatization of public goods and services, and increased deregulation; the cumulative effect of which has been a deepening of existing social inequities (Morrow, Wasik, Cohen, & Perry, 2009; Teghtsoonian & Chappell, 2008). In addition, there is a body of literature documenting the impact of neo-liberal restructuring on governments’ relationships with NPOs, the redefinition of the role and responsibilities of NPOs as well as their day-to-day functioning (Evans et al., 2005; Evans & Shields, 2000; Tenbensel et al., 2013). This literature includes a burgeoning body of international research on contracting with Indigenous NPOs in the area of health and social services and identifies a number of key tensions emerging from the application of NPM to current approaches to contracting and accountability (Boulton, 2005, 2007; Dwyer et al., 2014; Dwyer et al., 2009; Dwyer et al., 2011; Lavoie, 2004, 2005; Lavoie, Boulton, et al., 2010). These tensions play out in theoretical debates but also in the day-to-day functioning of Indigenous NPOs at the levels of program administration and service delivery, as well as relationally, between government funders and Indigenous provider organizations, and among NPOs (Dwyer, 2014).

2.5.2. Approaches to Contracting

Tensions over the appropriate approach to contracting are currently framed within debates over classical versus relational models of contracting (Dwyer et al., 2014; Dwyer et al., 2011; Lavoie, Boulton, et al., 2010; Macneil, 2000). Conceptually, funding approaches modelled after classical economic contract theory are illustrative of New Public Management (NPM) thinking (Dwyer et al., 2011; 2014). As Lavoie, Boulton, et al. (2010) explain, through the dominant lens of classical contract theory, contractual relationships between purchaser and provider within the public sector are defined as an exchange “of discrete, well-defined transactions in a market-like environment, where both parties enter into an agreement freely, and in which the purchaser or commissioner controls the power to define, and the provider competes for the mandate to provide” (pp. 666-667). Thus, classical contracts are often short-term, secured on a competitive basis, and very specific about the discharging responsibilities that define the contractual relationship (Lavoie, 2005; Lavoie et al. 2010; Dwyer et al., 2011). Contractual analysis informed by classical contract theory, therefore, tends to “side-step [...] the context in which purchasers and providers operate” as well as questions concerning the potential costs associated with these transactions (Lavoie, Boulton, et al., 2010, p. 667).

In contrast, relational contract theory “acknowledges ... that contracts do not occur in a social and relational vacuum” (Lavoie, Boulton, et al., 2010, p. 667). Macneil (2000) identifies four key assumptions that underpin a framework for contractual analysis informed by relational contract theory, including,

1) every transaction is embedded in complex relations;
2) understanding any transaction requires understanding all essential elements of its enveloping relations;

> 3) effective analysis of any transaction requires recognition and consideration of all essential elements of its enveloping relations that might affect the transaction significantly; and
>
> 4) combined contextual analysis of relations and transactions is more efficient and produces a more complete and sure final analytical product than does commencing with non-contextual analysis of transactions (p. 881).

When implemented, relational contracts are likely to involve long-term funding relationships, and they are often referred to as trust-based and/or cooperative contractual relationships (Lavoie, 2005; Palmer & Mills, 2003).

According to the contracting literature, both classical and relational contract models hold advantages and disadvantages (Lavoie et al. 2010). The need for relational contracting arises from situations where the relationship between funder/purchaser and provider is marked by an “information asymmetry”: in other words, the funder lacks the necessary competence to best provide the service in question (Lavoie, Boulton & Dwyer, 2010, p.1094). To accommodate this asymmetry, relational contracts need to be more flexible and less specific in defining the terms of service delivery than classical contracts, which in turn requires contractual relationships based on trust and cooperation (Lavoie et al. 2010). Relational contracting has, therefore, been promoted as more appropriate and effective for health programming in areas where the desired outcomes are expected to be long-term and service delivery is ongoing (Dwyer et. al. 2009; Lavoie et al. 210). Further, providing contracted providers with more autonomy over program design and implementation might promote services and programs that are more responsive to the local needs and priorities of the community (Lavoie et al., 2010). Relational contracts are also more suitable for comprehensive approaches to programming (Dwyer et al. 2014).

However, relational contracting also carries some risks for both providers and purchasers—although, compared to classical contracts, the distribution of risk between the two parties tends to be more balanced (Lavoie, 2005; Lavoie et al. 2010). For example, providers might feel that long-term contracts with one funder might put them in a situation of too much dependency, which might threaten their ability to negotiate on par because of the tremendous human and financial costs associated with losing the contract (Lavoie et al., 2010). Conversely, for funders, relational contracts carry the risk of being accountable for the delivery of a service that they have only limited control over and face difficulties in monitoring because of a lack of specific service deliverables (Lavoie, 2005; Lavoie et al., 2010). The fear here is that secure funding without monitoring might encourage provider complacency and compromise the quality and/or safety of the care provided (Lavoie et al., 2010).

Classical contracting is designed to address these concerns at least from the funder's perspective. Because they are highly specific in their description of service delivery, classical contracts facilitate performance monitoring and evaluation and withdrawal of funding in case of non-performance (Lavoie, Boulton, et al., 2010). In theory, the short-term, competitive nature of classical contracting further minimizes the risk for government funders, who maintain almost complete control over what and how services are delivered by determining funding criteria and performance targets (Lavoie et al., 2010). As Dwyer et al. (2014) point out, this framing of the relationship between funder and provider in terms of ‘principal’ and ‘agent’, along with the focus on performance management (PM) and competitive tendering, is emblematic of NPM.

For providers, NPM approaches to contracting raise complex tensions with respect to resourcing, program effectiveness, and accountability and self-determination. For example, there is a growing body of research showing that in situations where classical contracting is the dominant funding model for health and social services, Indigenous and non-Indigenous organizations are faced with having to secure “piecemeal” funding through a number of small and short-term contractual agreements within a quasi-market-like environment (Lavoie, Boulton, et al., 2010; Snyder et al., 2015; Sookraj et al., 2012). Further, while according to the logic of NPM, establishing competition between service providers is a key mechanism to ensure “efficiency and appropriate delivery of the services that are contracted out” (Young, 2011, p. 212) as well as a transparent and fair distribution of tax dollars, in reality, “attempts to implement quasi-classical contracting to purchase health care services have been consistently problematic” (Dwyer et al., 2014, p. 1095). For example, evidence from the PHC sector indicates that competitive and short-term funding arrangements for health and social programming privilege the imperatives of government funders, burden providers with high transaction costs, and undermine both trust between providers and clients and continuity of care (Dwyer et al., 2014; Dwyer et al., 2009; Dwyer et al., 2011; Lavoie, Boulton, et al., 2010; Tenbensel et al., 2013; Young, 2011b).

Moreover, short-term funding is widely known to create significant challenges for recruiting and retaining qualified staff, often leading to high-turnover rates among staff (Evans et al., 2005; Lavoie, Boulton, et al., 2010; Snyder et al., 2015). In addition, research conducted within the context of PHC has demonstrated the difficulties that

Indigenous PHC organizations tend to encounter when trying to reconcile fragmented funding with their commitments to holistic models of programming (Dwyer et al., 2014; Dwyer et al., 2011). As Dwyer et al. (2014) note, often, these providers “have little choice but to 'patch together' many precisely targeted funding programmes” in an effort to meet the complex health and social needs of the highly marginalized communities they serve (p. 10). Evidence suggests that the resulting “patchwork of services” creates complex organizational barriers for the delivery of effective programs and services (Lavoie, Boulton, et al., 2010, p. 673).

Another issue that has received much attention and is well-documented in the literature concerns the high transaction costs faced by providers (and funders) who are managing multiple contracts and operating within NPM contractual environments (Dwyer et al., 2014; Dwyer et al., 2009; Dwyer et al., 2011; Lavoie, 2005; Lavoie, Boulton, et al., 2010; Tenbensel et al., 2013). Transaction costs, in this context, include the administrative costs of acquiring funding, managing the contracts, satisfying reporting requirements and acquitting funding—all of which are amplified within classical contractual environments (Lavoie, Boulton, et al., 2010; Tenbensel et al., 2013). Some of the obvious concerns are that contractual arrangements based on short-term, competitive funding principles might put clients at risk of not having their needs adequately met because of gaps in and disruptions to care; there exists the potential for decreased quality of care as providers are challenged to spend more and more time on administrative tasks (Dwyer et al., 2009; Dwyer et al., 2011; Lavoie, Boulton, et al., 2010). This is, of course, a paradoxical outcome, given that the premise of classical contracting is intended to promote efficiency and effectiveness (Dwyer et al., 2011).

These tensions are compounded by the observation that classical contracting models can impede Indigenous participation both at the level of health policy decision-making and program implementation (Kornelsen et al., 2015). Narrow interpretations of the role of Indigenous organizations that cast them as agents to government policies (as opposed to co-producers) create barriers for contracted agencies to become involved in policy and program planning (Dwyer et al. 2014). Tensions also arise at the service delivery level due to service providers’ perceptions of being “forced to wedge their needs into funder criteria, creating restrictions around where and how services are delivered” (Snyder et al. 2015 p. 16). For Indigenous Providers, the positioning of contracted organizations as agents to policy and government funders creates a particular funding paradox that finds expression in complex accountability tensions (Dwyer et al., 2014; Tenbensel et al., 2013).

2.5.3. Accountability Tensions

Classical approaches to contracting promote unilateral accountability relationships, in which the provider as the agent is held accountable to the funder (the principal) through contractually defined performance-based targets (Dwyer et al., 2014; Tenbensel et al., 2013). As Tenbensel et al. (2013) point out, “such an imbalance of power is integral to models of contracting inspired by agency theory” which underpins NPM approaches (p. 4). The third and fourth sector literature identifies several problems with this approach (Dwyer et al., 2014; Tenbensel et al., 2013).

First, this approach clearly runs counter to the idea of Indigenous organizations as “co-producers” (Walker, 2011) of policy and health care programming, which would call for a mutual accountability framework essentially existing between two “co-principals” (Dwyer et al., 2014). Rather than fostering trust as a foundation for collaboration, NPM approaches to contracting foster mistrust and hierarchical relationships of control due to the normative assumption that funders “should be inherently sceptical of the agent’s performance” (Tenbensel et al., 2013, p. 4). This assumption places the contracted agency/provider into a situation where the responsibility for providing proof of accountability now lies with the contracted agency, which must demonstrate evidence to the funder that it is performing as articulated within the contract.

Secondly, as critics have pointed out, such a one-sided conception of accountability fails to account for the other relevant accountability relationships that exist for third and fourth sector organizations, including those they have to their staff and their constituencies (Tenbensel et al., 2013). These accountability relationships are foundational to the very existence of these organizations, because they provide the basis for their legitimacy and are integral to their mission (Tenbensel et al., 2013). Funding requirements and expectations that undermine organizations' capacity to implement programming that is responsive to the needs and expectations of the community they serve, can, therefore, create profound accountability tensions for these organizations (Lavoie, Boulton, et al., 2010; Tenbensel et al., 2013).

Thirdly, these issues are complicated further by the advent of performance-based contracting. As Dwyer et al. (2009) discuss, the onset of NPM as a new mode of public administration endorsed by governments around the world has transformed the accountability relationship between government funders and community-based provider organizations. Where previously contracting relationships were primarily “based on trust and the delegation of authority” (Dwyer et al. 2014, p. 17), under the growing influence of neo-liberal ideology, a new “regime of accountability to funders” formed, in which performance-based contracting has become the central “mechanism for making accountability to funders manifest” (Tenbensel et al., 2013, p. 3). In performance-based accountability frameworks, agents’ performance is monitored and evaluated against pre-established performance indicators within the contract; non-performance tends to bring financial sanctions (Van Dooren, Bouckaert, & Halligan, 2010).

In theory, the latter is enacted through monitoring and reporting on contractually-defined deliverables and performance indicators (Dwyer et al., 2011). Historically, the adoption of outcome-based accountability frameworks emerged alongside, and as part of, the introduction of the population health approach (BCPHO, 2003). In line with this perspective, the “greater emphasis placed … on accountability for health outcomes and determining the degree of change that can actually be attributed to interventions” has generally been regarded as positive because it enables the monitoring of progress towards health equity targets—information that in its aggregate form can provide important direction to policy and funding (Public Health Agency of Canada, 2014, para. 2).However, there has been concern that in reality the use of output and process indicators often prevail over outcome measures because the former are easier to measure and more directly under the control of providers (Tenbensel et al., 2013). The ensuing tensions between funders and Indigenous organizations about what is seen as meaningful run much deeper, however. Current PM frameworks and indicators have been developed within the context of mainstream health service delivery and are not necessarily appropriate or relevant for ‘by Indigenous for Indigenous’ approaches to health care (Browne et al., 2016; Lavoie, 2004; Lavoie et al., 2018; Wong et al., 2011). There remains a need for the development of indicators and measures that are meaningful, culturally appropriate and relevant within the context of Indigenous health care (Anderson & Smylie, 2009; National Aboriginal Health Organization, 2003). According to Tenbensel et al. (2013), performance-based management within contracting between funders and third sector organizations (TSOs) creates a “thorny paradox”:

> The routines associated with contractual performance monitoring require funders to define the outputs, processes and/or outcomes they seek to fund and to monitor for accountability purposes. But public sector funding agencies contract out to TSOs precisely because they do not know how services should be delivered to particular marginalized groups or what constitutes effective service delivery (p. 5).

Within the Indigenous context, these accountability tensions are heightened, fuelling debates about the extent to which “governments may be capitalizing on the discourse of self-determination to off-load services onto the shoulders of poorly-resourced Indigenous health services” (Lavoie, 2004, p. 19). Indeed, international research examining contractual arrangements for Indigenous providers of PHC services convincingly argues that what is needed is “a fundamental re-thinking” of the suitability of NPM approaches to accountability and the development of alternative models that take into account the unique context of government contracting with Indigenous community-based Providers in health care (Dwyer et al., 2014, p. 1108). More research is, for example, needed on how to develop and implement mutual or reciprocal accountability frameworks (Kornelsen et al., 2015)

2.5.4. Patterns of Contracting and Accountability Reforms, and Implications for Research

While comparative case studies on Indigenous community-based Providers of primary health care (PHC) conducted within the context of Canada, New Zealand and Australia shed light on important differences in the legislative and policy environments and approaches to contracting and accountability among these countries, evidence shows that the above tensions are common to all of these countries—as Lavoie et al. (2010) observe, “the disjuncture between the policy intention and implementation methods is an important feature of the contracting environment in these countries” (Lavoie et al. 2010, p. 669). Yet there seems to be a growing awareness that in order to realize their policy commitments to Indigenous self-determination and equitable access to culturally appropriate health services, governments must implement reforms in current contracting and accountability regimes (Dwyer et al., 2014; Dwyer et al., 2011; Tenbensel et al., 2013).

While reforms are still in their early stages, there seem to be an “incremental departure from 'principal–agent' approaches in contracting policy and practice,” (Dwyer et al. 2014, p. 1106). This shift seems to originate from a recognition that as providers and representatives of their communities, Indigenous community-based organizations “have a substantive and independent role in defining the parameters of health policies and programmes” (Dwyer et al. 2014, p. 1106). In contrast, reforms in accountability seem to lag somewhat behind (Kornelsen et al., 2015). As Dwyer et al. (2014) suggest, this is the case because current accountability frameworks remain deeply entrenched in New Public Management (NPM) regimes.

Given these complex tensions and the current state of knowledge, research conducted within different contexts that helps to shed light on how contractual policy environments and practices foster and/or impede the implementation of more effective, culturally safe and responsive health care to Indigenous communities thus has a vital role to play in supporting governments to achieve these policy objectives and resolve competing imperatives within as well as between government funders and Indigenous community-based Providers. While the international body of research from Australia and New Zealand discussed above has produced a considerable amount of literature on different funding and accountability models for Indigenous-controlled health services within urban areas, urban Indigenous-led organizations within Canada operate within highly complex historical, political and economic contexts that is decidedly distinct and locally specific (Browne et al., 2016; Lavoie et al., 2015). To better understand the extent to which findings from international case studies fit with the experience of urban Indigenous Providers in Canada, more research is warranted.

2.6. Summary

Indigenous community-based organizations are uniquely well-positioned to take on the role of co-producers of health policy and providers of culturally safe mental health and addictions services and programs for the Indigenous communities they serve and represent. The practice of contracting with Indigenous providers seems to embody a recognition of the vital role that these organizations can play for ensuring equitable access to effective and responsive health services, especially for Indigenous people, who tend to be most affected by (mental) health and social inequities and yet remain one of the most poorly-served populations within the mainstream health care system. At the same time, urban Indigenous peoples are largely excluded from federally financed (mental) health services provided to status First Nations on-reserve. Indigenous–state contracting does not occur within a historical or political vacuum, but rather, it unfolds within a neo-liberal and neo-colonial political climate. Under neo-liberal governance, contracting out may have expanded the scope of services provided by the third and fourth sectors, but as growing body of research and literature suggests, New Public Management (NPM) approaches to contracting and accountability may also be complicit in "inadvertently ... killing the golden goose" (Smith & Smyth, 2010, p. 297). The argument has been made that within the neo-colonial context of Indigenous health, these tensions are compounded further because of the unique historically and ideologically mediated relations in which Indigenous–state relationships are embedded. This is particularly true for urban Indigenous communities, which rely on urban Indigenous organizations to be visible but whose voices continue to remain largely excluded from health policy decision-making despite the increasing urbanization of Indigenous peoples and persistent and increasing health and social inequities.

Considering the important role that urban Indigenous organizations play as providers of culturally safe services for Indigenous people, further insight is needed into how the current neo-liberal context of health care reform politics intersects with neo-colonial relations in Indigenous health to shape government contracting with urban Indigenous organizations in mental health and addictions care. Within the Canadian context, little or no work has examined the contextual factors that shape contractual arrangements and relationships between urban Indigenous-led organization and government funders, nor how this might hinder and/or support culturally safe mental health and addictions care from the perspective of Indigenous Providers. While commitments made under the tripartite policy framework have seemingly filled longstanding policy gaps, guiding Indigenous mental health and addictions service delivery—and more recently, urban-specific Indigenous health programming—research has yet to consider how these policy intentions fit with current contractual realities and/or new funding and accountability models that have emerged over the last five years. Through a critical analysis of urban Indigenous providers' perspectives on and experiences of contracting, this study aims to help fill these knowledge gaps and generate a better understanding of how to foster culturally safe and equity-promoting approaches to contracting with urban Indigenous organizations for mental wellness programming by examining (1) Indigenous Providers' experiences of delivering culturally safe mental health and/or addictions care under current contractual arrangements; (2) the sociopolitical, economic, historical and institutional contexts that mediate these experiences; and (3) the specific institutional structures, policies and practices that support and/or impede the delivery of culturally safe mental health and addictions services and the achievement of equity in mental health for urban Indigenous populations. In the next chapter (Chapter Three), I proceed with articulating the theoretical perspectives and assumptions that guide the research. The theoretical framework is influenced by multiple, intersecting critical perspectives and underpins the methodological framework for this study, which I describe in Chapter Four.

Chapter 3. Theoretical Framework

As a non-Indigenous, White settler researcher who is engaged in the study of mental health inequities affecting Indigenous peoples, understanding and articulating my "tacit, personal, professional or organizational knowledges" (Parken, 2010, p. 85), biases, and assumptions takes utmost importance. As Reimer Kirkham and Anderson (2012) note, "we might claim to enter research from a scientifically neutral position, yet there are no value-free positions. Research is an intensely political process, with no one coming from an apolitical position" (p. 165). In keeping with this statement, my positionality is far from being a neutral one.

My deep-seated commitment to social justice and equity in health and experiences of working with groups of people who have been structurally and socially marginalized, lie undoubtedly behind my work as an academic scholar of health equity. In this sense, I approached this research from the position of an advocate for equity in health and equitable access to health care for Indigenous populations and other groups who are experiencing inequities in health. Yet, seeking to advocate *for* Indigenous communities is as Marker (2003) points out, "a suspiciously ethnocentric and patronizing goal" (p. 370). Although Canada's history of colonization and ongoing neo-colonial practices profoundly shape "the ways in which we think of ourselves, [and] one another," those of us who are not Indigenous do not necessarily notice (Clark et al., 2012, p. 108). Re-affirming the moral ends and justice-related implications of research thus demands critical consideration of how claims to advocacy may, unwittingly, reproduce colonial relations and what theories and methodologies researchers can engage in to decolonize systems of knowledge production, including those of academia (Clark et al., 2012; Smith, 1999).

While research has often had harmful and devastating repercussions for Indigenous peoples and has contributed to ongoing colonialism and oppression, non-Indigenous researchers engaging in Indigenous-related research have tended to benefit from research activities in more than one way (Bishop, 2005; Denzin & Lincoln, 2008; Marker, 2003). In recognition of the ways in which research and academia have often been implicated in the silencing of Indigenous peoples' voices, misrepresentation of the cultural 'Other' and the appropriation of Indigenous knowledges, I have been drawn to critical theoretical perspectives. In particular, I have been drawn to post-colonial feminist (intersectional) theorizing, as well as Indigenous and decolonizing perspectives as means to reposition myself as an ally and critical health researcher. In keeping with these perspectives, I do not seek to advocate on behalf of others; rather my goal is to engage in critical scholarship, which, as Reimer Kirkham and Anderson (2012) put it,

> enables the decentering of dominant discourses and promotes rigorous reflexive analyses that to open up the possibility for those who have been marginalized through their historical positioning to speak for themselves […] exercise their human agency and work alongside researchers toward social justice for all (p.168).

3.1. Critical Theoretical Perspectives

Contemporary critical theoretical perspectives are diverse and share important commonalities and distinctions (Reimer-Kirkham et al., 2009). Points of connection include a fundamental concern with social justice and "an evolving criticality" that is intent on producing transformative knowledge by unmasking, challenging and disrupting the historically embedded taken-for-granted social, political and economic structures that reinforce dominant ideologies and reproduce inequities (Kincheloe, McLaren, & Steinberg, 2011, p. 167).

In keeping with this evolving criticality, the research I present is positioned at the intersection of multiple critical perspectives, with each perspective putting forward a distinct set of ideas and a related body of critical scholarship that are relevant to the objectives pursued in this dissertation. However, as I and others have argued elsewhere (Browne, Smye, & Varcoe, 2007; Josewski, 2017; Reimer-Kirkham & Anderson, 2012), it is the unique vantage point that can be derived from exploring their perspectival points of intersection that in the context of this research holds the potential to generate greater analytical leverage for examining the central problematic addressed in this study. I discuss each of these guiding theoretical perspectives, my rationale for choosing them, and how they converge in my theoretical framework below.

3.1.1. Indigenist and Decolonizing Perspectives

Indigenist and decolonizing perspectives have a particular relevance to this study. While diverse, these perspectives share a common commitment to decolonize and disrupt the dominance of Eurocentric systems of knowledge production while seeking to develop "methodologies and approaches to research that privilege [...] indigenous knowledges, voices, and experiences" (Battiste, 2009; Grande, 2004;

LaRocque, 1996; Smith, 2005, p. 87). The inclusion of Indigenous perspectives, knowledges and experiences represents, therefore, a necessary precondition for conducting ethically responsible research (Denzin & Lincoln, 2008; Smith, 2005, 2009). In addition, Indigenous knowledges can serve as important counter-narratives to colonial discourses that operate within academia and policy and continue to delegitimize Indigenous ways of knowing as unscientific (Battiste, 2009; Bishop, 2005; Denzin & Lincoln, 2008). For these reasons, Indigenist and decolonizing perspectives are discussed under the umbrella term of critical theoretical perspectives.

The relationship between critical theoretical perspectives and Indigenist perspectives is, however, not straightforward (Bishop, 2005; Denzin & Lincoln, 2008; Smith, 2009). While inquiries informed by Indigenist and decolonizing perspectives are well positioned "within the antipositivist debate raised by critical theory" and share with critical theory a commitment to produce transformative knowledge in the pursuit of social justice and emancipatory social change through an analysis of power (Smith, 2009, p. 228), some Indigenous critics (see for example Bishop, 2005) have argued that critical theory has failed to adequately address issues of relevance to Indigenous peoples and communities, including "how indigenous cultures and their epistemologies ... [are] sites of resistance and empowerment" (Denzin & Lincoln, 2008, p. 9).

In line with this view, Russel Bishop (2005) suggests that Indigenous approaches to research, such as the Kaupapa (agenda/philosophy) Māori research, represent a distinct research paradigm that serves as "a form of resistance to critical theory" (Smith, 2009, p. 228). Along a somewhat different line of discussion, Smith (2009) advocates for an understanding of Indigenous research as an example of "localized critical theory"—in other words, "the modality through which the emancipatory goal of critical theory, in a specific historical, political, and social context, is practised" within an Indigenous context (p.228). As she explains,

> The localizing of the aims of critical theory is partly an enactment of what critical theory actually offers to oppressed, marginalized, and silenced groups. The project of critical theory held out the possibility that through emancipation, groups such as Māori would take greater control over their lives and humanity. This necessarily implied that groups would take hold of the project of emancipation and attempt to make it their own terms (p. 229).

According to Smith (2009), what is problematic and potentially re-colonizing is the unquestioned, yet pervasive, assumption that the characteristics of "critique, resistance, struggle, and emancipation" that underpin critical theoretical perspectives are universal and "independent of history, context and agency" (p. 229). The criticism of Smith (1999, 2005, 2009) and other Indigenous scholars (Battiste, 2009; Bishop, 2005) make it very clear that critical health researchers, in particular when non-Indigenous, have to pay very careful attention to the colonizing potential of critical theoretical perspectives and must ensure their application is responsive to and informed by decolonizing perspectives that are grounded in Indigenous epistemologies.

In response to the above, this research derives direction from the collective works of a cadre of Indigenous scholars and researchers, who, similar to Smith, have challenged the foundations of scientific disciplines and Western research paradigms and/or contributed to the articulation of Indigenist and decolonizing perspectives (Bishop, 2005; Brown & Strega, 2005; Mussell, 2014). According to Smith (1999), "decolonization is a process which engages with imperialism and colonialism at multiple levels" (p. 20) and thus involves multiple strategies simultaneously. Being reflexive and transparent about the epistemological and ontological assumptions that shape my theoretical perspective and methodological approach to inquiry is one strategic response to the ethical demands of a decolonizing methodology (Reimer-Kirkham & Anderson, 2012). To this end, I am carefully drawing attention to the limitations of the critical theoretical perspectives that are discussed next, pointing out and recognizing modifications that have been identified within the literature as necessary within the current neo-colonial Indigenous context. Additionally, I have tried to engage in self-reflexive practice throughout the entire course of this research by continuously reflecting on and interrogating how my position of relative power and privilege might make me complicit in inadvertently reproducing paternalistic and ethnocentric relations of power.

Further, in keeping with a critical applied Indigenous health research framework outlined by Tait (2008), the research design for this study aimed to foreground Indigenous perspectives and experiences and was informed by collaborative and participatory principles that make the researcher responsible to the Indigenous communities she works with (Brant Castellano, 2004). To bring an Indigenous perspective to this work, I solicited input and guidance from Indigenous advisors, knowledge users and community representatives. A more detailed description of what this entailed is provided in Chapter Four. In addition, I made a methodological decision to attempt to primarily seek out Indigenous participants and emphasize their experiences and accounts within the analysis of the data. Finally, the data were read in relation to relevant literature written by Indigenous theorists.

While there is much diversity in Indigenous literature, common to most Indigenous theorizing is an understanding of the world as "constructed through the lens of interconnectivity" and relationality (Victor et al., 2016, p. 424). As Cree scholar Wilson (2008) explains, from an Indigenous point of view, "the ontology and epistemology are based upon a process of relationships that form a mutual reality [while] the axiology and methodology are based upon maintaining accountability to these relationships" (p. 71). Such a relational worldview has implications, not only for what it means to conduct ethically-responsible research, but also for making decisions pertaining to which other theoretical perspectives can and should inform the approach to inquiry.

For example, contrary to the epistemological assumptions that underpin the dominant scientific paradigm, researchers drawing on Indigenous epistemologies understand knowledge as relational, which means knowledge cannot be meaningfully interpreted outside the context in which it is produced (Little Bear, 2000; Wilson, 2008). Analyzing contractual relationships between governments and Indigenous providers outside the relational contexts in which they are enacted emerges therefore as highly problematic. Instead, relational epistemologies direct scholars to see the fundamental importance of formulating research questions (such as those guiding the research presented) that allow the researcher to examine the politics of Indigenous–State contracting within mental health as a localized within a particular historical, economic, socio-political and cultural context. This injunction encompasses the shared experience of "the burden and contradictions of colonial history" and its impact on Indigenous nations, communities, families and individuals (LaRocque, 1996, p. 14) as well as a recognition of the multiple forms of "oppression, exploitation, assimilation, colonization, racism, genderism, ageism and the many other strategies of marginalization" that shape Indigenous lives and experiences of mental health (Battiste, 2009, p. xxi). In addition, it calls for analytical approaches that bring to the forefront the significance of Indigenous "perseverance, self-determination and resistance" in view of ongoing dynamics of colonialism and historically-mediated institutionalized racism (Clark, 2012, p. 133).

In seeking to bring these issues and concerns to the forefront of analysis, I have drawn on Indigenous scholarship that illuminates and/or addresses the ethical tensions and disjunctures that emerge between Indigenous and Western epistemologies and ontologies (Battiste, 2009) in particular as it pertains to: health and mental wellness programming and service delivery (Brant Castellano, 2006; Brant Castellano, 2010; Brascoupé & Waters, 2009; Menzies & Lavallee, 2014; Smye et al., 2010; Tait, 2008);

accountability (Kirkness & Barnhardt, 1991; Wilson, 2008) and contracting (Boulton, 2005, 2007). The notion of "relational accountability"[17] emerged, for example, as an important ethical and theoretical construct for shaping the research process as well as the analysis of the data and discussion of the findings. I will, thus, return to this concept in Chapter Four, as well as Chapter Eight. In addition, I engaged with the work of Indigenous and non-Indigenous scholars who have used critical theory proactively together with decolonizing methods to address Indigenous issues of social justice and equity in health, in particular those whose scholarship has been informed by intersectional, feminist and postcolonial perspectives to mental health policy and practice (see for example Browne, Lavoie, et al., 2009; Browne et al., 2016; Clark, 2012; Clark et al., 2017; Kirmayer et al., 2009; Smye & Browne, 2002; Tait, 2009).

3.1.2. Intersectionality

Over the last decade, intersectionality has emerged as a major critical discourse in health and social sciences (Carastathis, 2014; Dhamoon & Hankivsky, 2011) and feminist thought (Davis, 2008). Its theoretical foundations are rooted very specifically in Black feminist thought (Carastathis, 2014; Dhamoon & Hankivsky, 2011). In particular, this corpus includes the work of Black feminist and critical race scholar Kimberlé Crenshaw (1989; 1994) and other Black American feminists such as Patricia Collins (1990; 1993) and bell hooks (1981, 1984). By embracing intersectionality as a paradigm for examining the interlocking effects of different systems of oppression related to meanings of race, class *and* gender, among others, these scholars developed intersectionality theory as an anti-racist, feminist critique of mainstream, White-dominated feminism and its failure to account for the complex ways in which Black women's experiences of oppression and their struggles for emancipation differed from those of White women (Carastathis, 2014; Collins, 2002, 2004; Crenshaw, 1989). That being said, intersectional perspectives have been applied long before Crenshaw introduced the term (Dhamoon & Hankivsky, 2011). For example, intersectional thought is inherent to Indigenous ways of knowing (Clark, 2012; Hankivsky & Cormier, 2009).

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[17] According to Wilson, relational accountability "means that the methodology needs to be based in a community context (be relational) and has to demonstrate respect, reciprocity and responsibility (be accountable as it is put into action)" (p.99). Similarly, Kirkness and Barnhardt (1991) maintain that relational accountability requires "working with First Nations and attending to the 'Four R's' of respect, relevance, reciprocity and responsibility" (p.14).

The centrality of relationality in intersectional theorizing represents a significant point of convergence between intersectional and Indigenous perspectives. In addition, there is a shared emphasis on the important epistemological contributions of lived experience as a relevant form of knowledge for critiquing, challenging and unmasking historically embedded systems of oppression. Accordingly, Hankivsky and Cormier (2009) intersectionality assumes an "experience-based epistemology" (Simien, 2007) which calls for the centering of the voices of those who have historically been silenced in the social production of knowledge. It is, therefore, not surprising that intersectionality continues to evolve in various and contested ways through the work of Indigenous scholars and other critical researchers who are engaging with intersectionality in their work in a commitment to advance social justice and equity (see for example Clark & Hunt, 2011; Clark et al., 2017; Davis, 2008; De Leeuw, Greenwood, & Hankivshy, 2011; Grande, 2004).

Intersectional theorizing draws attention to the indivisibility of and intersections between multiple, different social identities and locations, such as class, race and gender, in shaping the lived experiences and health of individuals and groups, and the processes through which these categories of differences are constructed by and constitutive of the interlocking systems of oppression and domination (such as, colonialism, racism, capitalism and sexism, among others). Notably, the primary analytic concern here is with examining what is being produced at "these interactions in terms of power," rather than with the intersections per se (Davis, 2008, p. 68).

Ontologically speaking, intersectional perspectives are premised on a recognition that "human lives cannot be reduced to singular and distinct categories" (Hankivsky, Grace, Hunting, & Ferlatte, 2012, p. 17) or seen as the collective sum of the independent effects of isolated systems of oppression (Hancock, 2007); rather, social categories of difference and systems of oppression are seen as mutually constitutive. In other words, colonialism could not function in isolation from class exploitation, racial and gendered hierarchies (Dhamoon & Hankivsky, 2011; Razack, 1998). By advancing "an understanding of power as it is mediated through a range of social [and structural] relations based on, for example, gender, race, culture, ethnicity, sexuality, ability, and class," intersectionality offers a powerful analytical framework for illuminating how social inequities in health are produced and maintained (Morrow, 2017, p. 47).

Hankivsky and colleagues (2012) found, that intersectional frameworks "can significantly advance the operationalization of equity in public policy" (p. 7) including

Indigenous health and mental health policy (Browne, Varcoe, & Fridkin, 2011; Clark, 2012; Clark et al., 2017; Fridkin, 2012; Josewski, 2012). With its analytic focus on explicating how inequities in health are structurally and discursively reproduced and relationally constituted through multi-level interacting processes and systems of oppression (Dhamoon & Hankivsky, 2011), intersectionality provided thus a useful lens for this research. In particular, I used an intersectional lens to critically examining the unequal power relations embedded within contractual relationships, the complex macro-level processes that are shaping them as well as the ways these relations structure Indigenous mental health and addictions service delivery at the micro-level.

A point of contestation regarding the use of intersectionality is its lack of any defined methodology (Nash, 2008). In light of the complexity of intersectional frameworks, translating intersectional theory into a method of inquiry can be challenging. However, as intersectionality as a method to inquiry continues to evolve , new methodological frameworks are emerging (Hankivsky et al., 2014). One example includes the Intersectionality-Based Policy Analysis (IBPA) Framework (Hankivsky, 2012; Hankivsky et al., 2014), which has been developed in the Canadian context by group of interdisciplinary researchers as "a new and effective method for understanding the varied equity-relevant implications of policy and for promoting equity-based improvements and social justice" (Hankivsky, Grace, Hunting, Ferlatte, et al., 2012, p. 33).

By raising a series of "descriptive and transformative questions" for examining health and health-related policies, the IBPA framework can be a useful tool for researchers seeking to apply intersectionality as a lens through which to analyze policy problems and processes and generate equity-focused policy recommendations and responses (Hankivsky, Grace, Hunting, Ferlatte, et al., 2012). The analytical purpose of the descriptive questions contained therein is to critically explore "policy problems in their full context, with specific attention to the processes and mechanisms by which policy problems are identified, constructed and addressed" (Hankivsky, Grace, Hunting, Ferlatte, et al., 2012, p. 34). Transformative questions, on the other hand, assist to move the inquiry beyond a descriptive ethics to one that brings into focus the normative and theoretical dimensions of policy making (Hankivsky et al., 2014). This entails questioning "what policy should look like" (Hankivsky, Grace, Hunting, & Ferlatte, 2012, p. 11) and "what rationales, processes, values, and philosophies ... should underlie policy" (Varcoe, Pauly, & Laliberte, 2011, p. 336).

Such lines of questioning are particular relevant in relation to the central problematic addressed in this research. Applied to the examination of contracting with Indigenous Providers for the delivery of culturally safe mental health and addictions care, within the context of this research, IBPA provided analytical guidance by prompting me to ask a series of strategic questions as I engaged with the literature in the field and the data. For example, I asked, How does the interplay of different policy contexts and processes shape the definition of policy problems (i.e., the mental health needs of the urban Indigenous population) and responses (i.e., contracting)? What assumptions and rationales inform the institutional approach to contracting? How are contractual policies formulated and implemented? What are the effects in terms of advancing equity and social justice? What should contracting with Indigenous Providers in mental health look like, if the goal is to foster equitable access to culturally safe services and program that are responsive to the needs of urban Indigenous populations?

Another important criticism levelled against intersectionality is directed at the theoretical claim that no one form of oppression can be a priori determined to be more significant than another (Clark, 2012). Intersectionality posits that "a person’s relative social privilege or disadvantage will be dependent upon the context in which they live" (Larson, George, Morgan, & Poteat, 2016, p. 965). Within the context of Indigenous health, such a claim is, however, contentious. As many Indigenous health scholars have argued, Indigenous experiences of mental health and healing cannot be adequately understood outside the context of colonialism, both in its past and current forms, and, thus, must be considered a priori (De Leeuw et al., 2011; Greenwood et al., 2015; Loppie Reading & Wien, 2009).

Clark (2012) goes further to suggest that unless "intersectionality acknowledges its own colonial history" and its potential complicity in the reproduction of colonial relations, its transformational promise will fail Indigenous communities (p. 141). In continuation of this argument, she warns that while intersectional theory is intrinsically oriented to promote social justice, the meaning of social justice ought not to be taken as universal or common sense. Clark makes this point in the context of discussing Indigenous feminist scholar Sandy Grande's work (2004), which shows how intersectional analyses often remain underpinned by a common sense conception of social justice that is "rooted in western notions of democracy and sovereignty [and] that do not recognize the importance of tribal knowledge, spirituality and interconnectedness of past, present and future generations" (p.141).

To address these issues, Clark proposes extending intersectional frameworks to reflect Indigenous epistemologies, voices and visions. However, such a normative integration of Indigenous epistemologies into intersectional frameworks would suggest a departure from intersectionality's normative claim to not "assume primary importance of any one social category for understanding people's needs and experiences" (Hankivsky, Grace, Hunting, Ferlatte, et al., 2012, p. 35). Colonialism impacts on every facet of Indigenous peoples' lives and life opportunities, and thus, must be adequately theorized when conducting research in the area of Indigenous health. This is not to say that colonialism is the only system of oppression that is relevant for understanding and redressing inequities in health experienced by Indigenous peoples (it is not) nor is it to say that the narrative of the history of colonization is the most important narrative that there is. The need to focus on Indigenous stories of resilience and resistance in the face of systemic oppression is equally important to counteract dominant deficit-based constructions of Indigenous peoples, their cultures and identities (Battiste, 2009; Denzin & Lincoln, 2008).

3.1.3. Post-colonial Theoretical Perspectives

While intersectional and post-colonial theoretical perspectives share a commitment to equity and social justice, post-colonial theories are centrally concerned with a moral and political critique of the history and legacy of colonialism as a source of ongoing structural oppression and new forms of colonialism, racism and violence (Anderson et al., 2003; Browne & Smye, 2002; Browne et al., 2005; Kirkham et al., 2002; Young, 2001). Informed by a multitude of different disciplines and theoretical perspectives[18], post-colonial scholarship maps a critical intellectual space—one that is inherently interdisciplinary and often contested—for interrogating how colonial power continues to be exercised through past and current colonial processes, discourses and practices (Reimer Kirkham & Anderson, 2002). Following the publication of Edward Said's much-cited text, 'Orientalism' (1978), colonial discourse as an area of study became a distinguishing and grounding feature of post-colonial scholarship as exemplified by the work of such post-colonial writers as Homi Bhabha (1994) and

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[18] Post-colonial theorizing emerged from diverse disciplines, including literary studies, cultural studies, political science, and sociology, embracing strands from critical literal and social theory over postmodernism and poststructuralism to (more recently), neo-Marxism and feminism (Nichols, 2010; Reimer Kirkham & Anderson, 2002).

Gayatri Spivak (1988). In their work, these authors focus on questions related to representation and epistemology, especially in relation to "the mode of representation of the otherness" (Bhabha, 1994, p. 97) and "the representational authority of 'Western' intellectuals in relation to the West's 'Other'" (Nichols, 2010, p. 132). While the field of post-colonial studies defies unity, there are, nonetheless, several central themes that have emerged from and continue to be associated with post-colonial theorizing. As Reimer Kirkham and Anderson (2002) write, "postcolonial research inevitably explores at some level the two meta themes of *race* (with its adjuncts of colonization, ethnicity, hybridity, intersecting oppressions, and so forth) and power (in its various expressions)" (p. 10). The emphasis is on unmasking and disrupting the race-based thinking and racializing practices that are rooted in histories of colonization, and support and perpetuate colonial and neo-colonial relations of domination and oppression. Attentive to the ongoing tension between the particularities of subjective experiences and the universality of the colonial experiences, agency and structure, and the local and the global, post-colonialism provides a theoretical lens for exploring individuals' everyday experiences of oppression and resistance as situated within the larger contexts of the social, economic, political and historical forces that structure these experiences, "in essence oscillating one's focus between the micropolitics and the macrostructures of relations of power" (Reimer-Kirkham & Anderson, 2012, p. 164). Another feature of a post-colonial framing (today) is, thus, the deliberate inserting of human agency and centering of the (subaltern[19]) perspectives, worldviews and experiences of those whose voices have historically been marginalized and/or silenced by the dominant culture (Reimer-Kirkham & Anderson, 2012). As Bhabha (1994) writes, "it is from those who have suffered the sentence of history—subjugation, domination, diaspora, displacement—that we learn our most enduring lessons for living and thinking" (p. 172). According to Reimer Kirkham and Anderson (2002), "at its most basic level postcolonialism demands [thus] the right to speak rather than being spoken for, and to represent oneself rather than being represented, or, in the extreme cases, rather than being erased entirely" (p. 12).

Thus, post-colonial theoretical perspectives have obvious relevance to research focusing on Indigenous health more generally and the objectives of this study more

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[19] In response to Spivak's famous essay "Can the subaltern speak?" in which she problematizes the positivist stance and epistemological privilege of European intellectuals, in particular Foucault, while calling for a decentering of dominant discourses to create a space for subaltern voices to speak (Nichols, 2010; Spivak, 1988).

specifically. For example, within nursing scholarship, post-colonialism has been used to critique and challenge how historical and racialized relations and colonialist images of the 'Other' continue to be discursively and structurally reproduced through 'common sense' constructions of culture and difference, and taken-for-granted practices within dominant social institutions, such as health care, which tend to exclude and/or marginalize the worldview of the cultural 'Other' (Browne & Smye, 2002; Browne, Smye, et al., 2011; Browne et al., 2005; Reimer Kirkham & Anderson, 2002; Smye, 2004). In addition, there is an increasing number of Indigenous scholars who draw on and contribute to post-colonial discourses (Battiste, 2009; LaRocque, 1996). However, Tuhiwai Smith (1999) is critical of the notion of "post-colonial" as it purports the idea that "colonialism is finished business" (p. 98). Similarly, Mi'kmaq scholar Marie Battiste (2009) cautions that, although related, post-colonial Indigenous thought is not the same as post-colonial theory. Post-colonial Indigenous writers "seek to move beyond the existing Indigenous experience of colonization by liberating Indigenous thought, practices and discourse rather than by relying on existing Eurocentric or colonial theory" (Battiste, 2009, p. xix). According to Battiste (2009), such knowledge is essential for developing "transformative strategies" to address "the multiple circumstances and shapes of oppression, exploitation, assimilation, colonization, racism, genderism, ageism and the many other strategies of marginalization" (p. xxi), and an Indigenous vision for moving forward.

Within the historical and ongoing debates that characterize post-colonialism (and other Eurocentric theory), Indigenous voices have, ironically, often been marginalized, (Denzin & Lincoln, 2008). For example, traditionally, post-colonial theory has not been attentive to the intersection of different systems of oppression, such as racism, patriarchy and classism, and/or the intersecting effects of multiple social locations and identities. In *The Location of Culture,* Bhabha (1994) advances this critique by seeking to demonstrate that "the construction of the colonial subject in discourse, and the exercise of colonial power through discourse, demands an articulation of forms of difference—racial and sexual" (p. 96). In introducing the concept of hybridity, Bhabha seeks to disrupt the totalizing colonial discourse (proposed in Said's Orientalism), which constructs the colonizer and the colonized in binary and thus essentializing terms. As he argues, the construction of binary differences between the colonizer and the colonized is not only overly simplistic and essentializing but also complicit in establishing and perpetuating colonial relations of domination and subordination (Ashcroft, Griffiths, & Tiffin, 2007).

In recognition of the inextricable links between colonialism and other forms of oppression, and of the failure of post-colonialism to adequately theorize the complexities involved in colonization, post-colonial scholars (Anderson, 2004; Browne et al., 2007; Reimer-Kirkham & Anderson, 2012) have drawn on feminist theories, incorporating an intersectional lens into their analyses of "past colonial practices and their influence on present-day inequities, and the impact of inequities on health and a social status" (Reimer-Kirkham & Browne, 2006, p. 334). The work of these scholars is part of a burgeoning scholarship that has made important contributions to extending understandings of social justice beyond common sense constructions—such as "equal treatment for all" and "conventional notions of distribution"—to a more critical interpretation of social justice along the economic, political and cultural dimensions of injustice[20] (Reimer-Kirkham & Browne, 2006, p. 333). As Reimer-Kirkham and Browne (2006) demonstrate, post-colonial feminist theories can serve as a critical reflexive lens for scrutinizing

> how our epistemologies of social justice remain thoroughly Western, inscribed not only with core emphases on economic redistribution and resource allocation, along with normative principles to be universally applied, but also outside the realm of the values embedded in indigenous understandings of social justice that tend toward inclusive, community-based, and *relational* ideals (p. 335).

A post-colonial feminist lens thus offers a highly relevant angle of inquiry into the central problematic of this research. In addition, I draw on post-colonial feminist perspectives for the increased analytical leverage they offered. By bringing together the different analytical dimensions of a critical social justice conception, post-colonial feminist perspectives directed me to "refram[e] questions of justice in ways that account not only for concerns about distribution but also for *processes* [emphasis original] that inform distribution, including representation in policy making, recognition of who suffers

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[20] This work is informed the contributions of critical theorists Iris Marion Young (2011a) and Nancy Fraser (2003), who emphasize the need for more complex social justice conceptions that are attentive to the intersecting issues of redistribution, recognition, and participation. As a theoretical lens, a three-dimensional conception of social justice underwritten by post-colonial feminist perspectives helps to illuminate "how health ... inequities are created through institutionalized patterns of 'cultural valuing' that continue to constitute some members as 'inferior, excluded, Other or simply invisible' or as less than full partners in social interactions—both within healthcare and in our wider society" (Fraser as cited in Reimer-Kirkham & Browne, 2006, p. 335)

injustices, and the sources of and dynamics that sustain injustice" (Varcoe et al., 2011, p. 346).

3.1.4. Cultural Safety as a Theoretical Lens

As noted in Chapter Two, while the discourse of cultural safety has been widely adopted as an ethical principle in Indigenous health service delivery and policy, cultural safety has also been used as a critical theoretical lens by Canadian researchers engaged in critical, praxis-oriented health research involving Indigenous peoples (Browne & Smye, 2002; Kirkham et al., 2002; Reimer-Kirkham & Anderson, 2012; Smye, 2004; Smye & Browne, 2002). Conceptualizing cultural safety from a post-colonial analytical perspective, Smye and Browne (2002) discuss, for example, the relevance of "cultural safety as a moral discourse to inform an analysis of mental health policy" within the Indigenous context of BC. In this dissertation, I similarly drew on cultural safety as an ethical discourse to inform an analysis of the relations of power that shape Indigenous–State contracting for the delivery of culturally safe mental health and addictions care as it applies to urban Indigenous peoples and organizations in BC.

In keeping with the theoretical framing of this research, I applied cultural safety in a reflexive manner that was consistent with the post-colonial feminist and intersectional orientation of this study outlined above. As Smye and Browne (2002) write, as a reflexive tool underwritten by post-colonial (Indigenous and non-Indigenous) perspectives, "[c]ultural safety reminds us that it is incumbent on all of us in health care to reflect upon the ways in which our policies, research and practices [however, well intended] may recreate the traumas inflicted upon aboriginal people" (p. 47). Towards this end, cultural safety prompts a series of ethical questions about how dominant culture discourses "permeate research, [health care] institutions, policies and everyday practice" to create situations of "cultural risk" that place Indigenous people at risk for real and/or potential harm (Smye, Josewski, & Kendall, 2009, p. 20).

For example, within the context of this dissertation, cultural safety provided a valuable analytical device for interrogating the possibility that contracting with Indigenous Providers for the provision of culturally safe mental health and addictions care may be colonizing rather than decolonizing in its consequences. So guided, I critically engaged with such questions as, how do Indigenous healing knowledges, understandings of mental health and priorities shape contractual policies and practices, and vice versa?

What and/or whose agendas are driving contractual reforms in the area of Indigenous health? Do these agendas and currently employed contractual approaches recognize and support Indigenous rights or do they create barriers that constrain Indigenous Provider's ability to provide culturally safe mental health and addictions care? How are urban Indigenous voices represented at the level of policy? Do current contractual arrangements provide urban Indigenous Providers with the resources necessary to fulfill their responsibilities?

In this research, I thus used cultural safety in several ways: As "ethical lens" and "an interpretive lens for the process of policy analysis" (Smye & Browne, 2002, p. 52). I addition, I drew on cultural safety as a critical reflexive tool for turning my critical gaze inwards and scrutinizing the ways in which my own historical and social positionality and the research process might have been complicit in the reproduction of colonial relations by engaging with such questions as: "whose agenda is being served in research, whose voices are included in the data and in which ways [will] Indigenous people … be affected by the research, i.e., will they benefit?" (Smye et al., 2009, p. 18).

3.2. Summary

Appropriate to the aims of the research, the approach to inquiry taken was framed by multiple critical theoretical perspectives, including Indigenous and decolonizing perspectives, intersectionality, post-colonial feminism and cultural safety. Each of these perspectives was used to inform various aspects of the overarching methodological framework, which I describe in Chapter Four.

Chapter 4. Research Design and Implementation

The specific focus of this chapter is on how the research was conducted. I begin with describing the methodology guiding the research design and implementation. In keeping with the multiple critical perspectives that underpin this research, the method of inquiry for this study draws on multiple methodological strategies and frameworks. While such a practice in the history of qualitative research is considered unconventional, I choose it here because within certain contexts, the "rule-bound approach" of the past that requires researchers to adhere to prescribed methodological traditions can become highly problematic (Thorne, 2011, 2016; Thorne, Kirkham, & O'Flynn-Magee, 2004; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). This claim is particularly true for applied health sciences research involving Indigenous peoples where certain theoretical attachments my risk the reproduction of neo-colonial relations while missed opportunities to localize methodological strategies can undermine the meaningfulness and applicability of interpretations (Smith, 2009; Thorne, 2011).

To mediate these risks, Thorne writes that critical health researchers increasingly draw on methodological traditions carving out their own methodological toolkits by carefully "[d]isentangling methodological strategies from the theoretical assumptions associated with" various disciplines (Thorne, 2008, p. 27). This process includes "teasing out that which can be extracted from the conventional methods to advance our capacity for answering applied health questions, and those aspects which might just have to be abandoned" (Thorne, 2011, p. 449). The challenge is to "retain[...] the coherence and integrity of a theoretically driven approach to knowledge development … according to the specific features of context, situation, and intent" (Thorne, 2008, p. 27).

The methodological framework derived for this study has been developed in keeping with the logic of this non-prescriptive approach, which Thorne and colleagues have come to call "interpretive description" (Thorne, 2016; 2004). As part of this approach, I engaged in a process of variously exploring, integrating and/or rejecting different methodological aspects associated with the various theoretical assumptions and relative to the context, situation, and intent of this research. I start this chapter with a discussion of the method of inquiry that emerged from this process: a critical ethnographic approach foregrounding Indigenous perspectives and epistemologies and situated within an intersectional framework informed by post-colonial, feminist theorizing and in conjunction with the use of decolonizing methods.

Congruent with the application of the theoretical framing of this research, critical discourse analysis is considered integral to a critical inquiry in the ethnographic tradition (Reimer Kirkham & Anderson, 2002). Because various strands of discourse analysis exist, I also briefly discuss my approach to discourse analysis as a method in this research. Next, I provide an integrated discussion of how the core principles and assumptions of this method of inquiry have informed the research design and implementation process; this discussion includes a description of the community research partnerships, the methods used for gathering and analyzing the data, and the measures taken for ensuring the scientific integrity of the research. I conclude this chapter with a review of the ethical considerations and the limitations of the study.

4.1. From Theory to Methodological Inquiry: A Critical Ethnography

Critical ethnography provides a method of inquiry that links the critical theoretical perspectives outlined here with a methodology (Carspecken, 2005; Cook, 2008; Thomas, 1993). Specifically, it offers a set of methods that are well suited to examine contracting from the perspective and in the experiences of Indigenous Providers, and how such practices and policies may serve to reproduce or maintain historically- and ideologically-mediated structures within the context of mental health service delivery for urban Indigenous peoples. Firstly, in keeping with the theoretical underpinnings of this research, and in contrast to the positivist underpinnings of conventional ethnography, critical ethnography has its philosophical roots "in the domains of critical, feminist, [post-colonial], poststructuralist and postmodern theories" (Tedlock, 2005, p. 468), which situate ethnographic research within the broader context of social, political, economic, cultural and historical structural relations. Thus, ethnographic inquiries informed by critical theoretical perspectives are explicitly political, "openly ideological," and inherently praxis-oriented (Cook, 2008, p. 149). For Denzin (2003), critical ethnographic inquiries "should criticize how things are ... imagine how they could be different" and prompt action toward realizing these alternative possibilities (p. 130). Critical ethnographers seek to "describe, analyze, and open to scrutiny otherwise hidden agendas, power centers, and assumptions that inhibit, repress, and constrain" human agency and critical, social consciousness (Thomas, 1993, pp. 3-4). For these reasons, some researchers (see for example Fairclough, 2003; Johnson, 2011; Weninger, 2008) have argued "that a combination of critical discourse analysis and ethnographic analysis in fact constitutes what is regarded as critical ethnography" (Cook, 2008, p. 150). I will discuss my use of critical discourse analysis in the next section of this Chapter.

Secondly, critical ethnography emphasizes contextual, experiential approaches to knowledge based on the assumptions that knowledge is socially constructed and that lived experience cannot be meaningfully interpreted outside the contexts in which it is produced. As Lüders (2004) explains, critical ethnographers are tasked with examining "the perspectives of participants, the nature and forms of their knowledge, their interactions, practices and discourses" in order to draw connections between people's lived experiences at the micro-level and the broader social and structural relations at the macro-level that organize them (p. 225). The challenge for critical ethnographers is, as Cook (2008) notes, "to bridge the divide between micro-level interactions of participants and macro social and cultural systems rooted in historical traditions" (p. 151). To achieve this end, Hankivsky and colleagues (2012; 2014) suggest that researchers draw on intersectionality as a powerful, multi-level analytical framework that, when applied to policies:

> 1) provides an innovative structure for critical policy analysis;
>
> 2) captures the different dimensions of policy contexts including history, politics, everyday lived experiences, diverse knowledges and intersecting social locations; and
>
> 3) generates transformative insights, knowledge, policy solutions and actions that cannot be gleaned from other equity-focused policy frameworks (Hankivsky et al., 2014, p. 1).

Thirdly, an experience-based epistemology that centres Indigenous voices and relational inquiries, which use everyday experiences of participants as the starting point to bring into focus the contextual features of participants' lived realities, are key features of a method of inquiry that is informed by the theoretical perspectives discussed in Chapter Three. To this end, in-depth interviews with participants are a prominent method of critical ethnographic approaches and a method which I employ here. Many critical ethnographic studies, including the ethnography I propose here, focus on in-depth individual interviews as the primary data source for gaining an entry point into the everyday social reality of participants (see for example Madison, 2005). However, other ethnographic methods, such as observations, field notes, and a critical examination of policies and documents are often employed simultaneously producing "rich" ethnographic descriptions and accounts that allow for a more nuanced type of analysis by bringing to light potential tensions and "disjunctures" that emerge between different truth claims (Cook, 2008). In this research, tensions and disjunctures functioned as important entry points, or windows, into the workings of power. For example, a key tension that became visible through the use of ethnographic interviews in relation to a critical review of policies was between espoused policy objectives and the lived experience of Indigenous providers.

Explicating potential disjunctures and points of tension within the data and exploring the dialectics emerging between different data sources can enable critical ethnographers to gain deeper analytical insights into the ways in which social relations, processes and practices organize and create relative differences in people's experiences of everyday life (Cook, 2008). Researchers taking an intersectional approach can capitalize on these opportunities for increased analytical leverage by purposively sampling for participants who are located differently both socially (in terms of race, gender and class) and institutionally, with the latter axis of location represented by participants' positioning within the bureaucratic hierarchy and/or in terms of their organizational affiliations or professional roles and capacities (Reimer Kirkham & Anderson, 2002). The use of purposive sampling will be discussed in more detail later in this chapter.

(Critical) ethnographic methods also come under scrutiny. An important source of critique is the critical research community itself. The ensuing debates, which have their origin in postmodern, postcolonial, feminist critical thought, have shaped how researchers engage with critical ethnography by drawing attention to "the interplay between the researcher and the participant, between data and theory, and between research and action" (Cook, 2008, p. 150). Concerns about the power imbalances within the research relationships, the challenge of reconciling the use of theory with a praxis-oriented commitment to authenticity of voice and agency (i.e., the mutual negotiation of meaning), and a lack of action resulting from many ethnographic studies represent ongoing tensions that researchers have to continuously grapple with in order to fulfill the critical and emancipatory potentiality that critical ethnography has to offer. For example, in this study, my pre-existing assumptions about the need to explore contracting in relation to its intersections with colonialism and racism as systems of oppression inevitably created a tension with my commitment to ensure authentic representation of participants' voices and refrain from imposing my theoretical lens onto the data.

To attend to these tensions and promote scientific integrity, critical ethnographers must recognize that the reflexivity of the researcher is of enormous importance (Reimer Kirkham & Anderson, 2002). The reflexive researcher aims to create a relationship of reciprocity between the data and theory and to engage in a process of mutual negotiation of meaning (Cook, 2008; Lather, 1991; Reimer Kirkham & Anderson, 2002). Critical ethnographers are thus challenged to break down traditional power relationships between the researchers and the 'researched' and to create opportunities that meaningfully involve participants "as co-researchers with a stake in interpreting results and suggesting avenues for action" (Cook, 2008, p. 150).

For those who are applying critical ethnographic research involving Indigenous peoples, concerns regarding issues of voice and power are inevitably heightened and compounded further by the close involvement of early ethnographic research in the advancement of the colonial project. Smith (1999) reminds readers that under "the ethnographic gaze of anthropology," Western scientists collected, classified, mis-represented the Indigenous Other, "contribut[ing] in significant ways to qualitative research's long and anguished history, to its becoming a dirty word" (Denzin & Lincoln, 2008, p. 4). Thus, whatever potential critical ethnography might have to offer to health equity researchers today, such potentiality must never obscure that the history of ethnography is also a history of European imperialism and colonialism.

Mindful of this history and the moral pitfalls of ethnography, I applied a critical ethnography informed by Indigenist and decolonizing perspectives and postcolonial-feminist theorizing. In the following sections of this chapter, I describe how I worked towards integrating and enacting the theoretical underpinnings of this method of inquiry in the design and implementation of this research. However, before doing so, I provide a brief discussion of the methodological principles that inform my approach to critical discourse analysis with reference to the larger ethnographic project described above.

4.1.1. Critical Discourse Analysis

As mentioned previously, critical discourse analysis is an important methodological component of research in the critical ethnographic tradition. Many critical scholars have claimed critical discourse analysis as a necessary methodological element for critiquing and contesting policy and policy processes with a view to promoting equity-oriented social change (Bacchi, 2000). These scholars highlight policy as "ideologically constructed in particular political, historical and economic contexts that perpetuate dominating normative ideals with respect to class, gender and culture" and other social categories of difference (De Leeuw et al., 2010; Fiske & Browne, 2006, p. 92; MacDonald, 2003). Scholars who work from a stance of "policy-as-discourse" see both policy problems and solutions as discursively constructed (Bacchi, 2000), and thus they arrive at a very different starting place for policy analysis than analysts who approach policy through mainstream policy frameworks, which emphasize rational decision-making models for analyzing policy as a response an existing condition or problem. For example, as MacDonald (2003) points out, rather than taking the existence of policy problem as granted, discourse analysis prompts critical inquiry into "how needs are socially constructed and become issues for policy intervention [and] ... the implications of policy discourses for the reproduction and reconstruction of the policy environment" (p. 152). While MacDonald (2003) discusses the use of discourse analysis as methodological tool for understanding land reform, the potential value of such an inquiry for health policy, particularly as it relates to Indigenous peoples' health and health inequities, seems obvious.

However, as the literature makes clear, there is no single way to do discourse analysis. Understandings of discourses and discourse analysis vary according to disciplines and the theoretical framework that is informing the research. As a result, one common criticism of discourse analysis is that it lacks sufficient scientific rigor (Cheek, 2008). For this reason, it is important to articulate how the critical theoretical and methodological framing of this study inform my understanding and use of critical discourse. In this dissertation, I work with an understanding of discourse as "a specific series of representations, practices, and performances through which meanings are produced, connected into networks, and legitimized" (Gregory as cited in De Leeuw et al., 2010, p. 286). Discursive "meanings thus arise not from language, but from institutional practices, from power relations, from social position" (Ball as cited in Bacchi, 2000, p. 51). Dominant discourses set the parameters of "what can be said, thought and done" (De Leeuw et al., 2010, p. 286), they determine "who can speak, when, where and with what authority" (Ball as cited in Bacchi, 2000, p. 51) and ultimately, they "structure both our sense of reality and our notion of our own identity" (Mills as cited in De Leeuw et al., 2010, p. 286).

A primary concern of discourse analysis has therefore to do with how some discourses have come to be accepted 'truths' while others are marginalized and suppressed (Bacchi, 2010). The task of "policy-as-discourse" analysts is two-fold: (1) interrogate and expose the ways in which discourses operate within policy (for example, in the creation of the policy problem, its solution, and implementation) within the socio-political, historical and economic context; and (2) illuminate their effects, both imaginary/discursive and material, upon social identities, social and structural relations and systems of knowledge and belief (Bachhi, 2000). As Bacchi and Eveline (2010) point out, "policies do not simply 'impact' on people; they 'create' people" (p. 52) including their social locations, and access to power and resources. Using Foucault's (2000) language, policy can thus be understood as a "technology of power" (Fiske & Browne, 2006, p. 92).

In this vein, De Leeuw et al. (2010) argue that "the concept of discourse" offers a useful tool to conceptualize "[t]he intersection of colonial institutions, ideas, laws, and policies and their impact on Indigenous peoples’ addictions and mental health concerns" (p. 283). De Leeuw et al. (2010) show how critical discourse analysis can be used to examine and illuminate how inequities in mental health experienced by Indigenous peoples "are produced and perpetuated through texts, legislations, government policies and acts of state that (re)produce, rely on, and perpetuate understandings of deviance ... in Indigenous peoples" at the same time as they "produce non-Indigenous peoples as legitimate and necessary agents of care, protection, and improvement" (p. 283). In a similar vein, Fiske and Browne (2006) apply critical discourse analysis to examine how Canadian health policies construct "Aboriginal women as empowered citizens on the one hand and as discredited medical subjects on the other" and how these paradoxical constructions contribute to the ongoing marginalization of Indigenous women in health care and beyond (p. 91).

The work of Fiske and Browne (2006) and De Leeuw et al. (2010) illustrate that critical discourse analysis can serve as an effective vehicle for incorporating a post-colonial lens into an analysis of policy and policy processes, and "for articulating the complex factors shaping Indigenous peoples' health within an Indigenized social determinants framework" (De Leeuw et al., 2010, p. 286). In this research, I have applied critical discourse analysis to examine health policy discourses emerging as relevant from the data and to explore their material and imaginative consequences through a post-colonial feminist lens and a stance informed by the concepts of cultural safety and intersectionality. By examining "how [these] health policy discourses have been shaped in relation to political, social, cultural and economic structures, and in relation to one another," this method of inquiry helps to expose how certain knowledges, meanings and priorities continue to be privileged over others (Smye & Browne, 2002, p. 47) through taken-for-granted, discriminatory policies and practices within health care contracting that are rooted not only in colonizing histories but multiple intersecting systems of oppression, including (neo-)colonialism, neo-liberalism, biomedicalism, institutional racism, classism and patriarchy.

4.2. Research Design

As noted in Chapter One, the research objectives of this study are to (1) examine Indigenous Providers' experiences of delivering culturally safe mental health and/or addictions care under current contractual arrangements; (2) analyze the sociopolitical, economic, historical and institutional contexts that mediate these experiences; and (3) explicate the specific institutional structures, policies and practices that support and/or impede the delivery of culturally safe mental health and addictions services and equity; and (4) generate recommendations for promoting culturally safe and equity-oriented practice in contracting with urban Indigenous Providers of mental health and addictions care. To meet the research objectives, the research design and methods must: (a) provide an opportunity for Indigenous and non-Indigenous administrators and providers of urban Indigenous community-based organizations to describe their everyday experiences of planning for and delivering mental health and addictions services through government contracting; (b) provide an opportunity for managers, administrators and policy leaders affiliated with different government funders, both Indigenous and non-Indigenous, to relay their experiences with contracting with Indigenous Providers for the delivery of mental health and addictions service to urban Indigenous people(s); and (c) provide analytic insights into how these experiences and Indigenous–funder relations are influenced by wider institutional and ideological contexts. A qualitative design incorporating participatory principles and critical ethnographic methods—including in-depth individual interviews, field notes and a critical document review—best met these requirements.

In keeping with the participatory principles and decolonizing framework informing this study, a unique feature of this research design included the formation of an Indigenous Advisory Team, which was comprised of Indigenous community, policy and practice leaders within the area of mental health and addictions. As I will discuss in more detail below, input from the advisory members was ongoing and guided this research from beginning to end. In addition to assisting the researcher in building connections with community partners and potential participants, the Advisory members helped to foreground Indigenous perspectives in the work through affording the researcher periodical engagement with their wisdom, traditional knowledge and insights. That being said, different members brought different strengths to the project, and as such, their support was sought out to different degrees as the study unfolded.

4.2.1. Research Setting

I conducted interviews within three different urban centers located across three out of BC's five geographic health regions. The specific research sites included eight (n=8) community-based non-profit organizations (NPOs), including seven Indigenous-led organizations and one non-Indigenous organization, as well as three governmental funding and decision-making bodies. Participants chose the actual interview sites. Most participants were interviewed in their offices at their workplaces. Other locales for the interviews included restaurants, cafes, hotels and a public library. I gathered and reviewed most organizational documents in the university settings where the research project was housed; some, however, I reviewed at specific research sites due to confidentiality restrictions.

4.2.2. Nurturing Relationships and Building Alliances

Decolonizing methodologies "situate relationships as the foundation of ethical research with Indigenous peoples" (Victor et al., 2016, p. 424). The literature on Indigenous community-based research is clear: research partnerships that are built on and sustained through mutually supportive relationships between researchers and community-based partners produce research that is more relevant, meaningful and beneficial for the community (Bishop, 2005; Kovach, 2010; Victor et al., 2016; Wilson, 2008). Considering the 'violent' history of research and ongoing colonizing potential of Western research practices, non-Indigenous political and intellectual allies must "approach their research collaborations with an attitude of cultural humility" and "practice reflexive awareness to recognize their own positions of power while making conscious efforts to rebalance the power dynamic" (Victor et al., 2016, p. 424).

As part of this study, I formed research alliances both with funders (i.e., two regional health authorities) and with Indigenous community-based organizations. A pre-existing and evolving network of professional and community relationships held by the researcher, the researcher's academic supervisors and Indigenous advisory members, and other colleagues facilitated this process. As a researcher, I bring with me over ten years of research-related work in the area of Indigenous health within BC. Through my master's thesis research (2006–2009) and work as an integral member of several multi-year funded, Indigenous community-based research projects (2007–2017), I have extensive experiences working together with Indigenous researchers, leaders, health care organizations, Elders and providers within BC. The relationships of familiarity, mutual trust and respect between myself and several Indigenous community-based organizations and community-based leaders in BC that have developed over these years provided a critical part of the foundation of this research.

The impetus for this research comes from the findings of my master's research (Josewski, 2009), an exploratory study into Indigenous health policy and service delivery in the context of mental health care reform initiatives within one of BC's regional health authorities. The findings of that study brought to light the colonial potential of funding provision and contractual reform (Josewski, 2012). The relevance and need for an in-depth inquiry into contracting for Indigenous mental health and addictions service was further substantiated by the feedback that I received from other Indigenous providers and leaders in response to my findings within the context of several community-based knowledge translation events that took place in the participating agencies. I also sought feedback from key leaders in the area of Indigenous health, some of whom later formed part of the Indigenous Advisory Team to this study, to discuss in more detail the need for—and purpose of—this study.

In addition to my own relationships with and work within Indigenous communities and the networks my academic supervisors, members of the Indigenous Advisory Team provided essential support in assisting me in connecting and building alliances with health authorities and community-based organizations. For example, one member of the Advisory Team was strategically positioned to help me make connections and begin a dialogue with health authority staff while the community connections of another Indigenous advisory member enabled me to enter into dialogue with key Indigenous leaders and Indigenous community-based organizations, with whom I had no prior established relationship. Considering the often-busy work lives of these individuals and the negative connotation of research within Indigenous communities, the support provided by my academic supervisors and members of the Indigenous Advisory Team was essential in establishing connections with potential participants.

While many of these introductions occurred via e-mail, in my experience, building respectful and genuine relationships requires following up with in-person meetings to provide opportunities for researcher(s) and participants to get know each other, build trust and engage into a mutual dialogue, in which the possibility and parameters of a research collaboration and shared research agenda may be explored and discussed. According to Sweetgrass et al. (2016), alliances are formed around a common goal; to achieve this end, allies have to work together and build relationships based on mutual trust, accountability, "respect and appreciation, preferably with the aim of forming lasting bonds between researchers and community" (p. 424). In this research, it quickly became clear that understanding and fostering a culturally safe contractual environment for Indigenous health was of joint interest to the researcher, community-based leaders of Indigenous organizations, and health authority staff.

In all instances, dialogue culminated in a shared research agreement. Depending on the organization, this step involved an oral or a written research agreement between the representative leadership and the researcher; the agreement outlines mutual values, guiding principles, and reciprocal commitments and expectations (see Appendix A for an example of an anonymized research agreement). For example, some organizations had institutionalized pathways in place for researchers interested in establishing a research relationship. This could involve creating and submitting a detailed research portfolio to an organizational ethics or research review committee/board. Others, in particular the smaller organizations, did not have any formal committee or body in place. In these cases, oral agreement was sought through speaking with senior leadership. As part of these agreements, a key commitment on the side of the researcher was to pursue continued dialogue throughout the entire course of the study, to provide regular updates, and to create opportunities to review preliminary findings and themes. In return, I was provided access to confidential documents, such as contractual service agreements, as well as support in identifying and approaching possible participants. In addition, as potential knowledge users, the building of research relationships with health authorities was a crucial step in promoting the uptake of the findings of this study.

I was challenged, however, by striving to be relationally accountable (Wilson, 2008). In this study, navigating the demands and needs of the university, health authorities, and Indigenous community-based organizations within the shifting context of health care institutions turned out to be tricky, creating unforeseen problems that required substantive modifications to the research plan. For example, initially, the scope of the proposed research was specific to one particular health region and funding authority. However, institutional change within the health authority—which took place in between applying for and receiving funding for the research proposal—led to a renegotiation of the terms of the research relationship. This complication not only added a considerable amount of time to the research, but it also resulted in the researcher's commitment to broaden the scope of the research to address concerns regarding anonymity. Instead of focusing on one health authority region, the new research agreement required organizational representation from a minimum of three health authority regions in BC.

As a consequence, I entered into research relationships with one more health authority and expanded my sampling framework accordingly: that is, I took special care to include participants from community-based organizations located within three different health regions. However, to do so, I had to travel greater distances, which incurred not only greater costs than originally anticipated but also increased time. The prolonged time of recruitment for this study, which spanned a time period of 24 months from 2014 to 2016, is a direct reflection of the significant time commitment that often accompanies relationship-building and -maintenance as well as exploring the emergent aspects of qualitative research.

4.2.3. Participant Sampling

I employed purposive sampling to select research participants. Rather than using sampling as a method to ensure the generalizability of the findings, purposive sampling aims to create an in-depth understanding of the phenomena under investigation (Reimer Kirkham & Anderson, 2002): in this case, contracting with urban Indigenous Providers for the provision of culturally safe and mental health and addictions care. Guided by an intersectional multi-level analysis framework, this process involved the sampling of participants across the micro-, meso- and macro-levels of contracting.

To explore Indigenous peoples' experiences with contracting in mental health and addictions care at the micro- and meso-level, I purposively sampled participants working as service providers of community-based mental health care in addition to program coordinators of mental health-related programming and senior administrative leaders of community-based Indigenous NPOs. For the purposes of this dissertation, these participants are collectively referred to as 'Provider Participants.' Given that the primary focus of this research was to examine contracting in Indigenous mental health from the perspective of Indigenous Providers, a higher proportion of Provider Participants was sampled.

I defined Indigenous NPOs as organizations that were governed by a predominantly Indigenous board and which self-identified as Indigenous, serving a primarily Indigenous constituency. To be included in this research, NPOs had to fulfill at least one of the two following two criteria: (1) have a predominantly Indigenous governance system in place, and/or, (2) employ a significant proportion of Indigenous people. In addition, NPOs had to have a special mandate to provide mental health and addictions services and/or supports to Indigenous peoples. In line with the holistic and contextualized conceptualizations of mental health that underpin Indigenous worldviews, the operational definition of 'mental health and addictions' services and supports was deliberately broad, ranging from preventative medicine and health-promotion-based programming to group and individual interventions and support services. The nature of identified 'mental health and addictions' services and supports also included cultural programming and circle work, mental health and addictions counselling, Elder support programs, peer support, psychological and psychiatric care, outreach support, and community-building. Finally, while NPOs were primarily selected on the basis of pre-existing relationships, in keeping with the requirements of one of the research agreements discussed in the previous section, the researcher took pains to sample organizations from three different health regions.

To explore Indigenous experiences with contracting at the macro-level, I conducted interviews with people who had past and/or current experiences working in governmental funding institutions, such as health authorities, and/or who had in-depth knowledge of policies related to Indigenous mental health. I collectively refer to this participant group as Policy Participants. This group was sampled for the purpose of contextualizing Provider Participants' interviews and facilitating the critique of relevant policies and funding documents.

Finally, particular efforts were made to include participants who self-identified as Indigenous. Importantly, the objective here was not to dichotomize "Indigenous/non-Indigenous" but rather to foreground Indigenous knowledges and perspectives by speaking with and giving voice to a diverse group of Indigenous people(s) in addition to non-Indigenous people. For these reasons, I did not treat non-Indigenous self-identification as an exclusion criterion.

With respect to sample size, this study aimed for a total of 25–30 participants—a sample size which researchers in qualitative ethnographic work have found to be sufficient to produce in-depth analyses around the research questions posed (see for e.g., Anderson et al., 2003; Browne, 2005; Smith, Edwards, Varcoe, Martens, & Davies, 2006; Smith, Varcoe, & Edwards, 2005). However, the emergent and iterative nature of some qualitative research can make it difficult to accurately determine sample size ex ante. Within this research, I made a decision to terminate data collection at a sample size of thirty-three (N=33) participants based on the affirmative feedback and input gathered through sub-samples of participants who had expressed interest in reviewing preliminary interpretations of the data, and the fact that no new information was revealed past this sample size. This observation signaled to me that a point of data saturation had been reached and the data collection could cease.

4.2.4. Participant Recruitment

As I alluded to earlier, participant recruitment followed a highly relational approach, which built upon previously-established relationships with potential participants and organizations held by the researcher, the academic and Indigenous advisory committee members, and other colleagues. Supported through these relationships, I made initial contact with potential participants through e-mails, phone calls or site visits to introduce myself and the research and explore potential interest in the study. If the individual contacted expressed potential interest in the study, I sent a follow-up email with a brief overview of the study and offered to give a more detailed presentation of the research at the organizational site. On-site study presentations ranged from formal to more informal talks and these presentations offered opportunities for the organizational staff and leadership to get to know the researcher (and vice versa), as well as the research (i.e., what is the purpose of the study; what are the potential benefits for the organization; what would participation in the study involve; how would confidentiality be addressed; and so on). I also handed out research introductions (see Appendix B), which contained a short synopsis of the study information and relevant information about the researcher including my contact information.

Only upon approval from organizational leadership and/or ethics committees (where appropriate) did I make arrangements to approach individuals within the organization with an invitation to participate into an interview. This was done with the help of a senior administrative leader at the organization or a designated liaison person who acted with the approval of the organization/leadership as the key support person to the researcher. Senior administrative staff and/or organizational 'liaisons' helped to identify potential participants at different levels of the organization, as well as facilitating contact and/or the scheduling of meetings between the researcher and interim staff and/or providers. As the research unfolded, liaisons were essential in maintaining an ongoing relationship between the researcher and the organization, receiving and giving updates, and helping to organize follow-up visits for the purpose of sharing and gathering feedback on preliminary findings.

4.3. Overview of Participants

In this study, the total sample of participants (N=33). A summary of participants' socio-demographic and professional information is provided in Table 1 below.

Table 1: Summary Overview of Participants and Their Organizational Affiliations

Participants (N=33)	**Ethno-cultural Identity**		**Gender**		**Type of Employment**
	Indigenous	Non-Indigenous	Female	Male	
Provider Participants (n=23)	11	12	17	6	On Contract: 21 Government Employee: 2 Volunteer: 1
Policy Participants (n=10)	7	3	8	2	Government Employee: 8 Consultant: 1
Total	18	15	25	8	

Organizations			
Non-Profit Organizations (NPOs)		**Government Funders**	
Indigenous	Non-Indigenous	Regional-Level	Provincial-Level
7	1	3	2

The study population included a sample of 23 community-based Provider Participants affiliated with a total of eight community-based NPOs, including **seven** Indigenous organizations and **one** non-Indigenous organization. In addition, I interviewed ten Policy Participants with past and/or current experiences working for and/or in consultation with government, both at the regional and provincial levels.

4.3.1. Community-Based Providers Participants (n=23)

Of the 23 Provider Participants who I interviewed in total, nine were service providers working in a range of mental health and addictions services and programs; seven with program coordinators overseeing mental health related programming; and another seven with senior administrative leaders, such as executive directors or board members.

Many participants spoke, however, from more than one perspective. For example, several participants who were interviewed in their position as program coordinator explained that they had taken on that position after years of working as a mental health provider within the same organization. Similarly, several participants reported holding an organizational position that integrated a number of roles reflecting a number of factors, including an organization's commitment to maintain its programming despite funding cuts, increased administrative burdens, and/or the difficulties of maintaining a position funded by more than one contract. Where pertinent to the analysis, I highlight these nuances in the following sections alongside participant quotes within the discussion of the findings.

Service Providers (n=9)

Five out of the nine service providers interviewed were women and five participants self-identified as Indigenous—of these participants, three reported having residential school experience. Participants had been in their current position between two and 15 years with a mean time of four years—yet all had extensive working experience in their area, with an average of 19 years.

Service providers were working in a range of positions: the study sample contained three Certified Drug & Alcohol Counsellors; two Peer Support Workers; and, four Professionally Trained Mental Health Clinicians. Five of the participants had completed post-secondary education, including four with a graduate degree. Those participants who did not have a post-secondary degree had obtained specialized certification in counseling, which typically entails a two-year college education.

The scope of work provided was very broad and entailed informal and formal individual counselling; groups, such as talking circles, healing groups and group counselling; outreach; client advocacy, such as accompanying and providing support to service users in their interactions with other social and health care institutions (e.g., hospitals, courts, child welfare); cultural programming, including field trips, traditional crafts and ceremonies; referrals; as well as community-based events. Most providers were also responsible for collecting data on contractually-defined outcome measures to meet funders reporting requirements.

Seven of the nine positions were funded as part of contractually-defined health programs delivered by community-based NPOs. In some instances, a position was funded by more than one program. The residual two provider positions were not funded through contracts; rather, these providers were health authority employees working in community-based settings. The majority of providers worked full-time, with those who reported working full-time on a contractual basis earning an annual income between $54,000 and $62,000.

Program Coordinators/Directors (n=7)

All participants working in these middle management positions were women, and only one self-identified as Indigenous. The responsibilities of program coordinators were diverse and included contract management, staff management, grant writing, program planning and implementation, and community event planning. In three cases, these responsibilities also included direct service provision. Four out of the seven people interviewed held graduate degrees. Of these participants, two had a professional health designation. One woman had completed a college degree. Two women worked part-time, but the majority of participants had full-time positions. Compared to frontline staff, the mean ($70,000) and average income ($67,000) for full-time program coordinators was significantly higher. At the same time, program coordinators had been in their positions for less time than those working in front-line positions, with an average of 4.7 years and a mean of 1.75 years.

Senior Administrators (n=7)

Out of the seven senior administrators, four participants were women. With the exception of one participant, who was a long-term member of the Board of Directors for an Indigenous organization, all senior administrators interviewed were executive directors. Overall, six were affiliated with an Indigenous NPO. Of these, five identified as Indigenous. Participants had been in their current position for many years, with an average of 15 years and a mean of 20 years. Graduate degrees were held by four. Given the relatively small size of the Indigenous non-profit sector, I omitted income data for this participant group, which varied greatly. In one organization, the executive director also acted as a key provider of services.

4.3.2. Policy Participants (n=10)

Seven of the policy participants identified as Indigenous, and eight were women. Policy participants had been in their current position for a range of years spanning from two to over 12, with a mean of six years, compared to a mean of 25 years for those working within the area of Indigenous peoples' health. Participants were highly educated and represented the highest education and income group among all participants.

At the time of the interview, seven out of the ten were employed full-time in the area of policy, while two were speaking about their experiences in policy from positions held in the past. One participant was employed as a private consultant in the field of policy and mental health. Their specific professional roles are omitted here to protect participants' anonymity. However, with the exception of two, all participants had direct experiences with contracting in the area of mental health and/or addictions services. Institutional affiliations varied and included five different health authorities as well as the BC Ministry of Health.

4.4. Data Collection Methods and Procedures

The primary tools of this ethnographic study were semi-structured in-depth individual interviews with Provider and Policy Participants. In addition, I conducted a critical review of relevant policy and organizational documents. Both of these methods are well aligned with the theoretical and methodological framing of this research and have been used successfully for collecting rich and contextualized data in the context of health equity research (Browne et al., 2012; Lavoie et al., 2018; Smye, 2004). In keeping with the iterative nature of ethnographic research, this process involved "a constant moving back and forth" between the interviews, the critical document review, analysis, the literature and writing (Braun & Clarke, 2006, p. 86).

4.4.1. In-depth Individual Interviews

I developed interview guides (see Appendix C) in alignment with the overall purpose and objectives of the research and in consultation with my doctoral supervisors and members of the Indigenous advisory committee. Each interview guide entailed a set of trigger or prompt questions designed to elicit participants' experiences with—and perspectives on—contracting for the delivery of Indigenous-directed and community-based mental health and addictions care. I then formed subsequent questions in response to participants' experiential accounts of their experiences during the interview process. While prompt questions were open-ended and exploratory in nature, they were also semi-structured in that I organized them around a number of relevant a priori themes that I wanted to explore—themes that were further refined during the research process in response to the interplay between emerging insights from the data, including the document analysis, and the literature. For example, beginning to administer trigger questions prompted participants to describe their current role and responsibilities, which provided an easy entry point into the conversation and facilitated gathering of important contextual information. The focus of the questions then shifted onto participants' experiences with contracting within the context of their everyday work. The aim here was to explore tensions and challenges associated with contracting as well as discovering what worked well. In accordance with a stance informed by cultural safety and Indigenous epistemologies, at the outset of the interview process, the underlying themes that I wished to explore included issues of self-determination, culturally safe mental health practice and programming, the nature of funder–provider relationships, issues of collaboration, and equity more broadly. As more and more interviews were conducted, other themes emerged from the data, which were then explored further in subsequent interviews. For example, a salient theme that emerged from the interviews related to accountability issues, which was then explored with other participants. The final question of the interview guide concluded the interview; I asked participants, "is there anything I haven't asked that you see as important and would like to add?" To this question, several participants responded by adding to a particular issue that had been discussed whose importance they wanted to underscore.

While interview guides for all participant groups were similar, I adjusted interview guides for each participant group to better capture the differential experiences associated with participants' different positioning across the micro-, meso-, and macro-levels in health care. For example, in-depth interviews with community-based service providers of mental health and addictions care focused on participants' everyday experiences of delivering care and explored how contracting shaped their ability to provide and/or sustain care that they perceived as culturally safe. Interviews with program coordinators and senior administrative leaders of NPOs, on the other hand, focused more on how contracting shaped organizational day-to-day operations, mental health and addictions programming, and interactions with funders. In contrast, I found it necessary to adjust interview guides for policy participants to focus more on participants' experiences with respect to funding and policy decision-making in the area of urban Indigenous mental health.

All 23 interviews were conducted face-to-face, each lasting for approximately 60–90 minutes. As previously mentioned, participants decided both on the time and place of the interview, and most were conducted in the offices of the participants, with the exception of three interviews. These exceptions were conducted in the researcher's home, a public library, and a hotel room, respectively. The researcher conducted all interviews. To foster participants' level of comfort in sharing their experiences and perspectives, I deliberately sought to use a conversational style of interviewing.

Prior to the interview, I sought consent from participants. As part of the consent process, I provided participants with an introduction to the project and a verbal overview of the study, including the research objectives and methods, which were outlined in the research summary included on the consent form. Special attention was paid to ensure participants were aware of the voluntary nature of their involvement and their rights to: (a) refuse or withdraw from participation in this study at any time; (b) ask the researcher any questions related to the research during or following an interview; and (c) stop the interview at any time. To further promote informed and voluntary consent, I took great care to outline the steps taken to protect participants' confidentiality, stressing that neither employers nor co-workers would have access to any of the information provided. Finally, I emphasized that the purpose of this study was not to evaluate but rather to analyze the data through an equity and cultural safety lens to examine the broader structural issues related to contracting.

Following completion of the consent form (see Appendix D), the researcher gave each participant a copy for their own information and reference and asked the participant to self-complete a socio-demographic form (see Appendix E). With the permission of participants, I audio-recorded all interviews. I took field notes after each interview: as I reflected on the interview, I recorded my overall impressions of the interview, noting key ideas that stood out (including links that I saw to other interviews/data and/or the literature/theory) and recording potential questions requiring follow-up. In this way, the writing of field notes helped me to organize my evolving thoughts as I moved back and forth between collecting and analyzing different kinds of data in relation to other data and the literature.

4.4.2. Critical Document Review

I broadened the set of interview data by reviewing relevant policy and funding documents available on the internet. The data collected included Indigenous-specific (mental) health plans, agreements and reports, or provisions as well as funding programs for community-based organizations (both Indigenous-specific and not), including funding request for proposals (RFPs) and guidelines. Relevant documents and document sources were identified by participants in the interviews, as well as through the literature and a strategic review of organizational and governmental websites, including at the federal, provincial, regional and municipal levels. Key websites included those of BC's health authorities and Aboriginal Health Programs[21], as well as a number of provincial ministries (i.e., the BC Ministry of Health [BCMOH], Aboriginal Relations and Reconciliation, Children and Family Development and BC Ministry of Public Safety and the Solicitor General) and federal departments (i.e., Indigenous and Northern Affairs Canada). An overview is provided in Table 2, which summarizes the type of documents that were analyzed to inform the analysis.

In addition, I reviewed a number of contractual health service agreements that were sampled from participating organizations and community partners. This material was confidential, but I was able to gain access and review these documents through my

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[21] Each health authority in BC has a designated Aboriginal health program that is funded through Aboriginal-specific health dollars and overseen by Aboriginal program staff and one director. Contracts for Indigenous-specific health services and programs are financed and funds disbursed through a variety of different funding streams and initiatives within this program.

community partners, including both health authorities and community-based organizations.

Table 2: Summary of Documents Reviewed

Government/ Organization	Type of Document Reviewed	Funding Programs Reviewed
Federal/National National Centre for Truth and Reconciliation (TRC) Indigenous and Northern Affairs Canada (INAC) Mental Health Commission of Canada (MHCC) National Association of Friendship Centres (NAFC)	The TRC's Final Report (2015) United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007) Changing Directions, Changing Lives: The Mental Health Strategy for Canada (2012)	• Urban Partnerships Program: 2 Funding Streams—Community Capacity Support (CCS) and Urban Partnerships (UP) • Family Violence Prevention Program
Provincial BC Ministries of • Health • Aboriginal Relations and Reconciliation • Children and Family Development • Public Safety and the Solicitor General BC Association of Aboriginal Friendship Centres (BCAAFC) Provincial Health Services Authority	A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use: 10 Year Plan (2013) [Tripartite] Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (2010) Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs (1993)	• Community Gaming Grants • Aboriginal Domestic Violence • Victim Support
Tripartite First Nations Health Authority (FNHA)/(First Nations Leadership Council Government of BC Government of Canada	• British Columbia Tripartite Framework Agreement on First Nation Health Governance (2013) • BC Tripartite First Nations Health Plan (2007) • Transformative Change Accord (2005) • Partnership Accords	
Regional Health Authorities	Regional Aboriginal Health Plans	• Aboriginal Health Initiative Funding (AHIP) • Aboriginal Directs Services Contracts • Imagine Grant (Northern Health) • Smart Fund Grants (Vancouver Coastal Health [VCH])

Government/ Organization	Type of Document Reviewed	Funding Programs Reviewed
Municipal		Community Grants: Indigenous Healing and Wellness / Organizational Capacity Building

In keeping with my methodological approach, I complied, read and re-read these documents alongside the interviews; this step formed an important component of the data analysis. Importantly, this review was not intended to be comprehensive, and changes may have taken place since the data were collected that are not considered in this dissertation; rather, the purpose of this document review was to provide an important context for analyzing participants' interviews, including an examination of the assumptions, values and beliefs embedded within the texts to explore the kind of discourses that are operating with health and funding policies and practices, and the extent to which they disrupt and/or perpetuate existing ideologies.

4.5. Data Analysis

According to Thorne (2016), studies like this one that use multiple data forms and sources "offer the promise of richer and more complex data sets upon which to generate new findings" (p. 96). In keeping with this goal, I analyzed the two different interview data sets (i.e., Provider Participants and Policy Participants) and the outcomes from the policy and document review in relation to one another. I examined 'contracting' from different angles and across multiple levels by searching for inconsistencies and contradictions as well as commonalities within and between different data sets while gradually developing an increasingly integrated and contextual understanding of the whole. This being said, in consideration of the research objectives and the commitment to decolonizing methodologies, I placed in-depth individual interviews, especially with participants who identified as Indigenous and/or who worked for community-based NPOs, as a particular focus of the analysis.

I undertook an iterative and nonlinear approach to interpretive thematic analysis using procedures described in the literature for qualitatively-derived data (Braun & Clarke, 2006; Thorne, 2016). Data collection and analysis evolved thus "somewhat concurrently" as reiterative processes (Thorne, 2016, p. 155). Therefore, although the following steps illuminate the different stages of data analysis used in this study, analysis did not unfold in a linear fashion as this description might suggest but rather proceeded in a cyclical fashion.

Step 1: As I collected data, interviews were transcribed by a professional research transcriptionist. Once transcribed, I checked the transcripts for accuracy against the original audio-taped versions. As part of this process, I removed identifiable information such as names of people or organizations replacing them with categorical codes. I also transcribed field notes. Then, I uploaded all transcripts and field notes into an electronic database using NVivo®, a qualitative software program for data management, organizing and coding.

Step 2: Once I had completed several interviews, I started reading through whole interviews, familiarizing myself with the data. As part of this process, I began generating analytical summaries for each interview participant using NVivo's memo function, which allowed me to maintain a contextualized view on the interview data while engaging in analysis. In particular, I used analytical summaries or memos to record initial themes and concepts together with illustrative examples that I had gleaned from reading through the given interview. As I read through the interviews, I kept asking what worked well and what represented points of tension. As previously mentioned, in ethnographic work, points of tensions are often used as entry points for gaining deeper analytical insights about the social processes involved in organizing participants' everyday experiences. I used emerging themes and preliminary concepts to code the data and revise interview questions. As more data were gathered and I read and re-read the data, I reviewed and refined the themes and codes as part of a dynamic and evolving analytical process.

Step 3: Concurrently, I began critically reviewing health policy and funding documents (noted above) to contextualize the interview data and further assist the interpretative process. Where possible, I uploaded these documents to NVivo, too, linking them thematically to the other data sets. In keeping with my methodology and research questions, my analytical aims for the critical document review were to: (1) see whether I could identify dominant discourses, as well as other potentially competing discourses, operating within these texts; (2) explore the relations of power and ideologies underpinning these discursive formations; and (3) assist with the broader analysis of how these discourses are enacted through contracting practices and policies to govern the everyday work of Indigenous Providers and to what effect. To this end, I asked a series of critical analytical questions, such as: What are the underlying assumptions, key values and beliefs embedded in the different texts? How do the values apparent in Indigenous health policy objectives fit with the language of contractual agreements and funding regulations and practice of contracting? How do they fit with Indigenous aspirations and understandings and response to mental health? How do policy and funding documents (differentially) frame the current approaches to Indigenous mental health and addictions programming and service delivery? What is valued and why? Who has been involved in the development and implementation of the policy and who excluded? How do health policy and funding documents construct urban Indigenous people and Providers? How has this construction shifted over time? In developing these questions, I took inspiration from different analytical frameworks that have been developed for this purpose (see for example, Browne, Lavoie, et al., 2009; Hankivsky, Grace, Hunting, Ferlatte, et al., 2012; Lavoie, 2004).

Step 4: After having completed a substantial number of interviews, I stopped data collection and re-read the entire corpus of data, engaging in some secondary coding where appropriate. As part of this process, I compared and contrasted analytical themes within and across different data sets in greater depth, exploring "relationships among pieces of data and considering the manner in which these relationships play out (or don't) across the data set" (Thorne, 2016, p. 155). This process also entailed "searching for inconsistencies and contradictions … generating increasingly integrated conclusions about what is happening and why" (Thorne, 2016, p.172). For example, I asked questions such as, how does the policy language compare to current contractual arrangements that are in place, in which Indigenous Providers operate? Based on the experiences of Provider Participants, how do current contracting policies and practices 'govern' contractual relationships, mental health programming and service delivery, and what forms of resistance exist? Are tensions experienced at the micro-level of care a reflection of a broader context? In asking such questions, I came to understand contracting as a discursive practice.

In asking these and other questions and exploring possible answers in the data, I drew on different analytical lenses and methodological tools provided by the theoretical perspectives informing this study. For example, as an interpretive lens, cultural safety prompted me to pose a series of ethical questions about how contractual processes and practices might, unwittingly, reproduce colonial and neo-colonial relations that create particular situations of risk for Indigenous peoples depending on their social and professional locations and life circumstances (Anderson et al., 2003). The application of intersectionality, on the other hand, directed me to ask questions that helped to bring to light the ways neo-colonial and colonial discourses are perpetuated in contracting work together with other policy and social discourses, including gender and class relations. In addition, drawing on intersectionality provided a multi-level framing for an inquiry into the linkages between the micro-, meso- and macro-politics of contracting in Indigenous mental health. Meanwhile, I used a critical relational social justice (or equity) lens underwritten by post-colonial theory to explore the data in relation to issues of self-determination, participation, recognition and cultural valuing, and distribution. As part of this process, I used writing and visual mapping software (Mind Mapping) to map out emerging themes at different analytical levels and explore their relationship to one another. Through this process, analysis shifted to a more abstract level. Several higher-level themes and broader conceptual propositions were generated.

Step 5: In Step 5, I further explored these higher-level themes and tentative interpretations in relation to the literature and the feedback I had gathered from participants as well as the members of my Indigenous advisory and academic supervisory committee. As part of this process, a concerted effort was made to bring the analysis back to the participants—both funding institutions and community-based Providers—to provide opportunities for participants to review data and engage in a reflexive discussion about the tentative insights gleaned from the data. While ideally all participants should have been provided the opportunity to review and give input to the meaning-making process surrounding the data, the researcher made a decision to consult only with selected organizations due to time constraints and my need to keep within the scope of this dissertation. Nonetheless, I was able to share and engage in an in-depth dialogue about my interpretations with a total of nine participants from two community-based organizations and one health authority. I asked questions such as, "how does this theme fit with your experiences?" and "is there anything you want to add?" Dialogue in these meetings helped to clarify and affirm the meaning of my preliminary analysis and themes. In addition, this step provided assurance that my interpretations were trustworthy and credible (Thorne, 2016). Taken together, these insights led me to believe that I had gathered sufficient data to answer my research questions and supported me in my decision to terminate data collection. I subsequently incorporated this feedback into the analysis. I then continued with the analysis until there was a compelling basis for drawing the conclusion that the findings generated did justice to the research questions.

4.6. Ensuring Scientific Quality

For praxis-oriented qualitative health researchers, reflexivity, trust/transparency and attending to the issue of voice hold particular relevance for ensuring ethical, credible and trustworthy research that produces transformative knowledge and action, and thus makes a positive difference in the lives of people who have been oppressed and/or excluded in various ways (Anderson, 2000; Anderson, 1991, 1998; Dyck & Kearns, 1995; Reimer-Kirkham & Browne, 2006; Thorne, 2016).

According to Reimer Kirkham and Anderson (2002), reflexivity occurs when the researcher "engages in reflexive critique of the research process itself (e.g., the relationships formed with participants, the influence of the researcher’s positionality, and the dynamics of power at work) and the nature of the knowledge being constructed" (p. 14). In keeping with the theoretical perspectives and methodologies informing this research, I practiced reflexivity through an iterative process of examination, analysis, writing, and reflection using a number of strategies.

This process included my methodological decision to foreground Indigenous voices and experiences by (1) using semi-structured interviews as my primary method and data source; (2) purposively seeking out Indigenous participants and emphasizing their accounts within the data analysis process; (3) engaging with and incorporating input from Indigenous advisory members into the analysis; (4) creating opportunities for "a mutual negotiation of meaning" (Lather, 1991, p. 57) by presenting preliminary analytical insights and findings back to Indigenous participants for their critical considerations; and (5) taking a reflexive stance in examining the interplay between theory and research by resisting theoretical imposition while, at the same time, allowing the data to generate propositions (for example, by pursuing an inductive line of reasoning and examining the data from multiple theoretical angles); and (6) paying conscious attention to the relational and contextual nature of knowledge production through an ongoing process of self-reflexivity.

Given the past and ongoing exploitation and misrepresentations of Indigenous peoples through research conducted by non-Indigenous researchers, constant self-reflexivity was essential to promoting confidence in the authenticity and credibility of the research findings (as well as for conducting the research in an ethically responsible manner). In particular, I practiced self-reflexivity in relation to how my socio-political positioning as a non-Indigenous White European researcher was impacting my relationship with research participants, the interview process, and ultimately the quality of the data collected and produced in this research. Informed by my understanding of cultural safety and past experiences working with Indigenous peoples, I purposively adopted a relational approach in order to open up an "ethical space of engagement" (Ermine, 2007) between researcher and participants and to enact relational accountability (Kirkness & Barnhardt, 1991; Wilson, 2008). To this end, I sought to establish and nurture relationships built on mutual respect and trust by humbly acknowledging my position as a learner rather than an expert in relation to understanding participants' experiences, taking the time to form community partnerships and alliances, and positioning myself as an advocate in relation to achieving equity in mental health and well-being for Indigenous peoples. At the same time, I critically reflected on my own biases and beliefs and "reflexively hold them up to scrutiny" by making transparent and documenting how I engaged with the data in order to ensure that it was "scientific rigor, not preconceived ideology, that crafts the position of advocacy" (Reimer-Kirkham & Anderson, 2012, p. 166). For example, as previously described, I used NVivo's memo function to as a means of reflexive journaling providing an auditable trail of my analytical decision-making and interpretive pathways.

4.7. Ethical Considerations

Ethical considerations were of fundamental importance to the researcher and were addressed in several different ways. Firstly, I sought ethical approval for this research project through the Behavioural Research Ethics Board (BREB) at SFU, which approved the research after an in-depth ethical review of the proposed study, its procedures, methods and forms.

These procedures included strategies for assuring both participant and institutional/organizational confidentiality. I discussed methods for ensuring confidentiality with prospective participants and representatives of potential community partners as part of the consent process (described previously in more depth) prior to commencement of any individual data collection. I removed all possible identifying information from the transcripts, field notes, and computer files and replaced it with alphanumeric codes. The Excel spreadsheet that linked the codes assigned to participants and institutions/organizations with identifying information was password protected, kept separately from the data set, and was only accessible to my doctoral committee and myself. The Indigenous Advisory Team did not have access to this information. In addition, the researcher paid special attention to ensure that participants were aware that their involvement in this study was completely voluntary and would in no way affect their employment or related performance evaluations. Ethics approval with SFU's BREB was maintained throughout the entire research process.

Secondly, in keeping with my decolonizing and praxis-oriented commitments, I sought to undertake research that was informed by, and consistent with (where possible), ethical recommendations and guidelines for Indigenous health research. In particular, the research was guided by the RCAP’s (1993b) Ethical Guidelines, the ethical principles of Ownership, Control, Access, and Possession (OCAP) (Schnarch, 2004), the Canadian Institutes of Health Research (CIHR) Guidelines for Health Research Involving Aboriginal People (Canadian Institutes of Health, 2007), and Chapter 9 of the Tri-Council Policy Statement (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council, 2014), which outline strategies for ensuring that research findings benefit Indigenous peoples and communities.

Accordingly, I have adopted several strategies which have been described in more depth throughout this chapter. These strategies include the following: (1) this research was informed by critical theoretical perspectives, including a decolonizing framework and Indigenous epistemologies, which foreground Indigenous peoples' perspectives and knowledges and are inherently oriented towards ethical issues and equity; (2) the process of research, including the development of the research proposal, data collection, and analysis, has been guided by an Indigenous Advisory Team and academic supervisors with extensive experience working with Indigenous communities and researchers; (3) the research process has been conducted in partnership with Indigenous people, including Elders, health care providers, managers and decision-makers in the area of Indigenous health; (4) the research process has been governed by research agreements[22] (Appendix A) with representatives from the Indigenous community and key leaders in Indigenous health; the research protocol included seeking institutional and/or organizational research approval in advance of recruiting and seeking

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[22] The form and content of the agreements varied according to organizations' and institutions' desires. However, all agreements entailed clarifying the goals of the research project, the principles guiding the research relationship, ethical protections, identifying a common purpose, and mutual commitments in relation to data collection, analysis and interpretation, and the dissemination of findings.

consent of individuals; (5) given the inherent power imbalances within purchaser–provider relationships, research partnerships with health authorities (i.e., funders) were intended to mitigate potential harms to urban Indigenous provider organizations to the extent possible as well as to promote the uptake of the research findings. As part of the research agreements with community partners, I committed to reporting back to and consulting with research participants about the application of the findings in an effort to ensure that "research reaches the people who have helped make it" (Tuhiwai Smith, 2012, p. 16).

However, in any research focused on Indigenous peoples and any other ethno-cultural groups, there is a potential risk of generating and/or furthering stereotypes about these groups. Therefore, special care has been (and will continue to be) taken to avoid representing Indigenous peoples and organizations in ways that may perpetuate stereotypes. As discussed earlier in this chapter, I bring expertise and sensitivity in understanding the historical and political contexts of Indigenous–state relations, including health care, and this understanding will be reflected in all written work and presentations of the findings.

4.8. Limitations of this Research

The focus of this research has been to explore contracting for culturally safe mental health and addictions care from the perspective of urban Indigenous community-based organizational leaders, health care administrators and providers within BC. However, given the relatively small number of participating Indigenous NPOs in this study, it must be acknowledged that this research may not have captured all relevant perspectives on the phenomenon it set out to study. For example, organizations from only three out of BC's five health regions were represented, and there exists considerable heterogeneity across Indigenous communities in BC. With a representative sample of Indigenous community-based organizations from all of BC's health regions, this study might have produced an even more nuanced understanding of the complexities involved in contracting and, potentially, even beyond. However, given the importance that qualitative ethnographic work places on context, limited generalizability is a known limitation of such investigations. As such, this study was designed to produce neither generalizable findings nor representative coverage. However, based on preliminary feedback, it is likely that these findings will resonate with Indigenous

Providers located in other urban areas across Canada. Future research might explore the transferability of these findings to other contexts.

Moreover, as demonstrated in the literature and data, Indigenous health policy and governance systems in BC have been in a state of change, with the implementation of the First Nations Tripartite Policy Framework and the Truth and Reconciliation Commission’s (TRC) calls for action forming the political backdrop to this study. Therefore, the findings of this study must be considered with the understanding that the particular policy context and institutional environment in which government contracting with urban Indigenous Providers takes place has since evolved further.

A further limitation is that due to the extension of the scope of this project from one to three health authority regions, I was not able to sample service users or engage in a more in-depth analysis of contractual health service agreements as was originally envisioned. To do so would have required identifying collaborators and forming research alliances with yet another health authority to gain access to confidential contractual information, which in turn would have required considerably more time and resources that were beyond the scope of this dissertation.

4.9. Concluding Comments

As Denzin (2017) notes, "there is no one way to do interpretive, [critical] qualitative inquiry" (p. 10); rather, the term critical qualitative inquiry describes multiple interpretive projects. In keeping with this view, this research was informed by multiple guiding critical theoretical perspectives and a methodological framing, which in the tradition of interpretive description combined aspects of various methodological approaches, resulting in a methodological framework that is uniquely tailored to the needs and context of this research and the researcher. Integral to this approach to inquiry was a continual process of reflexivity that shaped how the data were collected, analyzed, and interpreted, as well as how meanings were derived and the findings presented. Congruent with interpretive approaches to inquiry, in the following three chapters, I liberally present illustrative excerpts from the interview data as a way of giving voice to—and grounding the analysis in—the experiences of different participant groups. The organization of these chapters according to the macro-, meso-, and micro-levels of analysis provides another demonstration of how my theoretical orientation informed my research. In Chapter Five, I foreground analysis of the macro-dynamics of power that shape the broader institutional environment in BC in which Indigenous health policy and funding decision-making related to contracting with urban Indigenous Providers take place, while in Chapters Six and Seven I focus on the meso- and micro-level processes, respectively. Importantly, although each chapter focuses on a different level of analysis, they are intrinsically intertwined.

Chapter 5. The Macro-Politics of Contracting in Indigenous Mental Health

In this chapter, I predominantly focus on the everyday experiences of Policy Participants to map out the relations of power operating within health care funding institutions and policy environments and to trace the dominant beliefs, attitudes and assumptions that underpin them. Reading the interview data from the Policy Participants in relation to institutional and higher-level policy documents enriched my analysis.

As the analysis unfolded, the material revealed a number of tensions and disjunctures, which I then explored in more depth to gain a better understanding of what happened here and why. Using the voices of policy participants and examples from the policy analysis, I illustrate how colonial and political ideologies[23] central to contemporary health policy and shifts in the culture of health care are at the basis of the tensions and disjunctures being examined. The chapter contains two inter-related sections.

Section 1: Colonial Continuities and Neo-colonial Realities. In this section, I present an analysis of how colonial ideologies (i.e., paternalism and ethnocentrism) operate through institutional policy and funding environments to create and reproduce patterns of domination and subordination and neo-colonial constructions of the "Other."

Section 2: (Neo-)Liberalism: "It's a real political dance." Here, I discuss the growing influence of neo-liberalism within the social organization of BC health care funding and policy reform, and its intersections with colonialism.

5.1. Colonial Continuities and Neo-colonial Realities

In the following interview excerpts, an Indigenous policy participant who was working as a senior administrator within a governmental institution critically explores the question of why government ministries and health authorities are contracting with Indigenous Providers,

> We contract for Aboriginal services because the mainstream organizations … don’t hire Aboriginal people so they don’t offer cultural safety so that you create a contract for another group outside of your

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[23] As Young (2011) wrote, within the context of institutional analyses, "ideas function ideologically ... when they represent the institutional context in which they arise as natural or necessary," thereby creating and reinforcing conditions, practices, policies, rules and regulations that reproduce inequitable social and structural relations (p. 74).

> mainstream organization to provide those services that you can't do. (Policy Participant 01)

The same participant goes on to explain,

> [T]hey're hoping that an Aboriginal agency is going to be better, more effective at reaching out to Aboriginal people because … even if you're a healthy middle class Aboriginal woman and you go to the hospital because your kid has broken his arm, that kid has brown skin and you have brown skin, and you're identified as Aboriginal, people are going to take a second and a third look at you whereas they might not if you're white. … so that's why we're contracting and that's why contracting is still necessary because number one they don't have the cultural competency, number two they don't have the connection to the Aboriginal community. (Policy Participant 01)

As someone with extensive work experience in health policy who also self-identified as Indigenous, this participant situates contracting with Indigenous organizations within the neo-colonial context of health care by drawing attention to taken-for-granted discriminatory practices within the health care system that continue to create situations of cultural risk for Indigenous peoples. A pervasive mistrust among Indigenous populations towards mainstream health care organizations, and a lack of institutional understanding about how to provide culturally safe services, make it "necessary" to contract with Indigenous organizations in health. This situation arises partly due to a perceived lack of Indigenous hires and expertise.

Many other participants echoed the perspective of Policy Participant 01 (for example, Policy Participants 02; 03; 05; 07; 08); however, my analysis revealed that, in the experience of both Policy and Provider Participants, contractual relationships between government funders and Indigenous non-profit organizations (NPOs) were, perhaps unsurprisingly, imbued with complex tensions. For example, while the interviewee above seemed to view contracting as essential to decolonizing the health care system and improving access to culturally safe services, they were also critical of how contracting is implemented: "What they do in contracting those services out is they say, but you have to do it the same way we do it. Here are the rules and you have to follow these rules" (Policy Participant 01). One dimension of "the problem with contracting" is that "there's very little room for prevention services … in mental health, for example, with [the] high, high rates of suicide there's very little room for addressing those" (Policy Participant 01). The participant's experience as a senior government administrator in Indigenous health speaks to neo-colonialism at work within government contracting in Indigenous health.

Emerging tensions are multi-layered and tied to a reproduction of colonial, paternalistic relations between funders and Indigenous organizations—along with an assimilationist tendency in health care contracting. The latter is evident in the ways contracting remains tied to government's "rules" and to a service model based on Western, biomedical understandings of mental health and treatment. As Policy Participant 01 suggests, the dominance of biomedicine within health care enforces an illness-based and interventionist focus in contracted services, which leaves "very little room for prevention." This despite the fact that from an Indigenous health perspective, Indigenous suicide, for example, is viewed for the most part as socially determined and most effectively addressed through culturally- and community-based approaches to life promotion and suicide prevention.

Although the above participant's account only begins to illuminate the tensions and disjunctures discussed by participants in this study, it reveals the ideological embeddedness of contracting. As the analysis unfolded, two colonial ideologies emerged as central to participants' discussion of tensions and disjunctures: paternalism and ethnocentrism (i.e., biomedicine). Neither paternalism nor ethnocentrism works in isolation. However, for the purposes of this chapter, I discuss each ideology separately.

5.1.1. Paternalism: "Culturally appropriate kind of services ... is a right for First Nations people, ... it's not a gift that non-native people are giving us" (Provider Participant 04)

While the narrative above and other Policy Participants' accounts in this study describe the "necessity" and "importance" of contracting with Indigenous Providers for promoting access to culturally safe and effective mental health and addictions care for Indigenous peoples, study participants' experiences revealed that the relationship between contracting and cultural safety was not straightforward. In the following excerpt, an Indigenous Provider Participant who was working for a regional health authority—but who also had close ties to the community—provides an experiential account that conveys several issues related to how paternalism is enacted within contractual relationships between Indigenous Providers and government funders:

> It's kind of a two-way street because we can ask for funding from mainstream services and they'll provide it for us but they're always going to dictate to us … what kind of programs we're going to be running … how we should be running those programs … The only thing we're, we're sound with is our culture and our identity … So in a lot of

> ways it’s almost … it’s almost like the dog’s tail is wagging the dog. … [Government Funder will say] 'oh like you can spend this money on this and we’re going to evaluate you after that and then see where you’re spending your money at'. In reality, you know, we’re a native organization … we’re working for our people like, you know, we want to work for our people. (Provider Participant 04)

In the experience of Provider Participant 04, paternalistic governance relations from the outside sustain and reproduce dominant interests (e.g., the funders’ interest in maintaining control over what services Indigenous Providers deliver and how) with seemingly little regard for what Indigenous Providers have to say. This perspective was echoed by several Indigenous Policy Participants (for example, Policy Participants 01; 02; 05; 06). As the account above and other similar excerpts suggest, these power-over relationships are further exacerbated by a near-total dependency of most Indigenous organizations upon government funding. Experiences with funders that govern from a distance and fail to recognize Indigenous perspective and Indigenous ownership are likely to compound Indigenous people’s historical distrust towards state institutions, but they also speak to a lack of trust from government funders in the ability of Indigenous organizations to manage programming and funding appropriately and responsibly. A key mechanism through which funders exert control is tied to a narrow hierarchical model of accountability, which entails strict spending regulations and tight monitoring of organizational compliance. The significance of accountability practices within contracting for reproducing and/or disrupting past and current colonial relations within urban Indigenous–government funding relationships emerged as a highly salient theme within the data overall and is explored in more depth in Chapter Six.

The issue of colonial control is further explored within another interview excerpt with a different Indigenous policy participant who was working as a senior administrator in Aboriginal health within government,

> I think contracting is hugely important because the provincial government and health authorities and all the service agencies are in no way reflective of, you know, the cultural competent services required by Aboriginal people. …. we’re seeing, you know, like all these horrible practices and nobody is being sort of held accountable for that so not only should we have contracts for Aboriginal service providers and I don't think we’re anywhere near shutting them down. … I think they could be better managed. The MCFD [Ministry of Children and Family Development] process in managing those contracts—it’s kind of a catch 22. For child and family service agencies the federal funding formula is that the more children you apprehend the more money you get. So Aboriginal agencies don’t want to apprehend children, they want to prevent them from being apprehended but there’s no money

> there for their services. So … we still need to be providing our own services but we don't, we're not really supported to be successful at that. (Policy Participant 01)

Here, the participant uses the example of Aboriginal child and family services to illustrate how the structure of government funding creates a serious ethical double-bind for Indigenous providers, and situations of cultural harm for Indigenous children and their families. To this participant, the use of funding criteria (i.e., population size of children in care) that force Aboriginal Agencies to meet performance targets is fundamentally at odds with the Agencies' mission and with social justice. Furthermore, the systematic exclusion of funding for services that would fit with Indigenous values and experiences are interpreted as an example of structural racism at the institutional level.

Shifting the focus of the discussion slightly toward the problem of bypassing Indigenous authority and voice *within* government institutions, in the next interview excerpt, an Indigenous policy participant provides an account of the everyday challenges of working within government.

> Sometimes I hear about … a program or a project about to launch and I can pull it back real quick and say 'whoa is there an Aboriginal lens applied to this, did you guys think about that?' Or unfortunately more often than not, it … goes way down the road … [before] it finally crosses my desk … So it is not hard wired, I've been working on that for years. The way it's worked so far in the years that I've been here is simply by building relationships with the leadership in these programs that are at my level. Not the ones up here but the ones that are basically frontline … And through those relationships … we've been able to have some success. It's never at the forefront, it's never at the beginning of anything, it's always been an afterthought … but afterthought is better than no thought at all. ... Hard wiring it would mean changing the way we do business, changing the way we make decisions … at least put me in a position where I'm at the right table, where when these decisions and thoughts are being first discussed I can go [and say] 'hey, hold on, this applies to the Aboriginal population and I would recommend you to do this, this and that' … but it's not that way right now. (Policy Participant 07)

This point is further underscored by another Indigenous participant who was working within an equivalent position to the participant above but within a different institutional setting:

> Every Aboriginal program except in the North, which is more progressive in some ways than other parts of the province, there [we] ... like [we are] seen as adults and they have a Vice President of Aboriginal Health, who sits at the table with all the big kids. But in other programs we're like a little bit ghettoized, in other organizations,

> we don’t sit at executive tables, we have other people speak for us which is problematic. (Policy Participant 02)

The participant accounts above highlight several points that speak to how Indigenous expertise and authority often are ignored within health policy and program implementation or reduced to an "afterthought." First, there seems to be a disjuncture between what the participants are mandated to do—to ensure the application of an Aboriginal lens across departments—and how they are positioned within the organizational decision-making hierarchy. By systematically excluding Indigenous policy participants from higher-level policy decision-making, the current institutional structure severely limits Indigenous authority, especially vis-à-vis the capacity to ensure that an Aboriginal lens is applied to programming that affects Indigenous peoples. In one participant’s words, the problem is with the "hard wiring," or the structural relations of the institutional health care complex, which uses the language of critical theoretical perspectives but which denies Indigenous people sufficient voice to seriously challenge the status quo. Assigning the responsibility for ensuring the application of Indigenous lens to health and social programming at various levels to a few selective Indigenous individuals "without passing the actual decision-making power necessary to truly transform these policy areas" (MacDonald, 2011, p. 257) is not only an impossible task: it is also reflective of longstanding patterns of paternalism and colonial authoritarianism that have shaped Indigenous–state relations within and beyond health care.

Secondly, while some successes have been achieved on the basis of relationship-building—the soft-wiring of institutional life—having non-Indigenous allies speaking or advocating *on behalf of* Indigenous agents in policy, while the latter continue to be deprived from the possibility to *speak for themselves*, is seen as reproducing colonial relations. With respect to health care programming, these dynamics raise the question of to what extent current health and social services and programs are in fact reflecting Indigenous perspectives. Elaborating further on these dynamics, one of the above participants goes on to contextualize the problem within the current policy context (i.e., BC Transformative Change Accord [TCA], the Tripartite First Nations Health Plan [FNHP], and the BC Tripartite Framework Agreement on First Nations Health Governance):

> So even though we have this high level legislated directive to serve the First Nations and Aboriginal people as a special population … the Premier and the Prime Minister, everybody says it way up here … actioning it and hard wiring it into how we do business is not there,

> not in education, not in health, not in any area. How it actually operationalizes … is by trial and error. (Policy Participant 07)

Several policy participants in this study identified a disconnect between the commitments articulated under recent tripartite policies: to achieve equity in health, substantive recognition of Aboriginal rights and relationships built on mutual respect, on the one hand, and the processes that are in place for implementing such commitments, on the other. Within this context, many policy participants in this study emphasized the ongoing challenge of trying to mobilize adequate institutional support and financial resources to realize Indigenous cultural approaches to mental health and addictions programming. Another Indigenous policy participant comments:

> we have one person … [in mental health and addictions programming] who is … bringing in culture, [and] … making it culturally appropriate … because … the person … happens to be [Indigenous], … [and] happens to know how to make it culturally relevant so … it is down to the personality, it is down to hit and miss. Most program people in the areas will avoid, you know, they're not going to be providing supports or funding or contracts for Aboriginal anything unless their hands are held to the fire. (Policy Participant 01)

Again, while some support for improving access to culturally relevant mental health and addictions services for Indigenous people exists, such initiatives appear to be dependent on a few individual champions and are more an outcome of chance than an organization-wide commitment to advance equity in mental health for Indigenous peoples. Instead, in the experience of the above participant, obstacles encountered when negotiating support for Indigenous programming range from avoidance to outright antagonism or hostility—a perception that is affirmed by another Indigenous policy participant, who notes that "there is always resistance and backlash" when attempting to prioritize Indigenous peoples' health and health care concerns (Policy Participant 02). An illustrative example of this kind of resistance and backlash is provided in the following interview excerpt with an Indigenous policy participant, who shares an experience related to the Indigenous Cultural Competency [ICC] training program (now known as San'yas Indigenous Cultural Safety (ICS) program).

> One woman when we started talking about rolling out ICC … [at this organization] started banging her head on the table like 'Are you kidding me? We can't even get … this … emergency skills training out and you're going to make them take cultural competency?' You know that kind of attitude, right? … But … how do you move past that sort of attitude, right? I mean these are prevalent attitudes in Canadian society where Aboriginal people are sort of a subspecies of humanity and we don't really count. (Policy Participant 01)

Despite serious commitments by regional and provincial health authorities to build and enhance organizational and staff capacity to foster cultural safety at the inter-personal, institutional and system levels within health care, several Indigenous Policy Participants recounted situations from their everyday work in which their efforts to operationalize these commitments were met with resentment and animosity. In much the same way as described by the participant above, other interviewees understood these commonly expressed attitudes as reflective of prevailing racializing and colonial discourses both within and outside the health care system, which construct Indigenous peoples as unfairly benefiting from their special status—contributing to an institutional climate in which overt “contempt,” “resistance and backlash” towards Indigenous peoples may be condoned or is at least tolerated. Dealing with these expressions of everyday racism was experienced as difficult and draining by participants based on the recognition that without institutional high-level support, on their own they could not disrupt this race-based thinking and its marginalizing practices.

Another Indigenous policy participant interviewed for this study relayed a personal experience that illuminates yet another way in which colonial and racializing constructions of "Indigeneity" are perceived to produce discriminatory treatment of Indigenous peoples working within government,

> I was scrutinized more heavily in some ways … [and] in other ways I was totally ignored simply because 'oh that’s an Aboriginal issue' -[or] 'at least someone is doing something with it, we really care' [but really] it’s not our deal.' So go on and do whatever you want', you know, so … both of these issues [were] at play at once in different ways. (Policy Participant 05)

The above narrative illustrates the contradictions embedded within colonialism and how colonialism is enacted within health care funding institutions. On the one hand, a deep-seated distrust associated with the colonial constructions of the "Other" often renders Indigeneity hyper-visible while other aspects, such as Indigenous health care needs and expertise, are often overlooked—a dynamic that provides the grounds for government to abrogate accountability for Indigenous health at the same time as it legitimates paternalistic modes of governance, control and surveillance. In the following interview quote, an Indigenous participant in this study who was working in the area of Indigenous mental health and addictions provides an account that identifies one aspect of Indigeneity as consistently rendered invisible within health policy discourses:

> [Having the option to access] culturally appropriate kind of services ... is a right for First Nations people, it’s not, it’s not a gift that non-native

> people are giving us ... I honestly believe that it's our given right ... if that's what we specifically ask for because that's what we care for, if we don't that's fine too, but if we do, the result is we want that service to be there. [And yet] it's like a few white people think of it as giving us a gift of being able to use our ... own Aboriginal services. (Policy Participant 04)

Here the participant draws attention to Indigenous peoples' rights. In the participant's experience, the legacy of colonial ideology continues to be evident in the sustained paternalistic attitudes and beliefs of some policy-makers and funders that frame the public financing of 'By Indigenous Peoples for Indigenous Peoples' health services in terms of state benevolence or policy rather than a matter of "right;" for example, the right of Aboriginal peoples to provide their "own" services and the right to have access to Indigenous approaches to health and healing. This participant's account draws attention to Indigenous peoples' ongoing struggle for recognition of their rights.

Policy Participant 04's claim is clearly consistent with international law, and yet, as the policy review shows, the language of rights in relation to urban Indigenous peoples' mental health is conspicuously absent from BC's guiding 2013 First Nations and Aboriginal People's Mental Wellness and Substance Use Plan and Regional Aboriginal Health Plans. Perhaps not surprisingly, therefore, both Policy and Providers Participants in this study repeatedly pointed to the inadequate level of government resources that were allocated to programming for urban Indigenous [mental] health and addictions. Furthermore, most attributed the chronic underfunding of community-based Indigenous programming to institutional racism.

The next interview excerpt illustrates this point. Policy Participant 01 speaks about how the government tends to be more likely to "take the necessary steps" to ensure "the highest attainable standard of … mental health" for some groups than for others:

> Every few years there's a big suicide pact among Aboriginal people and … then the spotlight is on them … [because] they don't have any Aboriginal specific programs … they've got a program for eating disorders because wealthy west side parents are, you know, hitting at the premier like 'my kid is starving herself to death so let's get a program here for them' … but for Aboriginal kids taking their lives well … Who out of … our population is going to … have any sway with the Premier … That's really fundamentally the big issue here is that Aboriginal people don't have a, we don't have any economic value except for the land that we own. (Policy Participant 01)

The participant's account directs attention to how deep-seated, historically-mediated economic and political disadvantages are reproduced within the political economy of health care today. These advantages intersect with colonial patterns of cultural valuing to produce an inequitable distribution of health care resources and mental health according to class and race (and other axes of oppression). Considering the associative nature of most urban Indigenous communities in BC and their general lack of land claims, the above narrative and other similar accounts suggest the importance of examining how issues of voice, resource distribution and cultural recognition might position and disadvantage urban Indigenous peoples and organizations.

Next, I will discuss ethnocentrism as an expression of colonial ideology and how it operates through institutionalized patterns of cultural valuing within health care funding organizations, which continue to constitute Indigeneity as "Other" and reproduce paternalistic and neo-colonial relations of inclusion and exclusion.

5.1.2. Ethnocentrism: "The hospital is the king of health services and ... the Aboriginal community services are ... those wicked stepchildren that you hide in the corner" (Policy Participant 05)

In this study, a common thread across Policy Participants' discussions of government contracting for Indigenous mental health and addictions care was the worldview difference between Indigenous understandings and responses to mental health and those of the mental health care system, and the tensions and disjunctures imbued therein. In the following interview excerpt, an Indigenous Policy Participant speaks to the tensions embedded with the current practice of contracting that arise from the existence of these two different centres of cultural authority and the disconnect between them:

> [I]n health contracting and going back to the mental health … we don't even know how to contract with mental health and addiction services … you know, maybe a little bit around addiction … but certainly … nothing around mental health services. People don't know and understand our worldview so they will contract it out, not doing so well at that … they have no understanding of an Indigenous worldview and so how do you contract out something that you haven't got a clue about. (Policy Participant 01)

This participant's account suggests that one aspect of these tensions stems from the dominance of a Western biomedical worldview within health care institution and the attachment of this worldview to current contracting practices, which appears to manifest in an inability and/or unwillingness of funders to understand *how* Indigenous understandings and responses differ from those developed in keeping with the Western biomedical tradition.

As the above interview excerpt and those of other participants (for example, Policy Participants 04; 05; 06; 08) indicate, unraveling how ethnocentrism may be constitutive of routine practices in contracting, contractual policies and regulations, and act as a barrier to the recognition of Indigenous approaches to mental health and healing, offers an important contribution to the understanding how colonial relations have structured, and continue to structure, the provision of mental health care for Indigenous people. This point notwithstanding, the quote above also draws attention to the ways Indigenous people are reclaiming their expertise and authority in mental health programming, illuminating contracting for Indigenous mental health and addictions care as an arena where resistance is being mobilized. Thus, while it is important to create a better understanding of how power operates within contracting and ultimately impacts Indigenous peoples' experiences of mental health care, it is equally important for the analysis presented here to recognize Indigenous agency and understand how power is resisted.

The ideological embeddedness of the Western biomedical culture within the mental health care system—and the Indigenous struggle to gain recognition of and respect for Indigenous ways of knowing in relation to mental health—is further discussed by the following participant who identified as Indigenous and had many years of experience working for government,

> There is a pretty straightforward model that addictions and mental services … things outside of that were pretty challenging and the … program [I was promoting] was integrating sewing, … and button work, weaving, … craft, active things as part of our group therapy sessions. … [It] was led by a qualified therapist. The topics were all therapeutically valid, you know. It was, it was a well-designed program. … [But] Mental health services told me frankly 'oh well you're just paying for crafts' which really upset me (Policy Participant 05).

For this participant, the interaction described above illustrates the bias against mental health care approaches that draw on holistic conceptualization of mental health and value other forms of evidence, including people's lived experiences of mental distress and mental health care.

As the analysis reveals, models of mental health programming that align with Indigenous perspectives and epistemologies continue to be discredited because they threaten the authority of biomedicalism. Although Indigenous peoples are not the only group negatively affected by the dominance of biomedical discourses in mental health, the tensions between Indigenous understandings and responses and those that dominate the mental health care system are particularly pronounced. This situation has profound implications for Indigenous peoples' experiences of and access to culturally safe mental health and addictions care. For example, in the scenario above, although the program was set up and running, the program never received the necessary structural support and resources to evolve into "what … [the participant] had hoped the …program to be." In the following interview excerpt, an Indigenous participant with over 20 years of experience working within government in the area of Indigenous health explains why:

> if you read the history of mental health and addictions you know it changes every year depending on what the, the DSM-4 is asking for… We First Nations are relational people. Land-based programs were relational that's where the significant difference is, is the culture and being close to the land had a lot more meaning than some Western philosophical idea because everything in Western thought is compartmentalized, there's no, they don't put a relation between what your environment is and what you think. … The research from the Aboriginal Healing Foundation, they've come up with the same … Land-based programs in the mental health and addictions area were the most effective, they had the most meaning for the people. You know, mental health there's no Aboriginal language for mental health. (Policy Participant 08)

Here the participant calls attention to the ontological and epistemological disjunctures between Indigenous approaches to mental health and healing and the dominant practices and treatment models of the mental health care system in BC, such as the routine use of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as a diagnostic classification system.

In the experience of the participant above and many other Indigenous participants, there is little doubt that community-driven and culturally-informed mental health and addictions programs, such as land-based programming, hold more meaning to Indigenous people and are more effective than treatment programs based on psychiatric diagnoses and Western psycho-pharmaceutical interventions. The body of evidence produced by the AHF substantiates this view. The three-volume final report of the AHF concludes that while the funded Indigenous programs often drew on the strengths of both Western and Indigenous cultural elements, cultural interventions, such as land-based activities, storytelling, Elders' teachings, language programs, talking circles, drumming, singing, dancing, and harvesting medicines, to name just a few, were not merely "supplementary" to healing but "integral" (Brant Castellano, 2006, p. 148).

Elaborating further, another Indigenous participant, who had a long history of involvement in mental health reform with a view to Indigenous peoples, talked about 'culture as medicine,' as an emergent Indigenist counter-hegemonic discourse to the authoritative discourses of biomedicine:

> to change the public narrative about mental health and addictions … a big part of that public narrative … [has] to come from the Indigenous people themselves. And as you know, today we talk a lot about 'culture as medicine' and … how … being steeped in our culture really can make a big difference. (Policy Participant 06)

The same participant goes on to provide the following account:

> So … an Indigenous lens would … bring to the surface the culture … the way Indigenous people, at least, I talk today about 'imagining' and 'knowing' and 'doing' so that's the spectrum. Indigenous people want to be … innovative, … innovative in the way they do things because they're imagining a new way of being. (Policy Participant 06).

By framing Indigenous culture as dynamic and innovative, 'culture as medicine,' as articulated by the participant above, disrupts dominant culturalist and ethnocentric assumptions that often underpin contemporary notions of Indigenous culture (as for example, inferior to Western Euro-centric Culture and fixed in time). Moreover, it counters the epistemological exclusion of Indigenous knowledges and voices by decentering dominant-culture discourses and reclaiming the notion of Indigenous culture as a source of strength rather than of shame. In fact, it could be argued that the mere articulation of 'culture as healing' poses a threat to the hegemony of Western worldviews by disrupting its claim to universality and singular truth, thus making it vulnerable to critique. Further, the same participant goes on to explain the Indigenous vision that informs 'culture as medicine' as an Indigenist counter-discourse:

> [Indigenous people] don't want to fit in the same old government model …that …was so very illness disease, sickness focused. We are trying hard to focus on wellness, which is a … major paradigm shift in the way we imagine, think and do. (Policy Participant 06)

As the above account makes clear, 'culture as medicine' seeks a paradigm shift within health care towards a model not based on disease and deficiency, but rather on wellness. A wellness perspective also lies at the core of several key guiding policy frameworks within mental health, including, for example, Canada's national mental health strategy, *Changing Directions, Changing Lives* (2012), BC's First Nations and

Aboriginal People's Mental Wellness and Substance Use Plan, *A Path Forward* (2013) and the First Nations Mental Wellness Continuum Framework (2015). An excerpt from Canada’s national mental health strategy reads for example, "[i]n *Changing Directions, Changing Lives*, the approach to recovery has been broadened to include the concept of well-being" (p. 16). The strategy explicitly adopts an understanding of "[m]ental health ... [as] different from the absence of mental illness and ... integral to our overall health" to inform an approach to recovery that is oriented to support people who experience a mental illness to reach a point of recovery where they can live well rather than to cure people from mental illness, which is not always possible (p. 6). The inclusion of Indigenous ways of knowing thus has a particular relevance to current mental health reform objectives.

The language of recovery is absent in *A Path Forward*, which uses the language of wellness and healing instead. Compared to the concept of recovery, the notion of healing might be more apt at capturing the root causes of the mental health inequities that are affecting Indigenous populations. For example, colonization and ongoing neo-colonial policies and practices are recognized within the plan as social determinants of Indigenous mental health and well-being. In keeping with this understanding, the Plan identifies "interdependence, connectedness, self-determination, and autonomy for First Nations and Aboriginal people in BC" as its core guiding values and calls for the development of "mental wellness and substance use strategies and actions for First Nations and Aboriginal people [that] reflect individual and family needs and are Community-driven and Nation-based" (p. 14).

As these two policy examples suggest, Indigenous wellness perspectives are increasingly recognized as valuable for improving the capacity of the mental health care system to provide equity-oriented, safe and effective care for Indigenous and non-Indigenous people—even though the notion of wellness has a particular meaning within the context of Indigenous mental health. However, while the review of the current mental health policy environment seems to indicate a positive shift, Indigenous Policy Participants’ experiences of institutional life make clear that policies do not easily translate into transformative action or change on the ground, as exemplified within the next couple of quotes. In the following interview excerpt, an Indigenous participant who was working in mental health speaks to how the institutional policies and practices in mainstream mental health have remained focused on care for people with serious mental illness:

> [Community-based] mental health services … [they] kind of [have] a narrow kind of view on, on what their mandate is: People who are, have persistent mental illnesses, they're chronically mentally ill so they, they won't get better, they will not get better, that's their mandate and they don't stray from that, in fact they encourage me not to stray from that mandate. … It's just mental health is not just chronically mentally ill, it's [about] substance abuse … trauma … suicide … Even residential school is not taken into consideration, yeah. (Policy Participant 04)

The participant's account suggests that biomedical ideology remains deeply embedded within the culture and structure of the mainstream mental health care system and continues to play out in several ways: (1) a persistent focus on the mental health needs of people with a psychiatric diagnosis of a serious and persistent mental illness continue to preclude adequate attention to Indigenous people's mental health needs and the role that historic and intergenerational trauma, and other structural inequities play in shaping them; and (2) the ways in which entrenched paternalistic attitudes and pessimistic beliefs about people with a diagnosis of mental illness, and their chances of recovery, support the status quo and make recovery-oriented approaches as described above a hard sell in mainstream mental health .

A similar perspective is articulated in the following excerpt from an interview with another Indigenous policy participant.

> This is the oldest service situation, we don't have a health system, we have an illness system, an illness management system and anyone who thinks it's anything other than that doesn't understand the system. …The community health service providers are putting a band-aid on some of that trying to prevent some of that illness. There's a lot of information out there saying that effectively carried out prevention services work. There's not a lot of information out there about how to ensure that those prevention services are effective (Policy Participant 05).

While policy language in key guiding policy documents for mental health reform (both at the provincial and national levels) appears to be changing in ways that demonstrate improved Indigenous participation in policy, the ideological embeddedness of biomedicine and deep-seated historical relations within the mental health care system and society at large seemingly continue to render Indigenous needs, rights and perspectives invisible. Taken-for-granted discriminatory practices and policies reproduce structural inequities and constrain efforts to apply an Indigenous lens to mental health programming. For example, although Participant 05 acknowledges that there has been a lot of (policy) talk about the value of prevention, an interventionist bias continues, precluding any critical engagement with such questions as, what would effective preventative services look like and/or what structures would need to be in place to support effective prevention services and/or which policies would require redress? Here, a participant points out how one of the problems with current approaches to contracting out Indigenous mental health and addiction services is that there is no room for prevention.

Reflecting on years of experiences working for government both at the provincial and regional levels, the same participant goes on to explore this line of argument further by discussing the impact of biomedicine on mental health care funding for community-based organizations:

> It was challenging all around for community services because the hospital is the king of health services and has the most money and has the most prestige and therefore the most power so community health services are the poor step child of the hospital system and the community service providers are the poor step children of the community health services. And the Aboriginal community services are, you know, those wicked stepchildren that you hide in the corner. You know, so it, it's hierarchy again. (Policy Participant 05)

Here the participant speaks to the ways in which health care spending is shaped by the ideology of biomedicine. As the participant explains, in the hierarchical funding structure of health care spending, the hospital, symbolic for the power of biomedicine, rules like a "king" that claims the lion's share of funding while marginalizing those health care organizations which do not necessarily abide by the rules of dominant health care culture. Moreover, as the participant's account suggests, while non-profit organizations (NPOs) are generally poorly funded, being an Indigenous NPO adds another layer of discrimination. In the experience of this participant, Indigenous NPOs are positioned at the bottom of the funding hierarchy. Specifically, while the participant's quote seems to imply that government funders approach contracting with third sector organization, generally speaking, with a certain level of distrust, the participant's description of Indigenous NPOs as the "wicked stepchildren" suggests not only a particularly deep-seated mistrust against Indigenous Providers but also the passing of moral judgement. The same participant elaborates further,

> When it's an NGO it's looked at much more in detail and with much more criticism than it is when it's within the ... health's authority own system. If it's an Aboriginal NGO on top of that they are castigated much more strongly and reviewed much more heavily than the general NGO would be and that's down to racism. ... The issue is that the

> Aboriginal population is reviewed much more intensely and expected to fail much more frequently. (Policy Participant 05)

In the view of this participant, the social disadvantage that Indigenous NPOs face is compounded by the intersecting effects of biomedicine and colonial processes of Othering. While colonial stigma presumably conjures up historically mediated and racialized images of Indigenous people as inherently disorganized, dysfunctional and potentially corrupt, ethnocentrism fuels the denial and denigration of Indigenous approaches to mental health and addictions care as credible, and potentially more effective, approaches to care for Indigenous people. In this process, organizations' cultural identity comes to be viewed as a liability.

5.1.3. Section Summary

While the analysis presented here only begins to illuminate the ideological embeddedness of contractual relationships between government funders and Indigenous Providers, the above discussion clearly elucidates how colonial and neo-colonial relations structure the wider institutional context in which Indigenous health policy and funding decisions are made, through the ways paternalistic and ethnocentric ideologies continue to be enacted within taken-for-granted, discriminatory institutional processes, policies and practices. These deep-seated historical relations create situations of cultural risk for Indigenous peoples working within both health care funding institutions and NPOs—and ultimately, for Indigenous people seeking mental health and/or addictions care—through deeply entrenched institutionalized patterns of cultural valuing that continue to privilege Western biomedical frameworks of mental health while silencing, discrediting and de-valuing Indigenous voices and perspectives. As the analysis suggests, paternalism and ethnocentrism intersect with the cultural hegemony[24] of biomedicine to blind policy decision-makers and others working within health care institutions to the assimilationist ethos that continues to be embedded within institutional governance structures and underpin policies and practices of surveillance[25]. However, in

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[24] I use the term hegemony to denounce the ways power or control can be exerted not only by force or active coercion but through dominant assumptions, beliefs and attitudes that have come to be taken for granted. Gramsci introduced the notion of hegemony in the 1930s to describe the "power of the ruling class to convince other classes that their interests are the interests of all" (Ashcroft et al., 2007, p. 95)

[25] Systems of surveillance have historically functioned, and continue to function, as powerful mechanisms of colonization and neo-colonialism (Ashcroft et al., 2007; O'Neil et al., 1998).

keeping with Foucault's (2000) careful observation about power and resistance, the data also illustrate that hegemonic dominance is never absolute but always contested through counter-hegemonic ideas and practices (i.e., culture as medicine.) as well as constantly shifting in response to ever-changing social, political, economic, and historical contexts.

5.2. (Neo)-Liberalism: "It's a real political dance" (Policy Participant 05)

Analysis of Policy Participants' discussion of contracting in Indigenous health also revealed the importance of analyzing how the meaning of contracting is constructed within particular political contexts. This point is illustrated in the following excerpt from an interview with an Indigenous Policy Participant:

> [The way funding or contracting is approached] depends on the contract manager, it depends on the particular government in power … lots of different factors come into play. … It depends on whether they want to have community services provided or they want to centralize community services. I've gone through several cycles where, you know, everything is contracted out, everything is pulled back … it's a real political dance based on a huge number of factors as to which the balance swings towards. (Policy Participant 05)

Here the participant draws attention to the broader political agendas driving health care reform and governmental contracting in BC. In BC, regionalization has been the focus of health care reform since the early 1990s. However, while regionalization is commonly associated with the decentralization of health care and devolution of responsibility, the participant's comment above suggests that the implementation of regionalization in BC has not been straightforward and involved conflicting political discourses that have given rise to both decentralizing and centralizing forces, with implications for the way funders approach contracting in health care with Indigenous non-profit organizations (NPOs).

Another Indigenous Policy Participant's account further adds to the discussion by providing a perspective on the regionalized governance structure currently in place within BC:

> So money comes in from the Ministry into [name of health authority]—'here's your bucket of money you need to do this, this and this with it'—it's already scripted for the most part. We're just a brokering agent ... A lot of it is outsourced so we don't own and operate every single residential care facility that's not the way it works anymore. (Policy Participant 07)

This participant's statement suggests that while regionalization has led to an increase in health care contracting, it has not resulted in a devolution of decision-making power but rather in the creation of a governance arrangement according to which the role of health authorities appears to be little more than "a brokering agent" between the interests of the Ministry of Health and those of third party contracted providers.

To explore these contradictions further, I now turn to the findings of the policy review. The following is an excerpt taken from the 1991 *Closer to Home* Report by the BC Royal Commission on Health Care and Costs (RCHCC), which served as the key guiding policy document in the development of the 1993 New Directions Policy, under which regionalization was first implemented:

> [T]he ministry [of Health] has delegated very little of its authority away from Victoria; it has very few mechanisms for involving interest groups in its operation … and … applied one set of rules to the whole province. The ministry believes that this management style promotes equality. This commission disagrees. Decentralization will shift a portion of the decision-making power away from Victoria, substituting several regional authorities for one centralized authority. Decisions which affect the whole health care system will still be made centrally in this decentralized system, but those that depend on regional differences will be made locally. In this new system, regional general managers will be responsible for the planning and delivery of all health care services within the regions and will report to a senior assistant deputy minister. They will receive their authority from this minister, who, in turn, will be responsible for ensuring that the people in the regions receive the planning and organizational support needed for effective service delivery at the regional level …This will result in a more efficient and cost-effective system (pp. B36-B37).

Here, the political discourse clearly espouses the values of equality, fairness and justice, suggesting political liberalism as the ideological origin of regionalization in BC as well as its scope, impetus and goals. Now consider this policy quote taken from a government document that was released a decade later by the then-newly-elected Liberal Party. The document was published in 2002 under the title, *The Picture of Health: How We Are Modernizing British Columbia's Health Care System,* and it reads as follows:

> Prior to January 2002, B.C.'s regional health structure was the most complex in Canada, with 52 health authorities throughout the province. Now there are six: five representing geographic regions and a provincial health authority to coordinate and deliver specialized health services to the entire province. By creating a more streamlined, cost-efficient, effective and accountable governance structure for health care in B.C., more resources can flow to patient care as a result of lower administrative costs and fewer bureaucratic hurdles. In delivering the full continuum of care to their local residents ... the five regions now have the flexibility to

> make decisions about what programs and services best meet the needs of local people. That means health services that are more responsive to local needs, and better accountability to the people health authorities serve (BC Ministry of Health Planning, 2002, p. 21).

While the language of citizen engagement seems to have been lost, the commitment to accountability, cost-efficiency and effective service delivery appears to have remained outwardly the same. However, a closer look reveals a subtle but noticeable difference in the composition of the political rationale underpinning the call for regionalization.

According to the *Closer to Home* Report, decentralization of governance structures was to lead to improvements in the accessibility and responsiveness of health care services by enhancing democratic accountability within health care decision-making through increased opportunities for citizen engagement. Gains in terms of cost-efficiency and effectiveness were anticipated as a result. Within *A Picture of Health,* this logic seems to be inverted. Better streamlining and cost-efficiency emerge as the new priorities, and it is in the process of realizing these objectives that public sector accountability and effective service provision are expected to improve.

Thus, while the meaning of accountability in *Closer to Home* is premised on local participatory democracy and citizens’ empowerment, the assumptions underpinning the notion of accountability and the kind of political subjectivities invoked within *A Picture of Health* are quite different. Rather than constructing a politicized version of accountability, *A Picture of Health* appears to define the meaning of accountability in terms of better resource management (i.e., "more resources can flow to patient care" and "lower administrative costs"), revealing a discursive shift from political accountability towards an administrative or managerial type of accountability and an increasing concern with cost-efficiency that are typical of neo-liberal ideology.

Having examined how political discourse underpinning regionalization in BC has shifted policy discourses in the arena of health care reform, I now return to the central question of how these changes have shaped the practice and meaning of contracting with Indigenous Providers, as claimed by the participant above. I ask how contracting with Indigenous providers has been conceptualized differently within the different political and policy discourses in BC across time, and how these different conceptualizations are implicated in the construction of Indigenous subjectivities. Accordingly, I return attention briefly to the time when regionalization as BC's focal point of health care reform was first conceived, and more specifically to some of the recommendations put forward on "Native Health" within the Royal Commission's *Closer to home* report. To quote from the report, the commission recommends that:

> - the government consult with and involve Native people in the design, development and implementation of programs, services or policies for Native people;
> - the office of the Chief Native Advisor for Native Health be made into a separate branch within the Ministry of Health with its own assistant deputy minister; [and]
> - the Ministry of Health support the development of Native-controlled health services, including services to urban Natives. (BC RCHCC, 1991, p. C-28)

Notably, the above recommendations call not only for improved Indigenous participation and decision-making power within local health authorities and higher-level government, but also for the development of urban Indigenous-controlled health services, revealing the direct connection commissioners seemed to see between increased Indigenous decision-making power and the development of "[c]ulturally appropriate programs which meet the needs of the community" (BC RCHCC, 1991, p. C-27). Within this particular context, contracting with Indigenous community-based organizations for the provision of Indigenous mental health and addictions services appears to be conceptualized as a strategy to empower Indigenous community-based organizations by devolving decision-making power and "control over how and what services are delivered" and it is expected that the strategy would improve the provision of effective "culturally appropriate" services (BC RCHCC, 1991, p.C-27).

At the same time as the language of citizen engagement seems to promote Indigenous aspirations for self-determination and governance, references to Indigenous peoples' inherent rights remain missing. This point is advanced further in the following excerpt from an interview with an Indigenous policy participant, who discusses the commonly expressed attitude that Indigenous peoples are just one interest group among many as an example of the discursive forms of democratic racism,

> in the current … political situation of Canada people are feeling very safe to start off racially at Aboriginal people, right because [former Prime Minister] Harper is not exactly in support of … [Aboriginal issues] and people … feel quite safe saying … that we are just one interest group, [and] we have lot of other interest groups here too. … I was at a [health] leader's meeting [at a provincial body] and there was about two hundred people there and I heard that a couple of times. … people … they see us as a special interest group or, you

> know, we want special services or special treatment or whatever. They don't have any understanding or analysis of … colonization. (Policy Participant 01)

By constructing urban Indigenous peoples as one interest group out of many, dominant interests are sustained and reproduced by, for example, constructing political support for policies and practices that might redress the health and social inequities affecting Indigenous peoples as a form of preferential treatment that conflicts with and threatens the egalitarian principles of liberal democracy. Hence, interest group rhetoric facilitates the obfuscation of Indigenous peoples; rights-based entitlements and the continued abrogation of government responsibility for improving Indigenous mental health. Moreover, as the above participant's account suggests, the discourse of interests groups is complicit with prevailing negative attitudes and resentment towards Indigenous people for having entitlements that other Canadian groups 'lack.' As the experience of Participant 01 and several other participants in this study suggest, while this kind of racist attitude is not uncommon; it appears to be expressed even more freely within a neo-conservative, neo-liberal context (at the point of the interview, Canada's Conservative Party was still in office).

In the following interview excerpt, another Indigenous policy participant elaborates further by describing a shifting political climate in Canada and its impact on Indigenous–state relationships more broadly,

> There's been a lot of cuts lately I think because of all the New Liberalism … there's a book now I believe his name is Bernstein he was interviewed on CBC and he wrote about Harperism which he's saying is a parallel … to Thatcherism and to Ronald Reagan. And, and so there are a lot of cuts, unilateral cuts. The Aboriginal Healing Foundation when that program was cut there was a lot of resistance to that cut because now people were starting to make progress, they were starting to recover and, you know, make, find hope and recovery and that got cut. … So I think … there's a big concern in our community that we're going to lose funding and maybe funding opportunities to support … our everyday health and healing strategies that seem to be working (Policy Participant 06)

The participant's account draws attention to increasing ideological influence of the "New Liberalism" or 'neo-liberalism' on Canadian public policy. At the same time, the above account suggests that neo-liberalism does not function as a "coherent corpus" (Larner, 2000, p. 10) but rather that exerts power through the enactment of different strands of ideological thought and liberal discourse. As the participant explains, under the Conservative administration of Stephen Harper (2006–2015), neo-liberalism emerged as an ideology of the “New Right” in which the central tenets of neo-liberalism are brought together with the more traditional values of family and nation emphasized by conservative ideology to create powerful oppressive conditions for Indigenous peoples. Given the relative importance that conservative ideology places on the nation-state, Aboriginal rights and title tend to be inevitably perceived as a threat to Canada’s sovereignty as a (settler) nation-state. When the resulting anti-Indigenous sentiment is then enacted together with neo-liberal discourses of the minimal government and fiscal accountability, new forms of state-sanctioned dispossession and democratic racism emerge that reinforce and perpetuate neo-colonial relations. As the participant above points out, in Canada this dynamic has amounted to the loss of the Aboriginal Healing Foundation. The decision to not renew funding was executed despite strong opposition from both Indigenous and non-Indigenous leaders and organizations across the country and rigorous evaluations of the funded community-based healing projects demonstrating strong evidence of the positive impact of these initiatives on healing.

While Harper’s conservative government has since been replaced by a Liberal Party leadership, the participant's account seems nonetheless relevant to the current understanding of the macro-dynamics of state–Indigenous contracting, as the data of this study make clear that an analysis of neo-liberal ideology is key to understanding how contracting might unwittingly be implicated in sustaining and/or contributing to colonial and neo-colonial relations. For example, as highlighted earlier, both mistrust and funding shortages remain pressing issues for urban Indigenous NPOs.

This line of argument is expanded further in the following account by the same Indigenous policy participant, who was previously quoted on the impact of regionalization on government contracting in Indigenous health,

> One of the great fallacies of service provision is that contracting out will reduce costs … the Ministry was using a business model … Health doesn’t really work quite the … same way despite the fact that the Ministry and the Health Authority to a certain extent doesn’t want to believe that. … So you’re expecting whoever you’re contracting it out to, to be able to provide the same service for less money. The only way you can do that is by having less staff, having less qualified staff, providing fewer services in a more general way even though your contract may say you’re providing the same services and having non-unionized staff. … So this is the government’s way of de-unionizing everything. (Policy Participant 05)

Here the participant exposes contracting as a quintessential element in the repertoire of New Public Management (NPM), in which contracting is primarily seen as a strategy to save and contain public sector costs. However, as criticized by the above participant, while this logic might be applicable to some sectors, it certainly does not apply to the health sector; health services are unlikely to improve in quality as a result of cutting wages and benefits of those who are responsible for providing the care. The above narrative highlights a central paradox underpinning government contracting with Indigenous providers that can be directly traced back to the growing space that neo-liberalism is occupying within the institutional policy and funding environment of government. This is a paradox that might account to some extent for the inadequate funding levels of community-based Indigenous programming reported by participants in this study.

An Indigenous policy participant who was working within a health authority elaborated further on the impact of neo-liberalism on institutional structures and Indigenous health programming, stating,

> It's … tough … because … the structures like from the Ministry of Health on down are so rigid … to change a small thing even like, you know. I always say it was so funny I was a bit naïve maybe like I'd never worked at a health authority before and I was like asking all these crazy questions … like why do we have to have a zero budget at the end of the fiscal year? … Population Health outcomes are twenty-five years long why are we tied to this crazy service industry? I understand why a hospital does or whatever but we … have to fit into the same mold and I don't … get stuff like that … how come nobody is talking about poverty? … There's an economic gradient in every health concern, you know what I mean? So the way of thinking and people become like part of the institution over time. (Policy Participant 02)

Here, the participant conveys several tensions related to the ways in which neo-liberal ideology and NPM discourse shape institutional structures, processes and practices. Health authorities have adopted a strong corporate culture characterized by: (a) an accountability model defined in fiscal terms rather than population health outcomes; (b) an inattention of health authorities to developing interventions that address the social determinants of health despite evidence of the role of social inequities in health; (c) a steep degree of organizational hierarchy which makes affecting institutional change very difficult; and (d) processes of assimilation through which employee perceptions, behaviors and understanding are assimilated into the institutional culture.

It is perhaps unsurprising, therefore, that participants' accounts highlight NPM as a neo-liberal mechanism that seems to compound the tensions and discriminatory effects associated with the political processes attached to colonialist ideologies, such as paternalism and ethnocentrism, and in particular biomedicalism, revealed by the data in this study. This point is illuminated further in the following interview excerpt with the same participant,

> I know the population public health people at [health authority] and the Ministry of Health are very interested in doing equity work but their equity work is quite superficial. They always want to go for the easy win like oh let's just put a training thing up on the pod, it takes half an hour and then people know more about equity great like don't get me wrong it's great. But where's the accountability in our performance evaluations in like manager skills they just don't exist. (Policy Participant 02)

While the participant acknowledges that some efforts are being made towards advancing the equity competence of the health care sector, these initiatives seem to be based on a very superficial understanding of equity and thus fall short of addressing those structures, policies and practices that produce and reproduce colonial and neo-colonial relations within health care institutions. This tendency to persistently oversimplify complex political concepts such as equity, and thus sabotage their operationalization despite repeated outward commitments to build a culturally competent health care system with a sufficient equity focus, points to the ways in which dominant ideologies constrain and/or limit critical thinking about and understanding of how inequities are structurally produced. As reflected in the discussion leading up to this point, neo-liberal discourses support an individualistic and de-politized ideological point of view in which accountability is viewed as unidirectional and seen in administrative/managerial terms. As the participant above explains, in the enactment of such a principal-agent type of accountability relationship, system or institutional accountability is rendered invisible.

5.3. Concluding Comments

By starting with an analysis of the different ideologies that operate at the macro-level of politics, this chapter has discussed the social, cultural, historical, political, economic and institutional context in which government contracting with Indigenous providers for mental health and addictions care unfolds. It thus lays the groundwork for an examination of how these power dynamics shape and are shaped by the politics of contracting at the meso- and micro-level (Chapter Six and Seven, respectively).

In keeping with this focus, in the analysis presented in this chapter, I have used the voices of (primarily) Indigenous policy participants and examples from the review of key guiding policy texts drawn from the provincial, national and international levels. This discussion has made explicit some of the workings of political and colonial ideologies that continue to pervade the wider institutional structures and everyday policies and practices of health care funding environments in BC, illuminating contradictions and inconsistencies within and between policy texts and Indigenous experiences of everyday work. In keeping with the work of Teghtsoonian (2003), who describes "the relationships between ideology, institutions and policy ... as complex and recursive" (p. 26), this analysis has provided insights into the ways in which these ideologies relate to institutional structures, policy discourses, practices and subjectivities. Rather than simply impacting policies and practices, the analysis reveals how ideological processes actively re-create the "Other" in colonial terms. Ideological processes embedded within the structure of health care funding institutions continue to constitute Indigenous people as

- discredited subjects requiring outside governance;
- deviant and/or dangerous subjects requiring monitoring and surveillance;
- undeserving subjects of public policy (and resources);
- medical subjects and consumers of health services; and/or
- invisible and/or universal subject (Allan & Smylie, 2015; De Leeuw et al., 2010; Fiske & Browne, 2006; Fiske & Browne, 2008).

Despite ongoing processes of contestation by Indigenous people, the enactment of such colonial images and ideologies within institutional structures, policies and practices have created different layers of stigma, discrimination and social disadvantages for Indigenous people. As "the wicket stepchildren" to the hospital king, “undeserving” Indigenous NPOs are not only discredited but also constructed as potentially dangerous. As a consequence, Indigenous Providers tend to be not only positioned at the very bottom of the funding hierarchy but also subjected to higher levels of scrutiny and surveillance than their non-Indigenous counterparts. Further, there is evidence that Indigenous voices continue to be silenced while Indigenous rights and needs are rendered invisible, and Indigenous understandings of and responses to mental health and healing are judged illegitimate and/or inferior to those derived from dominant Western systems of knowledge production, such as biomedicine. Furthermore, analysis suggests that contracting itself serves as a discursive strategy, as became evident in a series of tensions arising this chapter. A particularly salient tension emerges from the ways in which contracting is simultaneously constructed as a New Public Management (NPM) costing strategy, a paternalistic and assimilationist mode of governance as well as a decolonizing tool for promoting equity in mental health care for Indigenous peoples. My next task is to explore how these ideological tensions and their oppressive effects play out at the meso-level.

Chapter 6. The Meso-Level: Mediating Structures, Policies and Practices

The analytical gaze of this chapter rests on the meso-level of contracting—that is, institutional structures, policies and practices that mediate between governmental funders and community-based Indigenous organizations. I ask: what are the specific institutional structures, policies and practices involved? How do the ideologies identified in Chapter Five operate at the meso-level? And how does the meso-level promote and/or constrain equity in mental health for Indigenous people in an urban context? Drawing on the voices of Policy and community-based Provider Participants, as well as examples from the document review, I show that texts, including Indigenous health plans, policies and funding applications, mediate the impact of wider ideological contexts and often obscure their oppressive effects behind a discursive rhetoric that seems like common sense. In this way, I locate important points of tension between policy objectives and lived experiences. The chapter is divided into three main sections as follows:

Section 1: The Political Economy of Contracting in Indigenous Mental Health, a critical analysis of distributive issues affecting current approaches to contracting.

Section 2: The Politics of Inclusion. Here, I analyze multiple dimensions of the inclusion of urban Indigenous Providers in contract negotiations.

Section 3: A Politics of Account-Ability and Response-Ability. This final section explores performance management (PM) as a mediating practice.

6.1. The Political Economy of Contracting in Indigenous Mental Health

A salient theme in most participant interviews was resource allocation. The following comment by an Indigenous Policy Participant provides an opening to the discussion:

> We’re a native organization … we’re working for our people like, you know, we want to work for our people. You give us this chunk of money and we’re going to provide that kind of service for them whether it be children or youth or, or adults with substance abuse kind of issues and stuff—we want to provide those … culturally appropriate kind of services. And unfortunately, you know, the funders are gonna

> see that as 'well we'll give you some funding' and, you know, 'we'll give you like, you know, thirty percent of what you're asking for because, you know, we have other kind of cuts that are coming.' We have a number of organizations too that are applying for the same dollars so all of a sudden we're fighting with each other in order to get those same dollars, which is not very helpful. I mean to have four to five kind of substance abuse kind of organizations that are applying for the same dollars because they're substance abuse money. Well, you know, everybody wants their organizations to feel safe and … we shouldn't just have one native organization providing substance abuse kind of counseling for the whole city I mean that's not right. We should have, we should have a choice of whatever one we want to go to. (Policy Participant 04)

The participant draws attention to several issues with the current funding regime and its ties to neo-liberal ideology. First, in the experience of this participant, funding tends to fall dramatically short of what organizations say they need. Other participant interviews, as well as the contract review, substantiate this insight. The contract review showed that the overall value of the awarded contracts routinely failed to match Providers' budget projections. Similar findings were also documented as part of a 2006 independent evaluation of an Indigenous granting program—the Aboriginal Health Improvement Projects (AHIP)—undertaken within one BC's regional health authorities (Mussell, 2006). The participant quoted above also critiques competitive funding models that pit Indigenous organizations against one another. Likewise, many Provider Participants saw competitive contract tendering techniques as complicit in the reproduction of inequitable funding and discriminatory outcomes. Further, as the quote highlights, contracting is a practice. It thus needs to be interpreted within a particular social, cultural, political, and economic order where neo-liberalism has become hegemonic. The quote thus provides important clues about the kind of discourses that are constitutive of contracting practices.

The discussion that follows offers insights how these and other discourses operate within and through contracting to sustain, reproduce and perpetuate inequitable resource distribution along the lines of gender, race, class and social disadvantage for urban Indigenous non-profit organizations (NPOs) and communities.

6.1.1. The Politics of Distribution: "Is it because we're an Aboriginal institution that we have to be in this kind of contract ghetto?"

While contracting in health care with Indigenous NPOs has been framed as a mechanism to improve access to culturally safe mental health and addictions services for Indigenous peoples, analysis reveals that contracting has not actually resulted in resource distribution according to need. As one Indigenous participant with an Indigenous NPO noted,

> There's a huge number of young people in our community and, and young people that come to [name of the city] … that have huge, huge issues in terms of … drug issues and addictions and those kinds of things, right? So there's a huge need for those programs as well … [for] all of them there's a need to have increased services … I mean what I'm saying isn't much different than what any other ED would say, you know, that there is a need to have increased resources so, yeah. (Provider Participant 09)

These comments highlight the gap between communities' mental health needs and current funding. While this problem is not unique to the Indigenous context[26] this participant's account calls attention to contextual features that render Indigenous people, and in particular Indigenous youth, more vulnerable to the effects of funding shortages, such as (a) the disproportionate burden of mental ill-health that Indigenous communities, and in particular Indigenous youth, face compared to the general population; (b) the higher rates of mental health *and* addictions issues experienced by many Indigenous people and youth compared to non-Indigenous groups; and/or (c) the increasing number of young Indigenous people who are leaving their home communities to live in urban areas, with attendant loss of on-reserve support. Another community-level participant, a non-Indigenous person, who worked at the same NPO as the above participant and was responsible for overseeing mental health programming, said,

> There's never enough money and every program you talk to would say that. But if you look at the population we're working with like not every program in town is working with high-risk Aboriginal families. And we do lots of outreach, we go to people's houses, we pick up kids from school so those kids can access a program because they can't make it here, they have no car, they don't, they can't use a calendar, they don't have those life skills. So when you're working with families like that it's usually because they've been through lots of trauma and loss and have complex mental health issues related to that. So personally I don't think it's appropriate for someone like that to sit on a wait list. And I know every program doesn't want to have any list but it just it doesn't seem appropriate. The wait lists for child and youth mental health is about eight months and, of course, we prioritize the most needy and complex and children in crisis to get service. But almost all of the families that are referred to that program are like complex trauma kind of kids. (Provider Participant 04)

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[26] It is not uncommon for young people in Canada to wait a year or longer to receive mental health care (Canadian Mental Health Association, 2017).

This participant highlights the ethical ramifications of the current funding regime, including the normalization of waitlists in mental health and addictions care. Again, while they acknowledge that waitlists pose an important ethical issue generally, they argue that within the Indigenous context, the problem is compounded because (a) the mental health needs of many Indigenous families are enmeshed with trauma and social suffering (i.e., inequities shaping the lives of many Indigenous people); and (b) access to alternative mental health services is limited, given that "not every program in town is working with high-risk Aboriginal families."

Another non-Indigenous participant, who was working as a mental health provider out of an Indigenous NPO, elaborated on this lack of choice.

> At [name of NGO] where I used to work if they [clients] couldn't come to our centre we shut the file before we opened it. And there was no intent but we limited ourselves to middle class families … If a [person] … had an alcohol or drug issue… they would be sent to [different services provided by the health authority] … Because at [name of former employer] if anybody had a drug and alcohol issue they weren't allowed to be a client. (Provider Participant 05)

In this account, those most in need of mental health social services and supports are routinely excluded from help due to discriminatory practices within mainstream mental health care organizations, and because intake policies ignore the socio-historical, economic and political context of people's lives. Although the participant's critique here is directed at mainstream mental health care organizations, similar patterns seem to be replicated in mental health and addictions *funding*. Indeed, the picture painted by the Provider Participants in this study suggests that the vision outlined by BC's 10-year First Nations and Aboriginal People's Mental Wellness and Substance Use Plan (2013) remains a distant reality for urban Indigenous communities in BC.

Current patterns of resource distribution can be interpreted, at least in part, as a manifestation of the ongoing dominance of biomedical ideology within the health care system. However, biomedical thinking is not the only ideology at play. The following observation by a participant, who worked as an administrator (and provider) within an Indigenous NPO, calls attention to the growing influence of neo-liberal ideology on government contracting with Indigenous NPOs in mental health: "what we're finding is everything is being cut and cut and cut…" (Provider Participant 19). Most organizations in this study faced severe funding cuts at the time of the study. While not all organizations reported having lost programs due to funding cuts, the data make clear that the threat of cost cutting was omnipresent. In the above scenario, the harsh reality was that “almost all our funding in some way has been cut back” (Provider Participant 19). Thus, rather than finding evidence of a closing gap between funding and needs, the data in this research point to the existence of widening fault lines based on race, class, and historical and neo-colonial relations.

In fact, this work shows biomedicine and neo-liberalism operating together within contracting to reproduce a system of resource distribution that discriminates against and disadvantages urban Indigenous peoples. An Indigenous participant who sat on the board of another Indigenous NPO narrated how the organization lost one promising program:

> We … did have three but the government cut one and it was a very important one … It’s really tough to get any money and so they cut the [name of program] and we were doing so much good work there and they cut it. … They just said that they don’t have the dollars—it’s pretty, pretty cut and dried. We don’t have money for this but yet it was very successful we were just getting off the ground and momentum was going. And then I guess maybe they didn’t want us to become successful [laughing] … (Provider Participant 21)

This participant viewed the program in question as an essential component of the overall program environment, and saw its termination as profoundly unjust. This injustice was exacerbated, in their view, by the funder’s dismissal of the organization’s concerns. Other participants provided similar accounts, demonstrating that a funding system that denies negotiations and reciprocal accountability between Indigenous provider organizations and government funders creates distrust. As in the scenario above, other participants described funders using the rationale that public resources were too scarce to continue program funding. This had the effect of shutting down the possibility of mutual and respectful dialogue about the value of a program and/or the potential harms of losing it. The elusive nature and claim to moral superiority of this ‘ideology of scarcity’ makes it difficult to challenge and masks the ethical issues arising from it. The same participant went on to discuss, with a sense of urgency, the ethical consequences of the loss of funding for the program mentioned above.

> You’re raising your family on a shoestring budget … [a reality] mostly [for] single parents [but] even [for] two parents [so] how are you going to offer them services and hope and tools when, when there’s not enough dollars to run it? (Provider Participant 21)

To appreciate the seriousness of this insight, it is important to note that the program that was cut provided services and support for Indigenous women and their families with experiences of partner violence, a social group that—as the participant above alludes to—is particularly vulnerable. Race, class, gender and colonialism intersect to create powerful oppressive conditions that position Indigenous women at higher risk than any other social group in Canada of experiencing interrelated issues of violence, trauma, mental health and addictions, and poverty. Thus, the termination of this program is consequential. Without access to health and social services and supports, women might be placed at risk for ongoing abuse. Moreover, as the above participant alludes to, unilateral decision-making to terminate funding for Indigenous community-based programs also enacts violence at a symbolic level by conveying the message to people(s) that their health and wellbeing does not count.

The ethics of current funding arrangements are further discussed in the following interview excerpt:

> [Mainstream NGO] … they have more resources … and they're seeing middle class kids so … they're not seeing the kids that really need to be seen and it's not a White issue, it's not an Aboriginal issue, it's a 'let's look at the most needy children out there' and a service like [mainstream NGO] has psychiatry several times a week and has psychological assessments so they are testing several times a month and we just now got psychological testing. And we can test one person a month so we have like ten percent of the services that, the only other game in town has. (Provider Participant 05)

This participant's narrative points to an injustice: an unfair distribution of resources for mental health programming between Indigenous NPOs and their mainstream counterparts. However, an internal contradiction arises. On one hand, the participant is arguing that the Indigenous organization receives a fraction of the funding allocated to the mainstream mental health Provider, though the former meets a greater need. On the other hand, the participant opposes the idea that this funding discrepancy is the result of wider racialized inequities within society, insisting instead that the issue is framed in purely distributional terms based on individual need.

Several other Provider and Policy Participants (Provider Participants 09; 10; 11; 17; 18; 21 and Policy Participants 01; 05; 06; 07) argued that funding practices were discriminatory, including the following Indigenous Policy Participant, who used to work as a contract manager within government,

> Most of these contracts look expensive even though when you analyze how much money per person or per agency was being disseminated for Aboriginal health it was way, way less per person than any of the other contracts were getting. (Policy Participant 05)

Similar to Provider Participant 05, this participant's comment points to the existence of a funding disparity between Indigenous and non-Indigenous Providers of mental health care. However, in explaining what drives such practices, this participant argued along a slightly different line:

> Most of the aboriginal organizations were non-unionized, most still are as far as I'm aware. And therefore 'I'm sure they can charge less for, for staffing in some ways and therefore should be able to provide [the same service for less money].' And this is kind of never spoken about but certainly the overall theme that both the province and the region have in terms of their contracting out generally but also very particularly with aboriginal services … is a race-based, educationally-based, classist sort of thinking … and it never gets talked about, 'Oh no, we wouldn't do that, we're fair.' (Policy Participant 05)

From the perspective of this participant, existing funding inequities have to be interpreted within the intersecting contexts of neo-liberalism, race, class, and education. Inequitable access to educational and economic opportunities as a consequence of the interlocking effects of racism and past and current colonial policies and practices intersect with neo-liberal government policies to create social and economic disadvantages for Indigenous Providers—at the levels of both programming and workforce. The dominant lens of distributive social justice not only fails to capture these issues, but indeed, it helps to mask them through its overly individualistic view.

Hence, the interpretation that current inequities in funding distribution are a matter of inadequate attention to individual need must be second-guessed. While a distributive justice framework might seem appealing for its avoidance of antagonism due to political sensitivities surrounding issues of Indigenous 'entitlement,' the findings of this study suggest that it might perpetuate rather than challenge the status quo. Ultimately, this framework promotes the idea that social justice can be pursued without disrupting the underlying root causes that give rise to the unfair distribution of—and inadequate attention to—Indigenous need in the first place. Which is not to say that need does not matter. To the contrary, this study's data confirm that a focus on need is missing and ought to be included in the distribution of mental health service contracts.

A non-Indigenous participant responsible for directing an Indigenous NPO provides another account of how issues of race, class, culture and education play out in contracting in health care with Indigenous Providers:

> [The question] we keep putting forward to the [funder] is why … our … full time [provider] who's been with us here for thirty years … [is] making fifty-five thousand dollars a year whereas at [name of

> mainstream institution] they would be making almost eighty thousand dollars a year. So we have this … disparity and it's almost like a human rights issue. Is it because we're an Aboriginal institution that we have to be in this kind of contract ghetto where we're making so much less? (Provider Participant 18)

Contrary to the idea of contracting as an equity-promoting mechanism, this participant argues that contracting has, in fact, been instrumental in the economic marginalization of the Indigenous NPO sector and the creation of an Indigenous "contract ghetto" marked by low wages and wage inequality. In resonance, nearly all participants interviewed in their role as mental health providers said they were paid significantly less when working in the Indigenous non-profit sector, where their wages were based on health service contracts, than providers holding equivalent positions outside the sector. To the participant quoted above, the inequities in wages between Indigenous and non-Indigenous organizations represent a violation of human rights. Yet funders refuse to acknowledge the problem. The same participant considered why that might be:

> So, well one of the issues we have is when we started this organization over thirty years ago … it was hard to find Aboriginal people who had the appropriate education to do a certain position. … [Now] we've … got people who have been in a role for thirty years but they only have the grade twelve so that becomes an issue, you know, and it is experience versus education. And also the experience and education versus Aboriginal cultural knowledge is an issue. (Provider Participant 18)

Thus, while it appears that providers, both Indigenous and non-Indigenous, face wage discrimination by virtue of working for Indigenous NPOs, Indigenous providers who lack Western credentials seem particularly vulnerable to poor compensation, even when they are highly valued by Indigenous NPOs for their cultural expertise, lived experience and years working in the field—which is paradoxical, given that this expertise is often the impetus for government contracting with Indigenous Providers in health care in the first place, as it is lacking within mainstream health services.

A non-Indigenous participant who had long worked both as a provider and administrator for an Indigenous NPO, adds to this discussion by describing how recent neo-liberal funding approaches have compounded problems among Indigenous providers.

> Our funders were pretty static right? … Stable, yeah, we would apply for let's say … [a] program [and] it would be enough to pay for the staffing, be enough to pay for location, it would be enough that we didn't have to worry about, you know, getting funding from someplace else. And that's been cut back and cut back, now we need to go and

> find [new funding but] where else can we go? … So it's more I feel like … [a] kind of clawing whereas before it's like this is what you want, okay, you can do that and it was a lot easier to get funding. Now it seems like you're getting little pieces. (Provider Participant 19)

The participant reflects on a trend, supported by the data, in which funding has shifted away from long-term trust-based relationships, to smaller, more fragmented short-term contracts. The same participant noted that what funders are willing to pay for is not neutral.

> When … I first started … doing the proposals we had several contracts for up to twenty percent we could charge for admin fees which covered the overhead, the staff, you know, that kind of thing. Now a lot of them are down to five percent. And with … [some] there's no admin fees, it's just what it … cost[s] to run the program. So a lot of that has been changed … and … that's actually one of my bigger concerns right now is, how the overall organization is going to continue to function if the admin costs keep dropping. (Provider Participant 19)

The participant's narrative calls attention to a phenomenon that was discussed by several other interviewees (Provider Participants 05; 09; 17; 22) : funders are willing to cover the costs of service delivery but fail to pay for the administrative and organizational functions that support the delivery of services. As the data in this study show, funders impose increasingly tighter restrictions on the percentage of the overall budget Indigenous NPOs are allowed to spend on administration or overhead. Rather than promoting efficiency, this strains organizations' capacity to sustain effective delivery of the very services and programs they are contracted to provide, a position further compounded by the increasing administrative burden associated with "getting funding from someplace else," and the degree to which valuable human resources are tied up in managing small contracts from numerous sources. As a senior administrator with an Indigenous NPO, who identified as Indigenous, explained,

> When you go into contract negotiation a lot of the time we're nickeled and dimed and it's like, 'okay, well you now get ten percent in administration' … 'we're not going to be able to give an increase and, in fact, this is no longer allowable so you're now at seven percent administration.' It's a constant battle to keep that administration for your programs within the contracts because, … it costs money to run those contracts. The cost of keeping the lights on and the building heated, those kinds of things increase all the time, so your operational costs, which are what comes from administration, are always increasing, right? … And if … these costs are going up but that budget is not meeting that, in any way at all, then it's going to impact the way that you're going to be able to provide services and it's going to impact the infrastructure of the organization that those programs are attached to. … It could be layoffs but not in the program because

> you're deliverable is to deliver the program but it could be layoffs in admin. So maybe you lay somebody off in accounting or one of the janitors or, you know, whatever it is but all of those positions and people are part of that bigger team, right? (Provider Participant 09)

Considering the non-profit status of these organizations, this approach to funding means that Indigenous organizations are faced with the conundrum of having accepted responsibility to provide a program under conditions that make it increasingly difficult or even impossible to do so. In response, many participants reported that as registered charities they were "lucky," because that status allowed them to engage in fundraising events and to accept private donations in an attempt to fill gaps in core funding and compensate for government revenue shortfalls. For most organizations, charitable donations were the only way to generate some revenue, as contractual agreements tended to request that organizations return any unused amounts in the budget at the end of the contract.

The complex challenges arising from this situation are described in greater depth in the following interview excerpt with the same participant who spoke above,

> sometimes people are within a budget where they don't get an increase in salaries, you know, for three to five years … it's really challenging and … you know, we have staff that are in burnout right because they, we can't pay over time. … If there isn't even enough money to give increases, how can we do that? So then you're trying to juggle the waitlist versus ensuring that you get your reporting in that's a deliverable and important. So, you know, to be able to, to compensate staff and to honour them for the work that they do I think is a really important piece right? … And then there's the administrative part of it which is, you know, the operations of the organization as well so, yeah, it's constantly a juggling game. (Provider Participant 09)

The participant's account poignantly describes the balancing act that administrators across Indigenous organizations engaged in. Speaking from the perspective of a provider, in the next interview excerpt, a non-Indigenous participant shares a personal experience that illustrates the high-level personal sacrifice that many participants in this study described 'accepting' by working for an Indigenous NPO.

> So for me I love the work here but like many Aboriginal organizations there's no pension, there's no retirement and so I started here probably making what I made twenty years ago at [name of mainstream NGO]. … I left … [there] making seventy thousand and back in the day we considered that low. And I think now working two nights a week in private practice and all day Saturday that put me up to sixty thousand which I can't quit my other job and here I work so many extra hours just getting all of this stuff done right. So but it's not a retirement plan, it's not a good plan and I'm not a kid anymore so I

> don't know what the answer is with that. But what I do know is that we lose a lot of staff that want to take care of their families and [name of health authority] pays their employees tons more and they have retirement plans. (Provider Participant 05)

Likewise, several other provider participants noted that while their work was rewarding at one level (not least because they felt they were working in a culturally safe environment free from racism, which many reported was not the case in most non-Indigenous workplaces), their everyday work came with a heavy burden. Tangentially, a non-Indigenous Provider Participant who worked for an Indigenous NPO described how changes in the funding regime have led to a restructuring of work:

> I slowly slid into … working on other things for them so that's where the proposal writing comes in, I've done that for them. I do the policies and procedures, the manuals, that kind of thing for them as well so it's kind of evolved into a whole other world and still doing the [name of original program] as well, which is something you find in a lot of these organizations … as the funding gets cut back more and more we kind of tend to try and keep what we have because people don't necessarily want to lose it but it becomes more of trying to maintain everything at the same time with less and less funding. (Provider Participant 19)

Other Provider Participants in this study also described trying to mitigate the impact of ongoing funding cuts and sustain programming by not only absorbing additional work "off the side of our desks" (Provider Participants 05), but also taking on additional roles, such as the role of an administrator, in addition to their primary role as a provider or vice versa. A senior Indigenous administrator for an Indigenous organization considers some potential ramifications this has for the capacity of Indigenous Providers to deliver culturally safe care for Indigenous people with mental health and addictions issues:

> It's really, really challenging to recruit and retain staff, you know, because we're not able to pay them the same kind of money that they might get if they're working for a mainstream organization or a union organization. And so, you know, we recruit staff, we get them on board, you know, it's almost like we train them so that they can be scooped away from someone else. So… in terms of … what creates challenges for us those are some of the things. And, you know, in terms of your relationships with between staff and clients that are accessing those services, those are pretty critical. It takes a long time sometimes for those young people or other folks to gain that trust and, you know, get into relationships … of trust with staff and, you know, if we're always, you know, fighting that ongoing battle of recruiting and turnover of staff that makes it really, really challenging as well. (Provider Participant 09)

As the participant alludes to, a key element of providing culturally safe and effective care within the context of working with Indigenous people is relational practices, including relationships between staff and clients that are built on trust. However, high rates of staff turnover, work stress, and exhaustion diminish the potential to build trust and relationships of care, which require time and emotional investment—a tension that will be explored in more depth in Chapter Seven.

The following interview excerpt with a non-Indigenous provider who worked for an Indigenous NPO highlights how, within the current funding regime that limits hiring and wages, the mental health of providers is at risk.

> I won't let myself burn out so although some of the other staff have burnt out, yeah … for about a year and a half I've been on my own, you know, because positions have been vacant and [name] is actually the seventh … counselor since I've been here so that's turnover as well. And it's very difficult, very challenging. (Provider Participant 08)

While this participant acknowledges that the providers who quit their positions might have had diverse reasons for doing so, their account suggests that an important factor pertains to workplace mental health. In particular, it points to the need for a more critical understanding of the human impact of applying New Public Management (NPM) strategies. This observation suggests that NPM strategies have negative consequences for working conditions (for example, work intensification), especially in the area of care work involving people who suffer complex mental health and addictions issues, including past and/or current trauma. Specifically, in the context of contracting with Indigenous Providers in mental health, a paradox emerges between (1) policy commitments to promote equity in mental health for Indigenous peoples, and (2) total disregard on the part of funders for unbearable working conditions created by current contractual arrangements and their consequences for the mental health of the Indigenous non-profit sector workforce. Plainly, contracting with Indigenous Providers in mental health remains deeply embedded within a biomedical paradigm—an ideological embeddedness that is reinforced by the individualistic focus and growing influence of NPM.

To summarize, the above findings paint a troubling picture of the funding realities under which urban Indigenous NPOs operate as providers of mental health and addictions services for a primarily Indigenous clientele. As the data reveal, a gap exists between need and funding. Despite increased political attention and commitments to Indigenous health from all levels of government, this gap appears to be widening, rather than closing. Using the language of a 'gap' may be misleading, however, as the data clarify that this is not just an issue of distributional justice; rather, funding inequities are inextricably linked to issues of race, class, gender, and colonial and neo-colonial policies and practices. In particular, the analysis highlights the social fault lines that underpin resource distribution and the division of labour, creating what one participant poignantly described as an Indigenous "contract ghetto." Indigenous NPOs not only receive fewer resources to address more complex, systemic mental health and addictions issues than their non-Indigenous counterparts: they also face wage discrimination and marginalization. The latter is concerning not only because of the injustice and high human costs for Indigenous non-profit workers, but also because it constrains the capacity of Indigenous NPOs to provide optimal care.

6.1.2. The Marketization of Indigenous Peoples' Rights and Mental Health[27]

The inequitable funding patterns discussed in the previous section were revealed to be inextricably linked to the adoption of an increasingly market-based funding approach to contracting in mental health with Indigenous Providers. This link is illustrated in the following interview excerpt with a non-Indigenous participant, a senior administrator overseeing operations and programming at an Indigenous non-profit organization (NPO), who recounts how the organization lost a longstanding service contract because the funder switched to a proposal-driven, competitive funding model. The new system involved a tendering process open to Indigenous and non-Indigenous organizations alike.

> And then that [program] has been running more or less steadily for the last six years, however, the funding has shifted a bit so some years we've had … additional [federal government] funding and then we have provincial funding … And then that was discontinued last year, we had to apply, we had to go through a Request for Proposals (RFP) process province-wide and then we weren't awarded the funding for that. (Provider Participant 18)

This study shows this precarity was not an isolated event. With few exceptions, Indigenous NPOs access government funding through competitive funding schemes, illustrating the extent to which neo-liberal funding modes have been normalized. Participants viewed this shift as problematic for several reasons. First, it signals

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[27] This title is informed by Altamirano-Jimenéz's (2004) notion of the "marketization of Indigenous citizenship rights" (p. 349).

movement away from long-term funding relationships. Second, it turns access to culturally safe care into a market or quasi-market matter. Provision of Indigenous mental health and addictions services is thus severed from recognition of Indigenous peoples' collective rights (including to a high standard of mental health care). Implicit here is the neo-liberal belief that the marketplace, as neutral arbiter, will ensure the fairest distribution of resources via competition. Participant accounts challenge this assumption, however. One Indigenous participant, who sat on the board of an Indigenous community-based organization, said:

> [T]hey have you fighting over a few dollars, they'll have like maybe ten Aboriginal organizations fighting over a small amount of money, which is madness—it's like divide and conquer strategy here again. (Provider Participant 21)

In this view, competitive funding models for contracting in Indigenous health parallel the "divide and conquer" mentality of colonial governments. Contracting, then, can constitute a neo-colonial practice apt to foster community divisiveness by pitting Indigenous organizations against one another (much like the divisive legacy of the Indian Act). The document review echoes this participant's insights, revealing a disjuncture between funding objectives and resource allocation practices. For example, the Aboriginal Health Initiative Program (AHIP) is a provincially funded granting program launched in 2002 whose mandate "is to encourage First Nations, Métis communities, and Aboriginal NPOs to develop locally responsive health promotion and capacity building initiatives" (Vancouver Coastal Health [VCH], 2015, p. 1). However, as per the provincial directive in 2002, AHIP was to be implemented as annualized, short-term project funding, and, despite some modifications, in all but one health authority,[28] AHIP is administered via competitive tendering.[29] This finding is significant, considering that, in most health regions, AHIP represents one out of only two Aboriginal-specific health funding programs.

A closer look at AHIP policy texts reveals further tensions between competitive funding schemes and the overarching goals[30] underpinning its programs, which include

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[28] This health authority decided to convert AHIP contracts from short-term, competitive funding into ongoing service contracts that are rolled over on an annual basis.

[29] A non-Indigenous organization can submit an application only with endorsement from or in partnership with a First Nations community or Aboriginal organization.

[30] While the following goals are quoted from a regionally-specific AHIP grant application, an expanded reading of AHIP policies across regions shows that despite some differences, all regions use similar policy language to describe the funding objectives.

promoting Indigenous “Mental Wellness & Self-Esteem,” “build[ing] capacity,” “reduc[ing] inequities,” and “creat[ing] a supportive environment for health & well-being” (VCH, 2015, p. 3). Funders’ expectations that Indigenous organizations fulfill these objectives under the current funding terms seem grossly misplaced, however. For example, for one AHIP grant application (2016–2017), the highest possible value assigned to an AHIP contract is $40,000 per annum for a maximum of three years. The contract is non-renewable. Despite some regional differences, the majority of AHIP grants, especially those framed in health promotion terms only and excluding “direct health services” from their list of eligible expenditures, were designed as small and annualized grants, which tended to be far below the value of $40,000.

These narrow parameters again suggest that, besides neo-liberalism, a biomedical outlook can help explain such internal contradictions between funding goals and method of implementation. Funders may not see a problem, or they may accept competitive funding approaches as the best practice model. A lack of meaningful involvement of urban Indigenous voices in governmental health policy and funding decision-making may also contribute to this lack of awareness.

One non-Indigenous participant, an administrator who worked for a different Indigenous organization from the previous participant, described some of the frustrations of trying to access new funding after a series of funding cuts to existing programs:

> [As] a new agency going in—not new, I mean we’re very old obviously—but as an agency that’s never applied for the funding before the chances of getting into this funding are slim to nil. So that’s where it becomes frustrating is how to kind of break into these pools and try and do new things when the funders have basically already established, or it seems like they’ve already established, who their funding is going to … it’s about getting in the door … a lot of times applying for a lot less than [what you need] … just getting your name onto that list or that index card … they have [because] if you’re on the index card then you kind of get in there. (Provider Participant 19)

The participant’s account suggests that access to program funding is governed by a confusing mix of competitive funding practices and pre-existing relationships—a contradiction that is certainly at odds with the grand narrative of the market as the fairest and most efficient arbiter of resource distribution. However, several factors touched on earlier that characterize the health system, including “heightened political sensitivity in Aboriginal health,” “lack of trust and concerns about governance and competence in the sector,” and lack of Indigenous expertise, and may help explain this messiness. Funders might be reluctant to jeopardize existing relationships and/or to ‘risk’ entering new relationships with new Indigenous Providers. Another Indigenous participant, who oversees programming at another Indigenous organization, explored this issue further.

> [Our chances to obtain funding] that's challenged by, you know, these large organizations who are submitting things … and they have all the answers and sometimes I feel like I'm not knowledgeable of all what we're going to be judged on sometimes, right? I never know, I just go for something that I think, is going to help us and, yeah, … I just wish that … they can see that … need … but then maybe everybody else puts that need out there too and oh well, there's this huge organization and, you know, they're well known and, okay, we'll give it to them. So we're such a small organization that we feel like sometimes we're like pushed aside, yeah. (Provider Participant 17)

The participant's account provides a counter-narrative to the assumption that all organizations compete for funding on equal footing. In fact, multiple disadvantages can constrain organizations' chances of securing health programming funds, including small organizational size (with larger organizations better able to build relationships with funders) and obstacles to communication (with some organizations lacking the technical capacity to foreground their needs). Another community-level participant, a non-Indigenous administrator with a different Indigenous organization, elaborates, stating that,

> Not everybody has the ability to [or will] have somebody to write … a proposal … some of them are very hard to kind of comprehend what they're actually getting at but they're good proposals like they're great ideas. (Provider Participant 19)

This participant's comment reminds us that a distinct feature of non-profit organizations is their roots in social movements: in this case, the Indigenous health movement. It is this history and the cultural and local expertise and connections of Indigenous NPOs that make them so uniquely positioned to respond to the concerns of the community they serve and why governments are ostensibly engaged in the practice of contracting with Indigenous Providers for the provision of health care in the first place. While Indigenous NPOs have many unique strengths, professional grant writing is not necessarily one of them. Indeed, within the context of competitive and proposal-driven processes of accessing funding, these qualities appear to be not only significantly undervalued but potentially disadvantaging.

Troublingly, the same participant also described funders providing almost no explanation when rejecting applications: "for the most part it's, you either get it or you don't, there's just not a whole lot of feedback" (Provider Participant 19). This situation is problematic in at least two ways. First, organizations cannot learn from their mistakes in this situation. Second, far from being transparent and operating from a sense of partnership, funders foster a view of their practices as a big black box, obscuring how decisions are made. Unsurprisingly, such conditions engendered distrust.

Document analysis of funding applications or RFPs also revealed that most applications required applicants to identify their “target population,” provide “evidence” of “needs assessments,” and describe the relationship between predetermined programmatic inputs, outputs, and “outcome measurements.” For many community-level participants, such language was experienced as essentially foreign. Providers’ problems writing successful funding applications might, therefore, be better understood as an epistemic problem rather than a skills issue.[31] Yet, in order to be competitive and receive program funding, Indigenous Providers are expected to make their knowledge ‘fit’ both the logic and the format of Western ideas, revealing an assimilationist ethos. Nevertheless, interviews revealed some institutional awareness of the tensions and difficulty experienced by Indigenous NPOs in relation to funding competitions. A non-Indigenous administrator working for an Indigenous NPO shared an impression of a proposal-writing workshop they attended:

> I went to actually a proposal writing workshop a while back and the one thing she said is before you even take a pen to a proposal phone the funder to find out what they’re looking for, find out if you actually even fall under their criteria, find out what they’re looking for and then put your pen to paper don’t even bother before then which I think is really, really above all else it saves everybody time because if you go ahead and apply for funding and … the criteria doesn’t (sic) follow what you’re thinking; it’s a waste of time. (Provider Participant 19)

Although the participant appears to have found the advice that was given helpful, at a deeper level, we can discern a larger problem of funders inadvertently perpetuating colonial power-over relationships and constraining Indigenous self-determination in relation to community-based mental health and addictions programming. The funder’s criteria govern what health needs are to be addressed. Providers have to follow suit in order to successfully compete for program funding, reinstating a principal-agent kind of relationship typical of New Public Management (NPM) approaches to contracting. NPM discourses further seem to be manifested in a risk discourse in which the meaning of risk is primarily constructed in terms of efficiency—risk means wasting valuable resources, both public and private—rather than the health risks associated with unmet needs. The

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[31] For example, according to Connell, Klein, and Powell (2003), there is explicit knowledge, which “is knowing about,” and tacit or implicit knowledge, which is “knowing how”: for example, how care is provided, where the latter is generally derived from experience (p. 141).

following excerpt from an interview with the same participant illuminates what and who is rendered invisible as result:

> One of the biggest ways that I find challenging in writing the proposals is figuring out how we work with … certain criteria when we have funding and but yet we have our own needs at the level that we're at so when we're dealing with mental health, for example, when we're dealing with having people that have issues that the community [at large] just doesn't see, how [do] we express those in a way that, you know, we can get funding? (Provider Participant 19)

Here, the participant points to the disconnect between current funding criteria and the needs of the community; indeed, as the account suggests, current funder's criteria seem to determine not only what health care needs will be addressed, but also whose needs will be addressed, privileging some groups and disadvantaging others. In the experience of this participant and several others, concern is warranted because current funding criteria are imposed from the top down with seemingly little regard for what Providers might have to say. As the same participant explained,

> [W]omen, children, youth have the highest chance of receiving funding, men [are] way lower, like way, way lower, so that in itself makes an impact, which is why we apply for funding [for] the women's [program] … and [then] the men's [program], [which I am] … just starting to, to apply for more funding because the funding that we're having is like I said starting to get less and less so I'm trying to get out there and get more funding for the men which is, it's harder to get funding for men for sure. (Provider Participant 19)

The account above suggests that, under current funding arrangements, it is very challenging to find funding for men; this despite evidence that shows that Indigenous men also experience significant higher rates of trauma, violence, suicidal ideation, substance use and other mental health and addictions issues compared to the general population (Kirmayer et al., 2007; Mussell, 2005). Adding further to the discussion, the same participant goes on to say,

> we can't go down [any lower in the funding hierarchy] … we have men, and then we have men that have been charged that are in prison, and then we have, we have our sex offenders and it just keeps going. … It's really difficult to know how to emphasize how important it is to get funding to help those [men]. (Provider Participant 19)

This participant's account calls attention to how the application of needs-based and population-based funding approaches to resource allocation can inadvertently become complicit in the creation of a funding hierarchy of competing oppressions. To promote greater equity in relation to funding decision-making, in the following excerpt, an

Indigenous Policy Participant calls for a more explicit engagement with the values and principles that ought to be guiding approaches to resource distribution:

> [We need to ask] what as a health organization is your purpose and your intent? And who should be first in line to receive your services based on the very limited dollars you have, how are you going to make the best use of them? … But that, that's the problem it is so big and it's such a shift in how you make decisions, it's value-based decision-making. (Policy Participant 07)

By supporting a discourse in which the role of the market is seen as replacing that of the government, the use of competitive funding schemes effectively de-politicizes the issue of Indigenous mental health, eradicates any space for dialogue or negotiation between the parties that may have existed before, and provides the Canadian government with a publicly acceptable way of abrogating its responsibilities once again. While the introduction of market mechanisms, such as competitive funding models, into public-sector administration might appear to facilitate an unbiased, fair and transparent distribution of scarce resources, the findings of this study reveal that the funding criteria and processes in place are anything but value-free. The emerging tensions are complex, raising a series of questions. Perhaps most importantly, we can ask how far competitive funding models <u>can</u> take into account such concepts as 'needs,' 'equity,' and 'Indigenous citizenship rights.' The findings of this study provide growing evidence that current funding approaches, presumably aimed at addressing equity, are in fact implicated in the reproduction of social inequities in mental health for Indigenous peoples.

6.1.3. Contractual Relations as Structural Violence

Indigenous Provider Participants' experiences with contracting are also shaped by shifts in contractual relations. In this section, the analysis focuses on (1) Indigenous Provider Participants' experiences with different types of contractual relations; (2) the institutional practices and discourses that shape and are shaped by these relations; and (3) how these contract relations mediate between different ideological frameworks and the everyday realities of Indigenous Providers in terms of developing, administering and delivering mental health and addictions programs. Analysis of the data revealed tensions over the structure of contract relations, as well as how these relations shaped and were shaped by long-standing relations of power, authority, paternalism and forced dependency. The following participant quote by an Indigenous senior administrator with an Indigenous NPO provides an entry point into the discussion:

> [Annualized funding] compromises clients in a big way, you know, so if you're looking at your funding stream and you're going April 1st to March 31st so, you know, right around January you're hoping to have to start having dialogue around contracts because three months is not a whole lot of time because in, in that period of time you've got to consider if there isn't a contract in place what are your legal liabilities around your staff right? … There's a cost to close down programs just like there is to start programs. So what does that look like, what does that look like in terms of staff layoffs, how does that impact your clients because, you know, once you have a program going and clients hear about it then there's clients that are lined up trying to get into the program. And so, you know, it's huge, huge, huge impacts on the organization. (Provider Participant 09)

Likewise, many Provider Participants in this study agreed that short-term funding is highly disruptive to organizations' internal relations at all levels. Even still, study data show that annualized short-term funding is a predominant practice across all levels of government, revealing the existence of a major tension embedded within current contractual relations. In the following interview excerpt, the same participant quoted above elaborates on the constraints placed by short-term funding on human resources.

> So we've had contracts that are supposed to end on March 31st, we're literally in the past we haven't found out until a week before March 31st that it was going to continue to be funded. Well in that period of time you've given notice to your staff, often times they've already found a job so it's huge in terms of staff turnover and then those relationships and that commitment that staff make to those programs and to those clients are impacted in a huge way. Then you're always recruiting and trying to catch up. And, you know, when you're recruiting you're having to say to staff members that this is an annual contract … your contract is only till March 31st of next year. So that impacts the quality of staff that you get in the organization as well. (Provider Participant 09)

Short-term contracts thus place Indigenous Providers in a double-bind: on the one hand, such contracts are a means of obtaining much-needed resources; on the other, they tend to (1) compound already-existing problems in relation to the recruitment, training and maintenance of high-quality staff; (2) create highly unstable and stressful working conditions for staff; and (3) disrupt provider–client relationships and continuity of care. Moreover, while it appears that in some contexts, a possibility of contract renewal might exist, further complications seem to arise from the untimely manner in which funding decisions are made and/or communicated by funders. This has the effect of keeping Providers in an unnecessarily prolonged state of limbo. Damage control and "trying to catch up" again are often the only way in which organizations can move 'forward.'

The same participant also reflected on how short-term contracting impacts accountability.

> There are so many pieces and it's all about people, right? … So it's the staff, the clients, you know, the community as well because we get lots of referrals to our programs as well. And, you know, if we haven't got funding then we contact our community partners and so then it stops referrals that are coming in, you know, so it takes a little bit of time to build up the momentum then … they're having to build that confidence up again with community partners and getting the referrals and, you know, building up their client caseload. … you're always turning over your client base … if you are finding out so late then the staff have already put pieces in place to refer their clients that they've got, their caseload to somebody else right whether it's on their team or it's somebody in another organization. (Provider Participant 09)

Here, the participant provides a perspective on tensions and challenges associated with short-term contracting that arise from a relational understanding of accountability. For Indigenous NPOs, accountability to the funder represents only one accountability relationship involved in the effective delivery of mental health and addictions care. Others include accountability to staff, community, care recipients and other community-based NPOs. By disturbing the coordination of care among community partners, the uncertainty of short-term funding seems to threaten both continuity of and access to care. Unsurprisingly, the delivery of mental health and addictions services under short-term contractual arrangements creates frustration and a sense of disillusionment or fatalism for those providing the care—"it impacts the commitment that they have, that 'oomph' to make things happen," as the same participant explains. This finding is significant, considering that the motivation to 'go the extra mile' is a feature that research has shown to be one of the hallmarks of compassionate care (see for example Sinclair et al., 2016).

In the following interview quote, an Indigenous participant who was working with Indigenous women who were most marginalized by society offers a provider perspective that sheds light on the real harms that can result from short-term contracts. As the participant shares, "[in] my experience … when I leave different positions … I've had women … get upset because they're, it's like … another loss" (Provider Participant 15). Here, the participant draws attention to the histories of complex trauma that shape lives and experiences of health care for many Indigenous women. In this particular social context, the loss of a trusted program and/or provider can be experienced as an extension of the multiple other forms of losses and traumas. One Indigenous participant responsible for overseeing and directing the programming of another Indigenous organization and with a long history of working in the Indigenous non-profit sector described very clearly how violence can be enacted through contractual arrangements:

> The program ran for nearly five full years before we had to close it down because the funding ran out, we couldn't get any additional funding and that caused all kinds of problems because people were at different levels of dealing with their issues by the time we had to close it down… Some people couldn't cope with not being able to come back and finish up in talking to their counselors … and got back into their old habits and eventually killed themselves. So in a way it was a slow suicide for some of them depending on your point of view. (Provider Participant 10)

The (mental) health care system tends to construct mental health and addictions issues in bio-psychological terms. These issues are seen as treatable as discrete cases, in a fixed time frame. However, many study participants viewed recovery and/or healing as a life-long journey. There is no "quick fix," a conclusion touched on by the following participant, a non-Indigenous mental health provider with an Indigenous NPO,

> Well in order to do right by our clients and by our staff we need funding that is much larger than what it is now and we need the recognition there are so many people running around saying why did they stay in school, you know, why don't they just take care of their kids, as though residential school didn't matter: 'just get over it.' And there is still a lack of acknowledgement on the tremendous harm and intergenerational trauma that has happened and that takes generations to get past. And it impacts health for decades and there's not a quick fix to that. So being culturally relevant is involving Elders and all the work we do and again that slows down the process but it brings culture back (Provider Participant 05).

These insights shed light on the ethical dimension of contractual arrangements—and the question of whether they reinforce negative power differentials between Indigenous Providers and government funders. An Indigenous participant with extensive experience working as a policy consultant to different levels of government in the area of Indigenous mental health provides a policy perspective on this issue:

> We have to have values of sustainability … Making sure that whatever kind of interventions we promote or come up with … are sustainable … are here for the long haul, for the long term … because you know and I know, how funding arrangements come and go and people suffer when they go. And often in very arbitrary and unilateral way they'll go … the funding sources just aren't committed to having sustainable approaches. … So it, it's a cause for concern, sustainability—I would like to promote as a value. (Policy Participant 06)

This participant underscores the need for ethically sustainable solutions, while stressing that funders' system-level commitment to support sustainable solutions is lacking. The contention that sustainability is a value that funders ought to pursue as a regulatory ideal in relation to contracting in the area of Indigenous mental health and addictions resonated strongly with the experiences of other Provider Participants, as illustrated in the following excerpt of an interview with an Indigenous administrator who oversaw programming for an Indigenous NPO:

> The [name removed] program is the only one that is ongoing which is our most, well I would say they're all successful but I think because of the continuity of the program and the funds for that program it's what makes it really successful. Because we don't close the doors and say, oh I'm sorry, you know, we didn't get any funds this year, well come back next year, no, that doesn't work right? People can call and they remember us from years ago and they're like, yeah, I came here about years ago, you know, and now they're in trouble or whatever and they'll come back because they know where to come, they know that there's something here, yeah. (Provider Participant 17)

In the experience of this and many other community-level participants, successful mental health programming tends to be continuous and supported through ongoing funding arrangements. The apparent disjuncture between funding and program realities suggests the need to apply a new framework to contracting and accountability: one that directs funders to move beyond an individualistic understanding of contracting in purely transactional terms, according to which access to health care is little more than an abstract commodity, to an expanded reading of contracting and accountability.

An Indigenous Policy Participant working for a health authority reflected on the service delivery implications associated with two current contracting approaches in place to support Indigenous mental health and addictions programming and service delivery in their particular region and elsewhere: Aboriginal Health Initiative Program (AHIP) and Aboriginal Health Service (AHS) contracts.[32]

> AHIP because it was short-term funding … can be difficult because … what happens [is] we get some of the programs up and running and then their funding would …[run out.] Three years would come and go like that. So and then they'd have to reapply or, you know, do something else so, so I guess the longevity of programs is, is quite concerning … some programs are really great and doing wonderful work but we are not able to sustain them [beyond] three years without having to apply for something else. So … with the AHS contracts …

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[32] As previously mentioned, albeit there is some variation across regions, in all but one region, AHIP funding continued to be implemented as short-term funding. In this scenario, AHIP provided funding anywhere from one to a maximum of three consecutive years. In contrast, AHS contracts were continuously rolled over from one year to the next as long as the organizations met their contractually-defined obligations—as the data suggest the application of this or similar contracting approach was very uneven across the regions.

> because they're always continuing to roll over and roll over and roll over … it doesn't leave room for new innovative things to, to be available to community So just thinking about those, those kinds of restraints … on the programs. (Policy Participant 03)

At first glance, AHIP and AHS contracts seem to neatly fit the typical categorization of classical versus relational contracts discussed in Chapter Two.[33] In keeping with a classical approach to contracting, AHIP contracts tend to be short-term and secured on a competitive basis, while the nature of AHS contracts appears to better correspond to a relational contracting model. This situation seems largely descriptive of the kind of relationship between government funders and Indigenous Providers in relation to culturally safe mental health and addictions care, even though as the data revealed, a lack of trust remained at the forefront of participants' experiences of tensions. Considering the high degree of control that funders tend to retain within short-term contractual relationships, this hardly seems surprising within the context of classical contractual arrangements, at least from the perspective of Provider Participants.

As participants, including the participant above, repeatedly emphasized, the problems with various short-term contractual arrangements in relation to culturally safe mental health service delivery for Indigenous peoples are many. Consensus emerges that the short timeframe associated with classical approaches to funding, such as AHIP, impedes effective service delivery and, in many cases, obliges organizations to terminate programs, regardless of a program's success in filling existing service gaps and meeting mental health needs in the community. This funding failure not only points to ways in which agency seems be constrained for Indigenous people working within government funding institutions, but it also raises questions about the minimal extent to which accountability to the people who are using these services is factored in during the short-term contracting process. We can therefore ask how program effectiveness under short-term contractual arrangement is defined and measured. This question's significance is underscored by the following comments by an Indigenous Provider Participant, who shared that

> usually they're a one-year contract and I was fortunate to do the one with [name of funder] which they, they did three-years and that was so nice because, you know, you just sort of get going in your first year, you find out oh well, you know, this didn't work we've got to make changes, you know.

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[33] To remind the reader, in the contracting literature, the need for relational contracts arises from situations where the relationship between funder/purchaser and Povider is marked by "information asymmetry" because the funder (unlike the provider) lacks an adequate understanding of how to best provide the service in question (Lavoie, Boulton, et al., 2010).

> And so as the time goes over to the third year you kind of know what is working well, you know, and it's unfortunate we're, we're on our third year [now]. (Provider Participant 17)

The same participant recounted a situation in which the organization was denied access to continued funding for an apparently successful program as a result of the funder's insistence that after three consecutive years of funding, a renewal of funding for the same program was unattainable:

> [The funder] wanted us to do something else, … [even though] the women are really liking it. [So I was asking myself] what changes do I make, you know? It … was hard … and I really couldn't, I just, I didn't know at that time I really didn't know. I made a few changes within [the program] but that didn't work so it had to be more like a major change. (Provider Participant 17)

The participant's narrative highlights the absurd struggle of trying to modify the design of the program enough to meet the funder's regulations and qualify for the possibility of future funding, but not so much so as to compromise the program's meaningfulness. Interactions with funders whose approach to contracting was governed by abstract, prescriptive rules and regulations provoked feelings of frustration and mistrust among community-level participants, who were left with the question of "why would we change something that's working" (Provider Participant 17). As a result, many Provider Participants expressed a certain cynicism when describing experiences with current contracting arrangements, as illustrated by Provider Participant 17, who added in a subversive tone that in order to get funding "it's almost like you have to have a different project each year." These accounts are revealing; rather than being responsive to the needs of the community and/or oriented to promote equity, under short-term contractual arrangements, contractual relations are governed by the needs and values of the market—ideals such as efficiency, competition and innovation transform health care into a commodity.

The ideal of innovation seems to emerge from the intersection of Western science and the market. Scientific progress leads to innovation in the form of new products or technologies that can then be introduced into the market. Perceived to be inherently desirable, innovation has been adopted by funders as a largely uncontested value. Here, recall Policy Participant 03, who argued that the shortcoming of AHIP is that it is unsustainable, while the downside to long-term funding is that "it doesn't leave room for new, innovative things … to be available to community." In so doing, the participant's account calls attention to the way policy discourses of innovation implicitly link the notion of innovation to short-term contracting, while de-legitimizing the use of ongoing, long-term funding relations.

Also speaking to the value of innovation but in a different vein, this Indigenous Policy Participant observes that “the challenge for the Aboriginal community at this point is that there’s no new money and so there’s no incentive … to try and develop anything new or creative” (Policy Participant 05). Here the participant is arguing that in the absence of substantial increases to the region’s Aboriginal health budget, innovation and progress have been stunted. On one level, this argument seems to contradict the point above by Policy Participant 03. However, a critical reading reveals that there is also an insinuation embedded within the participant’s quote that seems to state that for innovation to occur, financial incentive is required. This logic is akin to the reasoning advanced by Policy Participant 03 and implies that long-term and stable funding relationships with Indigenous Providers create a barrier to innovation because there is no financial incentive. A similar way of thinking seems embedded within neo-liberal New Public Management (NPM) discourse. Here, the state is seen as inherently rigid and inefficient because of its bureaucratic machinery and position of monopoly, while the private sector under the rule of the free market is seen as intrinsically innovative because of the need to stay competitive. In this sense, Brandão and Bagattolli (2017) argue that innovation can be understood as “an almost natural consequence of the system incentives and penalties established as a result of market liberalization” (p. 51).

Even still, the concept of ‘innovation’ seems central to both neo-liberal and Indigenous healing discourses, as the following participant quote from an interview with an Indigenous thought and practice leader illustrates: “I think Indigenous people want to be … innovative … innovative in the way they do things because they’re imagining a new way of being” (Policy Participant 06). As this quote reveals, the concept of ‘innovation’ is constructed differently in these contexts. Here, ‘being innovative’ is linked to reclaiming an Indigenous cultural worldview to inform approaches to mental health and addictions programming, as well as the decolonization of Western health care along with its patriarchal and ethnocentric vision. In this sense, innovation is closely linked to Indigenous self-determination and autonomous health programming arrangements—processes that are best promoted through approaches to long-term, trust-based and ongoing contractual relationships. How the meaning of innovation is constructed thus varies depending on the context, with implications for contractual relations and mental health and addictions programs delivery.

However, as the following analysis of a federal granting program[34] suggests, this polysemy of ‘innovation’ seems obscured by the hegemony of neo-liberalism. According to this program’s administrative manual, the intent of the Urban Partnership Program is to “provide[…] core-like funding to Friendship Centres and other urban Aboriginal organizations so they can have a stable base from which to deliver programs and services that increase urban Aboriginal participation in the economy” (NAFC & AFCS, 2014, p. 17). Here the funder articulates a clear commitment to long-term funding relationships. The program invited proposals in several thematic areas, including one called “innovations,” defined as

> a novel solution to a problem that is more effective, efficient, sustainable, or just than present solutions and for which the value created accrues primarily to community as a whole rather than any one individual. (NAFC & AFCS, 2014, p. 8)

As the Manual reads, “innovation initiatives” aim to “remove barriers to increased self-reliance” and “create and mobilize systemic change” for urban Indigenous people with a view to increase their “participation in the economy” (p. 8). Notably, although the language deployed in the above program guidelines can be interpreted in a way that is congruent with an Indigenous social determinants of health framework, it takes up several key constructs derived from NPM discourse, creating the illusion that the two are compatible and, indeed, synergistic. However, the funding is constructed as short-term, whereby “projects are able to apply for a fixed term up to 15 months project funding” (NAFC & AFCS, 2014, p. 4), revealing the disjuncture between Indigenous and neo-liberal perspectives. The example highlights the powerful and covert ideology that operates behind the rhetoric of innovation. An Indigenous community-level participant said,

> With the funders putting the money out there, [then] taking it back, putting it out there and taking it back [again], … it’s not really moving forward in a society … because … we want to teach and empower women [as] givers of life … and we want to stop violence and poverty … and … substance misuse and so how are we going to make that work in regard to offering programs when the systems keep going back and forth? (Provider Participant 21)

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[34] Here I refer to the Urban Partnerships (UP) program for the new Urban Aboriginal Strategy (NAFC & Aboriginal Friendship Centres of Saskatchewan [AFCS], 2014). The UP program is one of two programs under the new Urban Aboriginal Strategy (2014), which is funded by the federal department of Aboriginal and Northern Development Canada (AANDC). It is administered through the regional/provincial Friendship Centre Associations.

Adopting a system-level perspective, the above participant highlights the structural shortcomings of short-term funding approaches, revealing a disconnect between what funders state their policy objectives are and how they go about achieving them. It is a piece-meal system which is ineffective. For example, the objectives of AHIP funding[35] are to “reduce health inequities,” “promote lasting effect in the community” and “build capacity.” Elaborating further on this tension between funding objectives and methods, the same participant goes on to add,

> I think there’s not enough funding in regard to mental health and addictions. … There’s always been clawing the money back and then giving it back, the same money and making themselves look good. So … for example, I’m going to give you a hundred thousand to run your program, oh, oh, we’re going to take it back now that program is over. So there is no money anymore that’s what the funders will say. And then, okay, guess what we do have money to give you again and then you get that same money. And so the funders or the government make themselves look good … giving back the same money for the same [or] similar program … for mental health that’s a huge spectrum and specifically if you’re talking about women you could talk the trauma, the PTSD, the depression, bipolar, the axis one illnesses, so schizophrenia, so that’s huge. (Provider Participant 21)

This participant notes that, by circulating the money around and around, a system of short-term, often non-renewable contracts obscures the inadequate funding levels while outwardly upholding a commitment to action that addresses inequities in health for Indigenous people. As an Indigenous Policy Participant cynically remarks, “as long as you have some money out there then you’re doing something about the issue, you know, from the health authority perspective” (Policy Participant 05). This comment serves with the account above as a reminder that for government funders, urban Indigenous health remains a politically sensitive area that requires political risk management to avoid harm to governments’ reputations and to protect the legitimacy of government authority. Indeed, pressures to save face have likely intensified with renewed political commitments to reconciliation and closing the gap in health, as articulated by all levels of government in recent times.

The next excerpt from an interview with a community-based participant, who identified as non-Indigenous and who was working for a different Indigenous NPO,

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[35] Source: Daniel Iwama, Community Grants Coordinator (September 25, 2015): Vancouver Coastal Health, Aboriginal Health Initiative Program. Available online at http://slideplayer.com/slide/9651935/

sheds light on yet another funding paradox embedded within current contractual arrangements:

> every year when the health authority people come in we go over our contract and we redefine our, the work plan, how many patients we are expected to see, how many Aboriginal, how many HIV patients we're expected to see …. So we work with the numbers together with the health authority and go over the contract every year and then we sign off on it. And it is year by year unfortunately. It's not like a five-year something we can count on and I can't imagine they would take away our funding but, but really it is only year to year and it would be good to know that we're good for five years instead of every year. And it's funny because we do the contract [the date of interview was October 22nd], you know, we just finished signing off on the contract, for like up to March 31, 2015 so it's already over … So they're always behind. (Provider Participant 14)

The contractual arrangement this participant describes is paradoxical because, on one hand, a reasonable expectation is in place that funding to the organization will be continuous, as would be typical for trust-based relational approaches to funding. On the other hand, the use of short-term contracts requiring annualized funding renewal suggests a lack of trust on the part of the funder, fueling uncertainty and distrust on the side of the contracted provider. Even though classical contracts managed in a relational manner also contradict the assumption of a competitive environment, such funding relationships were not unique to the above organization nor specific to this funder. Relational tensions appeared to be reinforced by funders' previously-mentioned inattention to timely contract renewal, which was perceived as disrespectful and reflective of a double standard. While such negligence might be easily explained by a lack of individual oversight and/or interpreted as an unintended consequence of the workings of bureaucracy, its pervasive occurrence suggests that the problem is more systemic in nature and rooted in the ideological dynamics organizing contractual relations between Indigenous Providers and government funders. In any case, untimeliness highlights deficiencies in transparency and relational accountability as barriers to truly cooperative and trusting relationships between funders and Indigenous community-based Providers.

As the following quote from a Policy Participant reveals, the tensions caused by such funding arrangements are at least partially known to funders:

> [AHS Contracts] are renewed … on a yearly basis and sometimes that can create, you know, some anxiety and stress for, for the organizations because they're not knowing whether or not they're going to be renewed again. But they have been pretty much renewed

> every year without much disturbance in terms of their funding levels and those kinds of things so, so that's been good. (Provider Participant 03)

In this light, the use of short-term contracts to provide ongoing funding reinforces and perpetuates historical patterns of paternalism and dependency. The funder has the power to decide the fate not only of the program in question, but also that of the entire organization, because "if the funding was to be moved it would cripple the organization" (Policy Participant 03). Relationally and administratively, this approach to long-term programming seems to be costly, time-consuming, and resulting in few benefits; the same, or worse, can be said for short-term, competitive funding arrangements. Yet, as the data from this study evidence, the vast majority of government contracts have been constructed as short- to medium-term contracts, and of those, the majority are less than three years in length. Of these, a small proportion is set up to be routinely renewed, provided that organizations meet their obligations and manage their finances responsibly. That said, some data indicate that certain government funders might move from annualized to longer-term contracts. The same participant said,

> all of our contracts are renewed yearly but that's one of the things that our team is looking at is which contracts we feel confident enough in their deliveries and their management and all of that to be able to move into multi-year contracts so that there's less, you know, uncertainty with them and more guarantee that they're, they're doing ….confirmation I guess that they're, they're doing well in the community. (Policy Participant 03)

This move to longer-term funding, however, is exceptional. Rather, the preceding discussion points to the existence of simultaneous funding shifts than run the other way, going from long-term funding toward competitive funding arrangements.

Turning the focus of discussion to those arrangements where ongoing funding is in place but tied to short-term contracts, a non-Indigenous mental health provider who was working for an Indigenous NPO provides another important perspective that helps to further illuminate the processes that give rise to a funding paradox like this:

> Well I think it is a control thing because of the money and I think that because, because we have more flexibility, more discretion it doesn't mean we're not providing the best service possible right? We have ethics and we have values and … we sort of maintained our independence although they because they have all the funding, the core funding for … our programs they really call the shots, right? And they can dictate. And if we don't, they can just refuse to fund and it's year to year that we get our funding, right? And at some point they

> may just say 'no, there's no more money,' right? (Provider Participant 08)

Here the participant points to the existence of a classical tension between the need for trust and need for accountability that governments must balance when they are contracting out public sector services to third-party providers. Within the context of contracting in Indigenous health, however, this tension appears to be particularly pronounced. In the account above, the participant sees the use of short-term, annualized contracts within ongoing funding relationships as evidence of funders' desire to retain control over the organization, and as a disavowal of the organization's autonomy. In this view, such a contracting arrangement is not simply a reflection of a fundamental lack of trust in the organization's capacity to properly deliver the program, but rather it is also a statement about the organization's moral integrity. This hints at the resonance between contract arrangements and a colonialist, moralizing construction of Indigenous peoples as inherently deviant, irresponsible and incapable of self-governance. Recall the Indigenous Policy Participant from Chapter Five, who described funders treating Indigenous Providers like "the wicked stepchildren." Funders' tendency to use short-term contracts when contracting with Indigenous NPOs thus might not only be a response to neo-liberal exigencies, but rather it may be a structural manifestation of the way colonial stereotypes of the Other are re-enacted within NPM approaches to contracting.

Yet the data also drew attention to Indigenous resistance. One non-Indigenous participant directing programming at an Indigenous organization whose funding came from one large, ongoing, and annually-renewed government contract, said,

> Our funding from [government funder] … we don't really consider it to be a contract, … it's more about government service because it's been going on for so long that once you take it away it, it's something that you have to have a good explanation for. (Provider Participant 18)

The participant's account suggests that even though this contract requires annual renewal, the considerable length of time over which that this contractual relationship has been in place (more than two decades) has shifted the power dynamics and strengthened a conviction by community members that access to the program in question represents a rightful entitlement rather than a government purchase. As the participant explains, any decision to cut this funding would likely provoke a political outcry and garner public criticism from Indigenous communities (and possibly the public), affording the organization political leverage that it would not otherwise have. The account highlights the ways in which the use of short-term contracts for ongoing funding undercut the ostensive advantages that in the contracting literature are identified for either type of contracting model—classical and relational contracts.

That being said, the same organization reported losing its funding for a program that had been in place for seven years due to a government decision to put the contract up for open unrestricted bidding. This example indicates that the powerful rhetoric of NPM and adoption of market-based methods for allocating resources might in effect provide government with the “good explanation” that—according to the participant above—is needed to evade political backlash by drawing on a discourse of rationality and efficacy.

6.1.4. Complex and Fragmented: Patchwork Funding

This section focuses on the highly fragmentary and increasingly complex nature of the contract environment and its impacts on Indigenous providers. The study shows that, besides short-term contracting and competitive funding models, additional factors were salient. For example, access to funding was mired in jurisdictionally complex vertical funding hierarchies. Participants reported that organizations secured funding for the provision of mental wellness programs from all four levels of government (federal, provincial, regional and municipal). The Urban Aboriginal Strategy (2016) serves as one example of a federal funding initiative that supports a range of programs for urban Indigenous communities. In BC, funding for these programs is administered and managed through the BC Association of Friendship Centres. While Provider Participants mostly responded positively to this recent devolution of funding decision-making, it also inserted one more layer of complexity. As the following excerpt from an interview with an Indigenous administrative leader of an Indigenous non-profit organization (NPO) reveals, the complexity was compounded by the fragmented nature of allocation pathways within and between government departments:

> there’s mainstream funding and then there’s an Aboriginal stream of funding as well. So there are different funders even within [name of regional health authority] that we receive money from. … [E]ven though we’re Aboriginal organizations we access funding from the mainstream as well as the Aboriginal Health Initiative Program (AHIP). (Provider Participant 09)

Similarly, the majority of organizations in this study reported administering a mix of funding through multiple contacts from Aboriginal-specific and mainstream sources. While this can be strategically useful for organizations because it potentially enhances their ability to mitigate risks, this funding reality is also a consequence of the inadequate budget appropriations for Aboriginal health faced by health authorities in this study. Fragmentation was also structurally produced by the disjointed nature of the policy environment for mental health services, as the findings from the document review and Policy Participants confirm. A non-Indigenous administrator with an Indigenous NPO described the contractual arrangements in place to support the mental health programming at this organization:

> we have to have four contracts pieced together to have a counseling program, there's huge reporting and you're trying to report on four different contracts … to four funders … [with] different service deliverables in their contracts, yeah. (Provider Participant 04)

The account highlights the disjuncture between Indigenous approaches to mental health programming that are congruent with a holistic understanding of mental health and the siloed policy approach that governs mental health and addictions care in BC. In the scenario above, the organization held four different contracts from four different funders, each with its own mandate, each providing funding for mental health-related programming and/or addictions services, and each according to their own rules, standards and criteria.

As discussed in Chapter Five, the Western biomedical worldview continues to shape the structure of the (mental) health care systems. For example, while there is increasing recognition of the importance of addressing the social determinants of mental health to improve Indigenous people's mental health outcomes at the population level and to redress persisting inequities, the structure of the health care system is such that the responsibility for addressing the majority of these social determinants of mental health falls outside the mandate the Ministry of Health, and by extension BC's health authorities. It was not surprising, therefore, that almost all NPOs in this study reported receiving part of their funding from non-health departments, such as for example, justice, education and housing.

Complicating the situation further is that responsibility for the provision of mental health and addictions care for children and youth is part of the mandate of the BC Ministry of Children and Families, while mental health and addictions care for adults is under the jurisdiction of the BC Ministry of Health (BCMOH). Further, although mental health and addictions were brought under one portfolio at the ministerial level in 2001, regional health authority data show that portfolios of mental health and addictions are often managed by different program directors, while tertiary mental health care and specialized mental health and addictions services are the responsibility of the provincial health services authority. The existence of these and other fault lines between different departmental divisions and units holding different portfolios (e.g., mental health and/or addictions; population health and Aboriginal health) within health authorities and governmental ministries have created a funding maze.

In recognition of the need to work together, cross-departmental and -jurisdictional collaborations have taken place, resulting in the creation of new integrated service models funded on a cost-sharing basis. The creation of a new BC Mental Health Tertiary Facility, which provides treatment for people with dual diagnosis, is an example of this. Another is the development of the ten-year First Nations and Aboriginal People's Mental Wellness and Substance Use Plan (2013) by the tripartite partners in collaboration with health authorities and input from the Urban Friendship Centre association. Yet, while the data of this study show some evidence suggesting that this collaboration has indeed resulted in innovative cost-sharing models in support of promising mental health and addictions service delivery models for First Nations, in relation to urban community-based mental health and addictions care, collaborative approaches appear to be lacking. Rather, the responsibility of collapsing the multiple structural and jurisdictional barriers that underpin mental health and addictions funding seems to have been off-loaded to Indigenous Providers. They face high administrative costs related to piecing together contracts in an effort to create holistic programming, each of which comes with different reporting requirements and formats.

Fragmented access to funding was further supported by the increasing separation of core funding from mental health funding identified in section 6.1.1 as well as the current extent of targeted funding streams for specific conditions or interventions within Aboriginal health funding programs. These were often treated as mutually exclusive funding opportunities—meaning that organizations could only apply to only one of the thematic funding streams within one program. As one Indigenous Policy Participant explained to the researcher,

> AHIP is more broad stream so whereas the, the other ones, the AHS ones, are all mental health and addictions focus. The AHIP ones have a variety of different focus, so we have food security, early childhood development, chronic disease, injury prevention and mental wellness [whereby] the majority of it is with mental wellness and self esteem and those are not direct service contracts so that's the main thing too, is that they're, they're more group activities and capacity building activities which a lot of times is a form of group things so, yeah, a lot of teaching in, in that area. (Policy Participant 03)

Although both initiatives (AHIP and AHS) within this particular health region offered funding for mental health and addictions programming, AHS provided more expansive program funding that included clinically-oriented services to mental health and addictions care. AHIP, conceptually more closely aligned with a health promotion and prevention approach, on the other hand, excluded support for direct care services, such as formal counseling. Instead, AHIP distributed project as opposed to program funding via five different funding streams, all targeting distinct health priorities.[36] Of these priorities, mental wellness was one; however, the funder's distinction did not necessarily match the perspective of Indigenous Providers, several of whom provided accounts of 'mental wellness' programs that were funded through official AHIP dollars but not targeted at promoting mental wellness.

An Indigenous participant acting as executive director of an Indigenous organization explains that the approach of this organization was to see mental health programming integrated across all programs. In their words,

> I would say that there's probably four to five specific programs but I think that themes of mental health supports and work run through all the programs but … like I was saying, you know, we have some programs that are specifically named mental health programs but mental health issues are right across the board for us like we see that in our housing in a huge, huge way, you know, we see that in our education programs … you know, many of these … young people that come to the programs have huge, huge, huge challenges and obstacles to employment as a result of mental health issues. (Provider Participant 09)

Other participants also highlighted the need to integrate mental wellness components into other social services and supports, such as housing or employment programs. In the following excerpt, the same participant goes on to share how their organization achieved this holistic approach to mental wellness programming despite a fragmented funding environment:

> so the cultural, the spiritual advisor, a little bit of the funding comes from everywhere, all of the programs and funders in here [`here' refers to an overarching mental wellness program funded through several different mental health and addictions contracts] but throughout the rest of the organization as well because … the person … works throughout the whole organization. And so bits and pieces of his funding come from all kinds of different programs. (Provider Participant 09)

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[36] Importantly, while regions differed in their particular distribution and funding regulations of AHIP and AHS dollars, the interview data and document review confirm the existence of equally complex and similarly fragmented funding pathways in other regional health authorities.

Here, a ‘cultural or spiritual advisor’ acts as a mental health and spiritual resource for all programs. This staff member’s salary was financed though several different contracts, including contracts for services that were not designated as mental health and/or addictions services, as the same participant explains:

> So within the organization we get the pot of money and we determine what the service delivery hours are going to be and then we attach those to the positions based upon those service delivery hours and based upon the core amount of work that they do within that program. (Provider Participant 09)

According to the participant, this was made possible only because of the long-standing relationships that this organization had with several of the funders and its reputation as a trusted service provider:

> So we have the ability … through [our] ongoing work with all these funders and our ongoing engagement and being able to deliver quality services for a long, long time. (Provider Participant 09)

This account highlights the important role that trust plays in enabling autonomous decision-making for Indigenous Providers in relation to holistic mental wellness programming and effective management of complex and fragmented contractual arrangements. However, such forms of resistance often came at a high cost, including the added administrative burden associated with managing multiple contracts within a funding environment where administrative costs were increasingly excluded from the list of eligible expenses, as previously discussed under section 6.1.1. Elaborating further on this issue, the same participant goes on to explain,

> So if we were to lose, for example, funding [from funder A] we would have to take a look at our whole staffing model up there because [funder A] is attached to each one of these programs even though they’re not necessarily [funder A] contracts, right? (Provider Participant 09)

Thus, the organization’s funding remains at risk despite trust and engaged funders. If they lose one contract, the staffing model and program infrastructure are de-stabilized. Notably, this risk is not equally shared between the funders and the contracted agency, but rather, it is concentrated on the provider’s side, entrenching dependency. Thus, the current funding environment seem to be structured in such a way that contracted NPOs are carrying both the responsibility for and the risks of finding creative solutions to funding complexities and fragmentation. In a similar but slightly different vein, a participant who coordinated mental health programming at a different Indigenous organization notes how the disjuncture between a complex, siloed funding structure and the organization's holistic program approach is not all negative:

> [W]hat makes [name of organization/program] unique is that we don't have to meet the mandate of mental health and addictions specifically because that … doesn't meet the needs of our clients because it excludes all the … care and stuff. So we kind of have to try and choose which parts of each of those programs we're going to meet and that's where it becomes difficult … because we fall under mental health and addictions [but] they don't have any other programs that do what we do. … So we follow the protocols that they set out but we also follow protocols that primary care sets out and we also follow protocols and policies and procedures that other people put out but we don't follow all of them, does that make sense? So it's kind of, the ones that we need to make this program work we use. We also do methadone right? So like that's where I mean it's confusing [but] it also allows us to be creative. So it's got its pros and cons. (Provider Participant 07)

Here the participant highlights how diverging from a given structure creates both challenges and advantages. On the positive side, it appears that it has afforded the organization creative freedom in program design and delivery and allowed them to sidestep top-down standardized practices rules and regulations. On the negative side, the data reveal that navigating and negotiating multiple, competing, and at times conflicting practice standards can also be time-consuming and challenging, in particular within a context where fiscal accountability pressures have intensified and/or where the relationship between Provider and funder is hierarchical and marked by mistrust.

This last point is exemplified in an interview excerpt with another community-level participant who administered service contracts at another Indigenous NPO. In the following excerpt, the participant, who identified as non-Indigenous, describes how a change in funding priorities can impede effective program planning and delivery:

> So we try to … do … planning, so we have, we're developing now a new … plan that's looking at what are we going to be doing for the next five to ten years? But again that's always influenced by funding. I mean we just went through a cycle with the previous federal government where every, they cut out most of the cultural type training, they wanted real employment outcomes, everything had to, you know, be focused around unemployed youth particularly and getting them into work as soon as possible. And that kind of thing happens a lot. (Provider Participant 18)

The participant's narrative illuminates the adjustment of priorities and plans to suit funders' agendas. In situations where one program is financed through two or more funders, such uni-directional changes by one funder can create serious dilemmas. In the scenario above, the agendas of two funders (in this case two different orders of government) no longer aligned. As a result, the participant explains, “we’re caught in this bind” trying to sustain a program that was accountable to the people it served, while also trying to resolve a conflict between the program expectations of two funders.

Conflicts can also arise over the division among funders of geographical areas. An Indigenous participant shares a story that illustrates how jurisdictional boundaries between funders can constrain Indigenous efforts to implement innovative culturally safe approaches to mental health and addictions programming for urban Indigenous people:

> I recall not too long ago there were a group of people here who within the [regional health authority [RHA] ‘A’] … got together, these are Aboriginal people, and they wanted to create a, a rural camp … where … people … could go to, to sober up and to do culturally kind of appropriate activities and ceremonies and … actually live close to the land in kind of an encampment that they would create themselves. And they found … a person with some land out in the [name of] Valley who was quite willing to loan them a patch of his land where they could set up this camp. And they came back to me and they were all excited and so on and I helped them write proposals and so on, only to … [to be] told that because the land was in the [region of HA ‘B’] they must go and talk to the … people [from RHA ‘B’]. So they went and they… tried to sell the idea to the [RHA ‘B’] …only to be told well all of your clients come from the [RHA ‘A’] so you’ve got to go back in there. And these people were just, you know … they just said to hell with it, this is stupid. And, and I had to agree with them it was absolutely crazy. (Provider Participant-10)

Given the importance of land-based programming for urban Indigenous people, this excerpt highlights the need for greater collaboration between funders. As discussed in Chapter Five, land-based approaches to mental health are meaningful to many Indigenous people, who nonetheless might have limited access to land within highly urbanized health authorities.

Following a somewhat different line of argument, several participants expressed concern about the implications of a highly fragmented and complex funding environment on system-level oversight and accountability. As one community-level participant observed, with “the pool of money … being split in so many ways … because … you have one big pocket which is the federal government and you have all these other little pockets [it becomes difficult to know] how much are we duplicating, what’s going on” (Provider Participant 19). The participant’s observation calls attention to current funding environments’ lack of transparency, which makes it difficult to assess the overall efficiency of current funding approaches in addressing the needs of Indigenous people who live with mental health and addictions issues. An Indigenous Policy Participant adds to the discussion by noting,

> AHS is … at such a primary level of development that while you might consider there to be some duplication by the sound of the contract, in fact, you're not really duplicating anything. There are huge, huge, huge gaps in services … and in appropriate services particularly. (Policy Participant 05)

While duplication discourse locates the problem of "waste" at the level of service delivery, and thus Indigenous Providers, this account hints that such discourse is false, and that it erases other considerations, such as (a) the economic uncertainty of Indigenous Providers within current funding regimes and (b) the continued absence of an overarching funding framework that could assist in the development of a coordinated, multi-jurisdictional funding approach for urban Indigenous mental health and well-being.

The lack of transparency of the current funding environment for urban Indigenous Providers also negatively impacted Providers' ability to access appropriate program funding. As a non-indigenous Provider Participant who was working both as a provider and administrator for a small Indigenous NPO explained, the predominant way to find out about potential funding opportunities was by "word of mouth … that's where networking comes in huge where you kind of hear what's happening or what's going on" (Provider Participant 19). Faced with a maze of funding sources and allocation pathways, many other administrators who worked for Indigenous NPOs in this study—particularly at small organizations—reported relying heavily on their established networks and relationships to learn about new funding opportunities.

In the following interview excerpt, another administrator, who identified as an Indigenous person and worked for a comparatively small Indigenous NPO, speaks to the pragmatics of deciding what funding to apply for:

> I'm writing proposals and writing grants but often times I find that … I don't have time to research, you know, what I could do. I know people they throw things my way sometimes and I'm going like even just to go through something and see sometimes I don't have the time, a lot of times I'll look at the amount of the funds and I'm going like do I really want to do this because that work is going to fall on my shoulders. (Provider Participant 17)

Thus, in-depth research into funding opportunities is often not feasible at small organizations. This participant, for example, only held a part-time position while also working as a mental health provider. Funding opportunities that are a good fit with the priorities of the organization might be overlooked in such cases because the costs of applying exceed the value of the contract itself. As the same participant remarks, “I pass up the twenty thousand dollar one … I would say …[but] if I saw something for forty, sixty, hundred, you know, those are [worth applying for], yeah” (Provider Participant 17).

In a similar vein, the previous interviewee, Provider Participant 19, explained the complexities involved in applying for funding:

> So you’ve got the proposal which is good but then you also have to do the networking to find out who your partnership is with, who’s going to support you, what does that mean, what’s their portion of, you know, because that’s the other thing a lot of these funders want partnerships with other organizations so what does that look like? It’s about creating those partnerships with other organizations, it’s about trying to know where you want to go and having a focus and being able to work with the staff and work with the board and work with the ED and make sure that everybody is, is getting a vision of where they want to go not just me going, okay, I’m going to apply for all these places so it means a lot of kind of sitting down and trying to see where it’s going, meeting with staff, see what they see, where do you see that we need more funding or where do you see that we need that so it takes a lot of time. (Provider Participant 19)

This narrative calls attention to community partnerships as a particularly arduous funding prerequisite because this requirement asks Providers to repeatedly approach other NPOs for and/or provide others with letters of support. Several participants expressed concerns about this step, especially considering that other Indigenous NPOs were competing for the same funding, and only very few proposals are successful:

> most of the time we’re rejected, you know, I, oh we had too many, you know, the answer is always we had so many applications and you were unsuccessful and like uh, uh, after spending, you know, it takes so many hours just to do a proposal. (Provider Participant 17)

Overall, it appears that rather than promoting efficiency, the implementation of competitive and/or short-term contracts within jurisdictionally complex and fragmented funding environment that is unique to both Indigenous health and mental health policy environments has created inefficiencies in the health care system, the costs of which are disproportionately borne by Indigenous Providers as well the communities they serve.

6.2. The Politics of Inclusion

Another overarching theme that threaded across participants’ interviews centred on inclusion—part of the larger map of inclusions and exclusions shaping Indigenous Providers’ experiences of contractual negotiations. Findings demonstrate that issues of recognition and representation are imperative to understand structural inequities that constrain the transformative potential of government contracting with urban Indigenous Providers in mental health. One Indigenous community-level participant who had been working as a senior administrator for an Indigenous organization for more than two decades remarks on the 'typical' collaborative approaches to Indigenous service planning between funders and organizations in the following:

> the problem is there's never any real negotiation in contracting when it comes to government funding. And … if there was maybe … we could get at some of the problems I'm talking about here because it becomes very frustrating. And … contracting usually comes out of a process where people in, in at some level of government have decided they're going to make a certain amount of money available to, to tackle a certain problem. And they're going to then immediately begin to say, 'okay, well if we're going to use this money what do we use it for and what would be the best use of it and how does it meet our need' whether the needs are political and administrative or bureaucratic or whatever. And, and so left out of that process is the discussion I've talked about with people who are on the ground trying to deal with problems. (Provider Participant 10)

This experience resonated with that of many community participants' accounts regarding the marginalization of urban Indigenous community-based voices in health care priority setting, planning and development for Indigenous mental health care programs and services. To this participant, the needs of funders and those of the community often misalign. Funders' priorities are perceived as being driven by predominantly administrative, bureaucratic or political needs, with little regard for what Indigenous Providers have to say about the needs and concerns of communities they serve. The same participant adds to the discussion, saying,

> [T]here's a misconception that somehow we align ourselves to … this is what they want us to do and this is why they're willing to give us money to do it but it's always something that gets designed in … an office by some people who think they know what the problem is out there and what … is needed in order to solve the problem rather than coming, you know, first and sitting down like we're sitting down and saying, okay, what do you think the problem is and … [what] do you think … if we make some funding or some resourcing available to you, what can be done about it? And, and that very seldom ever happens. And … what comes out of the other end of the process doesn't always make sense. (Provider Participant 10)

This account suggests that Indigenous Providers are placed in an agency relationship to government funders and policy decision-makers. Provider participants like the above saw contractual negotiations as one-sided, and as lacking both openness and priority-setting at the local level. In the words of Provider Participant 10, “I’ve yet to really negotiate a contract.” Another Indigenous participant, who had frequently acted as policy consultant to governments and other decision-making bodies in the area of Indigenous health, elaborates, stating that,

> Funding is good when you can access it let’s face it everybody is trying to get funds for all kinds of things today. But the government I think cherry picks and says this is what we want to fund because it’s working, it’s obviously going to give us a lot of street cred, you know, if, if we get ourselves involved in there. … [I]t’s kind of contradictory there’s a bit of a conflict, a contradiction in there. So … what I’m saying is how much is happening on the ground, how many wonderful good transformative change filled things are happening on the ground we don’t even know of … [And] how many others have been funded that [where] there’s very little take up by, by people because they’re not relevant, ready or meaningful? (Policy Participant 06)

Here the participant speaks to the pragmatics of funding decision-making within government, which, in this participant’s view, are shaped predominantly by a desire by government to protect and defend its own credibility and legitimacy by seeking to direct funding to programs and services that are seen as effective and aligning with their own priorities—reflecting perhaps the exigencies of an increasingly neo-liberal climate. As the above account and those of other Provider and Policy Participants suggest (for example, Provider Participants 10; 21; 22 and Policy Participants 01; 02; 05) a focus on ‘effectiveness’ and ‘risk management’ re-enacts paternalistic modes of governance. Tensions are compounded because the assumptions that underpin existing government priorities, the populations targeted for policy interventions, and governments’ preferred modes of intervention often do not fit with the perspectives of Indigenous community-based Providers nor their epistemological and cultural frames of meaning.

As the same participant alludes to below, transformative change seldom takes place at the level of policy only, but rather it is propelled forward by grassroots social movements:

> Some initiatives that are home-grown … that have been low cost, low tech … have been co-opted by the government. … I say co-opted because then, then the government moves in and takes it over and says, ‘oh look, look what we’ve created,’ you know. And they take it away from the First, the First People who created these innovations because then they’ll start funding it, right? And which is a good thing, funding is a good thing but then tailoring it so it meets government guidelines isn’t exactly what was intended in the first place. Like people … want to work with what works best for them not what has been tailored for them by the government. So I guess it’s sort of like a double-edged sword if I can say it that way. (Policy Participant 06)

This perspective, shared by many other Indigenous participants in this study, identifies that the most innovative, effective and meaningful health and healing programs for Indigenous peoples are "home-grown." Yet, while organizations in this study all reported receiving program funding from government, several factors make today's program funding a double-edged sword, including (1) the financial dependency of Indigenous organizations on government funds; (2) an ongoing lack of recognition of and respect for Indigenous ownership and control; and (3) an ongoing ethnocentrism. Taken together, these factors support the embeddedness of assimilationist ethos; for example, many Provider Participants who worked in the Indigenous sector (Provider Participant 04; 10; 11; 19; 22) talked about how they perceived to be co-opted into accepting government funding and funding terms they know threaten the meaningfulness of their programming. The notion of funding as a double-edged sword is also addressed by a non-Indigenous community-based participant who directed programming at a different Indigenous organization:

> Sometimes people will come to us … [with] a certain type of funding but we have to be careful … once we start developing a program that's a lot of work that goes into that, it's essentially an intellectual property. So we want to have some sense that we would be able to continue that after the particular funding that's available or a particular contract that's available. (Provider Participant 18)

Notably, to the participant, designing a program that is informed by Indigenous perspectives and community needs effectively represents intellectual property, or if we accept that all knowledge is cultural, cultural property. In this context, contracting might thus be interpreted as a neo-colonial practice that is implicated in ongoing processes of dispossession and assimilation.

Reflecting on several years' experience with contract management and negotiations pertaining to Indigenous mental wellness programming both on-and off-reserve, one Policy Participant, who was working in a governmental setting and self-identified as Indigenous, provides an account of contracting that illustrates how respect for and recognition of Indigenous self-determination and local expertise can inform contracting practices in the area of Indigenous mental health and addictions:

> basically what's involved with the contract is usually we're going to have some kind of a gathering where we all come together to go through the content so there'll be travel money sent to them … So I mean the year before we had kind of funded most start up costs so that people could develop … programming, …[and] they've really helped us a lot in developing the program. So … we kind of …

> whenever possible try to leave it [the Schedule A] as generic as possible because we don't want to be prescriptive we're like 'this is what we'd like but', you know, depending on the variability in community like size or whatever … they'll tell me, you know, how they want to run it and do it. (Policy Participant 02)

Elements touched on in this account (and also discussed by other participants) that seem to foster trust, mutual respect and shared responsibility between Indigenous Providers and government funders include: 1) relational approaches to contracting supported by resources (i.e., travel funding) and opportunities (i.e., gatherings); 2) contextual program tailoring including open-ended contracts; 3) recognition of Indigenous Providers as equal partners, including their involvement through the contracting process; 4) reciprocity and openness to learn from and with community partners; and (5) support of Indigenous Providers' autonomy and accountability to their communities.

As the participant explains, through the process they describe, Providers were able to take ownership of the program, which encouraged the community toward it, and in some instances, yielded results beyond those articulated in the contract:

> it ended up being this kind of amazing thing … [and] that's not something that's here [participant is pointing to the written contract] but that's something that happens just because, you know, you go well what are you guys going to do? (Policy Participant 02)

The two excerpts above point to the important role contracting can play in supporting community-based healing by fostering conditions that promote community autonomy and community ownership. In addition, as the narrative above suggests, healing may have an emergent quality to it, and as such, it may be best supported by contractual relationships that are based on trust, and on strength-based funding approaches focused on creating an enabling environment and building upon resources which already exist within the community.

Refocusing the discussion slightly, we turn to an Indigenous participant who worked as a provider for an Indigenous organization. They direct attention to the need for collaboration among urban Indigenous organizations and the inclusion of their voices into community mental health planning,

> I think we need more to get together … as a community … to plan, … different agencies coming together looking at what we have and more looking at [it] community wide rather than one agency … because … we all deal with the same people and … so if we work together in looking at, okay, how can we work with the mental health of people, we're all getting burnt out because of the work that we're doing in our

> own agencies because we're so short-handed. How can we better use the resources to, to work more efficiently and maybe we can find a way of working that is more effective … because … I think there's still discrimination … within the system … historical issues from the past … and I think it's all created by funders like … the funding system I should say. And I really think that it's … caused from … everybody fighting for the pots [of money]. (Provider Participant 02)

In this view, a collective stance could help redress the fragmented and divisive nature of current funding allocation. This participant interprets inattention to the structural inequities embedded within current funding arrangements as evidenced in a lack of an urban-focused Indigenous mental health policy as a manifestation of ongoing colonialism and institutional racism within the health care system. Likewise, in the following interview quote, a participant, an Indigenous thought and practice leader, speaks to the importance of creating a space for an Indigenous vision in policy that is at once inclusive and respectful of diversity.

> I thought it was commendable that they [the Mental Health Commission of Canada (MHCC)] would use an Indigenous lens and an equity lens … And I thought that was quite ethical and I thought it was quite ethical that … there was as much communication as possible with First Nations, Inuit and Métis. And I think … their issues were brought to the table by the advisory committee members … to make sure that we really shine a light on the Indigenous people in Canada and shine the light so that it … shows us the way. Not to shine it as 'oh look at these alcoholic, unemployed people who can't get it together' but to shine a light on us so we can find our way. Not that we're necessarily lost but … really trying to come up with a vision that could see us move forward. … So … their idea, their vision of what this should look like [and] I think, I hope that the Mental Health Commission recommendations move us to that direction. (Policy Participant 06)

From the perspective of the participant above, Canada's mental health strategy, 'Changing Directions, Changing Lives' (MHCC, 2012), provides an example of a policy that puts forward an Indigenous vision for improving Indigenous mental health and well-being. Guided by a First Nations, Inuit and Métis Advisory Committee, the strategy was developed within an Indigenous rather than the dominant cultural epistemological framework, attentive to the distinctiveness of Indigenous voices, and conscientious about giving voice to urban Indigenous communities. From a total of six strategic directions identified within 'Changing Directions, Changing Lives' (MHCC, 2012) for transforming Canada's mental health care system, one strategic direction is dedicated solely to Indigenous people's mental health, with Strategic Direction 5 calling upon all levels of government to "Work with First Nations, Inuit, and Métis to address their distinct mental health needs, acknowledging their unique circumstances, rights, and cultures" (p. 96). As this directive makes clear, Canada's national mental health strategy calls for a collaborative approach between government and Indigenous peoples. In so doing, it emphasizes the importance of paying increased attention to the unique features that shape Indigenous peoples' experiences of mental health needs within urban contexts. In line with this view, the Plan makes the following recommendations,

> 5.4.1 Develop a mental health and substance use strategy for First Nations, Inuit, and Métis in urban and rural centres.
>
> 5.4.2 Increase capacity to provide access to a full continuum of mental health services, treatments and supports for and by First Nations, Inuit, and Métis in urban and rural centres.
>
> 5.4.3 Take collaborative action across all levels of government to address complex social issues that undermine First Nations, Inuit, and Métis mental health, such as violence against women and over-representation in the child welfare and criminal justice systems, regardless of where people live. (MHCC, 2012, p. 104)

The above recommendations emerge as highly relevant in light of this study's findings. However, while alignment appears to exist between the national mental health directions and local experiences of Indigenous Providers, the current funding and policy environments supporting delivery of community-based mental health and addictions services for urban Indigenous peoples point to a disconnect between national and provincial/regional policies. As the above participants' accounts reveal, urban Indigenous voices continue to be silenced: funding and contractual negotiations are often perceived as co-opting community-based Indigenous NPOs into accepting funding terms that compromise organization's autonomy, cultural identity and relational accountability. Meanwhile, competitive methods of resource allocation are experienced as reminiscent of colonial "divide and conquer strategies." So what is/are the vision(s) of urban Indigenous peoples and Indigenous community-based organizations in BC moving forward? What vision is currently driving government contracting with urban Indigenous NPOs for the delivery of Indigenous mental health in BC? And how are urban Indigenous voices included in this vision, if at all?

In BC, A Path Forward (2013), BC's ten-year First Nations and Aboriginal People's Mental Wellness and Substance Use Plan, provides the current vision for Indigenous mental health. The plan is based on collaboration among tripartite partners, as well as representatives from the BC Association of Aboriginal Friendship Centres

(BCAAFC) and the Métis Nation British Columbia (MNBC), indicating some inclusion of urban Indigenous people. It opens with a shared vision statement taken from the Health Partnership Accord (2012), which is "capturing the vision of the [tripartite] Parties" and reads as follows,

> The Partners have a shared vision … The vision is a future where BC First Nations people and communities are among the healthiest in the world. We envision healthy and vibrant BC First Nations children, families, and communities playing an active role in decision-making regarding their personal and collective wellness. … In this vision, First Nations people and communities have access to high quality health services that are responsive to their needs, and address their realities. … These services are delivered in a manner that respects the diversity, cultures, languages, and contributions of BC First Nations (FNHA et al., 2013, p. 3).

As this excerpt makes clear, while tripartite partners have articulated a shared vision, the health and well-being of urban Indigenous communities, or the role of urban Indigenous peoples in "decision-making regarding their personal and collective wellness," are not included in this vision. Urban Indigenous people and organizations were not party to the tripartite negotiations. This exclusivity is odds, however, with the inclusion of the BCAAF and MNBC in the development of the plan, as well as with the overall focus of the plan, which is inclusive of "First Nations and Aboriginal People." Indeed, further into the document, the Plan states that the "[t]ripartite work is focused on transforming and improving systems while creating space that allows for increased decision-making by First Nations *and* [emphasis added] Aboriginal people" (p. 8), indicating that implementation of the tripartite policy framework might be more inclusive of urban Indigenous voices than its development and original language might imply.

Nonetheless, as the following excerpt from an interview with an Indigenous senior administrator of an Indigenous organization illustrates, the exclusion of urban Indigenous people has created vulnerability for urban Indigenous organizations:

> … now [where] we have the First Nation's Health Authority (FNHA)… are those dollars which right now are very specific to urban Aboriginal agencies going to be impacted by the changes … There hasn't been the dialogue around what the urban piece is going to look like and so, you know, we're very interested in creating processes so that we don't lose those dollars because that's, you know, that's a huge, yeah, that would have a huge impact to our organization as well as the others right? And so … if those dollars are eventually going to go over to the FNHA what does that look like and will there be different processes that are developed for urban agencies, right? Because at this time they're focusing very, very much on the First Nation's side of it. They haven't really and I don't think they have provincially done a whole lot

> of work around the urban pieces. So in terms of [name of health authority] and the Aboriginal Health Initiative Program (AHIP) dollars, you know, what is, what is the future of that going to be? (Provider Participant 09)

Thus, a high level of uncertainty and apprehension exists regarding the impact of the creation of the FNHA on urban Indigenous organizations. Despite some assurances, no dialogue seems to have taken place with urban Indigenous organizations—at least not in this health region. In the absence of one overarching representative governance structure for urban Indigenous peoples, the geopolitical boundaries of different health authorities' regions act as another factor that prevents urban Indigenous peoples from participating as full partners in policy decision-making. Despite the transfer of former federal functions (including the funding, planning, management and delivery of health services for First Nations) from Health Canada's First Nations and Inuit Health Branch (FNIHB) to FNHA, FNHA's mandate and funding structure remain tied to a paternalistic colonial policy framework that is focused on health care delivery on-reserve and fails to recognize responsibility for Indigenous people who are not registered under the Indian Act. As discussed elsewhere, historically speaking, federal policies have had the effect of rendering urban Indigenous communities largely invisible. Still, not all participants expressed apprehension about the FNHA. One non-Indigenous participant with a long history working as a mental health provider for an Indigenous organization identifies some potential benefits:

> [T]he First Nations Health Authority may be interested in taking us over … and that may be more reasonable to deal with them than [name of RHA] because we deal with a lot of people provincially right and resources provincially and First Nations not just [name of urban centre]. Many of our clients come from all over the place so I think it would be, it would be a lot better to have the First Nation Health Authority sort of providing our funding, providing our monitoring and whatever guidance [or] direction … that's my sense, more appropriate. But because our board of directors and an executive director said we're open to anybody that opens the door for [name of RHA], right? So that transition probably won't happen not right away, it may happen in a few years but it should have happened quicker right but it hasn't yet …and the federal government has more money. (Provider Participant 08)

There is an expectation here that dealing with the FNHA as a funder might mean (a) a less adversarial and more cooperative relationship, and (b) increased access to more (federal) resources. However, the participant seems to believe that such a shift in governance would be met with resistance by the regional health authorities, whose concern is, as perceived by this participant, less with the promotion of Indigenous self-governance than retaining authority and control over Indigenous NPOs.

Another participant, who was directing an Indigenous organization, makes an observation that illuminates yet another disadvantage experienced by urban Indigenous peoples within contemporary governance relations:

> it's an interesting governance issue … if the First Nations and the tribal councils and the provincial and federal Aboriginal organizations such as the Assembly of First Nations are the voice of the on-reserve people then who is the voice of the off reserve people because those organizations don't first and foremost represent off reserve? (Provider Participant 18)

Here, the participant calls attention to the lack of representational structures that exist for urban Indigenous people that would enable urban Indigenous people to have a voice at the policy table. This issue is also addressed by an Indigenous Policy Participant:

> Well you know the Aboriginal population in urban context changes frequently and so it's very difficult to have a long-term advocacy, consistent advocacy going on which is why organizations like [names of Indigenous NPOs] etc. have a role in community advocacy around patient care. That's not to say that they are the only voices or the full voice of the community, they aren't. But they are the limited structures that are in place in an urban environment that facilitate some of that language being passed on. (Policy Participant 05)

This observation suggests that long-term contracting in health with Indigenous community-based organization has enabled urban Indigenous organizations to act as the (necessarily incomplete) representative voice of the people they serve. An Indigenous participant who has worked within the policy area of Indigenous health for many years explains the role of the Indigenous non-profit sector as follows:

> NGOs of all the sectors and I speak to you about the private sector, public sector and blended sectors, NGOs are closest to the ground. They've got a pulse on what's happening for the people and what 'lived experiences' are about. (Policy Participant 06)

Here the participant points to the unique understanding that Indigenous NPOs have of the issues, needs and concerns in their communities suggesting that among all sectors, Indigenous NGOs are best positioned to represent those voices when it comes to health policy planning and programming. On a similar but slightly different note, another Indigenous Policy Participant working as a contract manager for a government body states,

> I think the intent [behind contracting] is that the Aboriginal people will deliver the service to the Aboriginal people so that they will be able to

> deliver their own services … they know the community best, what's needed and necessary and [so] they're the best ones to be able to deliver those services. So I think that that's one of the main goals and beliefs like an unspoken policy, I don't believe that it's written anywhere but, yeah, because it has been ongoing for a number of years (Policy Participant 03).

The participant's account highlights a contradiction in the policy discourse: on the one hand, the 'practice' of contracting is seen as a mechanism to realize urban Indigenous peoples' rights to design and deliver their own health services, and that the role of Indigenous NPOs is not simply that of a service provider; on the other hand, there seems to be no official policy articulating this commitment and/or holding governments responsible for outcomes.

The ongoing invisibility of urban Indigenous peoples—and their organizations, needs, and rights—is reminiscent of the colonial imaginary that continues to frame *urban* Indigenous peoples as out of place. Indeed, the data of this study reveal that 'policy texts' have remained largely silent on defining the kind of relationship government funders have to urban Indigenous organizations, as well as their role and responsibilities in relation to mental health care and the implementation of key guiding policy objectives, such as those identified in BC's First Nations and Aboriginal People's Mental Wellness and Substance Use Plan. Further, contrary to the new governance relationship between BC First Nations and provincial and federal governments, the nature of the relationship between urban Indigenous people and government has remained outside the scope of Indigenous rights discourses and invisible in the policy realm—as the above participant puts it so aptly, "unspoken" and "unwritten." Rather than being enshrined in a public contract, urban Indigenous–State partnerships and 'reciprocal' accountabilities seem to be articulated through a series of discrete, private contractual relationships, with contract negotiations that are not privy to public oversight or scrutiny. While contracting might have created some opportunities for the enactment of urban Indigenous citizenship at the level of service delivery, at the policy level, contracting seems to have had the paradoxical effect of depoliticizing urban Indigenous–State relations by keeping talk about urban Indigenous citizenship rights in the private realm.

This finding is striking and begs the question of what the broader policy vision for contractual relationships is between governments and urban Indigenous providers. An Indigenous Policy Participant who worked within a different governmental setting explains the basis for contracting with Indigenous providers as follows:

> we see … these horrible practices and nobody is being sort of held accountable for that so not only should we have contracts for Aboriginal service providers and I don't think we're anywhere near shutting them down. (Policy Participant 01)

Here, the participant seems to evoke a moral argument for contracting by framing contracting with Indigenous providers as the only mechanism currently in place to provide access to safe and effective health and social services and supports. However, the participant's narrative seems also to imply that once the mainstream system has achieved the status of a "culturally competent organization," contracting with Indigenous providers might cease to be necessary—an assumption that seems to construe the purpose of contracting with Indigenous community-based organizations in terms of service provision only.

Read in relation to each other, this and the previous participant's account point to two competing and conflicting visions of urban Indigenous organizations as they inform the discursive practice of contracting for Indigenous health care. One vision is of urban Indigenous self-governance as a platform for contracting. The other is of Indigenous organizations as little more than a government agent for the provision of Indigenous health care. As the following Indigenous Policy Participant argues, for a truly collaborative partnership to emerge, "we need to have some conscious discussion about …where [urban] Aboriginal people have fitted into society or not fitted into society and where they currently fit into society" (Policy Participant 05).

While there are many urban Indigenous voices, the following excerpt from a draft discussion paper on the topic of health and wellness developed by the Metro Vancouver Aboriginal Executive Council[37] (MVAEC) provides an example of a collective Indigenous vision that has been put forward by urban Indigenous NPOs:

> As self-determination is central to the health and wellbeing of all Aboriginal people, including those living in urban settings, it is vital that urban Aboriginal voices be involved and included in the design, development, delivery, and evaluation of health care services in Metro Vancouver. A healthcare system that is truly responsive to the needs of Aboriginal communities must take into account the unique issues associated with the urban context. Urban Aboriginal community-based organizations are the experts on the health and wellbeing of their community members and must therefore play a meaningful role in the

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[37] MVAEC is a society comprised by over twenty different urban Indigenous organizations located within two different regional health authorities, which formed in 2008 in response to "the urban Aboriginal community's desire for a more collaborative, strategic, and unified voice across Metro Vancouver" (p. 2).

> decision-making processes of regional health authorities (MVAEC, 2017, p. 4)

While this excerpt demonstrates that Indigenous organizations are in the process of reclaiming not only a collective voice but also their role as policy partners within health care, it also suggests that there is a shared view that urban Indigenous organizations have so far not been meaningfully involved in “the design, development, delivery, and evaluation of health care services”—this despite evidence of health authorities’ various policy commitments to do so. Moreover, while the data indicate that both of these regions (like all other health authorities) have created some participatory mechanism for urban Indigenous organizations, mostly in the form of advisory committees, the formation of MVAEC along with the quote above suggest that such structures are not always perceived as affording urban Indigenous organizations adequate or effective opportunities for health-policy participation.

The above excerpt is also noteworthy in directing attention to “the unique issues associated with the urban context.” In much the same vein as Canada’s mental health strategy, this comment supports the need for an urban lens for discerning how Indigenous people’s experiences of mental health and well-being and experiences of access to appropriate [mental] health care are differentially shaped by intersecting social locations. Indeed, a key point of advocacy articulated by MVAEC has been the development of “[a] culturally-driven, urban-Aboriginal specific framework for regional health care delivery in Metro Vancouver” (p. 4). Happily, the data from this study indicate that an urban Indigenous health strategy had been initiated during the time of this study within two health authorities. What remains to be seen is what vision will inform these plans, to what degree it will include the collective concerns and priorities identified by urban Indigenous organizations and peoples, and whether more health authorities will follow suit. As one non-Indigenous Policy Participant working in Aboriginal mental health phrased it,

> Given what we know certainly Aboriginal people living off reserve are … a big under represented client group that we are not serving and there is no good plan for how to address that big gap. … It [the recent tripartite developments] is a clear shift so the health authorities the way we look at mental health substance use … services … whether you’re living on or off reserve is irrelevant. If you’re living in the [name of health region] catchment area and you have service needs … we are responsible for the delivering those services. (Policy Participant 11)

While the participant is arguing that recent tripartite agreements have helped to clarify and endorse the jurisdictional responsibility of the province and regional health authorities to provide services for both on- and off-reserve Indigenous populations, they also identify a risk, claiming that a focus on ‘equal’ responsibility might have the unintended consequence of blinding policy-makers to the unique features associated with Indigenous mental health in an urban context. Equal responsibility does not necessarily mean equal treatment, and equal treatment does not necessarily mean fairness.

As the following interview excerpt with a non-Indigenous community-level participant exemplifies, when issues of diversity and difference are not taken into account, the outcome of policies can in effect fuel experiences of exclusion and discrimination, despite the best intentions:

> the way the funding was administered got switched, which was actually a positive switch, in some ways, which was they sub contracted with an Aboriginal organization to be doing the awarding of the contracts rather than the government themselves. … However the fundamental problem there is the B.C. Aboriginal, Association of Aboriginal Friendship Centres is made up of a board of twenty-one people who are from the Friendship Centres across B.C. … And in the urban Aboriginal community in [name of city] we don’t think that organization represents us very well. (Provider Participant 18)

Here, the participant calls attention to the complexity of fair and meaningful representation within an urban context, given the diversity of different Indigenous organizations. In this context, MVAEC appears to provide an interesting example of a representational mechanism and structural pathway for urban Indigenous self-governance and voice that a large proportion of urban Indigenous organizations have chosen to support. Yet, as the data indicate, while Friendship Centres and their associations receive governmental core funding, MVAEC has not found sustainable funding sources, with one participant noting that

> It [MVAEC] is still struggling because of this issue of contract funding so … the city … has stepped forward and they’re giving … thirty thousand a year … and then the organizations pay a membership fee … so … together … those two streams of funding they have [provided] a bit of a base but then in different years they get mostly project funding from the provincial and federal governments. [It] has been up and down, … a lot of changeover with CEOs … and never enough time to get one person really trained and able to kind of bring the organization forward in terms of, this is clearly how we operate and this is clearly who we are, this is clearly how we work with

> governments. But it’s kind of hobbling along and doing consultation work (Provider Participant 18).

This quote suggests reluctance on the side of health authorities to recognize and support existing self-organized forms of urban Indigenous self-governance. Notably, organizations are paying a private share in order to have a public voice. In addition, the quote points to how efforts by urban Indigenous organizations to reclaim and assert a collective voice at the policy table are undermined by short-term, project-based and competitive funding. Lastly, while “capacity building” is construed as a key funding and policy objective across all health authorities, funders seem to view capacity building as separated from urban Indigenous self-governance, both at the community level and organizational levels. The same participant goes on to state that, of all three levels of government, it “is the City … which has been the order of government that’s more likely to recognize … [MVAEC] as a voice of the urban Aboriginal community” (Provider Participant 18). Given that the mandate for the provision of Indigenous health falls under provincial and federal jurisdiction, this remark points to a tension.

A non-Indigenous participant with an Indigenous NPO shares an experience that that illustrates this tension. In what follows, they shed light on how urban Indigenous voice and self-governance continue to be routinely ignored at the federal level, the very place where funding pathways are designed:

> We had one program that was called [name of program] and it was a youth drop in program, it was basically just to keep the kids off the street, they had a safe place to go, we had a facility that was open pretty much for the whole night. … And then they shifted so their [focus] shift moved away from that into employment … Employment culture is essentially where their focus is so that meant revamping that whole program. In that particular case I think it was a hard adjustment because it’s what the youth needed at the time. So it would have been nice to be able to keep that type of focus where kids had a safe place to drop in. (Provider Participant 19)

Here, Indigenous program autonomy and control was compromised because of government funding priorities changing in a way that failed to take into account the complex wellness needs and clustering of social disadvantages that constrain employment access opportunities for Indigenous youth who are homeless.

In this study, more than one organization was impacted by this shift in federal funding, highlighting the reach such government-driven changes can have. An Indigenous participant, whose organization lost its entire youth program as a consequence of a change in funding priorities, said,

> It had to do with the cultural part or something because then the focus turned to employment, it had to be employment. … like to me your own health and wellness has a lot to do with employment, you know? Like some people are not ready for employment until they deal with all these things I would say, right? [But] … it just became harder and harder … to gain the funds. And then they, they changed, the government changes all the time and … they don't even know what happens …[at] the grass roots levels, they just work from an ivory tower and wheel their power (Provider Participant 17)

Much like the previous participant, the participant here calls attention to how the new funding program fails to address the root causes and lived experiences that act as barriers preventing Indigenous youth from participating in the employment market, such as poverty, homelessness, lack of educational opportunities, as well as trauma, mental health and/or substance use. This despite the fact that program in question was specifically designed for Urban Indigenous Peoples.

6.3. The Politics of Account-Ability and Response-Ability

Provider Participants identified another mediating practice that creates tensions when they are trying to both meet their multiple responsibilities and remain accountable: the use of performance management (PM) as an accountability mechanism. Analysis reveals that PM has promoted a version of accountability that is strongly aligned with NPM and predicated on a culture of control. Unsurprisingly, then, the experiences of Indigenous Provider Participants led to the idea that, behind the façade of pursuing accountability, colonialism continues to play out in PM practices within contractual relationships. Indeed, the findings reveal that the uncritical use of PM practices can encroach on both Indigenous Providers' response-ability—their ability to be responsive to the individuals and communities they serve—as well as their account-ability—their ability to give an authentic account of the work they do. These findings are discussed in relation to three interrelated themes: (1) performing under the gaze of PM; (2) account-ability; and (3) relational practice as a counter-hegemonic strategy.

6.3.1. Performing Under the Gaze of Performance Management (PM): "you unwittingly … become a liar" (Provider Participant 10)

The following interview excerpt with an Indigenous participant, a mental health provider working for an Indigenous non-profit organization (NPO), helps open this analysis:

> [since] I … started out … I've had three … direct supervisors with [name of funder] that were managing the contracts. And so each person definitely had a different outlook and take on things and reporting was changing each time … I felt anxious, like it didn't feel like they were really … being forthright about 'this is what we're looking at', 'this is what we're doing.' It felt a little bit more hidden so I mean that's when I felt my job was unstable … I like to run a good program, I like to be open but it wasn't that kind of back and forth dialogue it was more one way … I did try to get clarification with them because I did ask, I asked like what if targets aren't met like what happens … I didn't get a response. So that kind of left me a bit confused but I really do think they're just trying to look for accountability I think and to justify why the funding is there and they're using numbers to quantify that. (Provider Participant 22)

This story highlights how performance governance has gained common sense status and a kind of moral authority by which funders extend their power and control far into Indigenous NPOs' internal operations. To invoke Foucault's notion of governmentality, PM practices can become a mechanism of power through which funding institutions regulate and govern the conduct and activities of Indigenous Providers from a distance. By setting performance targets and using reporting templates to monitor compliance, government funders extend their regulatory gaze into the everyday world of Indigenous providers.

The perception of being under constant surveillance engendered a deep sense of un-safety among several participants. However, while the participant describes attempting to comply with funders' performance standards and to normalize experiences of external intervention and surveillance as part of a moral and/or legal obligation to demonstrate accountability, their description of the tensions involved indicates mistrust, scepticism and covert resistance.

Other Provider Participants similarly framed their accounts of tensions experienced while operating under the gaze of PM. One community-level participant, a non-Indigenous administrator who was working for an Indigenous NPO, said:

> One of the other changes in the contract was about finances so if our quarterly spending isn't on track so like we look at a year and at the

> end of the year we will have spent the money but we might be low or high in a certain quarter and we have to account now for if we're low or high in a quarter when we send in the report. So we're thinking it's not going to have an impact on programs because we'll just explain it as we send it in. But it looks like there's a lot more interest in the finances and accountability on our part and their part. …[Before] no-one asked any questions, no questions at all but lately there's been more questions, yeah. (Provider Participant 04)

This participant's account highlights the extent to which PM practices appear to have facilitated government control over and surveillance of Providers' internal operations, such as how funds are spent. The emphasis on financial performance and management, along with what seems like a shift towards increasingly tighter inspections and monitoring, points to the neo-liberal underpinnings of performance governance as an accountability framework and its linkages to other policy changes in the area of contracting, such as the normalization of short-term, competitive funding schemes. As the same administrator elaborates,

> there were things in our third quarter reporting like we had spent a lot more in supplies and a lot more in staff and we had reasons for doing that but … [the contract manager] had lots of concerns about why we would do that? (Provider Participant 04)

While the participant above seemed cautiously optimistic that the funder would accept the organization's deviations from the contractually defined norms given an adequate explanation, funders' heightened interest in supervising Indigenous NPOs' internal affairs had not gone unnoticed and was observed apprehensively.

An Indigenous community-based participant, an active board member of another Indigenous NPO, shared another perspective:

> Their rules are too strict or they have never been in the trenches themselves or got their hands dirty they just sit at the table and decide that's for the most part what happens that I've seen … 'this is how it's done' and there's no if's, and's or but's this is it. And on top of that … funder[s], they want the whole ten yards to every penny … which is their right but they're so strict they want pages and pages of everything, you know … I guess it makes sense to them and it makes a bit of sense but it's so extreme … When you do get funding … it's hard to maneuver the whole package. (Provider Participant 21)

Compared to the previous participant, this participant seems to have decisively less trust in government funders and contract managers to act cooperatively. The data analysis illustrates how this difference in perspective is shaped by a wider historically-mediated context of Indigenous–State relations at all levels. That context is the backdrop against which Indigenous Provider Participants evaluated their experience with contracting and interactions with government funders. For the above participant, current performance regulations and reporting requirements are so excessive that they represent a paradox of sorts, wherein Indigenous Providers' capacity to effectively 'perform' (i.e. deliver the contract) is constrained rather than improved by PM practices. The participant attributes this tension, at least in part, to the inadequate understanding that funding agents, such as contract managers and funding decision-makers, have of the social realities surrounding Indigenous NPO operations. This distance from context also appears to distance funding agents from responsibility for unintended consequences of their accountability practices. The same participant goes on to argue,

> It should be our own people that's leading … [but] it's a paternalistic point of view with the people holding the purse strings that we yet again cannot handle ourselves within our own … organizations, you know, it, it's like Ottawa running Aboriginal people for all those years. (Provider Participant 21)

This suggests that funders' neo-liberal gaze is interpretable as a neo-colonial gaze. As the participant argues, the relations of surveillance and social control enacted under current PM practices are continuous with colonial Indigenous–State relations and suggestive of ongoing paternalism, as well as an entrenched belief that Indigenous people are financially unaccountable and incapable of governing themselves. This account calls attention to how PM is implicated in broader political issues of Indigenous self-determination. We are urged to consider how colonialism weighs into the analysis of PM as a neo-liberal technology of power within Indigenous–State contracting for the provision of mental health and addictions care in urban settings (see for example Humpage, 2008).

In the following interview excerpt, another Indigenous participant, a senior administrative lead with a different Indigenous NPO, describes an all-too-common experience connected to this issue,

> They come … and they say … here's the contract that we have devised and if you want this money that's available, sign the contract … [this is how] the process usually starts. … [T]hen you read the contract and you think Oh my God, if we have to follow each and every part of this … (A) … you unwittingly … become a liar and (B) you're jumping through somebody else's hoops who knows nothing really about what, what it is you're trying to solve. … and it just becomes a, a game after a while. (Provider Participant 10)

Here, accepting responsibility for the delivery of a mental health and/or addictions service or program represents a paradox. Reconciling contractual provisions for accountability with the values that inform their approach to mental health and/or addictions service delivery becomes nearly impossible. As the above account illustrates, contractually specified provisions for accountability not only define the discharging responsibilities: they also shape and are shaped by the wider social and historical relations of power that structure urban Indigenous–State relations. In the scenario above, the power imbalances between the funder and the Provider were such that the participant's perspective and experience were silenced and/or ignored, reinforcing long-standing colonial patterns of oppression and assimilation. Notably, though, while the participant's account frames PM as a new mode of control and governance that reinforces and perpetuates paternalistic power-over relationships, it also points to ongoing processes of Indigenous resistance. The comparison of PM to a game implies that the rules and strategies for playing the game are not totally determined by the funder.

Another community-level participant working in an administrative role for an Indigenous NPO describes an experience of a routine interaction with a contract manager that captures this idea of 'playing the game.' In the interview, the participant was responding to the researcher, who had asked whether the participant could give an example of an encounter with a funder that was experienced as challenging.

> So we were dealing with someone … who was questioning our program activities. In our contract it says pretty much you can do whatever you need to do to meet the deliverables like very general things about wellness for people so it's really, really broad like. And this person was questioning why are you doing groups, 'I don't even think you're allowed to do groups, I don't think it says you can do groups in your contract' … So we had to go through the contract and have lots of meetings and find the language where it said we could do groups and it just it wasted a lot of time. And she was a person from a very financial law kind of background so really looking at our contract in a very different way than us who reads like do what you've got to do. So that was problematic it, it ate up a lot of time, we were very worried that our funding was going to be affected, that our report wasn't going to be accepted so that was very stressful. (Provider Participant 04)

The participant's account reveals that even when the written contract itself affords the provider near-full autonomy over how the program is to be delivered, how the contract is read and taken up differs according to the readers' intersecting social locations and contexts. The contract manager's social location as a member of the dominant cultural group and financial background seem to have created one lens through which the Provider's compliance to the contractual obligations is interpreted with seemingly little or no knowledge of Indigenous cultures and programs. Their terms of reference were those of a Western biomedical worldview with its implicit propensity toward individualistic models of care. In this process, the distinctive features of Indigenous cultural approaches to programming, such as group-based counseling, become hyper-visible and are construed as evidence of deviance and potential non-compliance. When such ethnocentric views are enacted together within a managerial and depoliticized approach to accountability, as is the case in PM, powerful oppressive conditions are created that can propel contract managers to inadvertently subject Indigenous Providers to higher levels of scrutiny than other Providers.

While in the scenario above, the organization was able to resolve the issue, a significant amount of energy and time was exhausted to overcome this hurdle, relationally, creating and/or furthering disrespect and mistrust. As an Indigenous participant, a provider with a different Indigenous NPO, remarks, with respect to contract managers' approach to governance, "they all kind of operate from a distance but I think that's the norm" (Provider Participant 22). Given this mode of governance and the surveillance culture cultivated under current PM frameworks, trust-based and cooperative relationships are thus unlikely to emerge. Indeed, as the accounts of several Indigenous participants suggest, in many ways the relationship that PM sets up between Indigenous Providers and contract managers is, historically speaking, not unlike that between Indigenous communities and the Indian Agent. Under this accountability regime, Indigenous NPOs are not constructed as autonomous cultural institutions or partners, but rather as objects of paternalistic intervention and surveillance.

Further, Provider Participant 04 described what could make current governance and accountability arrangements more supportive:

> someone with some flexibility who understands the kind of community that we're working with … that we're going to have to be creative and we're not going to be the same as … [name of mainstream program] … someone who appreciates the diversity that we bring. (Provider Perspective 04)

This participant's account highlights the need for more flexible arrangements to promote Indigenous Providers' capacity to deliver effective and culturally safe mental health and additions programs and services for urban Indigenous peoples. The need for more autonomy was echoed by many participants in this study, revealing the assimilationist tendencies embedded in current PM practices. Specifically, analysis suggests that PM serves at least three ideological functions. First, it supports the liberal ideal of neutrality. Contract managers are viewed as holding a neutral position linking two interested parties: government funder and Povider. Second, in their capacity as neutral arbiter between the two, contract managers are construed as being situated outside the contractual and thus the accountability relationship—their primary responsibility being to ensure that taxpayers' money is spent efficiently and contractually-defined accountability requirements are met. Third, by portraying management as impartial, PM legitimates hierarchical decision-making—the Provider becomes the object of external scrutiny and disciplinary intervention. As elucidated in the next passage from an interview with Provider Participant 10 (the same individual who spoke about being unwittingly turned into a liar), under PM, power is exercised not directly but rather through technologies of governmentality (Foucault, 2000):

> There are still a fair amount of attempts made to micro manage us in such a way as to, to lead us through our budget line by line and saying 'oh you know … we don't think that you … should be spending five thousand for this when three thousand will be enough in our estimation' … but they don't understand that we've already cut that five thousand it was once ten thousand and we used to use that … up … totally. And how we're being squeezed and squeezed and … they don't seem to realize that when they, they squeeze us on every budget line by line; it has an impact on how the services ultimately get delivered. (Provider Interview 10)

The participant's account highlights 'line-budgeting'[38] as an example of a PM practice that constitutes a neo-liberal technology. As evidenced by the study data, detailed line-by-line budgeting and attendant budget regulations are standard PM practice, and function, as suggested by this participant, as a subtle mode of control through which government administrators are able to retain almost total spending power over the use of contractual funds. For example, in some cases, the budget regulations applied did not permit organizations to shift funds across budget lines without prior consent. This finding highlights another double-speak underpinning contracting: Indigenous NPOs are at once autonomous providers of 'cultural' mental health services—contractual language with respect to how to meet the program deliverables tended to afford Providers considerable autonomy—and discredited agents of responsible self-governance who cannot manage

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[38] Under line-by-line budgeting, contractual funds are broken down and allocated in advance to different predetermined expenditure lines that correspond to governments' internal accounting systems.

contractual funds in an effective and accountable manner. Rather than being framed as an expression of urban Indigenous self-government, Indigenous NPOs become discursively framed as agents of government; in need of ongoing paternalistic surveillance and outside governance (i.e. subjects of the neo-colonial gaze). PM provides the perfect vehicle by neutralizing the politically-charged nature of such acts. This finding highlights the importance of deconstructing contracting policies and practices to produce a better understanding of the structural constraints that impede Indigenous Providers' capacity to effectively deliver culturally safe services, as well as how urban Indigenous peoples' rights continue to be rendered invisible.

The constraining effects of budgetary spending regulations seem to be further compounded by government use of line-by-line budgeting to both rationalize and obscure ongoing budget cuts. For many participants, the experience of being "squeezed," "nickeled and dimed," or forced to "beg and fight for every single dollar" had become normalized and was perceived as profoundly demeaning. In addition to the symbolic violence, the accumulating effects of these small but successive rounds of cuts to every budget line also had very real material effects that were perceived as increasingly threatening to organizations' overall capacity to effectively run the programs and provide quality services—analogous to 'death by a thousand cuts.'

Together, the above participants' accounts highlight how the narrow focus of the current accountability regime overshadows government funders' political and/or public accountability. Under performance-based accountability frameworks, the paradoxical impacts of current contractual and governance arrangements remain largely hidden behind the veil of privacy that protects the terms of contractual agreements between individual Indigenous NPOs and government funders. By so doing, it lays the conditions to shift responsibility and blame onto Indigenous shoulders when 'performance' targets and outcomes are not achieved and/or sustained.

These findings suggest that a different accountability framework is needed—one that brings into focus the political and ethical aspects of government contracting in Indigenous health. Such a framework would, for example, ask how well governments perform in working with and supporting Indigenous NPOs' capacity to deliver Indigenous mental health and addictions programming to redress the legacy of residential schools. How does the way governments currently practice contracting advance the process of substantive reconciliation?

6.3.2. Account-Abilities: “it’s not just black and white and cut and dried” (Provider Participant 21)

Another predominant theme emerging from participants’ discussions was the issue of account-ability, or the ability to give an account. Interviews captured how current neo-liberal policies and practices attached to contracting interact with institutionalized patterns of dominant cultural values to create and/or reinforce subtle forms of oppression and domination. An Indigenous Policy Participant with direct experience of contract management in the area of Indigenous health described a central tension embedded within the current accountability regime:

> All evaluation and evidence-based practices is very Western and it’s the same thing with contracting deadlines, deliverables it’s all pushed down through the institution, you know. Everybody is supposed to meet the same boxes. And that doesn’t really work for us so we have to learn how to be flexible but we have to have some kind of evaluation to show that we did something and that it’s at least somewhat valid or we don’t get credibility in the Western culture or the health authority, right? (Policy Participant 02)

The tension identified by this participant seems to be tied to the ways in which Indigenous ways of knowing and doing continue to be discredited and/or marginalized through the normalization of hierarchical and uni-directional accountability that do not fit Indigenous Providers’ experiences. Similarly, another Indigenous participant, who sat on the board of directors for one urban Indigenous organization while also volunteering as an Elder for this and another Indigenous non-profit organization (NPO), raised two questions that are key to this analysis: “how do you measure success? [And] if you can’t measure that success in your service delivery according to their standards, then is it a failure?” (Provider Participant 21). These astute questions highlight epistemological concerns with current evaluation frameworks and performance indicators. The participant prompts us to consider what counts as success within different epistemological frameworks. How are current discussions about performance measurements and accountability frameworks informed by Indigenous voices, if at all? Perhaps most importantly, what are the consequences in terms of Indigenous Providers’ capacity to provide culturally safe mental health and addictions programs that meet the needs of the community?

As the two accounts above imply, under current contractual arrangements, the reference points for program evaluations seem to be thoroughly Western. In line with this interpretation, the same participant called upon governments “to look at their own model of measuring and outcome because it’s not just black and white and cut and dried” …

> because how do you measure success of a woman who is empowered … and is able to … offer … self-care to herself which then goes out to her family and to her community … [using] the quantitative outcome measurements … [which] is what the funders want because that’s how the system is organized. (Provider Participant 21)

Many more Provider Participants expressed concern about the predominance of quantitative performance measures for evaluating Providers’ performance related to program effectiveness.[39] As this participant argues, programmatic measures of success that would be meaningful from an Indigenous perspective would need to be able to assess outcomes related to empowerment and self-determination across the individual, family and community levels—constructs for which quantitative and objective outcome measurement frameworks seem ill-suited.

The issue of ‘fit’—or lack thereof—between quantitative performance targets and the provision of mental health programming is discussed further in the following interview excerpt with a non-Indigenous participant who worked as a provider and had many years of counselling experience for an Indigenous NPO.

> The numbers thing … I don’t want to fake it, I want to be as real as possible but … in one month I may help ten people who did a lot of things and maybe fifty people who are struggling and trying to do something but it’s the ten people that did something and it was an outcome. They went to a program or, you know, something happened that’s what they’re seeing right? (Provider Participant 08)

Here, the participant points out that improvements in mental health do not necessarily translate into observable behaviours, raising doubts about the meaningfulness of quantitative performance indicators for measuring mental health program outcomes. The lack of validity of the knowledge produced through evaluation and monitoring frameworks can create a situation where providers fear a loss of program funding, even though the program is providing meaningful mental health supports to clients in their journey of recovery and/or healing. An Indigenous Provider Participant who broached the question of how to measure success extends this argument further, adding an Indigenous lens:

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[39] While the data show that most funders did provide space for some narrative performance reporting (mostly as part of the final fiscal year-end report), the vast majority of reporting entailed quantitative data, which had to be submitted on a quarterly and/or semi-annual basis.

> at the end of the day … all they want to know is how successful was that person. Are they healed now? … Here's my wand, you're healed. It's actually ongoing so it takes a lot [of time]. It took a long time to get to where we are today … you know, there could be a whole afternoon or more to talk about that but the short version is the colonization of our people. (Provider Participant 21)

In this view, evaluation frameworks must take account of the unique history and contexts affecting Indigenous individuals and populations and their experiences of mental health concerns. Frameworks must thus be grounded in an understanding of colonialism as a key structural determinant of Indigenous mental health and acknowledge that turning around the effects of historical and intergenerational trauma is a long-term effort.

As a non-Indigenous administrator from another Indigenous NPO poignantly explains in the following interview account, "it's not about quality, it's about quantity" (Provider Participant 04). As a result, the same participant went on to explain, "the numbers don't reflect a lot for us: we just hit the quota and do our own thing." However, as the same participant also pointed out, the inattentiveness of current quantitative reporting frameworks to the processes of care also creates problems: "it's … hard … because there's no, you don't get to put down a number for consulting with an Elder about your program … or maybe we only saw twenty people but we worked with the parents or we worked with the community or this service because it's so complex, the case and the history." This participant highlights how a narrow focus on quantity or productivity in the operationalizing of accountability impinges on Indigenous Providers' capabilities to enact culturally safe approaches to programming and care. For example, the data revealed that while consulting with Elders or spiritual advisors and working with individuals and their families within the contexts of their communities were conceived as essential aspects of designing and delivering high-quality, culturally safe mental health and/or addictions programs and care, they remained unaccounted for in current reporting frameworks.

While it is easy to conclude that the problems associated with quantitative measures are primary technical in nature, the accounts above suggest that the roots of the problem reach much deeper. Indeed, these accounts raise questions of ontology and epistemology. Rather than pitting qualitative and quantitative forms of evidence against one another, the findings call attention to how the privileging of simple quantitative (number of patients seen) over more complex qualitative (e.g., experiences of quality of care) performance measurements in current PM practices risks marginalizing Indigenous cultural knowledges and relational epistemologies even when the intent may simply be to collect data that can be collated to report at a high level. For example, the predominant focus on transactional and volume-based outputs, such as the number of clients attending a session and/or counseling hours provided, reveals a neo-liberal conception of performance as ‘production.’ From such a vantage point, health care is essentially a business transaction between two independent parties, while the primary objective of accountable health care is demonstrating cost-efficiency. Consequently, there is little concern for *how* care is actually delivered. Instead, PM practices and performance measures seem to operate on the assumption of a universal medical subject who exists in a relational vacuum—a conception that is largely congruent with biomedical models of care. In addition, New Public Management (NPM) discourse appears to be tied to Western ideals of scientism, reason and (post)-positivism embedded within both biomedical and PM discourse. The power of these traditions is evident in the emphasis on empirical data that can be ‘objectively’ observed, measured and quantified. Processes of care tend to be overlooked in this framework because they are neither easily observable nor quantifiable.

This background leaves funders oblivious to some of the most important dimensions of culturally safe mental health and addictions care and healing, including its relational, contextual and equity-promoting aspects. The implications in terms of accountability are—as participants discussed—far-reaching. In the following excerpt, a non-Indigenous administrator/provider with an Indigenous NPO describes one of the consequences:

> Contractually speaking we do through [name of mental health contract] seventy-five to eighty percent of it is outreach. So if you compare us to [name of health authority] or [mainstream mental health NGO] … they can have four or five fifty minute hour sessions because all the clients come in. Well we’re driving out to schools and we’re driving out to homes and fundamentally that takes more time right? And things don’t go in a fifty-minute hour when you do that. And so our stats aren’t going to show the same amount of numbers right and frequently very historically what I’m hearing is a lot of these [funding decisions] are based on statistics. … Anyway but it’s, you can’t have high client numbers when you do that much outreach it’s just not possible particularly if it’s across town right? (Provider Participant 05)

In the experience of this participant, under the neo-colonial gaze of PM, core aspects of culturally safe programming, including delivery of tailored and responsive care through outreach-based services, are transformed into a liability. In New Public Management (NPM) logic, value is operationalized as efficiency—that is, the ratio of contract value over the number of clients serviced. But delivery of outreach-based services requires more time per client than service delivery under dominant models of care. Thus, Indigenous NPOs, when contextualized within NPM discourse, might be construed as ‘producing’ less ‘value’ than mainstream service providers. The same participant illustrates this thought further when describing the difficulty of reporting on social support and advocacy work. The participant recounts an experience with a particular case in which the organization provided extensive support to a family during a court trial, which was experienced as highly traumatic by all involved:

> And so that trial every day [name of provider] was down there with the families and they would come back here … and we were providing them meals when they showed up … open their doors for sharing circles and for food and for whatever is needed. … And again an average organization doesn’t do that right? … And that work doesn’t happen by fifteen minute sessions … so I don’t know how to fit that into a box, right? … [Like] client contact hours when a client comes in. … we spend a lot of time supporting this family and it, it’s not a fifteen minute session with them coming in here, it’s sitting next to them in court, going outside when they’re on a smoke break and being with them when they’re crying and swearing and all those pieces right? … And that doesn’t really translate into the right boxes on a statistical form. (Provider Participant 05)

Purely quantitative frameworks of performance measurement cannot provide an adequate account of the relational nature of care exemplified in this account. While relational care often takes place within the context of people’s lives in recognition of the social determinants of health, the embeddedness of current performance-based approaches to accountability within the ideology of biomedicine erases the social context of care by constructing it in strictly individualistic terms. Framed in this way, it then becomes conceivable to break down care relationships into smaller units, such as “client contact time,” that are quantifiable can be used as performance indicators, highlighting once again how neo-liberalism and biomedicalism operate together in ways that are mutually constitutive.

Under these conditions, the value of the work of Indigenous Providers continues to be rendered invisible, and Indigenous NPOs become disadvantaged by their commitment to deliver culturally-safe care. As the account above suggests, this disadvantage can have very real material consequences—in particular within a quasi-market-like funding environment wherein Indigenous NPOs have to compete with mainstream organizations. Moreover, by de-contextualizing and de-politicizing Indigenous Providers’ accounts, current approaches to performance-based accountability frameworks deprive Indigenous NPOs of the means and opportunity to advocate for the needs of their communities and exact reciprocal accountability from the government that purchases their services.

Adding further to this line of discussion, an Indigenous community-based leader who was directing an Indigenous organization makes the following remark:

> We give our funders a really good bang for their buck if you will because again they're paying for a certain program but folks that come here access lots of different things here … and there is the ability to report out in a narrative kind of way but I don't think the funders truly appreciate those, those connections and the impacts to family. I don't think that they necessarily appreciate, you know, like really appreciate that when they get the, the reports, right? In fact, I sometimes wonder if they read the reports … because, you know, I think that those are really, really critical pieces. (Provider Participant 09)

This participant calls attention to the added value, in terms of mental health outcomes and healing, generated through their organization's holistic service environment (created by weaving together different contracts from different funders). This added value, they argue, is overlooked. In keeping with an understanding of the interdependencies among different dimensions of health (spiritual, physical, mental and emotional) and the social and relational aspects of health, the effects of holistic programming on the health and wellness of individuals and individual program outcomes are, arguably, not merely additive but multiplicative. As the data indicate, fiscal year-end reporting requirements from many funders include a narrative performance report. Similar to the participant above, several other Indigenous Provider Participants used this opportunity to provide what they viewed as an authentic and holistic account of their work and accomplishments. Yet, as this and other participants' account suggest, many funders fail to recognize the significance of this work that takes place outside the narrow confines of their contracted services and yet is fundamentally integral to the programs' success.

In part, this might be interpreted as a continuation of the historical privilege that Western institutions, including medicine and science, have placed on quantitative and presumably objective forms of evidence over qualitative and subjective forms of evidence. Narrative performance data appear to be viewed as secondary to statistical information in terms of importance—so much so that there seemed to be a widespread doubt among participants as to the actual degree to which their narrative reports were read and considered in policy and funding decision-making. Thus, while quantitative performance measurement frameworks and their attendant ideologies seem to constrain

Indigenous NPOs' ability to provide an authentic account, the institutionalized depreciation of qualitatively derived data appears to create conditions whereby when Indigenous Providers are provided the means to give a meaningful account, they are ignored.

Along a somewhat different vein, funders' lack of appreciation for the mental health promoting effects emerging from Indigenous Providers' relational work and efforts to create a holistic approach through a collage of contracted services might also be understood as symptomatic of an unquestioned assumption of linear cause–effect relationships that seems to underpin the logic of current models of program evaluation. Such a logic falls short of accounting for the complexities that arise from the interactive and relational nature of Indigenous approaches to culturally safe mental health and addictions programming. As the participant above describes, programs in a relational environment are intrinsically linked to other programs, to the values, culture and history of the organization and its staff, and they operate through relationships that Indigenous Providers have with individuals, families and communities. Given these complexities, assumptions about causality can be tricky and require careful consideration of what effects can be credited to the contracted program versus the complex interaction of the program (or components thereof) and the context in which the program is delivered. While such complexity appears to be acknowledged within key guiding Indigenous mental health policy—for example, according to BC's First Nations and Aboriginal People's Mental Wellness and Substance Use Plan, "a holistic approach [to mental health] encompasses more than just the individual … [but] must also consider relationships with and impacts of the family and community approach" (FNHA et al., 2013, p. 16)—the study data suggest that such a relational conceptualization of mental health programming is not present in how funders think about program evaluation within the context of PM frameworks.

An Indigenous Policy Participant helps draw out the implications, for Indigenous providers, of structural constraints to authentically accounting for performance to funders in the following excerpt. The Participant explained,

> this was one of my biggest pet peeves when I used to work in community federal funding … so the community gets the ten thousand dollars …[but] they'll actually spend twenty thousand dollars because even though federal funding said, you know, this is for … your mental health services, ten thousand wasn't enough so the community added their own money, spent twenty thousand dollars on the program or the services but when they filled out the report back to the feds, they only

> reported on the ten thousand, [and] only on the activity they were asked for … and the community would never report out on how much more they actually spent. So there was … this false understanding … that what they were giving the community was enough to provide this lovely service when in fact it wasn't—just because they balanced down to zero and said, yes, tickety box, we did what we said we were going to do [when] it really actually should have showed a deficit that it cost us twenty thousand dollars to run that program to actually get the benefit and the outcome that we needed. (Policy Participant 07)

As this participant's account suggests, by rendering invisible the extra-contractual work routinely provided by Indigenous NPOs, the narrow focus of performance-based accountability frameworks supports processes of privatization and responsibilization. Funders might have a very real political and economic interest in maintaining the status quo of performance reporting—one that seems inextricably intertwined with long-standing historical patterns of colonial relations, whereby certain responsibilities for managing and delivering health services are transferred from government to Indigenous communities, but without sufficient means to do so. Comments from an Indigenous Provider Participant, who worked for an Indigenous NPO, support this possibility:

> I don't know if they're actually like the reporting templates actually capture like, how useful it is for clients. I don't think it does. It's just looking at numbers and it's looking at … like we have a financial template as well that we submit, so looking at the budget and then looking at the numbers. … That's what it's looking at. (Provider Participants 22)

In this light, accountability requirements are oriented to serve the interests of funders more so than those of the people who are actually receiving and benefiting from the services in question. Within neo-liberal discourse, accountability is predominately directed towards the taxpayer, not the client. Many participants criticized this de-politicized version of accountability and described the struggle to re-centre the client by acting as a representative voice for them. The same provider who was quoted previously said,

> I think … I would need to be more consistent with getting my feedback forms filled out because that piece from your clients is your biggest piece of information of what was going well and what areas could be worked on [but] again I get so stressed out … and some of the time limits here like I have to do programming at lunch, it gets condensed, … [and], okay, now you have to leave and we're still talking so a lot of times I don't get to that, that feedback form. But that would be helpful for me if I could get those, I think those would be the biggest pieces of information because you know what's hitting home and what's meaningful and the areas to improve on. (Provider Participant 22)

As this participant points out, gathering client feedback is vital but often forfeited because it is time-consuming, and because organizations are not supported in their capacity as program evaluators. Most providers operate under immense time constraints and heavy workload conditions—an outcome that, as the analysis shows, is itself symptomatic of changes in the composition of contract funding. This participant's narrative also implies that funders view client feedback forms as the most expendable type of reporting information. Several funders' reporting requirements did not even include client feedback. In such cases, Provider Participants described taking their own measures to gather client feedback, as illustrated in the following interview example:

> Well what I, what I've done in the past we've had practicum students here and I've had them do evaluations … and … sort of focus groups … [with] stakeholders and clients involved in [discussing] what services are needed and how we can improve things, that kind of feedback is more relevant I think. (Provider Participant 08)

This and other similar excerpts act as reminders that Provider Participants in this study were not rejecting evaluations per se. Many expressed the view that program evaluations are useful when they support strategic planning and organizational learning about what worked and what did not. In contrast to funders' de-politicized version of accountability, Provider Participants unanimously shared the view that, as community-based organizations, gathering feedback from clients, community members and staff was central to operationalizing their organizational mission and approach to programming. Indeed, participants across all NPOs reported creating deliberate spaces for gathering input from both service providers and recipients. Smaller organizations, which felt the lack of administrative support more acutely, often approached client feedback through more informal pathways. By comparison, several of the larger Indigenous NPOs that participated in this study engaged in "pretty rigorous" and comprehensive approaches to gathering community-based feedback in order to enhance organizational programming and strategic planning—as exemplified in the following interview excerpt from an Indigenous participant who directed an Indigenous NPO.

> … getting these programs up and going and … enhancing them is never, ever a job just for us, it's something that we take back and we have different times where we do community consultation as well because it's really important to know what does community think of things right? … So, you know, it's just trying to look at things in a different kind of way rather than it being top down … I mean we have to be leaders and we have to make decisions that's how things are but I mean if we can include and celebrate and honor our staff and really be mindful of the impact of our decisions in this organization on our

> front line staff who do our work, if it wasn't for them I'm not going to be here. (Provider Participant 09)

This participant's account illustrates how, under this organizational leadership structure, Indigenous voices are moved from the margins to the centre, enhancing the organization's capacity to develop and deliver culturally-safe, locally responsive and meaningful programs, services and supports. Key aspects of this approach to community governance included organizational strategies deliberately aimed at flattening organizational hierarchies, and seeking input from all staff, especially those in most frequent contact with clients. Notably, the data show that those organizations that had relatively stable funding arrangements in place—in particular core funding that supported the position of the organizational leader—could better develop formal strategies and structures to actively involve staff, clients and the wider community in organizational planning and decision-making.

6.3.3. Relational Practice as a Counter-Hegemonic Strategy: "the human behind the contract" (Policy Participant 07)

While PM is implicated in the legitimatization and reproduction of (neo)-colonial relations of oppression and domination, the data also reveal the extent to which relational practice was deliberately used to mediate these oppressive effects. This is illustrated in the following interview excerpt with the same Indigenous community-based participant who was previously quoted:

> The way that you negotiate those contracts looks quite different for the different funders and it looks very different based upon the relationships that I have with those folks in those funding agencies right? So we have a very good relationship with all of them … the specific program officers … it's not across the board but if you have that ongoing relationship with them and, … if there is wonderful things you're inviting them out. So a lot of it is based upon relationship engagement really in terms of what your contracts look like and, and the support that we're able to get from those funders for ongoing funding. (Provider Participant 09)

The participant's narrative highlights the importance of relationship-building with funders, and the impact that a good relationship can have not only on increasing the chances of sustainable funding, but also on what autonomy and flexibility the contract will afford. Elaborating further, the same participant goes on to explain,

> We have funders that come out to our activities and so they can see firsthand the impact and that, you know, entire families are coming

> out. So I mean we do a lot of work not just internally, you know, in terms of programs but … that's my work right is, is to ensure that funders are aware and see that their money is more than about the person coming in to, to counseling once a month or whatever that there's other impacts right that contribute to the health and healing of that particular family. (Provider Participant 09)

This participant makes clear how much of their time is taken up making visible (through visits, etc.) outcomes of their organization's work that are either overlooked and/or excluded from quantitative performance evaluations (such as the collective impact on families). Likewise, several other participants spoke about how they felt incapable of conveying the true value of their work to funders unless they invited them out to see with their own eyes both the social suffering and the healing taking place. As these and other interview excerpts imply, neo-liberal accountability frameworks and colonial stigma may blind funders to the ethical dimensions of contracting through what are essentially dehumanizing processes. Within this ideological context, relational practice emerges as counter-hegemonic practice through which some Indigenous NPOs put a human face on statistics and narrow the distance that continues to mark funders' approaches to governance by opening up a possibility for an "ethical space of engagement" (Ermine, 2007).

The importance of the interpersonal relationship between contract managers and non-profit administrators was also recognized by Indigenous participants who worked within the context of government funding structures, as the following excerpt demonstrates:

> the only reason it works right now is because I'm the one making the decisions … because I'm Indigenous, because I understand and I know the communities, I know the families, … that's why it works out. If …someone in my position was non-indigenous, [and] did not understand any of that he would be less tolerant of that kind of spending … It will come down to a human factor, everything always does. So the human factor will always play a role in this and whether or not the human behind the contract—talking about the contract, writing the contract, measuring the contract—has the ability of applying an Aboriginal lens, an equity lens, a diversity lens because it's not how … business is conducted. (Policy Participant 07)

While the participant above confirms the significance of relationships between contract manager and Indigenous Provider, they also signal that while human agency is essential in transforming relationships of power, the nature of these relations is not merely interpersonal but also structural and ideological. In other words, while relational practice is important, it is not sufficient in and of itself. Relational practice needs to be accompanied by structural change and a shift in the dominant lens through which funders and other institutional agents see their relationship to, interpret the work of, and interact with Indigenous Providers. Such a lens would help administrators and decision-makers to see the partiality of their own cultural perspectives and examine the taken-for-grantedness of dominant ideals and practices, such as those underpinning performance-based contracting. A non-Indigenous Policy Participant describes applying such a lens to contracting:

> We have our Western way of looking at deliverables and it's a very business oriented outcome. … When it comes to delivering services in Indigenous communities it just absolutely doesn't fit whatsoever. Because some of the outcomes, some of the things that we're looking for to have happen are very intangible. … There's a big disconnect I think and so that's part of the conversations I've had to have … with … the mental health substance use leadership … I've had to ask for some space around having the time carved out to devote some time to go slow, to build relationship … because from, from the leadership perspective like 'what are the outcomes, let's go? [snapping fingers] How many clients are being seeing?' … We need some space, we're doing something different and you have to be tolerant … the way we deliver services in our partnerships here is quite different … (Policy Participant 12)

The participant's narrative highlights both the power and the limits of relational practice as a counter-hegemonic strategy. While individual allies can play an important part in supporting transformative change, both at the institutional level and in the contractual relationships between government and Indigenous Providers, equity-promoting commitments to support access to culturally safe mental health and addictions services through contracting cannot be fully enacted without structures, policies and institutional leadership that support the actualization of cultural safety within contractual relationships.

6.4. Chapter Summary

This chapter's analysis has focused on the meso-level institutional structures, policies, and practices associated with contracting for the provision of culturally safe mental health and/or addictions care, illuminating how current contractual and policy arrangements continue to support, often inadvertently, the institutionalization of neo-colonial relations of cultural valuing, dependency, domination and deprivation. Under the current funding and accountability regime, the material distribution of resources and the approach to contractual governance are such that urban Indigenous Providers' capacity to plan, design and implement culturally safe mental health and addictions programs and supports is constrained by a lack of means and opportunities to: (1) be meaningfully involved in policy and funding decision-making; (2) enact self-determination in relation to program decision-making, the management of funds and how services are provided; (3) access adequate and equitable resources relative to need and compared to mainstream Providers; and (4) give a meaningful and authentic account of their experiences, actions and accomplishments.

These findings are paradoxical, considering governments' espoused policy commitments and funding objectives; yet, these paradoxes have remained largely hidden behind a neo-liberal rhetoric that appeals to common values of accountability, innovation, fairness and efficiency to justify larger ideological shifts in policy toward privatization, de-politicization and responsibilization. In that process, neo-liberal policies and practices intersect with dominant biomedical discourses to reproduce and reinforce neo-colonial relations. As a result, Indigenous people's rights to mental health and access to culturally safe mental health care are rendered invisible and seem to have become a function of the market, while Indigenous Providers are cast in the role of government agents.

In spite of these interlocking institutional forms of oppression and domination, this analysis shows that urban Indigenous Providers are not passive victims but rather are engaged in ongoing contestation and counter-hegemonic practices. In the chapter that follows, the analytic gaze will focus on explicating how the meso- and macro-level politics of contracting for Indigenous health care shape the microcosm of mental health service delivery from the perspective of Indigenous Providers.

Chapter 7. The Micro-Politics of Contracting for Culturally Safe Mental Health Care

The analysis presented in this chapter focuses on the micro-level dynamics of government contracting with Indigenous non-profit organizations (NPOs) for the provision of culturally safe mental health and addictions care. It is guided by one overarching question: How do the broader ideologies and the meso-level policies, structures and practices discussed in Chapters Five and Six shape, from the perspective of Indigenous Providers, the delivery of culturally safe care for Indigenous people who live with mental health and addictions issues? In exploring this question, I draw on the voices of community-based participants. Informed by an intersectional perspective and the notion of cultural safety as an analytical lens, I examine participants' experiences of ethical tensions in their everyday practice to critically analyze how current approaches to contracting hinder and/or promote the response-ability of Indigenous Providers to safely and effectively meet the needs, rights, and expectations of Indigenous clients.

7.1. Ethical Tensions in Everyday Practice

The following interview excerpt with an Indigenous senior administrator who was directing the mental wellness programming within an Indigenous NPO provides a point of entry for the analysis presented in this chapter:

> Well I think the main problem with contracting generally when it comes to Aboriginal people in organizations like ours is that we start off with the fundamental misunderstanding about what it is we want to do and what it is the people who are doing the contracting want us to do. That's the key problem to the … whole thing. And when it comes to mental health problems the whole thing takes on, you know, more and more fuzziness because quite often I think the people who, who have devised the programs under which they're going to contract have a different idea of what the mental health issues actually are. ... And or don't have any firm notion or firm understanding of what the problems actually are. (Provider Participant 10)

Here the participant calls attention to how the disjuncture between Indigenous and funder understandings of the "problems" has led to a "fundamental misunderstanding" in how to best respond. As the analysis unfolds, it becomes apparent that Provider Participants experienced these disjunctures as giving rise to complex ethical tensions within their daily work. Specifically, participants' accounts helped to make visible how medical colonialism continues to be enacted within state–Indigenous contractual relationships and intersects with neo-liberal discourses of accountability and efficiency to constrain Indigenous Providers' ability to respond to the concerns and needs of individual clients and the community at large in a manner that was perceived to be culturally safe. For the purpose of discussion, three intersecting and overlapping patterns of experience of ethical tensions are identified: (1) Institutionalized Patterns of Valuing and Spaces of Omission; (2) De-humanization and Objectification; and (3) Acts of Intrusion and Exclusion. In the analysis that follows, I explore how these ideologically and institutionally mediated processes organize the everyday work of Indigenous Providers, how they are resisted, and how they impact Indigenous peoples' experiences of mental health care to produce and reproduce inequities.

In the next section, I move on to consider the accounts of Provider Participants as they reflect on the contradictions and tensions they encounter in their role as contracted Providers of culturally safe mental health and/or addictions care. While the mental health programs that Indigenous Providers in this study offered were diverse—reflecting differences in organizational mandates and priorities, funding arrangements and other contextual and organizational factors, such as organizational size—the data revealed that organizations shared similar values, beliefs and principles informing a common understanding of the key dimensions of high quality, culturally-safe mental health and addictions services for Indigenous peoples. These included the explicit adoption of an Indigenous cultural lens to care, the involvement of Elders and spiritual people, the incorporation of traditional healing practices, customs and rituals, and care that was responsive to inequities, contextually tailored, relationship-focused, trauma-and violence-informed, and strength-based.

7.1.1. Institutionalized Patterns of Valuing and Spaces of Omission

Although at first glance government contracting with Indigenous Providers for the delivery of culturally safe mental health and addictions care seems to be rooted in a politics of difference that recognizes approaches to health and healing derived from Indigenous knowledge systems as legitimate and often more appropriate ways to safely meet the needs (and realize the rights) of Indigenous peoples—compared to mainstream models of mental health care—community-based participants in this study described encountering a number of barriers in their everyday practice that point to institutionalized value patterns that continue to de-value Indigenous knowledge and healing practices. This dynamic is exemplified within the following interview excerpt with a non-Indigenous administrator who was responsible for overseeing several mental health programs at an Indigenous NPO:

> I think the way they [funders] support it [Indigenous cultural healing practices] is, it's usually in our contracts that they are working with us because they want us to work in a culturally appropriate way with the clients. So it will be right in the contract but in some contracts like our addictions contract it doesn't have extra money built in for elder honorariums or paying part of the spiritual advisor's salary, it's just two counselors'. So those little parts that we have to cover somehow we have to get creative with. … If we're going to do a blanket making workshop with elders for addiction clients, there's no money to buy the kinds of supplies that we need to do a drum making or a blanket making workshop like it's quite costly to support. (Provider Participant 04)

The participant's account highlights the embeddedness of a paradox within contractual relationships that was also discussed by several other community-level participants in this study. On the one hand, Indigenous NPOs are contracted to provide culturally appropriate services, and on the other, they are not allocated the funds to cover the costs associated with traditional cultural programming activities or aspects, such as drum making or a blanket making workshop, and the involvement of Elders, healers and spiritual advisors in the provision and programming of care. This oversight points to the hegemonic status of biomedicine, which leaves funders unfamiliar with Indigenous healing practices and seemingly unaware of the internal contradictions embedded in their approach to contracting. With biomedicalism as one facet of the hegemonic lens, dominant cultural value patterns seem to become (often unwittingly) reproduced within contractual budgets as funders' cultural ignorance seems to preclude attention to and/or awareness of the need to take into account the distinct features of Indigenous healing practices in the budgeting process.

Moreover, the account above suggests that within the context of New Public Management (NPM), Indigenous Providers' experiences of meaningful involvement in contract negotiations remain rare. A heightened lack of trust in Indigenous NPOs' capacity for self-governance, reinforced by the widespread adoption of NPM, preclude respect for Indigenous Providers' ownership and decision-making autonomy in how resources should be allocated. Colonial patterns of exclusion and inclusion within contractual relationships are sustained and reproduced through multiple acts and forms of omission.

In the following account by an Indigenous participant who was acting as a senior administrator for an Indigenous NPO further speaks to the issue by using the example of of a particular mental health program that the organization had developed with the vision of providing the community with access to an Indigenous-specific child and youth mental health program:

> The whole idea and the way that we wanted to provide service here was not to just put a brown face on a mainstream program we wanted to ensure that there was a cultural lens through which our work was done that we had all kinds of pieces around tradition and ceremony and spirituality that was not only connected but it was used as a way of healing and … providing services. … And that hasn’t happened and so … in my mind, there [remains] … a lot of work that needs to be done around that because the need is there. And we know the need is there based upon our waiting list, you know, and based upon the fact that … we know that seventy-three percent of the kids that are in care of the ministry are Aboriginal kids and … we know that it’s not just only the kids that are impacted by that but the families as well. (Provider Participant 09)

Despite being awarded the contract for the delivery of an Indigenous child and youth mental health program, the interview indicates that the allocation of resources within the contract was such that this organization was denied the means and/or opportunity to provide the program as they had envisioned it in alignment with an Indigenous approach to healing. This participant’s narrative highlights—similarly to the previous account—the extent to which biomedicine as the dominant cultural framework continues to be normalized within the context of government contracting, shaping the conditions under which mental health care is delivered by Indigenous Providers to Indigenous peoples. As the participant further points out, the attachment of contracting to biomedicine unwittingly places Indigenous children, youth and families at risk of not having their mental health needs and rights met.

Moreover, the participant’s account also points to a need to examine more carefully how ‘Indigenous culture’ is constructed within contracting and how this might factor into funders’ approach. Dominant understandings of culture often become conflated with racialized characteristic that mark the cultural Other as different. When culturalist perspectives are enacted within the context of contracting, as the participant’s narrative above suggests, they seem to promote an understanding of culturally appropriate or safe care as an individualistic transaction of culture between those who have it and those who lack it. Because culture is believed to be contained within the “Other,” culturalist assumptions might lead funders to conflate the act of contracting with an ‘Indigenous provider’ with the provision of culturally safe care. Contextualized further within neo-liberal approaches to contracting, dominant culturalist discourses might thus provide another explanation for the lack of resources provided to cover the costs associated with Indigenous healing practices.

However, while current funding practices render the implementation of Indigenous approaches to mental health and/or addictions programming difficult, Provider Participants’ accounts also attest to gains in the area of Indigenous self-determination in relation to how mental health and/or addictions programs are designed and delivered. For example, the above participant goes on to describe to the researcher how ‘culture as medicine’ has shaped programming within this organization:

> we build our program models all around … the medicine wheel, you know, so that everybody’s needs are addressed spiritually and physically and emotionally and mentally. Every program in the whole organization is developed in that particular way. (Provider Participant 09)

Informed by the notion of the medicine wheel, which stands for the interconnection between the spiritual, physical, emotional and mental aspects of health and well-being, programming in this and other Indigenous NPOs was informed by a broad and holistic view of mental health and well-being. In the following interview excerpt, the same participant goes on to explain to the researcher how capacity for holistic programming within the organization was built:

> We run our ideas across and get feedback … from the Elders. So we host Elders on site …., we provide space to Elders, we’ve got Elders that are on our board of directors and so we talk to our Elders all the time. You know this is what we’re planning on doing, you know, how might you support the work that we’re doing, what are your thoughts around the spiritual aspects of the program and what that might [that] mean for people. (Provider Participant 09)

In this study, the active involvement of Elders in the planning, development, implementation and evaluation of mental health and other programming was repeatedly identified as an essential strategy for operationalizing culturally safe and holistic mental health and/or addictions programs, services and supports. Elders were thus highly valued among Indigenous Providers: as a different Indigenous participant who was working as a mental health provider at another Indigenous NPO asserted, "Elders are really, really key" (Provider Participant 02) for promoting individual and community mental health and healing. In keeping with this statement, the data showed that Indigenous Elders were involved as care givers or providers—albeit to different degrees and in different ways—in the mental health programming of all NPOs, including the non-Indigenous Provider. In many cases, Elders provided support on an informal basis, for example within the context of drop-in sessions. In addition, they were engaged in a wide range of healing practices, such as healing circles, sweats and/or berry picking, which either took the form of standalone 'programs' or were attached to a mental health program. In a few organizations, Elders also provided one-on-one counseling services.

A participant, a non-Indigenous and Western-trained mental health professional who was working for yet another Indigenous NPO, added further to the discussion by providing the following perspective:

> there's that opportunity … like providing medicines for smudging … we also have Elders on site … so we can make that connection right away. We can … bring … [clients] up to talk … with them or … introduce them to the Elders so we do have that, that's very unique to this environment. I think too it's just like being able to connect [clients] more … easi[ly] … to ceremonies too. So we have the welcoming ceremony here, there's people on site that run sweats, sweat lodges so then ... [clients] can connect with them so that piece is definitely different working in this environment. And it allows for that more holistic piece of looking at wellness so it makes a big difference for the ... [clients]. (Provider Participant 22)

In the experiences of this participant, and other participants who were similarly positioned, being able to engage clients in mental health counseling in a programming environment in which they had the opportunity to work alongside Elders provided clients with the option to access Indigenous approaches to healing and partake together with clients in traditional ceremonies, significantly improving the quality and effectiveness of mental health services and thus clients' experiences of care.

However, not all organizations had Elders who were on site, even though all organizations saw Elder involvement as an essential ingredient of Indigenous approaches to mental health and addictions programming and care. Several organizations reported that they had funding for Elders in the past but were unable to sustain it. In more than one organization, Elders' services were only available on an occasional and irregular basis, with one Provider Participant who was working for an Indigenous NPO explaining that while the organization used to have an Elder on site, the funding for this capacity and other things "Indigenous" had been lost in the process of continual program cuts:

> We try and do the canning of the salmon, we do berry canning, we do different types of things like that … [but] those are things that are the first to get cut back when there's no funding. So the programs would

> still be able to maintain themselves, it’s: What is the quality of the programs are going to be like? (Provider Participant 19)

Participant 19’s narrative above provides a poignant account of how neo-liberal policies and practices intersect with ethnocentric patterns of institutional valuing to create subtle forms of dispossession, manifested in an institutionalized cultural and material value pattern that seems to systematically depreciate those aspects of programming that fall outside the realm of norms and values embedded within Western understandings of mental health care delivery. Indigenous culture-based activities and program aspects that are derived from Indigenous knowledge systems seem to be viewed as expendable, and consequently, they can be ‘the first to get cut’ within a health care climate marked by cost concerns and funding cuts. Thus, not only were funds specific to Indigenous healing practices difficult to access, they were also increasingly hard to sustain. This challenge prompted growing concerns about the quality and effectiveness of programs and services among Provider Participants, as discussed in more detail in the following interview excerpt with the same participant:

> They’re cutting back on the way that they do things. We used to have bannock on the run and that’s been cut back because food is not considered to be a primary source of [the program's objectives]. So because and that’s come straight down from [federal government] I believe so. But the funding from the Federal portion has come down to say, no, it's not food. Much of the culture around most First Nations is around feasting and meals and … then … the other part of my program has no food it's been cut back, cut out, I have no food available for my program. So we have people that [in] many cases are homeless, living in transition, have no money and they expect, the expectation for them to come in and sit during [name of program] when they haven’t eaten all day … is impossible. … So that’s one of my biggest kind of things … because food is really a necessary component. (Provider Participant 19)

The view that food really is "a necessary component" of culturally safe services was emphasized by nearly all community-based participants in recognition of (a) the pervasive poverty and issues of food insecurity that shape the lived reality of their majority of clients; and (b) the significance of food and food-related activities in many Indigenous cultures. However, participants from most organizations reported that funding sources for food were often particularly precarious. For example, while some Aboriginal-specific funding, in particular Aboriginal Health Initiative Program (AHIP), provided short-term contracts for specific cultural programming around traditional food preparation, ‘food expenses’ seemed to be increasingly omitted from the list of eligible expenditures. This omission created conditions under which providers felt constrained in their ability to ensure that services were delivered in an effective and culturally safe way. For example, from the perspective of the above participant, being unable to offer food to the program attendees was experienced as challenging ethical practice because of the provider's insight into how engaging in such practice was essentially reproducing the macro-level inequities and structural violence within the microcosm of health care—potentially recreating trauma and exacerbating clients' experiences of social suffering and distress.

The relationship between food and culturally safe mental health and addictions care was illuminated further by another non-Indigenous mental health provider who was working for a different organization:

> we use food as a way to engage with clients, as a way to get them to come in until they start feeling safe enough to talk … because of our philosophy and our program we look at the broader determinants of health. None of us here believe that you can do any counseling or supporting if a client is hungry. It's something that's a very foundational part of our program and I think enables us to do the work that we need to do later on when it comes to working with women and their substance use issues or mental health issues (Provider Participant 07)

Much like this participant, many other providers described the intentional use of food to foster a sense of emotional safety. Being aware of the multiple social and structural inequities that most clients faced in their everyday life, providers described the ability to provide free meals and food to clients as invaluable for supporting clients in a holistic manner and enhancing their capacity to effectively engage clients in the more specific mental health and/or addictions aspects of the program. As emphasized by several Indigenous participants, the connections between food, safety and mental health were particularly salient for many Indigenous clients. In the following interview excerpt, an Indigenous provider relays a personal experience that helps to understand why this might be:

> So for me myself I come from a village of a hundred people in the summer, in the winter its eighty. There are no roads in or out like a lot of our reserves. You come in or out by boat or plane and so you don't travel very much because it's very costly right? And so I remember when I came to [name of city] immediately I felt I didn't belong here, I was looked down on, I was told I was way behind in any school work I did, so my English wasn't great … so right away I'm brought down. And so when you come to a place like [name of Indigenous NPO] in a big city it's like going home. You're immediately welcomed, you're immediately fed, you're immediately asked, you know, how are you? …

> The support is there just like it was in my community. I think that’s the big difference with [this NPO] or with any other Aboriginal agencies … it's welcoming. (Provider Participant 20)

Here the participant refers to a number of interrelated issues that uniquely shape many Indigenous people’s experiences of and needs for safety in urban contexts and that were also raised by several other participants. For many Indigenous people who leave their home communities to live in an urban centre, poverty, racism, discrimination and social exclusion intersect with one another to create a particular sense of vulnerability and isolation that is exacerbated further for those whose lives are also shaped by mental health and substance uses issues. These social dynamics provide the backdrop against which many Indigenous people appraise their experiences of safety when seeking mental health services and supports. In this context, the provision of food and/or meals was thus framed by many as an important strategy to create culturally safe and welcoming spaces for Indigenous people within organizations. In addition, it allowed staff to promote a sense of community and belonging for Indigenous people within an urban context, highlighting yet another pathway through which food might contribute to mental health and well-being. This later point was further illuminated by another Indigenous participant who also drew from personal life experiences to illustrate the significance of community and social inclusion as a social determinant of Indigenous mental health and well-being:

> [Many] people live in isolation … they’re looking for that sense of community again. … I know when I first came to the city years and years ago … first thing we wanted to know is where are there Indians? … At that time it was Indians, right? So we found out the Indians are at the Friendship Center. And we would go in there and we’d meet other Aboriginal people, have a cup of coffee or tea, it was really a warm place to go, … talk to somebody. …. You know, … 'you can have a cup of coffee', I don’t care if you’re a homeless person on the street, you know? I think sometimes they get ostracized, you know, I just feel like they really kind of get kicked, you know. And I think that … we … have that … sense of inclusiveness. … the sense of community and the sense of belonging is, is there so … I think that’s why people like to connect back with us and, you know, continue to come. (Provider Participant 17)

Similar to the previous participant’s account, Participant 17’s narrative brings into view the multiple forms of violence, discrimination and exclusion that shape the lives of many Indigenous people, in particular those who are homeless and live with mental health and/or addictions issues, in order to draw attention to the importance of practices and activities that convey respect and unconditional positive regard for clients as a way of promoting a sense of inclusiveness. As the participant describes, even small acts like offering a person a cup of coffee can be invaluable in facilitating a respectful and safe connection with people, who are otherwise routinely "ostracized."

Moreover, several participants spoke about the ways in which activities related to food, in particular traditional foods, such as salmon canning or berry picking, promoted healing by providing opportunities for community building and re-connecting with Indigenous cultures, as reflected in the following comment by an Indigenous provider, who stated, ‘I think … it’s essential for people to reconnect with cultural backgrounds in order to heal. And so even if it’s talking about going … berry picking with the grandmothers, you know?’ (Provider Participant 02). Taken together the participants’ perspectives align with this body of literature and frame the provision of food and/or activities relating to food, in particular traditional foods, as a legitimate mental health promotion strategy and essential feature of culturally safe mental health and/or addictions programming for urban Indigenous peoples.

However, participants’ accounts demonstrate that funders have tended to overlook both the cultural and social significance of food and/or food-related activities as well as the ensuing ethical situations and challenges that participants describe facing within everyday practice as a result of the exclusion of food-related costs as legitimate programming expenses. On the one hand, this might be because of the fragmented nature of the current policy environment, which may prompt funders to be reluctant to cover the costs of food and other ‘non-medical expenses’ because they are seen as falling outside the jurisdictional mandate of health care. On the other hand, it may be a reflection of the ongoing ideological embeddedness biomedicalism within contracting practice, which might keep funders from recognizing food and/or food-related activities as an essential aspect of culturally safe and effective mental health programming and care—a view that is seemingly reinforced by the growing influence of neo-liberalism on health care and contracting policies and practices.

The wider repercussions are discussed further in the following excerpt by a non-Indigenous program administrator/provider with one of the Indigenous NPOs, who shared this concern:

> The society will sustain itself in the basic capacity … that’s not in jeopardy I don’t believe. … So I can offer a … program not a problem just like you go to [mainstream social institution] … that we could get the funding for that. The question is how [and] … if we … get grant [funding] to be able to get materials to make a star blanket or a button blanket. (Provider Participant 19)

As revealed by this participant’s account, while not intended as such, current contractual funding practices seem to support the continued embeddedness of an assimilationist ethos within mental health care, even as government funders contract with Indigenous Providers for the explicit purpose of providing culturally safe care. Inadvertently, current neo-liberal approaches to contracting impact the sustainability of Indigenous NPOs by creating conditions that threaten to change the organizational culture of Indigenous Providers, thus undermining Providers’ capacity to effectively deliver mental health programs and services that are perceived as culturally safe from an Indigenous perspective.

Along the same lines, an Indigenous participant who was directing another Indigenous NPO observed that within the current climate, "[y]ou have to be really creative. You have to determine what you feel are core services in the organization and be creative so that you can protect those" (Provider Participant 09). The participant’s comment demonstrates how under neo-liberal approaches to funding, Indigenous creativity is being redirected from promoting program innovation to finding creative ways to navigate the structural challenges posed by current contractual arrangements in order to protect and sustain the integrity of the organization’s core programs. A non-Indigenous administrator who was working for the same organization as the previous interviewee further elaborated on the challenges imposed by contracts:

> So my role in … [this organization is to address] issues about like program integrity or the limits of what we’re allowed to do within our contract or how we can be creative to meet client needs within the contract. … And then like applying for various funding to supplement the funding gaps so that we can hold community workshops or community health fairs … and making sure the reporting is getting into contractors on time. (Provider Participant 04)

The account above highlights the extent to which current contractual arrangements were perceived to constrain rather than facilitate Indigenous Providers’ ability to make autonomous programming decisions and deliver services meeting the needs of clients. The sense that contracts for culturally appropriate mental health and addictions care had, perhaps unwittingly, become a container of control and domination was echoed by many other participants, who expressed similar concerns about potential threats to the program integrity of their respective organizations. However, the participant’s account above can also be interpreted as an example of ongoing Indigenous resistance to neo-colonial forms of control and relations of domination. In line with this interpretation, the participant’s everyday work seemed to be organized around finding creative ways to: (a) generate spaces for Indigenous providers to safely meet the needs of clients within the structural constraints imposed by the terms of contracts; an, (b) fill the (widening) spaces or holes existing within and between contracts consequent to the intersecting effects of neo-liberal contract reform and the hegemony of Western biomedical thought.

In the following interview excerpt, the same participant goes on to describe one of the organization's strategies to sustain program integrity vis-à-vis the hidden assimilationist tendencies within the current contracting culture:

> And so it was our [...] mental health contract, we built it so that … all our staff is paid less than they would make if they worked for … [mainstream] mental health down the street. So that we have wage parity within the organization and money to do the cultural kinds of things we want to do. (Provider Participant 04)

This account demonstrates how contracting can come to operate as a mechanism of privatization by shifting public responsibility for finding the resources to provide Indigenous people access to culturally appropriate mental health and addictions care from government to Indigenous NPOs and ultimately to staff. The same issue is discussed in the following interview excerpt, this time from the perspective of a provider, a non-Indigenous participant, who was also working with this organization,

> I'd like to say twenty-five percent of my paycheck goes toward families and, you know, to a certain extent I'm really okay with that. I don't get any credit for it right … but I believe fundamentally that so many of our families really need the extra support if they're going to stand a chance to make it in this world and … their kids … that's money well spent. But it doesn't take care of us and so if we say, if we look at our plan on taking care of staff that's a huge issue and I don't know what the answer is I wish employees made enough money that they would willingly stay here for a few decades. I wish there was a pension plan but there's not money to do that. And when you look at it [from] a cultural perspective food matters, paying for families and not having them have to pay for services really matters. (Provider Participant 05)

Here the participant describes the costs of shouldering the burden of ethical responsibility to provide care that is culturally safe and responsive. While the participant appears to be acutely aware of the historically-mediated social and structural injustices that shape the lives and life opportunities of the people the organization serves, the participant's account makes clear that providers' commitment to 'donate' part of their pay cheque to clients and their families exacts significant personal costs from staff. As discussed in Chapter Six, these costs are magnified even further by those inequities in wages and other social securities that already exist between the Indigenous non-profit sector workforce and their non-Indigenous counterparts.

Other community-based participants described similar patterns of donating time and/or free ‘labour’ in order "to do right by … [their] clients" and provide care that was culturally safe. As another Indigenous participant—who was acting both as volunteer and board member for an Indigenous NPO—observed,

> People are now wanting it [culture-based services] but even though they want it, the dollars are being cut back still. Not just where I am but everywhere. … My friend who’s running the men’s group it's having so much trouble, she sometimes works for free. Isn’t that sad? For all her knowledge and teachings and they still want the program but there’s no money being offered on the table for healing so, yeah, anyway. (Provider Participant 21)

While volunteering is often celebrated as a way to contribute to community building, the above account and those of several other study participants (for example, Provider Participant 05; 09; 17; 19) suggests that volunteerism within urban Indigenous non-profit organizations must also be considered within the context of governmental abrogation of responsibility, inadequate resourcing and unmet Indigenous need. Indeed, without problematizing the politics of volunteerism within urban Indigenous communities, liberal discourses of volunteering are likely to prop up culturalist discourses in which volunteering comes to be seen as an attribute of Indigenous culture. Within a neo-liberal policy context of welfare-state retrenchment, the enactment of such culturalist framings may create powerfully oppressive conditions for urban Indigenous people by (a) legitimizing those unjust and exploitative relations; and, (b) providing the foundation for further abrogation of government responsibility and Indigenous peoples’ rights.

7.1.2. De-humanization and Objectification: Accounting for Care

Another source of ethical tension that many Provider Participants in this study encountered in their daily practice could be traced back to the failure of current performance-governed accountability frameworks to adequately account for processes of care. They perceived this situation as unwittingly placing clients at risk. Participants described the difficulty of trying to reconcile the values that informed their approach to care with those that underpinned the approach to accountability endorsed within performance management (PM) practices. A non-Indigenous mental health provider working for an Indigenous non-profit organization (NPO) provided an account that illuminates this tension:

> it's always cost efficiency... And that's not always the best way to look at things … but it's government and it's tax money, right? And I can understand that ... but if you're basing it just on outcomes or based on stats really, [then] no. I guess that's the easiest way to do it but … we deal with people here [and] that's not what we're thinking about. … We're thinking about how we can best serve the client, what we can do to help them and we do the best that we can. And we're really good at like I'm very knowledgeable about the resources and … I can be very productive … because I, I know the system … and it depends on the trust level too you have to develop that relationship with the clients, with the patients and if they trust you, you've got a good partnership … it makes a difference. (Provider Participant 08)

This participant's account highlights the subtle ways in which current PM practices and reporting frameworks are perceived as pressuring Indigenous NPOs and providers to reorganize care around the values of efficiency and administrative accountability. In the experience of the participant above, this narrow focus on efficiency and its concern with quantitative assessments of care utilization had the impact of promoting an approach to care that objectified clients and prioritized administrative needs over those of clients. The participant openly challenges and expresses resistance to this discourse of efficiency because it fails to take in account that care—arguably mental health care in particular—is essentially a relational process marked by human connection. This claim does not mean that the mental health care provided by the organization is inefficient; to the contrary, it is highly efficient in its work exactly because of the relationship it has to clients and the community at large. However, within New Public Management (NPM) discourses of accountability, the impact that such relational competencies might have on the efficiency and effectiveness of organization's service delivery seems to be entirely disregarded.

The following interview excerpt with another non-Indigenous Provider Participant with a different Indigenous NPO offers further insight into the kind of problems that arise within everyday practices as result of these value tensions. In what follows, the participant is discussing the nature of an ongoing frustration between the participant and the government administrator responsible for managing a certain mental health service contract that the participant's organization held:

> [The intake form] also asks questions about the PHN [Provincial Healthcare Number] …[and] some of our adults … actually don't have a PHN or at least they don't have access to it. … And again I understand it is counting for stats but then what [name of contract manager] tells me is, okay, well if we can't count that number then and it may be used, you know, against your future funding. … And probably thirty percent of the adults that come in for … [addictions] based issues don't

> have a PHN. So thirty percent of our clients are not counted … they don't count without this number and it's just a rule they follow … So I disagree, you know, like it's a real person with a real issue with real family members … with real trauma. (Provider Participant 05)

The account above provides a poignant account of how, under the current accountability regime, the needs, rights and social suffering of those most marginalized by social and structural inequities can be rendered invisible and left unaccounted for. For Indigenous peoples, such exclusionary and de-humanizing processes present a continuation of historical processes of colonization that continue to underpin wider Indigenous–state relations, for example as represented by the Indian Act. There is, for example, a noticeable parallel here to the ways in which the federal government has historically limited its responsibility for Indigenous peoples' health to those who count as 'real' Indians under the Act with little moral concern for the needs and rights of those who have been unable and/or unwilling to attain a status number under the Indian registry.

Processes of objectification enacted under performance-governing accountability regimes are thus far from being neutral; rather, as Smith (1999) writes, "[o]bjectification is a process of dehumanization" (p. 39). As the histories of colonization attest, the process of objectifying the Other has thus had very real consequences for Indigenous peoples in that it has allowed colonizers to morally justify a wide range of acts of violence against Indigenous peoples ranging from forceful dispossession and economic marginalization to overt assimilation to genocide. While current accountability regimes are not driven by an explicitly colonial agenda, their reductive and narrow approach to operationalizing accountability implicates them in the larger colonial project by producing objectifying accounts of Indigenous clients' experiences in ways that render invisible the very existence of those most disadvantaged by the system.

In the scenario above, under the current performance reporting framework, the provider is faced with the ethical dilemma to 'choose' between: (a) producing the numbers necessary to comply with contractual performance targets to meet their accountability to the funder so as to not jeopardize current and/or future program funding—in the extreme case, meaning that those who are most in need for mental health and social services and supports are denied care; or, (b) giving priority to the organization's accountability to the people and community they serve, in alignment with the equity-oriented norms and values that underpin the organization's mission and approach to care, despite the risk of possible financial repercussions, and in the extreme, the loss of the program. This dynamic is clearly paradoxical and irreconcilable with governments' social justice and health equity commitments, and yet, as illustrated through the next comment from the same participant, there seems to be little openness or understanding on the side of the governmental contract manager:

> I'm trying to have a good relationship I try to get everything in on time, [but] I've never met her in person. She communicates to me all the time about these forms that we don't have the information for so it feels a little bit like a scolding relationship. (Provider Participant 05)

Participant 05's account exemplifies how models of corporate governance can support processes of dehumanization and objectification through such ideals as managerial distance[40] and bureaucratic approaches to accountability. While not all relationships between contract managers and provider participants were poor, this participant's account represented common and rather frustrating occurrence among participants. Several of the participants, both Indigenous and non-Indigenous, spoke about the ways in which they experienced the interactions with their contract manager as paternalistic and their ability to express and make their concerns heard was constrained as a result. In addition, these dynamics intersect with the way in which 'Indigeneity' is constructed. While it is impossible to know the attitudes and biases the contract manager in the scenario above was bringing to work, within the particular ideological context, the fundamental lack of trust in and concern about the organization's moral integrity and/or credibility expressed by this individual are suggestive of colonial stigma.

The tension between accountability to funders and accountability to clients and community was described by many participants in this study and experienced as highly problematic. In the following interview quote, an Indigenous provider with an Indigenous NPO elaborates by speaking to the everyday ethical challenges arising in such milieux,

> I have to meet a certain amount of clients, a certain amount of hours, [and] do a certain amount of programming … which can also be helpful for keeping on track … [but it] … doesn't feel good … like for me I'd want to give priority to clients but if there's certain objectives I need to meet how do I achieve that?" (Provider Participant 22)

This account draws attention to how the values underpinning funders' accountability requirements were often perceived by providers as aligning poorly with the ethics of care

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[40] Within corporate governance, the concept of 'managerial distance' is used to describe "the extent to which the foundation's board of directors is detached from direct involvement in the affairs of the operating company and is placed, instead, in a position where the operating company's objective performance is highly salient" (Hansmann & Thomsen, 2013, p. 9). Evidence supports the idea that a high degree of managerial distance promotes company economic performance (Hansmann & Thomsen, 2013).

that was guiding their practice. Operating under efficiency-oriented models of accountability, many providers reported feeling pressured to ration their time and the care provided to clients in order to meet the contractually defined performance targets, to an extent that jeopardized their ability to provide care that was responsive to clients' needs (i.e., response-ability) and thus deemed ethical. Like the participant above, several participants described, for example, an inability to "feel good" about their practice, pointing to the profound ethical distress that many experienced in their day-to-day work.

In the next interview excerpt, a non-Indigenous participant with years of experience working as a mental health provider with Indigenous women provides a perspective that helps to understand why:

> People in our society with addictions … are stigmatized. … They're very much vilified by people … it's something that … in my work here [has been] very apparent … Most … of the women we work with have concurrent disorders, most of them have trauma histories. And so … the amount of courage it takes for someone to walk in a door and ask for help … that's huge. So once they develop trust with us . it's easier for us to work on those issues. … We have a lot of staff who have been here a long time and so the clients get to know us, they feel safe here, that's when they can start working on the issues. You're not going to get anywhere if they don't trust or feel safe. (Provider Participant 07)

Here, the participant calls attention to the trauma, violence and stigma—including that which exists inside health care—experienced by many of the people who this Indigenous NPO served and who experienced mental health and addictions issues concurrently. This situation emerged as a shared reality across Indigenous NPOs in this study. Such effects are likely to be exacerbated for Indigenous people as the stigma attached to mental health, substance use, and poverty intersects with other stigmatized aspects of their social identities and locations, such as racialization. Accordingly, provider participants agreed that attending to clients' safety needs was requisite for the provision of culturally safe and effective mental health and/or addictions care and must be integrated with harm reduction and trauma- and violence-informed (TVIC) principles of care. Both harm reduction and TVIC approaches incorporate building trust in relationships as a central component of ethical care. This point was further underscored by the interview with a Provider Participant who was responsible for overseeing and administering several different mental health and addictions contracts within the context of another Indigenous NPO:

> Almost all of the families that are referred to that program are like complex trauma kind of kids. Some kids might be kind of short term but there are some kids that we've been working with like for five years since the program started because they have just been so damaged that it takes them so long to build a relationship with the counselor like they think you're a social worker and … they've had their trust broken, right? So and they don't have any healthy supports not anywhere. … And it's not cookie cutters it's like very individual. (Provider Participant 04)

Providing care from a stance informed by cultural safety, participants recognized the impact of ongoing trauma and violence—specifically historic and intergenerational trauma and structural violence—on Indigenous experiences of mental health and addictions care. As this participant argues, for Indigenous people and families, mental health issues, trauma, and trust issues are inextricably linked to colonialism and neo-colonial policies and practices, of which the disproportionate separation of Indigenous children from their families and communities through "social workers" under the mandate of the child welfare system[41] is but one example. Because of the intergenerational and ongoing trauma experienced by Indigenous clients, building trust was often described as integral to healing and thus seen as a priority within culturally safe mental health and addictions care. Operating from this stance, community-based participants described the importance of fostering emotional and cultural safety by connecting with clients in non-judgmental and respectful ways, and an ability to cultivate relationships over time. In addition, emphasis was placed on ensuring that opportunities for self-determination and choice were woven into their practice and interactions with clients. For example, participants described how offering clients the option of drop-in counselling sessions as opposed to conventional provider-driven approaches that schedule clinical appointments ahead of time can be empowering to clients. Another aspect of the ethical tension embedded within current performance-based accountability arrangements was illuminated by a non-Indigenous mental health provider who was working for an Indigenous NPO and who shared the following account:

> So many times people aren't ready for counseling because there's poverty based issues, they haven't had any nutrition, they haven't, they don't have a good place to stay so they're not stable in those environments. And so for us to be able to help in fundamental needs that they have we build trust, we build rapport, when there's a sense of connection then we can move in a direction of the piece around

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[41] The child welfare system itself has been criticized for its dehumanizing practices (Bernstein, 2016).

> what’s happened in the past that’s gotten them stuck … and we can build a healthy relationship; and with their children as well. (Provider Participant 05)

Here the participant draws attention to the intersections of mental health, trauma, and addictions with poverty, homelessness, and food insecurity that shape clients’ needs and relative priorities, highlighting the importance of providing mental health care that is responsive to and aligned with those concerns that are taking priority in clients’ lives—even if this meant deferring the start of counselling in order to address other more pressing needs, such as food or a place to sleep. Being responsive to the social contexts of clients’ lives was perceived by participants as key to creating safety and building a positive trusting relationship, and thus, as a necessary precondition to the effective delivery of mental health and/or addictions services. In line with this perspective, several other provider participants in this study described making time to seek input from clients in identifying care priorities and discerning clients’ readiness to begin mental health counselling.

Provider responsiveness requires, however, contractual arrangements that allow providers to make autonomous decisions about how to use their professional time—something is often not the case, as the following account by an Indigenous provider illustrates:

> I do understand … we need numbers to justify funding but it’s different like this is a little bit different of an environment than a regular counseling office. A regular counseling office you would schedule your appointments ... here … it’s very different it’s not just a set time where I can sit in an office and do that piece, it has a lot more to it. So I do the counseling piece, I respond to crisis, you know, just supporting a more community environment running different programs, it’s a little bit more diverse. And preventative, right? So just being open and out in the common area it gives them like an opportunity to diffuse conflict right there. (Provider Participant 22)

Here the participant draws attention to the challenges arising from the perceived failure of current quantitative performance measurement frameworks to take into account the distinctiveness of this organization’s approach to programming and care. For example, there seems to be an obvious fit between current quantitative and efficiency-focused performance frameworks and conventional models of care. According to the latter, health care encounters take place within the confines of a doctor’s office, on the basis of pre-booked appointments and usually within a set amount of time. However, such an approach seems to be ill-suited for the program described in the account above. Here, appointments are client-initiated, and the delivery of the program is deliberately interwoven with—and, to a large degree, situated within the context of—other organizational activities in which clients were participating. Consistent with Indigenous notions of relationship-centered and holistic care, Participant 22's approach to delivering the program is based on the belief that placing mental health work within the realm of clients' interactions with others and their experiences of everyday life offers opportunities for empowerment and social inclusion that might not be possible within the context of traditional one-on-one counselling sessions; by way of example, "if conflict does come up … we can address it and work through it …[right there and] then, you know, even address it the next day about what was going on there, so it's a really huge area for growth and life skills as well" (Provider Participant 22). The impact of this lack of fit was felt by many provider participants, as the same participant went on to explain,

> I think it's because of [the way funders are] targeting certain things and then they don't see the full like impact or how much I'm stretched at times. And [I am] realizing like, okay, I need to do this programming but there's a crisis here ... and then it's hard [to meet these performance targets, and] I'm the primary person here for those counseling and crisis needs and so it's a bit of a demand, yeah. (Provider Participant 22)

Echoing some of the findings discussed in the previous chapter, the participant expresses concern that funders overlook the complexity of the work involved in the delivery of culturally safe mental health and/or addictions programming that is grounded in Indigenous perspectives because of the ways in which current performance frameworks limit what is being measured. While current indicators seem to be developed with a view to measure service providers' output and support accountability for the efficient use of resources, accounts from Participant 22 and other similar interviews suggest that they fall short on measuring the quality, processes and outcomes of care in ways that are culturally meaningful and relevant to Indigenous understandings of and responses to mental health and addictions issues. Moreover, in light of the evidence of the structural constraints and ethical tensions that provider participants in this study describe encountering within their daily practice, critical importance must be placed on facilitating the development of equivalent sets of indicators that measure the impact of the wider mental health service environments, including organizational and contractual arrangements, on providers' ability to provide access to care that is deemed culturally safe. However, movement in this direction seems to be impeded, at least in part, by funders' lack of understanding of how culturally safe mental health and addictions services are provided, and thus of how they can best be supported through contractual arrangements.

For example, as the data in this study show, nearly all providers reported finding themselves in an ethical double-bind whereby they were held accountable to provide a service under contractual conditions that made it increasingly difficult to do so. As result, participants pointed out, Indigenous clients were put at risk of not having their needs met. Sometimes this led to significant quandaries, as exemplified by the following account by a non-Indigenous provider participant who was working for one of the Indigenous NPOs:

> I've never had so much to do … it's just chronic … like I'm trying to get these stats done this morning… and then we have two kids that are suicidal … so then … I forgot where my numbers were on this stats because the kid is suicidal and it's really important … [but] so I've got to jump on those [participant is pointing to reporting templates that are lying on the table] too because … those really matter and there's just not enough time. (Provider Participant 05)

While most ethical challenges that participants described confronting in their daily practice were not matters of immediate life and death, the above account serves as an important reminder of what seems to be often overlooked in the practice of PM, namely that what is at stake here is the mental health and lives of Indigenous peoples. Given the often plural forms of trauma and violence and lack of social supports in their lives, for many Indigenous people, whose lives are also shaped by mental health and addictions issues, the relationship to a provider, when it is built on trust, can be a lifeline. However, as participants' accounts in this study reveal, the majority of ethical issues that are encountered by providers are subtler and extend far beyond those conventionally recognized within a biomedical paradigm. In combination with the objectifying lens of current performance measurement frameworks, this complexity might explain why funders have tended to fail to pay adequate attention to these ethical concerns—they might not understand the accountability tensions that Indigenous Providers report on as ethical but rather as neutral administrative matters. These issues intersect further with the way colonial ideologies, in particular paternalism and ethnocentrism, continue to be deeply entrenched within institutional structures and Indigenous–state relationships, including contractual relationships.

As the following interview excerpt with an Indigenous participant, a senior leader of an Indigenous NPO, suggests, due to their lack of cultural sensitivity, funders and others working within these institutional structures cannot see the paradoxical situations and ethical repercussions of their own accountability practices:

> … it makes a whole lot of sense that the majority of your staff time is going to be spent with people but the reporting requirements are increasing astronomically, you know, in terms of what the funders are expecting, in terms of reporting, tracking, data collection ... And there isn't additional money for administrative dollars, a lot of our contracts have stayed exactly the same for many, many years. (Provider Participant 09)

This account highlights how the blind pursuit of administrative accountability has led to a situation where funders' excessive expectations of monitoring and reporting exceedingly divert energy and time away from client care, compounding the ethical challenges arising from the emphasis that has been placed on quantitative and efficiency-oriented performance indicators. The ensuing tensions also intersect with the withdrawal of government support for costs not directly related to the delivery of the service, and the predominance of short-term and multi-funder contractual arrangements.

For providers, enacting culturally safe practice thus involved working the spaces in between their accountabilities to the funder and the clients and community, and navigating the ethical tensions and paradoxes that arose within and between these spaces. This work involved weighing risks including the possible financial penalties of failing to achieve the contractually articulated performance targets. In the following interview excerpt, a non-Indigenous provider with an Indigenous NPO describes how providers enacted culturally safe practice and resistance to the pressure to reorganize care priorities according to efficiency goals within the service environment of this organization:

> here at the [name of Indigenous NPO,] regardless of what the contracts we have say, ... [we] want to slow it down and build relationships so we have pow wows and we have feasts and we have days of camp and culture days ... we have beading workshops and evening beading workshops or evening crafts. And everything is drug and alcohol free and people that keep coming back become family members. (Provider Participant 05)

This participant's account suggests that in this NPO, cultural safety was endorsed by the organizational leadership as an explicit organization-wide mandate. The mandate involved a clear commitment to several shared values and certain essential elements that informed the approach to mental health and addictions at the organizational level, the level of programming, and the interactional level between front-line workers and clients. In the scenario above, this included a strong commitment to relational approaches to care, and Indigenous culture as medicine. Operating within such an organizational environment was experienced by Participant 05 and other providers as supportive as they worked between competing and at times conflicting values and interests, enacting ethical care from a stance informed by cultural safety. As a non-Indigenous Provider Participant with a different Indigenous NPO explained,

> [the providers who work directly under the health authority alongside our team] do not have ... the luxury of taking the time to develop the relationship ... [and] the time to see that relationship grow into the trust and then grow into I'm going to take better care of myself ... We have that luxury here even though there still is that time restraint ... but ... the society is the buffer ... between the health authority and what we can do here, yeah. We don't have somebody breathing down our neck saying how come that person isn't on [meds] yet? ... There's a lot of stress from my perspective ... put on them for meeting quotas and outcomes. And in order to do that what I see happening is them becoming so focused on that … they lose that relationship with that person. (Provider Participant 06)

Here the participant describes an arrangement where NPO staff worked alongside providers who were employed with the local health authority—a situation that seemed to be increasingly common. From the perspective of this participant, the problem with such an arrangement, among other issues, is that being a contracted employee of the health authority, rather than with the Indigenous NPO, places these providers in the same community-based working environment as non-profit staff, but meanwhile they are also in a direct agent-principal relationship with the health authority. Without access to the support and relative authority of an intermediary community-based organization that is primarily oriented to serve the community, the ability of individual providers to work the spaces in between competing accountabilities is severely constrained. So the participant's account highlights a number of important themes: (1) the power of collective and organized forms of resistance; (2) the importance of organizational structures, policies and leadership in supporting staff to enact ethical care that is congruent with the principles of cultural safety; and (3) the key role that Indigenous NPOs play in creating ethical spaces of engagement and possibilities for Indigenous peoples to enact their cultural agency and epistemologies. Nevertheless, because of the structural and ideologically mediated nature of many of the ethical tensions, and because of the power imbalances embedded within state–Indigenous contractual relationships, working the spaces in-between was challenging for providers and often led to the acceptance of compromises that did not always feel "right."

Revealing yet another layer of complexity, in the following quote, an Indigenous participant speaks to the added difficulty that comes with being the sole service provider responsible for the delivery of a contracted mental health program:

> The requirements that they give me I'm not sure they give that many to any other 'one' person ... I was ... looking at another program that they support and then there's a staff of six or eight and it's like they have the same requirements I have is what I feel. ... How is this equitable? So I mean for me that's a little bit I feel over extended at times. (Provider Participant 22)

Here the participant's account calls attention to funders' failure to tailor contractual performance-based reporting requirements to the capacity of the program and/or organization, which was perceived as unfair by this participant, who had no one to share the administrative burden with. As the data show, while reporting requirements might be adjusted to the contract value, there was no indication that funders were taking into account how the impact of their accountability requirements might be experienced differently by contractors depending on organizations' differing contexts and capacities.

The same participant went on to speak to the personal and professional toll that has resulted:

> Honestly it … has impacted me in terms of almost burn out because of how much I've been doing so it definitely for myself I need to set healthy boundaries and be more realistic about what I can achieve and like what, what certain programming will look like. … I have [tried to bring that up] and ... they just said that it was doable. I think I just accepted it a little bit too ... you don't want to be too contentious in that time when they're actually looking at funding (Provider Participant 22)

The above account aligned with the experiences other provider participants, exposing the corrosive effects of balancing the heavy weight of contractual compliance with the ethics of care that (broadly speaking) informed the approaches to mental health program delivery in this study. The implications are serious not only because of the human costs (in terms of the mental health and well-being of the Indigenous non-profit workforce), but also because of the potential negative impact on providers' ability to sustain high quality and effective mental health care that is congruent with the principles of cultural safety.

7.1.3. Acts of Intrusions and Exclusions: Managed Care

Another source of tension that Provider Participants' accounts were constructed around was a shared perception that their ability to enact cultural safety within their daily practice had become increasingly constrained by various acts of intrusion, defined as control or interference from the outside, with little respect for or recognition of the perspectives from the inside. As the analysis reveals, one such intrusion seemed to stem from the introduction of 'innovative' health information and management technologies into the day-to-day practice of mental health and addictions care. In the following interview, a participant who was working as a mental health provider for an Indigenous organization describes an everyday work experience that speaks to the ethical challenge arising from this kind of intrusion:

> I'm chronically reminded to do the AIMS [Addictions Information Management System[42]] forms which really is about pathologizing somebody's substance use and quantifying it … And these are intrusive styles of questions … around how much they drink a day and that's supposed to be done at the first session. And that's not culturally appropriate and it's very medical model (Provider Participant 05)

Here, the participant draws attention to the harms associated with importing standardized information management tools that have been developed within different contexts into routine intake procedure. In contrast to the performance reporting frameworks focused on collecting performance information at the program level with a view to meeting contractually defined performance targets, these client-based information management tools collect information specific to each client at different temporal points of care, 'for the purpose of administering, monitoring and assessing the services and outcomes of addictions programmes' (BCMOH, 2006). As evident in the scenario above, the way information is gathered is highly structured through the use of predetermined standardized questions in order to be integrated in the province-wide Addiction Information Management System—BC's large-scale performance measurement system for addictions treatment.

Health information management technologies and systems are meant to improve system accountability by yielding aggregate population data on addictions and substance use treatment that can be helpful to improve addictions service planning and quality of care (Rotondi & Rush, 2012). However, as the above participant's account highlights, it is critically important to ensure that the use of such instruments is culturally appropriate. In the scenario above, the prescribed questions were perceived by the

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[42] According to the BC Ministry of Health, the form collects personal information "from the client for the purpose of administering, monitoring and assessing the services and outcomes of addictions programmes funded by the Ministry of Health" (2006). AIMS is publicly accessible form for Addiction Information Management System retrievable from the BC Ministry of Health website: https://www2.gov.bc.ca/gov/content/health/health-forms/mental-health-forms

provider to be highly ‘intrusive.’ Although this participant did not identify as Indigenous, the participant seemed cognizant of the unique social locations and different social, historical, cultural, political and economic contexts that mediate Indigenous clients’ experiences of substance use and care. Operating from such a stance, the participant viewed the use of the above assessment tool as perpetuating a medicalizing discourse and thus as highly problematic for several reasons: (1) compromising the ability of the provider to build a safe environment and trust with the client; (2) inadvertently participating in the reproduction of racializing and stigmatizing misrepresentation of Indigenous peoples by collecting and reporting de-contextualized information on people; and (3) the potential of unwittingly re-enacting trauma and stigma for individual clients within routine intake situations. These findings highlight the tensions that can arise between accountability to the public and accountability to specific communities that are marginalized by society.

Another participant, a non-Indigenous provider/coordinator who was working for a different Indigenous non-profit organization (NPO), added further to the discussion,

> Our intake process is very easy, we don’t need to get every piece of information. ... I know that [name of funder] believes that doing the assessments is important and that getting those results so that you can have research [which] is important. But if somebody comes in and you’re trying to form a relationship and work on engagement and get them to a point where they trust you going through a twenty page assessment isn’t going to help with that. And so we have never had to do that, to this point (Provider Participant 07)

While the participant’s account indicates that in the past, some Indigenous NPOs were exempt from collecting data using health information technologies, it also points to an attitudinal shift across government funders. Funders’ new interest was met with similar concern about the ways in which compliance with this request would lead to a necessary re-structuring of provider–client interactions in ways that were thought to prevent relationship-building and client engagement as well as undermining providers' ability to attend to clients' needs for emotional and cultural safety. As previously alluded to, taking a strength-based approach to care that supports clients' sense of self-determination as part of a collaborative process to care planning was emphasized by many study participants as an essential dimension of culturally safe care for Indigenous peoples. For example, as one community-based administrator with yet another Indigenous NPO explains,

> we don't come from that western idea of we're the experts you are the patient, we know what's best for you kind of thing. So in counseling we're using more non-directive approaches where you assume the client is the expert on their experience and they can be well, … and just being respectful of people so … So just to try and make it as natural and comfortable for people recognizing their experience which isn't necessarily a cultural thing but a cultural teaching of respect. (Provider Participant 04)

Here the participant argues that providing mental health services based on empowerment or strength-based approaches requires participatory health care interactions that honour clients as experts of their own experiences, encouraging them to become involved in the planning of their own healing journey and/or setting of their individual goals for recovery (or whatever end is seen as desirable). Moreover, it is fostered by an approach to service delivery that takes into account the social realities of people's lives. In the example of the organization above and others, this approach included the delivery of outreach-based services.

In contrast, care governed by the kind of information management technologies described by the participants above seems to leave very little time and space for the implementation of such concepts; rather, as the above accounts suggest, it encourages standardized courses of client–provider interactions and prescriptive patterns of communication, according to which clients' experiences become objectified and their identity constructed in medical terms. Rather than being governed by client concerns and/or the professional judgment of the provider, care processes become centred around the imperatives of the funders and managed from the outside—for example, in many cases, the use of these instruments regulate not only what information is collected but also when it is collected and how.

This dynamic is illustrated further by the following interview excerpt with the same participant, who spoke about the risk of pathologizing clients through the uncritical application of certain standardized assessment forms:

> So for me it's a fear that … if you enter the information 'mum is in a bad mood, yelled at us as we had to get her kicked off out of the office, the child has been removed into care' … it just can be taken out of context and we have no control over it. And then it's hard to establish safety for our clients when, when we're saying well we have to report all this and put it in writing and, and the questions that are asked and like wow, 'I came here because I'm really struggling and you want to know how much I drank? And how long I've been drinking?' …you know, … it really pushes people. (Provider Participant 05)

Here the participant highlights some important ethical questions about information management technologies, particularly regarding the way in which information management technologies and systems have changed the longevity of client-based information and the possibility of future uses of the data collected. As a trained counselor, this participant felt uneasy about the extent to which information management technologies diminish providers' abilities to safeguard the confidentiality of the information shared by clients. This rupture in client information from the situated knowledge of the provider who recorded it—and the ongoing electronic existence of these pieces of information about the clients without any context—is of immense concern to the above participant, because it invites misinterpretations and it could place clients at risk for structural discrimination and violence.

Client data stored in health information management systems is aggregated and anonymous. However, provider's concerns are nonetheless relevant to the analysis for at least two reasons. In the first case, regardless of whether the risk is substantial, the fear is that such a system may create yet another obstacle to building a relationship of trust with clients. This concern is likely to be particularly true for Indigenous clients, many of whom share an understandable distrust towards social institutions as a consequence of the active role social institutions played in the colonization of Indigenous peoples in Canada and continue to play in the production and reproduction of social and structural inequities.

Secondly, the account provided by Provider Participant 05 helps to bring into focus the blurring of the boundaries between clinical assessments used to guide clinical decision-making about clients' care on the one hand, and on the other, assessments for the purposes of accountability and research. The differentiation is important, as each raises a distinct yet interrelated set of ethical questions. Similarly, while the intent to gather comprehensive client-based data, including clinical data, at the regional and/or provincial levels might prove valuable for addressing issues of system accountability from a bureaucratic perspective, the data of this study raise the question: At what price? Claims that information management technologies and systems will improve system accountability are, as the findings of this study suggest, clearly due for greater scrutiny.

Yet, while there are numerous ethical guidelines set out to ensure that research with Indigenous peoples is conducted in an ethical way in recognition of the harms done by past research, and in recognition of the potential future harms posed by ongoing research, equivalent ethical considerations and safeguarding seem to be absent within the context of gathering information for the purposes of accountability. Further, by injecting said technologies into points of care and the routine practices of non-profit providers, such as at client intake, Indigenous clients will likely have little choice about providing information for government research/accountability if they want access to mental health and addictions services and supports. Prompted by a cultural safety lens, this then raises the question of how funders' imposition of standardized tools for client-based assessments addresses such ethical principles as Indigenous self-determination, ownership, control, access and possession, if at all? It also raises the question of how the corporate culture of accountability impacts on the culture of Indigenous NPOs, their programmatic integrity and providers' ability to address client need? The significance of these questions is illuminated further within another quote by the same participant,

> We're supposed to do the BCFPI[43] [Brief Child and Family Phone Interview], that's an intake system where the Ministry of Child and Youth has put it out there to all the [health authority] funded and MCFD [Ministry of Children and Family Development] funded organizations. … It starts out with a phone interview that asks however much money you made in that year so they're calling in because my child got kicked out of school and I want to get him back in school and our first questions are like, well, okay, how much money do you make? (Provider Participant 05)

Here the participant describes another care-standardized technology, namely, a standardized and structured telephone interview assessment tool to be used by a clinical interviewer and a parent, teacher, or adolescent to assess "the likelihood and severity of problems the child may be experiencing" (*Brief Child and Family Phone Interview (BCFPI) User Guide*, 2017, p. 8). Although it seems that compliance with this intake and assessment procedure has so far not been seriously enforced by the funder, the participant's response indicates that here too there is an increasing expectation that the organization, as a contracted provider, will have to integrate the tool into health care practice, like all other programs in the province that fall under the mandate of this Ministry funder. However, as the participant above explains, there are serious ethical concerns about the use of the BCFPI as a routine intake and clinical assessment tool when working with Indigenous families and children. Especially considering the extent to which racism, stigma and discrimination continue to shape many Indigenous peoples'

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[43] The BCFPI is a standardized and structured telephone interview assessment tool between a clinical interviewer and a parent, teacher, or adolescent; it is used to assess "the likelihood and severity of problems the child may be experiencing"(*Brief Child and Family Phone Interview (BCFPI) User Guide*, p. 8).

experiences with the health and child welfare system, how would a provider who is following BCFPI protocol establish a trusting relationship and safe environment with an Indigenous client over the phone? Further, how does this protocol fit the lived realities of clients who live with mental health and addictions issues and are also facing poverty?

Again, Indigenous people who live in poverty, and with mental health and substance use issues, often experience multiple intersecting forms of stigma and discrimination. Mandatory questions like the ones described by the participant above that are not sensitive to these social and structural forms of violence shaping the everyday life of many Indigenous people and do not take into account the wider socio-historical and political contexts of Indigenous mental health and addictions issues, including experiences of family violence, are predisposed to undercut providers' efforts to provide care that is informed by a relational ethics. Furthermore, they may cause additional harm in situations where clients and/or clients' family members perceive these questions to be proof of stigma, racism and/or forms of discrimination.

Interestingly, this provider/coordinator participant worked for the same organization whose philosophy of care was previously described by a participant as one whereby…

> …we do an intake, we don't ask you two hundred really intrusive questions, we ask you five questions and they're very broad and it's a natural conversation. And, and we don't do phone intakes like we would come to your house or meet you at the school or you could come here or whatever. (Provider Participant 04)

Read in relation to each other, these quotations reveal that while the work of both participants seem to be guided by very similar values regarding how mental health care should be delivered, government funders' values and priorities seem to be steering their actions toward a very different place. Funders' demands to adopt care-standardizing technologies in health care threaten to undermine Providers' concerted efforts to create conditions to support the enactment of culturally safe mental health and addictions care by encroaching on providers' autonomy to make decisions and act according to their values, knowledge, and interpretations of individual health care interactions. This lack of authority means that providers are severely constrained in their ability to determine their use of time in relation to care. In this process, providers' knowledge and expertise are devalued and discounted as irrelevant—or worse, obstructive—to the successful delivery of the program.

Given the emphasis that was placed on control and outside management, it is perhaps unsurprising that Provider Participants expressed concern about this reform direction. Note the following excerpt from an interview with the same participant:

> I worry that one day they're just going to make us exactly like child and youth mental health and it won't be Aboriginal child and youth mental health anymore, we'll have to use their assessment and follow their treatment modules and it's just a completely different world. They use a computer program to tell them what to do with a client like it's completely foreign. (Provider Participant 04)

Here, the participant's account alerts us to the danger that "managed care" reforms may inadvertently become a new guise for colonial relations of domination and institutional processes of assimilation. Managed care quite deliberately shifts decision-making authority away not only from the client but also from the provider while constructing care-standardizing "technologies ... as the legitimate arbiters of need and care" (Choiniere, 2011, p. 340). In this sense, care itself becomes objectified along with providers and clients; Indigenous and professional knowledge and expertise are discounted, and Indigenous needs and rights are rendered invisible. As alluded to earlier, these dynamics intersect with Western hegemonic thought, which continues to inform the development of evidence-based clinical guidelines and care protocols that are attached to new and innovative information and management technologies.

Experiences with intrusive administrative governance structures that were imposed from the outside extended beyond managed care reform, as illustrated in the following excerpt from the same interview:

> The program it is hugely important, yeah, it's like that's our general counseling service that fits for all age groups [because] our other little counseling contracts are very specific like it's child youth, mental health or it's addictions and that's our only catch all. And so many of the people we work with like that have just lived through trauma and loss and that's like the core of it but it has to fit into this box to get service. (Provider Participant 04)

Here the participant calls attention to the extent to which access to community-based mental health and/or addictions care largely remains a function of factors that are outside the control of Indigenous Providers. As the account suggests, access to mental health care for Indigenous people is located at the intersections of neo-liberal contract reform, jurisdictional issues (for example, the fragmentation and siloing of BC's mental health policy environment), and dominant public health and policy discourses in mental health. The effects were visible in a reproduction of social inequities surrounding access to culturally safe mental health and addictions care, in which those who live with ongoing and complex trauma histories appear to be marginalized most. In the scenario above, from four mental health and addictions contracts that the organization held, only one did <u>not</u> require Indigenous people "to fit into …. [a] box to get service."

In light of this scenario, the ability of the organization above to obtain four different contracts and piece those sources of funding together to offer a counseling program must be interpreted as both an act of resistance and a demonstration of Indigenous ownership. However, while piecing together a range of different mental health contracts can be an effective strategy to fill the gaps in mental health programming and promote equitable access, the attendant increase in the administrative burden can weigh heavily on organizations and individual providers; as discussed earlier, this is the case to the extent that it might interfere providers' capacity to remain responsive to the needs of clients and deliver the services in an effective and safe way.

The following comment from an Indigenous participant, who held a senior administrator position with a different Indigenous NPO, adds further to the discussion by recounting an incident that happened fifteen years ago,

> we were approached by the federal government … and asked whether or not we would take or would accept the contract that would enable us to, to have some specialists come into our, our ... facility and provide mental health services to people that, that most needed it. And ... we had difficulty around a couple of issues, (a) whose definition were we using around people who needed the, the mental health services and (b) the main snag was ... that we could only provide these services to people who were status Indian under the Indian Act. So on that basis we just said well hold on, this is not going to work … it was kind of a lucrative contract but we couldn't bring ourselves to say, yeah, we're going to check people as they come through the door and, and only provide help to those people who had a number, so we rejected it outright. And the people that we were dealing with were absolutely aghast that we would do that. (Provider Participant 10)

The account above focuses attention on the complexities inherent in accessing mental health care funding and services for urban Indigenous peoples as a consequence of the jurisdictional divide as it intersects with policy discourses entangled with colonial constructions of Indigeneity and ethnocentrism to reproduce colonial patterns of exclusion and inclusion. Yet it appears that on the side of government administrators, there was little awareness or understanding of the complex ethical nature of the situation. Rather, the above account points to a mentality of paternalistic benevolence that seems to have given way to a sense of moral superiority; this viewpoint might have prevented those in charge from understanding the exclusionary and oppressive effects of their approach to funding. In the scenario above, accepting the funding terms would essentially have cast the Indigenous Provider in a role reminiscent to that of the Indian Agent by contractually binding the organization to administer a mental health program according to the colonial rules and regulations of the Indian Act. Hence, the organization's decision to reject the funding opportunity provides an example of Indigenous resistance to neo-colonial funding policies and practices.

Although the scenario above took place more than 15 years ago, the Indian Act still governs state–Indigenous relations, and as the findings of this study show, jurisdictional issues continue to disadvantage urban Indigenous organizations and peoples in several ways. This said, with the single exception of the one non-Indigenous NPO, none of the Indigenous NPOs in this study reported providing programs and services that required proof of Indigeneity even when Aboriginal populations were contractually defined as the 'target group.' Indeed, the status-blind and needs-based approaches of these organizations were seen by many participants as an organizational commitment to equity and an act of collective resistance towards the imposition of colonial constructed status hierarchies and cultural identities. However, this focus on needs and equity may also have contributed to the ongoing marginalization of rights-based discourses within urban Indigenous health care, making it more difficult for Indigenous NPOs to negotiate with funders on the basis of Indigenous peoples' distinct rights.

In the following interview, an Indigenous provider participant who was running an Indigenous mental health program at a non-Indigenous NPO provides an account of everyday practice that sheds light on the kind of problems that occur when funding restrictions are tied to Indigeneity.

> A lot of people request that we work with them because their children are Aboriginal but they are not Aboriginal but because our funding is only for Aboriginal women we can't work with them (Provider Participant 16).

The account highlights the lack of fit between the rigid and individualistic approach of this funder's 'identity' politics and the relational dynamics that inform health care interactions at the level of service delivery. As the same provider went on to explain, this dynamic often meant "not being able to work with entire families" which was experienced as "hard" (Provider Participant 16). Importantly, this is not to imply that there is no value in Indigenous-only spaces or groups, but rather to highlight the need for contractual arrangements that provide greater flexibility and opportunities for autonomous decision-making at the level of care. Such strategic shifts are needed to support the implementation of relational approaches to care that are more responsive to individual and family needs and the ‘messy’ realities that shape people’s lives.

The significance of relational approaches to care is explained further by an Indigenous participant who was working for an Indigenous organization and was able to draw on many years of working as mental health provider with Indigenous people. In addition, this participant also provided Elder support.

> We talk … about the medicine wheel… like the physical, mental, emotional and spiritual health [and] I think the one that we need to work more on is the spiritual connection … and when I talk to patients … that spiritual piece is missing … because with the native people … everything that has happened historically has disconnected them from their support, their families, which is the spiritual connection. (Provider Participant 02)

Like this participant, many other participants emphasized that care must be oriented to facilitate clients’ connection to family and community to turn around the intergenerational effects of trauma. However, most found that their ability to do so was constrained by the terms that governed their service contracts. This situation had implications for the way services were experienced by the people accessing these services, as illustrated in the following excerpt from an Indigenous provider interview:

> so say a woman wants to come in here for lunch for a drop-in she can’t bring her husband with her, so in her mind what is she thinking? 'Well what’s my husband going to eat for lunch?' or 'Do I have to find him something to eat before I come home?' It [the program] is not open to that type of thing. So it’s just putting more strain on the woman if she does have a partner in order to be able to access other programs, you know. (Provider Participant 16)

Here the participant highlights the access barriers that might arise for women when programs do not reflect an understanding of women’s needs within the contexts of their lives, in particular when those include lifelong experiences of interpersonal and structural violence. In addition, the account points to the need to consider how Indigenous women’s experiences of health, healing, and access to safe and responsive health and social supports might take shape differently compared to non-Indigenous women because of their unique historical, social, economic, cultural and political contexts.

When the rules and regulations governing contracted services recognize the multiple forms of trauma and violence that shape many Indigenous women’s experiences of mental health and health care encounters, a very different contractual arrangement can arise, as demonstrated in the following interview excerpts with a Provider Participant with another Indigenous NPO:

> So the clients that we work with are very marginalized, …so … [if] it's the first time they come in … sometimes they don't want … [medical] care because they don't trust doctors and … so we'll just feed them and … where[ever] they're at that's where we meet them. They're allowed to bring partners in with them, even if the partners are abusive because often if the partners don't come in they won't come in so we feed the partners as well. We also, when we used to just feed the women we found that they were giving their food to their partners now we feed both of them. So I mean basically what we're trying to do is just engage with the client to get them to a place where they feel safe, where they can start making the changes that they want to make, that takes time. (Provider Participant 07)

In contrast to the scenario described by the previous participant, this organization was able to adjust the program to better respond to the needs and realities of women's lives by providing food to both women and their partners. As these accounts suggest, to deliver culturally safe programs, contractual arrangements must be developed with an awareness of the ways in which interpersonal violence intersects with structural forms of violence. Without that understanding, programs might inadvertently have the effect of disempowering women and reproducing rather the remediating longstanding patterns of exclusion within systems of support. However, to do so, funders and/or contract managers need to be open to learning from and integrating Indigenous Providers' advice and knowledge in the design and re-design of contractual arrangements. Funders must also provide Indigenous organizations with greater autonomy and decision-making freedom to tailor their services to the local contexts, needs and concerns of the people they serve.

7.2. Chapter Summary

The focus of this chapter was on the ethical issues and challenges embedded within the microcosm of contracted mental health and addictions care from the perspective of Indigenous Providers. The analysis illuminates how the intersections between biomedical hegemonic thought and neo-liberal processes constrain providers' abilities to enact culturally safe care through: (a) continued omission of Indigenous perspectives from decision-making related to the allocation of program resources; (b) an approach to accountability that is narrowly focused on efficiency while failing to take into account the contextual and relational aspects of care; and (c) unilateral accountability practices that are predominantly shaped by funders' imperatives and intrude into how care is provided with seemingly little regard to providers' knowledge, values and expertise.

These dynamics creates complex ethical dilemmas for Indigenous Providers who have accepted responsibility to deliver culturally safe mental health and/or addictions services that meet the needs of the community but who find that their response-ability to do so is increasingly constrained by the contractual conditions under which they operate. By so doing, the findings in this chapter unmask a series of paradoxes embedded within current contractual arrangements and accountability practices through which contracting has, inadvertently, become complicit in reinforcing institutionalized patterns of neo-colonial relations that have the accumulative effect of supporting an ongoing assimilationist ethos within Indigenous community-based mental health care along with a process privatization.

The ethical implications for Indigenous people are serious. Clients face situations of cultural risk that place Indigenous people at risk of not having their needs and rights met, or worse, of potentially experiencing re-traumatization. At the organizational and staff level, Indigenous organizations and providers are caught between their accountabilities to funders and those towards clients and the wider community they serve. Their struggle to maintain ethical practice by mediating these potentially harmful effects of current contractual arrangements reveals both the ways structural violence operates through such mechanisms as privatization, accountability/surveillance, and individualization—as well as the costs and benefits of resisting it.

In the next section, the final chapter of this thesis, I consider the policy and practice implications of the findings chapters.

Chapter 8. Discussion & Implications

The purpose of this chapter is to discuss the findings and implications for government policy and practice arising from this study. This research aimed to (1) examine Indigenous Providers' experiences of delivering culturally safe mental health and/or addictions care under current contractual arrangements; (2) analyze the sociopolitical, economic, historical and institutional contexts that mediate these experiences; (3) explicate the specific institutional structures, policies and practices that support and/or impede the delivery of culturally safe mental health and addictions services and equity; and (4) generate recommendations for the promotion of culturally safe and equity-oriented practice in contracting with urban Indigenous Providers of mental health and addictions care. To illustrate how this study met its first three objectives, I begin this chapter with an integrated discussion of the major themes identified in Chapters Five to Seven. Specifically, I discuss their implications and how they extend, align with, or contrast with current evidence and literature. This discussion provides a foundation for the second part of this chapter.

In the second half of the chapter, I argue that contracting needs a new policy framework as a method for building capacity within funding institutions to understand and redress the complexities and paradoxes embedded within the contractual arrangements for Indigenous community-based culturally safe mental health and addictions care as well as their equity-relevant implications. The ostensibly neutral approach to contracting within New Public Management (NPM) discourse betrays the value conflicts that emerge between market-based notions of efficiency and accountability and those values and accountabilities that underpin culturally safe and equity-oriented care. This disparity has constrained the capacity of government funders and administrators to recognize the ways in which their own approaches to contracting might, unwittingly, situate Indigenous Providers and the communities they serve at risk of mental, social, spiritual and physical harm. In contrast, an equity lens such as the one embedded within the critical theoretical perspectives informing this research is, arguably, much better suited to provide such a framework. I conclude the chapter by putting this framework into action, explicating a series of policy and practice recommendations.

8.1. Integrated Discussion of the Empirical Findings

Although the experiences with contracting described by participants in this study are not necessarily specific to the urban Indigenous non-profit sector, they intersect with historical and social dynamics that manifest in particular ways in relation to urban Indigenous non-profit organizations (NPOs) and the communities they serve. Drawing on feminist and post-colonial perspectives, this study provides an account of how racist and stigmatizing discourses about Indigenous peoples and dominant assumptions about mental health and care operate together with neo-liberal ideologies to sustain and reproduce—albeit often unwittingly—deep-seated patterns of material and social disadvantage. These unique dynamics cut across the micro-, meso- and macro-level dimensions of contracting and have important implications for achieving equity in mental health for Indigenous peoples. I discuss these dynamics in terms of three overarching and salient themes that can be drawn from the preceding analyses as well as within the context of current evidence and literature. These themes include: (1) an inequitable distribution of resources along the axes of race, culture, class and gender; (2) the role of urban Indigenous Providers and their relationship with government funders; and (3) the culture(s) of contracting in Indigenous mental health and addictions care.

8.1.1. Inequitable distribution of resources along axes of race, culture, class and gender

The findings from this study highlight a number of profound ethical issues related to the way mental health care resources are distributed under current contractual arrangements and funding structures. One of the most striking findings is the extent to which conditions of economic marginalization, deprivation, exploitation, dependency and precariousness are normalized. Repeatedly, Indigenous health care leaders and front-line workers called attention to the mismatch between mental health service funding and the scale and scope of mental health care needs prevalent within the Indigenous communities they were serving. Their accounts detailed contradictory experiences of delivering mental health care under inadequately resourced and increasingly precarious conditions. Additionally, many community-based leaders lamented that their funding did not allow for competitive and adequate wages nor staff benefits and/or training. On the whole, participants' accounts painted a picture of organizations that were subjected to similar forms of discrimination and disadvantage as the communities to which they were accountable. The ethical implications in terms of equity and culturally safe mental health services delivery are serious.

Even though the challenges that Indigenous Providers in this study described were complex, many of the study findings echo those of other researchers who have examined the impact of neo-liberal reforms on the organization health care and the work of nurses more specifically (see for example, Choiniere, 2011; Henderson, Curren, Walter, Toffoli, & O'Kane, 2011; Varcoe et al., 2004; Varcoe & Rodney, 2002). For example, drawing on their program of research with Canadian nurses, Varcoe and Rodney (2002) illustrate how within an increasingly corporate culture of health care, more and more, nurses' work is organized around an "ideology of scarcity" and cost-efficiency (p. 102). According to these authors, "Canadian health care reforms are being enacted in an era when there are escalating inequities in the distribution of human resources—and a corresponding acceptance that actions to save money in health care or other social services are inherently justified" (p. 103). The results from the present study support this conclusion and elucidate how the normalization of these assumptions within health care has fostered a certain kind of 'accountability'—one that is predominantly concerned with addressing budget deficits and achieving cost-efficiency.

This observed shift in the culture of accountability in public sector administration and governance is consistent with the market-oriented norms and values of New Public Management (NPM) (Dwyer et al., 2014; Evans et al. 2005). The present analysis suggests that, similar to other sectors, NPM has become a dominant normative lens for funders and has profoundly shaped the ways in which contracting with Indigenous Providers in mental health is being taken up and implemented. Comparative evidence from the third sector suggests that the experiences of Indigenous Providers are, at least to a certain degree, representative of the predicament that NPOs in Canada face more broadly consequent to the exigencies of wider neo-liberal policy reforms (Eakin, 2004; Evans et al., 2005; Scott, 2003). For example, reporting on the survey findings from a Toronto-based study, Eakin (2005) writes that current salary levels of non-profit workers reflect neither the market rates nor the workers' level of experience and education. Additionally, the author found that the averaged costs of salary and benefits in the non-profit sector made up only 71% of organizations' total budgets compared to 80 to 90% in other human service organizations. According to Evans et al. (2005), this discrepancy is an indication "that nonprofit fiscal stress is being 'managed' by laying off core staff and restraining wages and benefits" (p. 83). Overall, it is estimated that contract funding arrangements with NPOs provide between 7–15% less than the real costs of service delivery (Eakin, 2002)—a trend that many are concerned is reflective of the new neo-liberal funding regime and increasingly threatening the sustainability of the non-profit sector (Evans et al., 2005; Tenbensel et al., 2013). This literature, while not specific to the Indigenous non-profit sector, lends important support to the empirical findings in the present research, pointing to the existence of significant gaps in wage rates, benefit levels and mental health program funding for urban Indigenous Providers in BC, even when firm data to support these claims do not yet exist.

These findings raise ethical concerns about NPM-inspired approaches to contracting and their potential to promote social inequities in mental health rather than redressing them. The systemic failure of government funders to provide fair and adequate wages and benefits when contracting with Indigenous NPOs not only threatens to undermine the capacity of the Indigenous non-profit sector to deliver high-quality, culturally safe mental health and addictions care: it also implicates contracting in the reproduction of racial, gendered and classist inequities. While Indigenous people continue to be underrepresented in the general health care workforce (Allan & Smylie, 2015), the Indigenous non-profit sector is known to provide an important source of employment for many Indigenous people (Lavoie, 2004), especially women (BC Association of Friendship Centres [BCAFC], 2011). As noted by the BCAFC in its 2011 report for the first Indigenous Human Resources Gathering, “compared to the non-Aboriginal workforce, it is estimated that a disproportionate number of Aboriginal people work within non-profit agencies, out of any other sector” (p. 6). While the lack of wage and benefit equity between government employees and the non-profit workers “doing the same or similar work” in the non-profit sector is not unique to the Indigenous non-profit labour force, its discriminatory effects are compounded by the unique context of the sector (BCAFC, 2011, p. 8). As the report goes on to assert, thorough consideration must be given to the ways in which “culture, colonial history, the impact of residential schools, and economic conditions that have placed ANP [Aboriginal non-profit] agencies on unequal footing with their non-Aboriginal counterparts” (BCAFC, 2011, p. 8-9). Yet, as this study reveals, such critical engagement with the contextual features of the Indigenous non-profit sector is generally lacking among government funders and administrators. Focused predominantly on issues of efficiency and taxpayer accountability, NPM approaches to contracting are, indeed, much more likely to preclude attention to how current best practices in contracting might perpetuate longstanding patterns of neo-colonial relations, thereby obscuring the potential for more equitable social relations.

At the same time, the findings from this study and those reported by the BCAFC (2011) make it very clear that inequities in the distribution of mental health care resources cannot be attributed solely to the effects of neo-liberal health care reform. From the perspective of both Policy and Provider Participants, the systemic underfunding of Indigenous community-based mental health services was seen as evidence of the ongoing dominance of the biomedical paradigm in the mental health care system and of a devaluing of any alternative approaches to mental health, especially mental health care programming that was grounded in Indigenous culture and healing knowledge. They described the existence of a funding hierarchy in which Indigenous mental health services were persistently situated at the very bottom.

These findings align with the vast body of evidence that shows that the majority of mental health care resources in Canada and BC continue to be allocated to biomedical approaches to mental health care rather than community-based forms of care (Browne, Varcoe, et al., 2011; Morrow, 2017; Morrow, Frischmuth, & Johnson, 2006). Underpinning this material bias towards medical forms of mental health care is, as Germov and Hornstoy (2017) argue, the discourse of medical scientism—“that is, a reverence for scientific methods of measurement and observation as the most superior form of knowledge about understanding and treating disease” (p. 14). Other ways of knowing, such as Indigenous approaches to mental health, tend to be dismissed as unscientific for being seen as rooted in culture and/or experience-based forms of knowledge as opposed to Western science (Germov & Hornstoy, 2017). This has created a hierarchy of power and legitimacy, or in Foucault’s (2000) language, a power–knowledge nexus. A related line of argument has been advanced by researchers applying feminist perspectives. Their work has drawn attention to the fact that ‘caring work’—the emotional labour that goes into building safe and respectful relationships and environments—has a long history of being systemically undervalued for being coded as something that women ‘naturally’ do (Choiniere, MacDonnell, Campbell, & Smele, 2014). Because Indigenous culturally safe mental health and addictions care is located at the intersection of these wider ideological forces, it is important that funders develop critical awareness of the ways in which these ideologies might be intersecting with neo-liberal paradigms to influence decision-making within funding institutions concerning the relative value of different mental health services and the consequent distribution and allocation of resources.

As the study findings illustrate, colonial and neo-colonial stigma remains a pervasive experience for many Indigenous Policy Participants and continues to pervade funding institutions, where it coexists alongside stated commitments to “hardwire cultural safety and humility” into the health care system (FNHA, no date, p. 8). Similar to research conducted in other areas of Indigenous health policy (Fiske & Browne, 2008; McKenzie, Varcoe, Browne, & Day, 2016), this study found that colonial constructions of “Aboriginal people as unable to meet modern standards of governance and [or] ... Aboriginal people as ‘taking advantage’ of the system” (Harding, 2005, p. 324) continue to be commonly evoked to justify the status quo and/or rationalize paternalistic forms of governance. This dynamic was evidenced in the way contracting in Indigenous mental health with urban Indigenous Providers continued to be framed as a matter of benevolent state policy rather than a recognition of urban Indigenous peoples’ inherent and constitutional rights. This lack of recognition appears to have reproduced a neo-colonial pattern of institutional neglect characteristic of paternalistic state policies in the past. As the study findings suggest, the continued failure of regional health authorities and the Ministry of Health to take appropriate action to adjust regional Aboriginal health budgets to the needs and changing demographics of urban Indigenous populations served must be understood as one of the ways neo-colonialism manifests itself today.

Policy Participants’ efforts to shift these attitudes of “benevolent paternalism” and “benign neglect” (Young, 1984) within funding institutions were often met with a mainstream resentment towards Indigenous peoples for enjoying ‘special treatment’ by government. Such attitudes are reflective of an ongoing tendency within governmental institutions to treat Indigenous people as merely one out of many interest groups (Fiske & Browne, 2008) and as MacKenzie et al. (2016) have pointed out, indicative of “how discourses of egalitarianism operate simultaneously with settler-colonial denial of Indigenous presence, history, and rights in order to construct Euro-Canadian society and governments as the victims of Indigenous people’s entitlements” (p. 12). In line with these authors and other scholars (Fiske & Browne, 2008; Henry, Tator, Mattis, & Rees, 2000), the findings of the present study cast light on the continued need for strategies that unmask and disrupt the ways in which dominant liberal discourse continues to fuel resentment of perceived racial privilege within institutions and the public at large. According to Henry et al. (2000), democratic racism offers “the most appropriate model for understanding how and why racism continues in Canada” despite the country’s espoused democratic values (p. 19). However, as the study findings also suggest, within the current neo-liberal policy context, efforts to address this form of systemic and institutional racism might be met with even further resistance as perceptions of this undeserved racial privilege collude with neo-liberal discourses of resource scarcity and (fiscal) accountability.

Increasingly stringent and narrow interpretations of what is considered a legitimate program expenditure, especially in relation to administrative costs and/or funders’ failure to adjust program funding to inflation rates, are revealing of how neo-liberal cost concerns and fiscal accountabilities have been turned into political priorities. This phenomenon has also been observed and discussed elsewhere in the literature (see for example, Evans et al., 2005; Dwyer et al., 2009). Evans et al. (2005) aptly describe it as “the ‘hollow core approach to funding,’ where funders provide financing for program delivery but fail to pay for the necessary administrative components of the job” (p. 82). For Indigenous Providers in this study, funders’ retreat from providing organizational funding presented a key challenge because it drained Indigenous Providers’ capacity to effectively deliver culturally safe and equity-oriented mental health and addictions care. Given the limited capacity of ‘non-profit’ organizations to generate revenue, many Indigenous Providers in this study reported having very little choice other than to try to sustain service provision with less and less funding. It was, thus, unsurprising that many Provider Participants spoke about increasing workload problems, observing that the demand of services frequently exceeded program capacity. According to the Canadian Policy Research Network, these issues are “warning signals” that point to the effects of governments’ offloading of responsibilities to a sector without providing adequate resources to ensure this new autonomy is beneficial (as cited in Evans et al., 2005, p. 90).

Problems were compounded further by the pervasiveness of short-term funding arrangements and competitive proposal-driven funding models. While competitive approaches to contracting are endorsed as “best practice” in the allocation of public sector resources (Brandão & Bagattolli 2017; Pal & Calrk, 2013), the findings of this study support existing evidence that shows that competitive approaches to resource allocation are inadequate to ensure an equitable distribution of resources (Collins & Gerber, 2008; Lavoie, 2005). Rather than prioritizing, competitive market-based approaches to resource allocation seem more likely to result in a distribution based on organizations' administrative and technical capacity than population health need (Collins & Gerber, 2008; Lavoie, 2005). The ensuing ethical ramifications are profound.

First, by tying urban Indigenous people's access to mental health and addictions care to the market, or quasi-market, competitive approaches to contracting in Indigenous mental health imply "that our moral capacity towards others is something up for sale" (Malone as cited in Fiske & Browne, 2006, p. 106). Secondly, it effectively disconnects issues of access to culturally safe mental health care from Indigenous peoples' rights while marginalizing Indigenous Providers' and communities' voices—a process that Altamirano-Jimenéz (2004) describes as the "marketization of Indigenous citizenship rights" (p. 349). This process unwittingly implicates current approaches to funding into a larger political agenda which supports the de-politicization of Indigenous mental health needs and rights along with a shift towards privatization and responsibilization. The findings of this study echo concerns voiced by Lavoie (2004), who arrived at a similar conclusion in her research within the context of primary health care (PHC).

> The proposal-driven process of accessing funding, currently in place for ACCHS [Aboriginal Community Controlled Health Services] in Australia and embedded in the competitive funding model for Maori providers in New Zealand, is remarkably adept at shifting the responsibility for accessing appropriate funding to the providers (p. 19).

Moreover, the use of competitive, short-term funding models might also be complicit in furthering the entrenchment of differential access to resources and economic disadvantage for urban Indigenous NPOs and the sector more broadly. While competitive approaches to funding are thought to be fair based on the assumption that all competitors start off on equal footing and are evaluated against the same standards, the findings of this study challenge that theory. Considering the correlation between organizational size and technical capacity, Provider Participants from smaller organizations often reported experiencing proposal writing and competing for available funding opportunities as more challenging than larger-scale Providers, who were more likely to be able to afford to fund a dedicated grant writing position by combining resources from several contracts. Similar differences in organizational capacity between Indigenous and non-Indigenous organizations might also place urban Indigenous Providers at a disadvantage when competing with mainstream organizations, as many funding opportunities were not restricted to Indigenous organizations. As reiterated in the report for the 1st Indigenous HR Gathering (BCAFC, 2011), Indigenous NPOs often do not stand on equal footing with their non-Indigenous counterparts due to the past and ongoing effects of colonial and neo-colonial policies and practices.

Access barriers to appropriate funding for Indigenous Providers were complicated further owing to a highly-fragmented funding maze that is reflective of a confluence of different contextual forces, several of which are specific to urban Indigenous community-based mental health and addictions care. These contexts include: (a) the jurisdictional divide for Indigenous health; (b) a regionalized mental health care system; (c) longstanding policy silos within mental health, principally reflecting the ongoing dominance of biomedical understandings of mental illness; and (c) a neo-liberal funding environment predominantly characterized by short-term and competitive funding arrangements and contract fragmentation. It was not surprising, therefore, that Provider Participants described how appropriate funding for mental health programs, services and supports was increasingly difficult to access, in large part because of the significant transaction costs involved—this at a time when funders' willingness to provide funding for administrative supports and core operating costs not directly tied to the service delivery was increasingly shrinking.

Consistent with the emerging body of research on contracting in health (Dwyer et al., 2009; Dwyer et al., 2011; Lavoie, 2004; Lavoie, Boulton, et al., 2010), in this study, short-term contracting and competitive tendering were a source of significant uncertainties and stress for Indigenous organizations, staff and clients. As a result of annualized funding cycles, Indigenous Providers are routinely forced to lay off program staff and then rehire when funding is renewed or new program funding has been secured. Many funders prefer short-term funding and contracts over long-term commitments because it is widely seen to minimize risks associated with contracting out (Lavoie, 2004; 2005; Lavoie et al. 2010). However, as the findings of this study make clear, rather than diminishing risks, the use of short-term contracting in Indigenous mental health carries significant for all involved: at the organizational level, short-term funding constrains urban Indigenous Providers' capacities to engage in long-term planning, recruit and retain qualified and trained staff, and create programming conditions necessary for the provision of culturally safe and equity-oriented mental health and addictions care. Relationships of care and trust between providers and clients are central to culturally safe care (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015; Tait, 2008), yet they are continuously disrupted by the way services are funded. As a result, clients are placed at risk not only of not having their mental health needs met, but also, in many cases, of re-traumatization—experiences that can exacerbate substance use and mental health issues, including suicidal ideation, especially for those most vulnerable due to multiple forms of past and ongoing trauma (Tait, 2008; 2014). This finding highlights how violence can be structurally enacted through contractual arrangements and can create situations of particular harm for Indigenous people, whose lives are shaped by intersecting issues of mental health, trauma substance use, stigma and racism.

Overall, while contracting is framed as a strategy to improve equitable access to culturally safe mental health and addictions care, the findings raise serious ethical questions about the harmful consequences of current contractual approaches to care provision for Indigenous populations and the ways in which a funding system dominated by short-term and competitive contracting models might compound existing social inequities in the distribution of mental health care resources. In addition, rather than promoting efficiency and effectiveness, this study supports existing evidence that shows that classical funding models currently in place in health care have fostered highly complex and fragmented funding and contractual environments which constrain rather than enable Providers' organizational and staff capacities to effectively deliver contracted care. Within the urban Indigenous mental health context, this complexity is exacerbated even further as a consequence of the intersecting effects of neo-liberalism, biomedicalism and colonialism. These contextual features place Indigenous Providers and the populations they serve at a particular disadvantage and create barriers to equitable access to program resources. This tension between funding objectives and methods has also been identified within the literature on contracting, where relational contracting (as opposed to classical short-term contracting) is seen as more appropriate and effective for supporting programming in areas where the desired outcomes are long-term (Dwyer et al., 2014).

Yet Indigenous mental health remains embedded within public health and policy discourses that are reductive to the extent that they might prevent funders from understanding the discriminatory and paradoxical effects of their own funding practices. System accountability is undermined by a contractual system that "makes inquiries of equitable access to funding unlikely" (Lavoie, 2004, p. 19). As Lavoie (2004) further observes, within a funding environment characterized by competitive and short-term contractual approaches, it is almost impossible to accurately assess whether Indigenous Providers are appropriately funded for the services they are contracted to provide or whether inequalities in the current distribution of health care resources between Indigenous and mainstream providers are indeed present. However, if contracting is to promote access to culturally safe services and create equity in mental health, funders need to take seriously the claims that current funding structures and the methods through which resources are distributed might in fact be part of the problem rather than the solution. Such an acknowledgement would be the first step toward system accountability and ethical policy. Without such a critical awareness, colonial and racist myths that depict Indigenous people(s) as somehow incapable of self-governance and healing will continue to be invoked by funders and the public when confronted with the evidence of the material and social deprivation and marginalization that shape the realities of both Indigenous Providers and the vulnerable populations they serve, partially as a consequence of the ways contractual relationships in Indigenous mental health and funding environments are currently arranged.

8.1.2. Relational Tensions

Complex tensions also arose from the nature of the relationships that current approaches to contracting and accountability forge between Indigenous Providers and government funders, and between Indigenous Providers and the communities they served. While government funders consistently expressed a desire to build “real partnerships,” “meaningful engagement” and “relationships that have reciprocal accountability,” the pervasiveness of short-term, competitive funding models and increasingly tighter PM practices have had the opposite effect.

A deep sense of mistrust towards government funders has been fostered by experiences with a funding system that fails to provide sufficient levels of funding, imposes seemingly arbitrary funding cuts, and has Indigenous Providers compete against one another. Most participants provided accounts that framed current approaches to contracting as an example of a neo-colonial practice, even though Indigenous participants were more likely to make specific references to neo-colonialism when discussing their experiences with contracting. This finding was particularly salient with reference to the current application of performance management (PM) practices. The rigorous enforcement of increasingly tighter performance reporting requirements was perceived by many as an instrument of colonial control and proof of the continued existence of colonial stigma towards Indigenous peoples depicting the latter as lacking trustworthiness and competence in matters of financial management and self-governance. Indeed, as the findings from this study indicate, colonial stigma and neo-liberal discourses of accountability mutually reinforce processes of institutional surveillance and/or paternalistic styles of intervention. For example, even though contracts often remained deliberately vague when it came to program specifications, findings show that Providers' abilities to make autonomous decisions at both the organizational and programming level were severely constrained due to the limited power Providers had over how to spend and allocate financial resources within the scope of their contractual budgets. Narrow 'performance' targets further curtailed autonomous decision-making, especially at the point of care, casting light on the ways neo-liberalism operates discursively within the enactment of PM. Relationships of care are "reframed in market metaphors of product" (Fiske & Browne, 2006, p. 106). Questions of cost-efficiency that privilege quantitative and predominantly volume-based performance targets work to displace attention from the relational aspects of care, such as client–provider relationships of trust, that are central to the provision of culturally safe care and the success of therapeutic interventions (Browne et al., 2016).

While from a standpoint informed by neo-liberalism, mechanisms such as short-term contractual arrangements, the imposition of care-standardizing technologies, and tighter monitoring routines and regulations are all innovative ways to improve accountability and efficiency (Choiniere, 2011), the findings of this study illustrate the problems that arise when such accountability measures are implemented without consideration for how they might impact the quality of care provided and/or Providers' abilities to fulfill their other accountabilities to the program recipients and their communities. For example, Indigenous Provider Participants frequently perceived that they were placed in an untenable position because their ability to adapt care and programming to the contexts of clients' lives, needs and priorities was constrained by funders' accountability regime. This finding is particular salient, considering that being responsive to the multiple forms of trauma and violence, including structural violence, historical and intergenerational trauma and other forms of discrimination in people's lives, was seen as a fundamental prerequisite for culturally safe care—a point consistent with current conceptualizations of equity-oriented care and evidence (Browne et al., 2012; Ford-Gilboe et al., 2018).

By illuminating the ways in which the enactment of PM approaches within contracting constrain rather than enhance Indigenous Providers' capacities to deliver culturally safe and equity-oriented care, this study adds to our understanding of the complex and unique ethical tensions that exist within current accountability relationships between funders and Indigenous Providers (Dwyer et al., 2014; Dwyer et al., 2011; Tenbensel et al., 2013). Moreover, the findings support the need for approaches to contracting that are consistent with the principles of culturally safe and equity-oriented mental health and addictions care and further that are reconcilable with Indigenous peoples' rights (Boulton, 2007; Browne et al., 2012; Kornelsen et al., 2015).

The importance of developing contractual arrangements that are conceptually aligned with the notion of cultural safety also aligns with growing national and international calls for more complex and relational accountability frameworks in government contracting in the area of Indigenous health (Dwyer et al., 2014; Dwyer et al., 2011; Kornelsen et al., 2015; Tait, 2008; Tenbensel et al., 2013). As noted by Evans et al. (2005), "under the neoliberal 'contracting regime' accountability is presented as a value neutral demand that is closely linked to market notions of efficiency" (p. 86). This common-sense construction of accountability seems to have obstructed rigorous scrutiny and obscured the significant ethical tensions that arise from the application of New Public Management (NPM) approaches to accountability within the context of contracting in Indigenous mental health.

Relational conceptualizations of accountability informed by the critical theoretical perspectives applied in this research correspond well with the relational perspectives of many Indigenous peoples and are needed to disrupt the decontextualized and depoliticized individualism of prevailing accountability discourses—and the power imbalances enacted within current contractual relationships. As Sullivan (2009) points out, "accountability is not only an instance of relations of power" but it is also constitutive of the social and structural relations that organize Indigenous–state relationships (p. 66). In this study, the need for a broader analysis of contracting in Indigenous mental health—and one that draws attention to structures of power—was evidenced in the contradictory ways in which Indigenous Providers are currently constructed by different discourses in contracting, as empowered public health partners for achieving mental health equity for urban Indigenous populations on the one hand, and as agents of government policy in need of regulation and surveillance on the other.

The "relational-classical funding paradox" (Dwyer et al. 2011), discussed in Chapter Six, most clearly emerges as a manifestation of this double-speak. As discussed in the literature and underscored by the findings of this study, for Indigenous

Providers to be able to mitigate financial risk, determine local priorities, and develop and implement alternative programmes that are grounded in Indigenous understandings and responses to mental health and addictions issues, organizational autonomy and flexibility in resource allocation are key (Browne et al., 2016; Dwyer et al., 2014; Dwyer et al., 2011; Lavoie, Boulton, et al., 2010). Yet contractual relationships that accommodate Providers' need for flexibility and relational autonomy are predicated on a workable level of trust between purchaser and provider, and the default position of both classical contracting models and PM frameworks is mistrust (Dwyer et al. 2011). Clearly, the adoption of NPM as the dominant normative framework for governments has increased the classical tension between the need for trust and the need for accountability that governments need to balance when contracting out public sector services to third-party providers. Within the urban Indigenous context, such tensions are, however, likely compounded further because of the colonial attitudes described above as well as an insufficient understanding of, and sometimes an unwillingness to understand, how Indigenous approaches to programming in mental health differ from those of the dominant culture in mental health. As Dwyer et al. (2011) explain, in a neo-liberal climate where governments are under increasing pressure to defend the legitimacy of their health and social services spending, governments "seek to direct funding to … jurisdictional health priorities, and to modes of care or interventions that are seen to be effective" (Dwyer et al., 2011, p. 39). These factors have created a situation where funders make assurances of ongoing program funding, and then construct such funding as short-term, annualized contracts that tend to be highly regulated. While such contractual arrangements minimize risk for funders by keeping the power balance shifted to their advantage, they impeded Providers' response-abilities to their staff, clients and wider communities. In this ideological and structurally mediated context, Indigenous Providers are cast as agents of government rather than as agents of self-governance (Dwyer et al. 2014, p. 1094). Thus, contrary to stated commitments to build partnerships based on mutual respect, trust and accountability and/or community capacity, contractual relationships remain largely embedded within principal–agent relationships.

The implications in terms of human costs are grave. Rather than being minimized, risk is shifted away from governments onto the shoulders of Indigenous Providers—and ultimately recipients of care—exposing the ways in which structural violence is enacted within current contractual arrangements by placing those most disadvantaged into harm's way. These findings are consistent with the experiences of

Indigenous Providers of primary health care (PHC) services in New Zealand and Australia (Dwyer et al., 2011), underlining the need for the development of ethically-motivated policy perspectives to contracting in Indigenous mental health (Tait, 2008; Tait, 2013; Tait, 2014). To move toward ethically grounded and sustainable approaches to contracting, the findings in this dissertation support the call for relational contracting models that move away from time-limited contracts and allow for more flexible funding arrangements (AFN & Health Canada, 2015; Dwyer et al., 2014; Dwyer et al., 2009).

However, outside individual service contracts, urban Indigenous–State relationships have remained undefined—as the findings elucidate, contracting serves as an “unwritten” and “unspoken” policy. This finding is important, because as Shore and Wright (1997) point out, policies are “narratives that serve to justify or condemn the present, or as rhetorical devices and discursive formations that function to empower some people and silence others” (cited in Fiske & Browne, 2006, p. 91). In keeping with this perspective, governments’ failure to develop an urban strategy and/or link contracting in Indigenous mental health with urban providers to higher-level policies, such as BC’s First Nations and Aboriginal People’s Mental Wellness and Substance Use Plan (2013), can be read as a neo-colonial manifestation of the ways in which Indigenous peoples’ needs and rights have historically been, and continue to be, rendered invisible within urban, off-reserve contexts. How urban Indigenous Providers and peoples are constructed within policy, official or not, has obvious political, material and social implications. For example, without a policy framework, political accountability is lacking. As Evans et al. (2005) write, while “public accountability is centred around the responsibility of government authorities to account in a full public manner for the kinds of support that they are providing for the provision of public goods and services,” political accountability is tied to government's commitments made in the political arena (p. 86), such as

> the Government of Canada’s commitment to work in partnership with Indigenous communities, the provinces, territories and other vital partners, to fully implement recommendations of the Truth and Reconciliation Commission [TRC], starting with the implementation of the United Nations Declaration on the Rights of Indigenous Peoples [UNDRIP] (Trudeau, 2015, para. 5).

However, with no policy presence, Indigenous Providers have little collective voice in the public realm but rather are relegated to the private realm where each organization is left to its own devices to negotiate with different funders about the terms of their contractual agreements. The construction of Indigenous non-profit organizations (NPOs) as quasi-governmental service providers might also serve to provide the justification for, and obscure the tensions arising from, funders' increasing reluctance to cover any costs that not are not directly relatable to the contracted service. As a result, many Indigenous Provider Participants reported finding it increasingly difficult to afford the resources to enact and/or sustain participatory processes to meaningfully engage with clients, staff and community and seek their input and feedback to inform strategic planning, program development and ongoing program adaptations. Clearly, community-based governance and community-driven programming are not viable or sustainable without the provision of adequate organizational funding.

Indigenous ownership and effective community governance were further threatened by the nature and demands of short-term and competitive, proposal-driven funding processes and performance-governed accountability practices. As revealed by the findings, funders' imperatives often aligned poorly with (i) the local realities and contexts of Indigenous organizations; (ii) the priorities and needs that Providers saw in their communities; and (iii) the mission, values and perspectives that informed their approaches to governance, programming and care. Problems arose as Indigenous Providers' capacities to engage in community-driven program planning and decision-making were increasingly constrained by factors such as rising transaction costs; accountability indicators producing information that was perceived by Providers as lacking meaning, authenticity and, hence, utility; and targeted program funding that did not always fit the needs of the communities.

Similar to other research (such as Dwyer et al., 2014; Sullivan, 2009), this study concludes that NPM reforms have not promoted accountability, neither locally nor at the system level. Instead, spaces of 'ethical' engagement seem to have been diminished as a consequence of the entrenchment of hierarchical, uni-directional accountability relations and competitive, short-term funding processes. The resulting arrangements are unsustainable, not only organizationally but also ethically. Clearly, as community-based organizations, community engagement is an essential component of organizations' credibility and legitimacy. When government funders fail to take into account the close ties between Indigenous Providers and the communities they serve as one of the distinct strengths of the fourth sector when planning for funding, the relevance, safety and effectiveness of programs are undermined and urban Indigenous peoples' needs and rights are at risk of being left unrecognized and unmet. As the findings emphasize, funders need to recognize that—in order to truly promote capacity for mental wellness for urban Indigenous communities, families and clients and foster equity in mental health—contractual approaches must create conditions that allow urban Indigenous people to have their voices heard. Providers need to be supported in their capacity to engage in advocacy and develop and implement mental health and addictions programs that are grounded in local priorities and Indigenous understandings and responses to mental health. As Rowse (2005) and others have noted, many Indigenous people, particularly those most marginalized by social, structural and health inequities, rely on community-based organizations to "become visible as citizens" and have their needs and rights realized (cited in Dwyer et al., 2011, p. 41). Being deprived of the opportunities and resources to do so is, thus, a direct violation of Indigenous peoples' rights. How contracting is being taken up and implemented, and how it is impacting Indigenous organizations and their communities, must, therefore, be understood as both an ethical and political matter. It is in this vein that Sullivan (2009) writes, "where the financial and regulatory aspect is emphasized and other aspects, such as dialogue and respectful attention to narrative statements, are ignored, accountability is reduced to an instrument of colonial control and manipulation" (p. 66). If contracting in Indigenous mental health is to be a mechanism for achieving equity, approaches to contracting must be framed with an awareness of and engagement with colonial history, the social determinants of Indigenous mental health, and the potential for contracting to be colonizing rather than decolonizing in its consequences.

8.1.3. The Culture(s) of Contracting

Another tension arose from a disconnect between New Public Management (NPM) inspired contracting and accountability reforms and Indigenous understandings, experiences and responses to mental health and/or addictions. In fact, the findings of this study expose how current funding practices and processes often inadvertently reproduce relations of care that are more closely aligned with the dominant culture of the mental health care system while Indigenous perspectives and cultural healing practices continued to be marginalized and excluded. Provider Participants' accounts of their struggles to reconcile the short-term and increasingly fragmented nature of contracts and the narrowly defined efficiency-oriented accountability practices with the needs and priorities of the clients, families and communities they served provide important insights into the complex and multifaceted nature of the ethical challenges that arise when funders fail to recognize the ways in which NPM-based best practice models in contracting support and reinforce the biomedical model of care.

While mental health and addictions services and supports in this study took many different forms, participants' accounts made clear that culturally safe mental health and addictions service delivery must be responsive to and informed by an understanding of the intersections that exist between mental health, addictions, poverty, and multiple forms of trauma and violence, stigma, racism and other forms of oppression. A majority of clients' lives were shaped by pervasive poverty and broader experiences of trauma and violence, including structural violence and intergenerational and historic trauma, as well as the effects of the multiple forms of stigma and discrimination that were often encountered within society and systems of care relating to clients' varying disadvantaged social statuses and identities (i.e., poverty, substance use, race/Indigeneity, mental illness and other health diagnoses). Culturally safe care was, thus, inextricably linked to trauma- and violence-informed care (TVIC), harm reduction principles, and inequity-responsive care. This finding is consistent with, and adds to, a growing body of research-based and theory-driven literature on equity-oriented care[44] (Browne et al., 2015; Browne et al., 2012; Ford-Gilboe et al., 2018; Smye, Browne, Varcoe, & Josewski, 2011). According to this scholarship, an understanding of the complex intersections of trauma, violence, poverty, mental health and addictions issues, stigma and racism is central to the effective delivery of equity-oriented care when working with populations impacted by social, structural and health inequities. Staff who have the knowledge and ability to recognize the broader contexts that influence people's life trajectories and experiences of health (care) and to tailor care, programs and services to better fit the realities of clients' lives must, thus, be recognized as a powerful organizational asset and strength (Browne et al. 2012; Browne et al., 2015).

As the study findings illuminate, at the level of care, such knowledge translates into building safe and respectful relationships and environments through practices that are strength-based and empowering, non-judgmental, and welcoming and that exhibit positive regard for Indigenous culture. At the programming level, this fosters broad-

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[44] According to this newly-emerging body of scholarship, equity-oriented health care (EOHC) includes three overlapping dimensions of care that build upon more conventional concepts: (1) Trauma- and Violence-Informed Care (TVIC); (2) Culturally Safe Care; and (3) Contextually Tailored Care (CTC) (Ford-Gilboe et al., 2018).

based and holistic programming, the inclusion of Elders and spiritual leaders, traditional and cultural healing practices, a long-term orientation to turn around the effects of historical and intergenerational trauma, and programming that involves working with families and the wider community, as well as outreach-based services. However, similar to research in the Indigenous primary health care (PHC) sector (Dwyer et al. 2010), the findings in this research also reveal that short-term contracting and contract fragmentation severely impede organizational and staff capacities to design, deliver and/or sustain such mental health and/or addictions programs and care. For example, in an effort to create and/or maintain holistic and relational approaches to programming that fit with Indigenous understandings of mental health and addictions, many organizations sought to build a collage of contracted services. While the resulting ‘patchwork’ of services enabled some of the larger Indigenous organizations to provide more holistic and comprehensive approaches to mental health and addictions programs, it also created a particular set of risks and vulnerabilities for Indigenous providers and the individuals and families who accessed their programs. As Provider Participants emphasized, the loss of any one contract could threaten the overall program integrity that the organization had worked so hard to create. Moreover, the transaction costs of weaving together multiple separate contracts from various funders were high and contributed further to the draining of limited organizational resources that might have been more productively spent on direct client care—an observation supported by Tenbensel et al. (2013), who warn of the risk that NPM approaches to contracting may be inadvertently “killing the golden goose” (p. 2).

The situation was complicated further by the fact that precisely those components that were viewed by participants as essential for making programs and services culturally meaningful and safe, and ultimately effective, were those most vulnerable to funding cuts. One of the hardest-hit areas included, for example, food. As Provider Participants from all organizations emphasized, food was a main concern—not only because of the extent to which poverty constrained clients’ lives and health but also because it holds an important cultural meaning for many Indigenous peoples. Thus, food played a crucial role in enabling providers to connect safely and respectfully with Indigenous clients and deliver effective mental health and/or addictions services and supports. This finding aligns with those from a recent review on the relationship between Aboriginal traditional diets and health, in which the author asserts that

> culture, a determinant of health, is intricately tied to traditional Aboriginal foods. Not only are traditional foods valued from cultural, spiritual and health perspectives, but the activities involved in their acquisition and distribution allow for the practice of cultural values such as sharing and cooperation (Earle, 2011, p. 3).

Despite the significance of food, funding to cover the costs associated with food as well as other programming features unique to Indigenous culture and healing practices, such as the presence and involvement of Indigenous Elders or material needed to perform cultural rituals and ceremony, was increasingly hard to come by. Increasing restrictions placed on core operating costs constrained organizations' capacities to create culturally safe and welcoming socio-spatial environments through, for example, the display of cultural art, the integration of Indigenous cultural practices and ceremonies in routine organizational operations, and the organization of community-wide events. While such socio-spatial practices may not be directly linked to the delivery of certain programs, they have been recognized as important factors in supporting the effectiveness and accessibility of care when working with marginalized populations by conveying positive regard for Indigenous cultures as well as a sense of being treated with dignity, belonging and community (Browne et al., 2012). As the findings suggest, however, NPM practices may not be the only reason for funders' reluctance to support the implementation of organizational strategies to enact cultural safety and practices that are grounded in Indigenous approaches to mental health and healing. Instead, the study results point to an ongoing lack of understanding, or a very superficial understanding, of how Indigenous conceptualizations of and responses to mental health and addictions differ from those of conventional biomedical models of mental health care. Much like Smye (2004), this research indicates that budgetary and funding decisions (i.e., what constitutes legitimate expenditures and what is expendable and ought to be cut in the pursuit of improved public sector accountability) continue to be made, presumably unwittingly, through the lens of biomedicine. In keeping with the fragmentary worldview of the dominant biomedical culture of the mental health care system, strategies and aspects of programming that were identified as core to the provision of culturally safe mental health and addictions and equity-promoting care were often only supported by piecemeal funding and/or "volunteer" labour. This lack of value that 'non-medical' forms of care were accorded within current funding decision-making, and the narrow understanding of what constitutes legitimate mental health care (and evidence of accountability in care), is revealing of a deeply-entrenched ethnocentrism. As anti-colonial and post-colonial scholars have pointed out, it is through such acts of omission that the colonizing culture attempts to reaffirm its sense of superiority of the Western (Ashcroft et al., 2007; Reimer Kirkham & Anderson, 2002). In the context of this research, such acts of omission included the tendency of government funders to fail to recognize the growing body of evidence that shows “that cultural activities are legitimate and successful healing interventions” (Brant Castellano, 2006, p. 148) and provide appropriate resources and time to address the social determinants of Indigenous mental health within programming. For example, as part of its mandate, the Aboriginal Healing Foundation (AHF) undertook a series of extensive evaluations of community-based healing approaches that it had funded. The results show that effective healing programs included a combination of Western mental health supports as well as healing programs that were grounded in Indigenous cultural expertise (Indian & Northern Affairs Canada [INAC], 2009). Notably, one of the factors critical for success identified in the evaluation was “the length of time programs had been in operation” (INAC, 2009, p. 54). However, there is little indication that these evidence-based results are informing current funding practices. Rather, as the findings in this research suggest, biomedicalism and neo-liberalism mutually reinforce one another to sustain and reinforce a medical colonialism under the guise of NPM. With its purported political neutrality and focus on efficiency, NPM discourse effectively precludes attention to culture at the same time as it bolsters an assimilationist ethos, which echoes and supports the biomedical model of care by the use of classical approaches to contracting and stringent PM practices that silence Indigenous voices and constrain urban Indigenous Providers’ capacity to deliver culturally safe mental health and addictions care.

In particular, the findings uncover how NPM approaches to accountability in the form of PM shape how care is provided in ways that further compounded concerns about organizations’ cultural integrity. Operating within a context dominated by performance-based models of accountability oriented to promote efficiency and meet quantitative indicators obliged providers to ration the time and care they were able to allocate to each client in order to meet their contractually-defined performance targets and reporting requirements. Rather than creating a climate of respect and safety, providers described these processes as de-humanizing and objectifying because they saw them as displacing ethical commitments to care with an accountability based on numbers and improvements in efficiency. Many reported that they felt increasingly constrained in delivering care that was constitutive of empowerment practices and tailored to clients’ priorities, values and contexts. These ethical tensions were compounded further by a heightened expectation to incorporate care-standardizing technologies into practice intended to manage and collect health information to improve accountability. While these technologies may fit within the clinical practice of mainstream mental health care settings, importing them into the practice of Indigenous Providers without tailoring them to the priorities, concerns, values and other contexts of neither the organizations nor the particular populations served was perceived as highly problematic by Provider Participants. For example, several participants expressed concern about how the high degree of prescriptiveness, the length, and the type of questions within some of these health information assessment and management tools could impact their ability to build relationships of trust with clients and create safe and respectful environments. As a result, Provider Participants repeatedly expressed ethical concern about unwittingly becoming complicit in the reproduction of cultural risk for Indigenous peoples who seek care at Indigenous non-profit organizations (NPOs). For example, providers detailed how they often found themselves in an ethical dilemma in which their ethical responsibilities to the client were in conflict with their accountabilities to the funder. Providers' efforts to mitigate both the risk to clients and the risk to the program—in terms of financial sanctions for non-performance—came at high costs to their own mental health as they stretched themselves to be accountable to both clients and funders with increasingly fewer resources and control over how care was provided. Under these conditions, Indigenous Providers felt that they even though they were contracted to provide culturally safe mental health and addictions care for Indigenous populations, ultimately they had little choice but had to re-organize their services to better fit the corporate values of current contractual and accountability systems, and by implication, those of the dominant mental health care system.

Participants' descriptions of the ethical distress they experienced as a result of the changes in how care was organized support those of other research suggesting that managerial reforms aimed at maximizing efficiencies in health care have "violent implications" for providers and the quality and safety of care (Choiniere et al., 2014, p. 47). For example, experiences of moral distress among health care providers have been linked to poor mental health and increased rates of burn-out (Varcoe et al., 2004; Varcoe & Rodney, 2002). Evidence of these acts of structural violence, and their ethical and political repercussions, continue, however, to be largely overlooked by funders. These findings help to extend our understanding of why many funding and contractual relationships between governments and Indigenous Providers remain tense despite espoused commitments to cultural safety and reconciliation. Moreover, they demonstrate the need for a framework that can serve funders as a guiding lens through which to analyze and challenge those institutional structures, policies and practices that reinforce structural inequities and violence, and constrain Indigenous Providers' potential to deliver culturally safe and equity-oriented mental health and addictions care. Clearly, contracting in Indigenous mental health can be helpful to urban Indigenous peoples if contractual approaches are implemented with an awareness of and engagement with colonial history and neo-colonial realties and in a manner that is accountable to Indigenous Providers, program recipients, and their communities. As Tait (2014) writes, to ensure that those targeted by policies or programs are not placed at harm, government funders must be "capable of weighing the therapeutic (biomedical or Indigenous knowledge) implications" of their decision-making (p. 225). As the analysis in the present study underscores, this includes a thoughtful and critical engagement with the potential implications of different contractual approaches and accountability mechanisms when governments are contracting with urban Indigenous Provider for the delivery of culturally safe mental health and addictions care. In addition, it requires a lens that would help funders and others working within funding institutions to critically consider the differences that exist between Indigenous and Western understandings and responses to mental health, and how institutional funding environments and contractual processes could be restructured to better support Indigenous Providers in delivering mental health programs that are grounded in Indigenous values and healing approaches. For example, rather than off-loading responsibility for effective delivery onto the shoulders of Indigenous NPOs, funding decision-makers ought to ask, what kind of institutional supports, resources and arrangements must be in place to enhance Indigenous Providers' capacities to deliver culturally safe and equity-oriented care? If governments are contracting with Indigenous Providers to help them fulfill their mandate because they lack the knowledge, connections and cultural resources to effectively deliver mental health and/or addictions services to urban Indigenous populations, then it follows that contractual practices would need to be integrated with wider structural changes and policies that are oriented to:

- maximize Indigenous community ownership and control (Allan & Smylie, 2015; AFN & Health Canada, 2015; Wise Practices Research Group, 2018);

- foster a strong, skilled and empowered Indigenous non-profit workforce, inclusive of Elders and cultural healers (TRC, 2015; Wise Practices Research Group, 2018)
- promote comprehensive and balanced approaches to improve the mental health of urban Indigenous communities that draw on both Indigenous and Western forms of expertise and combine prevention, mental health promotion, intervention and after care (FNHA et al., 2013; Tait, 2014; TRC, 2015)
- cultivate relational accountability (Tait, 2008); and
- support institutional process and structures that afford urban Indigenous Providers a voice in policy decision-making to address the distinct needs of urban Indigenous populations (TRC, 2015).

8.2. An Equity Framework for Contracting in Indigenous Mental Health and Addictions Care

Drawing on a growing body of research and literature on equity-oriented health and mental health care (Allan & Smylie, 2015; Browne et al., 2015; Browne et al., 2016; Ford-Gilboe et al., 2018; Lavoie et al., 2018; Tait, 2008; Tait, 2013; Tait, 2014; TRC, 2015), and the findings of this study, I argue that an equity lens informed by the principles of trauma- and violence-informed care (TVIC), cultural safety, harm reduction, intersectionality, critical social justice,[45] and Indigenous perspectives can provide such a framework. This lens would foster the operationalization of equity at every level of the mental health care system and foster the development of contractual approaches, as well as policy and funding environments, that are consistent with the principles of equity-oriented mental health care and, therefore, are better able to promote the effective design and delivery culturally safe mental health and/or addictions care for urban Indigenous people.

By situating contracting within the wider sociopolitical, economic, cultural, institutional and historical contexts that shape Indigenous–State relations as well as the inequitable mental health status of urban Indigenous populations, a policy framework informed by these theoretical perspectives would convey a politicized understanding of contracting. As Lavoie, Boulton, et al. (2010) have noted, in Indigenous health, the contract functions as a “microcosm” of the wider social and historical contexts that shape

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[45] Theoretically informed by post-colonialism and feminism.

the relationship between the state/funder and Indigenous Providers (Lavoie, 2010, p. 667). Making these relationships visible is, as Morrow (2017) asserts, “the first step towards shifting the power balance and the discursive landscape” (p. 46). As the findings from this research have revealed, the individualistic ideologies that underpin the dominant frameworks for both contracting and mental health policy can blind funders to the discriminatory, oppressive and exclusionary consequences of their own policies and practices. Analyzing institutional policies and practices through the lens of intersectionality can disrupt these individualistic tendencies and provide important analytical insights into how power structures imbue contractual relationships and how these relations place Indigenous Providers and the people, families and communities they serve in precarious situations whereby the mental health and safety of both parties is at risk of being compromised.

Harm reduction, cultural safety, and trauma- and violence-informed care (TVIC) are, thus, highly relevant concepts for operationalizing equity, not only at the micro-level of care but also at the organizational level within the Indigenous non-profit sector as well as the macro-level of policy and funding institutions. Just like Indigenous Providers, government funders have a responsibility to develop structures, policies and practices that are consistent with these dimensions of equity-oriented care so that the effects of their actions enable rather than constrain Indigenous Providers’ capacities to design and deliver mental health and addictions care that is perceived as culturally safe. The notion of TVIC draws attention to how policies and practice can intersect with people’s trauma histories and ongoing forms of trauma to exacerbate and/or re-create trauma within systems of care, in particular for populations affected by multiple systemic inequities and structural violence (Ford-Gilboe et al., 2018). According to Browne et al. (2012), “structural violence is increasingly seen in public and population health as a major determinant of the distribution and outcomes of health inequities” (p. 2). In keeping with a trauma- and violence-informed perspective, this research reveals how policy and contractual arrangements that put individuals and populations at risk of trauma and/or other harms constitute structural violence. Using a framework informed by TVIC can thus assist funding and policy-decision makers and others working in the institutional complexes of the mental health care system in recognizing and addressing structural violence and inequities embedded within current funding structures, contractual policies and practices, and ameliorate the traumas—the health-related, social and psychological effects—that result from these arrangements both at the individual and population levels.

An emphasis on trauma- and violence-informed care, cultural safety, and harm reduction within contracting would also highlight the need to tailor contracts and services to fit the unique contexts that are shaping Indigenous people's experiences of mental health, mental health care and safety needs. Operating from a stance that frames trauma as a response to the intersecting effects of interpersonal and structural forms of violence, rather than locating it within the individual psyche, would allow for a better understanding of how mental health and addictions issues intersect with violence, trauma, poverty, stigma, racism and other health and social issues (Browne, Varcoe, et al., 2011). Such understandings highlight the need for the development and expansion of relational contracting models that support more comprehensive approaches to mental health and addictions and long-term programming that have been shown to be effective in promoting individual, family and community healing, and turning around the intergenerational effects of trauma (INAC, 2009).

Incorporating these equity concepts into a framework for contracting within Indigenous mental health would, thus, support existing calls to reverse the current trend toward contract fragmentation and proactively explore new contract models that might be better suited to support mental health and addictions programs that meet the needs of urban Indigenous populations (Dwyer et al., 2014; Pomeroy, 2007). Moreover, it would bring into focus the heightened importance of supporting *organizational* strategies that have been identified as enhancing Providers' capacities to improve accessibility and enhance the acceptability of the mental health and addictions services for populations that are most underserved (Browne et al., 2012). As the evidence produced by Browne et al. (2012) and the present study shows, operationalizing equity at the organizational level requires organizational tailoring, which in turn requires adequate organizational resources and time, and a level of autonomy that allows community-based leaders, administrators and front-line providers to adapt their practices, policies and environments to the needs, concerns and priorities of the program recipients and their families and communities. From an equity perspective, relational ways of knowing that are grounded in the everyday experience of Indigenous Providers are, thus, highly valued because they produce contextual knowledge, which is critical to the delivery of culturally safe and equity-oriented mental health and addictions care (Anderson et al., 2010; Anderson et al., 2009). As Anderson et al. (2009) explain, knowledge for equity-oriented, competent, effective, and hence efficient health care delivery is knowledge that is contextual and emergent from the intersection of different forms of knowledge, such as “bio-medical, managerial, clinical and experiential knowledge that is co-constructed at the point of care” (p. 287). Such an epistemological shift would be well-aligned with Indigenous ways of knowing (Victor et al., 2016; Wilson, 2008) and might prompt funders and contract managers not only to reassess what counts as evidence within the context of culturally safe mental health and addictions care, but also to consider more carefully the repercussions, in terms of equity and cultural safety, of accountability practices that privilege certain forms of knowledge while ignoring others.

Indigenous Providers in this study did not oppose the need for efficiency, accountability mechanisms or quantitative forms of evidence, but rather they argued that Indigenous expertise and knowledge created at the point of care also had to be taken into account in order to ensure that no harm comes to those most vulnerable. This shift in focus is also important to provide services and supports in ways that are effective and responsive to the needs of clients and communities. As unmasked by the study findings, when accountability practices are operationalized through care-standardizing technologies and efficiency-focused performance-based reporting frameworks with little regard for the knowledge and expertise of Indigenous Providers, clients are put at risk of not having their mental health and safety needs recognized and met. Without expanding their perspectives on what constitutes evidence, funders need to recognize that their efforts to improve accountability are flawed and likely to have the opposite effects by undermining both the account-ability and the response-ability of Indigenous Providers. For example, the findings of the present and other research conducted with primary health care organizations (Browne et al. 2012) suggest that, for providers, the ability to make decisions about how to deploy and revise the use of their professional time based on clients’ needs, priorities and contexts is critical for creating relationships build on trust; yet it is being undermined by the constant pressure of time constraints that arise from the privileged place efficiency is currently accorded with performance-governed accountability arrangements. As a result, many Providers encountered ethical dilemmas in their everyday practice but found that they were unable to provide an account of them because of the reductive nature of current conceptualizations of accountability, and thus these issues were rendered invisible and often left unaddressed.

By directing attention to issues of safety and foregrounding a contextualized understanding of safety as relationally enacted and structurally and socially determined, an equity lens for contracting that is informed by the interrelated concepts of trauma- and violence-informed care, cultural safety and harm reduction therefore has the capacity to bring into focus important ethical dimensions involved in contracting. At the most fundamental level, it alerts funders and others who are far removed from the realities on the ground to the possibility that policies and practice may be, unwittingly, creating harm, thus alerting them of the need to ask, are our approaches to contracting, policies and practices safe or do they cause harm? As demonstrated in this study, used as a reflexive ethical lens, the concept of cultural safety provides researchers, policy-makers and practitioners with a tool to think more critically about, and ultimately disrupt, “unequal power relations [within the mental health care system] and the social and historical processes that organise these relationships” (Smye & Browne, 2002, p. 53).

Applied to contracting, a cultural safety lens may open up opportunities for funders to untangle the complex tensions and challenges that shape Indigenous Providers’ experiences with contracting by examining contractual relationships through a post-colonial lens. Rather than understanding contractual relationships as an economic transaction between two essentially independent parties, a cultural safety lens can help reframe contractual relationships between Indigenous Providers and government funders as being constituted by, and at the same time constitutive of, wider historically-mediated Indigenous–State relations. By locating contracting in the social, political and historical context of Indigenous–State relations, cultural safety can help to expose those structures, policies and practices that support and mask the ongoing legacy of colonialism in current contractual approaches and funding environments, in particular through the ongoing embeddedness of an assimilationist ethos. With such an understanding, government funders and administrators would be more likely to recognize the ways in which New Public Management (NPM) approaches to contracting and accountability may reproduce negative stereotypes of Indigenous peoples as disorganised and dependent as well as patterns of paternalistic relations. They may also be better equipped to detect and challenge the ways in which dominant biomedical assumptions about what constitutes legitimate mental health and addictions care are routinely mobilized in funding decision-making and budgetary processes.

Reflexivity would be aided further by a series of ethical questions about the ‘rightness’ of funding decisions and contractual approaches that cultural safety raises (Smye & Browne, 2002). As articulated at the outset of this research, I used cultural safety to ask, how do current contractual arrangements for mental health services fit with aspirations for self-determination and Indigenous peoples’ rights as articulated by Indigenous leaders, the Canadian constitution, and international law? Are current contractual relationships built on mutual trust, respect and shared responsibilities? How are current contractual approaches tailored to fit with Indigenous understandings and responses to mental health and addictions, if at all? And again, are current contractual approaches placing Indigenous peoples at risk of reproducing harm? In answering these questions, funders are reminded that Indigenous peoples in Canada have rights that other citizens have not, and that continuing to ignore these rights and/or rendering these rights meaningless by making them a function of the market is a violation of Indigenous peoples' rights—a gross act of structural violence that has both ethical and political ramifications. Using an equity lens informed by cultural safety offers, therefore, an effective method to "counter the tendency toward politically neutral calls for social justice" and accountability (Reimer Kirkham & Browne, 2006, p. 331).

Here, critical social justice perspectives can offer additional directions to help institutional decision-makers and administrators to meet the system challenges posed by these complexities and resist, as Beckemeier and Butterfield (2005) put it, the propensity to keep focusing on that which seems "less complex and more manageable" (p. 158). The significance of critical social justice perspectives for advancing health equity for Indigenous peoples lies in the fact that they serve funding and policy decision-makers as a "moral compass" (Reimer-Kirkham & Browne, 2006, p. 338). As the findings of this study illustrate, equity-relevant implications for contracting require exploration across the political, economic and cultural dimensions of social justice. As Reimer-Kirkham and Browne (2006) stress, how (in)equity is conceptualized will determine how we go about addressing disparities. Without an adequate conceptualization, we are left in a position that "ultimately leaves us oblivious to the many dimensions of oppression, and that prompts us to continually intervene in a partial manner, rarely addressing root causes of inequities and disparities" (Reimer-Kirkham & Browne, 2006, p. 337). Considering the dominant role that the distributive justice paradigm occupies within liberal democratic discourse and institutions, the intersecting nature of the structural injustices that shape urban Indigenous Providers' and clients' experiences with mental health contracting is easily overlooked. While obviously important, the analysis in this study reveals that the social justice issues involved in contracting in Indigenous mental health have implications that reach far beyond inadequate program funding. Such evidence suggests an urgent need for more complex frameworks in contracting that bring out all three of these analytically distinct dimensions while at the same time illuminating the ways in which these different strands of social justice are co-constitutive of one another.

A three-dimensional social justice conception would offer funders an analytical framework for examining what inequities currently exist in terms of distribution of resources, cultural recognition and participation, and how they mutually reinforce one another. For example, in relation to distribution, Fraser (2003) writes,

> the distribution of the material distribution of resources must be such as to ensure participants' independence and 'voice.' This I shall call the objective condition of parity of participation. It precludes forms and levels of economic dependence and inequality that impede parity of participation. Precluded, therefore, are social arrangements that institutionalize deprivation, exploitation, and gross disparities in wealth, income, and leisure time, thereby denying some people the means and opportunities to interact with others a peers (p. 36).

Issues of cultural recognition are equally important and "require that institutionalized patterns of cultural value express equal respect for all participants and ensure equal opportunity to achieve social esteem" (Fraser, 2003, p. 36). Fraser (2003) calls this the "intersubjective condition" of parity of participation and asserts that both conditions are necessary to ensure "participatory parity": the political dimension and normative core of social justice. According to Fraser (2003), the intersubjective condition

> precludes institutionalized norms that systematically depreciate some categories of people and the qualities associated with them. Precluded, therefore, are institutionalized value patterns that deny some people the status of full partners in interaction—whether by burdening them with excessive ascribed 'difference' or by failing to acknowledge their distinctiveness (p. 36).

Consistent with a health promotion framework, parity of participation thus brings into focus an understanding that "people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health" (World Health Organization, 2019, para. 3). To accept parity of participation as the moral grounding of social justice is thus to commit to addressing the socially constructed, unjust, and avoidable differences in mental health outcomes at the individual and population level that result from the way historically-mediated social, political and economic structures have systemically prevented some groups from having access to the means, opportunities and recognition necessary to participate as full citizens while privileging others (Reimer Kirkham & Browne, 2006). As Reimer Kirkham and Browne (2006) put it, this means that "[*p*]*articipation* (the political), then, qualifies how recognition (culture) and redistribution (economics) are interpreted as the objectives of justice" (p. 327). Such an expanded reading of social justice would challenge funders to broaden their focus beyond issues of distribution at the point of care to consider how care is relationally enacted through experience, culture, ‘race,’ gender, class, history and other intersecting social and structural processes across the micro-, meso- and macro-levels of mental health care. As underscored by the analysis in this study, promoting the capacity of Indigenous Providers to deliver equity-oriented, culturally safe mental health and addictions care to urban Indigenous communities demands simultaneous attention to, and action across, all levels.

Attending to the multiple dimensions (i.e., redistribution, recognition and participation) and levels of care (micro, meso, and macro) adds thus another layer of complexity to the proposed framework—but one that intersectionality can address by providing a conceptual framework that is attentive to and makes visible the linkages between the micropolitics of health care and the macrostructures of power. For example, as the analysis in this study illustrates, the ethical challenges that providers experienced trying to build relationships and trust with clients at the micro-level of care are connected to the increasing influence of neo-liberalism on public-sector reforms at the macro-level. In addition, by applying such a lens, the analysis has brought to light how the current use of classical funding models at the meso-level has resulted in a distribution of material resources that has fostered relations of dependency and continues to structurally silence Indigenous voices at the macro-level. Based on Fraser’s (2003) conceptualization of social justice, such an arrangement constitutes structural injustice. Critiquing this situation further through the lens of recognition produces an even richer understanding by bringing into focus how competitive funding models render invisible Indigenous peoples’ rights, effectively transforming them into commodities that are sold to the ‘highest bidder’ in the market. By looking at the issues from these various analytical angles, what becomes apparent is that while NPM-based approaches to contracting have been euphemistically marketed as ‘best practices’ that improve public sector accountability, in fact the opposite is true. The ingress of market technologies into the public sector to redistribute mental health care resources to improve equity in mental health for Indigenous peoples has not resulted in a fair distribution proportionate to need, but rather it has compounded existing problems leading to a widening disconnect between funding and need both for organizations and the people(s) they serve. The pervasive use of short-term and highly fragmented contracts has created conditions that oblige Indigenous Providers to tailor their services to program parameters that are often incompatible with Indigenous understandings of mental health, instead reflecting those of the dominant biomedical culture. Institutionalized patterns of dominant cultural valuation are reproduced through contractual approaches informed by NPM to deny Indigenous Providers the status of full partners, and as a result, an assimilationist ethos continues to prevail. As Young (2011) notes,

> [A]ssimilation always implies coming into the game after it is begun, after the rules and standards have been set, and having to prove oneself according to those rules and standards. In the assimilationist strategy, the privileged groups implicitly define the standards according to which all will be measured (p. 164).

Examining issues of redistribution with respect to contracting in their intersection with issues of recognition and participation yielded, thus, much deeper analytical insight would have been garnered otherwise. Indeed, as the findings demonstrate, this approach brings out concerns related to inclusion in decision-making, urban Indigenous citizenship, accountability and responsibilization, division of labour, culture, race, gender, class and colonial and neo-colonial relations, and neo-liberal health care reform. Considering the effects of these intersections across the different levels of care at the micro- and macro-levels further enhances our understanding of the various equity-relevant implications of contracting as well as where and how to intervene to make equity-based improvements.

Moreover, by making visible how micro-level experiences are linked to dynamics at the meso- and macro-levels, the proposed framework supports an alternative model of accountability—one that Young (2006) describes as a “social connection model of responsibility” (p. 102). Contrary to the current accountability framework and its blame-shifting tendencies, a social connection model of responsibility is, as Young (2006) explains, based on the assumption that “all agents who contribute by their actions to the structural processes that produce injustice have responsibilities to work to remedy these injustices” (p. 102-103). Young’s conceptualization of responsibility fits well with the relational orientation of Indigenous perspectives as well as the relational models of accountability discussed by Wilson (2008) and (Kirkness & Barnhardt, 1991). Compared to the administrative and liability-focused accountability promoted in NPM discourse, these relational conceptions of responsibility take us to a very different place in terms of action, because, as Young points out, “it can be discharged only through collective action” (p. 103). However, as Young adds, shared responsibility should not be construed as “an *equal* responsibility”—those in positions of relative power (i.e. government funders) have a greater degree of responsibility (p. 125). This explicit focus on power and the way power structures people's relative standing within the web of social and institutional relations depending on their intersecting social locations and contexts makes Young's model of accountability well positioned to foster critical political and social consciousness among public health administrators and funding decision-makers.

As the findings suggest, government funders and contract managers are often far removed from the realities that shape the everyday experience of Indigenous organizations and the populations they serve. This gap is often reflective of not only the institutional but also the social and cultural distance between those who occupy positions of decision-making and/or managerial power within funding institutions and those positioned in community. By making these structural, social and institutional relations visible, such an expanded reading of accountability might help funders and administrators to see beyond the contractually defined relationship and the discharging responsibilities it defines and bring into focus the many other relations that impact and are impacted by the contractual agreement, ranging from micro relationships of care to relations of labour, advocacy and decision-making at the meso-level to the wider macro-relations of oppression and domination and the political economy. Taking such relationships into account thus adds important ethically- and politically-significant questions to current accountability concerns. Within such a framework, tensions that arise between different and conflicting accountabilities must be recognized and exploited to a productive end by using them as entry points into a series of larger and ongoing conversations about account-abilities and response-abilities that bring together representatives of Indigenous non-profit organizations (NPOs), including frontline workers and administrative staff, funders from different sectors and levels of government, community members, and other stakeholders. Such spaces of engagement are key to identifying structural barriers and constraints that impede the actualization of equity across all system levels and ultimately, developing a coordinated and organized response across different jurisdictions and policy sectors to address the persistent mental health inequities that urban Indigenous populations continue to face.

In keeping with the theoretical and praxis-oriented commitments of this study, in what follows, I conclude the thesis by outlining a number of recommendations that are emerging as relevant from the research findings. These recommendations are meant to provide guidance for system-level changes that are informed by the experiences and perspectives of urban Indigenous Providers examined in this study and oriented to advance equity in mental health for urban Indigenous populations by enhancing system capacity for equity-oriented and culturally safe mental health and addictions care.

8.3. Recommendations Arising from this Research

The evidence and recommendations of this research will be shared with policy and practice leaders, including funders and Indigenous Providers to engage them into a thoughtful dialogue about how to use the emerging evidence and proposed system-level changes so that contracting with Indigenous Providers will translate into better mental wellness outcomes for urban Indigenous people, families and communities in BC. The recommendations I will be offering to government funders support the calls for action made by the Truth and Reconciliation Commission (TRC, 2015) and the priorities for action and opportunities for renewal identified within the First Nations Mental Wellness Continuum Framework (Assembly of First Nations [AFN] & Health Canada, 2015) and the Renewed Framework to Address Substance Use Issues Among First Nations People in Canada, Honouring Our Strengths (AFN, National Native Addictions Partnership Foundation [NNAPF], & Health Canada 2011), respectively. The recommendations from this dissertation are also in keeping with the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP,* 2007), the Mental Health Commission of Canada's Mental Health Strategy (MHCC, 2012) as well as the strategic directions and actions of *A Path Forward, BC's Ten-Year First Nations and Aboriginal People's Mental Wellness and Substance Use Plan* (FNHA et al., 2013).

Given the need for system-level changes, the recommendations and calls for action that follow are primarily directed at policy and funding decision-makers, administrative and policy leads, contract managers and others who are in positions to effect such change across different levels of government. However, in consistency with the proposed equity lens and the principles of cultural safety, they often require and/or are directed at promoting collaboration with Indigenous peoples and urban Indigenous Providers. Altogether I have identified 6 key recommendations, each with a set of action calls to provide clear directions and examples of how to operationalize equity within the specific context of contracting in Indigenous mental health and addictions care in BC. These recommendations correspond to the major cross-cutting themes that have been discussed within this dissertation and focus on policy approaches that can (a) redress and/or mitigate the effects of systemic inequities and structural violence enacted within the current policy and funding arrangements and approaches to contracting; and (b) help create the conditions for enhancing urban Indigenous Providers' economic, political and cultural capacities to deliver equity-promoting and culturally safe mental health and addictions care. Together they describe a whole-system approach for promoting strategic action across the macro-, meso- and micro-dimensions of contracting in Indigenous mental health and along the lines of participation, recognition and redistribution.

RECOMMENDATION 1: Recognize the foundational role that Indigenous culture plays for promoting individual and community healing and fostering equity in mental health for urban Indigenous peoples.

Calls for Actions:

1. Acknowledge that and take action to implement urban Indigenous peoples' rights to have access to traditional healing practices, express and develop Indigenous cultural knowledge and traditions, and enjoy of the highest mental health status possible (TRC, 2015; UNDRIP, 2007).
2. Build capacity for an intercultural understanding and appreciation of the differences between Indigenous approaches to healing and Western biomedical models of mental health and addictions care.
3. Recognize and support mental health and addictions programs and services that have been identified as promising or wise practices for individual and community healing by Indigenous researchers, policy and practice leaders, providers and communities (AFN & Health Canada; 2015; TRC, 2015), such as the body of evidence produced by the Aboriginal Healing Foundation.
4. In consultation and collaboration with Indigenous Providers, plan for and develop budgets that ensure the appropriate allocation of resources to culture-specific activities and healing practices.
5. Recognize and support Elders, traditional healers, cultural practitioners and spiritual advisors in their capacities as program planners and service providers (Wise Practices Research (TRC, 2015; Wesley-Esquimaux & Calliou, 2010; Wise Practices Research Group, 2018).

6. Support, invest and collaborate with in Indigenous-led, community-based research to identify, document and evaluate promising healing practices and approaches for addressing the physical, mental, emotional, and spiritual harms caused by residential schools and the sixties scoop in intersection with other ongoing forms of trauma and violence (Allan & Smylie, 2015).

RECOMMENDATION 2: Recognize that culturally safe mental health and addictions care for urban Indigenous populations must be integrated with other equity-oriented care principles

Calls for Actions:

1. Take into account that one size does not fit all and that equity-oriented, culturally safe care requires that Indigenous Providers have the capacity to tailor care to the needs, priorities, concerns and contexts of the populations served.
2. Enhance Indigenous Providers control and autonomy so that they are able to tailor the delivery of care to the needs, priorities and social realities of program recipients by exploring and adopting more flexible approaches to contracting and accountability (AFN & Health Canada, 2015).
3. Improve access to long-term mental health programs that are supported by stable funding arrangements and enable relational approaches to care (Brant Castellano, 2006; AFN & Health Canada, 2015). At the same time, move away from short-term contracts that place Indigenous clients at continual risk of substantial psychological and emotional harm, and re-traumatization (Tait, 2008).
4. Provide and/or advocate for funding for more comprehensive and balanced approaches to mental health and addictions programs that: (i) include a range of mental health and addictions services; (ii) draw on both Indigenous healing practices and Western models of mental health and addictions care; (iii) are integrated with other health and social services; and, (iv) allow for care that spans from prevention, and intervention to after-care (AFN & Health Canada , 2015; TRC, 2015; Wise Practices Research Group, 2018).

RECOMMENDATION 3: Develop policy-based approaches to contracting that are explicitly oriented to increase Indigenous governance, management and

ownership over community-based mental health and addictions programming within the urban Indigenous non-profit sector in BC and individual Providers.

Calls for Actions:

1. Acknowledge the multiple ways in which competitive and short-term funding models systemically undermine the capacity and governance within Indigenous non-profit organizations and the sector overall.
2. Create more stable funding arrangements to improve organizational capacity to engage in long-term planning, recruit and retain staff, and ensure continuity of care (AFN & Health Canada, 2015).
3. Recognize and meet the need for organizational core funding to enhance urban Indigenous Providers' capacities to engage in community-based, participatory program planning and evaluation, and policy development and advocacy. Without core funding, Indigenous Providers are limited in their ability to tailor organizational environments, policies and practices to the cultural and safety needs of the populations they serve. Core funding must be annually adjusted to reflect increases in the cost of living and rates of inflation (Allan & Smylie, 2015).
4. Move away from line-by-line budgeting and highly prescriptive performance management (PM) frameworks towards relational funding approaches and block-funding arrangements with multi-year funding terms that provide Indigenous Providers with much greater flexibility to enhance Indigenous Providers' relative autonomy over how services are provided (Browne et al, 2012).
5. In collaboration with urban Indigenous people and organizations, invest in the development and implementation of an Indigenous non-profit sector human resources strategy in mental health and addictions (AFN & Health Canada, 2015). As part of this strategy,
    a. Ensure that Indigenous non-profit work force have access to appropriate wages, benefits and pensions;,
    b. Invest in and create ongoing training and professional development opportunities; and,.
    c. Make funding available to support and promote the mental wellness of front-line workers and prevent burn-out (AFN & Health Canada, 2015; Browne et al. 2012).

6. Allocate and advocate for new resources to support urban Indigenous (preferably self-organized) forms of governance and leadership without tapping into the funds allocated for mental health care.
7. Create structures and policies to meaningfully involve Indigenous organizations in policy development and decision-making about resource allocation so that regional and provincial priority setting is informed by local priorities.

RECOMMENDATION 4: Develop policy intervention, contractual processes and funding structures that foster a collaborative, coordinated and comprehensive approach to urban Indigenous mental health and addictions care.

Calls for Actions:

1. Create cross-sectoral and inter-departmental and -governmental working groups to overcome the highly fragmented and jurisdictionally complex nature of the current funding and policy environment that is currently in place for Indigenous mental health and addictions programming in urban areas. Such a coordinated response is needed to improve equitable access to appropriate program funding, lessen the administrative burden associated with current funding arrangements and effectively redress the inequities in mental health and mental health care affecting urban Indigenous populations.
2. Explore using 'integrated contracting models' (Pomeroy, 2007) as a potential mechanism to integrate resources across jurisdictions and create spaces of engagement between different funders, levels of governments and the Indigenous Provider in order to foster a shift away from current supply-oriented funding models to more demand-focused bottom-up approaches and further reduce transaction costs.
3. Draw inspiration on existing policy interventions that have increased Indigenous governance and administration over Indigenous health services, such as the Aboriginal Healing and Wellness Strategy in Ontario, and the Indigenous governance framework that underpins the First Nations Health Authority (FNHA) in BC, invest in and create Partnership Agreements that recognize urban Indigenous Providers as key partners in the development and implementation of an urban mental health and addictions strategy for Indigenous peoples (Allan & Smylie, 2015).

4. Adopt asset mapping as a method (AFN & Health Canada, 2015) to develop, in collaboration with urban Indigenous Providers, urban-specific community wellness plans that can help inform strategic funding decisions at the community- and/or organizational levels and improve the capacity of individual Providers and the sector overall to deliver a continuum of comprehensive culturally safe and equity-oriented mental wellness and addictions services.

RECOMMENDATION 5: Foster a culture of equity

Calls for Actions:

1. Implement contracting in manner consistent with the TRC’s Calls for Action and UNDRIP (2007)
2. Using the study findings to raise critical social and political consciousness to:
    a) the failure of current New Public Management (NPM) informed contractual approaches and funding structures to advance equity in mental health, in particular within the Indigenous context;
    b) the structural violence and inequities embedded within current funding arrangements, including the assimilationist ethos that continues to be unwittingly supported and perpetuated by current NPM-inspired contractual approaches
    c) the need to examine contracting through a lens informed by equity-oriented care principles to ensure that they do not unwittingly place Indigenous people at harm (Browne et al., 2016; Ford-Gilboe et al., 2018; Tait, 2008; 2013; 2014).
3. Adopt population- and needs-based approaches to resource allocation (Baum, 2016) at the provincial and regional levels and increase funding levels to match the mental health care needs of urban Indigenous and other populations in order to ensure equitable access to culturally safe mental health services and supports. If equity in mental health and mental health care for Indigenous peoples is the goal, then using market-based, proposal-driven approaches to funding are inadequate.
4. Create annualized budgets for urban Indigenous mental health and wellness to keep pace with increases in the cost of living and population growth (Allan & Smylie, 2015)
5. Invest in and/or advocate for wider social and mental health policies to enhance access to social determinants of mental health for Indigenous peoples, such as a

range of housing options, including community-based supported living and halfway houses, educational and employment opportunities.

6. Make it an explicit goal to create funding conditions that allow for the monitoring and measuring of equitable access to funding and culturally safe mental health care for Indigenous populations.

RECOMMENDATION 6: Develop a relational accountability framework

Calls for Actions:

1. Establish a health equity surveillance system and create an accountability framework that is oriented to enhance Indigenous Providers' capabilities to design and deliver equity-oriented mental health and addictions care for urban Indigenous populations.
    a. Develop indicators to identify and monitor progress on redressing structural violence and inequities within current contractual arrangements. Waiting list and mental health burn out rates among staff and high-staff turnover are examples of indicators of structural violence.
    b. Recognize that some of these indicators need to be individually tailored to the specific organizations and populations served and engage with each organization in a process of assessing the strengths, weaknesses and opportunities for enhancing equity-oriented mental health and/or addictions care across the organizational, programming and service delivery levels (Browne 2015).
2. Examine the impact of contractually-defined performance-based accountability requirements on the capacity of individual Indigenous Providers to provide care and thus, the quality of care provided.
3. Challenge the narrow focus on efficiency and create a space for a dialogue with Indigenous Providers about how to develop indicators for monitoring and measuring the quality and safety of mental health and addictions care by applying an equity lens as proposed by this research.
4. Specifically, revise how time is currently being valued and accounted for within funding formulas and contractual performance targets to better reflect the time

needed to provide equity-oriented mental health and addictions care (Browne et al. 2012; Browne et a. 2018)[46].

8.4. Concluding Comments

This research reveals the complexities and paradoxes inherent in government contracting for the delivery of culturally safe mental health and addictions services within the context of BC's urban Indigenous non-profit sector. As the findings of this study illustrate urban Indigenous community-based organizations are uniquely positioned to effectively respond to the mental health needs and rights of urban Indigenous populations, in particular those most marginalized by the broader healthcare system and society as a whole. However, the current fragmented policy and funding environment, as well as the dominant approach to contracting, increasingly impose structural constraints on the abilities of Indigenous Providers to develop and deliver culturally safe mental health and addictions care that is responsive to the social inequities shaping people's lives and life opportunities. To address these structural constraints and adequately support urban Indigenous Providers in achieving their mandates, contracting needs to be accompanied not only by a significant increase in resources but also a significant shift in the socio-political and economic power structures and an increased critical awareness of the colonizing potential of current contractual policies and practices. Without a better understanding of how these relations create situations of particular vulnerability and disadvantage for both Indigenous organizations (their staff and leaders) and the people they serve, many urban Indigenous Providers and communities will continue to find contracting a double-edged sword. However, pursuing an understanding of how current contractual relationships and wider policy and funding environments are implicated in the creation and perpetuation of inequity and structural violence, and how they should be re-structured in light of wider policy commitments to equity and reconciliation, requires that government funders move beyond the narrow, apolitical view of contracting and accountability buttressed by neo-liberal and biomedical ideologies. By locating contracting for culturally safe mental health care within the contexts of Indigenous peoples' wider struggles for self-determination, historical and neo-colonial relations and

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[46] New empirical evidence demonstrates that "enhancing patients' comfort and confidence in their care and their own confidence in preventing and managing health problems" is essential to equity-oriented health care and "predict[s] improved health outcomes across time for people living in marginalizing conditions" (Ford-Gilboe et al. 2018, p. 363).

health care reform, funders can begin to conceptualize contracting and accountability in more politicized terms and challenge current neo-liberal policies and practices which create, reinforce and obscure neo-colonial relations giving rise to ongoing social suffering, stigma and discrimination. The recommendations arising from this study can serve funders as a useful starting point for addressing these inequities and developing contractual arrangements, policy and funding environments that are explicitly oriented to promote equity and reconciliation.

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Appendix A: Community Research Collaboration Agreement

Community Research Collaboration Agreement
Between [Name of Non-Profit Organization] and Viviane Josewski
for the Research Project "Moving Towards Cultural Safety in Mental Health & Addictions Contracting for Urban Indigenous Peoples: Lessons from British Columbia" conducted under the auspices of Simon Fraser University

Parties: This document constitutes an agreement of collaboration between [Name of Non-Profit Organization], as represented by [Name of Executive Director] and Viviane Josewski, PhD Candidate, Faculty of Health Sciences, Simon Fraser University

Purpose: The purpose of this Agreement is to establish a set of principles that will guide the conduct of the research project entitled "Moving Towards Cultural Safety in Mental Health & Addictions Contracting for Urban Indigenous Peoples: Lessons from British Columbia". These principles recognize and emphasize the core values, and ethical research principles of the [Name of Non-Profit Organization].

Process Records: Viviane Josewski will coordinate all administrative matters relating to the above named research project, with recognition of the collaborative partnership with [Name of Non-Profit Organization]. The research will be based at the Faculty of Health Sciences, Simon Fraser University, 8888 University Drive, Burnaby, BC V5A 1S6.

Ethical Considerations

The research collaboration partners to this agreement collectively share the responsibility for ethical standards throughout the project, and each partner has responsibility for raising any ethical concerns and/or issues. Ethical dilemmas are to be resolved on the basis of the research partners striving for a significant degree of consensus, and in alignment with ethical codes of conduct for research in Aboriginal communities as articulated by the Royal Commission on Aboriginal Peoples' Ethical Guidelines for Research (1993b), OCAP (Schnarch, 2004) and TCPS2 Chapter 9, which outline strategies for ensuring that research findings will benefit Indigenous peoples and communities.

Duration and Amendments

This Agreement on Research Collaboration will be in effect throughout the entire research process, from the moment efforts are made to implement the proposal, through the data collection, and analysis phases into the dissemination of and publication of the findings. This agreement can be amended upon mutual consent by the partners to this agreement.

We agree to follow these principles in the manner outlined below:

- **Community Benefit:** The research study will generate knowledge of the challenges, strengths and opportunities of different aspects of contracting for Aboriginal community-based mental health and addictions service delivery and their relevance for the development of an ethical framework for contracting in community-based mental health and addictions care that is grounded in the values of cultural safety.

- **Equity**: In this project, cultural safety is understood to be about respectful relations and equity; that is, about actualizing ethical practice at individual, program and organizational levels of mental health and addictions care as well as within the contractual relationships between funders and providers.

- **Empowerment:** The researcher recognizes that in any research focused on Indigenous peoples and any other ethnocultural groups, there is a potential risk of generating and/or furthering stereotypes about these groups. In all areas of data analysis, and in all written materials and presentations, the researcher will avoid representing people in ways that may perpetuate stereotypes. The researcher brings expertise and sensitivity in understanding the historical and political contexts that shape access to mental health addictions care for Indigenous peoples and service delivery; this understanding will be reflected in all written work and presentations of the findings.

- **Action-Oriented Capacity-Building:** The findings of this study will be shared with Aboriginal organizations, community partners and health authorities to strategize ways of applying the research findings in policy and practice. The confirmed partnership with Vancouver Coastal Health and Fraser Health as community partners is expected to strengthen the up-take of findings in the policy arena.

- **Participatory Approaches:**The researcher agrees to offer and provide the opportunity to review the data, concepts, and themes with a sub-sample of participants (those who are interested) for their critical consideration and a mutual negotiation of meaning (“reciprocity”).

- **Inclusion and Voice:** Indigenous perspectives will be sought at all phases of the research design and process through a) the ongoing input from the advisory committee members to guide this work from the beginning to end; and b) the methodological decision to provide opportunities for participants to review findings and conclusion.

- **Accountability**: The researcher will report regular updates to [Name of Non-Profit Organization].

- **Reciprocity:** A summary of the findings of the research will be submitted for publication to selected regional, provincial, and national health care agency newsletters as well as practice journals, and will be presented at conferences. The researcher agrees to acknowledge [Name of Organization] as a community partner if this is the expressed wish of the organization (and may not be). The explicit permission of acknowledge [Name of Organization] must be sought prior to acknowledging their contribution in a paper or presentation.

- **Collaboration:** A research partner, [Name of Organization] may chose to include a disclaimer if they do not agree with the content or views presented in a publication or presentation. In the case of a presentation, the disclaimer must be incorporated in the presentations in a manner which gives it the possibility of noticeable attention by those attending the presentation. The manner which the disclaimer is to be included must be approved by those providing the disclaimer.

- The researcher understands that [Name of Organization] reserves the right to withdraw participation from the research project at any time, if the partnership moves in a direction that ceases to be a god fit, or if the resources prevent [Name of Organization] from participating fully and ethically in the project.

Signed this ______ day of __________, 200_:

_______________________________________ __________________________________

Organizational Representative(s)

____ ___________________________________

Name of Researcher Witness

_________________________________ _____________________________________

Appendix B: Research Introduction for a PhD in Health Sciences

"Moving Towards Cultural Safety in Mental Health & Addictions Contracting for Urban Indigenous Peoples: Lessons from British Columbia" - (DORE Application #2014s0021)
Funded by the Canadian Institutes of Health Research (CIHR)

Primary Researcher: Viviane Josewski, PhD Candidate, Faculty of Health Sciences, Simon Fraser University;
Supervisors: Dr. Marina Morrow, Faculty of Health Sciences, SFU (Primary Supervisor); Dr. Victoria Smye, University of Ontario Institute of Technology (Primary Co-Supervisor); Dr. John O'Neil, Faculty of Health Sciences, SFU; Dr. Joseé Lavoie, Community Health Sciences, Faculty of Medicine, University of Manitoba.
Indigenous Advisory Team: Nadine Caplette; Tonya Gomes, Aboriginal Health Clinical Practice Initiatives Lead, Vancouver Coastal Health; William (Bill) Mussell, Principal Educator , Sal'i'shan Institute.

What is this project about?
This research study is being conducted under the auspices of Simon Fraser University in partnership with [name of health authorities]. The purpose of this qualitative study is to examine and understand the context and processes for enacting cultural safety in contracting for mental health and addictions services for urban Indigenous peoples; with the long-term goal to support the development of an ethical framework for contracting in community-based Indigenous mental health and addictions care that is grounded in the notion of cultural safety. Broadly speaking, in this project, cultural safety is about respectful relations and equity; that is, about actualizing ethical practice at individual, program and organizational levels of mental health and addictions care as well as within the contractual relationships between funders and providers.

What does this study involve?
This project draws on a participatory study design, which means that (a) the entire research process, dissemination of findings and evaluation are guided by an Indigenous Advisory Team, made up of Elders and members with longstanding experiences of working to improve the mental health and well-being of First Nations, Inuit and Métis peoples in Canada, and (b) I will provide opportunities for participants to review findings and conclusion. The specific methods of this study include in-depth individual interviews and a critical review of relevant policies and documents.

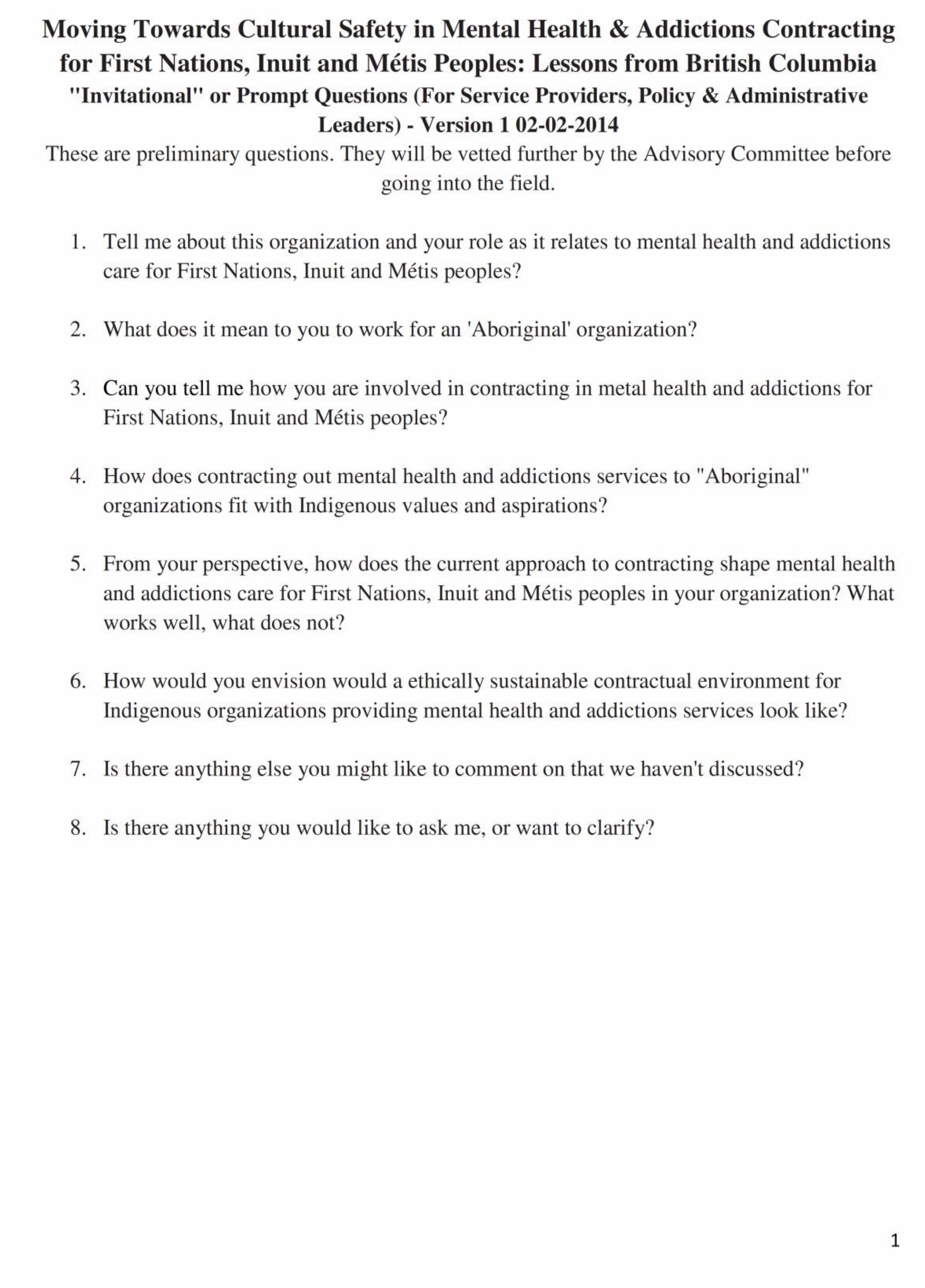
Primarily, this involves in-depth individual interviews (30-60 minutes) with policy and administrative leaders, and service providers from community-based organizations with a mandate to provide mental health and addictions services to First Nations, Inuit and Métis populations. In addition, I would like to speak with policy and administrative leaders from organizations that provide funding for community-based Indigenous mental health and addictions services. *To foreground Indigenous knowledges and perspectives, the intention is to speak <u>primarily but not exclusively</u> with participants who self-identify as First Nations, Métis and Inuit.*

What will happen after the research is finished?
After I have completed this study, I will share the research findings with people in charge of contracting for mental health & addictions care services, policy makers, mental health and addictions providers and community groups. I will also use the findings to complete the requirements of my doctoral studies in Health Sciences by publicly defending three publications based on the findings of this study.

How do I get involved?
If you and/or your organization is interested in being part in this study, I can talk to you or as part of a group to introduce the research project in-more depth, and explore your potential interest for how you and/or your organization can participate in this study

For more information, please contact: [redacted]@sfu.

Appendix C: Interview Guide



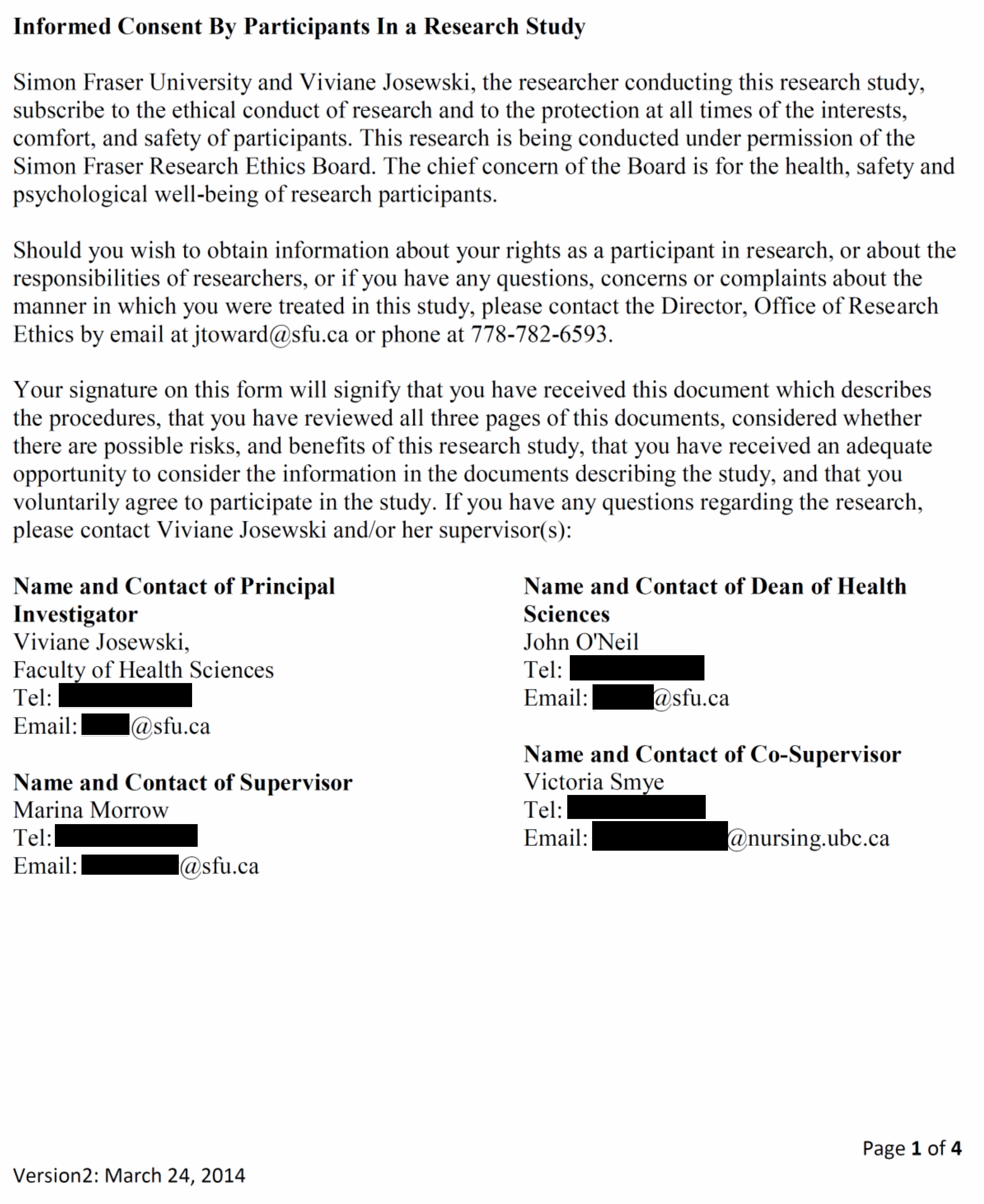
Moving Towards Cultural Safety in Mental Health & Addictions Contracting for First Nations, Inuit and Métis Peoples: Lessons from British Columbia

"Invitational" or Prompt Questions (For Service Providers, Policy & Administrative Leaders) - Version 1 02-02-2014

These are preliminary questions. They will be vetted further by the Advisory Committee before going into the field.

1. Tell me about this organization and your role as it relates to mental health and addictions care for First Nations, Inuit and Métis peoples?
2. What does it mean to you to work for an 'Aboriginal' organization?
3. Can you tell me how you are involved in contracting in metal health and addictions for First Nations, Inuit and Métis peoples?
4. How does contracting out mental health and addictions services to "Aboriginal" organizations fit with Indigenous values and aspirations?
5. From your perspective, how does the current approach to contracting shape mental health and addictions care for First Nations, Inuit and Métis peoples in your organization? What works well, what does not?
6. How would you envision would a ethically sustainable contractual environment for Indigenous organizations providing mental health and addictions services look like?
7. Is there anything else you might like to comment on that we haven't discussed?
8. Is there anything you would like to ask me, or want to clarify?

Appendix D: Consent Form



Informed Consent By Participants In a Research Study

Simon Fraser University and Viviane Josewski, the researcher conducting this research study, subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This research is being conducted under permission of the Simon Fraser Research Ethics Board. The chief concern of the Board is for the health, safety and psychological well-being of research participants.

Should you wish to obtain information about your rights as a participant in research, or about the responsibilities of researchers, or if you have any questions, concerns or complaints about the manner in which you were treated in this study, please contact the Director, Office of Research Ethics by email at jtoward@sfu.ca or phone at 778-782-6593.

Your signature on this form will signify that you have received this document which describes the procedures, that you have reviewed all three pages of this documents, considered whether there are possible risks, and benefits of this research study, that you have received an adequate opportunity to consider the information in the documents describing the study, and that you voluntarily agree to participate in the study. If you have any questions regarding the research, please contact Viviane Josewski and/or her supervisor(s):

Name and Contact of Principal Investigator
Viviane Josewski,
Faculty of Health Sciences
Tel: [redacted]
Email: [redacted]@sfu.ca

Name and Contact of Supervisor
Marina Morrow
Tel: [redacted]
Email: [redacted]@sfu.ca

Name and Contact of Dean of Health Sciences
John O'Neil
Tel: [redacted]
Email: [redacted]@sfu.ca

Name and Contact of Co-Supervisor
Victoria Smye
Tel: [redacted]
Email: [redacted]@nursing.ubc.ca

Title: Moving Towards Cultural Safety in Mental Health & Addictions Contracting for First Nations, Inuit and Métis Peoples: Lessons from British Columbia;

Consent Form for Providers, Policy and Administrative Leaders (Interview and Survey)

Principal Investigator:
Viviane Josewski, Faculty of Health Sciences, SFU
Academic Supervisors:
Marina Morrow, Victoria Smye, John O'Neil and Joseé Lavoie
Indigenous Advisory Team:
Nadine Caplette, Tonya Gomes and Bill Mussel
Sponsor:
Canadian Institutes of Health Research (CIHR)

What is this project about?

The purpose of this study is to explore the context and processes in contracting for community-based mental health and addictions services for First Nations, Inuit and Métis peoples. I am specifically interested in learning more about the experiences of policy and administrative leaders, and service providers involved in mental health and addictions funding, programming and service provision for First Nations, Inuit and Métis peoples to better understand how to support mental health and addictions services that are responsive the needs of First Nations, Inuit and Métis peoples in the context of living with histories of trauma, mental health and/or current or past substance use issues.

To do this, I am talking to policy and administrative leaders, and service providers involved in mental health and addictions funding, programming and service provision for First Nations, Inuit and Métis peoples. I also would like to speak with a small number of individuals who access mental health and addictions services at community-based organizations.

The wider goal of the study is to support the development of an ethical framework for contracting in community-based Indigenous mental health and addictions care that is grounded in the notion of cultural safety. To do this, my intention is to foreground Indigenous knowledges and perspectives by, for example, working together with an Indigenous Advisory team. Findings will be shared with a wide audience including health administrators, policy-makers, professionals, and representatives from Aboriginal health organizations.

What will the participants be required to do?

You are being invited to take part in this study in your capacity as an actor within the broader context of community-based mental health and addictions care for First Nations, Inuit and Métis peoples. If you say 'Yes', I will seek your participation in an interview in which I will ask open-ended questions about your thoughts about, and experiences of, how contracting for mental health and addictions services shapes mental health and addictions programming, service delivery, and care for First Nations, Inuit and Métis peoples. In addition, I will be asking you to answer some socio-demographic questions as part of a short anonymous survey (approx. 10-15 minutes).

You will be interviewed at your convenience. The setting of the interview may take place at your work or at a more informal location according to your preference. The length of the interview will depend on your availability but might average about an hour (30-60 minutes). I will ask for your permission to digitally record the interview. If you agree to be audio recorded, the interview will be digitally recorded and later typed. At any point in the interview, you can ask for the recorder to be turned off or have the recording erased. You are under no obligation to participate, and are free to withdraw from this study at any time, without any adverse (negative) effect on you or your employment. This includes a right to request the withdrawal of any information you provide to me. Throughout the course of the research project, I will seek to provide you with information that is relevant to your decision to continue or withdraw from participation. There is no reimbursement for participating in this study.

Risks and Benefits

There are no foreseeable risks to you in participating in this study. Approval for this study has been sought from you organization. The information will *not* be used to evaluate professionals' practice. Rather, the information will be used to discuss broader issues related to contracting in mental health and addictions for First Nations, Inuit and Métis peoples. In addition, the study will be done in and the findings will written up in a way that is respectful to the unique histories, cultures, languages and social circumstances of First Nations, Inuit and Métis peoples, and other groups. There may or may not be direct benefits to you from taking part in this study but it may help policy makers and community-based organizations to learn more about how to support safe and responsive mental health and addictions care for First Nations, Inuit and Métis peoples living with histories of trauma and current or past substance use. A copy of the results of this study will be made available to you if you so wish. You do not waive any of your legal rights by signing this consent form.

Protecting Privacy and Confidentiality

The information you provide (identifiable data) is strictly confidential. Your confidentiality will be protected in several ways.

1. Your name and that of any other person and/or your organization will not be used in the study or in any reports or articles written about the study.

   Instead, a number code will be given to each person and organization in the study.

2. You and the name of your organization will not be identified in any of my discussions with other participants of the study.

3. Information that could identify you or any other person you refer to, will be deleted from all interview recordings, notes, and documents.

4. Employers and co-workers will not have access to any of the information provided.

5. The research team members and a typist, will be the only people who will have access to the research information without your name on it. The research team members are listed above. All of these people are accountable for the safekeeping of the information and for maintaining privacy and confidentiality.

6. All digital recordings of interviews and focus groups will be deleted from the recorders and saved together with the transcriptions as computer files, password protected and encrypted on a university-based secured research drive to which only Josewski will have access to. Any print material and written notes will be stored in a locked filing cabinet within a research office at the university.

The results of this study will be written in reports and papers and presented at meetings. The research information will be kept for five years after the research is published and presented. When the research information is no longer used, it will be destroyed.

Consent

I understand that I may withdraw my participation at any time.

I also understand that I may register any complaint with the Director of the Office of Research Ethics, as follows:
Dr. Jeff Toward; Director, Office of Research Ethics; Office of Research Ethics; Simon Fraser University; 8888 University Drive; Multi-Tenant Facility; Burnaby, B.C.; V5A 1S6; email: jtoward@sfu.ca

I may obtain copies of the results of this study upon its completion by contacting Viviane Josewski, at (604) 345 7632 and/or vha1@sfu.ca.

Having been asked to participate in the research study named above, I certify that I have read the procedures specified in this document (pages 1-4) describing the study. I understand the procedures to be used in this study and the personal risks to me in taking part in the study as described below. When you sign this consent form, you agree to take part in the study we talked about. We will give you a copy of this consent form to keep.

Do you agree to be audio recorded?

Yes ☐☐ No ☐

Would you like a copy of your transcript?

Yes ☐☐ No ☐

Signature: ____

Date: ____
(yyyy/mm/dd)

Participant Last Name: ____________________________________

Participant First Name: ____________________________________

Participant Contact Information: ______________________________

____

____

Appendix E: Socio-Demographic Form

Preamble: You do NOT need to answer any question that you do not feel comfortable answering.

Personal Background Questions:

1. What is your gender (e.g. male, female, transgender)?________________________
2. What is your educational background and highest degree?_____________________
3. How would you identify your culture and/or ethnicity? (e.g., Indigenous (such as Aboriginal/First Nations/Métis/Inuit etc.), East Indian, South Asian, European Canadian etc.) ____

   If you identify as Indigenous, are you

   a. Status First Nation (specify Nation) __________________
   b. Non-status FN (specify Nation) _____________________
   c. Métis (specify Nation(s) if applicable) _________________
   d. Inuit ________________
   e. Other _______________

4. What language(s) do you speak? ____
5. Did you or your parents attend residential school? (yes/no)____________________
   a. If yes, for how many years? _______________________________________

Occupational Questions:

6. What is your position at this organization? _________________________________
7. What type of work are you doing? ____
8. How many years have you been working in this position? _____________________
9. How many years of experience do you have in your job? ______________________
10. What are your conditions of employment?
    a. Type of employment (Contracted, Full-time, Part-time): _________________
    b. Terms of pay (e.g. hourly, salary etc.): ______________________________
    c. Approximate annual income (before taxes if applicable) from this position: ________________