

**LOST IN TRANSLATION? A CRITICAL EXPLORATION
OF ABORIGINAL MENTAL HEALTH REFORM IN THE
INTERIOR HEALTH**

by

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ABSTRACT

Given the history and legacy of colonialism, Aboriginal peoples suffer from disproportionately higher rates of mental health issues than non-Aboriginal Canadians. Mirroring recent political achievements by Aboriginal peoples, British Columbia's health authorities are committed to closing this gap in health in partnership with Aboriginal peoples. Using institutional ethnography this study examines Aboriginal mental health reform as it is unfolding in Interior Health (IH). The impact on Aboriginal participation and cultural appropriateness of services is explored. Although IH's reform holds promise in the move to Aboriginal empowerment and healing, this research describes the tensions that arise from the intersection of neoliberal, colonial and bio-medical ideologies embedded within the mental health care system. These tensions have resulted in paradoxical policy outcomes that undermine meaningful Aboriginal participation and culturally appropriate mental health policies and services. The results of this study are relevant generally to policy makers and providers in Aboriginal mental health.

Keywords: Aboriginal Peoples; Aboriginal Participation in Health Policy; Empowerment; Culturally Appropriate Mental Health Services; Mental Health Policy; Ideologies

DEDICATION

This work is dedicated to all the strong women who contributed to the successful completion of this thesis. First and foremost, this includes the women, who shared their experiences with me and made this research possible. Then, I would like to dedicate this work also to Marina Morrow and Victoria Smye, whose commitment to social justice and health equity, has inspired and supported me the entire time. Finally, I would like to devote this work to my mother, whose values and beliefs in social equity, responsibility and respect for all cultures have made me chose this path.

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1: INTRODUCTION

1.1 Background and Overall Purpose of the Research

'Mental health and addictions' is a pressing issue facing Aboriginal peoples¹ in Canada. The mental health burden carried by Aboriginal communities is disproportionately higher than for non-Aboriginal people (Royal Commission on Aboriginal Peoples (RCAP), 1996; British Columbia (BC). Office of the Provincial Health Officer (PHO), 2002; Canadian Institute for Health Information (CIHI), 2004; The Standing Senate Committee on Social Affairs, Science and Technology (Kirby Report), 2006). Yet, the dominance of biopsychiatry in mental health program delivery models and the embeddedness of an assimilationist ethos in the mental health care system have created barriers to appropriate, culturally safe services for many Aboriginal people (Smye, 2004; Smye & Browne, 2002). Thus, "there is a tendency by First Nations people not to use the mental health services provided by the dominant culture" (Smye & Mussell, 2001, p.9). Therefore, the provision of culturally appropriate mental health and addictions services is a major concern to community-based leaders in Aboriginal health, health authorities, service providers and community members. Acknowledging that Aboriginal involvement is required to plan effective,

¹ In this thesis, I used the terminology by the Royal Commission on Aboriginal Peoples (1996) to refer to the Indigenous inhabitants of Canada. As such, I have used the term 'Indigenous Peoples' synonymously with 'Aboriginal Peoples'. The term Aboriginal Peoples refers to Status and non-Status First Nations, Métis and Inuit peoples. This specific nomenclature was used, when distinction between Aboriginal groups was needed.

accessible, and culturally safe health services, the BC Ministry of Health tasked health authorities to develop regionally-specific Aboriginal health plans and to increase Aboriginal participation at all levels of health planning (BC. Ministry of Health Planning, 2002; Interior Health [Authority] (IH), 2003; 2006). Since 2001, all of BC's health authorities have developed Aboriginal health plans in partnership with the local Aboriginal community, albeit independently from each other. As a result, despite some similarities, reform efforts and goals for reforming Aboriginal health care programming and delivery vary across health regions and are at different stages of implementation.

Within *Interior Health's Aboriginal Health and Wellness Plan* (IH, 2003; 2006), 'mental health' is highlighted as one of four key health priority issues. While IH's first Aboriginal health and Wellness Plan for 2003-2006 focused primarily on establishing a strong relationship between IH and Aboriginal communities through the creation of new Aboriginal participatory structures within the organization, at the time of this study in 2007, IH's Aboriginal mental health reform had shifted directions to a more action-oriented approach indicating that reform had progressed from the planning stage to the implementation phase of its Aboriginal health plan. Yet, very little is known about how mental health reform has unfolded and how it has impacted mental health and addictions care and service delivery for Aboriginal peoples.

Given the recent history of regionalization in BC, regional health authorities do not have a long history of citizen engagement; particularly with respect to Aboriginal peoples (Cheema, 2005). In addition, little is known about

what constitutes culturally safe mental health and addictions services and what culturally appropriate policy might look like. In 1999, the Aboriginal Mental Health Committee ('Best Practices' Working Group) was formed in response to inadequate Aboriginal mental health service delivery and the 1998 Mental Health Plan's shortcomings in addressing Aboriginal culture-specific needs (Smye & Mussell, 2001). The committee argued for mental health reform that addresses "the root causes of mental health problems such as intergenerational trauma, poverty, unemployment and lack of housing" while integrating Aboriginal traditions of spirituality (Smye & Mussell, 2001, p. 24). However, with the change of B.C.'s government in 2001 (from a social democratic to a liberal government), the committee was disbanded leaving regional health authorities with very little guidance on how to reform Aboriginal mental health care programming and delivery.

In the light of exclusionary and assimilationist practices and policies of the last century, this policy direction to increase Aboriginal participation in health programming to reform Aboriginal mental health could signify a shift of deeply rooted, colonial power dynamics toward a support of Aboriginal self-determination. However, challenges might arise not only from the lack of experience and guidance in how to implement Aboriginal participation and culturally appropriate services in mental health and addictions, but also from the broader socio-historical and political context. This includes an observed shift from a "collectivist" social policy to neo-liberal infused health care politics in BC (Morrow, 2004; Morrow, Dagg & Pederson, 2008; Fiske & Browne, 2008) and a

century of internal colonial practices, policies and politics (Browne & Smye, 2002; Smye, 2004; Browne, Smye & Varcoe, 2005). For example, in the context of rising health care expenditures, current mental health care treatment models are individually based and short-term focused. This ignores the unique needs of Aboriginal peoples whose mental health issues often involve a longstanding history of trauma, family violence and discrimination (Kirmayer, Brass & Tait, 2000; Kirmayer, Simpson & Cargo, 2003; Kirmayer, Tait & Simpson, 2009), and is likely to present challenges for professionals who search for avenues to create culturally safe services within the mainstream system. In addition, given the historically strained relationship between Canadian governments and Aboriginal leaders, the way to collaboration and partnership is likely to be rocky. Despite a relatively cohesive and comprehensive community-based Aboriginal mental health system, this community is by no means homogenous. Jurisdictional issues and the competitive resource allocation process have created tensions among Aboriginal organizations and left an overall distrust and scepticism toward governmental institutions (RCAP, 1996).

The purpose of this study is to provide a critical account of the impact of IH's mental health reform and its meaning for Aboriginal mental health and addictions programming and service delivery by exploring the diverse experiences of Aboriginal leaders and service providers in Aboriginal mental health and addictions within the institutional setting of Interior Health, as well as in community-based organizations on- and off-reserve within or adjacent to three urban centres in the Interior. The overall goal of this study is thus, to explore how

Aboriginal key stakeholders and service providers at various levels and settings of mental health programming and service delivery, experience the process of Aboriginal mental health reform, and to identify both incidences of Aboriginal empowerment² as well as barriers to social change within the context of Aboriginal mental health reform. Ultimately, it is hoped that the insights gained from this research will be used to inform ongoing Aboriginal mental health reform within Interior Health and other health authorities.

1.2 Review of the Existing Knowledge: Locating Aboriginal Mental Health Reform

1.2.1 Mental Health Policy and Aboriginal Peoples: Patterns of Tensions and Disjunctures

In Canada, the mental health burden carried by the Aboriginal population is much higher than for the non-Aboriginal population and despite a longstanding recognition of these critical mental health concerns, systematic inequities in mental health continue to persist. Evidence comes from both Aboriginal community and epidemiological studies. National suicide statistics from 1979 to 1994, for example, show that the suicide rate among First Nations peoples was three times that of the general Canadian population (Centre for Suicide

² I am aware that the notion of empowerment in the social and health disciplines has been criticised as paternalistic in that it conceptualizes a powerful-powerless dichotomy between professionals and clients (Powers, 2003). As Pease (2002) words it, “empowerment is often spoken of as something that is done to people, or that people do to others [with] those people who ‘do’ the empowering [being] increasingly likely to be health and welfare professionals” (p.137). Yet, while I agree that this critique holds true for individualistic notions of empowerment, I maintain in much the same way Townsend (1998) does, that if we understand empowerment as a social and political process aimed at creating more equitable relationships and practices at the organizational level, then empowerment can be a force for social justice. Thus, in this study I have used the concept of empowerment with caution but retain that is a useful concept for a critical exploration of IH’s Aboriginal mental health reform.

Prevention, 2003). And in 2000, 28 out of 100,000 deaths among Aboriginal peoples were due to suicide compared to only 13 for the general Canadian Public (CIHI, 2004). These findings are backed up by reports from Aboriginal communities themselves, who persistently identify depression, suicide, addictions and violence in the form of physical and sexual abuse, as key mental health issues that need immediate attention (Kirby Report, 2006; RCAP, 1996; BC. Office of the PHO, 2002). Given the persistency of these findings over time, from a population health perspective the central question is: *How are these disparities sustained?*

Historically, strong controversies regarding the role of government as well as jurisdictional responsibilities in the provision of health care to Aboriginal peoples have been a consistent feature and source of tension for Aboriginal health policy and remain so today. Despite acknowledgment of the Canadian government by its fiduciary obligation to provide health and health-related services, “the question of whether a treaty right to free, comprehensive medical services exists for Status Indians is one of the most controversial areas of Aboriginal health care” (BC. Ministry of Health Planning, 2002, p.86).

During the 19th century, provision of health care by local governments was seen as an act of benevolent paternalism and generally took the form of crisis relief. With the enactment of the *British North America Act* in 1867, however, legislative responsibility for health care and “Indians” was given to the federal government. As a result, provinces have historically tried to disclaim any role in providing health services to Aboriginal peoples (O’Neil, Lemchuk-Favel, Allard &

Postl, 1999). Even with the introduction of the Canada Health Act (1985), under which Canada adopted a publicly funded universal health care system (Department of Justice Canada, 2009), provinces continued to argue that all non-Canada Health Act matters, such as closing the health gap between the Aboriginal population and the rest of Canadians, fell under federal responsibility (Smye, 2004).

As for the role of the federal government, history shows that despite the stipulation of the *British North America Act*, the federal government was equally reluctant to take on responsibility for health service provision to Aboriginal peoples. The *Act* did not obligate the federal government to pay for medical care or provide for doctors and thus, in reality the money followed the settlements of 'white' people who held the right to vote (Kelm, 1998). Ultimately, only the necessity to contain the spread of diseases and associated health care costs resulted in a systematic provision of 'Indian' health services with paternalistic and authoritarian models of care that legitimized compulsory treatment in segregated facilities (Kelm, 1998; Smye, 2004). As a consequence, despite the government's recognition that Canada has a special responsibility for the health care of First Nations, "this responsibility is largely defined as a matter of policy and goodwill and is not considered by the courts to be a legal obligation" (BC. Office of the PHO, 2002, p.86).

One manifestation of this ideological conflict is the *Indian Act (1876)*. The Indian Act added another divide that complicated jurisdictional responsibility regarding the provision of health services to Aboriginal peoples in Canada. Smye

(2004) suggests that the classification of Canadian Aboriginal peoples into First Nations, Inuit and Métis “became one of the most divisive and destructive aspects of the Indian Act” (p.26) by tying legal rights and eligibility criteria to arbitrary boundaries that divided Aboriginal peoples into two mutually exclusive categories: the deserving versus the non-deserving “Indian” (O’Neil et al., 1999). Indeed, the introduction of the legal distinction between status and non-status Indians by the Indian Act formed the basic argument for both the federal and provincial governments to abdicate part of its responsibility to provide health care to Aboriginal peoples by restricting eligibility for health care to ‘Status Indians’ and people living on-reserve (O’Neil et al., 1999). As a result, the health needs and rights of Aboriginal peoples, particularly Métis and urban Non-Status First Nations, were often lost in the jurisdictional struggle of who has responsibility for what population of Aboriginal peoples (Smye, 2004).

One striking example of how these jurisdictional issues play out on the ground is the Downtown East Side of Vancouver, a community that is known to be the poorest neighbourhood in Canada with the highest concentration of Aboriginal peoples in Western Canada (RCAP, 1996). Despite the fact that the health and social conditions of Aboriginal peoples living in this neighbourhood is at least equally poor if not worse than for residents on-reserve, they are denied direct access to most federal funds and programs that are available to Status First Nations living on-reserve (O’Neil et al., 1999).

Under contemporary Aboriginal health policy, mental health services for Aboriginal peoples are to be provided collaboratively by regional, provincial and

federal governments in partnership with First Nations. On the provider level, regional health authorities have direct responsibility for providing health care delivery to all residents of British Columbia including Status First Nations, Non-Status First Nations, Inuit and Métis. However, while the majority of mental health services to Aboriginal peoples is provided through mainstream health services under the Medical Service Plan (MSP), there is a limited number of Aboriginal service providers working within the mainstream health care system.

Furthermore, mental health service delivery models that are designed in keeping with the dominant cultural views of mental health and illness, create barriers to access and often inadequately recognize the health care needs of Aboriginal peoples (Smye & Mussell, 2001). In addition, past experiences of racist attitudes by service providers and the stigma associated with mental health and addictions further undermines Aboriginal trust in mainstream services (Fiske & Browne, 2008).

As a result, Aboriginal peoples have constructed a disparate Aboriginal health care system that is characterized by a variety of Aboriginal-led not for-profit organizations on- and off-reserve, such as Friendship Centres and Aboriginal Health Societies. Despite different funding sources and jurisdictional mandates, these service providers identify as a distinct system. The funding for human resources and mental health and addictions programs comes from all three jurisdictions, regional, provincial and federal, and is usually proposal-driven or part of health transfer agreements. Urban Aboriginal organizations, such as Friendship Centres, for example, receive a large proportion of their funding from

regional health authorities, while the majority of on-reserve located programs and organizations are federally funded. Through these distinct Aboriginal-led organizations on- and off-reserve, Aboriginal peoples play a major role in mental health care delivery.

Yet, challenges arise for the integration and coordination of services not only between mainstream and Aboriginal systems but also within the Aboriginal system that operates within the old class structure of the Indian Act. Reflecting the historically strained relationship between Canadian governments and First Nations, funding for Aboriginal mental health and addictions programs has been notoriously scarce and short-term (RCAP, 1996). In recent years, however, First Nations have achieved some significant accomplishments in negotiations with both the federal and provincial government that will undoubtedly shape the provision of mental health care for Aboriginal peoples throughout BC; recent developments indicate that provincial as well as the federal government have renewed their commitment to close the social, economic and health gap between Aboriginal Peoples and the rest of Canadians.³ For example, following the

³ Following years of negotiations, in 2005, the National Aboriginal Leaders and Canada's First Ministers finally signed the Kelowna Agreement, which signifies a national commitment by Canada to strengthen the relationship between First Nations governments with provincial and federal governments and to close the gap in the areas of education, health, housing and economic opportunities. A substantial promise of funding accompanied the Kelowna Accord. In BC, the Accord triggered the ratification of the ten-year *Transformative Change Accord: First Nations Health Plan (TCA: FNHP)* (2006) by the British Columbia First Nation Leadership Council (FNLC) and the Province of British Columbia. This plan was inspired by the First Nations Health Blueprint for BC, published by the FNLC in 2005, and the Provincial Health Officer's Annual Report 2001. In addition, the FNLC and provincial government signed a Memorandum of Understanding with the Federal Government of Canada to develop a 10-year Tri-partite First Nations Health Plan by 2007, for which the TCA: FNHP ought to serve as a framework. On June 11th 2007, this plan was signed by all three levels of government and recent developments indicate that the implementation of this BC First Nations Health Plan is ongoing and paralleling Aboriginal mental health reform in the Interior Health.

recommendation of the Kirby report (2006), Canada established a First Nations, Inuit and Métis Advisory Committee to the Mental Health Commission of Canada (MHCC) in 2007. Yet, progress is rather erratic and characterized by many tensions as illustrated by Canada's recent refusal to sign the Declaration on the Rights of Indigenous Peoples adopted by the United Nations (UN) in September 2007.

1.2.2 Canadian Indigenous Health Movement: Aboriginal Healing

Understanding contemporary Aboriginal mental health requires a contextualized and historical approach that recognizes the aftermath and continued effects of colonization. The impact of colonization, systematic oppression and post-colonial forces of discrimination and institutional racism on Aboriginal bodies has been well documented (Kelm, 1998; Kirmayer et al., 2009; RCAP, 1996; Smye, 2004; Wade, 1995).

Colonization threatened practically every aspect of Aboriginal identity – individually as well as collectively (Smye, 2004; Kirmayer et al., 2009). European-introduced diseases, such as tuberculosis and smallpox, decimated Aboriginal peoples throughout the North American continent, while discriminatory and assimilationist government policies have led to a high degree of cultural, political and social breakdown of Aboriginal communities (Smye, 2004; RCAP, 1996).

For example, the imposition of the reserve system and the *Indian Act* (1876) by the federal government forced whole nations to give up their traditional lands and self-government (RCAP, 1996; Kirmayer et al., 2003; 2009). Under

intense governmental control and surveillance, First Nations were prohibited from openly expressing their own social institutional and traditional practices, such as the potlatch and the sun dance, that were integral to Aboriginal social, political and cultural life (Kelm, 1998; RCAP, 1996; Brasfield, 2001).

In addition, under compulsory residential school attendance, in many instances Native children were forcefully taken away from their families to be subjugated to an institutional Christian regime that fiercely suppressed and punished any expression of Aboriginal culture including the right to speak their native language (Kelm, 1998). Many former residential school survivors report on the high prevalence of sexual and physical abuse that occurred within these institutions. It is estimated that approximately one million children and in some instances, as many as five consecutive generations of children attended residential schools (Wade, 1995). BC had the most residential schools of all Canada; and the last school in BC was closed as late as in 1984 leaving behind about 35,000 British Columbian residential school survivors (RCAP, 1996).

As Kirmayer et al. (2003) notes, residential school experience has “had profound effects on Aboriginal peoples at every level of experience from individual identity and mental health, to structure and integrity of families, communities, bands and nations” (p.S18). On the individual level, narratives and life histories of residential school survivors suggest that former residential school students endure long-term psychological and social problems that manifest in the loss of individual and collective self-esteem and self-respect, internalised racism, substance abuse, suicide and a detachment to others, their families and cultural

communities (Kirmayer et al., 2009; 2003; Brasfield, 2001). In fact, Brasfield (2001) shows that in addition to a specific cultural impact, many residential school survivors experience symptoms that are characteristic of post-traumatic stress disorder (PTSD), such as “recurrent intrusive memories, nightmares, occasional flashbacks, and quite striking avoidance of anything that might be reminiscent of the Indian residential school experience” (p.79).

On the societal level, residential schools have had transgenerational effects on the Aboriginal community as a whole in that many Aboriginal communities and families are suffering from re-enactment of residential school trauma through the modelling of punitive parenting models, repetition of violence and abuse, and a lack of cultural belonging (Kirmayer et al. 2009; 2003). Subsequent to the closure of residential schools, many Aboriginal children have been apprehended from their families by the Child Welfare System and placed in non-Native foster families, where many of these children grew up with very similar experiences as their parents under the residential school system (Kelm, 1998).

Many Aboriginal families and communities are disrupted as a result of the legacy of policies of forced assimilation, such as the residential school system. They continue to struggle to overcome a history of individual and collective trauma, which has manifested itself in a wide range of health issues including high rates of mental health and addictions problems (Kirmayer et al., 2009; RCAP, 1996; BC. PHO, 2001; Smye, 2004). Cultural discontinuity, for example, has been strongly linked to the disproportionate problems of Aboriginal

communities with depression, addictions, suicide and family violence (Chandler & LaLonde, 1998;RCAP, 1995). According to a public opinion poll in 2002, 63 percent of Aboriginal participants reported that cultural discontinuity and loss of land have had a significantly negative impact on their health (Assembly of First Nations & Social Development Department, 2005). Conversely, studies found that the degree of control that First Nations communities have over civic life, such as education, health care, child and family services, and fire and police services, was negatively correlated with rates of suicide (Lalonde, 2005).

Furthermore, without access to higher education and employment opportunities, formerly self-sufficient nations were forced into state-dependence through the welfare system and the Department of Indian Affairs, making poverty endemic to many Aboriginal communities in Canada. Today, poverty, employment and housing are identified as key social determinants of Aboriginal mental health with some researchers calling Aboriginal suicide rates indicators of needy communities (Cooper, 1995; BC. Office of the PHO, 2002; RCAP, 1996).

The cumulative losses in population, land and economic resources, language and cultural teachings, self-government and self-sufficiency “mortally threatened holistic health while disrupting the ways and means through which health was taught, maintained, and restored” (Mussell, Nicholls & Adler, 1991, p.21). As a result, the circle of life was disrupted leaving wounds and scars on the bodies and minds of Aboriginal peoples, families and generations to come (RCAP, 1996; Kelm,1998). Hence, healing requires not only improving the physical health of Aboriginal peoples but recovery from the experiences of

powerlessness and dependency as well as from the damage to Aboriginal cultures, identities and self-esteem (RCAP, 1996).

A major contributor to building a vision regarding healing for Aboriginal Peoples in Canada was the work of the 1996 Royal Commission on Aboriginal Peoples. After extensive community consultation, the Commission published its final report five years after its creation. The following key principles and values identified for healing remain progressive ideas for Aboriginal health policy today and are consistent with Aboriginal perspectives articulated in the 2001 Provincial Health Officer's Annual Report on the Health and Well-being of Aboriginal Peoples in British Columbia and the recent report on Canada's mental health care system by Senator Kirby (Kirby Report, 2006; BC. Office of the PHO, 2002):

- 1.) Adoption of a formal commitment to improve Aboriginal Health;
- 2.) Recognition of the issues and challenges faced by Aboriginal peoples;
- 3.) Support for Aboriginal self-determination and control;
- 4.) Fostering of greater participation of Aboriginal peoples in designing, delivering and governing of programs;
- 5.) Improvement of the social determinants of health, such as economic prospects and housing; and
- 6.) Promotion of culturally appropriate, holistic approaches to health.

According to Brant Castellano (1999), "the healing process gains strength from many sources, but principally from rekindled confidence in traditional wisdom and a political-historical analysis of the genesis of present distress" (p.

95). As such, there has been resurgence of traditional ways of healing and healing concepts among Aboriginal communities.

Under the conditions of colonization, Aboriginal systems of medicine were disrupted, delegitimated and challenged through new infectious diseases and Western forms of medicine. However, they did not disappear. "Aboriginal ideas about the body, disease, and medicine, then, were not just remnants of some pre-contact past but were living ways of viewing the world" (Kelm, 1998, p.84). Traditionally, Aboriginal peoples understand health as a holistic concept, which results from a harmonious balance or equilibrium between different spheres of life, such as the physical, mental, spiritual, and social dimensions (Mussell, 1991; Smye & Mussel, 2001; Waldram, 2004). "Holism (as Aboriginal peoples use the term) means sensitivity to the interconnectedness of people and nature, of people and their kin and communities, and within each person, of mind, body, emotions and spirit" (RCAP, 1995, p.83). Family as an institution is central to Aboriginal culture and many Aboriginal peoples have argued that rehabilitation of Aboriginal families has to be part of the path to personal and community healing (Mussell, 1991). Hence, successful community initiatives distinguished themselves from mainstream services through the high degree of family involvement, a multi-disciplinary team approach and the mobilization of whole-communities under Aboriginal authority (RCAP, 1996). In the discussion paper on what works best for Aboriginal communities, the Aboriginal Mental Health "Best Practices" Working Group concludes that community-based initiatives and a balanced approach to mental health including treatment, prevention and health

promotion strategies have proven to be more effective than treatment-oriented mainstream services under non-Aboriginal authority (Smye & Mussel, 2001).

Yet, there is a continuing influx of Aboriginal people from reserves to urban settings who will be seeking mental health and addictions care and little is known about what actually supports Aboriginal mental wellness/health in mental health and addictions settings within the urban context. While Aboriginal-led health organizations have found ways to incorporate traditional healing elements (e.g., sweats, smudging and talking circles), mainstream mental health and addictions services that are designed in keeping with dominant cultural (biomedical) views of mental health and illness, ignore unique cultural identities and the shared socio-historical and political contexts of Aboriginal peoples (Smye & Mussel, 2001; Waldram, 2004).

As such, within the Indigenous health movement, the inclusion of Aboriginal voices in mental health care programming and delivery is imperative for improving Aboriginal health, overcoming system-related barriers to access, and to incorporating the element of choice for Aboriginal healing if so desired. However, while Aboriginal self-determination is central to the Canadian Indigenous movement, it manifests differently for on- and off-reserve Aboriginal communities. On-reserve, the primary mechanism for Aboriginal communities to increase self-governance is through different degrees of health transfer. In contrast, urban Aboriginal communities are deprived from this right. Instead, for off-reserve Aboriginal service providers and organizations, the notion of Aboriginal self-determination is engrained in the discourse of increased

participation and shared decision-making power in health policy and practice in partnership with regional health authorities. As such, many health authorities have pursued a human resource plan for Aboriginal peoples including the formation of formal mechanisms of participation for Aboriginal peoples into health planning and implementation. However, in the light of BC's diversity of First Nations and the cultural mix among urban Aboriginal peoples, the questions of fair representation and inclusiveness have become central and sceptics maintain that participation often remains token.

1.2.3 Mental health reform and Aboriginal participation

Mental health care reform in Canada has been linked to two concurrent, interrelated processes that are reflective of the broader project of health reform over the past decade. The first one is a shift toward greater public participation in policy and decision-making processes, and the second is the re-arrangement of fiscal and service-delivery structures as part of a nation-wide regionalization initiative, which decentralized the mental health care system within provinces (Morrow, 2004; Morrow, Dagg & Pederson, 2008).

British Columbia adopted a province-wide regionalization initiative in the early 90s (Davidson, 1999).⁴ The rationale for this was the assumption that decentralized health care planning and delivery would be more responsive to

⁴ Following the recommendation by the Royal Commission on Health Care and Costs in 1991, BC launched a province-wide regionalization initiative to restructure and reorganize health care delivery and administration. Under the New Directions (1993) policy, the goals of regionalization were articulated as i) increasing public participation and community engagement; ii) increasing effectiveness of organization and management; iii) improving local accountability; and iv) enhancing accessibility of services through better integration and coordination of services. (BC. Ministry of Health and Ministry Responsible for Seniors, 1993)

local needs and locally accountable through the fostering of public participation and participatory democracy (Weaver, 2006). Public participation in health care decision-making was the cornerstone of a progressive, new public management style that played a vital role in the empowerment of mental health consumers as illustrated in the emergence of new mechanisms for consumer participation in health care decision-making during the 1990s. The rise of Health Promotion and the adoption of a Population Health approach in health policy further promoted citizen engagement as a tool to empower traditionally marginalized populations (Davidson, 1999). According to the Canadian Mental Health Association (CMHA) both 'empowerment' and 'consumer participation' are named as mental health promotion principles that should guide mental health policy and practice (1999). As a result, regionalization has become a consistent feature of BC's health care reform for almost two decades.

Although BC's government is currently in the process of developing a new 10-year Mental Health and Substance Use Plan for BC (British Columbia, 2009), it is still the 1998 Mental Health Plan, *Revitalizing and Rebalancing British Columbia's Mental Health System*, that sets out the objectives and strategies for BC's most recent mental health reform (BC. Ministry of Health, 1998). The plan was a product of an extensive consultative process across the province and was designed to improve the quality of care for people with serious and persistent mental illness; that is those who experience long-term mental illness and disability, such as schizophrenia, bipolar or other affective disorders. In doing so, it called for the creation of mechanisms for the participation of mental health care

recipients in mental health care decision-making and for regional self-sufficiency for mental health services through the devolution of formerly provincially controlled tertiary mental health resources, such as BC's single large provincial psychiatric institution, Riverview Hospital, to regional health authorities.

Although regionalization has commonly been associated with the process of devolving decision-making power and responsibility from the Ministry of Health to new regionally defined structures (BC. Royal Commission on Health Care and Costs, 1991), in practice, regionalization of BC's health services involved both amalgamating of local structures as well as decentralizing of government.⁵ According to Church and Barker (1998), "regionalization may entail the shifting of responsibility for public health from a series of local boards to a regional agency, or a general devolution of power from a central governing agency to regional bodies" (p.468). For Aboriginal communities, both manifestations of regionalization, centralization and decentralization of health service administration and delivery structures, hold concerns.

Since Aboriginal peoples make up only a small percentage of the overall population and are geographically dispersed, decentralization may disproportionately disempower Aboriginal peoples. Thus, the composition of health boards and councils, how they are selected and who they represent

⁵ Modifications to the original plan outlined under *New Directions* (1993) show that the implementation of regionalization became increasingly more a function of centralization and amalgamation with regional jurisdictions representing increasingly larger geographical areas (Davidson, 1999). Originally, the NDP planned to amalgamate over 700 different agencies (hospital boards, long term care agencies and provider associations) to 82 Community Health Councils (CHCs) subordinated to 20 Regional Health Boards (RHB), which in turn were to be managed by the Ministry of Health. However, in 1996, this policy was replaced by *Better Teamwork, Better Care* (1996), which initiated a new phase of restructuring that drastically reduced the numbers of CHCs and RHBs (Davidson, 1999).

become key issues in a regionalized health care system. Peoples who are socially and economically disadvantaged in society are usually excluded from participation in decision-making due to systematic barriers, such as lack of resources in terms of education, skills, wealth and trust (Cheema, 2005). Yet, under the social democratic government in the 1990s, some safeguards for Aboriginal peoples were implemented. These included the mandate to have one Aboriginal governor on each Regional Health Board and Community Health Council (Cheema, 2005) and the creation of six regional Aboriginal Health Councils (AHCs) throughout the province and one Aboriginal Health Association of BC (AHABC) (BC. Ministry for Health Services, Aboriginal Health Division, 2001).⁶ The six regions were geographically defined and included the Lower Mainland (LMAHC), Fraser Valley (FVAHC), Thompson-Okanagan-Kootenay (TOKOAHC), Vancouver island/Central Coast (VICCAHC), Northeast (NEAHC) and Northwest (NWAHC).

While this system for Aboriginal participation in health-care decision-making seemed to be relatively separated from other regional health structures, it reflected a very high degree of community connection, particularly with Aboriginal organizations that are not part of the mainstream health care system, such as Aboriginal Friendship Centres.

⁶ Each AHC determined its own members who were selected to represent First Nations, urban, rural and Métis. The AHABC was composed of two members from each AHC and functioned as a coordinating body on the provincial level. As part of their mandate, each AHC conducted an annual consultation with Aboriginal service providers and community members to decide on regional priorities and funding allocation for program proposals in addictions, mental health and family violence submitted by Aboriginal organizations. Each region had a designated host agency with the position of a regional coordinator, which was contracted by the Aboriginal Health Division, Ministry of Health Services, to manage funding allocations to approved proposals by Aboriginal organizations in its region (BC. Ministry for Health Services, Aboriginal Health Division, 2001).

Yet, with the election of the Liberal government in 2001, the entire spectrum of Aboriginal health including strategic planning, service delivery and resources allocation was centralized and given to regional health authorities (Cheema, 2005). This restructuring involved the rapid amalgamation of 52 regional health boards and local councils to the current structure of five geographical and one provincial health authority (Weaver, 2006).

In many parts of BC, the establishment of these new regional intermediary structures was accompanied by the closure of local facilities and disbanding of existing local governance structures creating gaps in services while simultaneously removing avenues for citizen engagement (Kornelsen et al., 2005). According to Creese and Strong-Boag (2005), “shifts in the provincial health care system that centralize and reduce services over the last few years have particularly endangered residents in isolated and rural parts of the province” (p.14). Particularly hard hit are women, Aboriginal people, immigrants, the elderly and peoples with disability who experience various social disadvantages, such as poverty, social and geographic isolation and discrimination.

However, Aboriginal health has been kept a Ministry-mandated requirement. While the Aboriginal health council structure along with the mandate to appoint Aboriginal governors to health authorities was abandoned (Cheema, 2005), health authorities were given the mandate to develop regionally-specific Aboriginal health plans with the requirement to increase Aboriginal involvement in decision-making and planning and establish a meaningful working relationship with the Aboriginal community (BC. Office of the PHO, 2002).

Yet, no formal evaluation has been conducted to assess the degree of participation by Aboriginal peoples in regional health decision-making and so little is known about how regionalization has impacted Aboriginal decision-making or mental health and addictions service provision. Scanning the academic literature on regionalization and Aboriginal peoples yielded few publications, but some findings indicate, that despite increased Aboriginal participation in the design, delivery and evaluation of health services, there are many tensions in participatory Aboriginal health planning (Cheema, 2005). An assessment by the BC Leadership Council on the development and implementation of Aboriginal health plans, for example, concludes that “the participation of First Nations has, for the most part, been considered ineffective” (BC. First Nations Leadership Council (FNLC), 2005, p. 24) indicating that meaningful participation of Aboriginal peoples in health care planning remains limited.

Meaningful consumer participation is intimately tied to the concept of empowerment. According to Labonte (1993), “within empowerment theory, meaningful consumer participation occurs when consumers are invited to join in the problem-naming and problem-solving process, share decision-making authority, have resources for participation, and are accountable to the individuals/communities that they represent” (CMHA, 1999, pp.9-10). However, Church and Barker (1998) argue that “the claim that local governments, by virtue of their size and proximity to voters are more responsive and more accountable is flawed in several respects” (p.480). The degree to which regionalization promotes public participation and empowerment is closely connected to existing

power relations embedded within the health system, which are not necessarily shifted through regionalization. For example, meaningful participation of citizens requires training, adequate knowledge and information as well as organizational support (Cheema, 2005). Without appropriate training, the role of public participants who represent special interest groups, such as mental health consumers, are often reduced to token participation while health care providers and administrators virtually hold the monopoly of highly specialized knowledge. “The net result is that certain interests have both the incentive and the resources for continuing participation in the policy process, whereas others often lack either incentive or the resources to maintain a continuing presence” (Church & Barker, 1998, p.480).

As a result, the effects of regionalization on Aboriginal participation in mental health care decision-making and Aboriginal empowerment, more generally, are controversial. Contemporary critics argue that regionalization has brought about new tensions that challenge the progressive elements of health care reform, such as public participation and control, and the adoption of a population health approach (Morrow, 2004; Morrow, Dagg & Pederson, 2008; Morrow, Wasik, Cohen & Perry, 2009 in press). As such, providing for Aboriginal participation in mental health care planning and programming is clearly a challenge for BC’s health authorities. As the case of IH indicates, having only a recent history, regional health authorities in British Columbia are still experimenting with how to implement meaningful Aboriginal participation in

mental health planning and programming, warranting more research to support current reform efforts and their goals.

1.3 Research Questions

The overall goal of IH's Aboriginal health framework is "to create a *respectful, trusting, responsible partnership* between Aboriginal People and Interior Health to support the development of a *holistic health and wellness system* that is responsive to the needs of *diverse Aboriginal Communities*" (IH, 2006, p.6). Yet, little is known around how regional reform processes unfold. For example, what processes and mechanisms are successful in increasing Aboriginal participation in IH and how has reform impacted culturally appropriate mental health and addictions programming and delivery? Against the backdrop of the complex socio-historical and political realities described above, IH's Aboriginal mental health reform initiatives have to confront longstanding barriers for change. For these reasons, this research is exploratory. The purpose of this study is to elicit and explicate the perceptions that Aboriginal key leaders and service providers in the mental health domain hold regarding the key issues surrounding regional Aboriginal health reform within Interior Health. To enable participants to reflect on their experiences under Aboriginal mental health reform processes from different angles, the study was guided by four research questions:

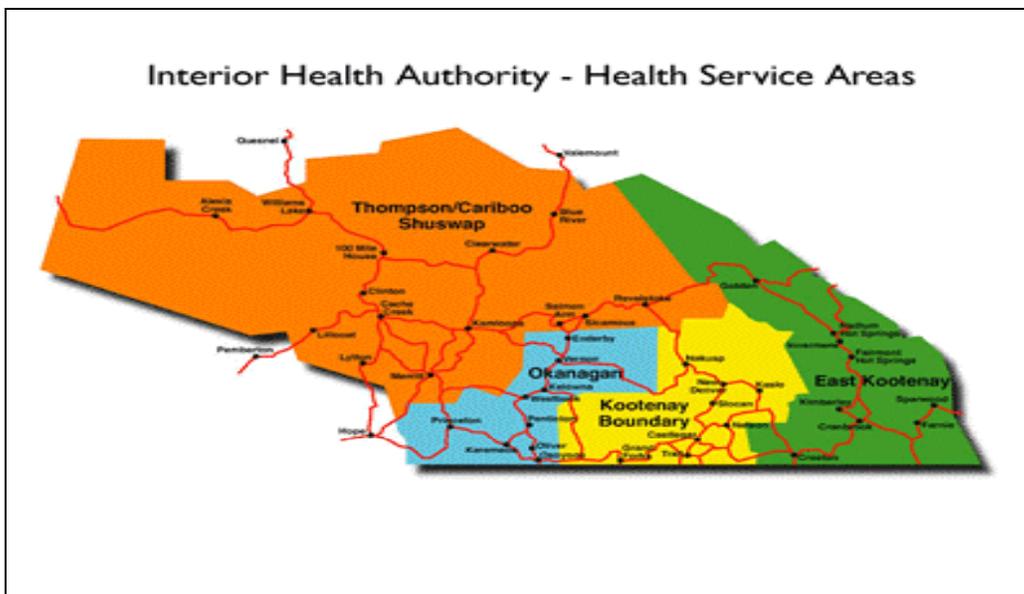
- 1) What kind of mental health services are provided for Aboriginal people and how are they accessed?

- 2) How do Aboriginal mental health services interface with mainstream mental health services given provincial-federal jurisdictional issues?
- 3) How are historical and current mental health reforms impacting Aboriginal mental health? And,
- 4) What would culturally appropriate services and policy look like?

1.4 Research Setting: Interior Health

IH represents one of six health authorities in BC that were created in December 2001. Its responsibilities include the planning and provision of services and programs for four health service areas: Thompson/Cariboo Shuswap, Okanagan, Kootney Boundary and East Kootney areas, that vary not only size but also in socio-demographic factors (IH, 2005; IH, 2003)

Figure 1: Interior Health Region



(IH, 2005)

IH serves a population of approximately 700,000 residents over a geographical area of 200,000 square kilometres (Interior Health, 2005) including many rural and remote settlements as well as some larger urban centres, such as Kamloops and Kelowna in the Thompson/Cariboo Shuswap and the Okanagan respectively. According to the 1996 Statistics Canada Census, Interior Health is home to 28,370 Aboriginal people; 21,310 are First Nations, 5,890 Métis and 175 Inuit (IH, 2003). Together, Aboriginal peoples make up approximately 4.3% of the total population in IH. Today, there are nine Nations including the Secwempc, Okanagan, Ktunaxa, T'silhqot'in, Nlaka'pamux, St'Wixt, Carrier, St'at'imx and Métis. However, only about 33.5% of the Aboriginal population is living on-reserve.

Under the *IH Authority Performance Agreements* between IH and the BC Ministry for Health services, IH holds the mandate for Aboriginal health (both 2002/2003). In 2003, there were approximately 70 Aboriginal health organizations throughout the Interior Health Region (IH, 2003), many of whom are still providing mental health and addictions care to Aboriginal peoples, primarily within urban settings. In the absence of the Aboriginal Health Council structure, IH administers the funding allocation for these programs. To a lesser degree, resources can also be allocated through the historically proposal-driven Aboriginal Health Initiative Program (AHIP), which provides funds for community initiatives within addictions, mental health and chronic diseases (IH, 2007).

As per Ministry-mandate, IH developed its first Aboriginal regional health plan, *IH's Aboriginal Health and Wellness Plan*, in 2002 (IH, 2003). The plan was revised in 2003 and 2006, and identifies Aboriginal mental health as a priority for the entire region. At the time of the study, the creation of new Aboriginal participatory structures within IH indicated that IH's Aboriginal mental health had advanced from the planning stage to the implementation phase of its Aboriginal health plan.

Building upon my prior involvement in other research projects⁷ in the IH, preliminary relationships with some Aboriginal community leaders had been established but little was known about the needs and concerns of Aboriginal communities in the Interior. Thus, IH presented a unique opportunity to explore how Aboriginal key stakeholders and service providers at various levels and settings of mental health programming and service delivery, experience the process of Aboriginal mental health reform, and to examine both incidences of Aboriginal empowerment as well as barriers to change within the context of Aboriginal mental health reform.

Since it is beyond the scope of this study to cover an area as large and diverse as the entire IH region, the study concentrated on the experience of Aboriginal service providers and key stakeholders within the area of three urban

⁷ In the SSHRC funded research project "Community Capacity, Gender and Mental Health Reform" (CCGAMH), Dr. Morrow and her team conducted an institutional ethnography of the recent devolution of the single large provincial psychiatric facility in B.C., Riverview Hospital. The CCGAMH project examined two towns in the IH to identify any challenges in establishing regional self-sufficiency in mental health. As part of the team, I conducted two fieldtrips to IH and was involved in ethnographic interviews and focus groups with service providers, staff and key informants within the domain mental health.

centers within two health service areas in IH. Thus, this research cannot account for differences between rural and urban areas, and differences across Aboriginal Nations or cultures. However, given the high proportion of Aboriginal peoples living in urban centres, this research sheds light on how IH's reform in Aboriginal mental health unfolds.

2: METHODOLOGY & METHODS

Reflecting colonial values and beliefs of Western superiority, the large majority of health research has been done *on* instead of *with* Aboriginal peoples resulting in either inaction or poorly designed policy or programs (First Nations Centre, 2007). Tuhiwai Smith (1999) suggests that the cultural formations of Western research draw on ideas that classify Aboriginal peoples as the “Others” and marginalize Aboriginal ways of knowing. Coloured by predominant Western disciplines and scientific paradigms, research often has been used to prove the cultural deficiency or inferiority of the Aboriginal ‘race’ relative to the standards set by the dominant Western society. With the rise of positivism and bio-medicine as the prevailing research paradigms in the early 20th century, these differences became measurable and quantifiable. By and large, Aboriginal peoples only participated in so far that they were the ‘objects’ of Western research, while non-Aboriginal researchers decided on what information was relevant and how to collect and interpret it. In the absence of Aboriginal input, poor scoring of Aboriginal peoples on such variables as health, economic and social well-being, has directly feed into existing stereotypes and racist ideas of the inferior “other” (O’Neil, Reading & Leader, 1998; Smye, 2004; Fiske & Browne, 2008). As such, Aboriginal peoples legitimately have expressed strong scepticism and criticism towards research. Current national and international ethics guidelines highlight the importance for researchers and Research Ethics Boards (REBs), who are

involved with Aboriginal communities, to practice research that is participatory and respectful to Aboriginal cultures, knowledge and diversity (Canadian Institutes of Health Research (CIHR), National Health and Medical Research Council of Australia & Health Research Council of New Zealand, 2004; CIHR, 2005; First Nations Centre, 2007).

2.1 The Researcher's Point of Entry

As a non-Aboriginal researcher, I am very aware of the harm that research has inflicted on Aboriginal communities and the ethical challenges that are intrinsically connected to my status. However, borrowing Geeta Cheema's words (2005), "my scope of thought and understanding [of my role as a non-Aboriginal researcher] is not reducible to a linear extrapolation of mainstream social mores and assumptions" (p.29), but draws on my personal, experiential and academic knowledge of how different societies have constructed power differentials according to such variables as culture, education, gender, 'race' and ability.

My experiences as a nurse working with marginalized people and my own immigration experience to Canada have profoundly shaped my understandings of privilege and oppression and the fluidity of these concepts, in that one can be both oppressed and privileged at the same time.⁸ In addition, in transitioning from one society to another, I became aware of the trajectory of different social and

⁸ For example, as a 'white', educated and able woman, I was aware that my 'immigrating process' was much easier in that I did not experience discrimination on the grounds of my appearance. At the same time, however, I learned what it feels not to possess the cultural capital to integrate completely due to language barriers and lack of understanding or connectedness to Canadian values and traditions. In addition, I experienced a deprivation of many rights that one usually takes for granted and the struggle to overcome bureaucratic barriers and immigration laws to gain back at least some of my citizen rights, such as the right to work in my profession.

political systems on the health and well-being of populations. Imbued with a strong sense for social justice and belief in human rights, I developed a particular interest in Aboriginal mental health. As a result, I have chosen an academic career within the realm of population and public health with a special interest in social and health inequities.

Population health reconciles my beliefs and experiences with a theoretical framework linking political and social experiences to health. The goal of population health is to prevent illness and promote health by reducing inequalities “in the underlying conditions that put some Canadians at a disadvantage for attaining and maintaining optimal health and well-being” (Federal, Provincial and Territorial Advisory Committee on Population Health for the Meeting of Ministers of Health, 1999, p. 173). As far back as 1848, Rudolf Virchow, a German physician and the father of social medicine, declared that “politics is nothing else but medicine on a large scale” (Raphael, Bryant & Rioux, 2006, p.116). While Virchow’s statement can be understood as a critical reflection on the impact of economic and political changes, such as neo-liberalism and globalization, on health within a democracy it also provides a springboard for social change: if health is political, then we not only hold the capacity but also the responsibility to endorse health as a human right.

I have entered this work with certain ideas, assumptions and biases despite my attempt as a researcher to be objective to the extent possible. One of these beliefs is that Aboriginal mental health and well-being are intimately tied to structural justice that includes both meaningful Aboriginal participation in mental

health programming and delivery as well as a cross-sectoral, social determinant approach to mental health.

While I feel that these values and beliefs are congruent with the Canadian Indigenous health movement, I am aware that my position and identity as a non-Aboriginal researcher have consciously and unconsciously influenced my research approach and interpretation of the data. However, I believe that my academic background and knowledge, gained from my nursing work and immigration experience, have served me well in this research project, and enhanced my sensitivity and awareness to different forms and shapes of oppression on an individual as well as on a systemic level.

2.2 Methodologies

In an attempt to choose a methodology that would be judged respectful and participatory by Aboriginal peoples, I have drawn from a variety of research methodologies that lay the foundation for a critical inquiry into the experience of Aboriginal mental health professionals, service providers and managers toward Aboriginal mental health reform in the Interior Health. In particular, this study applies a postcolonial-feminist framework.

While postcolonial theories share with feminist theories a common political and social concern with structural inequities, a distinguishing feature of postcolonial theory is its preoccupation with race and racialization⁹. Originating from interdisciplinary perspectives, postcolonial theory is a critical inquiry into

⁹ The term racialization, first coined by Fanon (1967), refers to a process of racial categorization by attributing social, economic and cultural differences to (supposedly) inherent or biological differences that define the 'Other' (Browne, Smye & Varcoe, 2007).

colonial and neocolonial practices of the past and present in maintaining and perpetuating race-based differences by using the perspectives of the marginalized as the starting point of analysis (Browne et al. 2007; Anderson, Perry, Blue, Browne, Henderson, Khan, Kirkeim, Lynam & Semeniuk, 2003; Young 2001). Postcolonial discourse thus provides an analytical frame that is most relevant for understanding the complexities of health and social inequality for Aboriginal peoples in Canada and elsewhere who share a recent history of colonization (Anderson, 2004; Browne et al., 2007). However, one critique of some forms of postcolonial theory has been its preoccupation with 'race' and its lack of attention to other analytical dimensions, such as gender (Gandhi, 1998). Another relevant closely related concept that draws on postcolonial theory for understanding how health inequities are sustained and perpetuated by the health care system itself is 'cultural safety' (Aboriginal Nurses Association of Canada (ANAC), 2009). As a critical analytical lens, cultural safety enables researchers and care providers to address access barriers to mental health care and culturally unsafe mental health service provision by exposing them to the socio-historical and political context of Aboriginal health and the ethnocentric and assimilationist policies, and practices inherent in mental health care delivery (ANAC, 2009).

Some forms of feminism on the other hand, have been criticised for their gender essentialism; the ways in which experiences of European women were generalized to be true for all women, subordinating experiences of race and class (Morris & Bunjun, 2007; Hankivsky & Cormier, 2009). In particular, feminist

scholars of Colour and Indigenous scholars have contested the way in which, “the experiences and struggles of women of colour [and indigenous women] fell between the cracks of both feminist and anti-racist discourse” (Davies, 2008, p.68) proposing an alternate concept to understand the experiences of women of Colour, Aboriginal women and many immigrant women (Hankivsky & Cormier, 2009; Davies, 2008).

As a theoretical paradigm,” ‘intersectionality’ emerged from U.S. Black feminism, Indigenous feminism, third world feminism, queer and postcolonial theory” (Hankivsky & Cormier, 2009, p.3). An intersectional analysis seeks to better understand the ways in which gender intersects with other identities defined through such social categories as skin colour, ‘race’, culture, ancestry, gender, ability and socio-economic status, and their relation to power (Association for Women’s Rights in Development - AWID, 2004; Davies, 2008). The premise of intersectionality is that intersecting social categories create a unique constellation of different of types of discrimination and privilege producing a distinct experience (Hankivsky & Cormier, 2009).

Inclusive of multiple axes of analyses, intersectionality moves beyond binary thinking (black/white and colonizer/colonized) to embrace the idea of interlocking systems of oppression and privilege (Anderson, 2004). Using views from the margins as the starting point of inquiry helps us to understand how policies, programs and institutions construct, maintain and perpetuate systems of oppression and privilege according to such social phenomena as race, class and gender (Browne et al., 2007). Black feminists, such as Bell Hooks (1984) and

Patricia Hill Collins (1990; 2004), argue that using the standpoint of marginalized women as the starting point of critical inquiry is essential to unmask hierarchies of oppression and discriminatory practices since, “dominant groups are especially poorly equipped to identify oppressive features of their own beliefs and practices” (Harding & Norberg, 2005, p. 2010).

Given the analytical scope and the limitations of postcolonialism and feminism, some scholars argue that the theoretical symbiosis of both perspectives is imperative when examining and “addressing the health concerns of diverse populations, such as Anglo-Canadians, immigrant populations, women of Colour, Aboriginal women, and health care providers” (Browne et al. 2007, p. 126). Anderson (2004) suggests that perhaps the richest analysis stems from stitching together different theoretical perspectives. In Canada, postcolonial feminist theories have been successfully applied to variety of issues including inequities in health and access to health care and have proven to be extremely valuable for both qualitative and quantitative Aboriginal health research (Browne, et al., 2007). However, despite its potential to mitigate social inequities and to promote social justice, Anderson (2004) warns that if postcolonial-feminism is not applied as an inclusive framework and turned into a methodology “for the marginalized, by the marginalized, rather than [a] scholarship that informs both margin and ‘center’” it will be rendered impotent as a tool for social change (p. 245). Thus, the lessons learned from post-colonialism is that oppression and privilege occur in a specific context and that “depending on the context, an

individual may be an oppressor, a member of an oppressed group, or simultaneously oppressor and oppressed” (Collins, 1990, p. 225).

In conclusion, the value of drawing on postcolonial-feminist theory for health researchers lies in its critical reflection on the status quo and the socio-political and historical context. It holds out the promise to generate awareness and knowledge of the ways in which inequities in the health care context are perpetuated and maintained by unequal relations of power and issues of domination and subordination based on relations of ‘race,’ class and gender.

2.3 Methods

Drawing on these methodologies, I adopted *institutional ethnography (IE)* as an analytic lens. Dorothy Smith (1987) first introduced IE as a method of inquiry to explore how everyday life and practice are organized through social relations and institutional structures. In her classical feminist text *The Everyday World as Problematic* (1987), Dorothy Smith uses the experience of women to describe how gendered experiences and knowledge are produced. IE has also been successfully applied to investigate a variety of social processes and institutions (Devault & McCoy, 2002).

Although not limited to the organization of health care (Smith, 2006; Mykhalokovskiy & McCoy, 2002), IE has been widely used to investigate social processes and ruling relations in the health sector. Elizabeth Townsend (1998), for example, investigated the work of occupational therapists and the tension between their professional goals to empower peoples with mental illness and

everyday practice. Other recent examples include the work by Mykhalokovskiy and McCoy (2002), who applied IE in community-based research to explore the social organization of “health work” by people living with HIV/AIDS, and the scholarly contributions by Rankin and Campbell (2006; 2009) who investigated the organization of health knowledge in nursing work within Canadian hospitals.

IE uses individual experiences as the starting point to inquire into how these experiences are produced (DeVault & McCoy, 2002). Instead of researching their subjects, institutional ethnographers rely on peoples’ implicit knowledge of how policy and ruling relations affect their practice and lives to explicate how ideological and social processes translate into experiences of oppression and privilege. In other words, IE helps to reveal the ways in which social relations and practice are organized by race, class and gender (Dobson, 2001). As such, IE promised to be a valuable strategy for exploring Aboriginal mental health policy reform processes in the IH and its connection to organizational practice from the standpoint of Aboriginal key leaders, mental health professionals and service providers.

2.3.1 Ensuring Scientific Quality

For qualitative research, the credibility of findings has been termed to be the most appropriate criteria for evaluating the rigor of a study. The notion of credibility is closely related to the concept of ‘internal validity’ and refers to the “trustworthiness” and “authenticity” of the research (Creswell, 2003; Kincheloe & McLaren, 2000; Denzin & Lincoln, 2000). Non-structured or semi-structured

interviews are often the method of choice for qualitative researchers and internal validity is seen as a strength of qualitative research (Creswell, 2003).

To validate the accuracy of findings in qualitative research, Creswell (2003) suggests eight primary strategies: 1) Triangulation: the process of using different data sources, 2) Member-checking of data or findings by research participants, 3) Rich and thick description when describing findings; 4) Self-reflection of the researcher to “clarify the bias the researcher brings to the study”; 5) Seeking negative or discrepant information within the data, 6) Prolonged time in the field, 7) Peer-debriefing and, 8) External auditor¹⁰ (p.196). As described in the following section, these strategies have been incorporated throughout this study.

Institutional ethnographic investigations rely on qualitative procedures, and draw on diverse methods and diverse sources of evidence. In this study, I collected data using two key features of ethnographic research: Interviews and documentary review. In addition to these two different sources, I conducted an extensive literature review on Aboriginal mental health reform providing a coherent justification for my later analysis. To promote the transparency of this study, I provide the critical reader with excerpts of the interviews and a thick description of the research process drawing connections between my methodology, methods and data analysis. Within the description of the research process, I make references to several self-reflective practices, such as the writing

¹⁰ To obtain my Master’s degree at Simon Fraser University, I will be required to defend the accuracy of my findings against the scrutiny of an external auditor, who will have significant expertise in the field of qualitative research and Aboriginal health.

of a research journal, the formulation of fieldnotes after each interview and several peer-debriefing sessions with my supervisory committee throughout the study process. By using those strategies, I was able to critically reflect on my own social location and epistemologies, which helped me to build rapport and relationships with participants as well as to be open for new ideas and different angles. In addition, I conducted two field visits, in which I spent one week each exploring sites and communities. This provided me with the appropriate context to understand participants' account of their everyday experience. Furthermore, I used the richness of the data I collected and drew on both differences and similarities in experiences to provide a credible description of the complexities embedded in the social organization and processes of Aboriginal mental health reform.

However, as described in chapter 1, the focus of this study is on exploring the key issues experienced by Aboriginal mental health service providers and key leaders within, and in the proximity of, three urban centers within two of IH's health service areas. As such, this study cannot account for differences in terms of urban versus rural experience.

2.3.2 Research Process: From Theory to Practice

Although there is no 'one way' to conduct an institutional ethnographic investigation, classic IE research can be broken into three interlocking sequences (DeVault & McCoy, 2002). First, the researcher identifies an experience or everyday practice. Secondly, the IE researcher identifies some of the institutional processes, texts and forms of knowledge that produce this

experience. Dorothy Smith (1987) refers to these social processes as ‘ruling relations’. Thirdly, the IE researcher seeks to analyze and describe the ideological and social processes that lead to the experience.

2.3.2.1 Beginning with the Experience

Ethnographic research methods are aimed at discovering and exploring everyday experiences and their determinants. They range from participant observations to focus groups and, individual and group interviews. For this study, personal semi-structured, exploratory interviews served as the major tool. Interviews are the most common technique used in IE studies.

Institutions, such as the mental health system, cannot be studied in their totality. Instead, “the aim of the IE researcher is to explore particular corners and strands within a specific institutional complex, in ways that make visible their points of connection with other sites and courses of action” (Devault & McCoy, 2002, p. 753). The goal of this study is to provide an integrated account of Aboriginal mental health reform processes and organizational practices within Interior Health and of the experiences they produce. Appropriate to an ethnographic approach and a postcolonial-feminist framework, the starting point of investigation is the experience of individuals whose everyday activities are shaped by and constituent of Aboriginal mental health reform processes implemented under the Interior Health Authority within the time span from 2001 to 2007.

Ethical Considerations

Ethics approval was formally sought through the Research Ethics Board of both Simon Fraser University and Interior Health Authority (see Appendix A & B). The research process and protocol were guided by the standards for health research with Aboriginal communities as outlined by CIHR (2005) and adhere to the principles of: 1) mutual respect; 2) mutual recognition; 3) mutual sharing; and 4) mutual responsibility.

Postcolonial-feminist theories remind us of the political nature of Aboriginal mental health policy and the trajectory of consequences that this type of research could have for individuals and Aboriginal lives if we, as researchers, fail in our responsibility to protect confidentiality or to see the historical locatedness of our actions. It is, thus, incumbent upon me to critically reflect on my responsibilities as a non-Aboriginal researcher and the consequences of my research in an ongoing fashion. As such, I paid special ethical consideration around the recruitment of study participants and relationship-building, the acquisition of informed consent and the ensuring of confidentiality (all of which will be discussed in further detail later in this section, within the context of the research process to enable the reader a better understanding of the practical meaning of these ethical principles).

Within this section, I would like to highlight one ethical conflict that was particularly challenging and foundational for this research and to my personal life. This conflict is rooted in the basic question whether or not non-Aboriginal researchers, particularly if they are members of the dominant group, have the

ethical right or even the ability to produce knowledge that is truly emancipatory and decolonizing to Aboriginal peoples (Tuhiwai Smith, 1999).

Of course this question is not easily answered but there are strategies available through the process of reflexive practice that can help the researcher to identify ways in which the research reproduces unequal power relationships. One strategy I adopted was to critically examine my own social location and values that I bring into this research, which I describe in detail under the section of the “researcher’s point of entry”. As a result, I realized that even though my research is intrinsically motivated by my devotion to social justice, I am coming from a privileged place in that I am a white, able woman with an academic background conducting research that will further my own career. At the same time, however, my identity and experience as a recent immigrant to Canada also enables me to more easily adopt a critically perspective onto the dominant Canadian value system. As such, it was important to reflect continuously throughout the research process on how these experiences hold the potential to impede and promote my relationship with research participants and my ethical conduct as a researcher. In addition, given my non-Canadian cultural background and only recent exposure to Canadian Aboriginal culture, I carefully selected a supervisory committee with extensive work experience and expertise in Aboriginal mental health and critical health policy.¹¹ With the insights from self

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reflection and the advice of my supervisory committee, I adopted a relational approach in my research that emphasized dialogue and reciprocal interaction. I tried to connect with participants through self-disclosing my values and insights as a symbol of mutual respect and sharing. In addition, I documented my experience via a research journal and fieldnotes to help identify emerging ethical issues in order to discuss them as part of regular meetings with members of my advisory committee.

I also undertook all efforts to deepen my knowledge about Canadian Aboriginal history and contemporary politics, and to contextualize my research findings by applying a postcolonial-feminist framework to this study. However, while the decision to adopt a postcolonial-feminist framework reflects my belief in the appropriateness of this methodology to provide for a critical and responsible analysis of Aboriginal experience in a way that respects and recognizes the historical and socio-political context of Canadian Indigenous peoples, it is also a response to the time and funding limitations of this project. From a critical

Marina Morrow, PhD, MA, BA: Dr. Morrow is an Assistant Professor at the Faculty of Health Sciences at Simon Fraser University. She is an expert in the field of mental health and women's health with a special interest in community development. She has a number of research projects underway, the most recent of which is a three-year study funded by the Social Sciences and Humanities Research Council and the Michael Smith Foundation for Health Research, examining the experiences of men and women being relocated from Riverview Psychiatric Hospital to smaller facilities throughout BC and the impact on their families, care providers and the larger community.

Victoria Smye, PhD, MHSc, BA, RN: Dr. Smye is an Assistant Professor at the School of Nursing at the University of British Columbia. She has extensive experience and expertise in the field of Aboriginal mental health. Her research focus is on access to mental health and addictions care with particular attention in women's mental health and Aboriginal mental health. Dr. Smye is funded by the Canadian Institutes of Health Research (CIHR) to explore Aboriginal peoples' experiences of mental health and addictions care (2006-2009/10) and is currently a member of the First Nations, Inuit and Metis Advisory Committee, Cultural Safety Subcommittee, MHCC.

perspective, a more participatory research methodology would have been preferable.

While I am aware that a limitation of this study was the decision to not bringing the analysis back to the participants to gather feedback from informants, I believe that the qualitative research design of the study provided for a certain degree of participant involvement and guidance in the study process. For example, the majority of participants were selected on advice from Aboriginal participants. In addition, by using semi-structured interview guides, I tried to provide adequate space for participants to share issues they experienced as most relevant. Furthermore, in ethnographic work, data collection and analysis are iterative (Anderson, 2004). As a result, I switched back and forth between analysis and data collection, and as the data analysis progressed, my questions shifted to focus more specifically on those issues that emerged as relevant from previous interviews, following pathways down which participants led. Finally, to reflect the voices and experiences of the participants of this study as fully as possible, I threaded participant quotations from the interviews throughout my data analysis, providing the reader with an auditable trail of my analytic and interpretative pathways. In all thesis materials, quotations from participants are anonymous and all identifying information, such as names of organizations and detailed role descriptions, has been carefully masked or deleted.

At the completion of the project, all participants of the study will receive a summary of the project findings. All identifying information will be destroyed. The data, however, will not be destroyed but will be safely stored as electronic

versions on my computer protected by my personal password. As per SSHRC guidelines, the complete data will be destroyed after five years.

Recruitment, Participant Profile & Participant-Researcher Relationship

When selecting informants, IE researchers aim for a diversity of experience in order to “trace how the people living in these different circumstances are drawn into a common set of organizational processes” (DeVault & McCoy, 2002, p.764). Thus, all efforts were undertaken to identify informants whose experience would shed light on the distinct experience of Aboriginal peoples and Aboriginal mental health advocates working at multiple sites within both the community-based Aboriginal mental health system (off and on-reserve) and within Interior Health’s Aboriginal Health Division.

Twelve interviews were held with a total of ten participants; two of whom were interviewed twice. Study participants primarily self-identified as Aboriginal with seven out of ten reporting Aboriginal ancestry. In addition to IH, four community-based Aboriginal health organizations, that provide mental health and addictions services to Aboriginal peoples, were visited. Within each organization, informants were purposively selected according to their involvement in, and expertise of, Aboriginal mental health and addictions services. As appropriate to an IE approach, I aimed to obtain a participant sample that would reflect the diversity of social locations within the organizational structure of the Aboriginal mental health system in IH.

In practice, this often meant that several members of the same organization were interviewed, as I was interested in learning the perspectives of

both i) participants working at the micro-level of mental health and addictions care delivery, such as service providers, and ii) individuals holding meso- and macro-level positions that involved different degrees of participation in mental health care programming and planning (e.g. managers, directors).

As table 1 shows, within the community, I interviewed two individuals working at community organization A (RP2 & RP3) and D (RP6 & RP7), and one participant each at community organization B and D. In comparison, within IH, altogether four individuals were sampled for interviews.

Table 1: Participant Profile

As a result, half of the research participants (RP3; RP4; RP6; RP8 & RP10) held, at that time of the interviews, positions that involved primarily front-line work with Aboriginal clients in the area of, or relevant to, Aboriginal mental health and addictions care. By selecting front-line staff, I expected to collect information on how reform processes in Aboriginal mental health have shaped service provision and work at the micro-level. In addition, given that two out of these five participants worked on-reserve, I was also hoping to be able to capture differences in experiences due to the jurisdictional divide between on-and off-reserve Aboriginal mental health and addictions service provision. The remaining five positions (RP1; RP2; RP5; RP7; RP9) on the other hand, were characterized by managerial roles that included responsibilities in the area of planning and programming of Aboriginal mental health and addictions care as well as funding decisions in terms of either proposal writing or resource allocation. Given their mandates, I anticipated these participants to would be better able to articulate their views on the nature of IH's Aboriginal mental health reform, as well as to reflect on their experiences of potential emerging disjunctures and tensions embedded in the unfolding reform. Because of this, I conducted two additional interviews with RP1 and RP2 within this group.

Due to the relatively small number of IH employees in the Aboriginal Health Division and the tight community of Aboriginal mental health service providers on- and off-reserve, no detailed role description or job title was assigned to the informants of this study in order to protect the confidentiality of the informants. Given the politics of Aboriginal mental health, identification of

certain individuals has the potential to be oppressive in that it could jeopardize the employee-employer relations or other funding arrangements and thus, must overrule research related aims. In keeping with an IE approach, for the purpose of this study the individual information of peoples' specific positions is less important than to describe the social processes that effect individuals across a range of positions. As such, I view it as more pertinent to the analysis of this research to provide an account of the range of positions within the social organization of the broader Aboriginal mental health system including Interior Health and community-based Aboriginal led organizations.

Due to the fact that the research setting of this study was three communities within the Interior of BC, initial contact with informants was made via e-mail and phone approximately one to two weeks before the interview was scheduled. On these occasions, I provided potential study participants with a study summary via e-mail to foster true consent (see Appendix C). For the interviews, I conducted two field visits, in which I travelled from Vancouver to the Interior. Both times, I stayed for approximately one week.

As part of the first field visit in spring 2007, I conducted two interviews with three informants (RP1; RP2; RP3). Via internet sources (homepages & webpages), I purposively selected contacts from both IH Authority and the community. Besides the interviews, the main objectives of this first visit were to introduce myself to the community and build alliances with individuals from the local Aboriginal community. The second round of informants were identified upon advice given by the previous interviewees. The rationale for choosing this

method was two-fold: i) using the expertise of members of the local Aboriginal community represented a mechanism to involve participants in the research process, and, ii) it was instrumental in identifying and connecting with other participants who could discuss the issues posed by the research questions due to their involvement in the field of Aboriginal mental health. As a result, I was able to conduct an additional nine interviews during my second field visit in summer 2007. Among those, five individuals were directly employed by Interior Health Authority, while four were service providers or managers of community-based Aboriginal organizations, such as urban Friendship Centres and one on-reserve Aboriginal health organization.

Prior to interviewing, I explained again the background, purpose and procedures of the study and reviewed the terms of confidentiality and voluntary participation. All informants provided formal consent to participate in an approximately one hour to an hour and a half interview recorded on tape (see Appendix D). None of the individuals approached refused to participate.

Given the oppressive history of research on Aboriginal communities by 'outsiders', I tried to be very mindful of how to present myself and the research as to not reproduce the impression that I was there to study the "Other". As such, I started each interview with an open conversation disclosing information about my self; including my identity as a recent immigrant to Canada, the context which had prompted me to develop a research proposal in the field of Aboriginal mental health as well as my experience as a new researcher. For example, I was very open about the fact that this was the first time I was conducting my own

qualitative research project.¹² In addition, I had prepared small non-monetary gifts for all of my participants in order to honour the support for this project. Following the advice of one of my supervisory committee members, I offered small leather medicine bags filled with sage as a symbol of respect to Aboriginal culture after the completion of each interview.¹³

Overall, my general impression was that the atmosphere was open and that participants related to me in a genuine manner. While I am aware that a limitation of this study was my decision not to bring the analysis back to the participants to gather feedback from informants due to time constraints, I am grateful to all participants for sharing their insights with me.

Ethnographic Interviews

According to DeVault and McCoy (2002), when using interviews in an IE investigation, the researcher's goal is to identify institutional processes and describe their generalizing effects that may produce similarities of experience and sustain broader inequalities. Thus, interview questions do not need to be standardized. Rather, as the research progresses, the IE researcher will modify her original questions to explore specific avenues that have been identified as important from previous interviews for understanding the institutional

¹² In my experience working as nurse, enabling another person to see beyond the professional identity has been very helpful in establishing a trustful, genuine and respectful relationship.

¹³ Even though, I learned from one participant that in my ignorance I had almost violated an important cultural ritual, since picking sage is viewed as a spiritual act that has to be done in certain ways under certain conditions, my participants all accepted my gifts in good spirit. For those who were aware of the inappropriateness of my act, I am still very appreciative that they chose to forgive me my ignorance and value instead the good thoughts I had intended.

complexities. Each interview provides an opportunity to identify another piece of the puzzle.

I developed interview guides comprised of eight open-ended questions and organized around the following themes: 1) Roles and responsibilities; 2) Key mental health issues for the Aboriginal community; 3) Accessibility and availability of mental health and addiction services; 4) The Interface between mainstream and Aboriginal services and other jurisdictional issues; 5) Mechanisms for the provision of culturally appropriate services and, 6) Challenges to implementing services and policy that are culturally appropriate (see Appendix E). In contrast to research that uses structured interviews, IE interviews are adapted to the researcher's developing knowledge of the institutional processes. As such, my interview questions changed as the research progressed, reflecting interwoven phases of analysis and data collection. For example, the interviews conducted as part of my first field trip were very open-ended inquiries and served primarily three purposes: 1) To introduce myself and the study to the communities; 2) To understand how things work and to check my understanding that I had developed so far; and 3) To learn about other key informants. In comparison, at later stages of my research, I made an effort to examine certain tensions and issues that I had identified.

All interviews with the exception of one were taped and transcribed verbatim. One interview was not recorded due to the serendipitous nature of the interview, so that I had to rely on taking written notes. However, to protect the rigor of my data, I offered a clean version of my recorded field notes to the

interviewee for review and incorporated the received feedback, which entailed minor omissions, additions and clarifications.

In addition, I recorded fieldnotes as soon after the interviews as possible in order to capture issues and insights related to the interview content and to make connections to what I had learned so far from other sources. In relation to my analysis, fieldnotes also helped me to create concepts and themes that linked different participant experiences; thereby guiding my research into the next phase of data analysis.

2.3.2.2 Describing Institutional Processes, Ideologies and Ruling Relations

Another prominent method of IE is in-depth document review. For this study, reviewing relevant health policies served three major purposes: First, as I am not part of the institution I wished to study, reviewing Interior Health web pages and key documents helped me to become familiar with the goals, strategies and structures that constitute parts of Aboriginal mental health reform. My primary concern was with Interior Health's Aboriginal health plans, including the *Aboriginal health and Wellness Plan 2002/03-2005/06* and *Interior Health's Aboriginal Health and Wellness Plan 2006-2009*, which informants confirmed to be the key policy documents guiding reform.

Second, I conducted a review of relevant health policy documents in order to position Aboriginal mental health reform in the Interior Health within the wider socio-historical and political context, and third, to explore competing ideologies and discourses embedded in contemporary Canadian Aboriginal mental health reform. As part of this work, I identified three interconnected themes highly

influential in the evolution of the current reform processes: 1) Health Care System Reform, 2) Mental Health Reform and, 3) BC's Aboriginal Health Movement.

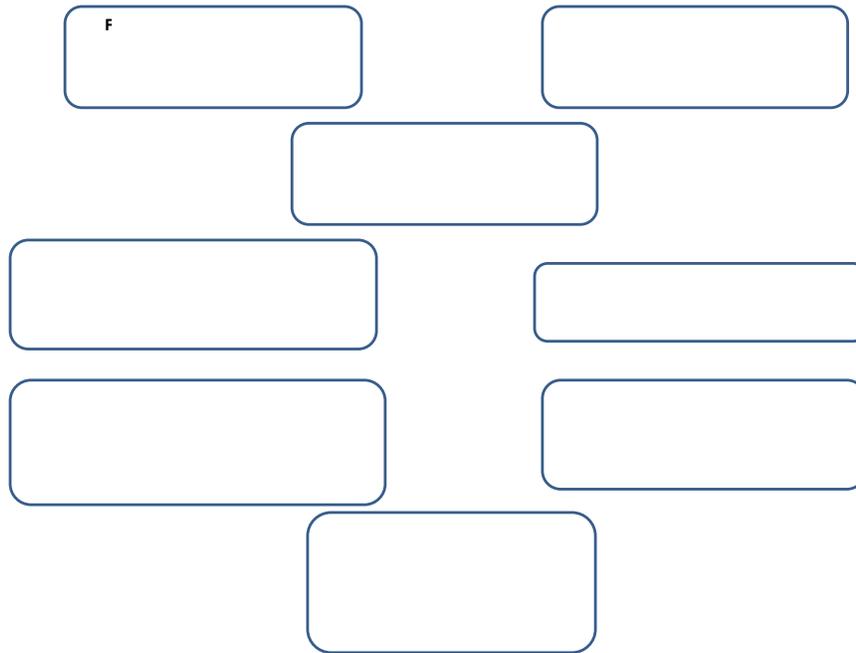
Under the first theme, I primarily reviewed historical and contemporary health policy documents to identify political trends and emerging discourses in health care reform that have been fundamental to the creation of the current regionalized structure and reform of BC's Aboriginal mental health and addictions programming and service delivery. These documents included, *New Directions for a healthy British Columbia: Meeting the Challenge – Action for a Health Society* (British Columbia. Ministry of Health and Ministry Responsible for Seniors, 1993), *BC's Health Goals for British Columbia* (British Columbia. Ministry of Health and Ministry Responsible for Seniors, 1997), *The Picture of Health. How we are modernizing British Columbia's health care system* (British Columbia. Ministry of Health Planning, 2002) and *Health Authority Redesign Accomplishments: A four-year Picture* (Interior Health Authority, 2005). In addition, I read the Romanow Report, *Building on Values: The Future of health Care in Canada* (2002) and many supplemental government publications that give additional information on how British Columbia's Aboriginal health system was organized prior the election of the Liberal government in 2001 (British Columbia. Ministry of Health Services, Aboriginal Health Division, 2001; BC Aboriginal Network on Disability Society, 2001).

For mental health reform, I closely looked at the *1998 Mental Health Plan, Revitalizing and Rebalancing British Columbia's Mental Health System* (British

Columbia. Ministry of Health and Ministry Responsible for Seniors, 1998) and the Kirby Report, *Out of the Shadows at Last - Transforming Mental Health, Mental Illness and Addictions Services in Canada* (2006). Here my rationale was to examine how current mental health care reform goals and recommendations have addressed Aboriginal mental health.

Given the focus of this study, I spent the majority of my time working through reports, policies and agreements in the area of Aboriginal health with a special curiosity for Aboriginal mental health. Part of this review served to provide a detailed picture of the contemporary political backdrop of Aboriginal Health in British Columbia and has been captured through a process called mapping. The following figure 2 shows the map of the different political landmarks for the Aboriginal health movement in BC.

Figure 2: Key Documents and Political Landmarks in BC's Aboriginal Health Movement



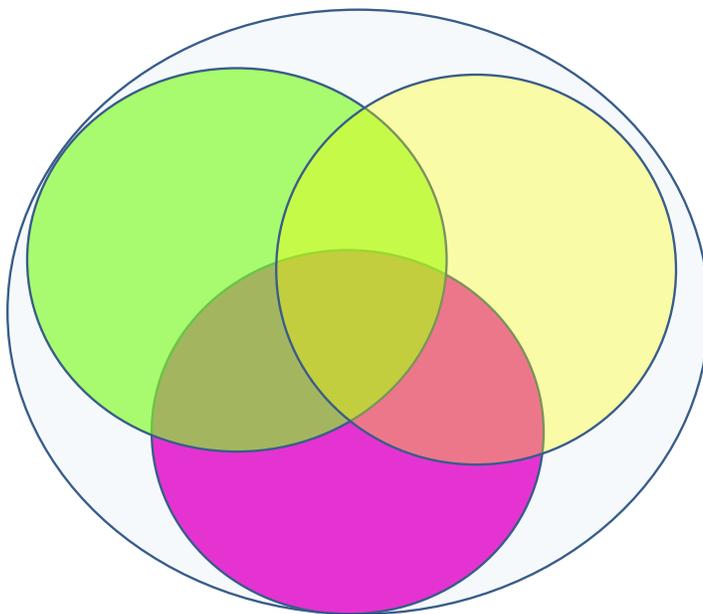
In addition, this review included the critical reading of the reports of the *Royal Commission on Aboriginal Peoples* (RCAP, 1995; 1996), the *2001 Report on the Health of British Columbians: The Health well-being of Aboriginal People in British Columbia by the Provincial Health Officer* (BC. Office of the PHO; 2002) and the report by the Best Practices Working Group on Aboriginal Mental Health, *Aboriginal mental Health: 'What Works Best'* (Smye & Mussell, 2001). The review of these documents was aimed at identifying those elements and goals that are central to Canada's Aboriginal health movement and the ways in which they apply to reforming Aboriginal mental health and addictions service programming and delivery.

2.3.2.3 Analyzing “Ruling Relations”

Generally, IE researchers do not follow the strict sequence of traditional study designs that draw on positivist research paradigms. Similarly, in this study, data collection and analysis are not two separate and consecutive research phases but one intertwined and iterative process. Borrowing Elizabeth Townsend’s words, I used a “back-and-forth method of exploration” in which I switched from interviews to document review to analysis and back (1999, p.21). As DeVault and McCoy (2002) point out this is not because IE researchers do not know what they want to study but “only step by step can they discover whom they need to interview or what texts and discourse they need to examine” (p.755).

In the following, I describe how the analysis of this study unfolded.

Figure 3: Theoretical Framework of Analysis



Townsend (1998) explains that what differentiates the IE researcher from experimental or interpretive researchers is that the IE researcher uses the insider's "experiences of tension as a starting point for tracing the actual activities and conditions of the everyday world to the organizational processes that invisibly rule that experience" (p.18). For this study, the starting point of critical inquiry was the experience of tensions between the vision of IH's Aboriginal mental health reform and the lived reality of the informants, which had emerged as overarching themes within the first three interviews with RP1, RP2 and RP3.

While the concept of 'tension' might evoke the impression in the reader that my analysis is preoccupied with negative elements, when reading the analysis, it becomes apparent that the analytic use of this concept does not exempt areas of success. In fact, tension is often necessary in the process of moving forward as it can be understood as a form of resistance toward the status quo. According to Foucault (1978), the traditional dichotomous understanding of power is insufficient since "where there is power there is resistance" (Pease, 2002, p.141). Thus, if we understand power as relational then we can understand tensions as a manifestation of social change. Therefore, I used the experience of tensions as a starting point of the analysis and kept asking "why is it that these people are saying what they saying?"

Following this revelation, my first objective was to distil different facets of these tensions by exploring both the vision that drives Aboriginal mental health reform in the Interior as well as the reality of those affected by reform. To capture these different nuances, I conducted interviews with key Aboriginal leaders and

mental health service providers from a variety of social locations (community-based organizations vs people working within the Interior Health Authority; on- vs off-reserve Aboriginal health organizations; frontline staff vs. directors & managers). I described and summarized my observations and thoughts following each interview and debriefed them with my supervisory committee. The discussion of these field notes proved to be invaluable for obtaining a general sense of the rich information given by my informants and to reflect on its overall meaning. Preliminary concepts and themes were captured in my research journal that I kept to track the project process.

Carrying forward an institutional ethnographic analysis, I first coded the data as a means of organizing and distilling different parts and processes of the Aboriginal mental health system in the Interior. I coded the data using NVivo®, a qualitative software program. Initially, I sorted data by grouping large chunks of texts under descriptive nodes, such as “roles and responsibilities” and “Aboriginal Health and Wellness Advisory Committee”. To capture the complexity of the institutional description, I started ‘mapping’ different constituents and their connections to better visualize “how things work”: Who makes what kind of decisions? How do community-based Aboriginal organizations interface with Interior Health? What kind of reform changes have occurred since 2001? What are the landmarks in Aboriginal mental health reform in the Interior? To find answers to these questions, I had to switch back and forth between a formal coding process, the interview transcripts and the document review.

By generating maps, I was able to consolidate information gained from interviews and document review into a succinct and easily understandable format, which I could bring back to informants to be checked for accuracy and completeness. In addition, visualizing hierarchies and historical timelines proved to be a very valuable tool in maintaining an institutional ethnographic lens and identifying gaps in knowledge that led me to seek out my next informants, who were identified by other research participants as important to talk to for this study.

After the completion of thirteen interviews, the need to generate new descriptive nodes had diminished. Consequently, I shifted my coding strategy and I started grouping the existing nodes under my initial research questions that I had broadly formulated at the outset of the study. The nodes under each question described a myriad of tensions that stretched from mental health service provision at the micro-level to Aboriginal mental health policy at the macro-level. Given the exploratory nature of this study, I thought I had gathered sufficient data, and my inquiry had reached a point of saturation that would allow for a deeper analysis of those threads that I had identified as meaningful within my preliminary analysis.

Around the same time, I completed my document review of relevant health policies in the area of a) health care reform, b) mental health care reform and c) Aboriginal health. After having read all the documents mentioned above several times, I was able to locate Aboriginal mental health reform as it pertains to the IH, the object of my study, at the intersection of these three axes. While I described each one of these spheres in detail in chapter one providing the context and

background for this research, in IE research, the scope of in-depth document reviews moves beyond descriptive analysis to an analysis of text-based forms of knowledge, discourses and ideologies. De Vault and McCoy (2002) use the metaphor of the 'central nervous system' to describe the functional role of 'texts' in large-scale institutions, such as the mental health care system, in that "it mediates relations of ruling and organizes what can be said and done" (p.765). As a result, my next step was to critically reflect what this intersection meant in terms of power relations. To answer this question, I started to see if I was able to identify values and beliefs within the language of reform which reflected particular ideologies and discourses embedded in contemporary Canadian Aboriginal mental health reform. For this purpose, I conducted an additional review on contemporary critical health literature.

Particularly influential to this part of my analysis was the work led by Victoria Smye (2004), Marina Morrow (2004), and Jo-Anne Fiske and Annette Browne (2008). Smye, for example, conducted a postcolonial discourse analysis of the 1998 Mental Health Plan and other mental health documents as a means to uncover the manner in which colonial ideologies are reproduced and shape Aboriginal mental health care practices. And more recently, Jo-Anne Fiske and Annette Browne (2008) researched the contradictions within health policy reform and its implications for First Nations women using a critical discourse analysis of texts and practices central to health policy reform, such as two Royal Commissions, the Referendum on Treaty principles, and the consultation of regional health boards with Aboriginal governors. Morrow's research examines

the effects of neo-liberalism on Canadian mental health reform with a special focus on the implementation of BC's 1998 Mental Health Plan (2004). The results of this inquiry are presented in **chapter 3**, in which I discuss several overarching ideologies that are differentially reflected within the key policy documents listed above.

In **chapter four** and **five**, I present the analysis that arose from the examination of the ways in which the tensions described between IH's vision of Aboriginal mental health reform and participants' lived experience are reflective of underlying socio-historical and political ideologies tying the analysis of my data to the results of my literature and document review. This meant an ongoing redunrum process of continual reflection and analytic questioning as well as repeated readings of both interviews and of key documents including IH's Aboriginal health plan (version 1 and 2). By doing this, I identified three emerging overarching tensions that are central to IH's Aboriginal health framework "to create a *respectful, trusting, responsible partnership* between Aboriginal People and Interior Health to support the development of a *holistic health and wellness system* that is responsive to the needs of *diverse Aboriginal Communities*" (IH, 2006, p.6). These tensions include: 1) Aboriginal Representation, Selection and Inclusiveness, 2) Meaningful Participation and, 3) Mistrust toward Government. While I discuss these findings that are more generally about the structure of IH's Aboriginal health reform in detail in chapter four, in chapter five, I shift my analysis to focus more specifically on how these tensions are reproduced within Aboriginal mental health programming and service delivery.

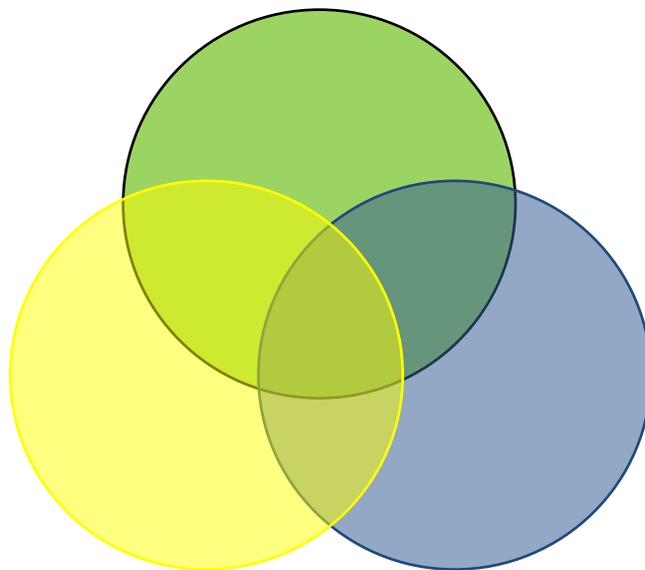
Using quoted excerpts from the interviews, I provide a rich and thick description of how Aboriginal mental health service provision is “ruled, controlled and organized” under IH’s Aboriginal mental health reform in ways that often contradict or overrule the good intentions that engendered the reform. In other words, I describe how competing ideologies conceptualize, categorize and coordinate activities and practices of individuals within the Aboriginal mental health system; thereby, creating experiences of tensions as well as resistance.

Despite an emphasis on critique throughout this study that goes along with my sense for social justice, I also struggled to recognize instances of empowerment. As a result, in **chapter six**, I discuss future implications and directions by focusing on both successes and failures of Aboriginal mental health reform with the hope to leave the reader with the sense that reform can respond to the mental health needs of Aboriginal people and empowerment is possible.

3: ANALYSIS & DISCUSSION: DOCUMENT REVIEW

This chapter explores some underlying forces that drive and shape reform in Aboriginal mental health from a feminist-postcolonial perspective by using the concepts of ideology and discourse. Aboriginal mental health policy reform is imbued with co-existing discourses that are based in historical and current social practices and movements. Through an extensive literature and document review, I identified three ideological spheres in which Aboriginal mental health reform occurs: 1. Health care reform; 2. Indigenous health movement and; 3. Mental health reform.

Figure 4: Locating IH's Aboriginal Mental Health Reform at the Intersection of Three Ideological Spheres



Each ideological field is informed by multiples discourses. In describing each discourse and the interplay between them, my objective in this chapter is to position Aboriginal Mental Health Reform within a socio-historical and political context that will allow for a critical analysis of the experiences reported by the participants of this study.

In the literature, definitions of ideology and discourse are diverse (Smith, 1987; Shore & Wright, 1997, Omi & Winant, 2002; Fernando, 2003; Fiske and Browne, 2008) but the notions of discourses and ideology are commonly used to study the processes through which different types of knowledge, social problems and actions are socially constructed. In my analysis, I adopted the definition of Shore and Wright (1997), who understand discourses as the basic building blocks of ideologies. Discourses are configurations of ideas that describe the terms of reference in which a social issue or concept is defined, thought of and discussed. Although social problems exist within a discursive field," ideologies, in turn, tend to reflect and perpetuate the normative ideals of the dominant society – in other words, the status quo" (Fiske & Browne, 2008, p.7).

However, while Aboriginal health policy may be shaped and restricted by one overarching ideological field, there is evidence that Aboriginal health reform is not uniformly oppressive but has meant some advances for Aboriginal peoples. As such, a diversified understanding of ideology will permit for a more complex analysis of the ways in which co-existing discourses in Aboriginal mental health policy reform engender strategies of rejection and subversion and create spaces

of struggle around such concepts as reconciliation and participation that are discussed in chapter 4.

For the purpose of this study, I will be focussing on three influential and intersecting ideologies, whose cumulative effects have not only created a range of barriers for accessing adequate mental health services for Aboriginal peoples but are also likely to challenge the actualization of progressive reform ideas. These ideologies include colonialism, bio-medical paradigm and neoliberalism.

3.1 The Past, the Present and the Future: Colonial Ideology in Mental Health

Colonial ideology with its assimilative and paternalistic ethos is a dominant ideology that has been both a promoting and inhibiting force behind the provision of health care services to Aboriginal peoples and many argue continues to do so today (Browne, 2005, 2002; Smye, 2004; Kelm, 1998; Kirmayer et al., 2003; 2009). To Narayan (1995), the colonizing powers have historically borrowed elements from both the 'rights' discourse and the 'care' discourse in order to justify both the right of domination and the forced 'civilization' of the colonized 'Other' by constructing the Native as an inferior and childish subject that is in need of paternalistic care. Kirmayer et al. (2000; 2009) and Kelm (1998), for example, argue that forced settlement and relocation of Aboriginal tribes to reserves, residential schools and bureaucratic control under the Indian Act 1876 served the economic and political interest of the colonizer and were sustained by racist ideologies that saw the Aboriginal culture as primitive and sick.

The ostensible paradox of a government whose powers were historically justified by the construction of Aboriginal need and the provision of paternalistic health care, and its reluctance to take on the responsibility for Aboriginal health has been described as 'the white man's burden.' According to Narayan (1995), this notion refers to the colonized perception that, "included both a sense of obligation to confer the benefits of western civilization on the colonial, and a sense of being burdened with responsibility for doing so – an obligation and responsibility rooted in a sense of being agents who had a world-historic mission to bring the light of civilization and progress to others inhabiting 'areas of darkness!'" (p.135). As a result, Aboriginal health has been historically positioned under non-Aboriginal governmental authority through the Indian Act, where it subsequently became subject to a mix of ethnocentric, paternalistic and neo-liberal policy-decisions (Smye, 2004).

One way in which these ideological underpinnings manifest themselves is in the longstanding reluctance on the side of the government to act and respond in any comprehensive way to issues related to Aboriginal mental health. Despite a steady stream of studies and reports by Aboriginal and non-Aboriginal analysts since the late 1970s, on the high incidence and prevalence of suicide among Aboriginal peoples, non-Aboriginal governments failed to attend to the structural inequities in mental health service delivery. Instead of addressing these structural inequities caused by the jurisdictional divide of, and historical struggle over, the responsibility for service delivery to Aboriginal peoples, governments have traditionally tended to only provide fragmented and short-lived crisis relief

(RCAP, 1995). The racial character of this inaction on the side of the government can be seen more clearly when comparing it to the government's response to several tragic deaths of non-Aboriginal peoples with severe and persistent forms of mental illness that had occurred during a short period between 1995 to 1997 (RCAP, 1995). These deaths resulted in a coroner's inquest, who attributed the deaths to the inadequacy of the mental health system at that time and thereby, engendered BC's most recent mental health care reform and the development of the 1998 Mental Health Plan (Smye, 2004). In comparison, the majority of Aboriginal suicides pass unnoticed even though, as Honourable Mr. Justice Thomas Berger stated in his report on Aboriginal suicide rates as far back as in 1980, "if an equivalent pattern and ratio of deaths were to occur in the non-Aboriginal population, it would be 'viewed as a national disaster'" (RCAP, 1995, p.70).

In the absence of a comprehensive national or provincial Aboriginal mental health plan, Aboriginal peoples continue to experience inequitable access to adequate mental health services. A particular problem is the complex system of mental health service delivery that Aboriginal peoples face due to the multiplicity of jurisdictions involved under the premises of the Indian Act that tie eligibility criteria to place of residency, band membership and status. Jurisdictional barriers between services for First Nations peoples living on- and off-reserve remain firm. Consequently, Aboriginal peoples in need of mental health care often report that they experience denial to services and very limited access to services (BC FNLC, 2005). According to an estimate by RCAP (1995),

“roughly 60 percent of Aboriginal peoples in Canada fall outside the self-defined responsibility lines drawn by Parliament and interpreted by federal government departments and agencies” (p.73). As soon as a Status First Nations person moves off-reserve, the person loses access to federal and band governed programs. Off-reserve, his/her health needs are expected to be met by mainstream services. However, under the jurisdiction of health authorities, access barriers to mainstream programs and services arise from, i) a lack of knowledge around Aboriginal history, culture and traditions by service providers, ii) the minimal coverage and recognition of alternative and non-medical treatment forms and interventions, and iii) from the under-representation of Aboriginal perspectives in the design and planning of health services (BC FNLC, 2005; Fernando, 2003; RCAP, 1996).

3.2 Mental Health Care: Bio-medical and Aboriginal Understandings of Mental Health

Mental health care in Canada has been described “as one of the orphan children of Medicare” (Romanow, 2002, p.178) due to its inadequate funding and attention by policy makers. According to Morrow (2004), part of the governments’ tendency to neglect mental health policy is rooted in the historically ambiguous aetiology of ‘mental illness’.

Historically, medieval conceptualizations of mental illness viewed certain kinds of mental states and behaviours as resulting from religious sins and possession by demons (Fernando, 2003). According to Foucault (1965), the public’s understanding of ‘mental illness’ as ‘madness’ represents a key surviving

historical discourse that juxtaposes the irrationality of the insane person against reason and as such, may have contributed to the widespread stigmatization experienced by people living with mental illness (Morrow, 2004).

According to the Romanow Report (2002), the lesser status of mental illness in terms of organization and service provision can also be seen in the longstanding history of segregation of 'mental illness' from the rest of the health care system. The idea of institutionalizing people with mental illness reaches as far back as to the sixteenth and seventh century, where the Enlightenment prompted the "era of great confinement" when large numbers of socially undesirable peoples were labelled insane and sent into institutional asylums (Fernando, 2003).

Perhaps ironically, the move toward deinstitutionalization in the contemporary era of mental health policy was empowered by scientific discoveries in the field of microbiology, genetics and biology, and resulted in a reductionist approach to mental illness that "de-emphasi[z]es ...the psychological and sociological contributors to illnesses" (Morrow, Dagg & Pederson, 2008, p. 3). The bio-medical paradigm became the dominant ideology in Western understandings of mental health and continues to contour contemporary mental health reform. In BC, the 1998 Mental Health Plan *Revitalizing British Columbia's Mental Health System*, the cornerstone of the most recent mental health reform, for example, is based on an understanding that "mental illness represents a diseased state of the human brain and not just disadvantaged social conditions" (p.58) and as such, "require[s] medical treatment" (BC. Ministry of Health and

Ministry Responsible for Seniors, 1998, p.26). In the face of the significant role of trauma in the experience of mental distress and addictions among the Aboriginal population stemming from a century of forced assimilation and its unquestionable connection to the social determinants of mental health, such as poverty, chronic unemployment and overcrowded housing, the plan has received strong criticism for its cultural blindness and illness service model with an individualistic focus of treatment (Browne & Smye, 2002; Morrow & Chappell, 1999). Similarly, the Romanow Report (2002) has been criticized for its lack of attention to addressing the social and economic determinants of health in its proposal for a new approach to Aboriginal health, and its scarce attention to mental health (Armstrong, Boscoe, Clow, Grant, Pederson & Willson, 2003).

The disjuncture between the Aboriginal understanding of mental health and the biomedical definition of mental illness is a historical and contemporary source of tensions that causes and sustains inequities in mental health services for Aboriginal peoples (Browne & Smye, 2002; Smye, 2004). The tendency of the mental health system to medicalise social problems in terms of mental illness, for example, strongly conflicts with the traditional Aboriginal understandings of mental health, which understands mental health as a holistic concept (Smye, 2004; Smye & Mussell, 2001). From an indigenous point of view, the wellness concept replaces the illness model. Wellness is the result of a balanced mind, body, soul and spirit (Kirby Report, 2006; Mussell, 1991; Smye & Mussell, 2004). In addition, mental health is contextualized by situating individuals into a historically, environmentally and politically meaningful context. Accordingly, the

analysis of Aboriginal mental health cannot be reduced to psychiatric or psychological disturbances of the individual's mind and emotions but has to go beyond this: from the individual to the collective and from the present to the past. In this light, the disproportionate mental health burden carried by Aboriginal peoples is viewed as the manifestations of cultural despair that threatens community survival and originates in the experience of colonial and neo-colonial practices at the individual and collective level of Aboriginal peoples (Kirmayer et al., 2009; Kirby Report, 2006; Smye, 2004). Evidence for the validity of this framework is provided by studies that show that suicide rates between Aboriginal communities vary according to the level of 'cultural continuity' present (Chandler & LaLonde, 1998; RCAP, 1995). Protective factors for communities were the degree to which they were involved in and had control over: Land-claim negotiations, self-government, education, police and fire-services, health services and cultural facilities (LaLonde, 2005). Other research shows evidence that cultural and spiritual revitalization "is an effective means of protecting against loss of inner meaning and direction... Communities with strong customs, religious ceremonies and traditional healing methods provide adolescents with a feeling of security and a sense of belonging" (RCAP, 1995, p.79)

The disjuncture between the Aboriginal understanding of mental health and the bio-medical approach to mental health creates problems at all levels of mental health service delivery. On the policy level, the 1998 Mental Health Plan, for example, falls short on addressing the majority of mental health issues experienced by Aboriginal peoples as well as their socio-political and historical

root causes since it is only designed to address quality of care issues related to peoples with serious and persistent mental illness, such as schizophrenia and bipolar disorder as defined by the DSM-IV (Smye, 2002). Similarly, BC's Mental Health 'Best Practices' documents (2002) have been criticized for their omission of a critical cultural lens and its biomedical ideological underpinnings that continue to define mental health issues and treatment in individualistic terms (Smye & Mussell, 2001). Indeed, "the relational language of an Aboriginal worldview generally is missing from the 'Best Practices' documents" (Smye & Mussell, p. 29).

As a result, mainstream mental health services and programs that are designed on the premises of the Western bio-medical understanding of mental health are not effectual, are underused and often are not adhered to by Aboriginal peoples (Smye & Mussell, 2001). Yet, within some recent health policy documents, such as the Romanow Report (2002), access issues for Aboriginal people remains narrowly defined in terms of insufficient supply and distribution of health care providers, while others, such as the Kirby Report (2006) adopt a more critical lens supporting the call by Aboriginal key leaders for a holistic and comprehensive wellness strategy for mental health and addictions.

However, while Canada followed Kirby's recommendation to establish a national Mental Health Commission, which is intended to guide mental health reform nation-wide, the commission purposively excluded addictions from its mandate marginalizing the mental health needs of many, including Aboriginal peoples who are disproportionately affected by both. Advocacy for the separation

of mental health and addictions was led by the national group on addictions itself who may have feared that the low priority ascribed to mental illness by policy makers would undermine recent achievements within the field of addictions.

As a result, despite BC's decision to merge mental health and addictions under one departmental responsibility in 2001, current mental health policy continues to categorize mental health issues into distinct jurisdictional divisions delineating 'youth' from 'adult' mental health, and 'mental health' from 'addictions'.

Most ideologies are made by and operate in favour of the dominant group. They legitimate and reinforce existing ruling relations through the subtle exercise of hegemonic power in all social domains of life (Smith, 1987). According to Gramsci (1971), hegemony denotes to the invisible role of dominant ideologies in organizing everyday practices and policy of social institutions in such a way that they are perceived as rationale and common sense (Omi & Winant, 2002, p. 130).

The exclusion of Aboriginal peoples from the making of knowledge and ideologies means that their experience, interests and worldviews have not been represented in the organizational/institutional and political processes and structures of society. Historically, this exclusion was sustained through consciously racist and often cruel practices. However, in contemporary society competing human rights discourses have replaced open racism with the subtleness of ideologies that continue to exclude the voices of peoples according to race, class, gender, disability and sexual orientation. Fernando (2003) refers to

this phenomenon as “institutional racism”; a term first coined by Carmichael and Hamilton in 1997, who defined institutional racism as “the collective failure of an organisation to provide an appropriate and professional service” to a racialized group of peoples (p.17). Fernando (2003) further argues that ideological and structural forms of racism are replicated in the field of mental health leading to institutional forms of racism that guide mental health policy and practice. According to Wade (1993), “institutional racism denotes the extent to which racism is embedded in the dominant organizations and power structures of society” (p.543) through which discriminatory practices are institutionalized into mental health policy and systems. Thus, if health policy makers remain uncritical towards how policies and practices mirror ideological frameworks, good intentions will continue to result in unintended consequences that are more oppressive than emancipatory to the expected beneficiaries.

3.3 Neo-liberal Ideology and Mental Health

In Canada, mental health reform unfolds within a neo-liberal climate. As such, progressive reform ideas that are concerned with issues of quality of life and quality care for peoples with mental illness are seen alongside neo-liberal discourses that promote reduction of expenditures on social programs, increasing privatization as well as a shift towards self-management (Morrow, 2004).

Neo-liberal ideology emphasizes economic individualism and the fairness of free-markets, and as such, fosters state discourses that favour reduced economic regulations and social support (Morrow et al., 2008; Peck & Tickell,

2002). According to Peck and Tickell (2002), neo-liberalism is an “ongoing ideological process” that emerged in the 1970s as a response to the world-wide economic crisis. Yet, as an explicit political-economic project, neo-liberalism became heavily criticized during the 1980s for its economic and social short-falls, resulting from the dismantling of the welfare state and increased deregulation of formerly government-controlled public sectors. As a consequence, neo-liberalism submerged as an explicit political project only to resurface in more subtle and “depoliticized” forms that have been referred to as “deep” or “roll-out” neo-liberalism. This most recent phase of neo-liberalism is characterized by a shift in rhetoric and an interventionist agenda that includes social subjectivities, modes of governance and institution-building within hitherto social spheres, such as the health care and mental health system. However, as social and health care reforms unfold, it becomes apparent that the new and increasingly technocratic neo-liberal project is, in effect, highly political and follows a course of punitive and restrictive policies, which individualize social suffering and create binary categories of “the deserving” and “the undeserving” poor to justify and legitimate its ongoing concern for cost containment and reduced expenditures for social assistance and public programs.

With the election of the Liberal government in 2001, BC’s restructuring of the social welfare state and the health care system has become an example of a jurisdiction that has followed closely the tenets of neo-liberalism (Morrow, 2004; Morrow et al., 2008). The implications of this political shift have garnered much attention due to the severe cuts in social welfare and rising homelessness. Since

2001, BC has witnessed a wide range of losses in the social service sector, including the abolishment of BC's Mental Health Advocate and Human Rights Commission, the closure of all Native Law Offices, severe cuts to women's services and social welfare rates as well as new restrictions on eligibility for welfare and disability benefits. As the BC Convention on the Elimination of All Forms of Discrimination Against Women (CEDEAW) Group reported to the United Nations Committee on the Elimination of Discrimination Against Women, on the occasion of the Committee's review of Canada's Fifth Report, "these changes have particularly harmful effects on Aboriginal women and their communities" and violate BC's international obligations to comply with International Human Rights Treaties, such as CEDAW (2003, p.4).

In complex simultaneity, BC advanced its neo-liberal project through the engineering of new social institutions and its new articulation of BC's health care reform goals. As part of the new health goals, equity issues are primarily framed as resulting from insufficient financial control in the face of rising health care costs with improved cost-efficiency as the proposed solution. As a result, the most recent iteration of regionalization, which amalgamated 52 local health boards to five regional health authorities, was justified "by creating a more streamlined, cost-efficient, effective and accountable governance structure for health care in B.C. [so that] more resources can flow to patient care as a result of lower administrative costs and fewer bureaucratic hurdles" (British Columbia. Ministry of Health Planning, 2002; p.21).

While social advocates were originally supportive of regionalization as a strategy to increase local accountability and citizen engagement, within a neo-liberal policy context, the actualization of the progressive nature of regionalization is challenged. Neo-liberal commitments, such as the integration of corporate management style into governments and a prioritizing of fiscal responsibilities, the free-market symbolized a profound shift in policy orientation from political to managerial accountability (Kornelsen et al., 2005; Davidson, 1999). Instead of electoral accountability of regional health governance structures, board members are appointed and likely drawn from the business sector and performance measurement has become intimately tied to fiscal responsibilities and spending money (Kornelsen et al., 2005).

Thus, mental health policy and reform are intimately tied to political and economic processes. Over the past decade, cost containment in health and social sectors has been paramount in the organization and delivery of health care services in BC (Morrow, Frischmuth & Johnson, 2006; Morrow, 2004). However, neo-liberalism is not only manifest in the ways that certain local institutions operate but it also exists in 'extralocal' spheres in that "it shapes the environments, contexts, and frameworks within which political-economic and socio-institutional restructuring takes place" (Peck & Tickell, 2002, pp. 400-401).

3.4 Conclusion

Understanding contemporary Aboriginal mental health requires a contextualized and historical approach that recognizes the highly political nature of Aboriginal mental health. As such, contemporary Aboriginal mental health

reform cannot be divorced from its colonial past nor from the neo-liberal context of the present.

Rooted in racist and colonial ideologies, policies that are paternalistic and assimilationist have traditionally guided (mental) health care for Aboriginal peoples. Ultimately, it is clear that colonial processes and practices, such as the residential schools, did not provide better care and often involved cruel treatment that has caused widespread individual and intergenerational trauma. Systematic social, economic and political marginalization of Aboriginal peoples has further weakened communities' capacities to heal and has nourished a deep distrust towards government and institutions. As a result, for Aboriginal peoples, healing is inextricably linked to regaining self-determination and addressing the social determinants of health.

While there has been a continuous shift in Aboriginal health policy towards greater participation and self-determination of Aboriginal peoples in mental health care planning and delivery, competing ideologies and discourses create places of struggle resulting in erratic progress and seemingly paradoxical policies and practices. Western ideologies embedded within the mental health care system clash with ideologies of Aboriginal understandings of mental health. Many mental health policies and institutions continue to align with the bio-medical paradigm of health creating gaps in services and barriers to access for many Aboriginal peoples. Because neo-liberalism justifies policies and programs that emphasize individual responsibility and generally favours short- over long-term strategies (Morrow, 2004; Peck & Tickell, 2002), BC's current political climate intensifies

this tension by propping up existing bio-medical discourses about mental illness (Morrow et al., 2008). Thus, despite calls for culturally appropriate services for Aboriginal peoples, the dominance of the biopsychiatry has left alternative mental health support and treatment options underfunded. In addition, at the same time, as the neo-liberal policy shift has intensified gap between poor and rich, its individualization of mental health problems effectively erases the impact that this socio-historical and political context may have for Aboriginal mental health.

As I framed it, my research interest lies in exploring how these ideological tensions play out and are experienced by Aboriginal key leaders and service providers in mental health within Interior Health, one of BC's five geographical health authorities, that is currently undergoing reform processes in Aboriginal mental health policy. This grounded and contextualized understanding of the socio-historical and political positioning of this study provides a rich starting point for the exploration of the Aboriginal mental health reform in the Interior of BC. Throughout the analysis, I will return to these streams of thinking and braid them into the discussion of my findings in order to shed light on the continuities of past and present tensions in Aboriginal mental health.

4: ANALYSIS & DISCUSSION: POLICY AND PRACTICE – THE LIVED EXPERIENCE

In chapter four and five, I present the analysis that arose from the examination of the ways in which the tensions described between IH's vision of the Aboriginal mental health reform and participants' lived experience are reflective of underlying socio-historical and political ideologies tying the analysis of my data to the results of my literature and document review. In chapter four, I start my analysis with a critical discussion of those findings that are concerned with IH's overarching Aboriginal framework for reforming Aboriginal mental health. By doing so, I provide the necessary background for chapter five, in which I shift my analysis to focus more specifically on how these institutional processes and structures have affected Aboriginal mental health programming and service delivery.

Using the voices of participants and examples from the policy review, in this chapter, I describe the rationale, mechanisms and changes that occurred under IH's direction and explore common tensions that are woven through the interviews. As explained earlier, I am using the concept of tension as a device to reflect on how broader ideologies are organizing everyday practice, such as funding and proposal writing.

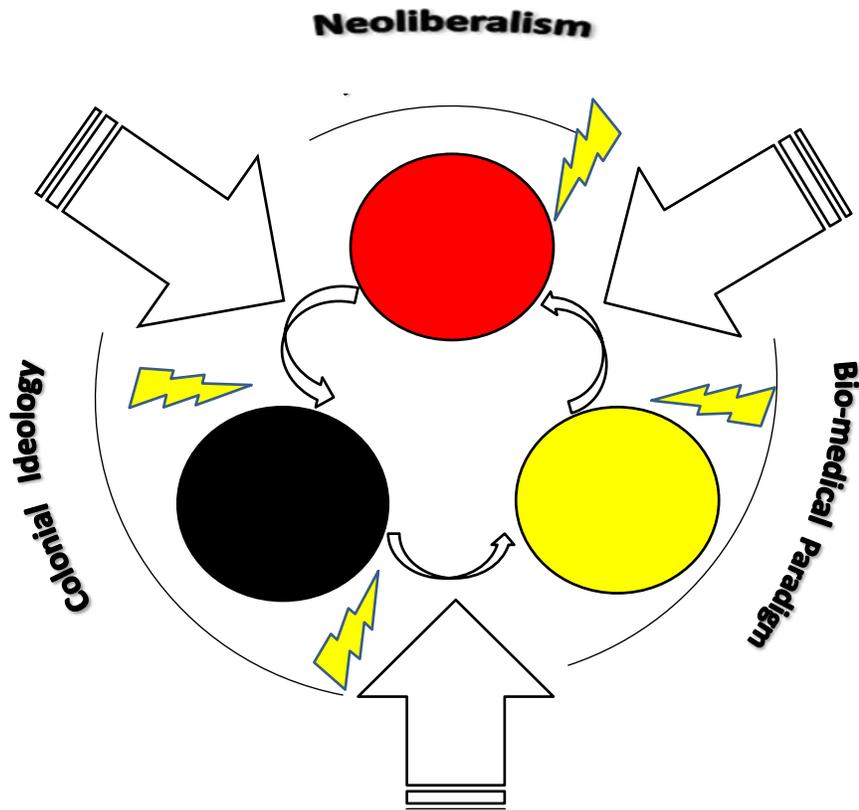
In the following interview excerpt by a service provider for an urban Aboriginal organization, the participant shares an experience that summarizes three common threads of tension providing an entry point to the analysis:

RP8: Interior Health says 'Oh yeah, well let's get an urban Aboriginal liaison, you know, let's get an Aboriginal team lead, let's get an 'Aboriginal'. So, they bring these people aboard but that does not provide culturally safe services. They are still making their decisions as to how they are going to fund, who they are going to fund, when they're going to fund, and how much they're going to fund.

This participant speaks to an overlay of tensions that paradoxically arise from exactly those values that are at the centre of IH's reform¹⁴. As the following figure 5 illustrates, IH's Aboriginal health framework defines 'diversity', 'partnership' and 'respect, trust and responsibility' as key ingredients for "the development of a holistic health and wellness system that is responsive to the needs of diverse Aboriginal Communities" (IH, 2006, p.6). Yet, as the participant's narrative shows, in everyday practice these values are experienced as tensions that emerge around three overarching themes: 1) Aboriginal Representation, Selection and Inclusiveness; 2) Meaningful Participation; and 3) Mistrust towards Governments.

¹⁴ The overall goal of IH's Aboriginal health framework is "to create a *respectful, trusting, responsible partnership* between Aboriginal People and Interior Health to support the development of a *holistic health and wellness system* that is responsive to the needs of *diverse Aboriginal Communities*" (IH, 2006, p.6).

Figure 5: Applied Framework of Analysis: The Relationship between Tensions, Ideologies and Core Values of IH's Aboriginal Health Framework



As the analysis unfolded it became apparent that these experiences weave through all interviews and are embedded in ideologies that are integral to the process of colonization, Western medicine and current neo-liberal reform politics. As a result, these overarching themes provide the framework of analysis for this chapter. In the following, I will describe each tension and its sub-tensions in more detail and explore the role of ideologies in mediating these experiences.

4.1 Aboriginal Representation, Selection and Inclusiveness

The creation of participatory structures for traditionally marginalized populations is likely to lead to significantly different policy than when the

dominant culture alone makes decisions (Arnstein,1971), and is generally regarded as serving two functions: First, it improves the efficiency of services and the responsiveness of the system (Church & Barker,1998). Second, creating avenues of participation for minority groups is empowering (CMHA, 1999). As such, Aboriginal representation in health care decision-making and delivery through the establishment of participatory structures and Aboriginal-specific positions can promote healing in that it has the potential to transform longstanding power imbalances rooted in colonial practices.

4.1.1 Aboriginal Empowerment: Hearing Aboriginal Voices

For Narayan (1995), the concept of justice is central and may even constitute “a precondition for the possibility of adequately caring for and about some people” (p.138). In much the same way, justice may be viewed as necessary for improving Aboriginal health in that it serves as a motivating force behind the social organization of Aboriginal resistance and as source of genuine care for and about Aboriginal peoples on the side of the government. Narayan (1995) establishes her position by arguing that historically, justice motives played an important role in transforming social relations and challenging ideologies of the inferior “Other” as part of large social and political movements.

The findings of this study seem to confirm this view. Aboriginal participants were without exception highly reflective on the political dimensions of their work and conscious of a collective strength stemming from the shared experience of oppression and survival under colonial relations and an indigenous worldview that connects Aboriginal peoples across all different cultures.

RP 1: It could be Status Indian, it could be non-status Indian, it could be Métis or Inuit, in many cases because we are Aboriginal people we bring with us an Aboriginal knowledge that isn't easily taught, so even if my cultural knowledge is different to the cultural knowledge of another Aboriginal knowledge, there is a shared value, understanding and respect to what has to happen in order to support theirs.

This idea of a shared Aboriginal identity and consciousness that this participant reflects on, is ideologically fundamental to BC's Aboriginal health movement,¹⁵ which makes Aboriginal involvement at all levels of health service delivery and programming a premise for improving Aboriginal health and well-being. However, while this discourse has served the Aboriginal community in negotiating structural change in health care policy, when applied within a neo-liberal health care policy context this discourse can also inform and engender practices that ignore the heterogeneity of the Aboriginal community, particularly within the setting of governmental institutions, such as the mental health care system with its longstanding history of colonial practices and tendency to construct Aboriginal peoples as the decontextualized "Other".

In the following, a member of IH's Aboriginal Health Division shares his 'insider' analysis regarding IH's approach to implement a participatory model of Aboriginal health policy that responds to the heterogeneous constitution of IH's community-based Aboriginal health care system.

RP1: We [IH] try to have lots of different ways that we communicate with the Aboriginal community, for example, through our Aboriginal Health and Wellness Advisory

¹⁵ Key policy documents, such as the Transformative Change Accord and the resulting BC's First Nations Health Plan, highlight the need for involvement of First Nations and communities to develop a culturally sensitive approach to Aboriginal health that will benefit all Aboriginal people in BC independent of their status (Province of British Columbia & FNLC, 2005; 2006).

Committee, where every Nation, the Urbans and the Métis have someone appointed to represent their interests. And then each health service area has an Aboriginal Health Improvement Committee or a Steering Committee. But it isn't necessarily community consultation in the broadest sense of the community in terms of the thousands of the, you know, 37,000 possible Aboriginal people in Interior Health had opportunity to have voice. And it's really more organization-driven, and it tends to be community health representatives, addictions counsellors, health directors employed by bands or tribal councils who come to those meetings and represent the needs of their clients.

Throughout the analysis of this study, however, it became apparent that the degree to which Aboriginal community members perceived their opinions and views to be included and represented within IH Aboriginal mental health reform varied. In the following excerpts, two participants who work for an urban Aboriginal organization comment on the capacity of AHWAC to represent the Aboriginal community in IH.

RP2: The Aboriginal Health and Wellness Advisory committee is actually comprised of mostly on-reserve. Yeah, it's mostly on-reserve representation. It's one of the reasons that we have a health and wellness plan specific to on-reserve, although the urban Aboriginal peoples are still guided by that, and have no need for a lot of the stuff that's in there.

And...

RP3: There was somebody proposed and I'm not sure who, if it's X or if it was Y who sits on AHWAC, I'm not sure who the representative is on that committee. And I don't think there's a lot of involvement amongst all the Friendship Centres talking to that person . . . I think once they had one seat, that IH decided who would be the best person to kind of have there.

These narratives provide insight into the perceived dissonance between the experience of urban Aboriginal community organizations and the role of AHWAC in representing urban Aboriginal issues in IH. According to the terms of reference for AHWAC (2002), "the Aboriginal Health and Wellness Advisory

Committee [is defined as] ... the formal link between IH and the Aboriginal communities at the strategic directions / policies level [with] all Aboriginal Peoples [being] ... represented and Committee members [being] ... accountable to those communities” (IH, 2003, Appendix P, p.19). However, while AHAWAC’s terms of reference set out that nine out of 14 seats go to each of the First Nations within IH, urban Aboriginal organizations in IH are represented by only five member seats including one Métis seat. Thus, AHAWAC’s constellation is pre-determined in such a way that it gives disproportionately more voice to on-reserve communities, undermining effective participation of both urban and Métis communities.

In addition, findings indicate that the current method of selection employed by IH to create structures of participation and Aboriginal positions has compounded tensions arising from issues related to representation and inclusiveness. Given that public members to health authorities, such as AHAWAC, are not elected but appointed, health authorities need to take special care to select Aboriginal members who are representative of the public (Cheema, 2005). For Aboriginal peoples, the issue of selection and representation is particularly complex since political interests and needs are diverse and may differ with status, band membership and place of residency.

Under BC’s original regionalization policy *New Directions*, local accountability and citizen engagement were premised on electoral accountability of local and regional health governance structures (BC. Ministry of Health and Ministry Responsible for Seniors, 1993). Democratic elections provide the public

with the means to direct the actions by health authorities as well as the power to sanction them by defeat at the polls. This is what Davidson (1999) calls political accountability. However, during the last decade of health care reform, BC underwent a profound shift in policy orientation from political to managerial accountability (Kornelsen et al., 2005; Davidson, 1999). The idea of elected board members to health authorities was abandoned and replaced with Ministerial appointments of board members and Chief Executive Officers (CEOs), who stayed in an agency relationship to the Minister.

Arguably, for effective public participation, public participants do not necessarily need to reflect the demography of their communities as long as they are knowledgeable and understanding of the needs and concerns of those they represent (Wharf Higgins, 1999). Yet, for Aboriginal peoples demographics, such as the place of residency, band membership and status, are not only descriptors but legal categories that determine access and eligibility to a variety of health and social services. As Smye (2004) argues, with the enactment of the Indian Act, Canada imposed a detrimental class structure on its Aboriginal population by tying Aboriginal rights and freedoms to the legal notion of Status First Nations and to on-reserve residency. Correspondingly, the majority of federal funding for Aboriginal health has been traditionally directed to on-reserve communities, leaving urban Aboriginal organizations in a fierce competition for the scarce resources provided through a variety of provincial authorities. Hence, distinct infrastructures emerged within the urban context and on-reserve.

The complexity and political nature of the relationship between urban and on-reserve communities in Aboriginal health would, therefore, suggest that any attempt to undermine fair representation of urban and on-reserve communities is likely to challenge effective Aboriginal participation in mental health care planning. The question however, how to achieve fair representation without elections remains a point of contestation that has created frustration and exacerbated pre-existing tensions among Aboriginal community leaders in mental health and Interior Health.

4.1.2 Regionalization: Does ‘Closer to Home’ Really Matter?¹⁶

Some Aboriginal service providers also stated that, in fact, they experienced a decrease of involvement in decision-making since the most recent iteration of regionalization and the creation of IH. In the following excerpt, a participant reports on how the re-structuring processes in BC’s health care reform have influenced the role of Aboriginal frontline workers in health care decision making in the Interior.

RP2: We used to be informed. We used to be involved. ... I supervise the addictions, the mental health and the sexual abuse program [at this community-based organization]. And through that I was invited to sit on the planning committees for Interior Health at that time. Since then it has been restructured and they actually have advisory committees, which takes the frontline workers off of those planning committees. That’s how it works now.

Here, the participant conveys the way decision-making has actually been further removed from Aboriginal communities through the creation of new committee

¹⁶ This title is taken from Weaver (2006) Regionalization of health care in British Columbia: Does ‘closer to home’ really matter?

structures and advisory committees under IH's Aboriginal health reform. The participant's perspective mirrors a common perception held by other urban Aboriginal organizations, who feel that their voices are no longer heard since the abandonment of the old regional system under which TOKOABC, the Thompson-Okanagan-Kootenay Aboriginal Health Council, was in place.

As alluded to elsewhere, regionalization entails both centralizing and decentralizing forces (Church & Barker, 1998) that are shifting the way Aboriginal participation in mental health planning and delivery is conceptualized and operationalized. Within the context of IH, by the end of 2001, decentralizing forces had created an Aboriginal mental health system that operated mainly outside the regional health boards and included strong working relationships with front-line service providers and Aboriginal community leaders in mental health and addictions. Under TOKOABC, Aboriginal service providers and community leaders in Aboriginal mental health and addictions were actively involved in Aboriginal health planning through annual consultations with urban Aboriginal organizations playing a pivotal role in this system. Correspondingly, urban Aboriginal service providers also played an active role in developing local Aboriginal health plans with regional health boards and councils throughout the Interior Health region. The synthesis of these plans later on produced the original version of IH's Aboriginal Health and Wellness Plan in 2002.

However, with unfolding reform processes under IH, these mechanisms of participation were restructured and centralized in the form of IH's Aboriginal Health Division. The following participant, who is a service provider and manager

for an urban Aboriginal organization, comments on how the meaning of Aboriginal participation changed throughout IH's Aboriginal mental health reform by choosing the re-development of IH's Aboriginal Health and Wellness Plan as a focal point:

RP4: They [IH] got feedback through their Aboriginal Health and Wellness Advisory Committee [with respect to the 2006-2010 revision of the Aboriginal Health and Wellness Plan]. So, there was feedback solicited from the Committee itself but not from the agencies. It was good that IH got feedback from the Committee. The Committee pretty much has represented us from across the whole Health Authority, on-reserve and off-reserve, but they didn't solicit any feedback from the contractors. They didn't go out and actually ask the people who have contracts with them about their strategic plans. So I think that's a big missing piece.

Here the participant expounds the problems of the removal of Aboriginal decision-making in health planning from the community to intermediary participatory structures, such as the AHAWAC. According to Davidson (1999), the retreat from community engagement in health planning towards a centralized decision-making process at a regional level is reflective of a more profound policy shift in BC's health care reform. It marks a gradual retreat from a population health approach that is conceptually and normatively bound to such concepts as local accountability and community empowerment towards a managerial model of accountability that is according to Kornelsen et al. (2005) engendered by a neo-liberal ideology.

The adoption of this new public management style dramatically changed the nature of Aboriginal health governance structures. First, it meant the abandonment of distinct Aboriginal governing bodies and second it signified a

removal of decision-making to centralized intermediary structures by expanding the role of management within IH, truncating the role of service providers and front-line workers.

As a result, dissatisfaction has overshadowed the working relationship between the urban Aboriginal community and AHAWAC which, at least for some organizations, has translated into a disconnection between the selected delegate and his constituency. This finding is of concern since “it is widely accepted that public participants are only effective to the extent that they can draw upon a constituency for ideas and support” (Cheema, 2005, p.17).

4.2 Meaningful Participation

Information exchange, power sharing and partnership are not easily embraced in a policy sector dominated by professional expertise in the clinical and managerial domain (Abelson & Gauvin, 2004, p.vii). In general, findings show that despite IH’s creation of avenues for participation for Aboriginal individuals and communities, informants from both IH and the community experience many barriers for meaningful participation that undermine progressive reform changes in Aboriginal mental health.

4.2.1 Decision-Making in the Business of Health Care

Many participants throughout the interviews showed signs that they were unconvinced of the capacity of the Aboriginal Health Division to empower Aboriginal decision-making in mental health and addictions and hence, to improve services and service accessibility for Aboriginal peoples with mental

health issues. The following participant, who is associated with the Aboriginal Health Division, again uses the example of AHAWAC to demonstrate barriers for effective participation due to AHAWAC's composition but adds another layer of complexity to the issue:

RP9: Their Aboriginal Health and Wellness Advisory Committee – they are not inclusive of the people who should be at the table. There's no safety for making proper decisions without recourse of action from Interior Health. There's no freedom of having open discussions. It's a committee of rubber stamps.

Here the participant draws attention to the structural barriers that limit AHAWAC's decision-making capacity. Within the Aboriginal Health and Wellness Plan, IH defines AHAWAC's purpose "in providing advice and direction to the Interior Health Senior Executive Team" (IH, 2003, Appendix P, p.1). Without the ability to enforce its advice, final decision-making power is retained by IH's senior executive team. As such, the participant above perceives AHAWAC is as a tokenistic "committee of rubber stamps". Arnstein (1971) calls this mechanism of citizen engagement a "placation strategy" by which the powerful "place[s] a few handpicked 'worthy' poor on boards of Community Action Agencies or on public bodies" while at the same time retaining "the right to judge the legitimacy and feasibility of the advice" (p.5). This structural power imbalance is further exacerbated by the observed disconnect between some AHAWAC members and some urban Aboriginal communities (due to tensions around representation and inclusion) undermining the organization of political power from the community to support AHAWAC's advice and press for certain priorities. This finding underscores Church and Barker's (1998) claim that public participation is

intimately tied to pre-existing power structures that are not easily shifted through regionalization.

The following participant, who represents an on-reserve organization, shares a perspective on how IH makes decisions for the Aboriginal community:

RP7: The Mental Health and Addictions dollars that were just allocated, there was only one person from Mental Health that sat on the team that made the final decision. All the rest were business managers that had no background. And that's one of our beefs. We are not happy with that but that's the way IH makes their decisions. That's their process. So there was one person that was from the Mental Health and Addictions background and that was it. And then there was the Aboriginal lead. So they felt that that was covered off.

This participant criticizes the fact that the majority of senior executive team members are drawn from the business sector, and are therefore lacking both a background in mental health and Aboriginal health. Yet, they are making decisions about how the funding for Aboriginal mental health and addictions is spent. According to Davidson (1999), management and governance structures merged because within a neo-liberal climate, management is incorrectly interpreted as a neutral and hence, an efficient and fair decision-maker.

As a result, governments introduced a business-like management style to health authorities with a new emphasis on improved management of care (Kornelsen et al., 2005; Davidson, 1999). Under the Liberal Government, health authorities are held accountable through annual performance agreements with the Ministry of Health, which places health authorities in an agency relationship to government and defines accountability in terms of fiscal responsibilities and spending money. As such, to some it might not seem surprising that with the

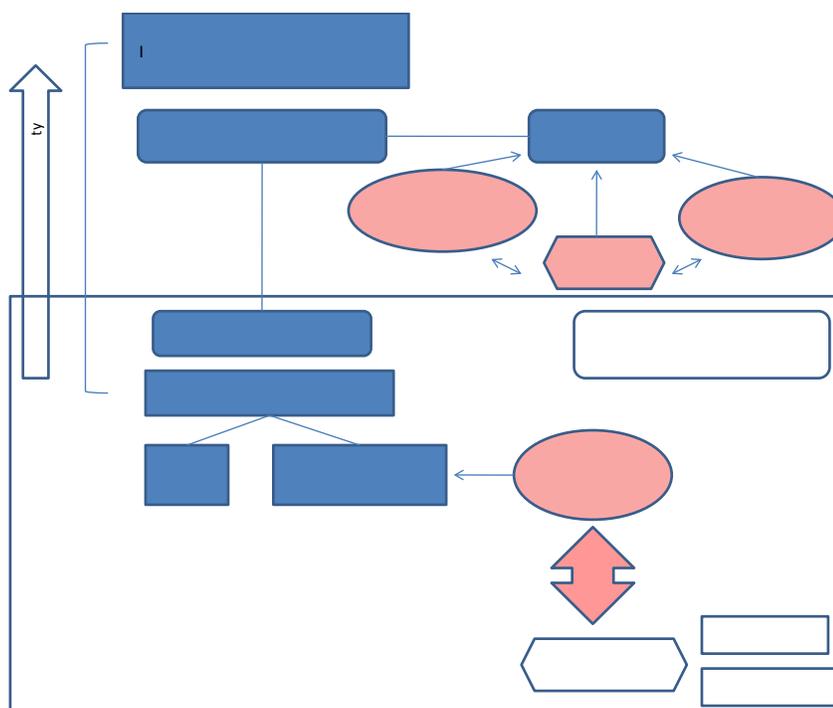
election of the Liberal Government in 2001, CEOs are now even more likely to be drawn from the business sector than before (Kornelsen et al., 2005).

“I mean we are in the business of health care” (RP1). Within a corporation, decision-making power follows a strict hierarchy. Likewise, decision-making capacity in IH is contingent on a set of certain criteria.

RP1: Whether you are in place to make decisions is [contingent on]: do you supervise staff, do you have control over quality insurance delivery of service, can you hire and fire, do you do performance evaluation, do you have a budget, can you contract a service, leverage a service or fund service. Those are all things that determine at which level in the organization you can make a decision.

As graphically depicted in figure 6, within IH, decision-making happens on the health service area level through the senior leadership team (meso-level) and at the regional level through the senior executive team (macro-level).

Figure 6: Decision-Making Structure of IH's Aboriginal Health Division



Until 2007, macro-level structures in IH's Aboriginal Health Division were limited to two Aboriginal-specific positions and AHAWAC. In contrast to AHAWAC, whose mandate is bound to an advisory role, the positions of the Aboriginal Policy Coordinator and the Aboriginal Strategy Coordinator provided for a certain degree of decision-making capacity. Although final decision-making authority remained with IH's senior executive team, these individuals played a fundamental role in the evolution of Aboriginal mental health reform. AHAWAC, which was created in 2002, for example, played a central role in the development of the Aboriginal Health and Wellness Plan for 2003-2006. Given that the plan was the product of an extensive collaborative project between existing local Aboriginal health boards and committees and the newly formed regional health authority (IH, 2003), the priorities outlined in this plan seemed to be the result of

effective Aboriginal community collaboration across jurisdictional boundaries. As confirmed by all interview participants, the creation of *Interior Health's Aboriginal Health and Wellness Plan* symbolizes the cornerstone of Aboriginal mental health reform in the IH.

The position of the Aboriginal Strategy Coordinator was added later on in September of 2003 to oversee the coordination and implementation of the plan including all contract management with Aboriginal communities throughout the entire IH region. Together with the Aboriginal Health Policy Coordinator, which was only established in 2006 with the mandate to integrate and coordinate Aboriginal health policy with other IH departments, these individuals reported to the Senior Medical Health Officer whose mandate is public health. As a member of the senior executive team (SET), the Senior Medical Health Officer continues to function as the link between the SET and IH's Aboriginal Health Division.

On the meso-level, IH's Aboriginal Health Division encompassed four Aboriginal liaison officers, who were responsible for bridging the divide between the health authority and Aboriginal community within each of the four health service areas. Aboriginal Liaisons facilitated, for example, Aboriginal Health Improvement Committees (AHICs) which were held monthly for the primary purpose of networking and information-sharing between IH and health service workers from on- and off-reserve. As such, the role of Aboriginal liaison workers was designed to first build relationships with the Aboriginal community, which included urban Aboriginal community organizations, such as Friendship Centers, and community representatives from local First Nations Bands, and second, to

put forward proposals by the community to address problems and concerns within the Aboriginal community. However, within the given structure, liaison workers did not hold any decision-making power as “they don’t have staff, don’t hire and fire and don’t have a budget” (RP1). Instead, if the community provided input, the liaison worker’s role was to bring the issue to the attention of the specific member of the senior leadership team who held the portfolio for Aboriginal health, who would then present the proposal to the senior leadership team of the given health service area for further action.

4.2.2 Capacity Building in IH’s Aboriginal Health Division: Quantity versus Quality

Given the relatively low number of Aboriginal positions at the macro-level and the lack of Aboriginal representatives at the meso-level, top-down and bottom-up structures within IH’s Aboriginal Health Division remained functionally disconnected rendering efforts to implement both strategies from the Aboriginal Health and Wellness Plan and community-proposed solutions forwarded by the Liaisons ineffective. The following IH employee sums up the challenges perceived by IH’s Aboriginal Health Division under the model described above:

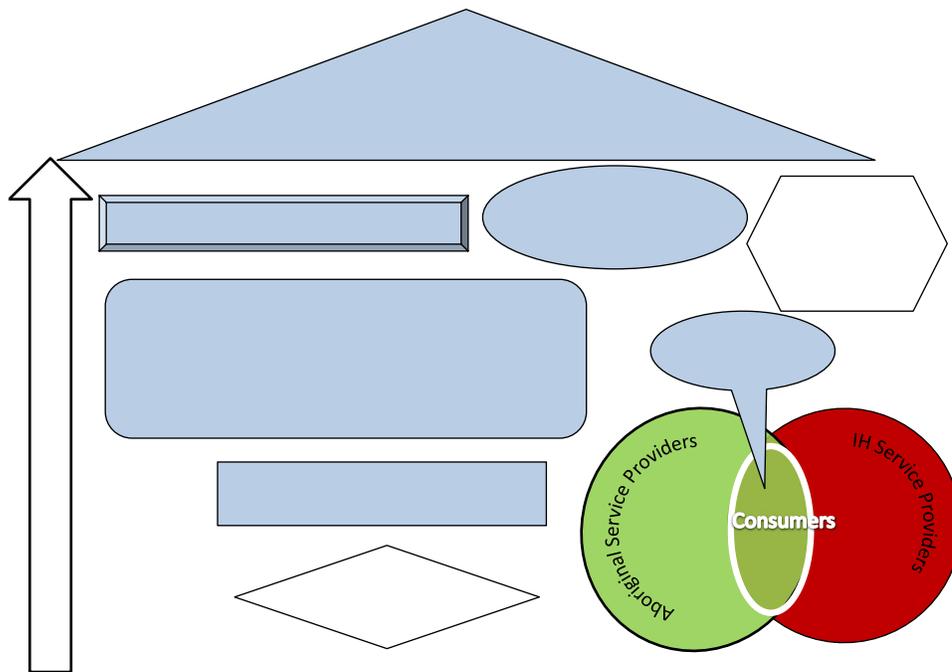
RP1: So, what our challenges that we noticed were, is that these are the only 2 Aboriginal positions (Aboriginal Policy and Strategy coordinator) that were placed in the organization I would call it at the corporate level, so they had a macro-vision of the whole health authority. Whereas these positions (Aboriginal Liaison) are placed closer to the community to build relationships but they are just geographically specific to a health service area and they really more about operations. So they don’t spent a lot of time talking about the strategy. They are not in any way decision makers.

As a result, at the time of the interviews in 2007, IH's Aboriginal Health Division was in the process of being re-structured. Under a novel Aboriginal Health and Wellness Plan for the time period 2006 to 2010 and the new authority of an Aboriginal Lead or Director, who was appointed in January of 2007, a budget was approved to expand IH's Aboriginal health division with the goal to double its Aboriginal positions by 2008. The second plan shifted the focus of reform from relationship building between Aboriginal communities and IH towards establishing integration and coordination of services (IH, 2006) initiating a new phase of Aboriginal mental health reform.

The newly proposed model¹⁷ for IH's Aboriginal Health Division is articulated by one of IH's employees and outlined in figure 7:

¹⁷ Under the new model, IH's Aboriginal Health Division is headed by the Aboriginal Lead. Subordinated to the position of the lead, which was put in place even prior to the start of this study, are the Aboriginal strategy coordinator, the Aboriginal contract advisor and three community engagement coordinators, whose main mandates would be to implement the Aboriginal Health and Wellness Plan within their priority area. As one priority area, 'Mental Health and Addictions' is to become a strategic area for one of the community engagement coordinators. Other avenues of community input would be the Aboriginal program advisors, formerly known as Aboriginal liaisons, and the Aboriginal Patient Navigators, who would be physically stationed within regional hospitals to help patients as well as mainstream service providers to 'navigate' services available to Aboriginal patients.

Figure 7: The New Model for IH's Aboriginal Health Division



Within the new model, IH proposes the establishment of several, new Aboriginal positions at the meso-level while authority over the entire spectrum of Aboriginal health within IH was given to one position, the Aboriginal Lead¹⁸. According to the same participant, the premise of the new model is...

RP1: ... to train and employ more people so we would have a greater number of Aboriginal expertise within the system who can then begin influencing the other areas of strategic service development and operationalization of services that are better able to meet the needs of the population.

¹⁸ The creation of the position of the Aboriginal Lead can be directly traced back to the signing of the Transformative Change Accord by the FNLC, the Province of British Columbia and the Government of Canada in 2005. The Transformative Change Accord is a cross-governmental commitment to a ten-year plan to close the social and economic gap between Aboriginal peoples and their non-Aboriginal counterparts. Within this document, BC's health authorities are charged with the responsibility to establish the position of Aboriginal Health Leads. As in IH, the Aboriginal lead was to be assigned authority over the entire spectrum of Aboriginal health within one health region to "work with local program and services staff on behalf of First Nations to better meet the non-hospital health service needs of Aboriginal people" (Government of British Columbia & FNLC, 2006, p.10).

As such, the rationale for the introduction of the new model is two-fold: First, it is anticipated to foster greater collaboration and coordination within IH's Aboriginal Health Division itself as well as between the division and other governmental departments, and second, it is expected to increase Aboriginal capacity with IH.

For example, part of the new job descriptions for the Aboriginal Lead and the community engagement coordinators entails developing special expertise as to what programs are offered by other departments or jurisdictions, such as IH's mental health Department and the Ministry of Health and First Nations and Inuit Health (FNIH). In addition, under the new model, Aboriginal positions at the meso- and macro-level, including the Aboriginal Liaisons (whose title would change to Aboriginal Program Advisors), would be joining the senior team leadership meetings at each health service area. As such, with respect to the first goal, IH's new design addresses some serious past and current issues that have been identified as barriers for change, such as the disconnect between bottom-up and top-down structures within IH and the disintegration of current Aboriginal mental health care service provision through the divide of provincial and federal responsibilities for certain groups of Aboriginal peoples.

Furthermore, although only some of these positions illustrated in figure 7 were actually established during the course of this study, it was confirmed that job descriptions for all of these positions were in the process of being written. Given that to date the majority, if not all, Aboriginal health positions within IH are held by individuals with Aboriginal ancestry, the provision of funding to expand IH's Aboriginal Health Division seems to reflect a serious and ongoing

commitment by IH to promote Aboriginal participation in health care programming.

Yet, while the new model would certainly increase Aboriginal expertise in the system, it remains to be seen if the internal restructuring will in fact increase Aboriginal participation in decision-making at the macro-level or meso-level and hence, Aboriginal capacity. Will the creation of these new positions, for example, translate into an increase of Aboriginal seats at the senior executive team, or will the Aboriginal Lead be the single voice for the entire Aboriginal Health Division? For some, it appears that no change in decision-making power would occur. For instance, although Aboriginal liaisons would join the senior leadership team, the role of Aboriginal Program Advisors (Aboriginal Liaisons) would continue to be strictly advisory. Given that Aboriginal Program Advisors like the liaisons would represent the only direct avenue for bottom-up input by the Aboriginal community, this decision reflects IH's general tendency to keep a disproportionate amount of decision-making power at the corporate level.

4.3 Mistrust toward Government

Given the strained relationship between governments and Aboriginal peoples, mistrust and scepticism towards large institutions often remain the foundation of newly established relationships between governmental agencies and Aboriginal representatives. Thus, for meaningful reform processes to take place, reconciliation between government and Aboriginal communities is a prerequisite for change.

Drawing on the work by the Royal Commission on Aboriginal Peoples, the Aboriginal Mental Health Committee ('Best Practices' Working Group) identified four relational principles as key for Aboriginal mental health and wellness programming: 1. Mutual respect, 2. Mutual recognition, 3. Mutual sharing, and 4. Mutual responsibility (Smye & Mussell, 2001).

Mutual Recognition & Mutual Responsibility

While the IH's Aboriginal Health Plan might formally uphold these principles, the plethora of tensions around issues of real partnership, meaningful participation and recognition of Aboriginal culture in mental health care reflects the disconnect between policy and practice that has fostered increasing animosity and mistrust towards IH's role in the ABMHR. The following participant's illustrates the disjuncture in perspectives.

RP9: So Interior Health has the understanding that this is about them doing some work with the communities, but really it's the other way around. It's the communities trying to address first of all the corporation's inability to understand and have a basic knowledge foundation of who they are to this land, who they are to their nationhood, and who they are to Canada. And until you create a relationship based upon those principles of respect, openness and peace sharing, then what we're doing right now is only addressing things as they come up, and on a very minimal scale.

Here the participant describes the tension that arises from IH's adopted leadership role in the AMHR that undermines the effective partnership and meaningful participation of Aboriginal peoples - even when working from within IH - by resisting the redistribution of power. Similarly controversially to the community was the appointment of the Aboriginal Lead by IH. Among community members, participants felt that Aboriginal people should have had a say in who

was to be hired. Yet, as a member of AHAWAC explained, AHAWAC's participation was reduced to writing the job description for the Aboriginal Lead, while the decision about the final candidate was made by IH without the committee (RP5).

Given the history of paternalistic care, discourses that justified and legitimized oppressing and demeaning practices by governments, Aboriginal people strive to re-gain control, ownership and responsibility relating to their health status (Government of BC; FNLC, 2006). As such, BC's First Nations Health Plan and the First Nations Health Blueprint for British Columbia establish the need for First Nations to be full partners in the design and delivery of Aboriginal health programs to close the gap in health between Aboriginal and non-Aboriginal peoples. Yet, given the perceived tension around meaningful participation by both Aboriginal people working under IH and community representatives of Aboriginal organizations on- and off-reserve, many participants have lost their trust in IH.

RP6: If I could wave my magic wand, I would wish that all this Aboriginal strategy that Interior Health is doing will be more than just lip service, which is what we think it is going to be.

Mutual Sharing

According to Cheema (2005), successful community empowerment is inextricably linked to "open, reciprocal information exchange as a basis of relationship building between communities, representatives and Interior Health." (p.97). In fact, Abelson and Gauvin (2004) define relationship building and answerability in the form of transparency as the strongest measures of citizen

engagement in health care. It is clear that if participation is only operationalized by giving disempowered groups a voice through such mechanisms as advisory boards but not the power to insure that this input is incorporated back into the decision-making process, participation remains an empty promise for Aboriginal peoples. IH's efforts to create avenues for communication between IH and both Aboriginal communities, such as the Aboriginal liaison position and the Aboriginal Health and Wellness Advisory Committee, have in fact remained functional one-way streets with little or no opportunity for feedback or negotiations.

RP4: And really, the process at Interior Health around Aboriginal Health, we don't have a lot of faith. A lot of the decisions that are made don't seem to be reflective of what the community wants, even of what the AHWAC Committee wants. We would have expected a better feedback process. We would have expected more transparent decision-making around the contracts, who was going to get what.

In the absence of sharing rationales behind reform changes, Aboriginal organizations and communities perceived their role in the Aboriginal mental health reform as rather re-active than pro-active, militating against any sense of agency.

Mutual Respect

Given the inadequate information sharing process by IH, mutual respect has been undermined and fostered the development of antagonistic and adversarial rumours within the community in its attempts to make sense of the severe funding cuts.

RP2: It's just ironic, it was really ironic to see that we lost how many hundreds of thousands of dollars in programming, but Interior Health now has a whole Aboriginal division of

employees working for them. But where are our dollars going? When you look at it, you see out in the community all these dollars are going down for agencies. And you see the hierarchy building at Interior Health.

One widespread rumour, for example, among participants from community-based organizations was that the service cuts within the community occurred because IH had used these dollars to create the Aboriginal Health Division. Even though this theory is incongruent with IH's position, the consequences of this rumour are likely to be far reaching in that they have resurfaced the longstanding historical animosity and distrust towards governments and institutions. As Arnstein (1971) writes, "this sham [of distorted participation] ties at the heart of the deep-seated exasperation and hostility ... toward the powerholders" (p.4).

The Challenge for Those Caught in 'Between': A Constant Tension between Compliance and Resistance

Aboriginal individuals who take on the challenge to work within the system face many challenges, one of them being the internal conflict of being torn between two sides. As the next two narratives describe, for Aboriginal people working within IH, the unique constellation of broader forces can generate an extreme conflict of interest as their role to advocate for Aboriginal peoples collides with their responsibilities as an IH employee.

RP9: The other part of it is that there is that assumption that the corporation determines how you act, how you react. And you fall under the corporation's mandate because you are now an employee, and you must address some of the policies and procedures of their organization that fall within that. So you are actually almost torn into two, because how do you advocate on

First Nations and Métis and Aboriginal peoples' behalf within the system when you're paid by them and employed by them?

and...

RP8: They say, 'Oh, we're looking for native people' but when you really look at it then – I don't know if they really are. If they were then there would be more Aboriginal people working with them. The same with the Ministry, they want Aboriginal peoples to go in and work in that field, but they have so stringent kinds of policy and the way they work and the different views, it is more of a stress to inflict that upon yourself willingly. So, it's sort of a double-edged sword.

Both participants eloquently describe the difficulties associated with trying to affect change from within the system of the dominant culture. In much the same way Bob Pease (2002) criticises that “empowerment [as a professional practice] gives agency to the worker in a way that contributes to the hierarchical character of the worker-client power relationship” (p.138), this study shows that despite IH's empowering vision to increase Aboriginal involvement in policy development to guide Aboriginal mental health reform, IH's institutional practices and organization perpetuate hierarchical power relations between government and Aboriginal communities and change agents. Thus, participants struggle to push for emancipatory and empowering practices, such as advocacy and the implementation of culturally appropriate services, while at the same time being employed by a hierarchical institution that prioritizes cost-effectiveness and privileges bio-medical understandings of mental health. This reflects what Pease (2002) describes as “a constant tension between compliance and resistance” (p.138). This finding is of concern for at least two reasons: First, it clearly highlights the limitations of Aboriginal participation, and second, it gives an account of the stress that this experience can cause for Aboriginal IH employees

who are caught between the interests of the community and IH. In addition, participant interviews indicated that the distrust and dissatisfaction toward IH was also projected onto individual change agents who work within IH increasing the stress and weakening the political support for Aboriginal people who have taken on the challenge to affect change from 'within' the system. Drawing on Freire (1985), Townsend (1998) writes that empowerment and social transformation is energized by a language of trust and hope. If the reverse is true, then the implications of these findings would mean that IH's Aboriginal mental health reform is at risk of losing momentum. Dissatisfaction on the job is, for example, likely to discourage other Aboriginal people from taking on this challenge and result in turnover of employees further undermining constructive working relationships within IH and between IH and the Aboriginal community.

4.4 Summary

Before we can modify institutional organizational forms, we must be able to see how they are actually put together in time, and this means explicating text-mediated, trans-local relations as accomplished by actual peoples in particular local sites and how they are hooked (and often objectified) into larger organizational processes (Dobson, 2001, p.154).

As I have attempted to show through the analysis presented in this chapter, reforming Aboriginal mental health is a highly political process that is infused by neo-liberal, colonial and bio-medical ideologies creating both opportunities and barriers for change. While there is strong consensus among the Aboriginal community and health authority that meaningful participation, partnership and respectful, trustful and responsible relationships are prerequisites for community healing and well-being, there are significant

institutional 'roadblocks' on the way to achieving genuine levels of Aboriginal participation in mental health care reform. Using the *ladder of citizen participation* Arnstein (1971) notes that meaningful participation is reached when power has been redistributed so that citizens that were formerly excluded from political and economic processes obtain control or self-determination through the majority of decision-making seats or managerial power. Yet, despite the creation of the Aboriginal Health Division with IH, the power of Aboriginal people to join in determining how information is shared, resources are allocated, and mental health programs are designed and delivered remains limited. In some cases, as for urban Aboriginal organizations, decision-making has become even further removed due to the creation of non-democratic intermediary structures, which then in turn only hold the 'power' to advise. Ultimate decision-making power remains with the corporate health board where Aboriginal peoples remain underrepresented – a board that is directed by neo-liberal discourses. These are discourses that Fiske and Browne (2008) discuss in their work as those that “reframe health policy in market metaphors of product, in terms of efficiency and fiscal accountability” (p.38).

5: ANALYSIS & DISCUSSION: MENTAL HEALTH SERVICE PROVISION

As the previous analysis has shown, in the experience of service providers and key leaders in Aboriginal mental health, the implementation of IH's Aboriginal framework has been limited, raising the question of how these policies changes have translated into culturally appropriate services. To answer this question, in this chapter, I turn my attention to the mental health service provision for Aboriginal peoples in the Interior. In the following, I deconstruct Aboriginal mental health reform by showing how the same ideologies that have engendered tensions around Aboriginal representation, participation in decision-making and collaboration between Aboriginal peoples and health authority also interact at the macro-, meso- and micro-level of mental health policy programming and delivery creating significant challenges for culturally appropriate service provision.

5.1 The Status Quo

In the Interior Health, mental health and addictions services for Aboriginal peoples are provided through a multi-jurisdictional 'system' that includes all levels of government and a wide variety of service providers. As table 2 illustrates, while a range of services is administered by Aboriginal organizations and governments, IH's Mental Health Department holds the regional mandate for tertiary psychiatric care, and mental health and addictions services that are

provided through smaller community-based health units and institutions (IH, 2009).

Table 2: Aboriginal Mental Health Service Delivery within IH

Stewardship	Service provider	Status Indian		Non-status First Nations, Métis
		Living on-reserve	Living off-reserve	
Federal	First Nations and Inuit Health (FNIH)	Non-Insured Health Benefits (NIHB) <ul style="list-style-type: none"> Short-term crisis oriented counselling (approx. 10 sessions) 	Non-Insured Health Benefits (NIHB) <ul style="list-style-type: none"> Short-term crisis oriented counselling (approx. 10 sessions) 	
	First Nations Band Governments	Health Societies & Social Development Departments (depending on band)		
		National Native Alcohol and Drug Abuse program (NNADAP) & residential treatment programs <ul style="list-style-type: none"> Round Lake Treatment Centre 		
Provincial	Interior Health Authority/ Mental Health Department	Psychiatric Tertiary Care	Psychiatric Tertiary Care	Psychiatric Tertiary Care
		Mental Health Unit: Counseling Alcohol & Drug Services	Mental Health Unit: Counseling Alcohol & Drug Services	Mental Health Unit: Counseling Alcohol & Drug Services
Interior Health Authority	Friendship Centers, Métis and Aboriginal not-for profit organizations	20 sessions of Addictions/ Mental Health Services	20 sessions of Addictions/ Mental Health Services	20 sessions of Addictions/ Mental Health Services

Participants in this study strongly differentiated between those services that are under Aboriginal mandate versus those programs that are administered by IH describing two distinct systems; one being the Aboriginal mental health system and the other the mainstream mental health system. As the analysis unfolded, it became clear that this distinction is reflective of two different

philosophies, one being the Aboriginal understandings of mental health and addictions and the other being the bio-medical paradigm.

Cultural Risk

In the subsequent account, a participant describes a perspective on what kind of issues arise for Aboriginal people who try to access mental health and addictions care through the mainstream system:

RP1: If you consider that the premise of the DSM-IV is based on what we consider as acceptable norms, there are pockets of our population that do not fit that. So really, you are being treated to be assimilated. That's not say that someone experiencing who has his first psychotic break and hallucinates and hears animal voices is spoken to by animals is not a concern in our culture or in any culture. It is and it should be and there are proper methods with which you can treat that but there is a piece of having a spirit animal being able to shift shape, being connected to greater levels of spirituality, connected to animals and mother nature that exists in our culture and isn't always clearly understood by the clinicians. So, you get this resisting rub or you could get potentially this rub between the two that can lead to all kinds of things: Non-compliance to the medical treatment model and a lack of desire to seek help in the first place because they don't see it as abnormal and lack the understanding of the terminology used to describe the experience.

This participant's account provides insights into some of the reasons why Aboriginal people tend to not use mainstream services or drop out before the end of treatment. The narrative clearly speaks to the limitations of the bio-medical approach to mental illness practised in the mainstream system to adequately – or appropriately -respond to the cultural experience of mental health problems by Aboriginal people creating problems for both, access and treatment. This participant's perspective is consistent with the findings of the Aboriginal Mental Health Committee (2001) and the RCAP (1996), who both identify the devaluing

and marginalization of Aboriginal knowledge by the dominant mainstream culture as a key concern. Based on these insights, 'cultural appropriateness' of health services for Aboriginal people has become a buzz word in Aboriginal health reform that occurs in literally all recent Aboriginal health policy documents including but not limited to IH's Aboriginal Health and Wellness Plan (IH, 2006), the First Nations Health Blueprint (BC FNLC, 2005) and the Transformative Change Accord: First Nations Health Plan (British Columbia & BC FNLC, 2006). However, despite its popularity, the term remains ill-defined.

In the following excerpt, another Aboriginal participant reiterates the impact of culturally-inappropriateness of the mainstream mental health system on Aboriginal service utilization but adds another layer of complexity by introducing the concept of 'safety:'

RP9: The [mainstream mental health] system is more institutionalized in its look and demeanour. It requires specific appointments and deals with people on a more formal basis. There's not really a friendly face there, there are all sorts of rules and regulations on how to access the service. So, the institutional practices and the building itself are just not compatible with reaching people in a place that they can feel safe. There's no safety there. And they have done nothing to change it.

This participant's narrative conveys several issues that relate to the lack of safety of mainstream mental health and addictions services for Aboriginal peoples. As the participant describes, the re-enactment of colonial relations and imposition of Western bio-medical treatment approaches within the mainstream mental health system create situations of risk for Aboriginal people. By privileging the dominant 'White' culture in the construction of mental health care delivery,

the current system reflects a high degree of ethnocentrism and a longstanding cultural blindness that is apparent in the individualistic and paternalistic model of care which requires compliance to stringent rules and procedures that mainly ignore the complexity of Aboriginal lives. In addition, the medicalization of social problems by mainstream mental health services and its tendency to construct mental health problems in individualistic terms ignores the impact that colonialism and the legacy of it has on Aboriginal mental health. For many Aboriginal peoples the recent history of residential schools has left them with animosity against large institutions, which trigger memories of emotional and physical trauma. Re-entering a system that does not take into account the legacy of residential schools can be re-traumatizing, particularly when faced with individual racism and stigmatization.

As such, the endorsement of ethnocentric treatment models that are designed according to bio-medical understandings of mental health, the institutional demeanour of the mental health system and experiences of individual discrimination have created significant access barriers, placing Aboriginal peoples who seek mental health and addictions care at risk for cultural harm. According to Cooney, cultural risk arises when health-care practices “demean or disempower the cultural identity and well-being of an individual” (1994, p.6). The antithesis of cultural risk is cultural safety, a concept that was first developed in New Zealand by Maori nurse leaders in collaboration with Maori people to provide a critical lens on how power imbalances in health care delivery sustain and perpetuate health disparities and access issues to health

care for minority groups (Ramsden, 1992; 1993; Cooney, 1994; Browne et al., 2005; Browne & Fiske, 2000). As the next interviewee remarks, cultural support in mental health care for Aboriginal people is essential for creating safety but lacking within IH's mainstream system:

RP1: There is very little if any cultural support to create safety and for those kinds of things that we would normally have gravitated to in order to deal with that imbalance if that's smudging, sweating, talking circles, drum making vision questing whatever might apply.

According to the ANAC (2009), and the Aboriginal Mental Health Commission (Smye & Mussell, 2001), a postcolonial understanding by all care providers and administrators and the integration of Indigenous knowledge into treatment models, such as traditional healing practices, are critical for providing effective and culturally safe care to Aboriginal people. As such, the literature and experience of Aboriginal participants suggest that cultural-safety is an important and necessary component of culturally appropriate care.

Yet, at the time of the study, few options for culturally appropriate care existed for Aboriginal people seeking mental health and addictions care. While the Aboriginal Health and Wellness Plan establishes "the inclusion of spirituality and Aboriginal traditional approaches to health and healing into IH programs" (IH, 2006, p.14) as a performance indicator of IH's Aboriginal mental health reform, until 2007, the preliminary focus of reform was on creating change at the macro-level through the creation of participatory mechanisms and the restructuring of funding processes with little or no impact on IH's service delivery model for mental health and addictions care. As such, a central question for IH and this

research is ‘what would a culturally appropriate mental health care system for Aboriginal people look like?’

5.2 Cultural Safety

Drawing from their experience as service providers in the Aboriginal mental health system, throughout the interviews many participants provided insights and examples of what elements create culturally appropriate and safe services.

Relational Practice

The next participant, who works for an urban Aboriginal organization, provides an example of how this organization tries to create a culturally safe environment by “making it comfortable for people.”

RP4: We have that lens that we all work through because of the way we were raised. We try to make things comfortable for people, and that’s in a way that’s cultural. We don’t want it to be the formal way, having to see the receptionist at the front desk and sign-in, sit and wait for somebody to come and get you and all of what happens as part of the medical model. We try really hard to make it comfortable for people here, when they come here.

In a similar vein, the following participant explains that cultural safety is generated when services are flexible around appointments, environments are non-institutional and when ‘relational’ practices inform the interactions between service providers and clients:

RP6: It’s often where the service is provided because of the residential school experience churches, schools [and other institutional settings] are often not psychologically accessible. Being flexible in the appointments is a huge thing, and it’s really hard to walk that tight rope between being flexible and having people being accountable.

Importantly, this service provider is aware of the historical impact that colonialism and forced assimilation has on Aboriginal lives, and thus, emphasizes an approach that promotes safety that it accommodates the complexity of issues in Aboriginal people's lives. As Browne and Fiske (2000) report in their qualitative study on First Nations Women's encounters with mainstream health care services and systems, many Aboriginal people feel alienated by the spatial and temporal organization of the medical fee system and its punitive clinic routines where patients are charged fees for missed appointments. Practices like this ignore the complex realities of many Aboriginal people's lives, where poverty, multiple health issues and family responsibilities limit people's ability to travel to the clinic or "organize their lives by the dictates of the clock" (Browne & Fiske, 2000, p.11). Thus, instead of adopting a punitive stance that conceptualizes the service provider-client relationship in terms of "a powerful-powerless dichotomy [which] may in itself disempower and marginalize clients" (Pease, 2002, p.138), culturally safe practice "challenges unequal power relationships" (ANAC, 2009, p.2). As such, "cultural-safety moves beyond traditional notions of cultural sensitivity" (Browne & Fiske, 2000, p.8) that have traditionally informed "cultural competence training, which [narrowly] focuses skills, knowledge, and attitudes of practitioners" (ANAC, 2009, p.2). By exposing health care providers to the power differentials inherent in the mainstream culture of health service delivery and their associated risks for cultural harm, cultural safety builds understanding on the side of the care provider for the experience of trauma and suffering inflicted on Aboriginal peoples through Canadian institutions, such as Christian churches,

residential schools, and Canadian law and its relationship to inequities in Aboriginal mental health (ANAC, 2009). As such, culturally safe practice creates a 'safe' space for building trust relationships between care providers and clients. Flexible appointments and cultural support that encourages connections to traditional ways of living promote the establishing of trust as they reflect respect for Indigenous knowledge and understanding of historical trauma transmission (HTT).

Trauma Therapy

In contrast to brief solution-focused therapy, culturally appropriate treatment approaches emphasize long-term treatment approaches, reciprocity and a holistic understanding of mental health and addictions. Another service provider from a different Aboriginal organization elaborates on this point by providing an insight into the service approach of their addictions counsellor:

RP4: Within our addiction service, we don't negate the fact that the addiction is a symptom, it's not the problem. We try and dig deeper than just dealing with the addiction itself trying to find out the reason for the addiction, which is usually some kind of trauma, or some kind of mental illness. And so that ends up being the core piece of the work that the counsellor does. It's getting past the addiction and finding out the reason why.

Here the participant speaks to the role of trauma and the holistic concepts of health that guide Aboriginal-appropriate mental health and addictions services. For the majority of Aboriginal peoples mental health and addictions cannot be reduced to life-style choices or psychiatric disorders that are rooted in biological brain imbalances but are social phenomena that result from the history and legacy of colonialism:

RP6: There are historical mental health issues arising from colonization and residential school, and then there are more current or contemporary mental health issues, which are related to the other two, and entail alienation, loss of culture, lateral oppression and all the drug and alcohol issues.

Thus, while Aboriginal service providers in mental health and addictions tend to adopt a trauma approach that deconstructs substance abuse as a symptom of underlying a deeper unresolved conflict stemming from the experience of multiple systems of oppression, “current trauma theory and therapy focus on the psychiatric disorder of posttraumatic stress disorder and may give insufficient attention to the other dimensions of experience that ...include issues of secure attachment and trust, belief in a just world, a sense of connectedness to others and a stable personal and collective identity” (Kirmayer et al., 2003, p.S20).

Interdisciplinary Teams & Holistic Care

Given the holistic understanding of health, Aboriginal service providers emphasized that the provision of culturally safe services for Aboriginal people necessitates an interdisciplinary team approach to address the complexity of social, medical and mental issues that Aboriginal people present with. In the following excerpt, a participant speaks to this:

RP9: It's a whole approach as opposed to pieces here and there. Our world view in thinking of how we work in the world is beyond the Western science's ability to encapsulate. Physical health symptoms, mental health symptoms, and emotional health symptoms are a manifestation of how we deal with the things that come before us, and how we digest it and absorb the different traumas, the different life challenges that we have as a person. And that manifests later as a disease or as a mental issue or emotional issue, it manifests itself that way within our body. And that's how we view health...[Thus,]

recovery requires an all-encompassing team effort - an interdisciplinary team.

As a result, in keeping with the principles of holism, all Aboriginal organizations that I visited provided a spectrum of services that would range from primary care to mental health and addictions to social services. In contrast to the mainstream health care system, which is characterized by a high degree of fragmentation often providing even mental health in isolation from addictions services, Aboriginal organizations have tried to create one-stop services as the following participant explains:

RP3: At this point, it's a one-stop shop. They can come in here and they can get their family counselling, deal with their addictions issues, their mental health issues, the family violence issues, issues that might be related to sexual abuse or residential school ...We also have a cultural component here, so many of those clients come here to access other services besides just mental health. So, they can integrate with the community and the culture.

Focus on Connectedness

As reflected in the excerpt above, consonant with the values in Aboriginal cultures, which emphasize relationships and connectedness, many Aboriginal organizations provide not only individual but also family counselling. According to Kirmayer et al. (2003), what distinguishes Aboriginal from the Euro-American “egocentric and individualistic” worldview, is the notion of connectedness in Aboriginal cultures, which reflects an understanding that individuals function within a “web of relationships that includes not only extended family, kin and clan but ...[...].elements of the natural world, spirits and ancestors” (p. S18). Given the experience of forced assimilation through the history and legacy

of colonialism, such as residential school, many Aboriginal people grew up disconnected from their cultural roots. In the literature, this experience of 'cultural discontinuity' has been widely linked to "a loss of individual and collective self-esteem, to individual and collective disempowerment and, in some instances, to the destruction of communities" (Kirmayer et al., 2003, p.S18).

Consequently, as the next participant explains, the notion of "knowing" is central to the contemporary Aboriginal health movement:

RP1: There is a movement within our own communities about re-birthing our knowledge. ...Residential schools, the banning ceremony until 1951, lots of similar family experiences that prevented us from being all knowing. There is a healing in the knowing regardless of whether my daughter or granddaughter at the end of the day ever chooses to smudge or sweat. So, what I am saying is that if we simply assess the symptoms if we don't take into consideration the strength of the individual for having simply survived to where they are at that point and we do not incorporate the opportunity for knowing, then we are hindering their ability heal and become whole.

According to Narayan (1995), efforts to emancipate are historically characterized by two processes: First, the assertion of rights, and second, the attempts to correct distortions of history and to tell of the harm caused by paternalistic care of the state. As a result, after a century of being silenced, in recent years, Aboriginal people have sought different avenues for 'truth-telling' and reconciliation. Such initiatives involve the creation of the Truth and Reconciliation Commission (TRC) under the Indian Residential School Agreement (IRSSA) in 2008 and the establishment of the Aboriginal Healing Foundation (AHF) in 1998, which supports Aboriginal-directed, community-based

healing projects to address the legacy of physical and sexual abuse experienced by Aboriginal people in the residential school system (AHF, 1999-2009). The TRC is based on a restorative justice approach that provides Aboriginal peoples who have been affected by the Indian Residential School legacy with an opportunity to share their individual experiences and stories, and to heal relationships between offenders, victims and the community (CBC, 2009). Under the scope of community-based healing projects, many Aboriginal communities have experimented with the use of smaller, traditional circle forms that include 'talking circles,' 'healing circle,' spiritual circles' and 'sentencing circles' (Kirmayer et al., 2003). Kirmayer et al. (2003) goes on to explain that while there are many forms of circles, they all have common "an emphasis on the individual's commitment to change, an etiquette that honours the individual voice through respectful listening, and a process of reaffirming collective and communal solidarity" (p. S20).

Traditional Knowledge

Another important concept of culturally appropriate mental health service provision emphasized by the participant above was the link to traditional healing practices and cultural programs. The following participant reiterates this need by arguing that culturally appropriate mental health treatment options need to move beyond the physical, mental and emotional realms to a place where a person can address his/her spiritual/cultural sphere of being:

RP9: So integration of our own cultural appropriateness along with treatment also is a need. It's been requested over and over because we understand that our culture and our identity is

so entrenched in the language and the land, that the healing cannot come from the institutional format that's been given. That it has to include our cultural component to the treatment plan. And if it is not there it is just going to be a symptom driven treatment.

While some organizations had formal cultural components, others held informal links to Aboriginal community members and elders who would have the knowledge and skills to perform ceremonies and rituals, such as sweats, circles or pipe ceremonies. Drawing on Foucault's analysis of knowledge and power, Pease (2002) argues that the insurrection of Indigenous knowledges is an integral part of empowerment since the disqualification and marginalization of Aboriginal knowledges and cultural practices is intrinsically connected to the oppression experiences by Aboriginal peoples. In much the same way, Browne and Varcoe (2006) argue "that culture is best to be understood as being enacted *relationally* through history, experience, gender and social position" (ANAC, 2009, p.2). As such, culturally safe service provision is predicated on the understanding that cultural health inequities are rooted in underlying socio-historical and political power relationships, and support for reclaiming Aboriginal traditions as a way to redress the existing power imbalances between Western, bio-medical and Aboriginal understandings of mental health.

Choice

While participants agreed that the cultural element was an important reason for why clients would choose to access services at Aboriginal organizations, providers also pointed out that these services are completely optional.

RP4: ... if somebody is not interested in their culture and does not want to include that in how they receive service, then we respect that. It is your call - whatever you feel comfortable with is what we will provide.

What this service provider stresses is the role of choice and different treatment options that include non-traditional and bio-medical approaches to mental health and addictions care respecting the differing needs of Aboriginal peoples. Within Aboriginal understandings of mental health, healing is often conceptualized as a journey (RCAP, 1996). The concept of 'healing journey' acknowledges that recovery is a process implying that people's needs will change depending on where they are at in their healing journey. This view is very compatible with the 'recovery' and 'harm reduction' model in mental health and addictions, which both stress that the importance of providing a range of services to meet people where they are at (Mental Health "Recovery" Study Working Group, 2009; BC. Ministry of Health, 2005).

5.3 The Challenges for Change

While these excerpts show evidence that some Aboriginal-mandated organizations in the Interior have been successful in implementing culturally safe mental health and addictions services, the findings of this study also indicate that Aboriginal key leaders and service providers within both the Aboriginal mental health system and IH face many challenges that have left a large number of Aboriginal people without appropriate access or continuity to culturally safe mental health and addictions care. Across the participants, there was consensus

that the most salient key issues are related to the jurisdictional divide and funding.

5.3.1 The Jurisdictional Divide

As apparent in table 2 in the beginning of this chapter, Aboriginal mental health and addictions services fall under different jurisdictional stewardship, which ties accessibility to services to strict eligibility criteria. For example, federally funded programs entitle only status First Nations to access mental health services through the non-insured health benefits package. Other mental health and addictions services that are provided to bands through various degrees of health transfer agreements and FNIH, such as the National Native Alcohol and Drug Abuse program (NNADAP), residential treatment programs and health organizations, make eligibility stringent on status, on-reserve residency and band membership. Based upon the Indian Act (1876), these eligibility criteria are functionally re-enacting colonial relations that have been detrimental for Aboriginal peoples in Canada. In the following, an urban Aboriginal service provider, who lives on-reserve, shares how this jurisdictional divide between urban and on-reserve is experienced, “you either need to be a part of it, or a member of it. There’s that red tape about where we live” (RP2).

For Aboriginal service providers on-reserve, these jurisdictional boundaries create an ethical dilemma as a high number of Aboriginal people migrate back and forth between reserve and urban centers. A service provider who works for an on-reserve Aboriginal health organization, speaks to this issue

and explains how the imposition of jurisdictional responsibilities undermines the organization's capacity to provide culturally safe services.

RP6: We don't want to buy into that whole fragmentation of off-reserve, on-reserve as much as we can. We are funded to provide service for on-reserve, but we know that the reality is some families will live off-reserve for a short period of time and come back, and so we don't let them go if they move off, because we know that they will come back. And then the real answer, I think the solution is to get rid of the off-reserve, on-reserve distinction, and to be able to provide services to either, but I think that's the way the government divides and conquers still, is by making that distinction, between off and on and status and non-status.

Given that in the IH only about 33.5% of the Aboriginal population is living on-reserve (IH, 2003), these funding practices and eligibility criteria have left the vast majority of Aboriginal people without access to mental health and addictions services provided on-reserve. In addition, participants indicated that many on-reserve communities still lack sufficient social and health infrastructure to provide mental health and addictions care within their own community, and thus, under the given circumstances are forced to employ their federal funds to contract MSP-approved psychologists from the mainstream system to provide mental health care to their residents.

Furthermore, simply because services are offered on-reserve does not mean that these services are always accessible. The NNADAP, for example, endorses a strict abstinence model, which can constitute a barrier for many people who suffer from addictions and who would respond better to a harm-reduction model (Poole & Trainor, 2000). As such, Aboriginal peoples on- and off-reserve disproportionately rely on mainstream and urban Aboriginal mental

health resources that are free of costs and without eligibility restrictions. Yet, as explained above, within IH's mainstream mental health system, culturally appropriate services are virtually absent leaving urban Aboriginal organizations as the only option for the majority of Aboriginal people to get their mental health and addictions needs met.

In addition, the different jurisdictional mandates under which these organizations operate and receive funding has led to a disintegrated service system that adds another layer of complexity. Participants, for example, described the structural limitations for communication and information sharing between on- reserve, urban and mainstream service providers as forming significant roadblocks for clients who often have to access services from more than one agency crossing jurisdictional responsibilities. Furthermore, competition for funding and imposition of political boundaries at times have contributed to tense relationships among bands themselves and between on- and off-reserve organizations further undermining the establishment of clinical pathways.

5.3.2 IH's Bestseller: The Recipe for Culturally Appropriate Service Design

Yet, while creating Aboriginal positions at the policy level within the mainstream system may look like the obvious solution for creating a more responsive and culturally safe mental health care system, the experience of participants working within IH's Aboriginal Health Division indicates that assimilationist tendencies and ethnocentric ethos within the system remain major obstacles for meaningful Aboriginal participation and the creation of culturally safe practices. As Fernando (2003) states, overt assimilation and racism has

become less apparent in modern mental health systems only to emerge in a more subtle form that he refers to as institutional racism. The following participant provides a perspective on how institutional practices and structures within IH militate against the ability of IH's Aboriginal Health Division to advocate for culturally appropriate services and community development.

RP9: So my role is dealing with community development, and with a corporation that has a different agenda and mandate. It is very difficult. Because as a community person, I believe in community development and know where some of the change can occur, and where it's going to take a bit of time. And then I deal with a corporation that has its own challenges in dealing with First Nations. First of all they don't even have the basic understanding of what a community is, what a nation is, and they rely on government subjective definitions of an 'Indian' and of a 'nation'. It is all categorized into detailed data, which is not going to reflect a true picture of the needs and priorities of the community or where the community is at. It does not give a clear picture because the health system is data-driven and based on Western science. IH is incapable to do anything other than utilizing its service delivery with some very small modified changes.

The participant draws attention to the intersection of ideologies by describing the limitations of institutional practices derived from neo-liberal, colonial and bio-medical value systems to truly supporting and advocating for Aboriginal understandings and responses to mental health. According to Smye (2004), unequal power relationships between the dominant culture and Aboriginal peoples in Canada are not only rooted in the colonial past but are sustained by colonial ideologies embedded within contemporary institutional structures and policies. While neo-liberal policy directions in BC have imposed a corporate model of management to health authorities that reinforces colonial power relations through the corroborating of power hierarchies that exclude the majority

of Aboriginal peoples from decision-making, the dominance of the bio-medical paradigm creates additional barriers for the development of community capacity and culturally appropriate services.

In the following excerpt, the same participant discusses the impact of funding schemes as one particular practice of concern:

RP9: All the funding is based on Western science or the general public's knowledge of how life is. It doesn't allow for cultural appropriateness. No, it is mainstream society funding criteria. It doesn't address the challenges that you have as an organization or a community. You fill it out just as you're supposed to fill it out, and you write in "mental health worker" because they like that name. You write in all the kinds of things that they want to hear and they want to do. And then when it the funding is in place, you design within that criteria and you write the reports that they need to hear, but your approach is going to be whatever you can do to make sure that the integration of cultural safety is going to be involved.

Here the participant describes the ideological clashing of Aboriginal understandings of mental health and the mainstream mental health system, which is dominated by bio-medical approach to mental health that according to Fernando (2003) applies "clear-cut treatment plans" and "seeks to maintain credibility as a 'scientific' endeavour" (pp.114-115). Within a neo-liberal context, which adds a strong concern for cost-effectiveness to health care planning, funding is usually tied to short-term mental health programs and services that can and have been scientifically evaluated against measurable performance or outcome indicators, and are therefore judged cost-effective.

Similarly, IH's proposal call required Aboriginal organizations, who applied for mental health and addictions funding, to provide a technical explanation of the

link between the proposed service and evidence-based practices as well as a plan of how to measure outcomes at the end of the three-year funding period.

Although IH's proposal explains at the very end of the application in an explanatory note that "IH recognizes that Aboriginal best practices will also incorporate culture and healing practices and experience" (2006, p.14), the overall tenor of the application reflects "mainstream society funding criteria" (RP9).

Consequently, as also illustrated in table 2, the majority of mental health services are only short-term focussed creating a disjuncture regarding how Aboriginal culturally safe services are conceptualized. NIHB, for example, funds only short-term crisis oriented counselling that, depending on the rate of the service provider, provides for approx. 10 sessions. Similarly, participants reported that IH caps the funding for counselling and mental health services to 20 sessions per client, "if [the client needs] more than that we have to give evidence to support why we're going beyond" (RP4). However, as the next participant emphasizes, overcoming grief and trauma requires building trust relationships and time, and thus is only inadequately addressed by "solution-focused therapy".

RP6: My understanding of where Mental Health [Policy] is going is brief solution-focused therapy, and there's a disconnect between the service providers that are out there and the needs of the people, our First Nations communities that will work for them, because they are all trained in this brief solution-focused therapy. I don't know how to breach that disconnect, but it's definitely there.

Short-term solution focused treatment approaches are reflective of an illness model that constructs mental health and addictions in individualistic terms

that puts the onus of responsibility for rehabilitation on the person with the mental health issue irrespective of the broader socio-historical and political context. This is particularly problematic given the long history of trauma that many Aboriginal people have endured – trauma that often warrants long-term treatment and healing approaches.

As a result, particularly urban Aboriginal organizations, who depend on IH funding, are likely to find themselves in the dilemma to either propose culturally appropriate services that do not really fit the funding criteria outlined in IH's proposal call and thereby diminishing their chances to be successful or to put forward an application that is more closely aligned with mainstream mental health services that are evidence-based but likely to be ineffective in improving the mental health burden carried by Aboriginal peoples. Within a neo-liberal context, the dominance of bio-psychiatry creates not only access barriers when Aboriginal patients seek care within the mainstream system but also when Aboriginal communities try to leverage funding for non-traditional and culturally appropriate mental health and addictions services.

The following participant reiterates this issue but provides insight in how IH constructs the problem emerging from the current proposal-driven funding scheme by offering an apposite analogy:

RP1: It's almost like we [IH] are translators. It seems silly but that's really kind of what we are. So we know the language, we're going to know what language the Health Authority needs to hear it in. We're going to help the Aboriginal community, we take the information they already have, they are already the experts. They already have the data, the stuff

we need. And we're going to help them translate it in a way that we hope the system will understand.

While this statement shows that IH recognizes that the “language” of the current funding scheme creates barriers for Aboriginal communities, it constructs the problem as stemming from a lack of community capacity. As a result, the future model for IH's Aboriginal Health Division proposes the position of the Aboriginal Contract Coordinator that would help Aboriginal communities to “translate” their concerns and ideas for mental health and addictions planning into the appropriate format that “the system will understand”.

Although the literature on citizen participation supports the importance of building community capacity in terms of knowledge and skills (Cheema, 2005; Abelson & Gauvin, 2004; Church & Barker, 1998), within this context, this rhetoric seems to obscure the deeper ideological conflict between the Aboriginal philosophy of care and the mainstream approach to mental health care. In fact, by trying to ‘educate’ Aboriginal communities how to write ‘successful’ research proposals, this strategy puts the onus for change on the Aboriginal community - a highly paternalistic stance that stresses the need for capacity building within community rather than the need for reciprocal capacity building.

5.3.3 Community Capacity: A Function of Funding

On the plus side, proposal-driven funding schemes do provide for a certain degree of community engagement in health care planning and programming (Abelson & Gauvin, 2004). According to the next participant, this rationale also guided AHAWAC's advice to IH:

RP1: So what the Aboriginal Health Advisory Committee said to Interior Health is, 'We don't want you to prescribe what kind of service to pursue with the Aboriginal-targeted dollars. You can't say you want a full-time Aboriginal Addictions Counselor providing cultural addiction services because the community should get to say what they need and what the service looks like. So we have to come up with a proposal form so that the community can select what their services look like and how they should be delivered.'

In addition, as the same participant goes on to explain, the committee argued for a more "equitable" and "fairer" process of funding allocation:

RP1: When IH took over control of [the Aboriginal health dollars], the Aboriginal Health Advisory Committee said, 'if this is the only money that we have, there should be a fair and equitable process for all Aboriginal people to be able to make an application for that money, just like we do with the AHIP fund. It should be equitably distributed across our health service area.' Because when you looked at Interior Health there were areas of Interior Health where Aboriginal people lived, where there were Aboriginal organizations but where there was zero Aboriginal-targeted programming or dollars going to it.

The New Funding Distribution: Why More Equity can Mean Less Capacity

Following AHAWAC's advice, IH restructured its funding distribution formula.¹⁹ This included the introduction of the proposal-driven funding scheme for direct services and the adoption of a population-based funding formula for health service areas in 2007.

¹⁹ Within IH, Aboriginal communities and organizations have access to two Aboriginal-specific funding sources: First, the direct services funds, and second those funds that are available through the Aboriginal Health Improvement Program (AHIP). While both funds are now proposal-driven, the former has been traditionally directed to urban organizations, which held longstanding contracts with the Ministry, such as Friendship Centers. AHIP, on the other hand, has historically always been open to both on- and off-reserve communities. The majority of Aboriginal funding for health services including mental health and addictions care is administered through the direct services. AHIP funds, on the other hand, make up only a small proportion of the overall resources and are aimed at community initiatives within addictions, mental health and chronic diseases that are not covered otherwise (IH, 2007).

Prior to this restructuring, all health services had to compete for one “pot” of money. While the urbanized regions that were able to establish a relatively well functioning Aboriginal health infrastructure received the lion’s share of the funding through long-standing contracts with the Ministry, more rural health service areas, such as the Kootenays, received little or no funding. Under the new formula, every health service area within IH is entitled to a population-based proportion of the overall budget providing for a more equitable distribution of funds. In addition, direct services funds are now allocated via proposal calls to provide Aboriginal communities and organizations with an avenue to directly inform health service planning and programming.

However, since the overall budget for Aboriginal-specific services remained fixed, the effect of this change in funding distribution was differential, with some long-time underserved geographical areas receiving first-time funding, and others experiencing service cuts due to the shifting of resources between health service areas. Overall, IH received somewhere between 43 and 56 proposals, of which only 19 could be funded, including seven mental health and addictions programs throughout the entire interior health region (IH, 2007).

The Disintegration of Mental Health & Addictions

Being aware of the limited overall funding, IH and AHAWAC made the decision to create two separate funding envelopes, one for mental health and addictions and another for community-based services, which includes “chronic and communicable disease”, “early childhood development”, “elder care” and “injury prevention” (IH, 2007). To “support a range of Aboriginal organizations”

(IH, 2007, p.3) IH 'capped' the maximum funding for proposals within each funding stream. Thus, although IH's funding categories within the proposal reflected the health priorities of the Aboriginal Health and Wellness Plan 2006-10, the set limitations on allowable funding made it feasible for most community organizations to target only one single health priority area within each funding stream.

While in absolute numbers the larger part of the funding (\$833,000) was protected for community-based services that include a wide range of priorities, a disproportionately higher amount of money was set aside for "mental health and addictions" (\$611,000) (IH, 2007, p.3-6) highlighting the pivotal role 'mental health' plays in IH's Aboriginal mental health reform. Considering that within the most recent proposal call the majority of communities submitted a proposal in the area of mental health and addictions, this decision seems to correspond well to the communities' needs.

However, given the limited overall budget, community organizations experienced IH's decision to merge 'mental health and addictions' and 'sexual abuse,' as controversial. Communities that were successful in establishing an Aboriginal mental health infrastructure under previous funding arrangements, were suddenly forced to set priorities among their mental health services irrespective of the fact that even with the existence of these services the majority of Aboriginal peoples remained underserved. The following participant, who was involved in writing a proposal in mental health and addictions for an urban organization, shares

a perspective on how the new funding scheme limited the freedom of the organization to provide and protect those services that they feel are needed within the community.

RP2: Well what ended up happening is our agency had to decide which program was more in demand, because they could only submit one proposal to that funding stream. 'Addictions' or 'Mental Health'. And Addictions was the one that they submitted. ... We could have put in a proposal for Sexual Abuse too, but the Sexual Abuse program was a quarter million on its own.

Cuts to either mental health or addictions programs were also reported by those interviewed in other urban Aboriginal organizations. Particularly hard hit were agencies that in addition to addictions counseling provided a range of mental health services including sexual abuse, family violence and mental health programs. In one case, for example, an urban Aboriginal organization was only able to maintain funding for the position of one addictions counsellor and lost 100 percent of its mental health programs and related staff.

As this experience shows, IH's decision to combine mental health and addictions services might have been successful in that it protected mental health and addictions funding, but the cap on this funding stream has in fact fostered a disintegration of addictions and mental health services. As a result, in face of the limited overall budget of Aboriginal health dollars, this policy shift, which was intended to promote equity, has paradoxically led to an increase of gaps in services and destabilized community organizations' capacity to provide culturally safe services.

The Challenges of Constant Reform

Despite promised funding for closing the gap in health outcomes between First Nations and other Canadians under the recent signing of the Tripartite First Nation Plan by the federal government in 2007, overall resources for urban Aboriginal organizations have not been increased. Instead, as the following participant, who works at the policy-level of IH, explains, until today it remains unclear if and how the funds “will be administered to the benefit of urban Aboriginal people.”

RP1: As excited as I am about the Tripartite Plan, it also is very vague on how it will be administered to the benefit of urban Aboriginal people. Again, we have broad strategies, we have the commitment of governments, First Nations, Federal and Provincial through a MOU [Memorandum of Understanding], new committees, new governing bodies, but to date, as a Health Authority we have received zero new money.

Given the government’s historical reluctance to provide long-term, adequate funding to Aboriginal mental health services, Aboriginal organizations have always struggled to provide service under short-term funding in form of pilot projects and a traditionally diverse mix of funding agencies, such as the Ministry of Children and Family Development, FNIH and the Ministry of Health. However, as one participant explains, “we have never been this low before, in the sense of those Aboriginal Health dollars. And it has progressively, for our agency anyhow, gone down in the last four or five years” (RP2).

Under ongoing reform changes, funding for Aboriginal programs were constantly restructured, shifting the landscape of Aboriginal infrastructure through the closure and re-naming of existing services and also through the

establishment of new resources. For example, when talking to one urban service provider about the programs and services that were listed on the organization's homepage, it became clear that the majority of Aboriginal health and social services had actually been abolished within the recent five years with the remaining four programs being up for reconsideration in the face of IH's new proposal call. As a consequence, the fear of being shut-down has been a constant feature for Aboriginal organizations and service providers as the following participant's narrative shows:

RP2: And so we would tried to download all our cases so we had just a few cases left on our file until we heard that we were re-approved again, and then we would start expanding again. So it's like that now for several years, kind of the kick of the ball, which wasn't helpful to the counselling sessions at all, because you would start to close them down and then you would say, 'Okay, we were re-funded again, I can continue to work with you.'

As a result, service providers in Aboriginal mental health are faced with the challenge to provide services to clients within a constantly changing patchwork of services.

Collaboration versus Competition

The need for Aboriginal service providers to coordinate services and collaborate with other community has intensified. Yet, at the same time as the need for collaboration increases, findings also indicate an increase in pre-existing tensions that is particularly pronounced between Aboriginal communities and organizations on-and off-reserve due to the jurisdictional divide which left urban Aboriginal populations historically underserved. Within the current context, this is primarily due to the shrinking of limited funding. However, IH's decision to open

up the direct services funds to on-reserve organizations, which have been historically given to urban organizations despite no formal policy that would have restricted eligibility of these resources to this population, have fuelled these tensions. In the following, two Aboriginal service providers, one from on-reserve and the other from an urban Aboriginal organization, share their experiences of how competition for funding has impacted the collaboration and solidarity among Aboriginal organizations and communities:

RP7: Yeah. We have done things with them [urban Aboriginal organizations] and there is a connection but it's not a strong connection. The system has been set up to keep the players fighting for these little pots of money, you know. Like they throw out these bones and we all go after them. So instead of working collaboratively we see each other as competitors. And it's unfortunate.

and...

RP2: I think what frustrates me is that – it is something that has always gone on in our history as Aboriginal people, and it is about pitting one Aboriginal agency against another Aboriginal agency to get those dollars. And really there should not be a fight amongst the agencies to have that, and it should be well distributed.

This finding is of concern for at least two reasons: First, according to some participants, the increase in competition has resulted in demoralized working relationships between different providers within the Aboriginal community that have, in other instances led to the discontinuation of referrals between certain organizations. Second, it is commonly accepted that communities with fewer competing political goals hold more capacity for participation and shared decision making (i.e., are better able to engage in collaborative decision making) (Abelson & Gauvin, 2004).

Thus, despite Interior Health's goal "to enhance and coordinate mental health and addictions services for Aboriginal clients and communities" (IH,2006) as the next participant, who works for IH, explains, after five years of reform efforts in Aboriginal mental health, IH is paradoxically back again to where it started off: "How do we build capacity [for culturally appropriate service provision]?" (RP1).

5.4 The Conundrum of Building a Culturally Safe Mental Health System

During the analysis, it became clear that despite common long-term goals and a shared understanding of what elements would promote cultural safety in mental health care delivery, Aboriginal mental health key leaders and service providers held diverging perspectives on how to best go about creating culturally safe mental health care system as part of Aboriginal mental health reform. For example, participants agreed that the implementation of culturally safe services requires an increase of Aboriginal representation and expertise within the mental health care system, but divergence arose around the question of whether this meant investing primarily in community approaches or in building Aboriginal capacity within the mainstream system.

Some participants advocated for a strict community approach due to the experience of working within the mainstream mental health system:

RP6: Monies could be put into First Nations organizations that are better positioned to provide the mental health services. I think there comes a time when we all have to admit that we can do something or we can't, and I think Interior Health needs to

admit that they're not the right people to be providing mental health services to First Nations.

Likewise, another participant expresses doubts that change from within the mainstream system is possible:

RP8: It's not Aboriginally-oriented unless you come to the centre here or to the Métis or to the Westbank First Nations. Mainstream is mainstream. There are always bio-psychosocial, and I think they just threw in the spiritual, just to say they're holistic or whatever.

The views of these participants speak to the longstanding history of ethnocentrism within the mainstream mental health system that applies to health care interactions at the macro- and micro-levels and is rooted in the historical power imbalance between the colonized and colonizers. As such, for many if not all participants, the lived experience of discrimination and resistance by the mainstream system to provide for meaningful participation of Aboriginal peoples and communities have engendered a strong belief that a well-funded Aboriginal mental health system would be better able to respond to the diverse needs of Aboriginal people.

However, while this is a common perspective among Aboriginal key leaders and mental health service providers, many participants held a more pragmatic view that, although it does not negate the important role of Aboriginal communities in providing mental health and addictions care, reflects a more collaborative approach between the two systems. In the following an urban Aboriginal service provider elaborates on this:

RP4: There is this whole political thing around ownership: White people coming here, taking our land, putting us on-reserves and treating us like we are not capable of taking care of ourselves.

So you will hear from a lot of people a backlash around 'Who are you to tell me what to do?' and I'm sure a lot of people will ask for specific Native service. Native people providing service to Native people. Which I think makes a lot of sense. I don't disagree with it, but I think I'm a bit more pragmatic in that we are not going to keep white people out now, it's kind of late. (laughs) And as people we should try to find a way to work together.

Another Aboriginal participant argues in a similar vein for the

implementation of an integrated mental health system:

RP1: So I am really a big supporter of if we can't have parallel systems with equality and equity for the client, then let's talk about how we adapt and integrate in depth about what we do to have at least a minimum improvement- the opportunity for those things to exist. Ultimately, my goal would still be to have the continuum of services within the Aboriginal community.

Likewise, RP5 does not believe in a separate health system for Aboriginal people because chances are that this would mean inferior, second-class services for Aboriginal people. Yet, at the same time, RP5 argues that there will always be a role for friendship centres and other Aboriginal-led organizations in Aboriginal health care.

The perspectives of these participants show that IH's policy direction towards 'adaptation and integration' is considered a compromise among Aboriginal key leaders and mental health service providers that results from pragmatic deliberations in which community interests are weighed against the reality of structural barriers and inadequate funding. However, IH is still lacking an Aboriginal mental health plan that could guide the implementation of an integrated mental health care system for Aboriginal peoples.

However, as mentioned previously, under the new model proposed for IH's Aboriginal Health Division, funding has been made available for the establishment of the position of the Community Engagement Coordinator in Mental Health and Addictions. According to one participant who works for IH, among the main responsibilities of this new position will be the task to develop a long-term Aboriginal mental health plan. The same participant explains the next challenge for IH's Aboriginal Health Division will be to create a plan regarding how to create a culturally safe mental health and addictions system:

RP1: And whatever model we come up with, in principle we need to do it in partnership with our Aboriginal community....I'm assuming it will include both [systems] because there are pieces of Mental Health and Addictions that Interior Health can do well – psychiatric assessment for example [and] there are pieces of Mental Health and Addictions that only the Aboriginal community has the knowledge-base to do well.

5.5 Summary

As this chapter shows, the clashing of neo-liberal and biomedical ideologies ingrained in the mental health system, and the Aboriginal understanding of mental health, place Aboriginal people who seek mental health and addictions care at risk for cultural harm. As such, participants identified cultural safety as a central concept in the definition of culturally appropriate service provision. The notion of cultural safety in Aboriginal mental health care refers to the redressing of power imbalances in service delivery between the dominant mainstream culture and Indigenous knowledges and conceptualizations of mental health. Informants described culturally safe practices as encompassing relational practice, trauma therapy, interdisciplinary

teams and holistic care, a focus on connectedness and the incorporation of traditional knowledge and choice. Yet, at the same time as these conflicting ideologies generate barriers for access and effective treatment at the micro-level of service provision, they also create significant challenges for culturally safe mental health policy development and programming. Funding practices, for example, are directed by neo-liberal discourses and Western bio-medical understandings of mental health, imposing short-term therapeutically models of care. In addition, under inadequate funding for Aboriginal mental health, newly established funding schemes have resulted in the weakening of community capacity and disintegration of mental health and addictions services within some health service areas. As a result, without an increase in Aboriginal health dollars, Aboriginal mental health advocates find themselves in the paradoxical situation that the more successful Aboriginal communities are in building community capacity in form of Aboriginal mental health infrastructure, the more the funding shrinks, creating intense competition among Aboriginal organizations that undermines the solidarity and cohesion of the Aboriginal mental health system. Arnstein (1971) calls this ironic situation “a new Mickey Mouse game for the have-nots by allowing them to gain control but not allowing them sufficient dollar resources to succeed” (p.6).

6: IMPLICATIONS & FUTURE DIRECTIONS

According to a Health Promotion and Population Health approach, the goal of public health is to improve the health status and quality of life of the whole population and thus, to reduce health inequalities and inequities between groups (Raphael et al., 2006; World Health Organization (WHO), 1998; Public Health Agency of Canada, 2001). In much the same way, IH's Aboriginal Health and Wellness Plan states that its overarching vision "is to improve the health and well being of Aboriginal People living in the Interior Health to the same or better standard of that of the non-Indigenous population" (IH, 2006, p.6). Integral to this vision is IH's belief system which premises a commitment to "reduce inequity in health between Aboriginal and non-Aboriginal populations" and "meaningful [Aboriginal] participation" in health care planning (IH, 2006, p.6).

The concept of 'health equity' recognizes the role of social determinants of health, such as race, 'ethnicity,' culture and gender, in creating "systematic disparities in health among groups with different levels of social advantage or disadvantage" (Raphael, 2006, p.110). Thus, it is intimately tied to the process of empowerment and social justice. According to the WHO (1998), the notion of empowerment refers to the "social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs" (p.6). Likewise,

Townsend (1998) defines “empowerment ... [as] a participatory process of learning to critique and transform individual feelings, thoughts, and actions, as well as the organization of society, so that power and resources can be shared equitably” (p.13).

Given that IH’s Aboriginal Health and Wellness Plan is the key guiding document for Aboriginal mental health reform in the IH, the implementation of the plan can be understood as a process of empowerment in that Aboriginal participation in mental health care policy challenges neo-liberal politics of health care and the ethnocentrism of the mainstream mental health care system, whose alignment with Western, bio-medical treatment models places Aboriginal people who seek mental health and addictions care at risk for cultural harm. For example, the findings of this study show that the critique by key leaders and service providers in Aboriginal mental health and addictions of the status quo and the collective understanding of what culturally safe and appropriate services in mental health and addictions look like has succeeded in obtaining an ethical commitment by IH to promote cultural-appropriateness in mental health and addictions service provision. Thus, although at the point of this study, relatively little or no change had been observed at the micro-level of mainstream service provision, findings indicate that IH’s Aboriginal mental health reform will soon advance to another stage that shows evidence for IH’s continued commitment to address Aboriginal inequities in mental health. Under the newly proposed model for IH’s Aboriginal Health Division, IH is planning to expand Aboriginal representation within IH and create the position of an Aboriginal community

engagement coordinator in Mental Health and Addictions whose main mandate will be to develop IH's Aboriginal mental health plan in partnership with the Aboriginal community.

However, without the critical scrutiny of current reforms and present discursive texts, these incidences of empowerment might be interpreted as evidence that empowerment has already been achieved (Townsend, 1998). As the analysis of this study reveals, empowerment work by Aboriginal agents within IH's Aboriginal Health Division, such as advocacy for community development and the fostering of culturally safe practices through mental health and addictions policy reform, was destabilized by institutional and organizational processes that are embedded within neo-liberal, colonial and Western bio-medical ideologies. Similarly, participants from Aboriginal community-based organizations, on- and off-reserve, reported that in fact their capacity for providing mental health and addictions in a culturally appropriate way had been undermined by recent reform changes pointing to a paradox explainable only by the trickling down effects of the ideological conflict experienced at the macro-level of Aboriginal mental health.

By uncovering these ideological underpinnings that drive and constrain the implementation of IH's Aboriginal mental health reform, this ethnographic analysis reveals the political nature of Aboriginal mental health reform and critically points to the disjuncture between policy and practice. By exploring the contradictions in policy and practice experienced by key leaders and mental health service providers in Aboriginal mental health and addictions, the findings

of this study highlight the emerging tensions, instances of empowerment as well as barriers for change.

As Fernando (2003) and Smith (1987) explain, ruling relations are often invisible processes but policies, funding and legislation in public institutions are highly ideological. The mental health system, for example, operates through a structural power hierarchy that is embedded in colonial relations and has historically excluded Aboriginal people from participating from all levels of health care planning and service delivery. Using the vision created by the Canadian Indigenous Health Movement (described in chapter one) as a point of reference, this study has identified several instances of empowerment for Aboriginal communities and Aboriginal health advocates in IH. Key instances include 1) the setting of Aboriginal health priorities by the Aboriginal community itself as represented by Aboriginal organizations, key leaders and AHAWAC primarily through the development of the Aboriginal Health and Wellness Plan, 2) the increased decision-making power and involvement in planning and implementing of the plan through the creation and increase of Aboriginal positions within IH, particularly at the macro-level and, 3) the engagement of the Aboriginal community (Aboriginal organizations and on-reserve health representatives) in resource allocation and program planning through a proposal-driven funding formula.

However, findings also indicate that IH's mission "to create respectful, trusting, responsible partnership between Aboriginal People and Interior Health to support the development of a holistic health and wellness system that is

responsive to the needs of diverse Aboriginal Communities” (IH, 2006) has not been fully translated into reality for Aboriginal key leaders, service providers and communities. Although extensive consultation with Aboriginal communities and key leaders happened in the development of IH’s first Aboriginal Health and Wellness Plan (2003-2006), this study shows evidence that these views can be erased and lost in the process of formulating and implementing policy. While at the macro- and meso-level of mental health care delivery, Aboriginal people observed a definite increase in participatory structures within Interior Health, participants perceived meaningful participation by Aboriginal people in mental health decision-making has been seriously hampered. In some cases, as for urban Aboriginal organizations, the implementation of the regionalized structure of health care delivery has removed decision-making even further due to the creation of non-democratic intermediary structures, which then in turn only hold the ‘power’ to advise. Ultimate decision-making power remains with the corporate health board where Aboriginal peoples remain underrepresented – a board that is directed by neo-liberal discourses, discourses that Fiske and Browne (2008) discuss in their work as those that “reframe health policy in market metaphors of product, in terms of efficiency and fiscal accountability” (p.38). Furthermore, the design of funding criteria according to neo-liberal discourses within IH’s proposal call have linked the prospect for funding to short-term and evaluable solution-focused mental health and addictions services that reflect Western bio-medical treatment models and only inadequately addresses the needs of Aboriginal people. In addition, under insufficient funding for Aboriginal mental health, newly

established funding schemes have resulted in the loss and disintegration of community-based Aboriginal mental health and addictions services effectively undermining community capacity to provide culturally safe mental health and addictions care.

The experiences of disjunctures between the vision of Aboriginal mental health reform and policy practices have eroded mutual trust and respect, and created severe tensions across IH, Aboriginal change agents working within IH and the broader Aboriginal community. As Arnstein (1971) claims “participation without redistribution of power is an empty and frustrating process for the powerless” (p.2).

Tensions between organizations are likely to increase barriers for “enhance[ing] and coordinate[ing] mental health and addictions services for Aboriginal clients” (IH, 2006, p.14), who under the severe funding cuts in mental health and addictions services within individual community organizations will depend on a range of community organizations to get their complex needs met. In addition, these findings are of concern as ‘collectivity’ and ‘community cohesion’ are central to the contemporary efforts by Aboriginal peoples to address the social origins of mental health problems in Aboriginal communities. According to Kirmayer et al. (2003), individual and collective healing demands social and political solutions that enable “Aboriginal peoples to recuperate and reclaim traditional knowledge and values as an explicit basis for collective identity and community cohesion” and thus, requires asserting collective power to confront structural power imbalances brought on by the legacy and history of

colonialism (p.S18). Furthermore, communities that are divided by competing interests are likely to be less successful in shifting dominant power relations (Abelson & Gauvin, 2004), such as the bio-medical tradition in mainstream mental health. As part of this research, participants seemed to agree that meaningful participation would involve

- 1.) a higher degree of decision-making power among Aboriginal position within IH;
- 2.) a more inclusive and fairer representation of urban Aboriginal community-based organizations within the Aboriginal Health Division;
- 3.) improved bilateral communication and transparency between IH and representatives of the Aboriginal Health Division but also between IH and Aboriginal community-based organizations; and
- 4.) sufficient funding, which necessitates a significant increase in Aboriginal health dollars.

As such, the findings of this study underline that the notion of community empowerment should not be understood as a dichotomous concept in which the antithesis of an 'empowered' community is a community that lacks any capacity to meet their own health needs. Rather empowerment work ought to be understood as 'enabling' in that it is aimed at reducing systemic and structural barriers that maintain and perpetuate the power imbalance between those who seek empowerment and those whose power has been supported by the ruling apparatus. As Townsend argues, the transformation of ruling relations does not

mean that “others must lose power”, instead “collaborative power is generated as hierarchical control and authority are dismantled” (1998, p.12). In much the same way, the findings of this study emphasize the importance of reciprocal capacity building that includes both IH and Aboriginal communities. Yet, as the findings reiterate, power is intimately tied to resources. Given the myriad of tensions in IH’s Aboriginal mental health reform that can be reduced to inadequate overall funding for Aboriginal Health, the need for sufficient resources might be the most salient finding of this study.

However, in the light of the many other challenges experienced by Aboriginal change agents that include deeply rooted colonial power hierarchies, jurisdictional issues and the synergy of neo-liberalism and the bio-medical paradigm within the mental health care system, one also has to raise the question, whether any modern institution, such as the mental health system, can actually be organized and reformed to promote empowerment (Townsend,1998). In other words, can IH, as a mainstream institution, be reformed through such strategies as integration and adaptation to promote Aboriginal healing as understood by Aboriginal peoples, or is the solution to call for a distinct Aboriginal mental health system that is under the ownership and control of Aboriginal peoples themselves?

While in British Columbia, regionalization has led to the incorporation of Aboriginal health structures into mainstream health institutions, such as IH, other regions and countries have chosen a different path. One Canadian example is the Athabasca Health Authority (AHH) in Saskatchewan, which is responsible for

the regional governance, management and delivery of health services for both urban and on-reserve Aboriginal communities (Athabasca Health Authority, 2005; 2006). Even though only a little over 50 percent of AHH's employees identify as First Nations and Métis, the planning and provision of services including mental health and addictions is guided by an Aboriginal philosophy of care. This includes an interdisciplinary and holistic health service approach, and the adoption of community driven interventions that focus on promotion and prevention, and incorporate traditional healing practices, such as healing circles and sentencing circles (AHH, 2004). AHH operates under a unique model that responds in a creative way to some of the structural challenges outlined above and thus, might offer an alternative approach to IH's Aboriginal mental health reform. For example, in contrast to IH, AHH is a community-based organization whose Board of Directors is directly appointed by the leadership of each community directing accountability primarily to the communities it serves. In addition, since it serves urban and on-reserve Aboriginal communities, AHH receives funding from both federal and provincial governments enabling AHA to better coordinate services across jurisdictional boundaries and to operate on a larger budget than if it was only funded provincially or federally.

Another Indigenous health model is the Whanaungatanga model of care in Aotearoa/New Zealand that is utilized by the Te Puna Haurora Kaupapa Maori service (Kaupapa Service); a unique secondary, publicly funded health care system by Maori for Maori that provides "safe clinical and cultural care, underpinned by the philosophies of whanaungatanga (relationship associations),

manakitanga (caring and commitment) and arohatanga (love and respect)” (Lyford & Cook, 2005, p. 27). The Kaupapa Service is offered within the Te Puna Haurora building that is separate but adjacent to the mainstream hospital providing for a culturally safe but collaborative environment. Thus, Maori people who seek care can choose to access mental health and addictions services through either of the two systems (mainstream or. Kaupapa) or to use traditional healing techniques in conjuncture with conventional treatments.

While both of these models might present a potential alternative to IH’s approach to reform Aboriginal mental health, more research is warranted that looks at the feasibility and applicability of these approaches in BC’s context. In addition, concerns remain regarding the efficiency and effectiveness of all three approaches in improving mental health outcomes for Aboriginal people. As such, an important role for public health research would be to contribute to evaluation of current models of Aboriginal mental health reform. While current epidemiological studies are helpful in describing trends in service utilization and assessing Aboriginal mental health status, this research indicates that Aboriginal healing and empowerment has only just started and will take time. This potentially undermines the validity of epidemiological studies that try to measure improvements in Aboriginal mental health by using traditional health status indicators, such as prevalence and incidence rates. Instead, the findings of this study point to an increased need for more critical inquiries into how current practices of empowerment under different reform models are experienced by Aboriginal service providers and consumers of mental health and addictions

services to establish feedback loops to policy makers and guidelines for implementing cultural safety in Aboriginal mental health service provision.

On a smaller scale, this study contributes to the understanding of the opportunities and limitations for creating meaningful Aboriginal participation and culturally appropriate services, and thus could provide valuable information for guiding IH's next phase of developing and implementing an Aboriginal mental health plan. In addition, although the data for this research have been analyzed with a particular curiosity for mental health, the lessons learned from this study go beyond the area of mental health. Given the holistic understanding of health in Aboriginal worldviews and the pervasiveness of neo-liberalism in current governance, and colonial and bio-medical power hierarchies in Canada's health institutions, these findings could inform broader policy development in Aboriginal health, which will increasingly involve Aboriginal collaboration. Finally, as discussed in the beginning of this study, all of BC's health authorities are currently engaged in various stages of implementing Ministry of Health-mandated Aboriginal health plans. Thus, it is hoped that the findings of this study might also be useful for guiding local Aboriginal health reforms and inspire future research that looks at how the experience of Aboriginal mental health key leaders and service providers in IH compares to the experience of Aboriginal peoples who have taken on the challenge to reform Aboriginal health in collaboration with BC's other health authorities.

However, "research is only one activity, perhaps even a fairly minor one, in any project of emancipatory social change" (Labonte, 2005, p.1). Often critical

research findings do not translate into action. Cohen (2006), for example, notes that “despite Canada’s reputation as a leader in population health, actual health practice in Canada does not adequately address poverty and other social determinants of health” (p.1576). In fact, in the results of her study, *Population Health as a Framework for Public Health Practice: A Canadian Perspective*, Cohen (2006) reports that many managers and frontline workers from different health disciplines lacked knowledge, skills or comfort with engaging in strategies that address broader social determinants of health. Similarly, the findings of this study demonstrate the need for tools, such as the concept of cultural safety, which will help health care providers and policy makers to provide and design responsive and culturally safe mental health and addictions services for Aboriginal peoples. Thus, another critical role of population health and public health is to link critical research findings and emerging concepts that direct attention to the limitations of dominant mainstream practices, particularly with respect to achieving health equity through the development of appropriate educational curricula within universities and colleges. Given the breadth of Aboriginal mental health, this would include multiple health and social disciplines, such as nursing, medicine and social work, as well as the development of access supports for Aboriginal students who are interested in choosing a career in those areas.

APPENDICES

Appendix A: SFU Ethics Approval

FOR CONTACT IN REFERENCE TO THIS REVIEW

Application Number: 38188

Dr. H. Weinberg
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Reference Ethics Policy 20.01: <http://www.sfu.ca/policies/research/r20-01revised.htm>

Notification of Application Status

APPROVED

By Hal Weinberg at 12:46 pm, Mar 15, 2007

Investigator Surname	Josewski
Investigator First Name	Viviane
Investigator Department	Faculty of Health Sciences
Investigator SFU Email	Vha1@sfu.ca
Investigator Position	Graduate
Investigator Position if Other	Graduate Student in MSc PPH program
Title Of Research	Aboriginal Mental Health Reform in the Interior Health
Supervisor Surname	Morrow
Supervisor First Name	Marina
Supervisor SFU Email	mmorrow@sfu.ca
Co-Investigators	
Risk	Minimal
Approval Status	Pending REB (Blue)
Approval Date	March 15, 2007
Approval Start Date	March 15, 2007
Approval End Date	March 15, 2010
REB Date	00/00/00

Grant Information

Submitted To Agency For Review	Yes
Approved Subject To Ethics Approval	Yes
Reviewed By Any Other Agency	No
Title Of Grant	Master's Scholarship
Granting Agency	SSHRC
Granting Agency Program	Master's Scholarship
Date Granting Agency Approval Began	May 1, 2007
Date Grant Ends	May 1, 2008

Page: 1

FOR CONTACT IN REFERENCE TO THIS REVIEW

Application Number: 38188

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Reference Ethics Policy 20.01: <http://www.sfu.ca/policies/research/r20-01revised.htm>

Amendment Date 00/00/00

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Appendix B: IH Ethics Approval

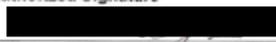


Research Office
 Research Ethics Board
 Suite 104 - 1815 Kirschner Road
 Kelowna, B.C., V1Y 4N7

Certificate of Research Ethics Board Delegated Approval

Principal Investigator: Viviane Josewski	Institution of Primary Association Simon Fraser University	IH Research File Identifier 2007-021
Research Study Title: Aboriginal Mental Health Reform in the Interior Health		
IH Sponsor Denise Taylor	Co-Investigators None	
Sponsoring/Funding Agencies SSHRC	IH Departments Involved in Research Study Mental Health Services	
Documentation received and reviewed IH REB Application IH REB Remote contact form 3 Research Proposal May 2, 2007 Informed Consent for Key Informants – Individual Interviews June 14, 2007 Interview Guide	Certificate of Approval from Primary REB Simon Fraser University March 15, 2007	
Certification It is the assessment of IH that this research study poses minimal risk to human subjects and therefore qualifies for delegated review. This Certificate of Approval is valid for the term specified below provided there are no changes in the experimental procedures. <i>The Interior Health Research Ethics Board is in compliance with the ethical principles presented in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans</i>		
Conditions for Approval It is the responsibility of the principal investigator to inform the IH Research Office if the assessment is deemed at any time to be greater than minimal risk for human subjects. It is the responsibility of the principal investigator to inform the IH Research Office if there are changes to consents or other materials used with human subjects – these must be submitted to the IH Research Office for review and approval prior to implementation.		
Approval Date June 27, 2007	Approval Term 1 year	
Reporting Requirements: Investigators must provide the Research Office with a final report.		
IH Authorized Signature 		
B. Ann Ferguson, Chair, Interior Health Research Ethics Board		<i>June 27, 2007</i> Date

Certificate of Research Ethics Board Delegated Approval- Renewal

Principal Investigator: Viviane Josewski	Institution of Primary Association Simon Fraser University	IH Research File Identifier 2007-021
Research Study Title: Aboriginal Mental Health Reform in the Interior Health		
IH Sponsor Denise Taylor	Co-investigators None	
Sponsoring/Funding Agencies SSHRC	IH Departments Involved in Research Study Mental Health Services	
Documentation received and reviewed IH REB Application IH REB Remote contact form 3 Research Proposal May 2, 2007 Informed Consent for Key Informants – Individual Interviews June 14, 2007 Interview Guide	Certificate of Approval from Primary REB Simon Fraser University March 15, 2007	
Certification It is the assessment of IH that this research study poses minimal risk to human subjects and therefore qualifies for delegated review. This Certificate of Approval is valid for the term specified below provided there are no changes in the experimental procedures. <i>The Interior Health Research Ethics Board is in compliance with the ethical principles presented in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans</i>		
Conditions for Approval It is the responsibility of the principal investigator to inform the IH Research Office if the assessment is deemed at any time to be greater than minimal risk for human subjects. It is the responsibility of the principal investigator to inform the IH Research Office if there are changes to consents or other materials used with human subjects – these must be submitted to the IH Research Office for review and approval prior to implementation.		
Approval Date Feb 25, 2009	Approval Term 1 year	
Reporting Requirements: Investigators must provide the Research Office with a final report.		
IH Authorized Signature 		<i>Feb 25, 2009</i>
B. Ann Ferguson, Chair, Interior Health Research Ethics Board		Date

Appendix C: Project Summary

Viviane Josewski, BsN; BA
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FACULTY OF HEALTH SCIENCES
West Hastings Street
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Vancouver

Aboriginal Mental Health Reform in the Interior Health Region

Overview: This study is conducted as part of my master's thesis at the Faculty of Health Sciences at Simon Fraser University. The purpose of this project is to explore the key mental health issues for Aboriginal people living in the area of x, y and z, and how they are addressed by mental health services and programs in the context of current health reform policies and development in Aboriginal health in the Interior Health region. An effort will also be made to identify key elements essential for the provision of culturally sensitive services and policy in Aboriginal mental health. The project is supported by the Social Sciences and Humanities Research Council and has received ethics approval through the SFU Research and Behavioural Ethics Board and the Interior Health Authority.

Goals and Objectives: Although mental health has been identified as a priority in the Interior Health's Aboriginal Health and Wellness Plan (2006-2010) and preliminary discussions indicate that Interior Health is reforming Aboriginal mental health care programming and delivery, little is known about Aboriginal mental health services and respectively, the needs and concerns of Aboriginal communities in the Interior. It is hoped that the findings of this study will be used to better understand the process of Aboriginal mental health reform within the Interior and provide guidelines/suggestions about culturally relevant services and policies for Aboriginal people with mental distress. The objectives of this study are to:

1. Explore the kind of mental health services that are provided for Aboriginal people and how they are accessed.
2. Examine how Aboriginal mental health services interface with mainstream mental health services given provincial-federal jurisdictional issues.
3. Explore how current mental health reforms are impacting Aboriginal mental health.
4. Develop an understanding of what culturally-appropriate services and policy could look like.

5. Examine how Aboriginal peoples are involved in mental health policy and programming.

Field Work and Time Frame: The first part of this study focuses on a review of the policy relevant literature on Aboriginal mental health and site visits aimed at introducing myself and the project to people working in Aboriginal mental health in the Interior Health Authority and in community-based organizations who deal with Aboriginal health. Through explorative interviews I am hoping to identify key contacts in Aboriginal mental health. In the second part of the study (July, 2007), 10-20 interviews will be conducted with representatives of Aboriginal communities in mental health-related positions, friendship centres and mental health institutions. Research participants will be asked to describe their perception of the key mental health issues for the Aboriginal population and their experiences with the current mental health system and policies in responding to the needs of the Aboriginal communities living on- and off-reserve. Special attention will be given to Aboriginal perspectives on how culturally-appropriate mental health services could look like.

All efforts will be made to enlist the cooperation of the management and staff before scheduling visits and interviews.

For more information about the project please contact Viviane Josewski at or her supervisor Dr. Morrow at mmorrow@sfu.ca

Appendix D: Consent Form

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Harbour Centre
BRITISH COLUMBIA
CANADA V6B 1A1
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Informed Consent for Key Informants – Individual Interview

A Pilot Study of Aboriginal Mental Health Services and Policy in the Interior Health Region of British Columbia

Primary Investigator:

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Overview:

This research is being conducted as part of a Masters of Science degree in Health Sciences at SFU and is affiliated with Dr. Marina Morrow's current research project *Community Capacity, Gender and Mental Health* on the relocation of people from Riverview Hospital to the Interior Health region. This study that will examine key issues related to Aboriginal mental health and policy with the goal to better understand the process of Aboriginal mental health reform and develop suggestions about culturally relevant policies and services for Aboriginal peoples. This study has received ethical approval by SFU and Interior Health Authority. It is also funded by the Social Sciences and Humanities Research Council.

Study Procedures:

10-20 interviews will be conducted with representatives of Aboriginal communities in mental health-related positions, friendship centres and mental health institutions. Research participants will be asked to describe their perception of the key mental health issues for the Aboriginal population and their experiences with the current mental health system and policies in responding to

the needs of the Aboriginal communities living on- and off-reserve. Special attention will be given to Aboriginal perspectives on how culturally-appropriate mental health services could look like.

Your Responsibilities and Rights as a Participant in this Study:

You are being asked to participate in one audio taped interview that will take approximately one hour. Each interview will be guided by 8 open-ended questions that evolve around themes relevant to Aboriginal mental health care. The style of the interview will be conversational and you are welcome to ask questions at any time throughout the duration of your interview and the study. You may also choose not to answer any questions. Participation to this study is completely voluntary. You may withdraw or refuse to participate at anytime during the study with no consequences.

If you show signs of doubt to whether you want to participate in the interview, the interview and the recording will be interrupted and you will be asked if you are still comfortable in proceeding with the interview. If you decide to withdraw during the interview, the interview will be ceased completely. As a consequence of withdrawal at any stage during the study, the information and data collected from you will be destroyed and not be used any longer for the purposes of this study.

Benefits of study to the development of new knowledge:

The information arising from this study will shed light on the strengths and weaknesses of the current mental health services and policy in the Interior Health in providing culturally-appropriate services to Aboriginal people. It is hoped that the findings of this study will stimulate further in-depth examinations of what culturally-appropriate mental health services look like and how they can be implemented. The results of the study will be shared with the health authorities, and the community-based organizations who have been involved in the study to help them enhance their support for Aboriginal people with mental health needs and to raise awareness where needed.

Confidentiality:

The University and those 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.

Please note that ethics approval for this project has not been sought from any Band.

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 Dr. Hal Weinberg, Director, Office of Research Ethics by email at hweinber@sfu.ca or phone at 778-782-6593.

Each participant's identity will be kept confidential by the researcher to the full extent permitted by law. Once the interview has been recorded on tape, the authentic name will be erased and replaced with a code name. The informant's identity will not accompany any research materials or reports or publications produced from this study; an identification number will accompany these instead.

Only the principal investigator, Viviane Josewski, her supervisor, Dr. Marina Morrow, and a hired transcriber who will be required to sign a confidentiality agreement will have access to the data. For recording purposes, I will use a digital recorder that enables the downloading of the taped interviews to a password secured server from SFU. The interview version on the digital recorder will be deleted immediately after the downloading process. All data will be safely stored as electronic versions on my computer protected by my personal password. For the purpose of transcription, the exchange of confidential information will use a protected electronic pathway, called tunnelier system to which only the transcriber and the primary investigator will have access. The data will be electronically stored at the same location on the SFU server for 5 years and will be destroyed as per SSHRC guidelines after 5 years.

A summary of the findings will be shared with research participants, opportunities to present the findings will be sought and a more detailed description and analysis will be contained in the final thesis.

You may obtain copies of the results of this study, upon its completion by contacting:

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I certify that I voluntarily agree to participate in this study and that I understand ...

- the procedures to be used in this study.
- that I may withdraw my participation at any time.
- that participation to this study is completely voluntary.
- that I may register any complaint with

Dr. Hal Weinberg
Director Office of Research Ethics
hal_weinberg@sfu.ca

or

the Chair of the Interior Health Research Ethics Board at 250 870-4649.

- that I will receive a signed copy of this consent form.
- the contributions of my participation in this study.

Participant signature Date

Printed name of participant Date

Witness signature Date

Printed name of Witness Date

Appendix E: Interview Guide plus Probes

1. Can you describe your role and responsibilities with respect to Aboriginal mental health?

- a. What kind of mental health and addiction services and resources does the Ki-Low-Na Friendship Centre provide?
- b. How is the Centre funded?

2. What are the key mental health issues that Aboriginal people present with?

- a. How are these mental health problems distributed among the Aboriginal population? Do they affect some groups more than others?
- b. Do you see the Aboriginal population living on-reserve presenting different mental health issues than the urban population?

Gender issues, women and violence, drug addiction, youth, residential school experience

3. Can you describe the typical pathway in mental health care for an Aboriginal person with a mental health problem?

- a. Would that be the same for a person living on- or off-reserve?
- b. What kinds of mental health and addiction services for Aboriginal people do exist?
- c. Are there any services or programs that are designed to integrate Aboriginal cultural values and traditions?
- d. Do you think mental health service providers are aware of Aboriginal health issues and culture?

Mainstream interface with Aboriginal, what services exist, accessibility and utilization of existing services, jurisdictional issues

4. Mental health services for Aboriginal peoples are provided through several layers of governance: federal, provincial, regional and Aboriginal bodies. What does that mean for the Aboriginal peoples who are in need for mental health services? What does it mean for those who provide these services?

- a. How is the coordination or integration between service providers: mainstream/Aboriginal and off-and on-reserve?
- b. How does the place of living “on-reserve” versus “off-reserve” play out for Aboriginal people in the need of mental health services?
- c. Are there specific Aboriginal mental health services offered on-reserve?
- d. Who can access them?
- e. Is this clear to the average Aboriginal person? Do they know about these services?

Indian Act, what kind of service provision (non-governmental, governmental, private and band services

5. What kinds of choices exist for Aboriginal peoples in terms of mental health and addiction services?

One goal of the Aboriginal Health and Wellness Plan was to maximize the successful mental health programs and services for Aboriginal people with IH.

- How many efforts have been undertaken to achieve this goal?
- That sounds as if there were already some successful programs in place. Was that the case?
- Overall, how much closer did we come to this goal since its formulation?

6. What do you think is key in developing and providing mental health services for Aboriginal peoples?

- a. Another objective was to increase the number of Aboriginal health workers through a human resource plan.
 - Is this plan available? Where can I get it from?
 - Was there an increase Aboriginal mental health workers?
- b. What role do you give prevention?
- c. Where do you see more research need?

7. Regionalization and the formation of Interior Health in 2001 led to many changes. How are Aboriginal people today involved in Mental Health Reform? What positions and mechanisms for participation are there?

- In the Aboriginal Health and Wellness Plan 2002/03 to 2005/06 states that there were mental health liaison persons (2 in Thompson Cariboo Shuswap and 1 full-time in the Okanagan). Do these positions still exist? When were the abolished? Why?

- I understand there is some kind of re-structuring on-going in the Interior Health
- How would you describe your role on the **Aboriginal Health and Wellness Advisory Committee?**
- What do you know about the **health transfer agreements** for First Nation communities?
 1. What kind of mental health services do they include?
 2. How many Aboriginal communities have qualified for an Indian Health Transfers agreement?
- What role do the **Aboriginal Health Improvement Committees** play for Aboriginal mental health planning?
- Do they still conduct **community consultation health planning meetings?**
 - Who is sitting on these meetings?
 - Are the minutes available to the public?
- What can you tell me about the **Aboriginal Health Initiative Program (AHIP)?**
 - When I last visited the IH website, I saw that the deadline for community-based proposals for mental health and addiction services was on February 2nd.
 - How often does IH request proposals?
 - Who will decide over the proposals?
 - How many receive usually funding?

Degree of Aboriginal self-governance, empowerment, IH structuring

8. One manifestation of mental health reform in British Columbia was the downsizing of Riverview Hospital in 2001 when Riverview clients began to be systematically transferred back into communities – one goal being to bring Riverview clients closer to their families. To your knowledge did this affect the mental health care for Aboriginal peoples?

- a. Is the Psych-social-rehab model an appropriate model for Aboriginal people with mental health problems?
- b. How many Aboriginal people are living at Riverview?
- c. Do you know how many clients transferred into the communities are First Nation, Métis or Inuit?
- d. Was/is the Aboriginal community in any way involved into the downsizing of RVH?

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