# THE NATURE OF THE TENSIONS AND DISJUNCTURES
## BETWEEN
## ABORIGINAL UNDERSTANDINGS OF AND RESPONSES TO
## MENTAL HEALTH AND ILLNESS
## AND THE CURRENT MENTAL HEALTH SYSTEM

By

Victoria L. Smye

B.A. Brock University 1986
M.H.Sc. McMaster University 1988

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# ABSTRACT

## The Nature of the Tensions and Disjunctures Between Aboriginal Understandings of and Responses to Mental Health and Illness and the Current Mental Health System

Aboriginal peoples continue to be affected by the mental health policies, structures, and social organization of the dominant culture which tends to exclude them. This study explored the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system. Using an ethnographic design informed by postcolonial and critical perspectives, in-depth individual interviews were conducted with Aboriginal people working in mental health and related fields; policy makers, both Aboriginal and non-Aboriginal; and nurses. A focus group interview was also conducted with health care providers (N=31). The 1998 Mental Health Plan and several documents of reform were also critiqued. Incorporating aspects of postcolonial theories, this study illustrates how dominant culture ideologies, mental health institutional policies, and everyday practices intersect to shape the tensions and disjunctures.

Using the interview data and policy critiques, I describe how mental health institutions and policies support the embeddedness of an assimilation ethos – revealed as paternalistic care, ethnocentrism, and the notion of [im]partial policy decision-making. Aboriginal perspectives are largely excluded vis à vis the intersection of the dominance of the biomedical model (i.e., psychiatry) and the ongoing jurisdictional debate regarding *who* is responsible for Aboriginal mental health. Dominant cultural frameworks and a lack of clarity about *who provides what* are interwoven and reproduced in the everyday world of mental health service delivery, being marked by acts of omission, colonial ambivalence, and the

normalization of Aboriginal suffering. Nevertheless, where normalization occurs, there are powerful points of Aboriginal collective resistance and healing.

The study concludes by arguing for the development of critical consciousness to challenge sustaining ideologies, institutional discourses, and predominating practices that exclude Aboriginality. The concept of cultural safety, positioned within postcolonial perspectives, is discussed as a means of fostering critical consciousness. By examining historically mediated relations of power, longstanding patterns of paternalism, ethnocentrism and assumptions about Aboriginality from a cultural safety lens, there is the potential to shift knowledge and attitudes in nursing and more broadly, in health care. Locating Aboriginal mental health and mental health care within its wider historical, social, political and economic context can help nurses to more fully contribute to social justice in the area of Aboriginal mental health.

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## ACKNOWLEDGEMENTS

First I would like to locate this work. I speak as a non-Aboriginal woman and therefore do not speak from a First Nations, Métis, or Inuit perspective but rather from a point of inquiry. I also bring to this work my understandings from clinical work, research, and teaching in the area of mental health over the past 30 years and from my more recent fieldwork with Aboriginal peoples.[1]

## CHAPTER ONE

Every disease has two causes. The first is pathophysiological; the second, political. (Ramon Cajal, pathologist, 1899, cited in Brant, 1993, p. 55)

## THE INTRODUCTION

### Background to the Problem

Aboriginal peoples in British Columbia (BC) and other areas of Canada continue to experience mental health inequalities and barriers to accessing mental health care that ultimately affect individual, family, and community mental health. A significant issue affecting equitable access and use of mental health services arises from what I have called, the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness, and the current mental health system.

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[1] Today, seventeen percent of Canada's Aboriginal people live in BC. This represents a large and culturally diverse community consisting of over 94,000 status Indians[1] as well as 70,000 non-status Indians and Métis. There are almost 200 bands (the bureaucratic organizational structure) with membership ranging from less than 10 to over 1700. Most of these bands have organized into 33 Tribal Councils (Elliott and Foster, 1995, pp. 98-100). In this dissertation, in much the same way as Browne (2003), I use these designations as consistent with the terminology used by the Royal Commission on Aboriginal Peoples (1996a). The term Aboriginal peoples refers generally to the Indigenous inhabitants of Canada, including First Nations, Métis and Inuit peoples without regard to their separate origins and identities. The Commission stresses that the term Aboriginal people "refers to organic political and cultural entities that stem historically form the original peoples of North America, rather than collections of individuals united by so called 'racial' characteristics. The term includes the Indian, Inuit and Métis peoples of Canada (see section 35(2) of the Constitution Act, 1982)" (p. xii). Specifically, the term "First Nation" replaces the term "Indian" and "Inuit" replaces the term "Eskimo". The terms Indian and Eskimo, however, continue to be used in federal legislation and policy, for example, the *Indian Act*, and in government reports and statistical data, particularly those generated by the federal department of Indian and Northern Affairs Canada (INAC). INAC retains the terms "status" or "registered Indian" to refer to people who have been registered by INAC as members of a First Nations under the terms of the Indian Act. When distinctions between Aboriginal groups are needed, specific nomenclature is used (Browne).

Early in the colonization process an assimilationist ethos prevailed in which Aboriginal peoples as "wards of the state" were to be assimilated into the fabric of Canadian society. Dominant culture ideologies, mental health institutional policies, and everyday practices have intersected to shape the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system. Aboriginal belief systems regarding health, healing and illness have been largely ignored, often being rendered invisible.

Colonialism is a dynamic phenomenon which intersects with and is influenced by social, economic, political, and historical processes; "yesterday's colonialism has certain features in common with today's colonialism, but today's colonialism has its own imprimatur"[2] (McConaghy, 1997, p. 77). However, whether speaking of the past or present, colonialism manages to disrupt in a spectacular fashion the cultural life of colonized people through the expropriation of land (geographical incursion) and rights (Fanon, 1967; Frideres, 1998), the negation of sociocultural [psychological] identities (Fanon, 1967; Frideres, 1998), the domination of legal relations introduced by the occupying power (Fanon, 1967), the marginalization[3] of Aboriginal peoples and their customs through the interconnected "processes of external political control and Aboriginal economic dependence" (Frideres, 1998, pp. 3-4), and, the domination of ideologies based on race and skin colour which place the colonizer as superior to the colonized (Frideres, 1998, p. 7). More insidiously, colonialism is attached to a political economy that renders it inherently incapable of meeting

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[2] McConaghy (1997) speaks about colonialism in the context of Australia and the indigenous people there. Instead of speaking about health and social policy, she refers to educational and social policy; however, I believe that what she says about these policies is equally applicable to health.

[3] A process by which mainstream society is represented as being at the center of community, while those with less power and resource are relegated to the periphery. Allocation to the periphery is usually based on identities, associations, experiences, and environments (Hall, Stevens, & Meleis, 1994; Reimer Kirkham, 2000).

the economic, [health] and social needs of the colonized people (Fanon, 1967).[4] According to

Frideres (1998) the provision of low-quality social services is a characteristic of colonization.

He says:

> [t]he ultimate consequence of colonization is to weaken the resistance of the
>
> colonized Aboriginals to the point at which they can be controlled. Whether the
>
> motives for colonization are religious, economic, or political, the rewards are
>
> clearly economic. (p. 7)

Colonialist domination has had extremely deleterious effects on Aboriginal peoples in

BC and across Canada and many live in conditions described as Third World in both urban

and reserve settings[5] (BC, 1998, p. 27; Fleras & Elliott, 1992, p. 16).

> Aboriginal people are more likely [than non-Aboriginals] to face inadequate
>
> nutrition, substandard housing and sanitation, unemployment and poverty,
>
> discrimination and racism, violence, inappropriate or absent services, and
>
> subsequent high rates of physical, social and emotional illness, injury, disability
>
> and premature death. (Royal Commission on Aboriginal Peoples, 1996a, p. 107)

Today, as central players in the tragedy of colonization, Aboriginal peoples have been

profoundly affected by the mental health policies, structures, and social organization of the

dominant culture which tends to exclude them. The 1998 Mental Health Plan, *Revitalizing*

*and Rebalancing British Columbia's Mental Health System* (RRBC), sets out the objectives

and strategies for the most recent mental health reform designed to promote the optimal

mental health and participation of people with mental illness in British Columbia's

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[4] Fanon (1967) notes that colonialism blinds the colonizer to the consequent negative effects of colonization (in terms of the social consequences for the colonized people).

[5] Often referred to as the *Fourth* World (O'Neil, 1986).

communities (RRBC, 1998, p.5). This plan is the product of a review of mental health care systems and the broader project of health reform over the past decade, as well as an extensive consultative process across the province of British Columbia attempting to address the current challenges that compromise quality care for people with mental illness, that is, those who experience long-term mental illness and disability, and those who experience acute, episodic, serious and persistent mental disorder.[6]

The overall tenor of the plan is reflective of Western understandings of health and illness and continues to be strongly influenced by psychiatry, with its attachment to biomedical traditions, individualistic approaches to treatment, and its long-standing history of cultural blindness (Fernando, 1991; Good, 1996) and racism[7] (Fernando, 1991). Although most recently there has been gradual shift to family-focused and community-based care, the mental health system remains aligned with an illness service model. Even where illness service models used across Canada reflect a more holistic, multidisciplinary, and multi-sectoral approach to health, generally this development within Western society does not fully reflect the holistic approaches of Aboriginal traditions (O'Neil & Postl, 1994; O'Neil, Lemchuk-Favel, Allard, & Postl, 1999), nor does it recognize or acknowledge the sociopolitical and historical context of Aboriginal mental health.

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[6] *Serious and persistent mental illness* usually refers to the following categories of illness as found in the Diagnostic and Statistical Manual of Mental Disorders (fourth edition, test revision) (DSM-IV-TR) (American Psychiatric Association (APA), 2000), for example, schizophrenia and other psychotic disorders; mood disorders, including bipolar disorder; and anxiety disorder. The 1998 Mental Health Plan (RRBC) commits to providing mental health treatment to "those who experience serous long-term mental illness and disability" and "to those who experience acute, episodic serious mental illness." This includes persons " who do *not* voluntarily access care, as well as those who present with additional conditions (e.g., substance misuse, developmental disabilities, positive HIV status)" (p. 18).

[7] I use racism in the same sense that Fernando (1991) does as essentially about "'institutionally generated inequality' based on concepts of racial difference; although it affects the behaviour of individuals, 'prejudiced people are not the only racists'" (p. 24). As Fernando notes, acknowledgment of difference based on notions of race tends to inscribe patterns of inclusion and exclusion based on colour and/or phenotypic characteristics.

Although many Aboriginal people have constructed a coherent and complex medical system out of disparate biomedical and Aboriginal medical systems, generally speaking, program delivery models which reflect predominately Western European concepts of mental health and illness have been identified as largely ineffective in responding to the needs of First Nations people (McCormick, 1996, 1998; O'Neil, 1993a; Warry, 1998). There is a tendency by Aboriginal peoples not to use the mental health services provided by the dominant culture (McCormick, 1996; Trimble & Fleming, 1990). If services are accessed, approximately one-half of these individuals drop out (Sue, 1981; Duran & Duran, 1995), and for many, treatments are not effectual (Duran & Duran, 1995, 2000; McCormick, 1996; Sue & Zane, 1987; Trimble & Fleming, 1990). Mental health programs and services designed in keeping with dominant cultural (biomedical) views of mental health and illness ignore the unique cultural identities, histories, and sociopolitical contexts of the everyday lives of Aboriginal peoples, putting them at risk of not having their mental health care needs recognized and met.

Persistent socioeconomic inequities and continued marginalization have taken a toll on the mental health of many Aboriginal people. Although they suffer from many of the same mental health problems as the general population, rates of mental health problems such as suicide, depression, substance abuse and domestic violence are significantly higher in many communities (Nelson & McCoy, 1992) and the overall mental health status of Aboriginal peoples is markedly worse than that of non-Aboriginal people by almost every measure (British Columbia Provincial Health Officer (BCPHO), 1996, 2002; First Nations Inuit and Health Branch (FNIHB), 2001; Foster, MacDonald, Tuk, Uh, & Talbot, 1995;

MacMillan, 1996; O'Neil et al, 1999; Vancouver/Richmond Health Board (VRHB), 1999[8]). Although most statistics continue to be generated by epidemiological studies and thus Western measures of health and illness, many Aboriginal people concur with the view that the issue of Aboriginal mental health requires urgent attention (Royal Commission on Aboriginal Peoples, 1995, 1996b).

Instead of thinking about mental health problems as medically defined disorders, many Aboriginal caregivers and policy analysts believe that it is more appropriate to focus on the mental health issues that pose the most serious threat to the survival and health of Aboriginal communities. They argue that suicidal and other self-destructive behaviours such as alcohol and drug abuse and violence are primarily "a by-product of the colonial past with its layered assaults on Aboriginal cultures and identities" (Royal Commission on Aboriginal Peoples, 1995, p. 21), the kind of assaults that have led to "a state of pervasive demoralization related to the breakdown of the moral order including religious, kinship and other social institutions such as the family unit..." (Kirmayer, 1994, p. 23). This sense of pervasive demoralization is what Durkheim (19571987) calls "anomie." Brant (1993) describes this as

> [a]n environment of despair on many reserves – an environment that includes welfare dependency, unemployment and poor educational experiences, an environment of poverty and powerlessness and anomie produces the triad of alcohol and other substance abuse, suicidal ideation, suicide attempts and depression. (p. 1)

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[8] The Vancouver/Richmond Health Board is now the Vancouver Coastal Health Authority as a consequence of a recent reorganization in the health sector that included a shift in regional boundaries.

This does not mean that Aboriginal peoples do not live with schizophrenia, bipolar disorder and other affective disorders, or that these are not of concern to Aboriginal communities, but rather that these disorders are considered less problematic in relation to community survival. In fact, little is known about the exact prevalence of mental health disorders, as defined in the <u>DSM-IV-TR</u> (APA, 2000), in the Canadian Aboriginal population (Brant, 1994).[9] However, there is agreement in much of the literature that Aboriginal peoples appear to be at higher *risk* for mental health problems than most of the general population, likely attributable to the consequences of colonization (Armstrong, 1991; Brant, 1994; Darymple, 1995; Duran & Duran, 1995, 2000; Fritz & D'Arcy, 1989; Jilek-Aall, 1974; Keltner, 1993; Royal Commission on Aboriginal Peoples, 1996a, 1996b; Sampath, 1974).

To understand the meaning of health within a sociopolitical and cultural context, one needs to elucidate "the intersectionality and simultaneity of race, gender, and class relations, the practice of racialization, the connectedness to historical context, and how the curtailment of life opportunities created by structural inequities influences health" (Anderson & Reimer Kirkham, 1999, p. 63).

## The Central Problem

The 1998 Mental Health Plan as it exists within current mental health reform in BC has tended to gloss over and/or ignore the broader sociopolitical and economic factors that shape the meaning and experiencing of mental health and illness for Aboriginal peoples. In light of these exclusions and the inequitable mental health status of Aboriginal peoples, the central problematic addressed in this study is the nature of the tensions and disjunctures

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[9] Of note, it is not known whether these disorders occur less often in Aboriginal people or whether the low access figures are simply a reflection of the fact that Aboriginal people have poorer access to diagnostic and treatment facilities for mental health problems – and/or are less likely to use them (Royal Commission on Aboriginal Peoples, 1995, p. 21).

between Aboriginal understandings of and responses to mental health and illness and the current mental health system. It should be noted that I am not elucidating Aboriginal understandings per se, but rather focusing attention on the conflict between those understandings and the current mental health system. In particular, I am examining and describing the nature of the tensions[10] or effects produced between these two forces which seemingly are often in conflict. The separations created between parties are what I refer to in this dissertation as the disjunctures.

### Research Objectives

The overarching purpose of the dissertation is to more fully understand: (a) the nature of the tensions and disjunctures mentioned above, and (b) to examine the extent to which the tensions and disjunctures shape mental health care to Aboriginal peoples. To address this problem, an ethnographic study informed by postcolonial and critical perspectives was conducted. The specific objectives of the research were to:

1. explicate the nature/attributes of the tensions and disjunctures,

2. identify the aspects of these attributes that are most problematic for people,

3. identify the structures, practices, and techniques that create barriers to alleviating and/or working within the tensions and impede the achievement of optimum mental health for Aboriginal people, and

4. generate recommendations concerning the role of nursing in contributing to mental health policy.

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[10] Importantly, I entered the study with the assumption that a tension or tensions existed and discussed this with the participants (see Chapter Four). This assumption of course, was at the heart of the research question and I needed to see what the participants thought about this view. In most cases, this question led to lengthy discussions about the essence of the tension from the perspective of each of the participants, revealing the complexity of what I was setting out to do.

To address these objectives, methods included in-depth individual interviews with policy makers, both Aboriginal and non-Aboriginal; Aboriginal people working in the mental health field and related fields; and nurses working in a hospital setting. A focus group interview was conducted with health care providers working with Aboriginal and non-Aboriginal people with multiple health issues, including mental health and substance abuse. In addition, a review/ critique of several current mental health policies was conducted. It was anticipated that this kind of critical interpretive inquiry would provide a text to identify and clarify the nature of the tensions and disjunctures.

## Organization of the Dissertation

The present chapter has provided an introduction to the research topic and specific purpose. The remainder of the dissertation is organized around a central line of argument, which illustrates how dominant ideologies, mental health discourses, and everyday practices within mental health intersect to shape the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system.

Chapter Two addresses the historical and current context of the tensions and disjunctures, particularly as they have influenced the mental health of Aboriginal peoples. I examine how colonial ideologies and practices as lived out in the history of Indian social and health policy continue to shape the collective consciousness of the dominant culture in this country, and influence relationships between Aboriginal and non-Aboriginal peoples. This provides the backdrop against which to examine the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system.

Chapter Three outlines the theoretical foundations of this work. Positioned within a critical interpretive framework that draws on postcolonial perspectives, I delineate the theoretical viewpoints that influence my understanding of Canada's colonial history, race relations, culturalism, difference, and racialization. These emerge as key analytic constructs in this study. I also draw on the perspectives of Aboriginal scholars who have critiqued these theoretical perspectives in terms of their relevance and applicability, and introduce the concept of "cultural safety" as a postcolonial interpretive lens in this study.

In Chapter Four, I present the research methodology. I discuss the procedures used to sample participants, collect and analyze the data, and maintain scientific rigor. This chapter also includes a reflexive analysis of how my social and professional positioning has shaped all stages of the research process.

Chapters Five, Six, and Seven present the empirical findings of this research. In Chapter Five, I examine how the ideologies of paternalism, ethnocentrism, and impartiality shape the tensions or disjunctures.

In Chapter Six, I focus on the mediating role of mental health institutions and policies, as they provide a point of intersection between dominant culture ideologies and everyday practices within the mental health complex.

In Chapter Seven, I shift the analysis to the dynamics of everyday practices within the mental health complex that act as barriers to access to mental health care for Aboriginal peoples. Using examples from my interview data and fieldnotes, I examine how the legacy of colonialism with its assumptions about Aboriginal peoples, culture, and difference continue to be interwoven and reproduced in the everyday experience of Aboriginal peoples accessing mental health services.

Lastly, in Chapter Eight, I reconsider the findings in light of the theoretical perspectives informing this research. In the process, I put forward recommendations for fostering the development of critical perspectives and critical consciousness in the health care sector pertaining to practice, research, and policy as strategies for improving access to mental health care for Aboriginal peoples.

# CHAPTER TWO

# TENSIONS AND DISJUNCTURES WITHIN AN HISTORICAL CONTEXT

In this chapter, the literature is reviewed to provide an historical and current context in which to examine the tensions and disjunctures that exist between Aboriginal understandings of and responses to mental health and illness and the current mental health system. To situate the mental health concerns of Aboriginal people in a wider social context, I begin by providing a brief overview of the social determinants of mental health and indicators. A critical examination of the epidemiological profiles of Aboriginal mental health provides an overview of the current mental health status of Aboriginal peoples in the context of social, economic, and historical influences.

Next, I move on to examine the history of Indian social policy and how the legal relations established by the *Indian Act*, 1876, have provided the foundation for the tensions and disjunctures that exist between Aboriginal peoples and the mental health care system. These perspectives illustrate how colonial ideologies and practices from the past continue to shape institutions, policies, and practices; they stand as a reminder of the colonial past and the neocolonial present (O'Neil, 1989). Then I examine the historical development of relations of paternalism, mistrust, and dependency in mental health care involving Aboriginal peoples in Canada. As I argue in subsequent chapters, understanding the historical and structural[11] contexts in which mental health care is delivered is critical to understanding the

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[11] I use the term "structural" in the same way as Browne (2003) to refer to those essential structures in society – "the state, the polity's social and economic status, local and global political economies, globalization and racialization, and dominant institutions including health, legal, educational and government systems – that define, determine and reproduce unequal power relations, racialization, class, and patriarchy as a basis for social relations" (p. 10). Choices available to "social subjects" are impinged upon and determined by those structural formations and social relations. In this way, the interests of some members of society are constrained, while others, usually the dominant cultural group, are privileged (Roman & Apple, 1990, p. 42).

issues of access for Aboriginal peoples. In this vein, I provide an examination of residential schooling and boarding homes as a means of locating the mental health issues of many Aboriginal peoples.

The focus then shifts slightly to self-governance, providing a current context for the health and healing of Aboriginal peoples in Canada. Here, I briefly examine the status of health transfer arrangements and the importance of self-governance to the future mental health of Aboriginal peoples.

I close by providing an examination of the structure of mental health reform with its consequent policies and services to provide a current context for the tensions and disjunctures. Thus, the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system are brought into focus within this particular political and historical period.

## Contemporary Determinants of Aboriginal Mental Health

Although disempowerment has received little attention as a determinant of health, it is known that perceived lack of power and responsibility contributes to a dependency mindset and further exacerbates the power imbalances produced by political marginalization (Ponting, 1997). As mentioned in Chapter One, "anomie" is a term coined by Durkheim to refer to "a state of pervasive demoralization related to the breakdown of the moral order including religious, kinship and other social institutions such as the family unit; suicides due to such social breakdown and normlessness, he termed 'anomic' " (Kirmayer, 1994, p. 23).

Anomie is considered to be one of the leading causes of suicide,[12] depression, anxiety,

substance abuse, and despair in Aboriginal populations today (Brant, 1993; Kirmayer).

From the preliminary findings of a review on Aboriginal health, including the Royal

Commission on Aboriginal Affairs and the Canadian Standing Committee on Health, Brant

(1994), identifies the following mental health issues in the Aboriginal community:

widespread substance abuse, including alcohol, solvent inhalation, street drugs, and

prescription medications; family violence, including spousal assault and the sexual and

physical abuse of children; and depression and hopelessness, often culminating in suicide.

These issues are identified consistently across many Aboriginal communities in Canada

(Chandler & LaLonde, 1998; Cooper, 1995; Rahim-Jamal, 1998; Elias & Greyeyes, 1999;

Jodoin, 1997; Kirmayer, 1994; Kirmayer, Brass, & Tait, 2000).

Despite continued resistance by many to the imposed institutions and belief systems

of the dominant Western culture, and "despite the brave (or stubborn) unwillingness of some

Aboriginal people to abandon traditional ways, all Indigenous cultures were weakened as a

result of their encounters with non-Aboriginal society" (Royal Commission on Aboriginal

Peoples, 1995, p. 26). The "culture of violence" enacted by the Canadian state on Aboriginal

people's cultural identity, self-concept, and social roles has taken its toll. In the 1993 Round

Table discussion of the Royal Commission on Aboriginal Peoples, Dr. Clare Brant

specifically identified poverty, despair, poor housing, and political alienation as the root

causes of the traumatic mental health problems that plague many Aboriginal communities

(O'Neil, 1993b).

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[12] This is in contrast with "altruistic" suicide which is done "for love of one's country, nation, family or other organization" or "egoistic" suicide which is done "when life no longer has meaning in terms of the meaning of existence for the individual" (Brant, 1993, p. 62). Suicide in Aboriginal communities may occur as a consequence of any of these, however, "anomic" suicide, which results from a lack of regulatory factors in one's life, is thought to be a significant factor in the suicides of many First Nations people.

Current social status indicators for Aboriginal peoples are well documented and

demonstrate major discrepancies in comparison to non-Aboriginal people. For example, in

1999, the First Nations infant mortality rate, a good barometer of social conditions and

health, was 1.5 times higher in First Nations than the Canadian infant mortality rate (INAC,

2002) and in BC, was 2.2 times higher for Indian babies than for other babies between 1991-

1999 (Vancouver/Richmond Health Board, 1999). In Vancouver and Richmond, the life

expectancy for status Indian people in 1997 was 16 years lower than for other people living

in these cities (Vancouver/Richmond Health Board). Age-standardized mortality rates from

all causes for status Indians between 1991-1999 was 1.7 times higher than for other BC

residents (Vancouver/Richmond Health Board).

Mortality is known to be significantly related to social class (Evans, 1993, p. 271) and

for at least fifty years, poverty has been known to be a determinant of health status[13] (Evans,

Barer & Marmor, 1994; Krieger, Rowley, Herman, Avery & Phillips, 1993; O'Neil & Postl,

1994, p. 82) and is evident within First Nations populations. For example, according to

Health Canada statistics, HIV infection among Aboriginal populations has increased 91%

from 1996 to 1999 (AIDS Among Aboriginals, 2001) and is disproportionately evident in

Aboriginal populations, in particular in relation to Aboriginal women's rates (Health Canada,

2002). Smoking rates are also alarmingly high in Aboriginal populations. Data from the First

Nations and Inuit Regional Health Survey (Reading, 1999) indicates that 62% of people who

self-identified as First Nations smoked as compared to 31% of other Canadians.[14] In addition,

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[13] Eight out of ten Aboriginal children live in poverty in the Vancouver and Richmond area
(Vancouver/Richmond Health Board, 1999).

[14] Percentage of smokers among First Nations young adults age 20-24 were as high as 74%.

tuberculosis, in the First Nations was 8 to 10 times that of the entire Canadian population[15] (FNIHB, 2001).

Poverty also undermines self-esteem and self-worth, making people more vulnerable to violence, alcohol and other substance abuse, and the risks associated with these[16] (Aboriginal Nurses Association, 1996; Dion Stout, 1997). Welfare colonialism has resulted in a high degree of unemployment, a high dependency on meager social assistance payments (Fiske, 1992) and low incomes relative to other Canadians[17] (Elliott & Foster, 1995, p. 103); notably, unemployment has been correlated with mental and physical ill health and with early death. More recent data from western Canada show that 40% of urban Aboriginal peoples live on incomes of less than $10,000 per year (Simard, 2001). It is well known that the general prosperity of a nation affects the health status of its people and that the distribution of income within a country is associated with health status (Royal Commission on Aboriginal Peoples, 1996, p. 217).

In addition to these difficulties, despair on most reserves is heightened by inadequate housing,[18] a shortage of recreation facilities, and inadequate educational[19] and health

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[15] Tuberculosis is correlated with overcrowded housing and poverty (FNIHB, 2001).

[16] Suicide also has been widely recognized as related to socioeconomic class (Brant, 1993, p. 59) and alcohol and substance abuse (FNIHB, 2003b).

[17] In 1996, the unemployment rate for First Nations people was almost three times higher than the Canadian rate (FNIHB, 2001). For 1997-1998, the unemployment on First Nations reserves stood at about 29% compared with a rate of 10% for Canada as a whole (INAC, 2000). Although income is gradually improving across First Nations peoples, the income levels on reserves in the 1996 Census were only half that of all Canadians (Armstrong, 1999, cited in FNIHB, 2001).

[18] "Nearly one fifth of Indian dwellings in BC are considered 'crowded' (10 times the rate for the rest of the province) (Elliot & Foster, 1995, p. 103). In 1999, only 56.9% of homes in First Nations communities in Canada were considered adequate (INAC, 2002).

[19] Few high schools are close to Indian reserves and, as a consequence, many First Nations adolescents find themselves in boarding situations so that they can attend high school. Leaving home is a stressor for some adolescents and their families, especially in the wake of the historical experience of residential schools.

facilities. According to Joseph (1991), the housing crisis has been exacerbated by the influx of women (and their families) whose status has been reinstated through Bill 31.[20] In relation to education, in 1996 within mainstream schooling, in Vancouver, less than 20% of self-identified[21] Aboriginal students who finished grade eight graduated with a high school diploma and in Richmond, 40% graduated in contrast to 80% of other youth. Thirty percent of Aboriginal youth do not even make the grade 8-9 transition (Vancouver/Richmond Health Board, 1999).

## Epidemiological Constructions of Mental Health and Illness

Current mental health indicators for Aboriginal peoples demonstrate major discrepancies in their mental health status compared with other Canadians.[22] For example, 'injury,'[23] which includes all forms of accidental death (unintentional injury), homicide, and suicide, accounts for 85.5 % of all deaths in First Nations people aged 15 to 24 years of age

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[20] One of the most oppressive and controversial aspects of the *Indian Act* was the enactment of patriarchal state ideology, which until the 1985 amendments to the *Indian Act* stripped women and their children of their status upon marrying non-Indian or non-status Indian men. These amendments, known commonly as Bill C-31, allowed women who had previously lost their status to regain status. Consequently, after 1985, many women returned to the reserve (Stevenson, 1999).

[21] "Aboriginal staff in the school system are clear that there is low reporting of ancestry as students or their family chose not to self-identify. Once self-identified, students are treated differently and some believe this increases the possibility of their being discriminated against by teachers and other students. There is also a belief that Aboriginal students are readily labeled as 'special need' because this increases funding to the designated school" (Vancouver/Richmond Health Board, 1999, p. 20).

[22] Although epidemiological data can be useful in drawing attention to the most pressing mental health needs of Aboriginal peoples, mental health data also can represent "systems of surveillance", which have been instrumental in determining public understandings of Aboriginal peoples and communities (O'Neil, 1993b, p. 34). As O'Neil, Reading and Leader (1998) state: Epidemiological knowledge constructs an understanding of Aboriginal society that reinforces unequal power relationships; in other words an image of sick, disorganized communities can be used to justify paternalism and dependency" (p. 230). Epidemiological constructions of risk factors for cervical cancer among Aboriginal women provide a case in point (Browne & Smye, 2002).

[23] The majority of Aboriginal deaths from injury are the result of motor vehicle accidents (with alcohol as a major contributing factor), drownings, house fires, and gunshot wounds. Such injuries are considered preventable in about nine cases out of ten (Royal Commission on Aboriginal Peoples, 1996b).

and for 59% of deaths among those First Nations people aged 25 to 44 years (Royal Commission on Aboriginal Peoples, 1996b, p. 153). In BC, the suicide rate[24] alone is approximately 80 per 100,000 males (Native) as compared to 57.8 per 100,000 males (Native) for all of Canada and 22.8 per 100,000 males (non-Native). For females, the rate is 19 per 100,000 (Native) compared to 14.5 per 100,000 (Native) for all of Canada and 6.4 per 100,000 (non-Native). Thus First Nations youth are two to three times more likely to commit suicide than their non-Native counterparts.[25] Tragically, for males the highest rate of suicide occurs in the 20-24 age group and for females in the 15-19 age group (Elliott & Foster, 1995). Also, adolescent males are six times more likely to commit suicide than adolescent females (p. 109). The high suicide rates in First Nations youth and young adults are particularly alarming given that approximately 66% of Canada's registered First Nations people are under 35 years of age (p. 98).[26]

However, it should be noted that these statistics should not be broadly viewed as an accurate reflection of all First Nations communities (Chandler & LaLonde, 1998; Chartrand, 1995). For example, one BC study showed that suicide rates across the 196 bands studied varied considerably: Over one half of the bands (111) experienced no youth suicides at all over the period of study (1987 to 1992), whereas, at the other end of the continuum, some

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[24] The suicide figure would be even higher if mysterious and accidental death were included given that many of these are thought to disguise suicide (Brant, 1993; Cooper, 1995; Kirmayer, 1994; Warry, 1998).

[25] "Reliable statistics are not available because there is some difficulty in documenting the actual incidence of suicide in Aboriginal populations, since non-status Indians may not be included in some statistics" (Brant, 1993, p. 55). However, Cooper (1995) reports some confidence in a study conducted by the BC Institute on Family Violence which found the same rates of suicide as those obtained in earlier studies using data collected from coroner's reports, including in-depth reviews of those reports. Also the study findings "were congruent with literature in documenting geographic variability when Aboriginal population size is high and underline previous warnings that rates calculated on small population bases may be very misleading" (Cooper, p. 211).

[26] A statistic that supports the idea of focusing suicide health promotion/prevention activities on children and youth (Royal Commission on Aboriginal Peoples, 1995).

bands had extremely high rates[27] (Chandler & LaLonde, p. 214). These differences were found to be related to the extent to which markers of "cultural continuity" were present in the given community. These "protective factors" included land claim negotiations, self-government, education services, police and fire services, health services, and cultural facilities.[28]

In another study conducted in BC, it was found that Aboriginal suicide rates were higher for on-reserve populations than for off-reserve populations and that characteristics of reserve populations such as "lower levels of education,[29] household crowding, less employment, more single parents and fewer elders, are associated with higher suicide rates" (Cooper, 1995, p. 220). Aboriginal people who commit suicide are also likely to have a higher number of adverse life history indicators than non-Aboriginals who commit suicide, including "higher rates of family and personal alcohol abuse, and/or physical or verbal violence either as a victim or as a perpetrator." Also, they were "more likely to be intoxicated at the time of the suicide, more likely to use hanging and likely to act impulsively, or at least without overt warning. It was rare for Aboriginal individuals who committed suicide to have consulted a health professional, whereas almost half the non-Aboriginals had done so" (p. 220).

Across the literature on Aboriginal suicide, it is a generally held view that suicide occurs with alarming frequency in some First Nations communities and that many suicides

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[27] High rates are often an artifact of a cluster of suicides.

[28] Although these findings do not suggest that the markers are causal mechanisms in terms of better mental health outcome (i.e., lower suicide rates), they do suggest that these markers are related in some way to differences in mental health status across First Nations communities, and are worthy of further investigation.

[29] However, Kirmayer (1994) reports that First Nations people who committed suicide tended to be better educated themselves. It is hypothesized that they are acutely aware of the problems surrounding them in relation to a lack of employment opportunities, and so forth.

could have been prevented (Brant, 1993; Cooper, 1995; Kirmayer, 1994). Most feared is the cluster of suicides that have occurred as a consequence of the contagion effect,[30] well documented in the suicide literature. Suicide and other forms of violent death are symptomatic of marginalization and the historic domination which has led to the chronic hopelessness and intergenerational despair experienced by many Aboriginal communities (Brant, 1993; Chandler & LaLonde, 1998; Cooper, 1995; Kirmayer, 1994; Royal Commission on Aboriginal Peoples, 1995, 1996b; Warry, 1998).

The pervasiveness of alcohol and drug abuse casts a similar shadow over the lives of Aboriginal peoples and is often implicated in violence and petty crimes that all too often result in incarceration (Duran & Duran, 1995, 2000; Waldram, Herring, & TK Young, 1995; Waldram, 1997; Wade, 1995). In her research in the central interior of BC, Furniss (1999) found that status domination often featured as the forcible ascription of negative identities to Aboriginal peoples – the most common being the "drunken Indian." According to Furniss, the 'drunken Indian' stereotype features so pervasively that, on occasion, sober Aboriginal people have been perceived by Euro-Canadians as drunks (p.129). Furniss found that many Euro-Canadians continue to define the problems that Aboriginal peoples face as tied to social ills: "unemployment, poverty, alcoholism, and poor living conditions" separate from the social, economic, and historical inequalities that divide Aboriginal and Euro-Canadian populations. She found that many people offered simplistic solutions to these problems; for example, "Aboriginal people must develop the will to go out and find work" (pp. 151-152). It would seem that, for many, these problems would be solved if the values of dominant culture were adopted (p. 152).

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[30] "For example, in Davis Inlet, 46 persons out of a population of 500 had attempted suicide during a single year" (Warry, 1998, p. 145).

There is tremendous variability in alcohol abuse across Aboriginal communities. It has been estimated that 50-80% of some adult populations have alcohol-related problems. Factors associated with substance abuse include "physical and geographic isolation, unemployment, and lack of recreational opportunities" – common features of Northern communities in general, and Native communities in particular (Warry, 1998, p. 78). Excessive alcohol use in women can cause Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE) across both non-Aboriginal and Aboriginal populations. The prevalence of alcohol abuse among Aboriginal children and youth is unknown, however, in many Aboriginal communities, gas sniffing has become a significant issue involving up to 30-40% of the youth in some Northern areas (Warry, 1998). Other substance abuse remains worrisome in some communities. For example, in the 1996 Northwest Territories Alcohol and Drug Survey (NTBS), it was found that Aboriginal people 15 years and older were almost three times more likely to have used marijuana or hashish in the previous year than non-Aboriginal residents and three and a half times more likely to have used LSD, speed, cocaine, "crack," or heroin (NTBS, 1996). It has been found that culturally relevant programs, which emphasize traditional Aboriginal values, tend to be the most successful treatment approaches (Warry & Moffatt, 1993; Warry, 1998; Westermeyer & Neider, 1984).

Today, domestic, sexual, and other forms of violence continue to be cited as one of the most pressing issues facing Aboriginal communities (Aboriginal Nurses Association, 2002; Ontario Native Women's Association, 1989). LaRocque (1993) argues that the alarmingly high rates of domestic and sexual violence experienced by Aboriginal women and children are "one of the most problematic legacies of long-term colonization" (p. 74). Although evidence about incidence rates is generally lacking, front-line workers and

community members identify abuse as a significant concern (Jodoin, 1998; Waterfall, Joseph & Van Uchelen, 1994).

LaRocque (1993) draws attention to the ease with which institutions[31] and organizations/ agents of the dominant culture – for example, the media, the justice system, the police, and the social service sector – mistakenly attribute violence and sexual abuse as Aboriginal cultural traits rather than "social conditions arising from societal negligence and policies" (p. 76). In response to this problem, Turpel (1993), an Aboriginal lawyer and scholar, has reframed the term "culture of violence" to include the effects of colonization perpetrated by the state on Aboriginal women's identity, self-concept, and social roles, in recognition of the broader historical and sociopolitical context of violence. In this regard, Warry (1998) includes the effects of what he calls "native child abuse by the child welfare system" (p. 81).

Family violence and, in particular, neglect and/or abuse of children, are often attributable to "highly stressful environments" usually created by a combination of social, economic, and health conditions. The synergistic effects of unemployment and poverty contribute to the proliferation of unmet human needs, social pathologies, and high rates of family violence (Dion-Stout, 1997; Young, 1994). As noted earlier, poverty undermines self-esteem and self-worth making women[32] more vulnerable to violence, alcohol and substance abuse, and the risks associated with each of those (Aboriginal Nurses Association, 1996; Dion-Stout, 1996, 1997).

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[31] Here I use the term "institutions" like Henry, Tator, Mattis, and Rees (2000) to refer to those systems that are foundational to the Canadian state including education, the media, the arts, policing, the justice system, human services, and corporate and government systems.

[32] Women and children are most often the victims of family violence, often attributed to alcohol and/or drug abuse (Aboriginal Nurses Association, 2002; Turpel, 1993).

Although the number of Aboriginal children living on reserves who are 'in care' has decreased, the percentage is still above the national average. In March 1999, about one half of Vancouver children "in care" were Aboriginal (48%: 638/1329). "The risk factors that contribute to placement of children in care include single parent families, social isolation, poverty, and drug and alcohol abuse" (Vancouver/Richmond Health Board, 1999, p. 24). The major cause of apprehension of children by social welfare agencies varies, however, the most common reason relates to violence and neglect in the home, often attributable to alcohol use (Vancouver/Richmond Health Board).

The prevalence of *serious mental illness* is less well documented in Aboriginal populations in Canada. The findings of a 1999 poll of mental health clinic services suggests that approximately 3.3% of the population accessing mental health services in the Vancouver and Richmond areas are First Nations people (R. Peters, personal communication, July 15, 1999 and November 12, 2003). However, between 1992-1998, far fewer Aboriginal people than anticipated accessed services at the Riverview Hospital.[33] According to the Vancouver/Richmond Health Board (1999): "If psychotic conditions occur at rates similar to the general population, then the 1-1.5% Aboriginal admissions to Riverview suggests about one-third of Aboriginal people who require care actually receive it" (p. 33). Population estimates suggest that approximately 4% of the population in lower mainland BC are Aboriginal. However, generally, little is known about the numbers of Aboriginal people who access mental health services because the designation of "Aboriginal" is not sought when health care is accessed and only persons with "status" can be identified. In addition, mental health information systems are not well established in BC.

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[33] A psychiatric tertiary care facility in BC.

In addition to the issues above, there is an overrepresentation of Aboriginal people in federal and provincial prisons across Canada, with the highest percentage of people incarcerated in the prairies (Monture-Angus, 2000; Waldram, 1997). To shed light on this issue, the Aboriginal Justice Inquiry of Manitoba commented:

> Cultural oppression, social inequality, the loss of self-government and systematic discrimination, which are the legacies of the Canadian government's treatment of Aboriginal people, are intertwined and interdependent factors. (Hamilton & Sinclair, 1991, p. 86, cited in Waldram, 1997, p. 22)

Discrimination and oppression, in varying forms, are strongly implicated in this dramatic overrepresentation (Monture-Angus; Waldram). For example, Aboriginal people are more likely to be charged with multiple offences than non-Aboriginal people, and receive longer sentences, and less likely to receive absolute or conditional discharges (Monture-Angus). Although the large numbers of Aboriginal peoples in the penal system has been the central focus of "every justice inquiry mandated in the last three decades… no commission or inquiry has managed to move beyond this fixation with numbers" (Monture-Angus, p. 369).

Drawing on the experience of psychologists and other mental health professionals, Waldram (1997) asserts that the long-term trauma "that flows from colonialism and oppression" experienced by many Aboriginal individuals and societies has had profound consequences for "both individual and collective behaviour"(p. 43). The narratives in his interviews with Aboriginal prison inmates reveal the significant disruptive role of long-term trauma (often beginning in childhood, and notably violent for some) in many of the inmates lives. However, the current Western mental health assessment and diagnostic categorizations fail to recognize the profound effects of colonization, for example, group trauma, on mental

health with the risk of subsequent inappropriate treatment of "pathological behaviours," for example, incarceration, (Duran & Duran, 1995; Waldram).

The mental health inequities of Aboriginal peoples cannot be glossed over as lifestyle, behavioural, or cultural issues, rather, they are manifestations of the historical, social, political, and economic determinants influencing mental health status and access to equitable health care. In the following section, I locate the tensions and disjunctures in their historical context.

## Locating Tensions and Disjunctures: Assimilation

The history of Canada is a history of the colonization of Aboriginal peoples, and colonialism continues to dominate and subjugate Aboriginal peoples in many ways even today. As LaRocque (1996) states

> Colonization is a pervasive structural and psychological relationship between the colonizer and the colonized and is ultimately reflected in the dominant institutions, polices, histories, and literatures of occupying powers…The tentacles of colonization are not only extant today, but may also be multiplying and encircling Native peoples in ever-tighter grips of landlessness and marginalization, hence, of anger, anomie, and violence…(pp. 11-12)

Early in the colonization process an assimilationist ethos prevailed in which Aboriginal peoples as "wards of the state" were to be assimilated into the fabric of Canadian society. In its earliest beginnings, imperialism and the process of colonization would set the tone and tenor of Indian social [and health] policy (Smith, 1999). The systematic subjugation of Aboriginal peoples has its origins in the colonial laws and policies enacted upon Aboriginal peoples in 1876 in the *Indian Act*. While this framework was premised on the pretext of

assisting Indians, the underlying intention to civilize and eliminate "Indians" is made clear in the words of Sir John A. Macdonald (1887): "The great aim of our civilization has been to do away with the tribal system and assimilate the Indian people in all respects with the inhabitants of the Dominion, as speedily as they are fit for the change" (Miller, 1989, p. 189). This was further elaborated in 1920 by Duncan Campbell Scott, Deputy Superintendent of Indian Affairs as follows: "... Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question and no Indian Department... (Leslie & MacGuire, 1979, p. 114; cited in Cairns, 2001, p. 17).

The assimilationist intent of the *Act* was pursued at many levels: Aboriginal lands were appropriated and reserves established; residential schools were instituted with the goal of indoctrinating children into the dominant culture – a collaborative effort between church and state; and, cultural spiritual practices were outlawed. In fact, the *Act* gradually took control of most aspects of life, including health services; welfare; taxes; livelihood, including hunting and fishing rights; citizenship, including the right to vote; organizational[34]/ ruling structures; and, "even the right to loiter in a poolroom" (Moran, 1999, p. 20). The consumption of alcohol was also prohibited.

In addition to these devastating social changes, the government designation of "Indian" became one of the most divisive and destructive aspects of the *Indian Act*. First, it divided the Canadian Aboriginal peoples, the First Nations, Inuit, and Métis, into an arbitrary but devastating class structure. Secondly, it created a schism between some reserve and urban

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[34] Even potlatching was outlawed. Traditionally, this was central to the whole concept of status and rank, and played a pivotal role in the social organization of the community. Because there was no writing system, the potlatch "served to publicly recognize an individual's claim to a particular status of inherited right. It also served an economic role, redistributing food and goods" (McMillan, 1995, p. 204). Today, potlatching remains an important aspect of community life for many West Coast people, although with somewhat different meanings than in earlier times.

populations. Currently, in several Aboriginal communities, this schism has been widened because of recent legislation (2002) which permits off-reserve people to vote in on-reserve elections.

Thirdly, the *Act* assisted in fueling the divide along lines of gender. Until 1985, when the *Act* was repealed (Bill C-31), Aboriginal women and their children were stripped of their status upon marrying non-Indian or non-status Indian men. Since the repeal, many Aboriginal women and children have claimed their status as "Indians," however, return has not always been easy for them and in some Aboriginal communities/ reserves, they have not been accepted[35] (Fleras & Elliott, 1992). Discrimination based on gender has had continuing effects and has "scarred many Aboriginal communities."[36] As LaRocque (1996) states, "Racism and sexism together result in powerful personal and structural expressions in any society, but they are clearly exacerbated under colonial conditions" (p. 15).

Fourthly, amendments to the *Indian Act* in 1884 and 1885 outlawed the ceremonial activities associated with the potlatch, or feast, among Northwest Coast cultures (Waldram, 1997). Historically, the colonizing of Aboriginal peoples focused on the dismantling of traditional ceremonial practices because of the perceived centrality of such practices to their cultural existence. These limitations were highly protested by many Aboriginal communities and therefore became politicized within the context of colonial relations. As a consequence,

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[35] Before the repeal of Bill C-31 women and children could not reside on reserve lands, receive payment of any benefits resulting from treaties, or be buried in a reserve cemetery. In addition, Fiske (1993) explains that "reinstatement of Indian status remains dependent upon male lineage" (p. 16). This kind of treatment, coupled with other discriminatory practices, such as the denial of property rights, directly affected women's capacity to support themselves and their families, contributing both to their economic marginalization and to welfare colonialism (Browne, 2003; Fiske, 1993).

[36] For example, male-dominated Band councils frequently sided against women and with the Canadian government in the belief that to do otherwise would undermine the Crown's trust responsibility for Aboriginal people" (Turpel, 1989, p. 154).

many traditional healing practices went underground. According to Waldram, the *Act* served to alienate Indigenous peoples from their "land, labour and resources" (p. 5).[37]

Lastly, the *Indian Act* created a divide between levels of government, federal and provincial, which has resulted in continued jurisdictional debates regarding who has responsibility for the social and health concerns of Aboriginal peoples, profoundly affecting their mental health and well-being. With the enactment of the *Act*, those who had status were entitled to special rights from the Canadian nation and those who did not became – "a Canadian version of a dispossessed race" (O'Neil et al., 1999, p. 134).

Although the *British North America Act*, 1867, stipulated federal responsibility for health, it provided for a provincial role "in establishing and delivering health services" (O'Neil et al., 1999, p. 146). Regardless, the provinces viewed the *British North America Act* as clearly setting out federal responsibility for First Nations and Inuit health (and according to O'Neil et. al., in some cases all Aboriginal health programs, except those prescribed by the *Canada Health Act* for all Canadians).

Today, the provinces *do* provide many services to First Nations peoples through the mainstream service delivery system. The rationale for provincial involvement is Section 87 of the *Indian Act*, 1951, which states that "[a]ll laws of general application from time to time in force in any province are applicable to and in respect of Indians in the province, except to the extent that such laws are inconsistent with this Act" (Armitage, 1995, p. 82). However, in relation to the health portfolio, this becomes a much muddier issue because of the lack of

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[37] According to Waldram (1997), it is not clear how many Aboriginal people were incarcerated for practicing banned religious activities, however, it has been suggested through the oral tradition of many Aboriginal peoples, that this was common, "with or without formal charges or convictions" (p. 8). Even with the 'Indian Rights' political movement post World War I, repeals of *the Indian Act* were not successful until 1951. By that time, the criminalization of Aboriginal spirituality had already taken its toll.

regulation of health (and child welfare) accorded in the *Indian Act*. Irrespective of the health

and child welfare issues, the province continues to be the chief legislative body for First

Nations services, a perpetuation of earlier notions of integrating First Nations services with

regular provincial services.

Métis peoples[38] and non-status Indians get caught in the jurisdictional struggle

because the provinces generally disclaim any responsibility for them given their position that

the federal government is responsible for all non-*Canada Health Act* matters (Cairns, 2000).

In addition, the First Nations and Inuit Health Branch (FNIHB) (formerly Medical Services

Branch) does not provide services to non-status Indians and Métis, whether living in urban or

rural settings. However, recently, the federal government has started to provide some

resources for "targeted programming" to the Métis and non-status Indians[39] (O'Neil et al.,

1999, p. 147).

Over the past several decades, notions of "integration" and moves to self-governing[40]

arrangements have been undermined by an assimilationist ethos which, one could argue,

remains tightly woven into the fabric of Canadian society. Although some progress had been

made in terms of according Aboriginals self-governance, under the guise of supporting

Aboriginal "autonomy", federal support of self-government is considered to be mere rhetoric

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[38] The Métis have been referred to as 'The Forgotten People' (Daniels, 1979) or 'The Non-People' (McKay, 1972) because they have most often been virtually ignored by the federal government (Cairns, 2000).

[39] In Gathering Strength, a federal government response to the recommendations of the Royal Commission on Aboriginal Peoples, all Aboriginal groups were included in the Aboriginal action plan, and strengthening of partnerships across all levels of government was recommended as key to addressing the needs of Métis and off-reserve Aboriginal peoples, including those in urban areas (O'Neil et al., 1999, p. 147).

[40] Asch (2002) defines self-government as "the ability of a group to govern its land and the people on them by setting aside goals and acting on them without having to seek permission from others" (p. 66). According to Tennant (1990), "The demands for self-government have always been implicit in land claims: in recent years these demands have become prominent and explicit" (p. 13).

by some[41] (Armitage, 1995; Fleras & Elliot, 1992). The deeply-rooted ideologies that were foundational in the construction of Indian social policy remain. For example, the *Indian Act* continues as the formal basis for Indian policy. In addition, the Indian Affairs Branch of the Department of Indian Affairs and Northern Development (DIAND) remains the central federal body concerned with First Nations issues. The shift in Indian policy and administration is plagued with problems related to dealing with the remnants of colonizing practices, the reality of opposing parties with competing interests and ideologies, and federal-provincial jurisdictional issues.

In the next section, I examine how the history of provision of health care services to Aboriginal peoples was part and parcel of the process of colonization, an important feature in the fostering of disempowerment and dependency (Kelm, 1998).

## Historical Context of Paternalism in Indian Health Policy

Colonial praxis has situated Aboriginal bodies at particular sites of struggle… Medicine, its perspectives, and its practitioners, have been instrumental in shaping colonial relations, both within the dominant society through formulations of colonial power, and between the colonizers and their subjects. (Kelm, 1998, p. 100)

As noted earlier, the history of dependency on fledgling services can be traced to the epidemics that devastated Aboriginal communities during the period of early contact with non-Aboriginal traders, explorers, and settlers (Royal Commission on Aboriginal Peoples, 1996a; Waldram, Herring, & Young, 1995). The *Indian Act* in its inception was the

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[41] For example, while resources are administered in a manner that permits local decision-making by the band, "what can be permitted can also be withheld" and the exercise of self-government limited by extensive accountability mechanisms (Armitage, 1995, p. 82).

enactment of grand scale colonialism. The gradual appropriation of traditional lands, movement to reserves, prohibitions placed on hunting and fishing, and marginalization from the wage economy resulted in endemic poverty and forced economic dependence across Aboriginal communities (Kelm, 1999; Ponting, 1997; Waldram et al.). A relationship of increased dependency was created by the domination of Aboriginal economies, governing structures, and local level institutions by the development and expansion of the dominant society's economy and institutions, including medicine (Kelm, 1998). Even for the Métis, who, like the Inuit, had largely been ignored by the federal government, "paternalistic care" became the norm when provincial government interest (in Alberta and Saskatchewan) was aroused by the poor socio-economic conditions among the Métis in the 1930s and 1940s (Cairns, 2000). Status Aboriginal people became "administered people," "wards of the state," with a separate branch of the federal government devoted to their affairs.

In response to the many societal changes threatening their existence, Aboriginal leaders entered into agreements and treaties with the state aimed at ensuring the survival of their people (Royal Commission on Aboriginal Peoples, 1996a). Often, limited food rations and medical resources[42] were provided to Aboriginal peoples in exchange for economic gain and religious conversion (Browne, 2003; O'Neil & Kaufert, 1990).

Historically, the question of whether the provision of medical care paid for by the Department of Indian Affairs is an Aboriginal right "has been an important fulcrum around which the ideological underpinnings of the Indian Health Services Branch of the Department

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[42] Aboriginal medicine was *not* supplanted by Western approaches; rather, a state of medical pluralism developed in which Aboriginal peoples drew on both Aboriginal and Western medicine to deal with new diseases (Kelm, 1998). Throughout the first decades of contact, early settlers availed themselves of Aboriginal substances and medicines and Aboriginal peoples built medical systems that incorporated new remedies while "maintaining an indigenous base of medical thought" (p. 153). However, it was the processes of colonization, complete with systems of thought that excluded Aboriginal forms of medicine as quackery or superstition, that stifled the cross-cultural exchange (p. 153).

of Indian Affairs have been articulated" (Kelm, 1998, p. 100). However, as noted earlier, whether federal health services are considered a treaty right,[43] that is historically contingent, an inherent right, that is "based on the nature of being human," *or* a matter of policy[44] continues to be debated.

Being constructed by the Canadian state as "wards of the nation" in need of being "civilized," Aboriginal peoples were provided with health services in the spirit of "benign neglect" and "benevolent paternalism," generally in the form of medical relief or crisis response (T.K.Young, 1984). The construction of Aboriginal people as diseased and their community life as disintegrating, provided the moral grounding for the 19th century position that bringing Western medical science to the Aboriginal peoples was the right thing to do.[45] As noted earlier, even residential schooling was considered a means of preserving the health and well-being of children who required protection from their supposedly "negligent and ignorant parents" (Kelm, 1998, p. 62).

Prompted by concern about the spread of contagious disease, in particular tuberculosis, to external society, a system of primary care clinics, a public health program, and regional hospitals were instituted by the Canadian state in the 1930s (O'Neil et al.,1999; T.K. Young, 1984). Growing demoralization and dependency, however, were reinforced by services and practices founded on paternalistic and authoritarian models of health care

[43] The treaty right to health care is usually referred to as the medicine clause in Treaty 6, signed with the Cree of central Alberta and Saskatchewan in 1876 (Kelm, 1998; O'Neil et al., 1999). Negotiators of Treaties No. 8 (1899), 10 (1906), and 11 (1921) were unsuccessful in having similar provisions brought into their treaties (Kelm).

[44] The official position of the First Nations and Inuit Health Branch of Health Canada (FNIHB), the federal governmental branch responsible for status First Nations and Inuit health, is that health services are a matter of policy, not an "inherent" right (First Nations and Inuit Health Branch, 2003; Health Canada, 1995).

[45] In fact, by the early part of the 20th century, "allopathic medicine was able to monopolize public resources and the majority of public sympathy in the west" as the only 'scientific' medical tradition (Thorne, 1993).

delivery. In some places this was further heightened by racism and jurisdictional disputes which created a barrier to access to treatment (Kelm, 1998). Access to treatment often meant that people had to leave their home environment and travel great distances for care,[46] sometimes remaining there for extended periods of time. This fostered a growing internal colonialism with its implicit message that the treatment of disease was entirely in the hands of the colonial power (Browne, 2003; O'Neil & Kaufert, 1990) and that Euro-Canadian doctors and nurses were superior[47] (Kelm, 1998).

With the advent of antibiotics and the expansion of health services in Aboriginal communities, mortality and morbidity rates of infectious disease were greatly reduced. However, health status inequities between Aboriginal and non-Aboriginal peoples persisted (Browne, 2003; T.K. Young, 1984). Most health problems stemmed from extreme poverty, lack of clean water and sewage systems, inadequate nutrition and housing, and unemployment. By the 1960s, the concern with infectious diseases, although still endemic in some areas, was overshadowed by social pathologies: mental health concerns such as depression, anxiety, and suicide; high infant mortality rates; and, social problems such as alcoholism and family violence (T.K.Young, 1994). In keeping with biomedical epistemological assumptions and approaches to health care, social problems were treated as biologically-based diseases or lifestyle issues, separate from the social and economic circumstances of Aboriginal people, and therefore treatable according to the prevailing

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[46] In particular, this related to the need for treatment of tuberculosis, which placed people in enforced quarantine in 'Indian' hospitals. Notably, Aboriginal and non-Aboriginal populations were usually segregated in hospital and clinic settings prior to the 1950s in BC.

[47] In no way is this intended to imply that individuals involved in the provision of health care to Aboriginal people were "co-conspirators with the Canadian state," but as Kelm (1998) points out, "The very nature of humanitarianism under colonial relations works to legitimate those relations and the power bases supported by them" (pp. 127-128).

medical model (O'Neil, 1986). This medicalization discourse has continued as one of the central mediating practices which shapes and is shaped by Western notions of health and illness and the everyday practices of mental health care delivery.

In the following section, I provide a brief overview of the historical imposition of the residential schools (and boarding schools) as legislated through the *Indian Act* to show how Aboriginal identities and bodily health were further weakened, and their dependency supported. Although residential schooling was not completely negative (Fiske, 1996) and the assimilationist intent was unsuccessful (Kelm, 1998), the overall impact of residential schools has been devastating. As Kelm (1998) states, "[t]his was a period during which the cultural hegemony imposed by the colonizing force of residential schooling shaped Aboriginal bodily health and representation in profound ways" (p. 57).

### Colonizing Identities: Intergenerational Trauma

Most scholars would agree that European-introduced disease was a major factor in the catastrophic decline in the North American Aboriginal population. Aboriginal people lacked immunity to infectious diseases and were therefore appallingly vulnerable.[48] The fact that Aboriginal traditions have survived at all is extraordinary, and testifies to their exceptional strength and resilience (Fiske, 1995; O'Neil & Postl, 1994). Contact with European-introduced disease marked the beginning of Aboriginal dependence on the Canadian state and its fledgling health services.

The inscription of disease on Aboriginal bodies was not simply a product of the

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[48] It is estimated that the pre-contact Aboriginal population in Canada was approximately 210,000 dropping to about 80,000 in 1870 and recovering to 120,000 in the early 1900s (O'Neil, 1993b, p. 29). However, over 30 years ago, William Duff estimated that the First Nations in BC lost 65,395 living individuals in the first 150 years after contact, representing a 74% decline in population (Kelm, 1998).

processes of nature (an idea often propagated by those in authority), but also a direct consequence of the process of colonization with its accompanying racializing practices. Enormously high death rates, which carried personal sorrow and family and community desolation, were further punctuated by the environmental changes that had begun by the early 20th century, that is, "increasing restrictions to land and resources" as well as "intensifying interventions," such as residential schools, into the lives of Aboriginal peoples[49] (Kelm, 1998, p. 18).

Residential schools and boarding homes have been the most often cited cause of the mental health concerns of Aboriginal people. Although residential schooling was not uniformly negative for all people,[50] its overall impact has been devastating.[51] This is a history of loss of 1) attachment to community and the relationships of trust built there; 2) cultural values and norms which provided a sense of cultural identity including language and spirituality; 3) health and in some cases, life; 4) life skills usually taught by parents, elders, and other community members, for example, parenting skills; and 5) self-identity/worth, for

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[49] The high mortality rates amongst Aboriginal people relative to non-Aboriginal people continued.

[50] In her research with Carrier people of north central BC, Fiske (1996) carefully documents how women advanced their social, economic, and political roles within and outside their communities using some of the skills and knowledge acquired in residential schools. In spite of harsh treatment, these women were paradoxically able to build structures of resistance to a system that unintentionally provided them with the tools to do so. She states: "Women (and men) selectively utilized novel skills and knowledge beneficial to themselves. And, in doing so, they effectively subverted the missionaries' intentions by broadening their economic strategies and by developing sophisticated political responses, which to a large measure were spearheaded by a schooled female leadership" (p. 181).

[51] The intergenerational effects of residential schools and boarding homes are now well known and understood (Chrisjohn & Young, 1997; Fournier & Grey, 1997; Kelm, 1998; Royal Commission on Aboriginal Peoples, 1995, 1996b; Waldram et al., 1995; Waldram, 1997; Wade, 1995; Warry, 1998). However, I thank members of the Aboriginal Mental Health 'Best Practices' Working Group, BC for drawing attention to the fact that this "trauma" has not had the same consequences for all Aboriginal people. In fact, many people have done extremely well. It is for the benefit of those who have not fared so well that I draw attention to this important issue. In recognition of the intergenerational effects of residential schooling, the Aboriginal Healing Foundation was established in 1998 by the Federal government. It has been mandated to allocate $350 million towards addressing the legacy of abuse inflicted on Aboriginal students in residential schools.

example, belief in one's creative abilities.

Moral discourses of Aboriginal inferiority reflect a deeply engrained assumption of Euro-Canadian superiority and paternalist benevolence (Furniss, 1999) that has its roots in early Aboriginal – non-Aboriginal relations. As a principal strategy of Indian social policy known as "aggressive civilization" (Wade, 1995), the attitude of Western superiority was inculcated into the minds of Aboriginal children within the residential school system. The building of residential schools[52] often took the place of building day schools to ensure that children would not be "contaminated" by their Aboriginal parents, family, or community (Fleras & Elliott, 1992): "Predicated on the notion that the First Nations were, *by nature*, unclean and diseased, residential schooling was advocated as a means to "save" Aboriginal children from the insalubrious influences of home life on reserves" (Kelm, 1998, p. 57). The painting of Aboriginal parents as "incompetent" provided the moral justification for removing children from their homes (Kelm) and extended families, usually for 10 months of the year, from the age of 5 or 6 years until they were old enough to leave the institution (Mussell, Nichols & Adler, 1991).[53]

Although authorities continued to espouse the belief that residential schooling was essential to the survival of Aboriginal peoples, mortality and morbidity rates were alarmingly high. According to Kelm (1998),

> the goal of residential schooling was to "re-form" Aboriginal bodies, and this they
>
> did. But the results were not the strong robust bodies of the schools propaganda,

[52] The first residential school in BC opened in 1861 and the same school was the last to close in 1984 (Ward, 2001).

[53] According to Haig-Brown (1988), students were sent home for a few reasons – when they became ill, some who ran away were allowed to stay home and, others left school when they reached the final grade, which for many years, was grade eight. Later, in the 1950s, "when high school was included, some people graduated" (p. 115).

well trained for agricultural and domestic labour, but weakened ones,[54] which,

through no fault of their own, brought disease and death to their communities. (p.

57)

Morbidity and mortality rates were attenuated by worsening conditions in the schools

brought on by decreasing funding. Poorly ventilated buildings and overcrowding, in addition

to the fact that children were sometimes inadequately fed, overworked, and abused, left the

residents more vulnerable to communicable diseases such as tuberculosis, measles, and

influenza as well as to the complications of less serious illness (Kelm, 1998). Often children

were discharged home to die, only to infect their family and community members; others

were returned to school ill because there was no other place they could receive care.

Regardless of the interventions by a few officials, mandatory enrollment and these

problems continued. While many Aboriginal parents intervened on behalf of their children,

some were actually jailed for contravening the legislation that mandated government

schooling for their children.

The colonization practice of using residential schooling as a means of producing

cultural conformity is a global phenomenon and one which has been practiced for some time.

Regardless of the fact that social control is widespread (and an element of all education), it

can be particularly destructive in the context of colonial relations (Kelm, 1998). According to

the Brazilian educator Paulo Freire (1970/1997), the intrusion into and blatant disregard for

the cultural context of another group (the "oppressed") through education of this kind serves

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[54] As early as 1907, Dr. Peter Henderson Bryce, soon to be the medical officer for the Department of Indian Affairs, found that on the prairies, "at least one-quarter of the students enrolled in residential schools, died while on school rolls, or shortly thereafter, from diseases, predominantly, tuberculosis, which they contracted while in the institutions" (Kelm, 1998, p. 64). At one school in British Columbia, Bryce found that 34% of the students admitted to the school since 1892, were dead by 1909 - a "scandalous procession of Indian children to school and on to the cemetery" (p. 64).

to create a barrier to the creativity of the invaded by limiting their expression, with disastrous social consequences.

Although there are no exact figures, it is estimated by Aboriginal peoples that up to one million children attended residential schools in their over 100 year history, including about one half of the school aged children in BC (Wade, 1995). In some families, as many as five generations of children attended. Daily forms of dehumanization, isolation, and abuse have been well documented in many of the residential schools (Chrisjohn & Young, 1997; Wade). Many parents lost confidence in their parenting practices and experience[d] feelings of ineffectiveness, and those who were schooled in the residential school system themselves learned their parenting skills within institutional environments, which were sometimes abusive (Brant, 1993). This latter phenomenon continues to haunt many Aboriginal communities today in the form of family violence and other types of abuse,[55] including lateral violence.[56]

Although many individuals reintegrated into their communities following their schooling period, this was not possible for everyone. According to Kelm (1998), for some graduates, integration was not possible and they were described as being "cross-cultural

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[55] Of note here, Ojibwa elders have spoken about the precontact notion of child abuse as ob-je-e-tim "just not done" (Royal Commission on Aboriginal Peoples, 1995). Many First Nations children have left the reserves for the streets of urban centres in response to the abuse in their homes only to find more abuse and hardship. In fact, 37% of the people using needle exchange and 65% of the children in the sextrade in Vancouver's Downtown Eastside are Aboriginal (Vancouver's Downtown Eastside, 1999). Suicide is often the result.

[56] This is violence inflicted from within a particular group. As an illustration, I cite the following example – the headline of a BC paper reads, "Rid us of this brute: Members of a BC band are living in fear of a chief they say has operated a reign of terror over three decades" (Fournier, 1999). This article describes the effort of a reserve community in BC, "to get rid of their Chief" who has been re-elected numerous times since the late 1960s, "despite convictions for sexual assault in 1972, 1990, 1998 and several attempts to remove him." Several members of the community accuse the Chief of nepotism, threats of violence, sexual assault and reprisals for those who oppose him, for example, withholding education and social assistance funds. Lateral violence is a well-documented consequence of colonization (Duran & Duran, 1995, 2000; Fanon, 1967).

zombies, empty bodies moving across the landscape of which they cannot quite be a part" (p. 79).

Initially, when returning home, many of the residential school graduates learned traditional knowledge and skills through family members. However, a few generations later, fewer individuals had these opportunities because of the decline of traditional economies. Also, small numbers of Aboriginal peoples were able to find employment on reserve and if they did, they tended to find seasonal work "which involved physically demanding labour and/or poor pay"[57] (Mussell et al., 1993, p. 14). This reality has led to the high rates of unemployment, poverty, and despair for young people in many Aboriginal communities today:

> Old methods of coping, the old philosophies and religions, which taught resilience, survival and a sense of being at one with nature, have been denigrated and destroyed by dominant culture and discarded by many aboriginal people. (Brant, 1993, p. 62)

Although many gains have been made as a result of reconnection to Aboriginal traditions "such as sweat lodges, sweet grass ceremonies and the establishment of departments of Aboriginal studies at various universities where young people rediscover the old ways" (Brant, 1993, p. 62), the intergenerational effects of residential schooling continue to be experienced in Aboriginal communities and have been compounded by life on reserve for many.

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[57] Of Canada's approximately 2284 reserves, which vary in number over time according to the policy of the federal government (Frideres, 1998), 1600 are located in BC. However, "the paradox of aboriginal life in British Columbia, as in many other parts of Canada, is that the reserve is home, but on reserve, there is little employment opportunity" (Elliott & Foster, 1995). This reality forces many Aboriginal people to live and work off reserve.

The cultural hegemony imposed by the colonizing force was pervasive. Indoctrination of dominant values, language,[58] and culture were central to the education of Aboriginal children, including health education, which set out to supplant traditional Aboriginal approaches to health and healing. As Kelm (1998) states, "Just as 'healthy' and 'Christian' were equated, so were 'traditional' and 'diseased'" (p. 62). Although many of the discriminatory sections of the *Indian Act* were eventually repealed, it was "not in time to stay the internalization of many European patriarchal notions and practices" (Stevenson, 1999, p. 74). Negative identities created in the past endure today as engrained attitudes of Western superiority continue to foster the tensions and disjunctures within mental health institutional settings and policies.

In the next two sections, I shift the focus of the discussion to the current context of Aboriginal mental health and healing. I begin by discussing the issue of self-government and healing. Several authors assert that self-government has the potential to break the cycle of poverty, violence, and the many social ills experienced by Aboriginal peoples and as such, "significantly alter the web of causation that now results in the extensive burden of illness of Aboriginal people" (O'Neil et al., 1999, p. 151). I then go on to discuss the impact of mental health reform which provides the context in which mental health care continues to be provided. In several ways, mental health reform provides another level of challenge to self-governing arrangements.

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[58] Children were often severely punished for using their Aboriginal language (Chrisjohn & Young, 1997; Fournier & Grey, 1997; Haig-Brown, 1988; Wade, 1995). For example, at the Annual Native Mental Health Conference in London Ontario in 2002, one female participant recounted being punched in the face by the school master when she was heard using her Aboriginal language on the school playground at recess.

## Current Context: Self-Government and Healing

Since the early 1970s, there has been increased pressure by Aboriginal organizations

for the right of Aboriginal peoples to govern themselves (Armitage, 1995). For many

Aboriginal peoples in Canada, constitutional recognition of Aboriginal rights as understood

from an Aboriginal perspective is fundamental to health improvement. Because the causal

mechanisms that explain ill health extend into "all aspects of the social, cultural and political

lives of the Aboriginal peoples," it is difficult to establish a direct causal link between self-

government and health. However, it is expected that self-government would result in

improved health for Aboriginal peoples in several ways. It is expected to (1) improve

economic status through the resolution of lands claims and consequent resources in the form

of cash or land, as well as through increased employment opportunities and improved wages;

and (2) improve self-esteem and empowerment. It is believed that by strengthening

community participation using empowerment approaches and grounding self-government in

"traditional social values of Aboriginal medicine teachings," political, cultural, and health

development will be further facilitated (O'Neil et al., 1999, p. 150). In essence, self-

government will improve the health of Aboriginal peoples by addressing the poverty,

disadvantage, and consequent hopelessness that now cause an extensive burden of illness in

Aboriginal communities (O'Neil et al.).

Health transfer arrangements,[59] officially launched by Health Canada in 1986,

represent a critical step towards self-government (O'Neil et al., 1999; Read, 1995). Although

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[59] Under 'health transfers', a process has been underway for transferring certain responsibilities for managing and delivering health services, especially community health and primary health care services, from Health Canada to Aboriginal communities. As of 2001, 82% of eligible First Nations and Inuit Communities have, or were in the process of, transferring responsibility, with 46% having signed transfer agreements (First Nations Inuit Health Branch , 2001; Romanow, 2002, p. 212 ).

transfer of health and health care responsibilities to Aboriginal communities is considered an important objective, there are several concerns: (1) some fear it will result in federal government withdrawal from its historical commitment to protect the health of Aboriginal peoples (Waldram et al., 1995); (2) others criticize the policy for failing to consider emerging needs and consequent costs (O'Neil et al., 1999); (3) some speculate that the transfer arrangements may be part of the government's plan to offload programs and contain costs rather than provide support for initiatives focused on meeting Aboriginal community needs (Culhane Speck, 1989; Gregory, Russell, Hurd, Tyance, & Sloan,1992; O'Neil et al., 1999); (4) newly imposed ceilings on spending[60] preclude arrangements in which program enrichment can occur and thus, the medicalization of federally delivered services continues without the option for new models of health and social programming which can address the broader social determinants of health (Gregory et al.; O'Neil et al.); and (5) the continued dominance of the medical model as an organizing approach to service has resulted in 'Health Transfer' arrangements which have accomplished little in the way of addressing the relations of power over Aboriginal people (Gregory et al.). [61]

Most of the community health development initiatives in Aboriginal communities have occurred under the auspices of the 1986 *Transfer Initiative* of the Medical Services Branch of Health and Welfare Canada ( now First Nations and Inuit Health Services Branch). Although there have been numerous pre-transfer and transfer projects of this kind since 1991,

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[60] A newly imposed ceiling on spending to First Nations and Inuit Health Services initiated in 1995/96 has limited the capacity for growth in the budget. In addition, although the *Romanow Commission Report on the Future of Health Care in Canada* (2002) makes several noteworthy recommendations to approaching Aboriginal health issues, including new funding partnership arrangements, it failed to recommend increased funding for Aboriginal health.

[61] Gregory et al. (1992) argue that by definition the medical model maintains relations of power over Aboriginal peoples.

again, these agreements afford the Aboriginal community only administrative control as opposed to *absolute* control over the planning, implementation, and design of such programs (O'Neil & Postl, 1994; O'Neil et al., 1999). Little *real* empowerment of Aboriginal communities may be occurring due to inconsistencies in transfer arrangements (Fleras & Elliott, 1992), "the unclear relationship with self-government, the lack of recognition of treaty rights to health, the lack of legislative authority to enforce public health laws, and, the need for program enrichment to meet new needs" (O'Neil & Postl, p. 78). In addition, these constraints intersect with political economic interests and the prevailing platform on Aboriginal health to shape how medical services evolve.

Regardless of their overall improved health status, Aboriginal peoples continue to struggle to address the persistent mental health inequities stemming from wider socioeconomic and political issues. Nevertheless, locally controlled health services have resulted in positive changes in some communities and transfer arrangements continue. For example, in a study of the results of primary care *under band control* in Montreal Lake, Saskatchewan, Moore, Forbes, and Henderson (1990) reported thirteen direct or indirect positive healthy outcomes.[62]

Aboriginal peoples are seeking responsibility for administering and controlling their own health programs with the belief that "true community healing and well-being can be found only through self-government and self-determination" (O'Neil et al., 1999, p. 149). Importantly, health policy agendas will be set by Aboriginal peoples. As O'Neil et al. assert

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[62] "People feel the reserve is safer; People feel better cared for; Confidentiality and trust of health care staff have been enhanced; Elders feel better cared for; Healthy changes in lifestyle were reported; Children were hospitalized less often; Less violence was reported in the community; There was less alcohol and more "dry" activities; Coordination with hospitals was better; More comprehensive services were provided; There were better emergency and acute care services; Earlier intervention in the disease cycle was reported, with projected lower hospitalization rates; and, Health center staff were perceived as role models for community health development" (Moore, Forbes, & Henderson, 1990, cited in O'Neil et al., 1999).

If employment, self-esteem, and personal empowerment are improved, there will be a diminution in the number of injuries, suicides, and homicides that plague communities today. And with the control implicit in self-government, Aboriginal people will assume roles now filled by non-Aboriginal people. The positive impact of this role modeling on young Aboriginal people will diminish alcohol and drug dependency, violence, and other social ills. (p. 151)

The colonial legacy with respect to Aboriginal people is long; it is a legacy that is well entrenched, and its vestiges continue to be visible today. Some progress towards self-governance is being made, however, control of institutions and services has not been achieved in many areas. As Armitage (1999) asserts, "[a]lthough there has been an increase in the number of Aboriginal service-delivery agencies, it is naïve to equate the creation and operation of these agencies with self-government" (p. 76). The following section on mental health reform provides a brief overview of some of the obstacles facing Aboriginal peoples in achieving recognition of Aboriginality[63] within mental health service delivery in the context of mental health reform. As one of the most vulnerable populations in Canada, the residents of Aboriginal communities are particularly sensitive to the consequences of downsizing and other cost-cutting measures in the health care system (O'Neil et al., 1999, p. 148), including the threat it poses to Aboriginal autonomy.

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[63] In the dissertation, I use the concept "Aboriginality" in the same way as McConnell and Depew (1999) to refer to "the complex social and cultural diversity represented by contemporary Aboriginal people in Canada" (p. 353) rather than a superficial and abstract view of what is entailed in being Aboriginal. According to McConnell and Depew this kind superficial view often amounts "to little more than attributes and attitudes that non-Aboriginal people associate with, and find palatable in, the idea of Aboriginality. In fact, Aboriginality is often being ignored" (p. 368).

## Mental Health Reform: Current Patterns of Tensions and Disjunctures

The current context of mental health reform also informs the analysis of the nature of the tensions and disjunctures in this study. Health reform is a global phenomenon, affecting the lives of people across the globe, but certainly not equally (Anderson, 2000, p. 223). Discourses of scarcity and efficiency over the past several decades have led to cost containment in countries such as Canada, and a massive restructuring of the health care system (Anderson, 2000; Burgess, 1996; Evans, 1992; Storch, 1996; Varcoe and Rodney, 2002). In keeping with this movement, the 1998 Mental Health Plan, *Revitalizing and Rebalancing British Columbia's Mental Health System* (RRBC), was produced as a tool of overall mental health reform with the goal to "support the development of comprehensive, integrated regional mental health care systems for British Columbians with the most serious and disabling mental illness, their families and the communities where they live" (p. i). RRBC was also intended to build on the continued redevelopment and decentralization of Riverview Hospital, a tertiary psychiatric care facility, into community-based specialized care facilities.

This 1998 Mental Health Plan (RRBC) is consistent with the recommendations of the national discussion paper, *Best Practices in Mental Health Reform* (Cochrane, Durbin, Goering, 1997), prepared for the 'Federal/Provincial/ Territorial Advisory Network on Mental Health', which represents the most current information about effective, evidence-based services and service models in the North American experience (RRBC, 1998, p. ii). This document has been highly influential in setting the themes of reform, including assertive case management, consumer involvement, crisis response/emergency services, family support and involvement, housing, inpatient/outpatient services, psychosocial rehabilitation,

and, the protection of human freedoms and rights. In addition, although each province is preparing a response to meet mental health need relative to their own circumstances, mental health policy across all jurisdictions in Canada is informed by Health and Welfare Canada's health promotion and prevention framework (Epp, 1986, 1988).

However, the central driving force of mental health reform over the past several decades has been deinstitutionalization. This movement, which began in the 1950s, escalated in the 1960s, and between the 1960s and 1976, the number of beds in the mental hospitals decreased considerably "from 47,333 to 15,011" (p. 372). However, at the same time, there was an increase in community-based alternatives, including general hospital beds, "from 844 to 5836," and a substantial increase in in-patient hospitalizations (p. 372). From the late 1960s until the early 1980s, "mental disorder rose from the fifth most common to the leading cause of in-patient treatment in general hospitals" (Blishen, 1991, pp. 36-38, cited in Dickinson, 2002, p. 372). While some believe that the new popularity of the "biological cause" theory of mental illness coupled with the new psychotropic medicines was responsible for this growth in general hospital psychiatry, others see it as another form of social control prompted by economics and politics, namely soaring costs and the need for constraint (Dickinson, 2002, p. 374). In reality, it was probably motivated by both. Policies are neither neutral nor mere instruments of efficiency and effectiveness, but rather a part of the apparatus of politics, ideologies, and power (Shore and Wright, 1997). To date, the majority of mental health costs are associated with general hospital-based treatments, and the deinstitutionalization movement is considered a failure (Dickinson, 2002; Trainor, Church, Pape, Pomeroy, Revill, Teft, et al., 1992). Although the creation of general hospital in-patient

beds, in its early phases, was intended as a movement towards community psychiatry, the movement to establish community-based services and resources has failed miserably.

One of the most serious consequences of this plan has been the growing numbers of people living in the streets of urban centers: homeless or near-homeless persons with mental illness are a ubiquitous feature of the Canadian landscape (Baxter, 1991; Dickinson, 2002). In addition many individuals have become caught up in the criminal justice system[64] (p. 383). "Nancy Hall (the former mental health advocate in BC) estimates that 32% of the inmates in correctional facilities have some kind of mental disorder" (Dickinson, p. 383). Unfortunately, only too often the jail becomes a "default position" for those who cannot access the mental health system (Hall, 2001). As noted previously, a disproportionate number of Aboriginal peoples are represented in Canada's correctional facilities, a fact associated with several factors including discrimination[65] and oppression (Waldram, 1997). Many of these individuals struggle with mental health issues associated with histories of violence, poverty, unemployment, despair, and hopelessness (anomie). Crime in the Aboriginal community is also often linked to alcohol and other substance abuse and marginalization of Aboriginal people with an alcohol and/or other substance abuse issue and/or mental health problem is all the more likely (Furniss, 1999; Waldram, 1997).

In response to the failure of deinstitutionalization, policy makers have embraced decentralization and regionalization with the goal of improving mental health program

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[64] Dickinson refers to this as transinstitutionalization, or movement from one system into the other (p. 383).

[65] For example, critical analysts believe that Aboriginal people are more likely to attract police [and social] attention than non-Aboriginals (Waldram, 1997).

planning and development.[66] In essence, it is expected that (1) mental health service delivery needs will be location-specific and thus meet local need, and (2) decentralization and regionalization will facilitate the opportunity to mobilize and reallocate resources in the communities of most need (Dickinson, 2002, p.383). Dickinson reports that on the one hand, some feel this will mobilize *"democratic"* [italics mine] decision making into new areas of community life (p. 383). However, others express concern over the divisive nature of this kind of local decision-making regarding resource allocation that may result in an politicization of health care at the local level.[67] The composition of regional health authorities has become increasingly important because of the number of vested interests in mental health with diverse visions, and therefore, the nature of the membership of regional planning and administrative bodies that is emerging across the country needs to be considered if democratization is to be achieved (Dickinson).

In relation to Aboriginal peoples in BC, the regionalization process creates challenges in a couple of ways: (1) another level of jurisdictional confusion is created – "downsizing and restructuring of health services to a population that relies on services from different jurisdictions encourages attempts at 'cost shifting'" (O'Neil et al., 1999, p. 149);[68] and (2) with devolution, there is a decentralization of Aboriginal power. In December 2001, the new BC Liberal government introduced its health care restructuring plan, *A New Era in Patient*

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[66] In the 1980s, in the health care system more broadly, increasingly declining federal transfer payments coupled with escalating health costs forced provincial governments to begin a dramatic overhaul of their provincial health care systems (O'Neil et al., 1999).

[67] The assumption embedded in idea of a *democratic* decision making is that all people have equal opportunity to have their voice heard and responded to – however, for those who are oppressed and marginalized this does not necessarily hold true (Sherwin, 1992; Young, 1990).

[68] According to O'Neil et al. (1999), where provincial governments have cut back, the federal government has been pressured to fill in. A recent two year cap on provincial funding likely means that Aboriginal health needs are not going to be met by any level of government in BC (Vancouver Coastal Health Authority, personal communication, October 4, 2003) given that federal funding also operates with funding restrictions.

*Centered Care*, which created five regional health authorities out of the previous 52 different health authorities (BC, 2001). The overall goal of this plan has been to "improve efficiency, strengthen accountability and allow better planning and service coordination....and to create a sustainable, affordable public health system" (p. 1). As part of the devolution process, the Aboriginal Health Division of the Ministry of Health was eliminated along with several other smaller Aboriginal Health agencies. Instead of a central Aboriginal health body at the level of the Ministry of Health, each of the five regional health authorities has hired an Aboriginal health individual with varying position titles across the regions including: director, manager, contract coordinator, strategy coordinator, and liaison person. In relation to the mental health complex, nine Aboriginal mental health liaison workers were hired across the five regions. To date, although the positions are in place, there has not been *designated* resources to support the development of Aboriginal mental health *programs* (Policy Participants, 19, 20). In addition, the Aboriginal Mental Health *Best Practices* Working Group,[69] with a membership of Aboriginal and non-Aboriginal peoples across BC, was eliminated by the Ministry at this time (within one year post election). This group had completed a discussion paper, *Aboriginal Mental Health: What Works Best* (Mussell & Smye, 2001), for distribution among and input of Aboriginal peoples across the province to assist with the development of

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[69] The Aboriginal Mental Health *Best Practices* Working Group formed out of the Aboriginal Mental Health Advisory Committee which began meeting in July, 1999. The group formed in response to concerns that mental health service delivery, including the field of community psychiatry, did not adequately – or appropriately – deal with the needs of Aboriginal people. The membership of the Committee/ Working Group reflects the broad range of expertise already available among BC's Aboriginal community, as well representing the full range of mental health professionals. The following key areas for its work include the need to: i) review, assess and develop Aboriginal perspectives on Best Practices in Mental Health and facilitate the development of a BC Aboriginal Mental Health Plan; ii) disseminate a plan specifically related to best practices in Aboriginal mental health to the health authorities in the planning of mental health reform; iii) conduct research into Aboriginal best practices and effective service and program models; and, iv) examine alternative models of service delivery that are accessible, culturally appropriate/safe and accountable for Aboriginal people. Funding was provided by Adult Mental Health Services, Ministry of Health, administered through Mental Health Evaluation and Community Consultation Unit (Mheccu), Department of Psychiatry, UBC until September 2001 (Mental Health Evaluation and Community Consultation Unit, 2001).

a provincial Aboriginal Mental Health Plan. Although this process was halted, the paper is available on the Ministry of Health, Adult Mental Health Division under the Mental Health Evaluation and Community Consultation (Mheccu) website. This phasing out of separate Aboriginal institutional structures in BC implies an underlying assimilationist ethos (Fleras & Elliott, 1992, p. 54; Fleras, 2000) and a lack of support for Aboriginal autonomy and governance in the BC Liberal government's Indian policy.

Although "closer to home" approaches create an opportunity for Aboriginal communities, both urban and rural, to liaise with one board, the effectiveness of this process varies from region to region dependent on several factors including the proximity of the Aboriginal community to the major service center in the region, the receptivity of the health authorities to Aboriginal health issues, and, in the case of First Nations, their preference for dealing with the federal government (O'Neil et al., 1999, p. 148). As O'Neil et al. also note, regional health authorities sometimes exclude First Nations from consultation because they are seen as a federal responsibility. Also, notably, although the shift to move resources from hospital to community-based initiatives in mental health will likely benefit some people, it is unlikely First Nations and Inuit communities would benefit because of the jurisdictional issue, (i.e., community services are considered a federal responsibility). Here, the lack of attention to Aboriginality precludes a commitment to tripartite arrangements between federal, provincial/regional,[70] and Aboriginal bodies and again, respect for Aboriginal autonomous decision-making in this matter.

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[70] I consider provincial and regional governance bodies in this way because in BC, the province remains the policy making body and the region allocates resources in response to the health priorities the regions sets. For example, the regional body is mandated by the province to address Aboriginal mental health, however, the regions choose how they prioritize it alongside other important health issues (Policy Participant, 19).

In addition to these issues, as noted in Chapter One, current mental health reform remains attached to biomedical traditions, in particular, psychiatry. Not surprisingly, the target population of reform is those persons with serious and persistent mental illness as defined within a biomedical framework. Although this does not necessarily preclude attention to the mental health issues of some Aboriginal peoples, the assessment, diagnostic, treatment, and research modalities associated with biomedical traditions are embedded in Western thought and generally remain uninformed in relation to the beliefs, values, and histories of Aboriginal peoples (Duran & Duran, 1995, 2000; McCormick, 1996, 1997, 1998; Mussell et al., 1993). For example, Duran and Duran (2000) comment on the damage that has been done to some Native Americans as a consequence of using assessment tools that do not fit with Aboriginal perspectives/ worldviews – an example of what they see as "institutional racism" (p. 93). In relation to treatment, they note that although there are isolated instances of success in treatment, generally, programs addressing alcoholism, chemical dependency, and high rates of suicide "appear impotent" (p. 90). The emphasis on treatment approaches within the mental health system leaves few resources for developing innovative approaches to prevention of a poorer mental health status (O'Neil et al., 1999, p. 147).

In relation to research, Duran and Duran (2000) assert that "social scientific investigation into mental health deproblematizes the material history of science... the objectification of Native American psychological problems deprives them of their material history and hence of a crucial aspect of their truth" (p. 96). Instead, a methodology of psychological research needs to be broadened and made more relevant in terms of addressing the kinds of complex social problems facing Aboriginal peoples (p. 96) . Duran and Duran argue for a psychology that looks "deeper into the multidimensional nature of mental health

for fresh perspectives and empowering interventions instead of privileging a universal scientific discourse over the voice of the subjects" (p. 97). In relation to reform, although the documents of mental health reform address issues of family and community, they do so from an understanding of a "universal" subject and an individualistic approach to health and healing. In addition, the language of *Best Practices* privileges "evidence-based" approaches steeped in biomedical scientific traditions. Non-Western forms of thought have not yet been legitimated.

As I discuss in subsequent chapters, the ideology of assimilation with its attendant ideologies of paternalism and ethnocentrism both shapes and is shaped by institutional structures, policies, and everyday practices.

## Concluding Comments

The provision of health care to Aboriginal people has been shaped by over a century of internal colonial[71] practices, policies, and politics (Frideres & Gadacz, 2001; Ponting, 1997; 2001; Royal Commission on Aboriginal Peoples, 1996b; Waldram et al., 1995; Warry; 1998). As a consequence of this history, the current mental health system is plagued by the same problems. Despite a number of important events over the past two decades,[72] which have drawn attention to the mental health concerns of Aboriginal people and the attendant

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[71] According to O'Neil (1986, 1989) internal colonialism is a 'Fourth World' situation in which a minority indigenous population is enveloped within a nation-state wherein powers and privileges are held by the colonizing majority that consciously or unconsciously subordinate the original inhabitants of the land.

[72] Examples include the 1979 Berger commission report; the 1982 Special Committee report on Indian Self-Government; the Solvent Abuse initiative of Health Canada and INAC; establishment of a Steering Committee on Native Mental Health between 1990 and 1991 which developed a mental health framework document in consultation with First Nation and Inuit organizations and stakeholders; the recommendations of the Royal Commission on Aboriginal Peoples (1996b); and, the reconstitution of the Mental Health Working Group in 1998 with membership from the Assembly of First Nations (AFN), the Inuit Tapirisat Council (ITC), and Medical Services Branch (now FNIHB) "with its new mandate to provide leadership in planning and coordinating First Nations mental health services across Canada..." (Elias & Greyeyes, 1999, pp. 7-8).

systems of health care, Aboriginal mental health is largely glossed over by the health authorities.

According to the findings of the Canada-wide environmental scan of mental services in First Nations Communities conducted by Elias and Greyeyes (1999), the main problems with mental health services identified by Aboriginal people in the Pacific region[73] were as follows: MSB (now FNIHB) is leaving the programs post health transfer too early,[74] setting programs up for failure; there are too few trained First Nations therapists; there is a lack of funds to transport therapists and clients; information systems are not in place; there is lack of continuity between programs; crisis response is poor; there is a lack of support for family concerns, and a lack of programs for victims and perpetrators of sexual abuse; youth are underserved; and there is a predominance of the medical model. Overall, they assert that there is a lack of comprehensive programs. Instead, many people want a community mental health model which includes *credible*[75] Aboriginal healing methods (pp. 27-29).

Examining the significance of previous colonial relations is necessary to understanding the current social, political, and economic conditions influencing Aboriginal mental health. In particular, I have emphasized how colonizing attitudes continue to influence the way in which mental health care is provided to Aboriginal peoples. As I argue later, current institutions and policies remain embedded in ideological frameworks that shape and are shaped by everyday practices within the mental health system; dominant ideologies, mental health institutional policies and everyday practices intersect to shape the tensions or

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[73] These are similar to problems identified in other regions of Canada.

[74] In some cases, before the respective community has the infrastructure necessary to administer (and hopefully develop) the program successfully.

[75] Here "credible" refers to the validity and legitimacy in accordance with Aboriginal belief structures.

disjuncture between Aboriginal understandings of and responses to mental health and illness and the current mental health system.

The study presented here aims to explicate the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system by examining (1) the everyday practices that create barriers to access to mental health care for Aboriginal peoples, (i.e., the tensions and disjunctures); (2) the ideologies underpinning institutions, policies, and practices (i.e., why the tensions and disjunctures); and (3) the institutions and policies, (i.e., how institutions and policies support the embeddedness of ideologies). In the next chapter, I proceed with the analysis of the data by viewing the nature of the tensions and disjunctures through a particular theoretical lens informed by postcolonial perspectives.

# CHAPTER THREE

# LOCATING THE PROBLEM IN AN HISTORICAL CONTEXT:
# THE POSTCOLONIAL

In the previous chapter, I outlined the significance of locating an analysis of

Aboriginal mental health within the historical context of colonialism and, in particular, policy

development, as well as today's internal colonial context. Postcolonial theoretical

perspectives have obvious relevance to the objectives pursued in this dissertation. The

research I present, therefore, is positioned within an emerging body of postcolonial

scholarship.

Given my own location within the field of Aboriginal mental health, I am also

conscious of the need to engage critically with postcolonial theories that are congruent with

the perspectives of Aboriginal scholars. Therefore, I begin by drawing on the work of

Aboriginal people who have considered the relevance of postcolonialism to Aboriginal issues

as a means of examining what some might consider an imposition of Eurocentric theoretical

perspectives onto issues of central importance to Aboriginal peoples. Then, I examine the

theoretical foundations of postcolonialism and its relevance as an analytic framework in this

study. I go on to explore the ways in which the postcolonial provides an opportunity to

uncover notions of "race," "racism," "culture," and conceptions of racialized "Other,"[76] and

how identities have been created and are located within particular historical periods.

Lastly, I introduce cultural safety from its New Zealand context to the Canadian

policy arena. Cultural safety is discussed as an analytic lens for critiquing mental health

policy, for unmasking the ways in which the current policies and practices unwittingly

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[76] As per Anderson (2002), I use a capital here to denote a particular constructed identity conferred on non-Western people "as inferior through the process of racialization and cultural essentialism" (p. 8).

perpetuate inequities in health care and, as a consequence, the poorer health status of Aboriginal people.

Postcolonialism is one of the critical theories that provides another point of scrutiny regarding knowledge development, taking us from the experiences of those "who have suffered from the sentence of history – subjugation, domination, diaspora, displacement" (Bhabha, 1994, p. 172) to examine the social and historical locatedness of the production of dominant discourses (Anderson, 2002). In nursing we can use a postcolonial lens to

envision how to meet nursing's social mandate of addressing the social aspects of

health and illness, situate individual experience within the larger social context,

give voice to subjugated knowledges and foster social justice through an

uncovering of social inequities. (Reimer Kirkham & Anderson, 2002, p. 9)

## Postcolonialism and Aboriginal Voice

There is an increasing number of voices and forums "converging to form a new perspective on knowledge" with a commitment to "reclaiming indigenous voice and vision" (Battiste, 2000, p. xvi). Many of those voices belong to Indigenous peoples who have lived the legacy of colonial oppression and "cognitive imperialism" (p. xvi). While positions vary on postcolonial theoretical perspectives, Aboriginal scholars who address issues of relevance to Aboriginal peoples share concern over "the burden and contradictions of colonial history" (LaRocque, 1996, p. 14). For LaRocque, a Plains Cree Métis writer and professor, critical inquiries provide an appropriate framework for examining the pervasive structural and psychological relationship created by colonization, and ultimately reproduced in the institutions, policies, histories, and literatures of dominant culture(s) (p. 11).

LaRocque (1996) suggests a Canadian scholarship which attends to "macroscopic" examination of the dynamics of oppression. In the context of understanding the impact of a protracted period of colonialization, she calls for scholarship which seeks to unmask the faces of both colonizer and colonized within academe and society at large. From her perspective, there needs to be an increased awareness of the "function of power and racism and its impact on Aboriginal peoples as well as the signficance of resistance" (p. 11). While committed to the plight of all Aboriginal people, LaRocque is particularly concerned with the way in which oppression affects Aboriginal women. She writes:

> [t]he tentacles of colonization are not only extant today, but may also be multiplying and encircling Native peoples in tight grips of landlessness and marginalization, hence, of anger, anomie, and violence, in which women are the more obvious victims. (p. 12)

Therefore, scholars who engage in this kind of work need to understand that "to study any kind of violation is, *ipso facto*, to be engaged in ethical matters." How we do research and use that knowledge, can have serious ramifications for others, therefore, "[t]hese destructive attitudes, unabashed biases, policies, and violence that we footnote cannot be mere intellectual or scholarly exercises" (LaRocque, 1996, p. 12) . Increasingly, Aboriginal scholars have engaged with postcolonial discourses as a way of reclaiming and repositioning indigenous voices, knowledges, and analyses (Battiste, 2000).

Battiste, a Mi'kmaq professor, calls for an "Indigenous" scholarship which exposes neo-colonial practices within the education setting. In her view, "Aboriginal consciousness" cannot be maintained without addressing the underlying assumptions of modern society, including the education system, in tandem with language revival, maintenance, and

development as part of the project of decolonization (p. 193). However, from her perspective, the "*foundation*"[italics mine] for postcolonial transformation is an Indigenous scholarship and research that "requires moral dialogue with and the participation of Indigenous communities" (p. xx). In addition, Battiste cautions against the conflation of postcolonial theory in literature with postcolonial indigenous thought. In her view, the latter is crucial to pushing beyond Eurocentric theory to transformative praxis[77] – to address the multiple forms of "oppression, exploitation, assimilation, colonization, racism, genderism, ageism and the many other strategies of marginalization" (p. xxi). In this regard, Battiste cites the words of Marc Renaud, President of the Social Sciences and Humanities Research Council of Canada, from his address to the academy,[78] in which he asserted that the traditions of the university to "publish or perish" have been globally tested and that the new agenda for universities will need to be "go public or perish"" (p. xx).

Battiste (2000) continues to question the place of non-indigenous researchers in the area of Indigenous research. In relation to this issue, LaRocque (1996) notes the way in which Aboriginal scholars highlight the usefulness of postcolonial discourses as means for challenging their non-Aboriginal colleagues to "re-evaluate their colonial frameworks of interpretation, their conclusions and portrayals, not to mention their tendencies of excluding from their footnotes scholars who are Native" (p. 13). This phenomenon, coupled with the

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[77] Here I have inserted the notion of praxis. In my view, Battiste is speaking of praxis-oriented inquiry in an emancipatory context in which research and knowledge development are focused on "generating useful or practical knowledge, interrupting patterns of power, participation in socially transformative processes toward such ideals as justice, equality, and freedom" (Thorne, 1997, p. 126). In particular, she is foregrounding Indigenous knowledge. According to McCormick and Roussy (1997), [t]he notion of praxis acknowledges that research and practice are inevitably theory-laden and that these theories are influenced by individual's ideological commitments...Nurses who have a commitment to critical nursing praxis recognize the importance of theoretical perspectives that help expose the power and hierarchy embedded in the social world in which health decisions are made" (pp. 269, 279).

[78] Sorokin Lecture, University of Saskatchewan, Saskatoon, February 4, 1999.

growing body of literature on "post-colonial voices" (p. 13), is a reflection of the global emergence of indigenous voice and vision.

In a somewhat different voice, Linda Tuhiwai Smith (1999), a Maori researcher and educator in New Zealand, calls for the "decolonization" of research methods. In her book, *Decolonizing Methodologies: Research and Indigenous Peoples,* she unmasks the ways in which research is linked with European colonialism and introduces the notion of an Indigenous research agenda, not unlike research programs which connect research to the "good" of society but different in the inclusion of key elements reflected in words such as healing, decolonization, spiritual and recovery. In her view, the "post-colonial" marks "an era of new realities, new social identities, [and] new power alliances" with which the Indigenous world has been confronted and has now challenged – it is a place not yet reached. According to Tuhawai Smith, to name the world as "post-colonial" is to "name colonialism as finished business". She prefers instead to think of this time as the period of "decolonization," involving a long-term process of "bureaucratic, cultural, linguistic, and psychological divesting of colonial power" (p. 98).

In yet another voice, Duran and Duran (1995) introduce the notion of a "postcolonial psychology," a theoretical discussion of problems and issues encountered in Native American communities and the means of addressing those issues that legitimize Native knowledge and healing practices. These authors underline the importance of understanding intergenerational trauma and internalized oppression in order to understand anomie and its attendant problems. While "difference" is acknowledged across worldviews – Western and Native – the authors argue for a world in which both can live in harmony, seeking something *new* between them.

While there are many other Indigenous voices within postcolonial discourse, common to these particular scholars is the commitment to a new scholarship or way of being which challenges Eurocentric assumptions and value structures in both academe and society at large. Importantly, a space is created for those knowledges that have been previously subjugated, and, for an Indigenous *vision* for moving forward. Postcolonialism provides a lens to examine the ways in which the various racisms and racializing practices continue to operate to create barriers to the implementing of these visions. Recognizing the contestations inherent in the broad range of theories contributing to postcolonialism, these are the applications of postcolonialism that I turn to for their potential to challenge and disrupt the reproduction of colonial social formations (McConaghy, 2000).

## The Postcolonial: Theoretical Foundations

In the last decade, postcolonialism has taken its place with other theories as a major critical discourse in the humanities (Gandhi, 1998, p. viii) as well as in various other disciplines such as literary criticism. According to Quayson (2000), postcolonialism

> involves a studied engagement with the experience of colonialism and its past and
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> present effects, both at the local level of ex-colonial societies as well as at the level
>
> of more general global developments thought to be the after-effects of the
>
> empire... [t]he term is as much about conditions under imperialism and
>
> colonialism proper as about conditions coming after the historical end of
>
> colonialism. (p. 2)

However, rather than signifying a temporal location, McConaghy (2000) asserts that the "post" in postcolonial does not mean the notion of "after colonialism" but rather explains the postcolonial "as a place of multiple identities, interconnected histories, and shifting and

diverse material conditions. It is also a place where new racisms and oppressions are being formed" (p. 1). For example, in Canada today, the lives of many Aboriginal people are still organized in large part by the *Indian Act*.

Drawing on Homi Bhabha (1994), McConaghy (1997) describes the postcolonial as a time for reflecting, a moving back and forth and beyond the colonial. This reflexive process, which characterizes the postcolonial

> is a sign that we are now more aware of our historical locatedness, less sure of the rightness of our policy decisions, more alert to the possibility that our decisions may be colonizing rather than decolonizing in their consequences, more able to be responsive to new situations of disadvantage and more able to correctly analyze and redress the specifics of local oppressions. (p. 86)

At this time when diversity, voice, and choice are embraced as important considerations, postcolonialism takes us back and forth between ideas of the past to solutions in the present and the structures that create them (McConaghy 1997). Today, as we engage in debates about Aboriginal health and social policy issues in the context of mental health reform, we need to understand that in a sense "we are making decisions about what constitutes [Canadian] colonialism" and "what we have determined to be the essential aspects of anti-colonial work" (McConaghy, p. 82). Our challenge is to determine when and under what circumstances an initiative (policy or research) might be "oppressive" and "limiting" and when it might be "emancipatory" (p. 82).

Said's (1978) foundational text, *Orientalism* provides a systematic challenge to expressions of Western culture which takes the form of colonial oppression and domination. It is a kind of first phase of postcolonial theory in which Said "directs attention to the

discursive and textual production of colonial meanings and, concomitantly, to the consolidation of colonial hegemony" (Gandhi, 1998, pp. 64-65). Said has been criticized on several fronts in relation to Orientalism, namely, that he failed to acknowledge the influence of Marxism in this work, that he presented an overly essentialized image of both the "West" and the "Orient" and that he ignored the part that resistance and complicity of colonized peoples play in the creation of knowledge about them (Quayson, 2000, p. 4). Regardless, he has made an important contribution to the field of postcolonial studies by articulating an "analysis of representation." Vis à vis Orientalism, Said makes the linkage between knowledge and power, between representation and "the ultimate constitution of imperial and colonial power" (p. 4).

McConaghy (2000) summarizes Orientalism as follows:

> Orientalism is a mode of discourse with supporting technologies, structures, and institutions; a style of thought which enshrines certain values and aesthetic criteria; a corporate institution for dominating and exercising authority over others; and a vital component of the development of Western economic strength. (p. 18)

Orientalism acts as an historical informant for my study. Along with its many critiques it assists in adding to an understanding of the linkages between Canadian colonialism and the embeddedness of dominant Western ideologies in health care institutions, policies, and 'everyday practices'. It uncovered the extent to which colonial ideology permeated virtually all facets of Western knowledge, science, literature, and culture to provide "a political vision of reality whose structure promoted a binary opposition between the familiar (Europe, the West, us) and the strange (the Orient, the East, them)" (Said, 1978, cited in Loomba, 1998, p. 47). However, the inauguration of colonial discourse analysis was predated by the erudite

works of Franz Fanon (1967), Aime Césaire (1972), Memmi (1965/1991), and others who write in the anti-colonial genre. All of these postcolonial scholars provide the analytic apparatus to examine the ways in which the Other has been constructed and contrasted with the West (Anderson, 2001; McConaghy, 2000; Reimer Kirkham & Anderson, 2002). Since Said, theoretical perspectives have been advanced by post-colonial writers such as Stuart Hall, Homi Bhabha, Gayatri Chakrovorty Spivak, and Chandra Mohanty, to name but a few, across a wide spectrum of disciplines (sociology, anthropology, literary criticism, cultural studies, political activism and analysis, psychoanalysis, and others). Heavily influenced by postmodern and poststructuralist traditions, and more recently by feminism and neo-marxism, these divergent disciplinary applications preclude any single, unified "entity" or "paradigm" of postcolonialism (Reimer Kirkham & Anderson, 2002, p. 3). In the past 15 years, the proliferation of increasingly diffuse uses of the term "postcolonial" has risked diverting attention away from its historical processes (Ashcroft, Griffiths & Tiffin, 1995). Nonetheless, several themes remain characteristic of postcolonialism, including race, difference, culture, ethnicity, nation, power, subalterns, subjectivity, identity, displacement, hybridity, historical positioning, and the construction of Other (Reimer Kirkham & Anderson, p. 3). Importantly, postcolonialism recognizes the colonial project and its aftermath as an "epistemological malaise at the heart of Western rationality" (Gandhi, 1998, p. 26).

Postcolonial discourses have been criticized for reproducing the very practices they aim to disrupt. Firstly, they have been criticized for reverting to the politics of binary opposition, i.e., colonized and colonizer (Hall, 1996; McConaghy, 2000; Narayan, 1997), thereby ignoring the complexities and shifting ambiguities of political positionalities and

various forms of resistance (McConaghy). Secondly, concern has centered on the presumption of an essentialized, shared experience of colonization among members of a group (Gandhi, 1998; Reimer Kirkham & Anderson, 2002). Thirdly, the preoccupation with questions of race, ethnicity, and culture to the exclusion of other forms of colonial oppression based on gender, class, and nation carry the risk of privileging one set of oppressive relations over another (Reimer Kirkham & Anderson). Fourthly, citing Ahmad (1955), Gandhi raises the issue of the postcolonial intellectual whose studied gaze at those on the margins does nothing to actually address "the real politics of the collectivity" (p. 13). As LaRocque (1996) argues, the postcolonial scholar has a moral obligation to the project of social justice (p. 11) and to praxis-oriented scholarship. Lastly, Gandhi highlights Spivak's (1993) questions to the postcolonial scholar working within the academy – as academics, can we position ourselves "outside the teaching machine" (Spivak) [and as nurses outside the health institutions whose structures we are examining]. Can we examine the margins while buying into part of the center?

With these caveats in mind, I argue for a postcolonial nursing scholarship that is committed to exposing the inequities and multiple levels of discrimination that face Aboriginal peoples within the mental health care complex, and illuminating the experiences of Aboriginal peoples to enable the creation of transformative knowledge[79] and praxis-oriented inquiry. Central to meeting this goal in postcolonial scholarship is Spivak's (1988) question, "Can the subaltern speak?"

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[79] According to Anderson (1998b, 2000a) transformative knowledge is "knowledge that is, first of all, undergirded by consciousness on the part of healthcare providers, and that unmasks unequal relations of power and issues of domination and subordination, based on assumptions about "race," "gender," and, "class relations" (p. 205, p. 225).

### *Subaltern Voices: Positioning Marginalized Voices and Knowledge*

A core feature of postcolonial nursing scholarship is,

> the deliberate decentering of dominant culture so that the worldviews of the
>
> marginalized become the starting point in our knowledge constructions.... a
>
> postcolonial commitment results in the weaving of the perspectives and
>
> experiences of those marginalized in our society into the very fabric of our nursing
>
> science. (Reimer Kirkham & Anderson, 2002, p. 12)

As Battiste (2000) and Tuhiwai Smith (1999) note, Indigenous voice has long been silenced

in the social sciences. "[D]ehumanization and bias have been entrenched in Canadian studies

about Native peoples" and as such voice needs to be used not only as an expression of

"cultural integrity," but also as a means of balancing this legacy (LaRocque, 1996, p. 13)

Postcolonialism demands "the right to speak, rather than being spoken for and to represent

oneself, rather than being represented, or, in extreme cases, rather than being erased entirely"

(Reimer Kirkham & Anderson, 2002, p. 12). Thus, voice becomes a central issue in

postcolonial scholarship placing responsibility on the researcher to ensure the expression of

subaltern perspectives.

The construction of knowledge located in subaltern voices means that one must make

space for critical examination of multiple voices from different socio-historical locations

(Anderson, 2000, p. 225) "using strategies such as purposive sampling for diverse groups of

participants with a range of experiences, listening carefully to the accounts of these

participants, and liberally using their verbatim stories in written reports" (Reimer Kirkham &

Anderson, 2002, p. 12). Feminist theorists such as Smith (1987, 1992) and Collins (1998)

agree that some social locations are better than others as starting points for the development

of transformative knowledge. This does not mean there is not a place for knowledge developed using paradigms of inquiry other than the one here. Rather, my interest is in beginning inquiry from Aboriginal perspectives as a way of unmasking taken-for-granted processes, often invisible to us, that structure life experiences and ways of being in the world; in this way, how these processes have been produced can be examined (Anderson, p. 226).

Thinking about Spivak's question about the "subaltern voice" and the positioning of Aboriginal voice raises the question about who has the "right to speak," in this study, a basic question about whether or not non-Aboriginal researchers can truly understand the experiences of racialization and racism. For example, there are those who believe strongly that research in the field of Aboriginal health is best undertaken by Aboriginal researchers, and, as noted earlier, those that support the position that Indigenous scholarship can be done "along with research that requires moral dialogue with and the participation of Indigenous communities" (Battiste, 2000, p. xx; Duran & Duran, 2000; LaRocque, 1996). In conducting this research, I have taken the position of Reimer Kirkham and Anderson (2002) that "rather than pursuing the legitimacy of our roles as researchers based on one aspect of one's social identity, (i.e., whiteness), one's legitimacy as a researcher is based on one's ability to explicate the ways in which marginalization and racialization operate" (p. 13). However, attached to this position is the need to remain attuned to the implications of continued production of knowledge from dominant positions (p. 13). Later in this chapter, I will discuss the role of "cultural safety" as a reflective device in this endeavour.

Central to the postcolonial project is theorizing the nature of "colonized subjectivity" and the assorted forms of cultural and political resistance (Reimer Kirkham & Anderson, p.

3). Several of the central themes of postcolonialism are expanded in the following sections in order to offer further background.

## Theorizing about Racialization, Culture, Difference and Other

Postcolonial scholarship integrates critical analyses of the damaging effects of "race" and "racialization" while at the same time revealing "the shifting and inconsistent operation of intersecting oppressions of everyday life" (Reimer Kirkham & Anderson, 2002, p. 2). As social constructs categorizing and ascribing *difference*, race, culture, and ethnicity are often used interchangeably and with little consistency when any one of these terms is applied (often implying inferiority) (McConaghy, 2000; Reimer Kirkham & Anderson, p. 3). In the next section, I will examine features of these concepts in order to unravel how complex issues of racism and racialization interconnect with issues of culture and difference to influence relations within health care.

### *Race and Racialization*

Although the notion of race as socially constructed takes us beyond the 18th and 19th century understandings of race as biologically determined, controversies about its significance and the dilemmas of racial injustice and conflict which accompany it today are transported into the realm of politics (Omi & Winant, 2002, p. 128). In this way race has been manipulated "to define, structure, and organize relations between dominant and subordinate groups" (Reimer Kirkham & Anderson, 2002, p. 4).

Omi and Winant (2002) warn of the difficulties inherent in thinking of race as an essence or, equally problematic, as a purely ideological construct, which could be remedied using some "ideal nonracist social order." Rather, they understand race to be "an unstable and 'decentered' complex of social meanings constantly being transformed by political

struggle" (p. 121). While attempts to delineate human groups along racial lines present serious difficulties, it is their view that race continues to play a fundamental role in structuring and representing the social world. Thus, they believe race is an element of social structure, a dimension of human representation (p. 121). It is in this context that they posit the notion of "racial formation" to signify "the sociohistorical process by which racial categories are created, inhabited, transformed and destroyed" (p. 124). At the heart of the racial formation process is a vast array of "racial projects" that are ideologically and historically situated. These projects mediate between "the discursive or representational means in which race is identified and signified on the one hand, and the institutional and organizational forms in which it is routinized and standardized on the other" (p. 127).

A central concept of this dissertation is that racializing processes, policies, and practices have been fundamental to the colonial project of defining, categorizing, and ordering the lives of Aboriginal peoples with devastating consequences: health and social inequities, economic and marginalization, and continuing negative images and stereotypes. Fanon (1967) first coined the concept of "racializing" conditions and expressions, contrasting them significantly with "humanizing" ones to suggest the ways in which racial conceptions and structural conditions order lives and delimit human possibilities (Goldberg & Essed, 2002, p. 6). The term "racialization" was later adopted by Miles (1989), who defines it as "a process of delineation of group boundaries and of allocation of persons within those boundaries by primary reference to (supposedly ) inherent and/or biological (usually phenotypic) characteristics" (p. 74). Racializing is a representational process of categorizing or "defining an Other." It is a "dialectical process of signification" in which a group of

people is to be understood as a supposed biological entity (p. 75). This signification then also ascribes a "self" identity by the same criterion.

Issues of race, racial formation, and racialization are inherent in the construction of the Canadian nation and entrenched in the fabric of Canadian society: they are not insignificant processes that we simply move beyond (Anderson & Reimer Kirkham, 1998; Henry et al, 2000; Reimer Kirkham & Anderson, 2002). As Reimer Kirkham and Anderson note,

> [a]s a constitutive element in our common sense, race is a key component of our taken-for-granted reference schema through which we get on in the world. Individual psyches and relationships among individuals are shaped by race; collective identities and social structures are racially constituted. (p.4)

### Intersections of Racialization, Class, Race, Gender and Health

Although postcolonial scholarship focuses attention on "race," it is important to note that "race" does not necessarily hold "the trump card over all other forms of oppressions or marginalizations" (Reimer Kirkham & Anderson, 2002, p. 13). Collins (1990) notes that sexism, racism, and classism become interlocking categories of analyses. In addition, she observes, an individual may be an oppressor and the oppressed concurrently, depending on the particular context: for example, an Aboriginal man may be privileged by gender but penalized by race (cited in Reimer Kirkham & Anderson, p. 13). Recognizing the shifting nature of these intersecting oppressions helps to explain how all groups "possess varying amounts of penalty and privilege in one historically created system" (Collins, p. 225) and how multiple identities coexist (Reimer Kirkham & Anderson). In this study, the notion of intersectionality is used to explain the complex nature of mental health care delivery – in

particular, how decisions are made regarding the target population of mental health services and treatment modalities.

Race cannot be neatly sifted apart from processes of racialization, issues of gender, class relations, and other social relations that structure peoples' lives such as their education level, employment status, health, and well-being. As Bannerji (1995) notes,

> [r]acism is after all a concrete social formation. It cannot be independent of other social relations of power and ruling which organize the society, such as those of gender and class..... (p. 128).

McConaghy (2000) concurs that racism "as a process of differentiation, is integrally linked to other social processes of differentiation and identity formation such as sexism, ageism, homophobia and classism. All of these processes of differentiation are based upon a self-other binary" (p. 42). While racialization is about "Othering," racism is about representing the other in some essentialized way (McConaghy, 2000, p. 42).

Many theorists have examined the various intersecting forms of racism, including Banton (1977), Essed (1991, 2002), Essed and Goldberg (2002), Goldberg (1993), Hall (1989/1996), Henry et al.(2000), Miles (1989), Omi and Winant (1986/2002), Solomos and Back (1996), among others. According to McConaghy (2000), combining ideological and discursive theories of racism provides powerful insights into the role of "(con)text and text in the formation of particular racisms..... [r]acism is not a thing but both a product and expression of social relations: more accurately, racism is located within specific social relations" (p. 34). Common to the various racisms, are their "exclusionary and inclusionary undertakings" (Browne, 2003; Goldberg, 1990, p. xiv; McConaghy, 2000). In the next section, I will examine how various racisms overlap and intersect to sustain social inequities

and unequal relations of power among and within groups as a means of providing further context for the tensions and disjunctures described later in the dissertation.

### *The Various Racisms*

As a precursor to all other forms of racism (Essed, 1990), cultural racism is one of the most important frameworks of interpretation and meaning for racial thought in society (Henry et al., 2000). It is an essential apparatus whereby the dominant group reaffirms itself through image and representation, and it is the medium through which marginalized groups are excluded. Yet it is rendered virtually invisible as it is seamlessly woven into the collective fabric of the dominant group vis à vis forms of representation such as the mass media, the arts and religious doctrines, ideologies and practices (Henry et al., 2000, pp. 56-57). Armitage (1999) describes cultural racism as "the assumption that the culture and institutions of one group is superior to another" (p. 69). In the findings chapters of the dissertation, I examine the ways in which the mental health system continues its strong attachment with Western worldview approaches to the exclusion of Aboriginal or other worldviews, rendering the system inaccessible for many people. For example, the health and illness belief models of Aboriginal peoples are often ignored, as reflected in polices, procedures, and practices.

According to Henry et al. (2000), democratic racism is the most appropriate model for understanding how and why racism continues in Canada (p. 19). For example, it is useful in explaining how Canadians can espouse liberal principles of equality, tolerance, fairness, and justice and at the same time hold negative, racialized views of the Other, for example, Aboriginal people (Browne, 2003). Thus, democratic racism is a "racism of paradoxes" – it is an ideology in which two sets of values coexist, yet necessarily conflict. Deeply embedded in

Canadian society in its ideological and discursive forms, democratic racism is difficult to challenge without seemingly attacking the essence of Canadian value structures (Browne, 2001; Henry et al, 2000; Young, 1990). Citing Hebridge's (1993) understanding of "frames of reference," Henry et al. assert that democratic racism is located within society's frames of reference defined as

> a largely unacknowledged set of beliefs , assumptions, feelings, stories, and quasi-memories that underlie, sustain, and inform perceptions, thoughts and actions. Democratic racism as racist discourse begins in the families that nurture us, the communities that socialize us, the schools and universities that educate us, the media that communicate ideas and image to us, and the popular culture that entertains us. (Henry, 2000, p. 24)

In Chapter Five, I discuss the way in which discourses embedded within democratic decision-making processes, where equality is viewed from a uniform or undifferentiated perspective, serve unwittingly to advantage some groups over others.

The (seeming) neutralization of "race" is a central feature of democratic racism – that is, "the shifting of attention away from racism, racialization, gender and class as intersecting processes that disproportionately disadvantage some groups and not others" (Browne, 2003, p. 59). In this regard, several authors draw attention to the problem of conflating culture with "race" (Gilroy, 2002; McConaghy, 2000; San Juan, 1999) noting how this tends to construct particular groups as united "exclusively in terms of culture and identity rather than politics and history" (Gilroy, 2000; Gilroy, 2002, p. 251). The denial or minimization of racialized inequities in dominant institutions such as the mental health care complex avoids confrontation with the various racisms within, for example, institutional and individual

racism, and discounts connections between structural inequities and disadvantage (Dyck & Kearns, 1995).

Individual or personal racism (Armitage, 1999) is probably the most commonly understood form of racism. Attitudes, beliefs, stereotypes, and judgments are attached to a racial group, generally seen as inferior. According to Henry et al. (2000), "individual racist beliefs provide a lens through which one sees, interprets, and interacts with the world". However, these beliefs do not occur in a vacuum, rather, they psychologically reflect, and are embedded in, the structure of social relations (p. 53): Individuals are *not* located outside of the social relations through which racisms operate (Essed, 2002). For example, racial discrimination in the form of subtle gestures and openly demeaning insults and behaviours has been observed in many locations across BC and described by several researchers (Browne and Fiske, 2000; Fiske, 1995; Furniss, 1999). In subsequent chapters, I illustrate how everyday inclusions and exclusions of Aboriginality within the mental health care system reflect and reactivate pre-existing social and structural inequities and tensions and disjunctures.

Essed argues that in some sense individual racism may be a contradiction in terms, since, by definition, it depends on "the expression or activation of group power" for its existence (p. 179). However, despite the mutual interdependence of individual and institutional racism (McConaghy, 2000; Omi & Winant, 2002), theories of institutional/structural racism are useful for understanding the "structural relations of production" which exist in social institutions such as the health care complex, academia, and the justice and education systems. Blauner (1972) posits a notion of institutional racism that is tied to colonialism. In his view, "institutions either exclude or restrict the participation of

racial groups by procedures that have become conventional, part of the bureaucratic system of rules and regulations" (Blauner, cited in San Juan, 2002, p. 75). Similarly, Henry et al. (2000) note the differential privilege that these policies, practices, and procedures may "promote, sustain or entrench" for certain groups of people, whether "directly or indirectly, consciously or unwittingly" (p. 56).

Essed's (1990, 1991, 2002) conceptualization of "everyday racism" assists in illuminating the relationship between individual and institutional dimensions of racism. The concept of everyday racism as used by Essed is characterized by practices which have become "systemic, recurrent, and familiar" and can be "generalized." Thus, it is a form of racism which has been infused into the familiar, involving socialized attitudes and behaviour and our social relations (Essed, 2002, pp. 188-189). Essed contends that even when racism is attached to the cultural and ideological remnants of previous historical processes it is not a natural and/or permanent artifact of European history. Racism is determined by a complex of economic, political, social, and organizational conditions of society – it is reinvented.

In the same vein, Smith (1987) locates everyday social practices within practices that reflect social organization and "ruling relations" (power). In this view, the structural characteristics of a social formation account for the existence of racism, for example, as it exists as a policy initiator or a rationale, instead of "being the product of actions of groups or individuals formulating and implementing policies that benefit particular groups or classes" (San Juan, 2001, p. 45). According to Essed (2002), everyday racism is both the manifestation of and mechanism by which racist beliefs and practices and social institutions are normalized. It provides the linkage between "macro (structural-cultural) properties of racism as well as the micro inequalities perpetuating the system" (p. 180). A system of

dominance is created and preserved based on the construct of race through specific social relations (Henry et al., 2000; McConaghy, 2000). In this context, individuals [and organizations] may be unwittingly complicit as agents of racism and racialization by virtue of the systematic way in which they are socialized and exposed to "representations that justify White dominance" (Essed, 1991, p. 46).

As Essed (2002) explains, "Structures of racism do not exist external to agents – they are made by agents – but specific practices are by definition racist only when they activate existing racial inequality in the system..." (p. 181). As I discuss in the following chapters, the gaps in accessible mental health services to Aboriginal peoples are best understood as reflections of a whole range of historically and politically mediated relations reproduced and reinforced in health and social policy, rather than as omissions and erasures of individuals per se. Nevertheless, individuals and agencies are implicated in socially organized relations of power.

### *Culture and Culturalism*

As with race, the construct of "culture" carries a range of meanings (Gilroy, 2000; Reimer Kirkham & Anderson, 2002) which have shifted over time. For example, in earlier times culture pertained to the process of tending something, usually crops or animals and then altered in meaning to 18th and 19th century ideas of "civility"(p.4), which, according to Lock (1993), distinguished the educated and "cultured" from the "uncivilized" peasants (p. 144). From here the notion of civility was gradually transformed into its more recent usage, as pertaining to modern cities and their peoples, the "cultured," versus rural peoples, the "uncultured" (p. 144). Therefore, how we have come to conceptualize culture is historically and politically mediated and influenced by colonial relations.

Historically, the Western/non-Western cultural divide was a politically motivated colonial construction. For example, beliefs about the "superiority" of Western culture and "inferiority" of Aboriginal cultures functioned as the rationale and mandate for colonialism (Kelm, 1998; Narayan, 1998, p. 89). On the one hand, while the colonial project was engaged in the agenda of assimilation and the "imposition of sameness" vis à vis cultural imperialism, on the other hand, "cultural difference" provided the justification for the existence of colonialism by way of cultural essentialism (Narayan, p. 89). This process relied on the sharp binaries between Western (us) as superior and the Other (them) as inferior.

Culture remains difficult to define today. In nursing and other health care literature, culture is commonly presented as comprising the beliefs, practices, and values of particular ethnic or religious groups (Culley, 1996), and as a framework for human behaviour (Reimer Kirkham & Anderson, 2002, p. 4). With its roots in "cultural pluralism," multiculturalism, the official state policy in Canada (1983) and Australia, embraces the liberal notion of respect for diversity. However, according to Lock (1990) one of the difficulties is

> that in establishing boundaries as to what exactly is a culture or an ethnic group....a 19th century style of thinking is usually drawn upon in which nation states, or large regional areas, language, religion, and even skin colour or other physical features are taken as immutable markers. (p. 240)

Although acknowledging and celebrating cultural diversity in this way has resulted in increased public awareness and appreciation for the diversity of peoples in Canada, critically-oriented scholars are concerned with the conflation of culture with differences (and identity) and the lack of analysis of culture as inextricably mediated by historical, economic, and political conditions (Gilroy, 2000, 1992/2002; McConaghy, 2000; Narayan, 1998; Reimer

Kirkham & Anderson, 2002). Although descriptions of cultural characteristics and practices have been useful to health care practitioners and researchers, they can also reinforce stereotypes and simplistic views of particular groups as outsiders, as different, and as Other. These culturalist discourses also view issues of access, compliance, and poor health status as stemming from cultural characteristics that conflict with mainstream, routine health care practices rather than being shaped by larger social and political structures. Therefore, simplistic representations of culture as transparent, ahistorical and/or apolitical are problematic because of the way they divert attention away from the underlying structural inequities influencing health and health care (Anderson & Reimer Kirkham, 1999).

Viewing health as located within static belief systems – "the culture" – leads us in an entirely different direction than locating health within "a complex network of meanings enmeshed within historical, social, economic, and political processes" (Anderson & Reimer Kirkham, 1999, p. 63). Congruent with this latter idea is Hall's (1997) conceptualization of culture as a process and a set of signifying practices through which meanings are produced and exchanged: "[c]ulture permeates all society" (p. 3). Grappling with these more complex notions of culture can assist health care practitioners and researchers to uncover societal structures that mask the way people are disadvantaged on the basis of culture. However, despite growing concerns about images of the Other being reproduced through these discourses, static notions of culture continue to predominate in health care discourses.

An examination of the complex practice and ideology of culturalism provides a structure for understanding the continuities between essentialized notions of culture, race and racism. Portraits of Western, [Aboriginal], White, or the like, as well as the pictures of the "cultures" that are attributed to these various groups of people, are often fundamentally

essentialist. As Narayan (1998) writes: "They depict as homogenous, groups of heterogenous people, whose values, interests, ways of life, and moral political commitments are internally plural and divergent" (p. 94). This kind of Othering confers cultural characteristics, differences, or identities onto members of diverse groups, not based on real or actual identities but rather on stereotyped identities, and as such erases the complex multiplicities of heterogeneous Indigenous identities and experiences in favour of essentialized accounts. Most insidiously, cultural essentialism obfuscates the way in which "culture" is transformed through the historical, social and political contexts in which it is used. In this way, it obscures the dynamic, ever-changing quality of culture (Anderson & Reimer Kirkham, 1998). As Narayan asserts,

> cultures are not pre-discursively individuated entities to which names are then bestowed as simple labels, but entities whose individuation depends on complex discursive processes linked to political agendas. Moreover, this historical sensibility also needs to be attentive to the historical and political processes by which particular values and practices have come to be imputed as central or definitive of a particular "culture". (1998, p. 93)

For example, the *difference* attached to "Aboriginal" often assumes a coherent group identity within the various nations and bands prior to their entry into social relations, making Aboriginal people a target for stereotyping and dangerous assumptions. As a form of racism, this kind of Othering is central to establishing and reinforcing unequal social relations (Browne, 2003). Essentialist representations of culture infused within culturalist discourses operate by assuming and creating a bifurcation between Western culture and non-Western cultures or between Western culture and particular other cultures (Culley, 1996; Narayan,

1998). According to Ahmad (1993) by "defining the Other (usually as inferior) one implicitly defines oneself against that definition (usually as normal or superior)" (p. 18).

Increasingly, *culture* is used in dominant discourses and in health care as a metonym for difference that implies inferiority (Reimer Kirkham & Anderson, 2002). Often *race* operates in tandem with *culture* but as a silent subtext (Reimer Kirkham, p. 5). "Common applications of the construct of culture may draw on historical and colonial notions of race and in so doing, reinforce longstanding patterns of domination and inequities" (p. 5). According to McConaghy (2000), culturalism is "centrally about identity politics...it privileges culture as an explanatory tool for knowing matters of social difference; and it is uses culture indiscriminately to explain issues in colonial contexts" – for example, mental health[80] (p. 43). In the context of providing mental health care to Aboriginal peoples, when culture is used this way, we run the risk of conflating the culture of Aboriginal peoples with the cultures of poverty, substance use, and dependency. When images such as this are discussed as cultural attributes or differences, we run the risk of rearticulating colonial images of the Other and reinforcing unequal power relations (Reimer Kirkham & Anderson, 2002). More insidiously, by conflating culture with racialized characteristics, the discriminatory significance of cultural characteristics becomes masked by more acceptable, neutralized terminology (Browne, 2003; Goldberg, 1993) and Other becomes normalized and naturalized (McConaghy, 2000). Later in Chapter Seven, I will examine this process in relation to the way in which depression, suicide, and other mental health issues have been 'normalized' through the internalization of these identities *within* Aboriginal communities.

In the next section, I turn to explore the exportability of the concept of "cultural safety" from the health care discourse in New Zealand to inform mental health policy

discourse in Canada. As a researcher doing policy research in Aboriginal communities, I use cultural safety as a tool or lens for a reflexive process informed by postcolonialism, which alerts us to the importance of historical, social, economic, and political structures in the analysis of contemporary health policies as they impact the mental health and well-being of Aboriginal people. First, I introduce the concept of cultural safety from a postcolonial analytical perspective, and consider its relevance in the Canadian context. Then I illustrate how I use the concept of cultural safety as a moral discourse to inform an analysis of mental health policy as it applies to Aboriginal people in BC, Canada.

## Cultural Safety

Ramsden (1993), a Maori nurse-leader in New Zealand, developed the concept of cultural safety within a nursing education context in response to colonizing processes in Aotearoa/New Zealand. These processes historically disregarded the illness and health belief systems of the Maori, and instead privileged those of the dominant White culture in the construction of the health care system. As Ramsden (1992) writes, cultural safety was designed to focus attention on "*life chances* – i.e., access to health services, education and decent housing within an environment where it is safe to be born brown – rather than *lifestyles*, i.e., ethnography" (p. 22). Cultural safety is, therefore, not about cultural practices; rather, it involves the recognition of the social, economic, and political position of certain groups within society, such as the Maori people in New Zealand or Aboriginal people in Canada.

Cultural safety is derived from the idea of *safety* as a nursing standard that must be met, almost like an ethical standard (Polashek, 1998). Attention is focused on health service delivery, and on broader system issues such as "general nursing policies, the nursing settings

in which care is provided, and the broader health care structures of which nursing is a part"
(Polashek, 1998 p. 454). Informed by a notion of biculturalism[81] in New Zealand, cultural
safety is concerned with fostering an understanding of the relationship between minority
status and health status as a way of changing nurses' attitudes from those which continue to
support current dominant practices and systems of health care to those which are more
supportive of the health of minority groups (Polashek, 1998).

By acknowledging the inequities in health care delivery (for example, arguing that
Maori people in New Zealand or Aboriginal people in Canada receive less than adequate
service), cultural safety draws attention to the issues embedded within the social and political
context of health care delivery. Cultural safety, therefore, aims to counter tendencies in
health care that create cultural risk (or *unsafety*) - situations that arise when people from one
ethnocultural group believe they are "demeaned, diminished or disempowered by the actions
and the delivery systems of people from another culture" (Wood & Schwass, 1993, p. 2).

Cultural safety reminds us that it is incumbent upon all of us in health care to reflect
upon the ways in which our policies, research, and practices may recreate the traumas
inflicted upon Aboriginal people; we need to ask if Aboriginal people, in particular, and all
Canadians in general, are being placed at risk. We need to concern ourselves with how health
policy discourses have been shaped in relation to political, social, cultural, and economic
structures, and in relation to each other, if we are to elucidate the ways in which certain
knowledge is privileged in this particular historical period (Foucault, 1973).

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[81] Cultural safety assumes that all nursing interactions are bicultural regardless of the number of people or the
number of cultural frameworks through which messages are filtered. Nurses are taught that in every encounter,
they need to reflect on their own values and beliefs as one interacts with the values and beliefs of the Other.

In this study, I do not use cultural safety as something I am looking at, but rather as something to look through, as an interpretive lens which itself is being reflected on and interrogated. Cultural safety prompts the asking of a series of questions to unmask the ways in which current mental health policies, research, and practices may be perpetuating neocolonial approaches to health care for Aboriginal people. It becomes a vehicle for translating postcolonial concerns into praxis, pushing beyond culturalist approaches to policy. Given these features of cultural safety, I turn next to consider its relevance in the Canadian context.

## The Importability of Cultural Safety to the Canadian Context

Although cultural safety has not been widely drawn upon outside Aotearoa/ New Zealand, or outside its original context, Dyck and Kearns (1995) and Lynam and Young (2000) convincingly assert the transportability of cultural safety to a research context and in particular, to the research-participant encounter as a means of ensuring that the "dignity and historical context of individuals is recognized" (Dyck & Kearns, 1995, p. 144). Several nurse-researchers are applying the concept to examine health care involving a number of marginalized groups including Aboriginal patients (Anderson, 1998, 2001; Anderson, Perry, Blue, Browne, Henderson, Lynam et al., 2003; Browne, Fiske, & Thomas, 2000; Browne & Fiske, 2000, 2001; Browne & Smye, 2003; Reimer Kirkham, 2000; Reimer Kirkham, Smye, Tang, Anderson, Browne, Coles et al., 2002; Smye & Browne, 2002). Given my own engagement in policy research, I use cultural safety not only to reflect on my research relationships within Aboriginal communities, but also as a moral discourse, as I examine mental health institutions, policies, and practices affecting Aboriginal access to mental health care.

Despite a number of differences and distinctions between the Canadian and New Zealand contexts, which add another layer of complexity to the analysis when considering the importability of cultural safety, in both countries, the health consequences of the processes of colonization and marginalization cross geographical and political boundaries.[82] Colonization has had extremely deleterious effects. It is in this context that cultural safety can be used to examine the health and social relations and practices that are shaped by dominant organizational, institutional, and structural conditions. Specifically, I illustrate how cultural safety as a moral discourse helps to inform a critique of mental health policy as it affects Aboriginal people in BC.

### Cultural Safety as a Moral Discourse Informing Policy Critique

In the context of mental health reform in BC, I use cultural safety to inform a series of moral questions about the rightness of policy decisions and actions initiated within the dominant health sector. For example, do current mental health services fit well with Aboriginal understandings of health, illness, and healing, or are they at odds with them given the current sociopolitical environment? How are the myriad social issues, such as poverty and homelessness, which serve to curtail the life opportunities and health of many Aboriginal people, being addressed by reform? Will Aboriginal people be able to get to the Regional Health Authority decision-making table and, if they do, will they be able to participate in proportionate numbers? Do the policies being examined and "reformed" put Aboriginal

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[82] In both countries Indigenous peoples are over-represented on the negative side of the social economy, for example, unemployment and imprisonment, and under-represented on the more positive side, for example, income and education. The loss of land, cultural traditions and the erosion of language have contributed to the loss of identity in both countries (Fleras & Elliott, 1992). Generally speaking, however, the health status of Maori people is better than that of Aboriginal people in Canada. This relates, in part, to the larger representation of Maori (27%) in the overall population and the earlier presence of Maori in the political arena in New Zealand (Elliott & Foster, 1995).

peoples' health at risk? For example, are they left out in any way?

As mental health reform unfolds, cultural safety also prompts us to ask a series of moral questions related to the broader agendas driving reform, such as deinstitutionalization, decentralization, and devolution. For example, does the devolution of authority to regional bodies assist Aboriginal people in creating effective services which meet individual community needs, or does this structure insert yet another layer of complexity alongside federal and provincial jurisdictional debates regarding who is responsible for Aboriginal mental health? What does the notion of "increasing democratization" mean for Aboriginal people? Will the poorer health status of Aboriginal people be taken into consideration at the decision-making table? How do these debates create barriers to providing essential services? Do these agendas support Aboriginal self-governance?

In the context of a consultative process, we must also be concerned about whether or not the voices represented are those of Aboriginal people or simply the rhetorical voice of policy makers espousing the benefits of reform, in the absence of real material gains for Aboriginal people. Are Aboriginal people involved, and is their involvement merely symbolic or is it influential and meaningful? What agendas prompted reform? For example, in BC, mental health reform occurred on the heels of several brutal mental health-related deaths and the mobilization of the BC Schizophrenia Society (BCSS) and other important consumer-driven groups. How can the high suicide rates in Aboriginal communities compete with other important mental health concerns in the mainstream?

These questions go beyond issues of resource allocation and equity to an interrogation of the injustices embedded within social, economic, and political processes that impact the

health of Aboriginal people. In unraveling the complexities of the policy process, cultural safety becomes a reflective device/interpretive lens for the process of policy analysis.

## Concluding Comments

The factors most often identified as contributing to the discrepancy in mental health status between non-Aboriginal and Aboriginal people are multiple and include poverty, unemployment, poorer education in some communities, threats to cultural identity, and a poor sense of self-worth as a result of discrimination and racism (Kilshaw, 1999; Royal Commission on Aboriginal Peoples, 1996a, 1996b), at both individual and systemic/institutional levels. These are moral issues that nurses in practice, education, research, and policy must attend to in the provision of health care involving marginalized, disenfranchised populations.

In research with Aboriginal communities, cultural safety provides a postcolonial framework to examine unequal power relations and the social and historical processes that organize these relationships. The notion of culture in cultural safety is used to address the meanings that Aboriginal people give to mental health and illness, and the needed responses to mental health issues. Given the postcolonial perspective used to frame this discussion, individual, social, and political meanings that Aboriginal people attribute to health and illness not only need to be recognized and respected at the micro level but also need to be utilized in the shaping of mental health structures, understanding that meanings shape systems and practices, and vice versa. The notion of safety helps us, as researchers, to focus on health outcomes – that is, are Aboriginal people benefiting from the mental health care system as it currently exists, or does it place them at risk? For example, do suicide prevention strategies

address the root causes of despair and hopelessness apparent in many Aboriginal communities, and fit with Aboriginal perspectives?

Although applicable to service delivery, research, and policy across diverse populations, it is my view that cultural safety is particularly useful in the area of Aboriginal health because of the historical context of Aboriginal health and health care, and relations within the political economy. By viewing cultural safety in this broader context, issues of institutional racism and discrimination that continue to shape the provision of health care for Aboriginal people in Canada can be better critiqued. Cultural safety provides a means of critiquing mental health policy, research processes, and clinical practices.

The postcolonial framework offered by cultural safety alerts us that we need to examine not only current inequities manifested in health and health care, but also to examine the long histories of economic, social, and political subordination that are at the root of current health and social conditions among Aboriginal people. Importantly, a postcolonial interpretation locates these health and social conditions in the structural disadvantages that shape them. These are the issues of concern as mental health reform is unfolding in BC, not as esoteric theoretical entities, but as everyday realities influencing the lives and health of Aboriginal peoples.

## Summary

Perspectives drawn from postcolonial theories provide the interpretive lens through which I approach this research. Cultural safety, with its attention to historical power relations, assists in focusing my gaze on the nature of the tensions between Aboriginal understandings of and responses to mental health and illness and the current mental health system. Together, these theoretical perspectives are used to critically examine (a) the

ideologies and structures underpinning the delivery of mental health services in BC, (b) the policies and practices that mediate between the ideologies underpinning service delivery and everyday practices/ barriers to accessing mental health care, and (c) the everyday practices in mental health service delivery that impede Aboriginal access to mental health services.

The risk inherent in applying these perspectives lies in predisposing researchers to focus on some aspects of the data and not on others (Browne, 2003; Reimer Kirkham, 2000). As noted earlier, it is my intent to apply theory as an interpretive lens, so that the theory does not become a container into which the data must be poured (Lather, 1991, p. 62). As I go on to explain in Chapter Four, engaging critically with theoretical perspectives and maintaining an ongoing process of reflexivity are central to conducting this research. As Kelm (1998) notes

> A deep understanding of the nature of colonial relations and their impact upon Aboriginal lives, in this case particularly referenced as mental health, is essential to any process that seeks to undo the racist teachings in our history and to promote social and political change. (p. xxiii)

### Summary of the State of Knowledge

Examining the significance of past colonial relations is necessary to understanding current social, political, and economic conditions influencing Aboriginal mental health and the generally poorer mental health status of Aboriginal peoples. Although there is a literature describing the barriers to access to adequate Aboriginal mental health care, there is a paucity of research examining the social relations shaping the local historical process and constituting the everyday world of mental health service delivery to Aboriginal peoples. The study presented here aims to address this gap by examining the nature of the tensions and

disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system. I do this by setting out to answer the following questions in this dissertation: (1) What are the everyday practices that act as barriers to access to mental health services for Aboriginal peoples? – i.e., What are the tensions and disjunctures?; (2) What are the ideologies and structures underpinning the way mental health care is delivered to Aboriginal peoples – i.e., Why the tensions and disjunctures?; and (3) How do institutional policies and practices support the embeddedness of ideologies underpinning mental health service delivery – i.e., What are the patterns of tension and disjuncture?

# CHAPTER FOUR

# RESEARCH DESIGN AND IMPLEMENTATION

## Introduction

It is challenging to do this research when I, as the researcher, am situated within academia – an institution in which a Eurocentric worldview tends to dominate, often subjugating knowledge of the non-dominant studied group. As Smith (1991) articulates, what I do as a [nurse and academic][83] is bound to a discourse deeply implicated in the "ruling relations"[84] (p. 157). Neocolonial ideologies and subsequent practices shift and reemerge in different forms, often making them difficult to recognize and unmask. Given the central problematic of this study and these concerns, I have striven to conduct this research from a postcolonial stance. In addition, I have included critical inquiry in the ethnographic tradition because of my commitment to a research approach committed to a more just social order (Denzin, 1997; Lather, 1991).

This chapter focuses specifically on how the research was conducted. I begin with the methodology guiding the research. After a brief discussion of critical ethnography, I move on to elaborate on the use of a postcolonial standpoint in this study. I then describe the research design, the research participants, and the techniques used for gathering the data, namely, in-depth interviewing and a critique of policy. Data analysis procedures, criteria for evaluating the scientific rigor of the research, limitations of the study, and ethical considerations are

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[83] I borrow from Smith (1991) who is referring to what we do as individuals and intellectuals, and in her case, what she does as a sociologist (p. 157).

[84] Smith (1987) articulates "ruling relations" or "ruling apparatus" as those intersecting organizing practices of educational, legal and economic institutions, and "that familiar complex of management, government administration, professions, and intelligentsia, as well as the textually mediated discourses that coordinate and interpenetrate it" to form a network of social relations (p. 108).

then reviewed. Finally, I conclude the chapter with a reflexive analysis that attempts to make transparent how my social location shaped the process of research.

## Selecting a Design: Critical Ethnography

Early ethnography grew out of an interest in the origins of culture and civilization, particularly those considered to be less civilized, as in "primitive cultures" (Vidich & Lyman, 1994). As a research methodology, it has emerged from cultural anthropology and sociology to describe the social and cultural worlds of particular races and groups (Omery, 1988). Underlying *traditional* ethnography was an ontological position in which reality could be observed and described objectively. "Ethnographers connected meaning (culture) to observable action in the real world" (Denzin, 1997, xi). This mode of inquiry involved entering the field (often for extended periods of time), engaging with the group as a participant observer, and interviewing key informants,[85] so that the reality of the selected group could be represented. The two main criticisms of this form of ethnography relate to the issue of representation and the relationship between research and practice. Traditional approaches to ethnography tend to remain strongly influenced by the philosophical underpinnings of positivism, scientism, and the belief that one can represent an independent social reality, all indicative of the researcher's denial of his/her participation in the field and in the data analysis. Also, these approaches have led to a debate about the extent to which ethnography could contribute to practice, the criticism being that earlier applications of ethnographic method did not recognize this potential (Hammersley, 1992, p. 2). In addition, from a postcolonial, postmodern (Lather, 1991), and feminist perspective (Alcoff, 1991),

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[85] Although many ethnographers continue to use the term key informant, in agreement with Rodney's position (1997), I refrain from using is because it denotes a hierarchical relationship. I also prefer the word participant and use it in this text.

early ethnography has been criticized because it privileges[86] the position of the researcher and as a consequence, enables the continuance of power inequities, often unwittingly becoming a reenactment of oppressive relationships. Therefore, a new ethnography emerged from a period of discontent with earlier ethnographic traditions (Anderson, 1989).

Ethnography as presented by Denzin (1997) is "the form of inquiry and writing that produces description and accounts about the ways of the life of the writer and those written about" (p. xi). Today, ethnography is evolving in the context of a postcolonial, postmodern world. Because of globalization, national boundaries and identities have blurred: "it is necessary to think beyond the nation." Subjects *of* study have become participants *in* a study and often scrutinize the text of ethnography; feminism and "queer" theory have raised questions regarding the narrative text in terms of gender and heterosexism; at the centre of the project is its emancipatory aim; the text is focused in the lived experience; and the ethnographic text has become a "moral, allegorical, and therapeutic project" (pp. xii-xiv). While participant observation and interviewing continue to be used as the main methods of data collection in critical ethnography, the researcher seeks a deeper immersion in the world of the other, and a more intimate understanding. For some cases in the field, this has meant taking on a role within the group of study such as "sister or mother in an extended family." The field worker is both a participant and an outsider (Emerson, Fretz, & Shaw, 1995, pp. 3-4).

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[86] I use the word privileged in the same sense as Alcoff (1991) uses it: "to be in a more favorable, mobile, and dominant position vis-à-vis the structures of power/knowledge in a society. Thus privilege carries with it presumption in one's favour when one speaks. Certain races, nationalities, genders, sexualities, and classes confer privilege, but a single individual (perhaps most individuals) may enjoy privilege with respect to some parts of their identity and a lack of privilege with respect to others. Therefore, privilege must always be indexed to specific relationships as well as to specific locations" (p. 30).

Criticisms of versions of a new ethnography as methodology are that it is overly reflexive, rampantly subjective, narcissistic, and not scientific. However, the ethnography I am proposing here moves beyond a solely text-based theory of difference to one that is also social and historical (Kincheloe & McLaren, 1994), an ethnography deepened by a critical engagement with postcolonial perspectives. A new ethnography reflects the view that the "real world is no longer the referent for analysis." Instead, the ethnographer recognizes that "humans live in a secondhand world of meanings" (Denzin, 1997, p. xvi), a world of social constructions. Thus, the ethnographer's task is to reveal the multiple truths apparent in others' lives (Emerson, Fretz, & Shaw, 1995), a good fit with the attention of postcolonial nursing scholarship to an infusion of subjugated knowledge and the illumination of the experiences of those marginalized within society and within health care (Reimer Kirkham & Anderson, 2002).

## From Theory to a Method of Inquiry: A Postcolonial Framework

The postcolonial method continues to evolve from within a postcolonial nursing scholarship as a dialectic between theory and research (Reimer Kirkham, 2002). As an angle of inquiry, a postcolonial nursing method incorporates several themes. Firstly, as noted in Chapter Three, the research project is viewed through a political lens – a postcolonial framing attends to *power relations* with an "overarching mindfulness of how domination and resistance mark intercultural health care encounters at individual, institutional, and societal levels" (p. 10). Inevitably, a postcolonial critical lens explores the "meta" themes of "race" and its accoutrements – colonization and racialization, and so on – and "power," in its many forms. Thus, a feature of a postcolonial research method is its open commitment to praxis-

oriented inquiry, which has to do with unmasking power and resource inequities in ways that contribute to a more "just society" (p. 13).

Secondly, a postcolonial method locates human experience of the everyday in the larger contexts of mediating social, economic, political, and historical forces and the realities of the tensions between these places, "self and society, the local and the global, the particular and the universal" (Reimer Kirkham & Anderson, 2002, p. 11). The central focus of this research is to examine and describe the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system. In keeping with a postcolonial critical lens, I begin this study with the standpoint[87] of Aboriginal peoples in BC as a point of entry into the everyday world of mental health service delivery, and link these experiences to the institutional and ideological formations which shape and are shaped by those experiences.

Thirdly, the postcolonial method is intended to "deliberately decentre" dominant culture to feature those voices which have been displaced to the margins by dominant culture worldviews (Narayan & Harding, 2000; Reimer Kirkham & Anderson, 2002). This perspective does not imply a common standpoint or voice, but rather recognizes the heterogeneity of people's experiences. As Reimer Kirkham and Anderson argue, the researcher can attend to this issue by providing an opportunity for polyvocality, using such strategies as purposive sampling for diverse groups of participants with a range of experiences (p. 12). I will discuss the use of this sampling strategy later in this chapter.

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[87] Here I am using the notion of standpoint in much the same way as Dorothy Smith (1987) and Reimer Kirkham and Anderson (2002). Smith's (1992) standpoint perspective provides "a method of thinking about society and social relations, and of doing research" (p. 91). Inquiry which begins from the everyday world of experience aims to show how those experiences are linked into and "shaped by social relations, organization, and power beyond the scope of direct experience" (p. 89). However, unlike some standpoint theorists, Smith's methodology does not imply that there is one standpoint "from which the world can be best viewed" (Campbell & Manicom, 1995, p. 8).

Fourthly, a postcolonial method recognizes the co-existence of multiple identities. Informed by the work of Patricia Hill Collins, Reimer Kirkham and Anderson (2002) argue for an analysis of oppressions, for example, racism, sexism, and classism, which recognizes them as intersecting categories of analyses located within "a complex matrix of domination in economic, political and ideological spheres" (p. 13). As noted in Chapter Three, in this sense, the oppressed and the oppressor may be one and the same: For example, an Aboriginal man may be oppressed in relation to how the notion of *race* operates but may in fact be the oppressor in relation to how *gender* operates to demean Aboriginal women.

Postcolonial methods also come under scrutiny. As Reimer Kirkham and Anderson (2002) caution, there are epistemological implications when a researcher takes on *race* and *power* as preexisting 'meta' themes – the researcher runs the risk of imposing the theoretic interpretive lens vis à vis the participant. For example, in this study, a tension was created between my a priori assumptions about racism and its embeddedness in the everyday world of mental health, a position I held strongly but nevertheless did not want to impose on the participants. To address this issue, Reimer Kirkham and Anderson suggest that the nature of the researcher-participant relationship in this kind of praxis-oriented scholarship provides room for exploration of these taken-for-granted assumptions and for tension to remain between interpretations of the researcher and participants. In the end, the reflexivity of the researcher is enormously important in the examination of the particular dialectic between theory and research (Reimer Kirkham & Anderson) – in this way, data is used to inform the generation of ideas, but at the same time, room is left for the use of a priori frameworks (Lather, 1991, p. 56).

Thorne (1997) reminds us of the way in which knowledge is shaped by this kind of research orientation, as a social construction rather than as "knowledge in the factual sense" (p. xiii). Similarly, underpinning Smith's (1992) standpoint perspective is the assumption that knowledge and experience are socially constructed. As Campbell (1998) explains,

> [e]xperiential data, whether from interviews or observations, thus inform a method, allowing researchers an entry to social organization for the purpose of explicating the experiences; by explication I mean to write back into the account of experiences the social organization that is immanent, but invisible, in them. (p. 60)

Therefore, for purposes of this dissertation, a postcolonial critical ethnography is an appropriate vehicle for conducting research focused on examining and describing the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system within a limitless array of historical and cultural specificities, including the poorer mental health status of Aboriginal peoples relative to their non-Aboriginal cohort.

## The Research Design

As noted in Chapter One, the research objectives of this study are to (1) explicate the nature/attributes of the tensions and disjunctures, (2) identify the aspects of these attributes that are most problematic to people, (3) identify the structures, practices and techniques that create the biggest barriers to alleviating and/or working within the tensions and which impede the achievement of optimum mental health for Aboriginal people, and (4) generate recommendations concerning the role of nursing in contributing to mental health policy. Therefore, to meet the research objectives situated within a postcolonial framework, the research design and methods needed to (a) provide an opportunity for Aboriginal people to

describe their experiences with the mental health system; (b) provide an opportunity for policy makers, both Aboriginal and non-Aboriginal, to explicate their experiences with mental health policy development and application; and (c) provide analytic insights into how these experiences are influenced by wider ideological and social contexts.

A qualitative study incorporating in-depth interviews with Aboriginal people working within mental health and related fields and with Aboriginal and non-Aboriginal policy makers, a focus group with Aboriginal care providers in an urban center, and a critique of several mental health policies fits with these requirements. I had the expectation that mental health policy and consequent programs would be informed by research which provides a description of the nature of the tensions and disjunctures.

### *The Research Setting*

The setting for this study was urban, rural, and remote BC I conducted my interviews on sites chosen by the participants, who lived across a wide range of geographic locations. The actual locale for the interviews varied from offices in the workplace, restaurants, and hotels, to the participants' homes. A few of the interviews conducted with participants from more remote locations were conducted in Vancouver where they were visiting and/or working at the time.

### *Beginning in the Field: Building Alliances*

Here, I use Haig-Brown's (1992) reframing of the notion of negotiating or gaining access to discuss what she describes as "beginning relationships" (p. 97), and what I will refer to as *building alliances*[88] in this study. Building alliances has involved becoming immersed in the area of Aboriginal mental health over the past five years. The data collection

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[88] As a nurse researcher, I think I have a comfort with the language of *alliance* because of my experience as a nurse therapist. As a therapist and researcher, one is trying to establish a relationship built on trust as an ally with the participants. In the field, the researcher has an opportunity to engage with those studied, "to develop mutual understandings as they work together" (Haig-Brown, 1995, p. 3).

for this study was initiated after working in the area of Aboriginal mental health for approximately two years as the coordinator of the Aboriginal Mental Health *Best Practices* Working Group and as a consultant in several areas in BC, where I assisted with the development and evaluation of mental health programs in several Aboriginal communities. For the past four years, I have been connected to one BC community where I have had the opportunity to work more closely with community members and have developed significant alliances and friendships. In addition, I am involved in a couple of Aboriginal agencies/ organizations committed to the improvement of Aboriginal mental health.

Most particularly, this study was made possible by members of the Aboriginal Mental Health *Best Practices* Working Group with whom I was able to discuss the purpose and methods of the study. I was chiefly interested in the comments they might offer with regards to the focus of the research, given their vast and varied experience and knowledge in the area. Based on their collective feedback, some modifications were made in relation to the study. In addition, the members of the Working Group were instrumental in assisting me to access participants from across BC who would be able to discuss the nature of the tensions and disjunctures. Several took the initiative to contact people whom they thought would be particularly helpful in this regard. Therefore, the people whom I contacted for interviews were aware of my purpose in approaching them about being potential research participants. Some participants contacted me regarding their interest in the study.

In my experience to date, the process of building alliances involves listening and observing as well as ongoing dialogue and respectful, genuine relationships with people in the field. These have been foundational to this research and to my personal life.

### *Sampling Procedures*

In this kind of research the goal was not to show the effect of an independent variable on a dependent variable or to examine the nature of the tensions and disjunctures described under controlled situations. Rather, the goal was to examine and describe the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system – to explicate the historical and sociopolitical contexts that shape those relations. The primary selection of participants was made on the basis of their ability to reflect on and articulate their experiences and views regarding the nature of the tensions and disjunctures, (i.e., the sample was selected based on their ability to answer the research questions and speak to the issues posed by those questions). Therefore, purposive and theoretical sampling of Aboriginal people working in mental health and related fields and Aboriginal and non-Aboriginal policy-makers, was used. In purposive sampling, participants are selected according to the need in the study.

At the outset of the study, to answer question One – What are the everyday practices that act as barriers to access to mental health care for Aboriginal people? or what are the tensions and disjunctures? – I conducted in-depth interviews with Aboriginal people working in the field of mental health and/or related areas and conducted a focus group interview with service care providers in an urban center. To answer question Two – What are the ideologies and structures underpinning the way mental health care is delivered to Aboriginal peoples? or Why the tensions and disjunctures? – I did a critique of several mental health policies and interviewed policy participants, both Aboriginal and non-Aboriginal, who had an in-depth knowledge of the policies related to Aboriginal health, mental health reform, and the reform process. To answer question Three – How do institutional policies and practices support the

ideologies underpinning mental health service delivery? or what are the patterns of tension and disjuncture? – I conducted in-depth interviews with Aboriginal and non-Aboriginal policy makers and Aboriginal peoples working in mental health and related fields. Many of the participants in this study are or have been grassroot providers, and several of the participants have also accessed mental health services, therefore, the participants in this study speak from multiple perspectives.

As noted earlier, I began the selection of my sample with the Aboriginal Mental Health *Best Practices* Working Group as a source of information about possible participants because of their experience, knowledge and interest in mental health issues and because of their various geographic and social locations and connections to other Aboriginal peoples, who would also be able to speak to the issues of concern in this research. At the outset of this study, I did not know the members of the Working Group, and it was through the process of conducting fieldwork, and collecting and analyzing data during the research process that relationships were built. Importantly, people participated in this study from their own perspective as an Aboriginal person or non-Aboriginal person – they were *not* speaking on behalf of others, for example, giving the perspective of service providers or Aboriginal people per se. In fact, several of the Aboriginal participants in this study made it clear that although they were speaking as *an* Aboriginal person, they were not speaking on behalf of Aboriginal peoples. As Battiste (2000) argues, there is no one representative Indigenous voice but rather multiple voices and perspectives.

After a significant proportion of data were analyzed, theoretical sampling was used to explore relevant concepts and insights arising from the data with particular participants. For example, after analyzing the data from several Aboriginal participants who noted the

invisibility of Aboriginal people within the mental health system, I recruited a focus group from the urban setting with people who would be able to speak from *a* grassroots perspective on this issue. This group was recommended by another participant because of their experience working with a large number of Aboriginal people with multiple health concerns including mental health and/or alcohol and drug use issues. These participants had a great deal of experience trying to access mental health, addiction, and other health services, with and/or, on behalf of their clients.

Theoretical sampling was also used near the end of the study to select an additional two policy participants: one who was involved in planning services for First Nations at the regional level, and one who had designed policy at the macro level. Both perspectives were sought in relation to gathering non-Aboriginal policy perspectives to gain a clearer sense of whether or not the findings of the research resonated with their understandings of the wider issues influencing mental health care for Aboriginal people. In addition, an Aboriginal participant was recruited at the end of the study because of the breadth of knowledge and experience this individual brings to the area of Aboriginal mental health in relation to the Canadian landscape. Again, this was done to gain a clearer sense of whether or not the findings fit with the perspectives of this individual (Thorne, Reimer Kirkham & McDonald-Emes, 1997).

It has been noted that data from 15-20 people – sometimes less – can be sufficient to provide a comprehensive understanding of a phenomenon under study (Sandelowski, 1995; Browne, 2003).[89] In this study, the sample of participants included a total of 14 Aboriginal participants working in mental health and related fields – 13 First Nations and 1 Métis; a total of 6 policy participants – 3 Aboriginal (2 First Nations and 1 Métis) and 3 Euro-Canadians; a

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[89] Of course, this is dependent on the phenomenon being studied.

total of 9 health care providers in a focus group – 2 First Nations and 7 Euro-Canadians; and a total of 2 Euro-Canadian registered nurses (RNs), for a grand total of 31 (N=31) participants.

Because of the complexity of issues related to consent, all of the participants were over 19 years of age. English was spoken by everyone. The participants were recruited to participate in in-depth interviews and were presented with the option of giving feedback on the final draft of the dissertation.

### *Recruitment*

Again, as noted earlier, I began the recruitment process through the Aboriginal Mental Health *Best Practices* Working Group, which I coordinated from July 1999 until March 2002 through the Mental Health Evaluation and Community Consultation Unit (Mheccu), Department of Psychiatry, UBC, funded by the Adult Mental Health Division, Ministry of Health. Initially, I simply discussed the study with various members of the working group, and when I was ready to recruit, I took time to explain the study at a couple of our meetings. I also handed out project pamphlets to the group (all pamphlets are in Appendix A). The pamphlets contained information for the participants including an outline of the purpose of the project; relevant information about the researcher, including contact information; and the extent of the commitment for the participant. I asked the working group members to contact me if they were interested in being in the study and/or recruiting for it. They were told that they were under no obligation to participate, and their non-participation would make no difference to their working relationships within the group. Potential participants either called me to say they were interested in the study, or gave me the name of a potential participant to call. The initial participants in the study were given extra

information pamphlets and a couple of them mailed pamphlets to other potential participants. Others telephoned contacts they thought might be interested. I had asked those participants who also became recruiters to call me if their contact was interested in the study. I then telephoned the contact and set up an appointment time. Those participants who became recruiters were provided with more pamphlets. As mentioned previously, the pamphlets outlined the study and invited participation.

Policy-makers involved in the design and implementation of documents related to recent mental health reform were asked to participate in interviews through the researcher's contacts in Adult Mental Health and Aboriginal Health Division, BC Ministry of Health. Following telephone contact with the participant, a study pamphlet (Appendix A) was sent and an interview appointment date set.

The nurses in the hospital who were recruited were contacted by an on-site physician who gave them a pamphlet. They both approached the researcher to be interviewed.

All of the participants provided written consent prior to participating in the interview after the purpose of the study was explained by the researcher.

### Overview of Participants

### Aboriginal Participants Working in Mental Health and Related Fields (RP) (n=14)

The demographic profiles of the 14 Aboriginal participants working in mental health and related fields who participated in this study are listed in Table 1. All participated in individual in-depth interviews. There are 6 males and 8 females. Thirteen of the participants in this group were born and/or raised in reserve communities. At the time of the study, the participants reported their status and residence as follows: 6 status on-reserve (2 living on remote reserves, 2 on rural reserves and 2 on urban reserves), 6 status off–reserve living in

the urban setting, 1 non-status living in the urban setting, 1 reported that status was not

applicable and was living in the urban setting.

The ages of the participants ranged from 32 to 63 years, though the majority (N=12)

were over age 40. Educational levels varied from secondary school to university. One

participant had secondary school education, one had college and two had some tertiary

education. The majority (N=9) had a university education: 4 had Masters degrees, 3 had a

BA, and 2 had "some university courses." At the time of the study all of the participants were

employed full-time and two participants also did consulting work. The professional roles of

the participants included 3 executive directors, 1 regional coordinator, 1 community

development specialist, 1 Chief, 2 adult educators, 1 counselor, 1 supervisor, 1 program

administrator, 1 consultant, and 2 program managers.

### Policy Participants (P) (n=6)

As illustrated in Table 1, three of the policy participants were of Euro-Canadian

descent, two of the remaining participants identified as First Nations, both non-status, and

one participant identified as Métis.[90] Five of the participants lived and worked in the urban

setting and one in a remote setting.

The participants' ages ranged from 38 to 62 years with most of the participants (N=5)

being more than 40 years old. All of the participants had some university preparation (N=6):

one had "some university courses," 3 had BAs, 1 had a Masters Degree and 1 had a PhD. At

the time of the study, five of the participants were employed full-time in the area of policy

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[90] Despite their essentialist connotations, I have chosen to retain these categories to distinguish between the policy participants. In keeping with the work of Furniss (1999) I have used the term Euro-Canadian. She notes that this is "the accepted term in formal academic discourse to refer to the dominant segment of Canadian society" (p. xi; Browne, 2003). However, on occasion I do use the term non-Aboriginal when making comparisons across people in the dissertation.

and one was employed as a private consultant in the field of policy and mental health. Their professional roles included 1 senior policy analyst, 2 policy consultants, 1 research and policy analysis, 1 chief executive officer (CEO), and 1 manager, treatment and policy. All of the participants were experienced in the field of policy development and/or analysis.

### Focus Group Participants (F) (n=9)

As noted in Table 1, two of the participants were First Nations and seven Euro-Canadian. The two Aboriginal participants in this group identified as status peoples, 1 living in an urban reserve setting and 1 off-reserve in the urban setting.

The participants' ages ranged from 42 to 56 years (N=7). The education level of the participants ranged from high school to university. One participant had "some high school", one had grade 10 (LPN), three had college education (1 RN), three had a university education (1 BA, 1 MA, 1 BScN). The participants' professional roles included 1 nurse coordinator, 5 outreach workers, 2 counselors, and 1 outreach nurse. Some of the participants had worked in this setting since the program was initiated.

### Nurse Participants (NP) (n=2)

The nurses were interviewed in a hospital setting in a remote area of BC. One of the nurses had been born and raised in this area and had recently returned and the other had been working in this community for several years. Both were Euro-Canadian nurses who had worked in the field for more than 15 years and both were experienced working in the area of Aboriginal health. They worked full-time in this setting.

Table 1: Socio-Demographic Characteristics of Study Participants (N=31)

| Participant | Ethnicity | Country of Birth | Age | Employment Status | Highest Educational Attainment | Attended Residential School | Accessed Alcohol and Drug (A & D) or Mental Health |
|---|---|---|---|---|---|---|---|
| **Aboriginal Participants (RP)** **(n=14)** 6 males, 8 females | First Nations 13<br>Métis 1 | Canada 14 | 19-30 0<br>31-40 2<br>41-50 5<br>51-60 5<br>61+ 1<br>Unknown 1 | Full-time 14<br>Part-time | Elementary<br>Secondary 1<br>Some Tertiary 2<br>College 1<br>University 9<br>(includes 1 RN) | Yes 5<br>No 9<br>Parents 12<br>Grandparents 5<br><br>Boarding School 1 | A & D 3<br>Mental Health 3<br>Counselling 2<br>Other 1 |
| **Policy Participants (P)** **(n=6)** 3 males, 3 females | First Nations 2<br>Métis 1<br><br>Euro-Canadian 3 | Canada 5<br>Other 1 | 19-30<br>31-40 1<br>41-50 2<br>51-60 2<br>61+ 1 | Full-time 5<br>Part-time<br>Consultant 1 | Elementary<br>Secondary<br>Some Tertiary<br>College<br>University 6 | Yes<br>No 3<br>Parents 2<br>Grandparents<br>n/a 3 | A & D<br>Mental Health<br>Counselling 3 |
| **Focus Group Participants (F)** **(n=9)** 4 males, 5 females | First Nations 2<br><br>Euro-Canadian 7 | Canada 2<br>Unknown 7 | 19-30<br>31-40<br>41-50 5<br>51-60 2<br>61+<br>Unknown 2 | Full-time 9<br>Part-time | Elementary<br>Secondary 2<br>Some Tertiary 1<br>College 3<br>University 3<br><br>RN Degree 1<br>RN Diploma 1<br>LPN 1 | Yes 1<br>No 1<br>Parents 2<br>Grandparents 1<br>n/a 7 | A & D 3<br>Mental Health<br>Counselling 2 |
| **Nurses (N)** **(n=2)** | Euro-Canadian 2 | Canada 2 | Unknown 2 | Full-time 2 | RN Diploma 2 | n/a | A & D<br>Mental Health<br>Counselling |

Nations represented in this study include: Gitxsan, Sechelt, Esquimalt, Cree, Sto'lo, Mi'qmac, Coast Salish, Nuu chah nulth, Shuswap, Lilloet, Haida, Heiltsuk, Tsimshian, Ojibway

### Data Collection Methods and Procedures

The primary tools of this ethnography are unstructured in-depth individual interviews, a focus group interview and policy critique. The critique of the documents of mental health reform, including the *1998 Mental Health Plan: Revitalizing and Rebalancing the Mental Health System in BC* (RRBC, 1998) and the *Best Practices* documents of Mental Health Reform,[91] took place during the interview phase of the study. I moved back and forth between the interviews, my critique of policy documents, analysis, the literature, and writing, in an iterative fashion (Anderson, 1989).

### Recording Fieldnotes

Fieldnotes were made after each interview to contribute to the process of developing knowledge through reflection on the experience. This involved a combination of both intuitive and empathic processes, attempting to attend to what I, the researcher, found important and interesting, in combination with what was important and interesting to the participants (Emerson, Fretz, & Shaw, 1995). In this way, the writing of fieldnotes was a kind of interpretive event in this study (Denzin, 1994, 1997). The fieldnotes helped me to process contextual, methodological, and theoretical insights related to the interview process. For example, I recorded "conceptual structures" that were informing what the participant was saying (Geertz, 1973). In relation to the more theoretical issues, I made notes about the research process and questions for follow-up as well as notes linking observations to the literature and theory. This assisted in organizing my evolving thoughts about analysis (this

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[91] The *Best Practices* documents included: assertive case management, (British Columbia (BC), 2000a), consumer involvement (British Columbia (BC), 2000b), crisis response/emergency services (British Columbia (BC), 2000c), family support and involvement (British Columbia (BC), 2000d), housing (British Columbia (BC), 2000e), inpatient/outpatient services (British Columbia (BC), 2000f), psychosocial rehabilitation (British Columbia (BC), 2000g), rural and remote (British Columbia (BC), 2000h, and guidelines for elderly mental health care planning (British Columbia (BC), 2001a).

began after the first few interviews). In addition, I made notations related to how my own social location may have influenced the research process as well as the researcher-participant relationship. Lastly, quite separate from the interviews, I jotted down thoughts related to newspaper clippings that seemed relevant to the issue of Aboriginal mental health to provide contextual insights for the study.

As Emerson, Fretz, and Shaw (1995) explain, recording experiences and observations is neither "straightforward" nor "transparent" – there is no one way to do it (pp. 4-5). Denzin (1997) challenges the ethnographer of the 21st century to move to a form of interpretive text that is increasingly acoustic – to create fieldnotes that reflect a multiplicity of perceptions and interpretations. As explained by Emerson, Fretz, and Shaw, doing and writing are "dialectically related and interdependent activities" (p. 15). Transcribing (Clifford, 1990) or inscribing (Geertz, 1973; Denzin, 1994; Lather, 1991), translating, narrating (Emerson, Fretz, & Shaw), and textualizing (Clifford & Marcus, 1986; Denzin, 1997; Marcus, 1986) the social discourse helps the researcher to understand what has been experienced and observed in charting the research course.

### Research as Conversation: The Ethnographic Interviews

Interviews formed the nucleus of this study. In-depth, open-ended interviews were conducted in which I explored the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system. In addition, one focus group interview was conducted.

Interviews with Aboriginal Participants in Mental Health and Related Fields

In-depth interviews were conducted with Aboriginal people working in mental health and related fields (RP) to explore their experiences with the tensions and disjunctures. All

fourteen participants participated in one face-to-face in-depth interview which lasted for approximately 60-90 minutes. Many interviews were conducted in the offices of the participants with the exception of two interviews, which were conducted in hotels with people from outside the lower mainland who were in Vancouver on business. One other interview was conducted in a restaurant and another in my home. All interviews took place at times and places convenient for the participants and many of the interviews were quite informal (Germain, 1986). I conducted all of the interviews.

In addition, I had short check-in telephone, email and face-to-face conversations with some of the participants as I worked through the data analysis. Most of these took the form of checking the accuracy of data and in a few cases an exploration related to the emerging analysis.

In-depth unstructured interviews were guided by a set of preplanned trigger questions posed by the researcher (Appendix C). Subsequent questions were formed during the interview in response to the participants' accounts of their experiences (Spradley, 1979). During the interviews, I tried to provide adequate space for the participants to present issues they thought important for me to hear, and many participants led me on to other pathways. The interviews with participants evolved in keeping with the process of data analysis and became more specific as the interviews progressed and I began to look for commonalities and differences.

In conducting the in-depth interviews, although I had compiled a list of questions to act as prompts for the participants, formal questions were kept to a minimum. There was a direct introduction to the research topic and I spent time with the participants at the beginning of the interview to try to get acquainted and put the participant at ease. The first

question I asked everyone after introducing the study was, Do you think there is a tension (or tensions) between Aboriginal understandings of and responses to mental health and illness and the current mental health system?,[92] to which almost everyone responded *yes*. I then moved on from there in the direction of the participant's response, generally exploring the texture of Aboriginal – non-Aboriginal relations. This took many forms because of the variability of responses, however, most participants described a tension created by differing worldviews – Aboriginal and non-Aboriginal. Another particular focus of the interview was related to the issue of social change, therefore, I asked questions related to the participants' experiences of the mental health system in terms of its benefits and challenges and what they might change.

In accordance with using the concept of cultural safety as a means of transporting postcolonial concerns into praxis, the issue of *racism* was explored with many of the participants and usually prompted considerable discussion. This was a mechanism for linking micro-level interactions to macro-level issues in the health care context. Many of the participants raised the issue of racism *without* a question prompt.

At the end of every interview I asked the participant, Is there anything I haven't asked that you see as important or would you like to make any further comments? At this point, most of the participants did add to a particular aspect of earlier discussions.

<u>In-depth Interviews with Policy Participants – Aboriginal and non-Aboriginal</u>

In-depth unstructured interviews were conducted in the same manner with policy makers (P) who, in addition to the questions asked to the Aboriginal provider group, were able to speak specifically to the process of mental health reform and/or to the issue of

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[92] Although I needed to clarify what I meant by "tension" for a couple of the participants, most seemed to understand the question.

*difference* from a policy maker's perspective (Appendix C). For example, I asked all of the policy makers why Aboriginal suicide was not on the mental health agenda. Similar to the interviews with Aboriginal participants working in mental health and related fields, these interviews were followed up with short check-ins with a few of the participants, particularly related to providing current information about the changes within health care in BC that had arisen since the study began. One of the Aboriginal policy participants emailed a narrative account two days post interview. In an informal fashion, the same participant has provided ongoing input in relation to the data analysis.

Four of the interviews were conducted in the participants' offices and the other two interviews were conducted in restaurants.

## In-depth Interviews with Nurses

The two registered nurses (N) within a remote setting of BC were chosen to add another perspective in this research – that of nurses working within a hospital setting with Aboriginal peoples. These interviews were also unstructured and guided by similar trigger questions (Appendix C). They took place during the nurses' breaks in an informal fashion in an empty clinic room in the hospital. I was also able to engage with these nurses in informal chats before and after the interviews.

## Focus Group Interview

The focus group (F) was part of the theoretical sample, chosen for the ability of the participants to speak to the issue of access to mental health care as care providers working with a large number of Aboriginal clients in an urban centre. At the beginning of the focus group, a general introduction and explanation of the purpose of the research included reminders to the participants stressing that there were no correct or incorrect answers. After

the explanation of the purpose and process of the discussion was given, the participants were asked to introduce themselves. This gave all of the participants an opportunity to speak at the beginning of the interview. In addition, all of the participants were encouraged to participate in the discussion. Some of the same trigger questions were used as in the in-depth individual interviews with Aboriginal participants in the field, and as with the in-depth individual interviews, questions were modified in response to group input. However, given that these participants were part of a theoretical sample, I spent much of the time exploring earlier findings such as the issue of *invisibility*. Again, at the end of the interview, I asked the group if they had anything to add or if there was anything I had missed, to which they wanted to speak.

During the focus group interview, silence was used as much as possible to allow for individual expression (Sandelowski et al., 1989; Starzomski, 1997), and as the group progressed, I made modifications, as necessary, to the interview style. The focus group was audiotaped and transcribed verbatim. In order to assist with the technical problem of having multiple speakers, I made fieldnote jottings during the interview as an attempt to clarify who was speaking. This interview was conducted within the clinic setting in the time allotted for a staff meeting – approximately two hours in length. The staff provided refreshments which added to the informal ambiance of the interview.

### Policy Review/Critique

In addition to the interviews, several provincial mental health documents were reviewed/ critiqued including the 1998 Mental Health Plan, *Revitalizing and Rebalancing British Columbia's Mental Health System* (RRBC, 1998) as well as *the Best Practices in Mental Health in BC* documents. These seven documents include: Assertive Case

Management, (BC, 2000a), Consumer Involvement (BC, 2000b), Crisis

Response/Emergency Services (BC, 2000c), Family Support and Involvement (BC, 2000d),

Housing (BC, 2000e), Inpatient/Outpatient Services (BC, 2000f), Psychosocial Rehabilitation

(BC, 2000g). In addition, the draft document, *Guidelines for Elderly Mental Health Care*

*Planning for Best Practices for Health Authorities* (BC, 2001a), and the *Best Practices* Rural

and Remote document (BC, 2000h) were reviewed.

First I read through all of the documents mentioned above. Then I re-read them to see

if I was able to identify a language of reform and consider beliefs and values which reflected

particular positions and ideologies to provide a context for this research. Concepts and

themes were developed and used to code the data. These documents were reviewed

periodically and concepts and themes were revised as appropriate.

To summarize, the multiple forms and sources of data obtained in this study provided

detailed and rich information concerning the nature of the tensions and disjunctures.

Although participants were initially interviewed to inform particular questions, their

perspectives were not treated as discrete entities in the analysis of the data. Data from the in-

depth interviews with the Aboriginal participants, the policy-makers, and the nurses, and the

focus group interview were used to inform all levels of analysis, everyday practices,

ideologies and structures, and institutions and policies. Aboriginal and non-Aboriginal voices

were identified. Although this was not always the case, I did observe that grassroot providers

across both groups tended to focus their attention on access issues related to the everyday

exclusionary practices they experienced in their practice, whereas, the Aboriginal participants

who were in positions of leadership within their organizations tended to focus on access

issues related to the broader barriers such as a lack of resources and governance issues such

as the jurisdictional debate and self-governance at the policy level. As would be expected, the policy participants, Aboriginal and non-Aboriginal, spoke more directly to issues of inclusion and exclusion as they might relate to policy. However, although many of the questions were the same across the interviews, some were group specific. All of the participants focused attention on the tensions and disjunctures as primarily related to the exclusion of Aboriginal worldviews and knowledge.

## Data Analysis

According to Sandelowski (1995)

> Data collection, analysis, and interpretation are processes that overlap temporally and conceptually in qualitative work ...there is no clear line in qualitative work that can be drawn between analysis and interpretation, as the data preparation process itself triggers analysis and an analytic structure is often the basis for an interpretation. (p. 372)

As Denzin (1994) states, "[T]he thick descriptions and inscriptions create thick interpretation. Thick interpretations interpret thick descriptions, in terms of the local theories that are structuring people's experiences" (p. 506). The interpreter is always attempting to uncover the theories and show how they are working in the lives of the people being studied through the text (Denzin, 1994, 1997; Smith, 1992). Therefore, as mentioned earlier, the process of analysis involves an ongoing dialogue between the data and theory (Lather, 1991). "The search is for theory which grows out of context-embedded data, not in a way that automatically rejects a priori theory, but in a way that keeps preconceptions from distorting the logic of evidence" (Lather, p. 62).

In this study, an interpretive thematic analysis was completed using processes

described for qualitatively derived data (Anderson, 2001; Denzin, 1997; Sandelowski, 1995). In ethnographic work such as this, the stages of data collection and analysis do not occur in a linear fashion but rather are iterative processes (Anderson, 2000, p. 202). Therefore, although the following steps highlight the process of analysis used in this study, they were not necessarily sequential. Step 1: After each interview, I listened to the tape and then sent it out for transcription; I also transcribed the fieldnotes and reread them. Step 2: Once the tapes were transcribed they were checked for accuracy against the recording. Step 3: During the data collection period, I critiqued the documents of reform (noted above) in which I was able to identify a "language of reform" and consider beliefs and values which reflected particular positions and ideologies, as a preliminary step to providing a context for this research. Concepts and themes were developed and used to code the data. These documents were reviewed periodically and concepts and themes were revised as appropriate. Step 4: Once I had several interviews completed and the transcriptions had been returned, I began to read through the complete interviews and fieldnotes to identify recurring, converging, and contradictory patterns (Morse & Field, 1995; Sandelowski, 1995). Key concepts and preliminary emerging themes were recorded on the transcripts to inform the ongoing data collection process, and in particular, revisions of interview questions. In addition, possible linkages to theory were noted. Preliminary concepts and themes were developed and used to code the data, and, as more data was collected, were reviewed and revised as appropriate. All coding was done by me. Step 5: As the coded categories developed, I entered large portions of corresponding data into files under those headings as a means of organizing the data and providing easy access to it. Step 6: Clarification of the categories and concepts was achieved through ongoing interaction with the literature and with a couple of the participants with

whom I had regular contact. In an informal way, I spent time with several of the participants reflecting on the relevance of the categories and themes, and we frequently talked about them at length (Lather, 1991). I asked questions such as, "Does this particular category or concept fit for you?" I found these informal conversations invaluable and I am grateful to those who were interested enough to dialogue with me. These informal chats provided a dialectic between the data, the participants, and myself which assisted in raising new questions, gaining further information, testing preliminary themes, and looking for commonality and differences in themes among the participants' stories (Lather). This also assisted in reducing threats to verisimilitude (Denzin, 1995, 1997) and other forms of validity (Lather, 1991, 1993) in the work. Then, as the data analysis progressed, the questions shifted to focus more specifically on issues that the process of data analysis elucidated. For example, the issue of *institutional racism* was discussed in the context of everyday practices of mental health service delivery.

In all, I developed **12** categories, each composed of subcategories, reflecting the perspectives of the participants as they reflected on the nature of the tensions between Aboriginal understandings of and responses to mental health and illness and the current mental health system. The **12** categories were (1) Baseline data, for example, sociodemographic characteristics of participants; (2) Safety, for example, cultural, physical and emotional; (3) Ideology, for example, assimilation, paternalism, ethnocentrism and impartiality; (4) Racism, for example, institutional and individual; (5) Everyday Life, for example, normalization, resistance, hypervisibility, and invisibility; (6) Solutions, for example, relational, hybridity, recognition of difference and education; (7) Governance Structures, for example, jurisdictional debate and self-governance; (8) Mental Health Issues,

for example, addictions, depression and suicide; (9) Worldviews, for example, healing; (10) Education; (11) Acts of Omission, for example, language, lack of fit, worldview, education and working in a vacuum; and (12) Research Methodology. These categories were not discrete, meaning that the data were often coded into more that one category. This kind of categorization provided a way of organizing large quantities of narrative data and at the same time provided a framework for further analysis and discussion with several of the participants.

Ideally, more of the participants would have had input into how the data was constructed and presented and been able, in a more formal way, to inform descriptive and interpretive validity (Thorne et al., 1997). While I am aware that a limitation of this study was the inability to bring the analysis back to all of the participants due to time constraints and the nature and scope of dissertation research, I am grateful for the feedback and insights shared by the participants who did provide consultation time.

### Postcolonial [Critical] Discourse Analysis

To further assist with the interpretive process,[93] I engaged with aspects of postcolonial critical discourse analysis to assist with making the linkages between discursive formations and current social structures in the analysis of texts (Mills, 1997). Therefore, the rationale for the inclusion of discourse analysis is twofold: (1) as part of the researcher's commitment to a reflexive process, and (2) as a means of uncovering in the 'style' and subject matter of discourse, "the manner in which ideology is reproduced in them" (van Dijk, 1993, cited in Lupton, 1992, p. 145). Although the expressed view of the participant is of importance in this work, the addition of aspects of postcolonial and critical discourse analysis

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9 One of the criticisms of critical approaches to ethnography is that because praxis is foregrounded, the methodological side of interpretation is left unclear (Denzin, 1997, p. 63).

takes the reader beyond the textual expression to those factors that influence its production (Mills, 1997, p. 129).

Discourses provide another lens to the interpreter in locating the text as a reflection of social relations and as a means of constituting or constructing those relations (Fairclough, 1992, p. 3). In particular, in this project, the researcher is interested in "... how discourse is shaped by relations of power and ideologies and the effects discourse has upon social identities, social relations and systems of knowledge and belief, neither of which is normally apparent to discourse participants" (p. 12). Although not a simple application of Foucault's work, Fairclough (1992) demonstrates how an analysis of this kind is not simply about describing the various elements of interaction or highlighting the imposition of power in a particular situation, but rather about how it displays the complexity of the workings of power relations within society as a whole[94] (cited in Mills, 1997, p. 153). "In discourse, cultural values are enacted and social structures come alive" (Denzin, 1997, p. 38).

In this project, several documents of mental health reform were used to illuminate the workings of power within the mental health complex. Here as I read the texts, I asked questions such as: Who wrote this document? Was there a process of consultation? Why was it written? Who would benefit? Who was the target group? What resources are attached to it for its implementation? What are the important inclusions and exclusions? What are the central ideologies/ philosophical underpinnings?

In summary, data from policy documents, interviews, and fieldnotes were used in the analysis to create a composite description and critical analysis of the nature of the tensions

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[94] Fairclough (1992) acknowledges that his work has been influenced by Foucault and his notion that the social world is largely constructed through discourse as well as his interest in the relations between and within discourse structures (Mills, 1997).

and disjunctures between Aboriginal understandings of and responses to mental health and illness and the mental health system. Throughout, an auditable decision trail of analytic and interpretive pathways was maintained. Analysis continued until a synthesized account of the nature of the tensions and disjunctures was developed.

### Ensuring Scientific Quality

According to Denzin (1994) care must be taken *not* to legitimate a text's authority according to positivist or post positivist criteria. Regardless, in our efforts to produce useful social knowledge, that is, a text which will have an impact in the struggle for social justice, we must pursue rigor and relevance (Denzin; Lather, 1991; 1993). As Lather argues

> Our best tactic at present is to construct research designs that demand a vigorous self-reflexivity...For praxis-oriented researchers, going beyond predisposition in our empirical efforts requires new techniques and concepts for obtaining and defining trustworthy data. (p. 68)

In critical interpretive work, reflexivity appears to be the central means to achieving this goal: It is a dialectic process that engages both the researcher and the participant in a process of constructing and then exploring the extent to which (1) the text rings true or fits for them; (2) the researcher is able to create a research ambiance in which theory has been changed by "the logic of the data," yet remains non-impositional; (3) the researcher seeks both "counterpatterns and convergence"; and (4) the text invokes a commitment to action, however subtle or substantial (Lather, 1991).[95] According to Anderson (1989) reflexivity "involves a dialectic process among (a) the researcher's constructs, (b) the informant's

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[95] Referred to as face validity, construct validity, triangulation and catalytic validity respectively (Lather, 1991). However, I agree with Denzin (1997) that validity from a post positivist perspective tends to establish the text's authority by referring to a set of rules outside of the text (p. 6). It acts as the researcher's mask of authority (Lather, 1993, p. 674). Therefore, I prefer to talk about validity in terms of rigor and relevance.

commonsense constructs, (c) the research data, (d) the researcher's ideological biases, and (e) the structural and historical forces that informed the social constructions under study" (p. 254). It becomes an iterative process of examination, analysis, writing, and reflection in which the researcher is able to draw distinctions between these places by creating a dialogic between the theory and the data. Given the past exploitation of Aboriginal participants in research conducted by non-Aboriginal researchers, reflexivity holds particular importance in this kind of research (Anderson, 1991, 1998b).

Central to this kind of research process is the building of rapport in order to reduce the distance between the researcher and the participant – to have the kind of relationship conducive to ongoing dialogue. The researcher needs to have some assuredness that what is being presented by the participant is *significant*, an important criterion for scientific quality (Hall & Stevens, 1991, p. 22). Informed by Lather (1991), the interview methods in this study included several elements. First, attention was focused on those aspects of the participant's experiences that challenged my own preconceptions. For example, I reflected on my own ideas about *racism* and through the process of analyzing the data in this study was prompted to think about the complexity of social relations as per the intersection of *race*, *class*, and *gender* etc. Secondly, there was an educational aspect to the research process as it provided me with an opportunity for a reciprocal educational interaction through the exchange of ideas related to both the constraints and the potential for change, in relation to this research as I explored themes and concepts with the participants. For example, I was fortunate to have regular contact with several of the participants who reflected on the use of the concept of "cultural safety" with me. In this regard, in addition, one of the participants asked if I would present the concept at a conference as a means of checking out its

applicability within a Canadian context with Aboriginal peoples. Another participant was interested in the concept of "cultural safety" and asked if I would send her copies of some of the articles about it, which I did.

Thirdly, there was an opportunity for dialogue related to the contradictions in the participants' current understandings. Although there didn't seem to be too many contradictions within and across participant accounts, one of the most interesting for me was the use of *difference* – on the one hand *difference* was bifurcated into Aboriginal and non-Aboriginal, and on the other, *difference* was framed as problematic because it produced stereotypes and discrimination. Fourthly, I worked at creating a *safe* environment where participants could actually question my own ideology. As an example, a few of the participants made mention of their frustration with knowledge being created by non-Aboriginal people who come in from outside "to help" (Fieldnotes, RP9, RP11). Given my position as a non-Aboriginal female and nurse who is conducting this research as part of doctoral preparation, I asked the question – "well, how do you feel about what we are doing right now?" One of the participants in particular responded that she believed that, while Aboriginal and non-Aboriginal peoples needed to work in partnership in this area, non-Aboriginal people needed to be committed to listening to and taking the lead from Aboriginal people (Fieldnotes, RP9). Another participant relayed the following sentiment: "...to say that we as Aboriginal people can probably do it for ourselves, by ourselves... give us that faith and that belief and then let us, let us show you that we can" (P17). The participant went on to say that support was helpful but that *doing for* was not. Nonetheless, it remains impossible to definitively determine the authenticity of the response during interviews; this is a recognizable limitation of this kind of social inquiry.

Lastly in this project, I provided an opportunity to explore how to use this research with the participants. I discussed this with most of the participants during the interview phase of the data collection. I also continue to have dialogue with several of the participants in the study regarding this issue and when the final summary of the text is sent out I will request further input from the other participants (see "Research as Praxis" later in this chapter).

As I illustrate in subsequent chapters, the remarkable stories shared by participants and the candor with which they spoke reflect some comfort in the expression of their views. As Browne (2003) notes in her doctoral dissertation, this does not mean that the participants thought the research was necessarily important. However, many of the participants *did* express the view that Aboriginal mental health was one of the most important foci of Aboriginal health and one of the least well-served. Overall, my general impression was that the participants related to me in a genuine manner.

### Expected Outcomes: Research as Praxis

It is expected that results from this study will be used to inform understandings of Aboriginal mental health and the development of mental health policy and related Aboriginal mental health services. The text which has been created identifies and clarifies some of the issues that require special attention in relation to how policy development needs to intersect with issues of culture – the categories and conceptual themes as they have been elucidated by Aboriginal people within their local experience provide a part of the detail necessary to inform policy development.

As noted, Aboriginal participants and policy makers (both Aboriginal and non-Aboriginal) were interviewed during this project. I plan to spend time in consultation with them about the ways in which this text might be written, disseminated, and used to influence

policy decisions. National and provincial policy makers in mental health, for example, First Nations and Inuit Health Services, Health Canada; Native Mental Health Association of Canada; Adult Mental Health Services, BC Ministry of Health; Canadian Mental Health Association of BC; First Nations Chiefs Health Committee, BC; and, United Native Nations, BC, are some of the places we may consider in terms of dissemination of the executive summary of the final report, as well as the world wide web. The regional health authorities in the areas in which I conducted my research might also be a target group, including the Vancouver Coastal Health Authority. The Vancouver Native Health Society will receive a full copy of the final report of the dissertation, as will the Health Committee/Tribal Councils on reserve.

A summary of the findings will be submitted for publication to selected regional, provincial, and national health care agency newsletters as well as practice journals, as appropriate.[96] All participants in the study will receive a summary of the project findings.

### Ethical Considerations

This research was approved by the UBC ethics review process. Informed consent was obtained from participants prior to the initiation of the interviews (Appendix B). All consent forms were signed in keeping with the Ethics of Conducting Human Research. All participants were informed about the nature of the project. All were told their participation was voluntary and that they could withdraw at any time and/or refuse any questions. As noted earlier, during two interviews, the participants requested that the tape be turned off while relaying a particular story – these stories were not documented or referenced in any way. The participants were told that all information was confidential and that their anonymity

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[96] I discussed how the participants would like the data to be used prior to the initiation of the study and will do so again at the conclusion of the writing of the dissertation.

would be protected by assigning an individual code to all participant data (tapes, transcripts, computer files, fieldnotes, and written reports). To maintain anonymity, the gender of the participants was not disclosed. In addition, I re-contacted a couple of participants to be sure I could use a particular narrative because of the concern that they might be identified. Names and addresses of the participants are known only to me. At the completion of the project, all identifying information will be destroyed. Data is kept in a locked cabinet in my home. In all dissertation materials, quotations from the participants are anonymous (none of the participants indicated to do otherwise). The data will not be destroyed but will be retained for my exclusive use, subject to approval using standard procedures.

## Limitations of the Study

There is considerable heterogeneity across Aboriginal communities in Canada, and in particular, in BC. Differences also exist in terms of urban and rural experiences. Given the small number of participants in the study, I do not expect to necessarily capture those differences.

## Reflexive Considerations: The Location of the Researcher

Postcolonial theories remind us that when we enter debates in relation to Aboriginal policy we need to be aware of the historical locatedness of our actions, and of the real and material consequences of our decisions in terms of the lives of Indigenous peoples, in particular, and all [Canadians][97] in general (McConaghy, 1997, p. 77). We also need to be aware that the policies and practices that we engage in today have the potential to be oppressive or non-oppressive in their consequences and that the negative affects will be felt more profoundly by some than by others (p. 77).

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[97] McConaghy (1997) is speaking about Australia. Here, I transported this idea into the Canadian context.

As Linda Tuhiwai Smith (1999) reminds us, scientific research has often been one of the "worst excesses of colonialism," still felt acutely today (p. 1). Forms of colonization may be so subtle "that even those with the best intentions and supposedly critical approaches fail to see that they continue to serve the dominant ideology" (Haig-Brown, 1992, p. 105). Given the history of exploitation of communities in past academic research (O'Neil, et al., 1999), the expropriation of knowledge from Aboriginal communities (Tuhiwai Smith, 1999) and the long history of domination in the area of Aboriginal research by non-Aboriginal researchers, it is incumbent upon me as a Euro-Canadian middle-class woman to reflect upon my responsibility as a researcher in this field in an ongoing fashion.

As mentioned in Chapter Three, a basic question posed by several postcolonial scholars (Battiste, 2000; LaRocque, 1996; McConaghy, 1997; Reimer Kirkham & Anderson, 2002; Tuhiwai Smith, 1999) is whether or not "White" researchers, as members of the dominant culture, can do this work – do they have the "right" to "speak" (Spivak, 1994). Can they "truly understand the experiences of racialization and racism..." (Reimer Kirkham & Anderson, 2002) and can they hear and understand what Chakrovorty Spivak (1994) refers to as the "subaltern" voice. Reimer Kirkham and Anderson (2002) argue that "[a]t its most basic level postcolonialism demands the right to speak rather than being spoken for, and to represent oneself rather than being represented, or, in the extreme cases, rather than being erased entirely" (Reimer Kirkham, 2002, p. 12). Therefore, the challenge posed is for nursing scholars to make nursing knowledge representative, not only of the dominant majority, but also of those who have until now found themselves on the margins, by working to make possible the expression of subaltern perspectives (p. 12).

Further to these issues, inquiry from a postcolonial (Reimer Kirkham & Anderson, 2002) and critical (Lather, 1991) perspective is, of necessity, reflexive. Lather, for example, suggests that "an empancipatory social research calls for empowering approaches to research where both researcher and researched become ... 'the changer and the changed'" (Lather, p. 56). I understand the privilege that being a nurse, and more recently an academic, affords me in terms of the politics of knowledge production (Reimer Kirkham et al., 2000) and the accompanying responsibility. In this regard, I turn now to a personal experience.

It was only after beginning my doctoral studies that I entered into the area of Aboriginal mental health. Because I had worked in mental health for many years, when I began my studies, a friend and colleague asked if I would be interested in assisting with addressing the need for mental health services for Aboriginal people in BC within the agency he directs. Initially, I approached this idea with considerable reticence because of my lack of formal education and experience in the area of Aboriginal health and because, quite frankly, I was afraid of doing more harm than good. However, concurrent with the early discussions with my colleague, I had the good fortune of meeting several Aboriginal people who encouraged my interest (which began with an invitation to become a member of the planning team for a local Aboriginal Mental Health conference) and at the same time fanned my inner caution. This beginning work was not without mistakes.

In my naiveté, I agreed to facilitate a meeting to bring together a representative group of people working in the area of Aboriginal mental health to discuss the issue of mental health service delivery for Aboriginal people in BC. Although everyone invited came to the meeting and were polite to me, it was clear that I had offended several of the people there by assuming control as initiator and facilitator of such a meeting. I realized later that I had

unwittingly been complicit in a colonial form of "paternalism" (Narayan, 1995, p.134) and in the very practices I was just beginning to comprehend through my studies and new found alliances. While I didn't pull out of the work, I did step back into a position of support as deemed appropriate by the membership. As a consequence of this experience and of my learning since then, in the process of this research project, I have continued to ask questions including: Is there any way in which *this* research is just another form of academic colonization (Reimer Kirkham et al., 2002, p. 230)?; and/or Is this research in some way reproducing hegemony? Informed by a postcolonial perspective and the lens of 'cultural safety', I continue to ask these and other questions (see Chapter Three). Of course, the questions are not easily answered due to the complexity of the issues, but there are strategies offered through the process of reflexive practice that I have employed in this study, beginning with my relationship with the participants.

During the course of each encounter with participants, I worked towards ensuring an interaction that was both reciprocal and dialectical. Oakley (1981) emphasizes the importance of a dialogic rather than hierarchical interaction. She cautions the researcher to pay close attention to any tendency to create the interviewer-self as expert (part of a hierarchical stance and contrary to Aboriginal views). Lather (1991) also emphasizes the dialogic, give-and-take nature of reciprocity as a "mutual negotiation between meaning and power." In this way, reciprocity operates as the nexus point between the researcher and participant(s) *and* between the data and theory (p. 57). Informed by Oakley and Lather, I used several strategies towards enacting reciprocity in research including (1) engaging in an interactive dialogic manner that included self-disclosure; (2) continuing contact with some of the participants which focused on exploring some of the research issues in more depth; and

(3) as noted earlier, continuing to negotiate meaning by "recycling description, emerging analysis, and conclusions to at least a subsample of participants" (Lather, 1991, pp. 60-61). In addition, in this study, I interviewed Aboriginal people with a range of experiences and knowledge, listening carefully to their accounts, and reproducing their stories verbatim throughout this dissertation (Reimer Kirkham & Anderson, 2002). The voices of Aboriginal people were foregrounded (Haig-Brown & Archibald, 1996), providing the entry point of the analysis. Nevertheless, I understand that the interpretations of Aboriginal perspectives and the findings I present are filtered through my interpretive lens as the researcher. This is a limitation one must accept as part and parcel of social inquiry (Anderson, 1998; Browne, 2003; Smith, 1987), but a position that I remain mindful of in terms of issues of domination and subjugation.

I continue to be aware that my own location in social relations related to my gender, race, class, and other positionings will always frame what I see (Dyck, 1998). In this regard, McConaghy (1997) also argues for engagement with reflexive practice to assist the human science researcher in avoiding the trap of assigning identity and categorizing human existence (p. 82). While there needs to be a way to discuss *real* differences between groups, we must do so without sliding into an attachment of fixed identities and them-us bifurcations. Gandhi (1998) notes this tension in her critique of Said's "Orientalism":

> Sometimes, in this obdurate determination that Orientalism silenced opposition, Said ironically silences opposition. So also he defeats the logic of his own intellectual egalitarianism by producing and confirming a reversed stereotype: the racist Westerner. After Orientalism, it becomes our task not only to demonstrate

the ambivalence of the Oriental stereotype, but also-and crucially-to refuse the pleasures of an Occidental stereotype. (p. 79)

Furniss (1999) also comments on the problem of on the one hand, idealizing Aboriginal/ non-Aboriginal differences, or, on the other, denying them. As she observes, both discourses are "central dynamics within colonial discourses and practices" that can serve to further compartmentalize and marginalize (p. 13) – a tension that is ever-present in the writing of this research. As I continue to make sense of these issues, my goal is twofold: (1) to unmask the ideological and structural formations that contribute to the barriers to mental health care for many (but certainly not all) Aboriginal people, and (2) to "use generalizations heuristically to highlight historical and colonial patterns of relations, and at the same time, leave room for "attention to differences and particularities of context"" (Narayan, 2000, p. 97, cited in Browne, 2003).

### Concluding Comments

Borrowing from the imagery of Franz Fanon, Duran and Duran (2000), Aboriginal psychologists, discuss the "lactification" or whitening of the production of knowledge in order for it to be palatable to the academy, a form of ongoing epistemic colonialism/ violence. They caution against "cross-cultural" research conducted through the inoculated gaze of disciplines whose discourses are founded on the premise of the universal subject – "the subject of a historical project of emancipation via reason" (p. 87) – whereby western subjectivity and consequent hegemony is again imposed on Aboriginal peoples. They argue for a postcolonial paradigm in which knowledges from differing cosmologies would be considered credible in their own right without having "to adhere to a separate cultural body for legitimacy" (p. 87). By examining my own assumptions, motivations, and positionality-

through journaling, fieldnote jottings, reflective analysis, ongoing discussions with several of my participants, supervisor, dissertation committee members and colleagues – I have attempted to remain cognizant of my identity and responsibility throughout the research process at all stages, recognizing the challenge that Duran and Duran pose. The analyses I present in the following chapters foreground the tensions these writers highlight. It is my hope that this research might be a step in the direction of their vision for transformations which will "open the door for different/ other models of healing, normalcy and identity" (p. 87).

# CHAPTER FIVE

## IDEOLOGIES AND STRUCTURES: THE SCAFFOLDING

In Chapter Four, I described the thematic categories. Here, in making sense of the data, I look to the ideological underpinnings of institutional polices and everyday practices. In examining the data and as a means of organizing the analysis, I ask one central question: why are there tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system? Using the voices of the participants and examples from the policy analysis, in this chapter, I examine the notion of ideology and how it works.

As the analysis unfolds, it becomes apparent that the ideologies central to the process of colonization and the way in which "Aboriginal" has been constructed are the basis of the tensions and disjunctures being examined. Some of the most poignant accounts of participants in this study and the review/critique of several documents of mental health reform revealed the embeddedness of colonial ideology and, in particular, assimilation. As noted in earlier chapters, an assimilationist ethos underpinned the colonization process and many argue continues to do so today. Therefore, it was not surprising that the various manifestations of assimilation were discussed most often across the interviews. Examination of the interviews revealed three broad categories, which I discuss in detail: (a) paternalistic care, (b) ethnocentrism, and (c) [im]partiality. Later, in Chapter Six, I note how institutional practices and policies support the embeddedness of ideologies, and in Chapter Seven, how everyday practices do the same. Notably, although these micro, meso, and macro level processes are written into three separate chapters, they are not discrete entities but rather intertwining ones.

## Drawing on Theories of Ideology

In the following interview addendum, written by an Aboriginal policy participant and sent to the researcher a few days post interview, the participant shares an example from a life experience that illustrates the notion of ideology in the workings of institutional and everyday life:

> <u>Someone in authority decided</u>[98] that I needed something [speech therapy] and gave it to me. <u>I wasn't consulted</u>. I'm sure if the decision maker was asked about why they provided this service to me they would think it was a good thing, something to help this kid be accepted in the world, help her to communicate, not be made fun of by others in the school, etc. I doubt they wondered how I felt about it or how I was interpreting their actions- because they believed they were doing something good for me. I'm sure that's what they conveyed to my parents – if in fact they gave their 'informed' consent for this service. So after 2 years of speech therapy I spoke more like the other students in my non-aboriginal schools and less like my family [who spoke with an 'Aboriginal' accent]. Teasing from school decreased while teasing from extended family increased. I was different – trying to be better than everyone else, act white. This enhanced family disharmony and a sense of cultural displacement. It has influenced my life in both subtle and obvious ways for over three decades now. <u>While the decision maker was right that speech therapy to learn to speak like the mainstream society around me helped in selected</u>

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[98] Because some of the narratives are long, I have underlined particular aspects to draw the attention of the reader to them. In addition, the participants are identified at the end of each narrative through a code identifier – (RP) refers to the Aboriginal participants working in mental health and related fields; (P) refers to the policy participants; (F) refers to the focus group participants; and (N) refers to the nurse participants. The number beside each code identifier is a number signifier for the actual participant's name. This system has provided a means of tracking the transcript references.

ways, it also had other effects that (probably) weren't expected or planned for. They didn't consider cultural norms or internal family effects on roles and relationships. My experience with many policy makers and service providers is that they don't think outside their area of academic expertise in the development of policy. They may not have personal or community experience with the issue therefore don't consider other than the obvious consequences. The valuing of the scientific process in Western society minimizes the analysis of individual human complexity and subtlety into group trends and population data. For a culture that values individual contribution to the group dynamic and function, the scientific process feels dehumanising, patronizing and patriarchal. When whole groups of policy makers act blindly over a long period of time without making efforts to address or understand both the obvious and subtle effects of their work, especially as it pertains to one ethnic group, that both feels and appears to me to be institutionalized racism. But it is so much a part of Western societal functioning and expectations of function that it is invisible except to the oppressed and those sensitised to oppression. Have you ever used those old hand powered meat grinders that you put meat in the top and it comes out hamburger? Mainstream society is like that meat grinder. We're all tossed in the top, chewed up by the actions of the meat next to us and the structure that squishes us into homogenous little pieces spit out the end. Add a little flavouring, a little colouring, bind us together with a little egg white and we make nice little comforting hamburgers. Except when the cooker is too hot and we burn or [the hamburgers are] too cold and we make everyone sick....(P19)

How do we make sense of this data? To begin, I would ask why this "authority" was compelled to make the decision to provide speech therapy to an Aboriginal child (in grade one) as treatment for an "Aboriginal accent." First, it suggests that the authority thought he/she possessed special knowledge about what was best for the child, what might be deemed as "paternalistic care" (Narayan, 1995). Secondly, we could surmise that the authority figure believed Aboriginal language required remediation. Speaking English a particular way was privileged – it was important for the child to fit within a dominant culture framework. Finally, all of the decisions were made without regard for the possible adverse consequences of determinations that fail to consider the unique characteristics of a specific group of people, including the beliefs and values that bind them, within the context of their community. In particular, the importance of Aboriginal language to the inner workings of the participant's life was ignored. Dominant ideology is so embedded as to render it invisible to the oppressor – however, to this participant it is transparent and inauspiciously linked to "institutionalized racism" – a kind of taken-for-granted underpinning of this account.

Making use of Marx and Engels's early formulation of ideology, Smith (1987) posits the notion of ideology as the ideas, images, symbols, concepts, and vocabularies which order, organize and sanction the "ruling relations" in our society and act as the medium for the way in which ideas, specialized practices, and social relations are organized and operate in everyday life (pp. 54-55). In a similar vein and prompted by the varying debates that Marxist thinking has engendered regarding ideology, Hall (1997) advances the notion of ideology as the way in which different classes and social groups make sense of their social world through a variety of "mental frameworks" and systems of representation (p. 26). In this way ideology influences the ways in which people interpret social, cultural, political, and economic

systems and structures (Fleras & Elliott, 1992). As revealed in the previous account,

colonialist ideology infiltrates educational systems to the extent that Aboriginal language and

speech patterns are seen as defective and consequently the effort is made to eliminate them:

This harkens back to a time when all traces of Aboriginal languages were rooted out as part

of a colonialist agenda to create cultural conformity, a process driven by an ideology of

assimilation, underpinned by a belief in the superiority of the colonizers' worldview

(Chrisjohn & Young, 1997; Kelm, 1998; Wade, 1995). The narrative above suggests an

*embeddedness* of practice within this particular ideological framework which has become

common sense or taken-for-granted – in short, hegemony[99] (Hall, 1997; Omi & Winant,

2002).

Hegemony to some extent explains the pervasiveness of the notion of European

cultural supremacy (Said, 1978). The attempt to eradicate Aboriginal language and cultural

practices played an essential role in the assimilation process, or what Lee and Cardinal

(1998) call "the unification of people into a common consciousness" (p. 217). However,

hegemony is not static. It is constantly challenged through counter-hegemonic ideas and

practices, and it is constantly changing in response to ever-shifting social, political,

economic, and historical contexts. In relation to this dynamism, Lee and Cardinal draw

attention to the feminist movement as situated within the discourses and practices of

hegemonic nationalism, as part of a hegemonic project itself, rather than being located

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[99] Gramsci (1971) was instrumental in shaping our current understanding of 'hegemony' as the power of the ruling class to dominate a subordinate group without force or necessarily coercion/persuasion, but rather, generally accomplished by a more subtle and inclusive power over the economy and state apparatuses such as education as well as in the critical domains of cultural, moral, ethical, political and intellectual leadership (Omi & Winant, 2002, p. 130).

outside Anglo-Canadian authority/control.[100] In this way, the state[101] becomes a central agent

of hegemonic dominance (p. 217).

It is through this kind of social control that colonization has worked to subjugate the

lives of Aboriginal people. In the interview addendum above, the participant's narrative

points to the embeddedness of colonial authority and control vis à vis the educational system

which profoundly affects the participant's life and impacts the mental health of a population

of people. Recall the participant's words: "While the decision maker was right that speech

therapy to learn to speak like the mainstream society around me helped in selected ways, it

also had other effects that (probably) weren't expected or planned for. They didn't consider

cultural norms or internal family effects on roles and relationships."

Ideology emerges as a pervasive issue in this study. It becomes an interpretive and

analytic lens for understanding the nature of the tensions and disjunctures between

Aboriginal understandings of and responses to mental health and illness and the current

mental health system.[102] I now turn to discuss three aspects of the ideology of assimilation as

revealed in the data (paternalistic care, ethnocentrism, and impartiality) all interconnected

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[100] It is precisely because of this location that the feminist movement became aligned with the interests of white middle class women and was criticized for the ways in which it ignored the plight of those women at the margins, such as Aboriginal and immigrant women. As the voices and actions of marginalized women hastened a repositioning in the cultural boundaries of Anglo-Canadian nationalism, neo-conservatives attempted to render feminist activists as threats to 'the' nation (Lee & Cardinal, 1998, p. 217).

[101] Lee and Cardinal (1998) refer to the term 'state' as ever-changing, historically mediated and a site of contestation and struggle. It includes "all levels of government, institutions and agencies, policies, procedures and regulations as well as state agents who initiate, implement, manage, and represent the state" (p. 238). I use the term 'state' in the same way.

[102] Here I am not suggesting that ideology is always oppressive to others. We all have ideologies which are ever-present. But rather, I am suggesting that we need to identify and recognize ideologies to understand power relations.

with an assimilationist ethos and the way in which "Aboriginal" has been constructed in the history of the Canadian nation.[103]

**Promoting the Welfare of the Colonized: "Paternalistic Care"**

In this study, discussion of tensions and disjunctures inevitably led to the way in which the Aboriginal participants perceived how their lives remain under the control of the Canadian state, particularly in relation to the *Indian Act* and its administrative arm, Indian Affairs. However, this relationship in and of itself is not a straightforward one. An Aboriginal participant working as a director in an urban Aboriginal wellness program and providing leadership in a number of ways in the community, describes this complexity as it exists today:

> P: Well I think the *Indian Act* in some ways keeps us in a position of co-dependence, or dependency on some resources - for some government to take care of us, right? However it does separate us and it does restrict us and <u>band resolutions are required to decide if we want to have somebody join our tribe and things like that</u> ...
>
> R: It's a recognition of your nationhood in a sense?
>
> P: Yes. (RP8)

While this participant acknowledges how dominant interests are sustained and reproduced by the enactment of the *Act*, there is also an acknowledgment of the way in which the *Act* has served to paradoxically raise the profile of Aboriginal peoples as a distinct group. Although the *Indian Act* continues to exercise sole power over who shall be recognized as "Indian" and the criteria by which Indian status can be gained or lost (Fiske, 1995, p. 5), this participant's response highlights the existence of a tension imbued in this arrangement. In the following

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[103] Although I discuss these categories as discrete entities, they are interdependent and as such interwoven.

interview excerpt with an Aboriginal participant in this study, the interviewee describes one dimension of this tension, outside administration of a federally-funded health promotion program in an urban area. In the participant's experience as the local program administrator, this is an example of an all too frequent paternalism that occurs in the administration of Aboriginal health programs:

> P :... we had a very good site, you know, set up in an excellent manner and Health Canada had a bureaucrat who used to work for the coast guard down in Jamaica or something like that [and then] became a Health Canada bureaucrat. We found out later that they were just trying to get rid of him. Health Canada had to take him on because of some kind of government policy around employees. He wound up being the guy overseeing our [program] here .... unfortunately for lack of a better word, [he is] a damn racist and he was in charge of how our program dollars were going to flow ... He was the one that said yes, it's okay, or no, it's not, and the President of *Name of Organization*, finally kicked him out of his office when he said, <u>just listen to me and I'll tell you how to take care of your kids</u>. That was two years ago ... (RP3)

Here the participant conveys a couple of issues related to the way in which paternalism is enacted. First, the federal program-funding representative who oversees the operation of the program from outside sometimes has only a little or no knowledge of Aboriginal culture and programs. Secondly, relationally, there is seemingly little trust from outside that Aboriginal local administrators know what they are doing, (i.e., that they can manage a program and

funding appropriately and responsibly).[104] In this case, the local Aboriginal programmer experienced the outside administrator as paternalistic and "racist."

The tension created here is multi-layered, tied to an ideology of Western superiority reminiscent, historically, of the Indian Agent[105] coming in from the outside to make decisions about programs without respect for or knowledge of the insider perspective. Unfortunately, in this particular case, the program was paralyzed by the actions of the outside government official who made decisions about the destiny of the program without prior knowledge and adequate consultation.

As mentioned in Chapter Two, the construction of the colonized as "childish" and "inferior" subjects justified the denial of their rights and legitimized the need for paternalistic guidance and rule by their "superiors" (Kelm, 1998; Narayan, 1995; Ponting, 1997; Said, 1993). Said writes,

> [n]either imperialism nor colonialism is a simple act of accumulation and
> acquisition. Both are supported and perhaps even impelled by impressive
> ideological formations that include notions that certain territories and people
> *require* and beseech domination, as well as forms of knowledge affiliated with
> domination. (p. 9)

The colonizing project was seen as "being *in the interests of, for the good of,* and as *promoting the welfare of* the colonized-notions that draw our attention to the colonialist care

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[104] While there has been mismanagement of health funds in some Aboriginal communities, many have functioned extremely well. In addition it is important to note that Aboriginal governing bodies do not have a monopoly on mismanaging funds.

[105] In the 1950s in British Columbia, "band councilors and even chiefs were expected to stand, hat in hand, outside the Agent's office waiting for an audience. When the people went to town, they walked with their eyes downcast to avoid making eye contact with whites, not so much because they feared an attack…but simply to avoid the insulting glance they would get in return" (McFarlane, 1993, cited in Cairns, 2000, pp. 65-66 ). While not all Indian agents were uninformed etc., it was the overall oppressive nature of this relationship that was so devastating to Aboriginal cultures.

discourse whose terms have some resonance with those of some contemporary strands of the ethic of care" (Narayan, 1995, p. 134). While Narayan acknowledges the powerful economic motivations underlying colonialism (and slavery), she asserts the view that the justifications for colonialism, in terms of crude self-interest, seem to have been rare, but rather "were made morally palatable by the rhetoric of responsibility and care" for the colonized Others. Therefore, Narayan argues for a critical examination of contemporary care discourses, understanding that although care discourses insist on acknowledging human needs and relationships, historically, notions of "care" also "justified relationships of power and domination between *groups of people*" (p. 135).

In the following interview excerpt, an Aboriginal participant who directs an Aboriginal health program reports on the planning of an Aboriginal Healing Centre in an urban centre.

> P: One of the main recommendations [of the Aboriginal Health Report, 1999] was to create an Aboriginal Healing Centre ... and you know, there's nothing wrong with the notion but it's not going to be anything like as if we ourselves were creating it.... They were allowing [a bunch of Aboriginal people] to be involved in its creation but in all of the literature I've read on it, there is not one shred of evidence that they're thinking of some kind of governance structure for it other than what exists... So that's a big ploy there.... And I can see that being yet another source of tension because [although] there may be people out there who are less cynical, who might be looking forward to the day that it begins to operate, I can't see [this] being anywhere near as successful as it should be if it were

allowed to be governed by the people who it's supposed to serve...not only its

management structure, I think ownership. (RP5)

Here the participant notes that while the Aboriginal Health Centre is on the books in the

region, its governance is entangled in the web of dominant bureaucratic machinations and as

such governance from outside. While it is the expectation that the Aboriginal Health Centre

will provide services that fit for many Aboriginal peoples, full Aboriginal control and/or

ownership is not in the plan.

In this study, "paternalistic care" was often discussed by the participants in terms of

governance structures. Many participants reported that although some Aboriginal health

programs were being funded and others were being planned, their governance most often

remained under non-Aboriginal control. Another Aboriginal participant, who works as an

educator and director of an Aboriginal health agency, provides a perspective on the issue of

self-governance with the researcher in the context of discussing the referendum on treaty

rights in BC:

> P: It is a demonstration of the embeddedness of attitudes that continue to keep
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> First Nations and other Aboriginal peoples under control, keep them in a state of
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> conformity because their government's institutions are not being acknowledged,
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> not being supported or encouraged. The need for them, the need for our
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> community is to become self-governing really. It is a vision for the future, that is
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> not based on this referendum – if you really look at the implications of it, anything
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> where we do something to be unique and different, and proud and tall and to be
>
> able to walk proud and tall, it's really not being valued or encouraged. What they
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> want is for us to be good little Indians basically, and it's not working well because

> more and more of us are beginning to understand the politics of our lives, our whole existence is political. The more we begin to understand the effects of our history that have led to institutional racism, the quicker we're going to be able to find strategies that will help us to learn how to manage our lives in a way that has the least negative effect on what it is that we're living as life. (RP6)

In contrast to the assimilationist ethos still alive today, the major policy goal of Aboriginal organizations since the 1970s has been the recognition of the inherent right of self-government (Cairns, 2000; O'Neil et al., 1999), and today, "in every province and territory, Aboriginal people are designing, implementing, and evaluating programs for their own communities … New forms of self-governing arrangements have been emerging, particularly in the last decade" (Hylton, 1999, p. 433); consider, for example, the completion of formal self-governing arrangements between Aboriginal nations and Canadian governments, which includes, among many, the conclusion of arrangements within the context of the recent Nisga'a Treaty in British Columbia (p. 433) and Nunavut.

Nevertheless, the narrative above and several other accounts in this study suggest that there continues to be a significant lack of acknowledgement of Aboriginal governance. The participant here identifies this problem (and the recent referendum in BC) as "institutional racism" with an assimilationist intent. According to Williams (1985) institutional racism is defined as "those established laws and practices which systematically reflect and produce racial inequalities in American society." Importantly, an institution is racist if "racist consequences accrue," regardless of whether or not there was intention involved (p. 323). In addition, recall the words in the first narrative: "When whole groups of policy makers act blindly over a long period of time without making efforts to address or understand both the

obvious and subtle effects of their work, especially as it pertains to one ethnic group, that both feels and appears to me to be institutionalized racism." These accounts suggest that an assimilationist intent, and particularly paternalism, may inadvertently blind policy makers and others working within our large institutional structures to the pervasive effects of their exclusions.

In the following account, an Aboriginal participant, directing an Aboriginal health agency in an urban centre, comments on the positive effects of autonomous programming arrangements:

> P: I'm both daunted by the task that we're trying to do, particularly in the area of health generally, but also in mental health, and at the same time I'm buoyed up about just being able to contribute and being able to finally be involved with a semi-autonomous organization that has some latitude to be able to [incorporate practices that fit for Aboriginal peoples]. (RP5)

Here the participant notes the importance of movement in the direction of governing arrangements that promote autonomous functioning and services that fit for Aboriginal peoples. As the organization in which this participant works has developed and grown it has become increasingly self-directed and as such shifted its services to fit with the needs of its large Aboriginal population. The same participant goes on to explain the importance of this as follows

> P: ...[Aboriginal peoples] have always managed somehow to find a way to try and deal with our own problems, you know, be it at a local level or a more regional level or even a provincial or national level and that's been one of the things that keeps the interest high amongst our people and may contribute to the tension too,

because people who aren't aware of our history would see that as a threat or see it

as a way for us to get more money and that kind of thing so … (RP5)

Again, the participant shares a perspective on an aspect of the tension tied to Aboriginal need

for independent functioning, a need that might be negatively perceived given the

embeddedness of practices within particular ideological frameworks, (i.e., the containment of

Aboriginal autonomy, or "conformity," within an assimilationist ideology). Many in this

study recounted incidents in which others misunderstood the intent of Aboriginal autonomy

and aspirations, for example, "racism towards Aboriginal people has been since time

immemorial, you know, the assumptions that we get a free ride, that everything is free to

us…so that has a lot to do with our mental health and how it's developed" (RP1). In

describing why there is a tension, this participant recounts a commonly expressed attitude,

understanding it as "racist." This and other similar excerpts suggest the importance of

unraveling the ideological underpinnings of institutions and policies that may act as barriers

to the recognition and promotion of Aboriginality. Everyday practices within institutions

(such as this kind of attitude, often freely expressed) shape ideologies and vice versa,

profoundly affecting the mental health of many Aboriginal peoples.

Along slightly different lines, an Aboriginal policy participant with responsibility for

several Aboriginal health portfolios discussed the problem of bypassing Aboriginal authority

and expertise *within* government institutions.

P: [The bypassing of the Aboriginal mental health program people within the

Ministry of Health] is an example of what we have been discussing. You know

that the people with the expertise around those issues are the academics, whether

or not they know anything about Aboriginal life or not, they're the ones who are

going to do something for those Aboriginal people, which is good that something is happening, but it's where it comes from, how it comes [that makes it a problem or not]... We've had more than enough patronizing. You know we have skilled people, we have knowledgeable people, we have educated people and although they may not come from the same roots of development as the non Aboriginal people, that doesn't mean they're less skilled or not able to take the lead on something or provide accurate perceptions. You know, the other thing we get is, well you're an Aboriginal person, so you're biased and so your opinion is skewed on this issue. (P19)

The participant draws attention to the way in which Aboriginal knowledge is subjugated within the ranks of government structures. The presence of Aboriginal persons does not guarantee that their expertise will be acknowledged. Although it could be argued that the bypassing of people within government is not only about Aboriginal people per se, in this case, a colonial history and the continued frequency of its occurrence renders it suspect as a neocolonialist and paternalistic practice. Pertaining to this excerpt, although there was an Aboriginal policy person allocated to address Aboriginal mental health issues, a consultant from outside was brought in by another division to assist in organizing a provincial response to the issue of Aboriginal mental health in BC, unbeknownst to the Aboriginal person. Although someone in authority wanted to do something to be helpful, this action unwittingly had the effect of increasing the tension between parties. In fact, most of the Aboriginal people asked to take part in this group expressed a great deal of anger about it and initially several refused to participate (Fieldnotes, July 9, 1999).

According to several authors (Cairns, 2000; Furniss, 1999; Henry et al., 2000;

Ponting, 1997, 2001) and supported by the findings of this study, "paternalistic caring"

(Narayan, 1995) is still evident in policy today. The expectation that Aboriginal people need

to be governed and protected as "wards of the state" reflects a deeply-rooted cultural

prejudice – one embedded in a long history of Aboriginal dependency on the Canadian State

cultivated within the colonial project. In the early years of the 19th century, Aboriginal

resistance to being assimilated into a European value structure was viewed as a sign of being

inherently inferior and incapable of self-governance[106] (Elliott & Foster, 1995; Kelm, 1998;

Henry et al., 2000). The strongly held belief in European racial and cultural superiority

coupled with a shift in economic development from a commercially-based economy, reliant

on the fur trade and natural resources, to an agriculturally-based and later an industrially-

based economy, led to expansionary settlement, increasingly intrusive colonizing measures

(Henry et al., pp. 125-127), and "welfare colonialism." Even today, Ponting (2001) suggests

that the *Indian Act* approximates what sociologists call a "total institution"[107]:

> It not only establishes a system of dependency and control in which Indians are at
>
> the mercy of a paternalistic institution (the Department of Indian Affairs and
>
> Northern Development and its minister), but also operates to change the very
>
> identity of those who are subjected to it. (p. 41)

Cultural practices embedded in the discourses of religion, philosophy, science, and

art, collaborate to instill and make sense of the "Western superiority part of the collective

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[106] After the war of 1812 with the United States, British colonizers no longer required Aboriginal peoples as allies, explorers or traders. Instead, Aboriginal tribes came to be viewed as an obstacle to the progressive settlement of Canadian society (Elliott & Foster, 1995).

[107] "Total institution," a term used by Goffman (1961/1997), refers to institutional care (as provided in asylums) in which the residents had every aspect of their life managed and evaluated. Indian residential schools could be easily likened to a "total institution." Ponting (1997, 2001) has extended this notion of the residential institution to a social institution, referring to the extent of the colonial gaze cast by the *Indian Act* and the pernicious effects on Aboriginal identities.

worldview of people in the colonizing countries" thus sustaining the paternalistic moral vision of colonialism (Narayan, 1995, p. 134). As Said (1993) argued, imperialist superiority[108] permeates the whole culture of the imperial center. The colonial project was one in which the colonizers, as agents of Western civilization and enlightenment, were on a mission of obligation and responsibility to bring "the light of civilization" and progress to others inhabiting "areas of darkness" (Narayan, 1995, p. 135).

Although evident in a slightly different form, paternalism as it relates to Aboriginal health and social policy today remains strongly tied to *power over* relationships. An Aboriginal participant who directs and consults in the area of Aboriginal health nationally, provincially, and regionally, discussed the relational aspect of governance with the researcher as follows:

> P: I think [the tension] has quite a lot to do with life experiences of the people, at the interface, that have not resulted in the conditions necessary for genuine partnerships... The Royal Commission on Aboriginal peoples, in their study, talked about partnerships as being really important and being characterized by mutual recognition, mutual respect, sharing and mutual responsibility and frankly I've not seen much of it myself in my lifetime and see even less of when it's a larger group, community or an agency... It's an undeveloped challenge. [Partnership] doesn't really exist federally... I don't think it really exists either between federal departments and government or between federal departments, the

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[108] Cairns (2000) states that in the belief structure of European imperialism, "imperial rule was sustained by a cultural (and often racial) hierarchical worldview that placed European civilization at the top, and the cultures of Asia and the middle East in the middle, and tribal peoples – often thought of as surviving examples of the childhood of the human race – at the base, and hence with the longest distance to travel before they could work their way to the top" (p. 30).

government and national Aboriginal organizations. It doesn't mean it cannot be

achieved in time, but I really think there are certain conditions that must be met in

order for that process to evolve. I think we live with a lot of need on the part of

people with authority and power to expect conformity, to almost demand

conformity. That to me as an Aboriginal person smacks of assimilation as opposed

to integration because if we're in a genuine process of integration, we would

welcome difference.... would welcome uniqueness, distinctiveness, all within the

context of being responsible and accountable and democratic and so on and that's

hard to find really anywhere. Even in our own communities it's hard to find

because again the effects of colonization are very powerful and people have a hard

time in our communities for various reasons as I said, accepting difference and I

think the people today are who are most different are those who have found their

voice and are able to stand up and be counted and have the ability to express an

opinion and have the ability to agree to disagree and have the tools to ask

questions ... and people who do those kinds of things in most of our communities

as I see it, especially in a political sense are usually not valued, they aren't

welcomed or valued. They're not necessarily welcomed or valued in the Western

world either. (RP6)

Regardless of the movement by the federal government in the 1950s and 1960s to design a

framework of social policies and services "for the benefit of all citizens," (i.e., the policy of

integration), (Armitage, 1999, p. 65), and the amendment of the *Indian Act* to provide the

legal basis for extending provincial social services to Indians, many argue that today, the

policy of assimilation continues (Armitage, 1999; Cairns, 2000; Henry et al., 2000). While

the policy of integration marked the removal of a separate set of social polices for Aboriginal people based on *race*, it did not recognize distinct Aboriginal cultures or the colonialist legacy of a hundred years of paternalistic rule. It was expected that Aboriginal people would become part of the cultural mosaic of Canada with no special recognition of unique Aboriginal status.

In the excerpt above, the participant is arguing that an assimilationist ethos continues to underpin governance structures and that true partnerships are not likely until mutual respect, reciprocity, sharing, and responsibility can be achieved. In the participant's experience, although the difficulty in developing partnerships is not exclusive to Aboriginal – non-Aboriginal relations, the relationship between Aboriginal peoples and the Canadian State remains tied to its colonialist history and *power over* dynamics.

Importantly, the participant also speaks to the pervasiveness and power of internal colonialism whereby some Aboriginal people have internalized the norms of the colonizer – in this case, the taking on of dominant culture values and beliefs. Part of the imprimatur of colonialism is the way in which some oppressed actually accept dependency on the state and become critical of those who do not, often creating a powerful internal politic (Fanon, 1967; Said, 1993).[109] The participant goes on to share from personal experience the challenge ahead:

> P: I tend to look upon the challenge …<u>for us to understand what, if anything, we</u>
>
> <u>do in our everyday life that makes us an oppressor and/or helps us to recognize</u>
>
> <u>that we're living a life as an object.</u> We're the oppressed people, and at the same

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[109] As mentioned in Chapter Two, lateral violence is another consequence of colonial practices (in particular, 'group trauma') and one to which several of the participants drew attention. Many expressed the belief that *community* healing is paramount to moving forward because of the powerful negative impact of internal politics and its interconnection with lateral violence to community life (Fieldnotes, RP6, October 4, 2003).

time, get in touch with the possibility that we don't always have to live like that. There are times when we could enjoy reciprocity in our relationships with others and through that experience learn more about what it is we know. We should be able to create more knowledge as we identify the tools we can use to make meaning of our internal world and our external world; and to be able to share those experiences with others and together create and re-create knowledge is really important. I think one of the difficulties today is that we don't know how to begin, how to begin to think... The challenge we face today is to create a process where more and more of us begin to understand institutionalization and institutional racism. A lot of people talk about racism and don't do anything about it in terms of creating processes that could lead to change and I think that's an indication of the complexity of the phenomena of racism and how difficult it is for many people to talk about it, particularly if they are living it.... If they're living it, then it's important for them to look inward, to be able to look and step outside of what's happening and be able to look in and begin to see what really is going on, to reframe their experiences – to [examine the] ways that we live to begin to recognize what, in fact is happening. I think that's very threatening, it's very threatening to everyone especially people in professional roles and responsibilities. I saw that, for example, in my home area when a few of us were anxious to make the changes regarding the performance of our children in the provincial school system and all we did was get a lot of lip service from the senior people in the school board. My sense of their reaction was that they really believed they were doing a good job because a few more of our children were doing a little better than

other Aboriginal children in other school districts - but we still had less than three out of ten Aboriginal students reaching grade eight graduating within six years. They were being very complacent about that when, in fact, in the non-Aboriginal population in that system, seventy-six percent of people reaching grade eight graduated within six years, a tremendous difference. But we were getting lip service from some of those officials in the school board and all we could conclude was that they were unwilling to do any more than they were doing and yet they received thousands and thousands and thousands of dollars per capita for on reserve status children in the school system. (RP6)

Here the participant elaborates on the challenge of Aboriginal recovery imposed by internal colonialism and ongoing neocolonialist practices, for example, the lack of attention to the lower rate of Aboriginal graduates from high school. This narrative suggests that outside care and responsibility for the education of Aboriginal children, perhaps unwittingly, has become a container of control and domination.

I will now return to the introductory narrative which suggests that paternalism does not exist in isolation but rather is inextricably connected with ethnocentrism. Recall the participant's words: "While the decision maker was right that speech therapy to learn to speak like the mainstream society around me helped in selected ways, it also had other effects that (probably) weren't expected or planned for. They didn't consider cultural norms or internal family effects on roles and relationships." Aboriginality was rendered invisible.

**Ethnocentrism: Rendering Invisible the Other**

The degree to which the Western biomedical worldview shapes the mental health care discourse and access to mental health care could add yet another dimension to understanding

the ideology of assimilation, and, in particular, ethnocentrism. In this study, the participants referred to the dominance of Western biomedical traditions as rendering other approaches invisible. In particular, a chasm was articulated between mechanistic views of mental health and more holistic approaches to health. "Well our perspective is very different. Our people find it very difficult to go to a non Aboriginal for mental health help because it's very different, very structured, door closing, usually prescriptions - medication is given rather than dealing with the whole person - the spirituality part, the body, the physical part and the mind part..." (RP12). In the following interview excerpt, an Aboriginal policy participant working within government explores the complexity of this issue:

> P: ...I think probably tension is as good a way to describe it as any, just in the sense that there's a distinct leeriness and maybe even in some cases a sort of a cynicism towards mental health services and a lack of belief in the idea of their effectiveness. I would say tension is as good a way as any of describing that. I think that a lot of the times there's an overlay. One of the interesting things I think in terms of sorting some of this out would be separating these things too because most Aboriginals are also country folk, you know, so I think that there's an overlay. For example, if you were to talk to anybody who is from some tiny isolated rural community in British Columbia you would encounter several of the same types of apprehensions and misunderstandings or even in some cases an act of dislike of mental health services that you would find within Aboriginal communities. So some of that just comes from the fact that mental health problems are in some ways seen as big city urban problems in the first place, or that going to seeing a psychiatrist or another mental health service provider would be something

that you'd do in a big city as opposed to something you'd do in a small community where people rely on the social network within that community, the church or whatever supports you have within that area. So some of it I think is that and then I think other parts of it, and that's the interesting part, is trying to figure out which of the parts that are the actual cultural overlay to that stuff.

...I think it's a combination of cultural and historical. I think that there's going to be certain factors which are separate and distinct from anything cultural, for example, <u>a mistrust of the group that has displaced and colonized and done all these other kinds of things to Aboriginal people</u>. I think one part of it is that perspective, another part of it may be more the actual cultural perspective. <u>That's where you get into the concept of holistic health. To me it is one of the most important aspects in terms of distinguishing why people have some unusual attitudes towards the mental health system. Because it artificially separates out components of a person's whole being. That just doesn't make sense to a lot of Aboriginal people, to separate out, so the idea [of mental health] doesn't make sense to them at some level. And it's presented with an underlying set of, I guess, Western, European and North American nuclear family types of underpinnings. That don't make sense from the perspective of typical daily Aboriginal family existence...</u> (P20)

This participant speaks to an overlay of issues addressed by several participants in this study: 1) the existence of an Aboriginal rural or perhaps small town perspective regarding mental health, not unlike that of a rural non-Aboriginal perspective; 2) a mistrust of any service offered by the dominant group based on historical relations; 3) the incongruence between the

conceptualizing of *person* with separate parts and the notion of *person* without artificial distinctions made between the physical, mental, emotional, and spiritual elements of the self; and lastly, 4) the lack of fit with services which are underpinned by Western, European models of family. Essentially, services continue to be offered in a way that is foreign to many Aboriginal people. The same participant goes on to explain why services that might fit for many Aboriginals aren't offered:

> P: When you look at things from the point of view of the mainstream system and people who are willing to give money for things, they have to be able to understand it in the first place and they have to be able to have confidence in it enough to support it and to provide resources for it. I think both those things are lacking within the system. I think that there's no clear conception of what people are talking about when they talk about other people's spirituality or native understanding or a cultural component or whatever you describe it as. They don't know what you mean in the first place... We understand what a psychiatrist is and what a psychiatrist does and we understand the education that a psychiatrist has had and we understand the credentials that a psychiatrist has had. We've got organizations that can accredit facilities and can look at how things are structured and the processes that are used to get from A to B within the organization. We can understand what the goals are regarding how these things get accomplished and so forth. To the degree that we have confidence in them, we say we'll fund them because it has been looked at and it's understood. So when it comes to things like..., why don't we bring in traditional healers and have them work at the Mental Health team?... Even within the Aboriginal community it's hard to get ideas like

that to move forward because even among members of the Aboriginal community, they flounder somewhat on the idea of the lack of credentials that are involved for somebody like a native healer. It's all kind of word of mouth and who trusts who and that sort of a thing, which I would say probably is another example of what might work in a very small community. You can pretty much depend on people that you've known since day one that you've grown up with ... in terms of their opinion. You get into the big city and - who are you?, where are you from?, I don't know you and then this person will say to you that you should hire him... and give him lots of money (laughter). (P20)

Here the participant uses the example of psychiatry to point to the embeddedness of Western biomedical cultures and attendant ideologies, that have shaped mental health care discourse and rendered other voices silent. The mental health culture of the dominant group provides the lens for funders to interpret the value of services and the consequent allocation of resource support. In the following interview excerpt, an Aboriginal policy participant, also working within government structures, highlights the embeddedness and impact of dominant culture ideology within the mental health system.

P: ...the way that the mainstream system uses the terms mental health, mental illness interchangeably is quite different from the way that our communities conceptualize it. Mental health is often not something that is really articulated in our community. It's more broadly wellness. The mind is also part of the body and so we talk more about physical wellness and that can incorporate, as we're talking about it, the concept of mental wellness or mental health as well. I think it's only in more recent times that we've really talked about mental illness and most don't

separate it out. Certainly the concept of spiritual wellness is integrated into that in our communities and you're probably more likely to have people talk about spirit rather than mental health - spiritual health rather than mental health. Which is very different than the way that the Western society conceptualizes it... And so we move into a society and a service structure that actually forces those distinctions. And you can no longer integrate the mind, body and spirit in the way that we might, if we are younger or untutored in the structural ways around us... In terms of policy and service development, it is much more complex to be able to do something when it is holistic and not separated out into the nice little boxes that we as policy people tend to put things in. (laughs) So that I think is one factor that creates the tension because once you put the structure in place, changing it, although we have structural change all the time, but from my experience with the so-called structural change, you are just changing names. You're not actually changing the structure underlying those name changes. So you're still keeping the boxes, you're just maybe calling it something a little more amendable to your own political viewpoint. (P19)

Similar to the perspective of the previous participant, this participant points to the impact of ideology on mental health structures, but also to the way in which those structures shape ideology. In particular, a system of health and healing that is shaped by notions of *wellness* will be quite different from a system that is driven by notions of *illness*. Here one might suggest that the difficulty in changing structures most probably stems from the steadfastness of the ideology underpinning those structures and vice versa. This is further elaborated in another interview, with a non-Aboriginal policy participant involved in mental health reform:

P: I think that what Aboriginal people are experiencing is not really very different from what people in mainstream are experiencing, so that's part of the reason why there's so much pressure on all the health care system - people are looking at so many other societal ills through the health care system and they want to solve those ills through the health care system because the personal manifestations of this disease, social level disease, comes through in individual symptoms of ill health, they may be physical or they may be mental. The problem that we've got from within the health care system – it is worse for mental health, but it's not really different from some kinds of chronic disease that will affect physical conditions - the health care system can only fix some of those things, so when we start to move into housing and nutrition and education and rehabilitation, in vocational rehabilitation, driver's education for people with head injuries... there's a whole host of other agencies that we should be thinking of in terms of social ailments. It's the government's responsibility rather than just the health care system's responsibility but they tend to get shoveled under the health care system and I think it's part of why people are unhappy with the services provided by the health care system. (P21)

Here, the participant is explaining how the structure of the health care system is such that it cannot bear addressing all of the social ailments that accompany health, a fact that makes many people, Aboriginal and non-Aboriginal, unhappy with the system. An Aboriginal policy participant comments on this in terms of Aboriginal health:

P: For our community members, the determinants of health [poverty, lack of adequate housing, disconnection with community networks etc.] are pretty

<u>determining</u>. They have a major impact on life experience which, of course, leads to our abilities to cope, the levels of stress that we're under etc... (P19)

Biomedical approaches and practices within health care tend to separate health from its social determinants. Like this participant, many in this study commented on the problem of compartmentalizing health separately from the social aspects of life because of the determining nature of those social ills on the lives of Aboriginal peoples. In a similar vein, the non-Aboriginal policy participant above, who spoke about the limitations of the health care system in terms of providing services that address the social determinants of health, goes on to speak about another disjuncture between Aboriginal perspectives and the mental health system:

> P:... it seems to me there is very much of a gap with the <u>Western model of health
> care, which is very much based on rational scientific approach, breaking things
> down into smaller pieces and seeing them as a consequence, somewhat in
> isolation.</u> So I think that mental illness, in particular, which is not well served by
> such an approach, and I would guess then, Aboriginal perspectives, which reflect
> an approach to physical illnesses as well as mental illness, which is also more
> holistic, would suffer further. (P21)

Here the participant notes the rationalist perspective embedded within the dominant discourse that highlights cause – effect relationships as being at odds with not only the "more holistic" perspectives of Aboriginal peoples but also the treatment of mental illness in the population at large. The participant then goes on to explain the attachment of funding arrangements to that worldview:

P: I agree with what you're saying, the resources are important but I think it's a mistake to focus only on the resources particularly as we're not going to have them. <u>I think that there are other ways to get at these things, the best practices approach I think is really fundamental.</u> You're probably looking for synergies within existing programs. <u>But some of the hardest things to do is not actually finding additional resources, it's getting the existing resources to shift their focus to function differently so that there are a lot of people in the system doing different things. Are they all as deeply valued?</u> Are we satisfied with all of the work that is currently being done as top priority? I would guess that it isn't and I would predict that identifying what isn't top priority is the easy step, getting people to shift their practices is going to become more difficult and much more controversial.... (P21)

Here the participant speaks to an essential feature of mental health reform, that is, *Best Practices* approaches and the reality that funding within the mental health system will be attached to the foci of reform and an attachment to *Best Practices*. As discussed in Chapter Two, provincial and regional mental health programs have adopted the nationally-driven *Best Practices* in Mental Health approaches. The same participant goes on to speak about this in terms of Aboriginal mental health:

P: That was always the intention with our *Best Practices* work that we would start out with the foundation elements, which will be seven best practices reports[110] on different treatment approaches isn't quite the right word, perhaps elements of

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[110] As noted in earlier chapters, the seven BC's Mental Health Reform *Best Practices* Reports were informed by the national *Best Practices* Discussion Paper and include: Assertive Case Management (BC, 2000a), Consumer Involvement (BC, 2000b), Crisis Response/Emergency Services (BC, 2000c), Family Support and Involvement (BC, 2000d), Housing (BC, 2000e), Inpatient/Outpatient Services (BC, 2000f), and Psychosocial Rehabilitation (BC, 2000g). In addition the *Best Practices*, Rural and Remote document (BC, 2000h), and Guidelines for Elderly Mental Health Care Planning (BC, 2001a) were also reviewed/critiqued. These reports were developed by working groups across the topic areas. Membership to the working groups was by invitation – and included providers, consumers and government representatives.

reform and then particularize it to <u>sub groups</u>, the elderly, the women, the youth,

<u>Aboriginal</u>, and then ultimately some of the other smaller minority groups… (P21)

The *Best Practices* aspect of the mental health plan is explained by the participant.

Aboriginal people are one of the "subgroups" being considered separately in the reform

process. Although it could be argued that here at least Aboriginal people are being

considered as separate and distinct, many of the participants in this study were concerned

with processes brought to them from the outside into which they would be made to fit. For

example, in the Aboriginal Mental Health Best Practices Working Group (BC), many of the

members queried the language of *Best Practices* and its Western biomedical underpinnings,

for example, they asked, how does *Best Practices* with its strong attachment to psychiatry

and individualistic models of care fit with Aboriginal notions of health and illness and

healing practices? And, Does the notion of *Best Practices*, which is attached to "evidence-

based" approaches, exclude Aboriginal knowledge, (i.e., what constitutes *evidence*)? This

was not an indictment of *Best Practices* approaches per se but rather a question about how

they might fit with Aboriginal perspectives. Later, the Aboriginal Mental Health *Best*

*Practices* discussion paper *Aboriginal Mental Health: What Works Best* (Mussell & Smye,

2001), developed by this group, was not supported with resources for its intended

dissemination across the province for input or its development into a Provincial Aboriginal

Mental Health Plan. How does one read these inclusions and exclusions?

In the following interview excerpt, an Aboriginal participant working as a director of

an Aboriginal health program identifies one aspect of this problem:

P: As most often happens whenever somebody finally gets around to trying to

design something for Aboriginal people, <u>it's always done kind of as an</u>

afterthought, so we're always trailing everybody else and there's never really adequate consultation done when things are being developed and the monies are usually monies that are scarce or left over in some bureaucrat's budget. So, against all of that, it's pretty hard for the two sides to really come together. (RP5)

In the experience of this participant and several others in this study, Aboriginal mental health has not garnered the support of government, (i.e., it has not been placed on the provincial health agenda), and as such there are few designated monies for Aboriginal mental health. As a case in point, the Aboriginal Mental Health Best Practices Working Group meetings were funded by the Ministry of Health, Adult Mental Health Division, with monies left over from other programs rather than from designated monies (Fieldnotes, Aboriginal Mental Health Working Group, April , 2001). In another interview, an Aboriginal policy participant working within government explains why it can be difficult to shift the health agenda to focus on the issue of Aboriginal health:

> P: So little has happened around Aboriginal health in general and Aboriginal issues often times because there hasn't been significant awareness or concern. People have to be concerned enough to actually want to learn and ask the questions. So it's a back and forth process. We are trying to raise awareness to spark enough interest that people will actually ask the questions and then answer their questions. They have the buy in.... All people see are the negative statistics, they don't really think about the implications of those statistics... We're seeing more concerns primarily from an economic analysis, such as the impact of accidents - what they cost. You know, the impact of addictions, what do those cost? So it's still not really seen in the context of the impact on the individual and

> what does that cost in individual wellness, happiness, the sense of hope and the ability to live a happy and fulfilling life. That's still way down the line in terms of where we're at with policy and with people thinking about Aboriginal mental health issues... [Here the participant inserts the voice of a non-Aboriginal person] "But, you know, that's the way Indian people live so it is not a problem for them the way it is for us as non Aboriginal people"– [ending here]. We've been really pushing our agenda but it's not seen as the significant issue and it doesn't have an urgent impact. We as Aboriginal people live in crisis everyday but because it's been such a long-term crisis, it's standard. This is the level of where we're at... it is not an urgent crisis. It's going to be there tomorrow. There's nothing we can do about it today that's going to change it for tomorrow - so we'll get to it at some point in the future when we have some time. [Right now] the media attention is on the waiting list to get our eyes lasered or whatever ... (P19)

The participant notes the pragmatics of priority setting within the policy area at two levels: 1) the reality of economic analysis driving policy decision-making, (i.e., cost benefit analysis etc.); and 2) the current popularity of the particular health issue as evidenced by the attention it is given by the media and society at large.[111] In addition, these issues intersect with the way in which "Aboriginal" is constructed. Aboriginal mental health issues have been rendered invisible through processes entangled with an ethnocentrism that creates a kind of cultural blindness – perhaps people don't ask the questions because they don't know the problem exists and/or because the conditions under which many Aboriginal people live have become "standard" and thus normalized.

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[111] Although the participant is expressing a certain cynicism in relation to the media, the example was meant to draw attention to how the popular media reflects the health foci of dominant culture health concerns.

Lastly, again recall the participant's words: "Mainstream society is like that meat grinder. We're all tossed in the top, chewed up by the actions of the meat next to us and the structure that squishes us into homogenous little pieces spit out the end." While paternalism, as it has evolved historically, seems to account to some extent for the way in which *care and responsibility* have been configured in relation to Aboriginal peoples, and ethnocentrism is implicated in the erasure of Aboriginality within the mental health complex, further analysis of the data revealed yet another level of ideology underpinning mental health policies and institutions that might account for the absence of attention to Aboriginal mental health issues, such as high suicide rates. In the following section, I turn to examine the idea of *impartiality* and its intersection with notions of *race* and *class*. The narratives in this study strongly suggest that mental health policy decision-making has serious repercussions for Aboriginal peoples and raises the question: How would Aboriginal mental health get onto the provincial policy agenda given the embeddedness of current ideological frameworks?

**Intersections: The Ideology of [Im]partiality, [Institutional] Racism and Class**

I open here with the question I asked all of the policy participants:

R: Can I ask you a question here? How much was the latest reform prompted by the BC Schizophrenia Society (BCSS) and the crises that occurred. There were several bizarre sort of deaths and I'm wondering how much that shifted the focus - I noticed a very clear articulation of serious and persistent mental illness. So I'm just wondering how much the consumer groups drove that agenda?

P: Well they did to a fairly significant degree. I mean they were effective in being articulate about the issues. The press also picked up on this. There were a few inquests that were quite high profile. And I can remember when people like Bill

Douglas who was the executive director at the time - he had a whole sort of presentation of headlines. You know, the mental health system fails and I mean it was very effective and so I think it was certainly those groups. I mean the bureaucratic, the clinical system sang the same sorts of things as what the advocacy groups were saying. There were lots of letters to the Minister and it wasn't orchestrated but it was all coming. It was all saying the same thing, coming from different directions. So yeah, I think it was important. (P18)

Here the participant, a non Aboriginal policy person involved in mental health reform, is providing an historical perspective on the reform process. In particular, the participant reports the impact that consumer groups and the media had on the direction of reform. At the time, the climate was rife with concern for those persons with schizophrenia, engendered in large part by several tragic deaths.[112] In the following interview excerpt, an Aboriginal policy participant who works within a government setting is discussing the inquests into the suicides of several *Aboriginal* people with the researcher:

P: I would say very few of the inquests related to Aboriginal people had any major impact. Probably in the last ten years there has been more of an effect from

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[112] The tragic deaths of three young people resulted in inquests with the consequent examination of the mental health system: Benjamin Wright committed suicide in 1995, two days after being released from the Lionsgate Hospital. In 1996, after being in and out of hospital three times because of suicidal ideation, Brenda Barass committed suicide. Brenda frequently accessed the system (>50 contacts). In 1997, Ruth Miller was murdered by her son Aaron while he was in a psychotic state due to a schizophrenic illness. Unfortunately, Aaron had 'fallen through the cracks' within the system with disastrous consequences for his family (BCSS, 1998). In most provinces in Canada, the U.K (Eastman, 1996), and many jurisdictions worldwide, inquiries into homicides and suicides committed by psychiatric patients are currently mandatory. In BC, the inquest hearings invite testimony from particular parties such as the medical practitioners and family members. Other interested parties many be given 'standing at inquest' status. 'Standing at inquest' means that the parties invited to do so, present a case for whatever evidence and recommendations they would like to bring forward. However, this means the interested parties must employ a lawyer. Interested parties who are not 'standing at inquest' can give their recommendations to the jury also. Recommendations from the coroners' inquests often are sent to a number of different departments dependent on the nature of the directive. Mental health –related inquests often receive enormous media attention (BCSS, 1998). The BC Schizophrenia Society (BCSS) had 'standing at inquest' status at the inquests. The group was able to able to hire a lawyer to represent their position, as required.

inquests than there ever was in the past. But those changes are responded to briefly, are in the media very briefly for the most part, and they don't have a lasting impact other than at a very subtle long term way where I, as an Aboriginal policy person, can say, well, look at this inquest report study etc. – let's see what it says – and in our work basically it seems to be a matter of being able to layer enough printed evidence because anything verbal is strictly anecdotal and not relevant. It's just one person's opinion and I hear that quite a lot. So it is extremely frustrating in that sense. Has any inquest about suicides or violence in our communities really created change? No... I think that's partly because of the colonial attitude that is really integrated into the Canadian psyche. (P19)

How are we to understand the lack of organized response to the suicides of Aboriginal people, many of them young adults? The participant attributes the lack of response, at least in part, to the embeddedness of colonialist attitudes/ ideology – an attitude that subjugates Aboriginal knowledge: "in our work basically it seems to be a matter of being able to layer enough printed evidence because anything verbal is strictly anecdotal and not relevant." This account suggests that Aboriginal knowledge about what is happening is rendered invisible by political processes  attached to colonialist ideologies such as paternalism and ethnocentrism. There may be other attitudes/ideologies to consider. Another Aboriginal policy participant, also working within a government structure, speaks to this issue:

> P: I mean so thirty years plus anyways there have been people pointing to the discrepancies in the overall health status, including the mental health status of the Aboriginal community and there just hasn't been any activity put into place that's had any real and significant impact on that. I mean we still have that third world

<u>profile in the health status and the mental health status of the Aboriginal</u>

<u>community in Canada</u> and so I would agree with people that would say it's very

hard not to look at that as being a good example of <u>institutional racism</u>. (P20)

Again, this participant draws attention to the absence of an organized response to Aboriginal

mental health issues, and tries to make sense of this phenomenon with the researcher. Given

the above excerpts, I ask - how are decisions made that privilege one group's interests over

another? Is this related to institutional racism and/or to something else?

Many of the participants in the study expressed concerns about the poorer mental

health status of Aboriginal peoples and, in particular, about the higher suicide rates, as they

explored these questions. Most referred to the absence of an organized response to

Aboriginal mental health issues as an example of [institutional] racism. In the following

interview excerpt with an Aboriginal policy participant working within government, the

participant reflects on the question – why mental health reform, at least in part, was fueled by

the tragic deaths of individuals living with schizophrenia with no comparable response to the

high suicide rates of Aboriginal peoples in BC:

> P: When you're talking about what motivates change and you're looking at
>
> schizophrenia versus suicides, well how many people have we lost to
>
> schizophrenia, you know, a very difficult disease. I have all the sympathy in the
>
> world for those who have to live with it and their families…<u>And there's no</u>
>
> <u>comparison whatsoever. But because we [Aboriginal people] have a non place in</u>
>
> <u>Canadian society, it just doesn't have an impact on change</u> and I think, this division
>
> [in government] has been really good… [However], the people don't see the
>
> concern or because it's not in black and white, it's not apparent… Because

[institutional racism] is subtle and complex it's not acknowledged …..<u>We have made some systemic change primarily because we've had a few senior individuals who were supportive of that</u>. (P19)

Here the participant attributes this problem to the "non place" of Aboriginal peoples in Canadian society. While there have been some changes, these have been slow and dependent on "a few senior individuals" who were supportive – apparently, a response to Aboriginal mental health is tied to particular individuals who are likely to come and go within the institutional setting. The long-term entrenchment of differential advantage and privilege of the dominant sector of society (Henry et al., 2000) makes "institutional racism" a likely suspect here; the mental health needs of those persons with serious and persistent mental illness continue to preclude attention to Aboriginal mental health.[113]

An interview excerpt with another policy participant, this time non-Aboriginal, refocuses the discussion on the shaping of decisions within the reform process:

P: In any of these things you've got to have public opinion but you've also got to have a response of government …… And, you know, I think that the bureaucrats, especially people like *name of person* and the, you know, the ADM's [assistant deputy ministers] and the DM's [deputy ministers], because I mean it is pretty easy in these things for somebody up there to derail something…<u>You would think well why doesn't this happen, well it doesn't happen because the bureaucrat doesn't believe in it ….You know, he says this budget thing is more important but it was supported all the way up</u>. (P18)

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[113] This does not suggest that those persons with schizophrenia or other serious mental illness should not receive high priority and care.

The participant notes the inner workings of decision-making regarding mental health reform – decisions are driven by economic realities, affiliations, affinities, and politics. The same participant goes on to discuss the personal connections of the Minister of Health at the time:

> P: And Joy McPhail was the Minister of Health at that time and I happened to know that she knows some people who know this area very well, not in office but people with actual sons and daughters [with schizophrenia]...That sort of thing and I mean, I don't know this, but I think that when ministers have a really good knowledge about something, it can be very helpful... It is not a secret. McPhail will tell you that she knows people who have in-laws... (P18)

Presumably, here, decision-making was inextricably linked to the knowledge and personal interest of the Minister of Health as well as the way in which consumer groups, the media and clinical support came together to draw attention to the issue of serious and persistent mental illness, in particular schizophrenia, bipolar illness and depression. The idea of impartiality as a kind of taken-for-granted underpinning of democratic decision-making is placed in serious question by this narrative.

According to Young (1990), the rule of government officials in our society is legitimated by an ideology of impartiality, which she explains as follows:

> ...government administrators, judges, and bureaucrats are supposed to be the experts in impartial decision-making... their jobs are to stand apart, regard the whole of the diversity of interest and aims, and make decisions...turning over decisions to a popular assembly of people discussing their various needs and interests is positively a bad idea, because it would create irresolvable conflict (p. 113).

In the example above, the Minister of Health, presumably, did not act with detachment. Her decision making was influenced, at least to some extent, by her personal attachment to the health issue at hand. As Young and the data from this study would suggest, "impartiality is a myth" (p.114). It is impossible for moral agents to remove themselves from the group affiliations and commitments that constitute their identity and give them a perspective on social life (Young). When considering issues of social justice, one needs to remain cognizant of the way in which the idea of impartiality in decision-making supports the notion of a "neutral state"; legitimates bureaucratic authority, at the level of government, institutions and practices; and creates the "particular" and "universal"[114] as binary opposites (p.112). The idea of impartiality is deeply embedded in Canadian institutions, masking the inevitable *partiality* of perspective in the process of moral decision-making (p. 115). Young states: "If some groups' experience differs from this neutral experience, or they do not measure up to those standards, their difference is constructed as deviance and inferiority. Not only are the experience and values of the oppressed thereby ignored and silenced, but they become disadvantaged by their situated identities" (p. 116). In this way, if the issue of Aboriginal suicide is assimilated into suicide prevention and treatment programs more broadly, ignoring the specifics of its historical, social, economic, and political location – Aboriginality – we run the risk of perpetuating the poorer mental health status of Aboriginal peoples.

A non-Aboriginal policy participant involved in the process of mental health reform examines decision-making processes as they relate to priority setting and the issue of Aboriginal suicide:

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[114] Young (1990) argues that the idea of impartiality "generates a propensity to universalize the particular" by presenting as "objective," assumptions and commitments that derive from "particular histories, experiences, and affiliations" (p. 115).

P: I think it's whether you can draw an analogy, say with <u>best services</u>. Once upon a time that person would go into a mental health center, for example, would receive the best services that were available, okay, which may not include signing [for the deaf], may not include attention to that person's particular problem which is necessary to attend to in terms of communications to help the problem that they've come for. <u>I would tend to see it as a lack of awareness - a lack of resources, in other words, you know, if somebody said, okay, well, why don't we hire seventy-three people who understand that [issue], etc., etc., Now the fact that we don't do that, what does that mean?</u> .... I mean we just had an instance with kids with autism, some people saying, now look, my child should get whatever it is for say [autism] treatment [or] You know I shouldn't have to wait on a wait list for six months to get my hip surgery. I mean you can conceive of it as well as more prejudicial - prejudicial is not the right word but you know what

R: Discriminatory?

P: Yes, that's right... (P18)

Here the participant puts on the lens of the policy decision-maker and draws a comparison with a number of controversial areas in health care. There is a subtle yet appealing quality to the idea that decision-making is a neutral activity and that all groups stand to be discriminated against *equally* – it could be a need for signing, increased surgical time, services for children with autism etc., failing to address the social, economic, political, and historical factors that disadvantage some people more than others. This narrative also suggests that the expressed interests and perspectives of particular groups would be heard as

"biased" and "selfish self-interests." This makes it difficult to expose the *partiality* of the supposed universal standpoint, particularly for those who are oppressed (Young, 1990).

Young (1990) argues that when decisions are made within participatory structures that value the input of various cultural groups, we are led to a different place than when those decisions are made by the dominant cultural group without that recognition. Another Aboriginal participant, working as a consultant within an Aboriginal health agency, adds yet another layer of complexity to the issue of impartiality:

P: ... being involved with schizophrenia society where I come from ...some of them are between middle class and high class people, so they have money and they're also high tax payers. They also have the ear of the politicians. You know, they go to the NDP parties, they belong to the Liberal party, you know, they have those connections. Well how many Aboriginal people are in that middle and high class... or have the knowledge of how to work the system. You know we talked about working the system, well, if you're in the higher class you can phone so and so and so, and so and so knows so and so, like sometimes I think it is all about people you know.

R: So you also think that this isn't just isn't just about being Aboriginal or non Aboriginal, this is also about class as well.

P: Yes. Well, and when you look at it, you look at the educational levels of probably those upper class people and the education of Aboriginal people - of being a parent of a child that's committed suicide. You know,...you can look to the generation [before] me and you can look at their educational level and you can look at my generation, we have higher education, but it's really hard ... (RP11).

This narrative points to the intersections of ideas of impartiality, [race], class, and education; implicit here is the need for attention to a further layer of inequity imposed by class structures and educational levels as various groups vie for voice and ultimately, for resources. Here, being Aboriginal possibly intersects with issues of class to create increasing layers of discrimination.[115] In the same vein, a non-Aboriginal policy maker, involved in the mental health reform process, adds to the discussion:

> P: ...When you look at the impact of mental illness, you'd say there should be more resources there. Why aren't there more resources? I'm not sure it's so much institutional racism as institutional prejudice, more broadly and I would say that prejudice basically favours the people who can articulate for themselves, people who have got resources, generally that's white middle and upper class people....Well not only white, I would say that middle and upper class people generally, I would say it's discrimination on the basis of income as much as anything else and I don't see that it so much institutional racism as institutional discrimination or prejudice....I think in a pluralistic society like ours, racist is really racial discrimination as a sub set of class discrimination. So why do we spend so much money on breast cancer and prostate cancer despite the evidence of diminishing returns for what we're spending? Well because of the fact middle aged and older people who have a lot of clout in the system [have these problems]...And why don't we spend money on mental illness or fetal alcohol syndrome because it's basically the invisible in the system so I think a lot of it is

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[115] Although I think it is unlikely that members of the BCSS are only from middle and upper middle class groups, the point here is that the BCSS probably had more clout, in part, because someone with stature was personally affected by schizophrenia – something less likely to happen with the issue of Aboriginal mental health. According to Navarro (1976): "the analysis of power in the health sector in most Western developed societies shows that the power is primarily one of class..." (p. 118, cited in Anderson, 1990, p. 78).

about class and that's why I make reference to that study in the U.K. which found

some evidence that the expression of symptoms varies by class. (P21)

The participant highlights that resources usually are attached to the health needs of the most

articulate, that is, middle and upper class [and perhaps White] populations. In addition, the

participant suggests that race can be subsumed under class – that the invisibility of

Aboriginal mental health issues may be more about the issue of *class* than *race*. Certainly,

this is one interpretation, however, here I aim for an analysis that recognizes the powerful

intersection of both forms of structural exclusion. As we know, poverty determines poorer

health status for many Aboriginal people, and the health agendas of Aboriginal communities

are marginalized in relation to dominant social agendas, with the consequent subjugation of

Aboriginal input regarding health and other social issues.

The same participant goes on to further discuss the issue of *equity*:

P: I think this government and the health authorities really have to start looking at

what equity is and what is meant by that and we're not going to have any kind of

equity until more money is put towards some of these issues. And it's probably

where the reformers, usually on the right, who want more personal responsibility,

do have an important point to make, which is that I think the responsibility for

your health has to start with yourself because without that you're not able

assertively to get what you need from the system. And that's obviously going to be

very difficult for a sub group of the population that's already feeling like they have

no power... (P21)

This narrative suggests some ambivalence on the part of the participant. On the one

hand there is an appeal to government, to provide more resources for "some of these issues,"

for example, Aboriginal suicide, to address the issue of equity and on the other, there is

pragmatism about (a group) taking responsibility for their health – presumably by advocating

for what they need even though that might not be as easy for them. Ponting (1997) notes that

"[m]ost Canadians have come to view equality in terms of a uniformity model (no "special

status" or "special privileges" for any sector of society) rather than an equity model which

would recognize the need for different arrangements for differentially situated sectors of

society" (p. 49). Perhaps unintentionally, implicit in the above narrative is the suggestion that

taking responsibility for your own health and advocating for it, is *a level playing field* kind of

activity. It assumes equality across groups. This ideology is strongly tied to a belief in

decision-making processes that are fair and just because everyone has equal opportunity to

present their case. I recall a special CBC National Report titled *Nunavut*, where an Inuit

interviewee made the comment: "we just want to be on the playing field, let alone a level

one" (Nunavut, November 26, 2002).

According to Young (1990), in the pursuit of social justice, social policy ought to

afford special treatment to some groups (p. 158). Kymlicka (1992) refers to this as "cultural

pluralism," and McConaghy (2000) as "cultural relativism," both having fundamental

implications for the way we conceive citizenship and both having the potential for

inclusionary and exclusionary practices.

In accordance with the principles of cultural pluralism, people are treated on the basis

of their group affiliation and, in some cases, are treated according to different rules (Pal,

1997, p. 50). According to Young (1990) those who qualify for special treatment are those

who belong to those social groups identified in terms of salient social, cultural, or racial

differences that have experienced oppression in a society marked by radical inequality and oppression.

How *difference* is lived out in health policy is important to the health of Aboriginal peoples. On the one hand, the mental health complex is committed to the promotion of the well-being and welfare of all members of society. On the other hand, mainstream health services continue to be shaped by essentialized concepts of difference, deficit cultures, hegemonic power imbalances, and Western models of care delivery that are alien to many non-dominant populations (Henry et al. 2000). A racialized discourse underlies the mental health complex and reflects the strong resistance of policy makers to transformative models of social change.

**Summary**

By starting with a discussion of ideology, the groundwork has been laid for the further exploration of the nature of the tensions and disjunctures in the next chapters. The aspects of assimilation presented in this chapter have provided insights into why there are tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system. Ideologies of paternalism, ethnocentrism, and impartiality, embedded within an assimilationist ethos, continue to prevail despite the impetus from Aboriginal peoples to move towards autonomous control and self-governing arrangements – in a number of ways, Aboriginality continues to be ignored and/or rendered invisible through the powerful workings of particular ideologies. My next task is to explore how the patterns of tension and disjuncture located in institutions and policies at the meso level support the embeddedness of ideologies.

## CHAPTER SIX

## MEDIATING PRACTICES:
## MENTAL HEALTH INSTITUTIONS AND POLICIES

In the previous chapter, I examined the ideological underpinnings of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system, (i.e., why the tensions and disjunctures exist). In Chapter Six, the focal question is: what are the patterns of tension and disjuncture. Using the voices of the participants, I examine how institutional policies and practices support the embeddedness of ideologies.

Rooted in postcolonial theory, cultural safety is used here to provide a critical interpretive lens through which to examine power inequities in mental health institutions and policies. By calling for the transformation of deeply ingrained relations of paternalism, power, and authority in health care, cultural safety is intended to diminish cultural risk for indigenous peoples, defined as a "process whereby people from one culture believe that they are demeaned, diminished and disempowered by the actions and the delivery systems of people from another culture" (Wood & Schwass, 1993, p. 20). Examining mental health institutions and policies helps to make visible how these features mediate between ideological frameworks and the everyday practices of mental health care delivery.

Analysis of the data revealed the notable lack of an Aboriginal mental health plan, strategy, policy, and/or services nationally, provincially, and regionally. In addition, where mental health policies do exist, particularly within the mainstream, most often there is a lack of fit with Aboriginal understandings of and responses to mental health and illness and the most pressing mental health concerns of Aboriginal peoples.

Analysis of the data in this study suggests that the lack of clarity and resolution regarding *who is responsible for Aboriginal mental health* intersects with the notion of *worldview difference* to act as significant barriers to access to adequate mental health care for Aboriginal peoples. Most of the participants in the study, Aboriginal and non-Aboriginal, referred to these absences in the context of the "jurisdictional debate" – the way in which bureaucratic obfuscation often unwittingly leads to an abrogation of responsibility for Aboriginal mental health and supports an assimilationist ethos, (i.e., the rendering invisible of Aboriginality). As I began fieldwork in the area of Aboriginal Mental Health, the jurisdictional issue was often at the forefront of discussion within committee and community work, therefore, I was not surprised to see it emerge predominantly in this study. Another central feature of the participants' narrative accounts is the overall lack of attention to *difference* within the mental health system. As noted in earlier chapters, cultural blindness of the dominant group often precludes attention to the health issues of Others.

The following interview with an Aboriginal participant, working as a consultant in the area of Aboriginal health, provides an entry point to the analysis of the findings in this chapter:

> P: And we don't look at the [mental health system] as community based. I can remember where I come from we had a youth that was let go from a psych ward, given medicine and went home and hung himself. Because he was of age, the parents didn't know and so that had a whole devastating effect on them. It wasn't them that picked up the pieces, it was the Aboriginal community. Because this person was still in high school, we had other teenagers that were thinking about suicide and it was as a community that we got together and helped everybody

through it. Mental health was involved in it but they were one piece of the pie....
And so when there's distrust, then it brings the professionals and the individuals
farther and farther apart and I think that's where we are now - somehow we've got
to bridge that gap again...and every time there's a change of government, there's a
change of services and how service are being delivered effects the bottom line
consumer. (RP11)

First, this example suggests a disjuncture exists between mental health policy related to the sharing of information[116] about a child who is "of age," and Aboriginal understandings of family and community, a policy that may have unwittingly contributed to the youth's death and family and community upheaval. Secondly, the participant places this example within an historical context, reminding the reader of the colonialist ideologies underpinning policies and institutions that render invisible the perspectives of Aboriginal peoples. Experiences with a system that fails to recognize Aboriginal perspectives creates a distrust between Aboriginal peoples and health care providers in a climate already rife with tension. While there are non-Aboriginal people who might express the same kinds of concerns about the mental health system (Hall, 2001), that disillusionment is not located within the same colonialist history in terms of impact. Lastly, the participant notes the disruption of services created by shifting governance and respective structures. Analysis of the data in this study revealed a pervasive misunderstanding about who is to provide mental health services to Aboriginal peoples embedded in policies and institutions.

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[116] Confidentiality agreements within the health sector prohibit the sharing of information when an individual is considered to be competent to make their own decisions. Although I do not know why the family was not notified that this young man was being discharged, it may have been related to this issue.

Because the jurisdictional issue featured so centrally in my early fieldwork, the analysis of the data in this study, and the literature, in this chapter, I begin by presenting participants' accounts related to it.

### Bureaucratic Obfuscation and Abrogation: Whose Responsibility is Aboriginal Mental Health?

An Aboriginal policy participant, working as a director in the area of Aboriginal health in a mainstream health organization, describes the complexity of the jurisdictional issue:

> P: ... Well, I guess it depends on what level of health transfer that First Nations is at and I guess it depends on whether the person is living on reserve, whether the person is living off reserve, whether that person is status or non status. I do know that in British Columbia all people are entitled to all medical services equally and that MSP which is Medical Services Plan which is a provincial government but then if you're status and you live on reserve, you are or should be able to access some services that are provided by the federal government, now known as First Nations and Inuit Health Branch, formerly MSB, Medical Services Branch. And then you have the issue of non-insured health benefits and how some of those have been withdrawn and are no longer covered by NIHB, Non Insured Health Benefits and so I don't know.... And you're right, in theory everybody is supposed to be entitled to equal services for all but as the people you've spoken to have explained, that doesn't always happen in reality... And I do believe that perhaps people are denied services because somebody didn't understand whose supposed to be providing what and it's like when you to go to a restaurant and the waitress says

that's not my table. You go to a restaurant and you expect to be waited on and served food but it's not her table, okay, whose table is it and where are they? (P17)

Here the participant outlines the "who" and "what" of the jurisdictional issue, capturing the varying levels of responsibility for Aboriginal mental health (see Appendix D). Regardless of how responsibility for services is laid out, however, as she and others in this study point out, two questions remain: who is going to do it? and where are they?

At one level, the absence of acknowledgement of Aboriginality within mental health policies and subsequent services could be understood as a matter of unresolved conflict between federal, provincial, regional, and Aboriginal governance bodies. On the heels of discussing "why" the absence of attention to Aboriginal mental health issues within the provincial and regional structures, a non-Aboriginal policy participant, who has been a part of the mental health reform decision-making process, makes the following comments:

> P: ...I think one issue, and more may be made of it than what should be, but the issue of responsibility - who is responsible for health services on reserves as a for instance? I mean I think that some of it gets unfortunately lost in that sort of little discussion, important discussion - the jurisdictional thing. So the province knowing that health services on reserves, or I think that's what they know, are a federal responsibility right? Whatever it is, an outbreak of diphtheria, or whatever, and says, that's not our responsibility, that's their responsibility... I mean I think the same thing probably applies, be it education, or whether it would be a health issue... It's a big [issue]. I mean I haven't talked to the feds on this issue but do they say, no, look, this is not our issue, it's the province's issue... I certainly knew about off reserve, but if it's an on-reserve [I'm not sure]... (P18)

The participant raises the jurisdictional issue with the researcher while discussing the provincial role in the provision of mental health services to Aboriginal peoples in B.C. and as the discussion further progresses checks out the correctness of this understanding with the researcher. Acknowledging the jurisdictional divide, the 1998 Mental Health Plan, *Revitalizing and Rebalancing B.C.'s Mental Health System* (RRBC) reads:

> Services need to support the improved coordination of interjurisdictional (federal, provincial and aboriginal governments) policy development and service provision that will promote access to quality mental health care across reserve boundaries for First Nations people and for those living off reserve. (p. 27)

Here the provincial body has clearly articulated a commitment to work in collaboration with the two other governance bodies to provide mental health care to First Nations peoples. However, the words of the non-Aboriginal policy participant above: "I mean I haven't talked to the feds on this issue but do they say, no, look, this is not our issue, it's the province's issue," suggests that the provincial and federal policy decision-makers do not have a clear working relationship. How do we make sense of the gap between what exists in text and what is occurring in practice? For example, why isn't there a tripartite arrangement *five years* after the publication of the Mental Health Plan? Why doesn't a provincial policy maker involved in reform know the position of federal policy in this matter? This narrative suggests that Aboriginal mental health is deferred as a federal responsibility, and thus ignored.

As noted in Chapter Two, the creation of the nation of Canada through the *British North America Act,* 1867, gave legislative authority for "Indians" to the federal government. The provinces interpret this *Act* as a clear directive for federal responsibility "for First Nations and Inuit health services (and indeed in some cases, all Aboriginal health programs),

outside of those prescribed for all Canadians in the Canada Health Act" (O'Neil et al., 1999, p. 146). However, the *British North America Act* also provided for a provincial role in "establishing and delivering health services" (p. 146). In addition to this mélange, the *Indian Act*, 1876, created the status - non-status divide regarding the provision of health services to Indians. Paragraph 73 (1) of the *Indian Act* reads

> [t]he Governor in Council may make regulations ... *(f)* to prevent, mitigate and control the spread of diseases on reserves, whether or not the diseases are infectious or communicable; *(g)* to provide medical treatment and health service for Indians; *(h)* to provide compulsory hospitalization and treatment for infectious diseases among Indians;...... (*Indian Act*,
>
> http://laws.justice.gc.ca/en/1-5/70676.html)

In accordance with the *Indian Act*, health services are provided to those persons "on reserves" and deemed "Indian," and are explicitly related to disease control and more ambiguously to the broader provision of health care. Thus additional uncertainty is created concerning which level of government actually has responsibility for what population of Aboriginal peoples. However, a range of mental health resources *is* provided to Aboriginal peoples based on the designation of "status on-reserve" by the federal government or "status off-reserve" by the provincial government with non-insured health benefits (NIHB)[117] paid by the federal government both on and off reserve (see Appendix D).

For the most part, with few exceptions (for example, Quebec) provincial and territorial governments have not directly provided health services in First Nations and Inuit communities but rather have negotiated methods of reimbursement with the federal

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[117] There is a list of non-insured benefits determined through medical or dental necessity (O'Neil et al., 1999).

government. In some provinces, the federal government has contracted directly with university medical faculties to provide these services (O'Neil et al., 1999, p. 146). For example, in B.C., psychiatric on-reserve consultation is provided through the Mental Health Evaluation and Community Consultation Unit (Mheccu) at the University of British Columbia, Department of Psychiatry through a fly-in service.[118] Mental health is medicalized as psychiatric services.

Unfortunately, the lack of clarity generated by the *British North America Act* and the *Indian Act* confers a certain degree of latitude for governments to vacillate on their position regarding Aboriginal mental health issues, possibly unwittingly contributing to the health disparities among Aboriginal peoples and between Aboriginal and non-Aboriginal populations.

In the following, a non-Aboriginal policy participant, responsible for Aboriginal health services across several *rural and remote* communities, discusses this complexity further:

> P: It's pretty much the same in the North West Territories as it is here. There's a kind of a shoehorning along guidelines and perimeters in terms of diagnostic criteria. If you don't fall into an ICD-10-CM[119] then you're not mental health or for that matter don't fit into the kinds of treatments and definitions and what have

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[118] Through this arrangement, a psychiatrist is flown in to the community on a regular basis, for example, once per one or two months, usually staying for a few days at a time to see clients and provide consultation services with local mental health and community workers.

[119] This is the International Statistical Classification of Diseases, Injuries, and Causes of Death (ICD) now in its 10th edition (ICD-10-CM) developed by the World Health Organization (WHO). The DSM-IV (APA, 1994) refined the diagnostic categories based on available empirical data, and proceeded to make the current diagnostic system compatible with that of the current 10th revision of the ICD. However, there have been difficulties with compatibility between these two systems, and thus payment (Bogenshutz & Nurnberg, 2000, p. 825).

you....Yet in terms of the funding streams we're totally into the, for want of a better way of saying it, 'Western law'. If we wanted to set up desks and hire a person to write reports and lots of statistics and whatever, then well, we're heroes. But if it is something that's sort of more a mentoring and walking with and listening to and maybe helping people discover what is good in their life and what they're proud of and to know how to be a good person in their particular culture and that sort of thing or for that matter feel pride in what they are - finding funding for that is a whole other venture and makes it very difficult... It's been my experience in working in Northern Canada as well that you don't have a lot of what would actually be classified as a mental illness and so if you're working on that sort of statistical measurement driven kind of system, you're going to run into real trouble because you're not going to be able to qualify for diddle. Which doesn't mean that you aren't going to have lots of people who require hospitalization. For instance, in the hospital here, the number one presenting diagnosis... is unspecified psychiatric disorder.[120]

R: Anxiety, depression?

P: Depression

P: You know, suicide, alienation, that type of thing. So you know he presents with physical [complaints],stomach aches, abuse of peers. You know, I might want to kill myself. I've taken literally just enough aspirin to scare everybody but not enough to kill myself kind of thing. Which would be true cries for help

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[120] This code is used 1) for a specific mental disorder not included in the DSM-IV classification, 2) when non of the available Not Otherwise Specified categories is appropriate, or 3) when it is judged that a non psychotic mental disorder is present but there is not enough information available to diagnose one of the categories provided in the classification" (APA, 2000, p. 743).

R: So do you see this to be PTSD (Post Traumatic Stress Disorder) kinds of

symptoms?

P: Very, very much so. (P22)

This narrative suggests a powerful intersection between the jurisdictional issue and the

dominant culture worldview, (i.e., "Western law"). For example, funding arrangements are

inextricably tied to diagnostic categories and other aspects of the mental health accoutrement,

posing an incredible challenge for administrators of Aboriginal health programs both on and

off reserve because the criteria/ diagnostic categorizations differ across federal and provincial

bodies. An additional challenge is posed for administrators, providers, and families in terms

of continuity of care, for example, if an Aboriginal client on reserve needs to access a

provincial hospital. The same participant shares an account that illustrates the workings of

federal – provincial accountability:

P: … there was a lady here from the community who needed to leave the

community because she required a supported living environment because she was

mentally challenged. She couldn't live with her family any longer because they

were just exhausted and her needs were too large and she was put in the hospital

which was a very difficult thing, of course, because for quite some time she was

very unhappy. The community does not have the resources to support this kind of

thing and no group homes or anything like that. So a meeting was called of all the

potential players, federal, medical services branch, provincial people who were

responsible for that kind of care etc. They chartered a plane and came together for

this meeting. The first suggestion raised was that she could go to a place in

Kelowna and needless to say she'd be too far away from her family. This lady has

a mental age of about four so I mean just think how hard that would be for her and the family. Without regurgitating the whole meeting, we went around in circles from about ten in the morning until probably about two, two thirty in the afternoon, but basically the needs of the person [and their family] were ignored and the various bureaucrats were saying well, we really like your plan but why this and why that, and we can't do this and toe tapping, you know, and they just skirted around every issue. Then the chief counselor, who had actually called the meeting (people were needing to fly out in an hour and were getting concerned about it getting dark early), said "I've sat here and I've listened and I haven't said very much around this and it just sounds like to me that you don't plan to do anything, so I think that you should be aware that the airport here is on band land, and run by the band. Now, I want to tell you that there might be some question if we don't reach some agreement as to what is going to happen with her, as to whether or not you will be able to leave." You should have seen those people's faces, I mean quite literally, I mean after the silence, it seemed like about an hour or so but I'm sure it was about half a minute, but after the silence, they virtually all started talking at the same time and you can't believe the arrangements that had been made for her [to accommodate her needs] - with split payment. I mean if that was available after the threat was made.

R: It was available before?

P: Absolutely. (P22)

This participant's account, while humorous, represents a common and rather frustrating occurrence in Aboriginal community. Several of the participants spoke about the way in

which the needs of patients and families were ignored because of the disjuncture created between federal and provincial bodies regarding who would pay for a service such as that required above. As often occurs, the disjuncture is created by economic realities, (i.e., the need for costly services).

An Aboriginal participant, who directs an Aboriginal health program, provides an *urban* community perspective on this issue:

> P: I always call the people living off reserves the sandwich people especially those who don't have their status and some of them probably have no less native ancestry than some of the people that do have their status but they get caught there and they can't seem to get funding and that's why it was so important for me to ensure that there was a place here where people could come where they didn't have to pay... And I think a big part of it [the tension] as well is the separation I feel again from the government, those policies of on and off reserve, status and non status, Métis. And that creates a mistrust and a lack of respect for Aboriginal people. I always say when I go to the meetings, boy, if we could start working together with trust we would be a most powerful people in being able to address all the issues. It is very divisive among Aboriginal peoples and creates disrespect. I can even see it now today - like it is not like something that [just] happened a hundred years ago [the creation of the divide by the state]. (RP8)

The participant suggests that Aboriginal peoples have been alienated from one another through the creation of hierarchical distinctions attached to the provision of government support and service delivery, relationally creating disrespect and mistrust. The relational tensions go beyond Aboriginal – non-Aboriginal relationships to those between Aboriginal

peoples – a "have and have not" division, if you will.[121] In the following interview excerpt, an Aboriginal participant, working as the director of a mental health program in a reserve setting, explains the complexity of the jurisdictional issue in terms of access to counseling services:

> P: ...We have people living out in remote isolated areas and for those individuals, to fly out and come out to a Vancouver mental health office, it would cost them something like about five or six hundred dollars... To come to a mental health office to get mental health counseling on a weekly basis or even twice a week when some of them need it twice a week. The cost would be just outrageous... ,yet nobody, neither the provincial nor the federal government will cover those costs.... So individuals cannot access services because the services, are just out of their reach, it is out of their area and they can't. We tried to get assessments for people who are suicidal and each individual was out in areas where you can only get to them by plane or by boat. And yet the federal government does not recognize that we need to have these services, the funding is not adequate. They allow us a certain amount of money to provide counseling and the counseling services do not, do not allow for mental illness, people with mental illness... it allows for the basic counseling (RP9)

The participant points to how the issue of responsibility gets played out in relation to who will pay for these extremely costly services. Fiscal constraints and a lack of understanding regarding the need for both counseling and/or psychiatric services preclude attention to the

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[121] There are additional issues related to individuals who live on-or-off reserve in terms of their ability to access services; for example, if NIHB-funded counselors practice off-reserve, there may be difficulties in traveling to/attending counseling sessions. In addition, the number of counseling sessions available per client varies by region and in some cases, there have been reductions imposed on the maximum number of sessions that a client would be funded to receive. Approval for funding also can be labour and paper intensive (FNIHB, 2003b).

issue of transportation to mental health services. This narrative suggests a disjuncture

between the funders' understandings of mental health and illness attached to Western

biomedical traditions (and as such what they will pay for) and what Aboriginal people are

saying they need – this, of course, intersecting with economic realities. As discussed in

Chapter Five, both excerpts, rural and urban, illustrate what happens when governance is

provided *at a distance* and suggests the continued existence of paternalism underpinning

these arrangements.

Provision of mental health services is mired in an organizational complex that creates

tremendous frustration for those trying to access services for their clients. Living in a rural

and remote area of BC creates problems of access for many of its residents (Aboriginal and

non-Aboriginal) to such an extent that this challenge prompted the development of the

document, *Rural and Remote - Best Practices in Mental Health in BC* (BC, 2000h),

applicable to the general population. According to Health Canada (2003), geographical

location is an important contributory factor when considering the continuing disparities

between Aboriginal and non-Aboriginal health status because of the number of Aboriginal

peoples living in the more rural and remote areas. In addition to this messiness confusion is

created by different interpretations of "who" is to provide "what" by providers themselves.

The same participant as above gives an example:

> P: Well, you know, I think it's because of jurisdiction and I think that there's a
>
> constant question as to who should be doing the counseling. When we send
>
> somebody to the (provincial) mental health office to have an assessment, they may
>
> be suicidal. What they (the mainstream counseling service providers) end up doing
>
> is they send that individual back to us and say to one of our counselors that they

don't have the counseling services. One of the problems we run into all the time is that we are under funded, under employed, you know, we don't have enough counselors for the number of referrals we receive and one of the things that they (mainstream counseling service providers) say to us is that this individual would like to see a First Nations counselor and yet many of our counselors are not First Nation but they use that as an excuse [so they (the mainstream service providers) don't have to provide the service]. (RP9)

A tension is created, at least in part, by the general shortage of mental health resources across Aboriginal and mainstream service organizations and intersects with the providers' lack of understanding regarding who provides services to Aboriginal people. Interestingly, here, attention to difference, (i.e., recognition of Aboriginality), is used as a means of exclusion from counseling within the mainstream, a good example of how attention to *difference* can be used to support inclusionary or exclusionary practices. Here, an apparent obfuscation of responsibility at the level of policy is interwoven with the abrogation of responsibility at the level of everyday practice in mental health service delivery.

Transfer arrangements intersect with on-reserve/ off-reserve issues, the provincial mandate to provide services to *all* persons, the provision of services to status First Nations and Inuit people through FNIHB, and the reality that some non-insured health benefits (NIHB) are still in place and others are not – all seemingly clear delineations until the provider or client tries to access the service. Bureaucratic obfuscation has seemingly left open the possibility of abrogating responsibility for Aboriginal mental health.

Regionalization

In addition to this mélange, an Aboriginal policy participant, working within a regional body, comments on the impact of regionalization:

> P: ... I guess I was wanting to say that I think that regionalization just the geographic physical aspect of regionalization is probably also a factor that ought to be taken into consideration when trying to figure out what does this mean [reform] for the Aboriginal community because although the idea was to give local control and all this type of good stuff, I think that reality has been that you've broken down the Aboriginal community below critical mass within any given region so that the probability of dealing in meaningful ways with Aboriginal concerns I think has actually dropped through regionalization ... it was nice in some ways when that was centralized, the community numerically is small enough that at least if you look at the Aboriginal community provincially, there was enough people there to really say, okay, what are we going to do about this? ... Especially when we were up into twenty plus geographic areas and everybody had local control, I think that a lot of the times the Aboriginal community just dropped right off the radar screen. (P20)

Regionalization has been a focal strategy of health reform with the goal of providing local control of health care planning and resource allocation. Several of the participants in this study expressed concerns for the voice of Aboriginal community in this arrangement. A Chief from a small rural community notes the difficulty created by small numbers at the funding table when bartering for resources in the context of regional bodies:

> P: Well we get swallowed up and I think that some of the things that I've been talking about.... There was [a number of us] and we're going under health transfer

> this year and mental health wasn't even part of it, you know, we started talking
>
> about it and we were trying to say we should bring mental health in here too
>
> because, when it comes to the table, I said the *number of* small nations aren't going
>
> to be able to survive because the funding formulas that they have for small nations
>
> just doesn't work, you know, it's based on population and our needs are greater ....
>
> We end up with half-time workers, quarter time workers and nobody wants to
>
> come and work for the small nations on a quarter-time salary or half time salary,
>
> so they just come in and we have a turnover in staff because nobody wants to stay
>
> and collect a small salary, you know, it's only the ones that have, I can't really, I
>
> don't know how to put it, they haven't worked for the, the real feeling inside to stay
>
> and say, okay, I'm going to help..... We've got a staff of about eight people with
>
> about twenty-four different hats (laughs). (RP4)

Several participants in this study spoke about being marginalized in decision-making forums

by the lack of presence of other Aboriginal people. As this Chief notes, the problems of small

Aboriginal communities do not necessarily grab the attention of the larger body when so few

people are being represented in large regional forums. Funding formulas often preclude

special attention to Aboriginal mental health issues because of the small numbers. The

liberalist notion of equality, discussed in Chapter Five, does not recognize the disadvantage

imposed by being a member of a particular group (Browne, 2001; Pal, 1997; Sherwin, 1992;

Young, 1990). Another Aboriginal participant, who works as a director of an Aboriginal

health agency in an urban center, comments on these decision-making forums:

> P: And it goes back to respect again and I can really feel for those people that sit
>
> on those committees because they'll start and they'll quit because it's just like you

just sit there and you're like a token... and the only reason I had a real voice in the last while is because we hosted all the CEO's in the province....and I was the chair (laughs). (RP8)

This participant also expressed concern about the small number of Aboriginal people sitting around the decision-making table and went on to discuss the need for Aboriginal peoples to become "political," (i.e., as advocates), in order to access mental health resources for their people/ communities. However, in discussing their own work, many of the participants talked about how exhausted they were by trying to provide leadership within their respective programs as well as representing their community interests at the bargaining table. Another Aboriginal participant, who is a director of Aboriginal health within a health body, speaks about the importance of *fair* representation, (i.e., safety in numbers):

P: I mean through the development of any mental health policies or guidelines there should be at least two or three Aboriginal people sitting on there so they can give direction and guidance in the development from the Aboriginal point of view..... (RP2)

A situation of risk is created by the much smaller numbers of Aboriginal peoples in any given region, that is, Aboriginal mental health issues may not get on the agendas of the regional health authorities without strong Aboriginal voice in mental health decision-making forums. Without it, Aboriginal issues and needs are at risk of being lost.

In a slightly different vein, an Aboriginal participant, working as a director of an

Aboriginal health agency in an urban center, added further to the concerns about

regionalization:

> P: ... I've been meeting with the CEO's from all over and what I'm understanding
>
> is that we're going back again sixteen or more years to trying to educate the
>
> provincial government and it's frustrating to be another fifteen years trying to
>
> create that understanding within the region. (RP8)

Since these interviews five regional health authorities have been created, each with

responsibility for Aboriginal mental health. Consequently, there are new players with varying

levels of understanding of and interest in Aboriginal health, who require education. It should

be noted that, while the regions are mandated to provide health services to Aboriginal

peoples, each functions relatively autonomously regarding the prioritization (or not) of

Aboriginal mental health issues (Fieldnotes, P19, October 4, 2003). There is a notable lack of

regional resources being allocated for Aboriginal mental health in the regions.[122] The lack of

designated provincial funding in the area of Aboriginal mental health limits long and short-

term strategic planning in this area.

Although "closer to home" concepts might work better for Aboriginal people in some

ways, the small numbers of Aboriginal peoples at the bargaining table places them at higher

risk of having their needs ignored. In addition, as noted in Chapter Two, regionalization

brings decision-making to the local level where there are many interest groups in the

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[122] In the last one and one half years, nine *Aboriginal mental health liaison worker* positions have been created across the five regions and all have been hired, however, there are limited *designated* resources attached to those positions to develop mental health programs. There is one First Nations mental health worker who has been working in Vancouver's downtown eastside as a liaison person between the Strathcona mental health team and the Aboriginal community for the past five years. The liaison worker provides a bridge between Aboriginal people seeking services and the mental health clinic and in addition, will help people access Aboriginal healing approaches as appropriate (R. Peters, personal communication, September, 2002).

decision-making process with strong lobbying power (Dickinson, 2002).

In the following interview excerpt, a non-Aboriginal policy participant, involved in the process of mental health reform, adds a further caveat regarding the policy - funder relationship:

> P: So I mean the funding that is provided from this section goes over to the other side as it were (federal to provincial). <u>Although we within our policy group, we don't actually fund</u> but, you know, a few years ago, we did. And those funds go out to the regions. So I presume what happens is in a region, we'll say a region with a fairly high Aboriginal population, the northerners in particular, that the discussion of [who pays for what] is very front and center with the health boards. (P18)

Here the participant reminds the researcher that policy decision-making is now quite separate from funding arrangements (which might account for this participant's earlier lack of clarity regarding current federal-provincial responsibilities in the area of Aboriginal mental health). This narrative also suggests that this kind of funding arrangement distances policy people from how resources are allocated, and thus from some of the responsibility for their decisions.

The data from this study and several authors (Cairns, 2000; Elias & Greyeyes, 1999; O'Neil et al., 1999; Ponting, 2001) suggest that the jurisdictional debate continues to act as a significant barrier to the development of comprehensive federal/national, provincial, and/or regional Aboriginal mental health strategies. The lack of clarity and resolution regarding who has responsibility for Aboriginal mental health attached to colonialist policies and ideologies and coupled with economic constraints on the health care system, has contributed to the poor response to Aboriginal mental health concerns.

In the next section, I examine how the mental health institutions and policies fail to meet the unique needs of many Aboriginal peoples as located within their unique beliefs, values, organizations, and social histories through the privileging of dominant culture biomedical approaches to mental health, and thus support the embeddedness of ideologies of assimilation.

## Worldviews: Drawing on Discourses of Culture

As mentioned in Chapter Four, at the beginning of each interview, I first asked the participants in the study if they felt a tension (or tensions) existed between Aboriginal understandings of and responses to mental health and illness and the mental health system, and, if so, how they would describe the essence of that tension. This initial interview discussion revealed several themes that became the thread to mapping out the social relations that underpin the tensions and disjunctures. Consistently participants began by speaking about the difference between Aboriginal worldviews and those of the mental health system, (i.e., the "Western" worldview). Most participants then described the exclusion of Aboriginality as an exclusion of Aboriginal knowledge attached to the discrete differences between worldviews – between ideas about health and healing. In the following interview excerpt, the participant, a nurse and educator in a large urban setting, uses the braid to illustrate an aboriginal perspective on 'health' (Diagram 1):

> P: ... what the braid represents to Aboriginal people is one strand meaning the body, the other strand meaning the mind and the last one meaning the spirit so you have three strands and those three strands are braided together. Looking at mental health, that would be under the mind. Usually what happens in the mental health system as it exists today, they only deal with the physical part of the mind using

drugs, not really looking at the spiritual part, the third strand of the braid, therefore, the whole body isn't cared for. <u>So in order to be holistic, you need to braid those three strands together, the mind, the body and the spirit. If you don't, you're dealing with two things. You're dealing with the physical aspect of the person and the mind aspect of the person, that isn't really good enough. You need to bring in the strength of Aboriginal people and that is the culture, that is the ceremony of prayer, of our own healing lodges like the sweat lodge or the long house or the elders. The language is part of our people, the land is also very important to our people because the land has everything that we need in order to exist on this earth</u> ...(RP12)



**Diagram 1: Holistic Health**[123]

Here the participant is clear that this is the way Aboriginal people view health. Drawing on the notion of *interconnectedness*, this individual, like most of the other Aboriginal participants in this study, explains health as the interconnection of mind, body, and spirit with language and the land. The inability or unwillingness to understand this worldview difference is described as one of the fundamental tensions between the mental health system and Aboriginal understandings of and responses to mental health and illness. While the biomedical system has tended to treat the body and mind as distinct and separate entities,[124]

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[123] Used with the permission of the participant, although drawn horizontally rather than vertically for purposes of preserving space.

[124] A theory which has been central to the history and development of Western biomedicine is the mind-body dualism first proposed by Descartes and later developed by thinkers in all of the human sciences (Hepburn, 1988). "Descartes acknowledged the existence of human elements which were beyond the reach of science, but relegated them to the non-scientific domain of religion and philosophy. Cartesian dualism is clearly evident

using the language of disease and its impact on various body organs and systems, Aboriginal

medical systems are centered on the belief in the indivisibiliy of the physical, mental,

emotional and spiritual aspects of the self, and thus captures the context in which the

individual and community live, that is, both the physical and social environment. Many

Aboriginal people believe that illness is the outcome of a lack of balance or harmony in one

or more of the physical, mental, emotional, or spiritual dimensions of life (Brant, 1994;

McCormick, 1996; Mussell et al., 1993; Waldram et al., 1995; Warry,1998; Waterfall,

Joseph & Van Uchelen, 1994 ).

In the following interview excerpt, the participant, an Aboriginal educator and healer

in a rural Aboriginal community, elaborates further on Aboriginal belief systems today:

> P:  Well our <u>worldview continues to evolve</u> but I think that we have cultural
>
> beliefs and tenets that are continuous and they define how we adapt but <u>essentially</u>
>
> <u>the values remain the same so</u>, for example, in regards to mental health, we have a
>
> belief system about wellness and maintenance of wellness. However we're
>
> currently facing a magnitude of issues, multi generational that have forced us to
>
> realize that we need to redefine, you know, wellness, in the context of what faces
>
> us in eventuality... So [our worldview] is evolving in the context of our response
>
> to various crises [that have] magnified and multiplied. (RP14)

According to this participant, regardless of the evolution of an Aboriginal worldview, there

are cultural beliefs and values that remain continuous and essentially direct how people live,

for example, *wellness* as a focal point of mental health. This was a common theme across the

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today in the conceptual distinction between disease and illness, referring to the objective evidence and the subjective evidence, respectively, that characterizes contemporary Western biomedicine" (Thorne, 1993, p. 1932).

interviews. Although many of the participants noted the dynamic nature of and heterogeneity across Aboriginal cultures, they also reported a fundamental difference between Western and Aboriginal medical systems related to this idea of a worldview.

As noted in previous chapters, the mental health culture is characteristically marked by its long history of attachment with psychiatry, generally propagated as a "scientific" approach to the erasure of illness and/or the symptoms of illness. In this worldview, mental health and illness are generally seen as two sides of the same coin (Fernando, 1991, p. 199). Therefore, it is not surprising that the target population of mental health reform over the past decade has been those persons with *serious and persistent* mental illness (SPMI), which is considered to be primarily biological in nature, and often amenable to pharmacological intervention. As mentioned previously, in keeping with health care reform across the country and elsewhere, the 1998 Mental Health Plan (RRBC) renewed its commitment to designate people with SPMI as its highest priority for services, to sponsor effective innovation, and to improve the accountability of the system (Berland, 2001, p. 2).

What does this mean for Aboriginal people whose mental health issues are most often related to the aftermath of colonization and consequent life circumstances? An Aboriginal participant, working as a therapist within an urban Aboriginal treatment facility, discusses this:

> P: Aboriginal people who have decided that they require some help first of all have reached probably more of a breaking point than non-native people because they're pretty apprehensive to enter any system of authority for fear of losing their children or for fear of losing their dignity... fears around white people in general.... And the whole institutional system, right, like people are usually quite

fearful so they've reaching a breaking point and are quite vulnerable when they have decided to reach out for help. Now some people will go through social services and that and of itself doesn't work out ninety-nine percent of the time - or with a non native counselor or with just a lay person, for two reasons. One is, health workers in outreach or anyone whose not native usually doesn't understand the effects of residential school or the effects of racism or any effects of living in segregation, whether that's ghettoization in the city or on reserves - so all of those details get missed. So someone will come in and say, I'm suffering from a lot of anxiety, I'm paranoid, I feel like my life is falling apart, I feel helpless, I feel hopeless and then someone will say, well, you've got schizophrenia or you've got this and they want to give them pills and they don't really understand that a lot of Aboriginal people presenting with mental health problems [are related to] long term exposure to trauma, whether that was in the home or in residential school system or an extension of that foster care or jail or the street, right?.... So the disjuncture exists then in that - we're misunderstood and the people are pathologized as people who just have drug and alcohol problems or family violence problems... Even in communities where they're dry, so not using drugs and alcohol, there's the same level of violence and that level of violence stems from, a deep pain, like group trauma... And there's a lot of anxiety and paranoia... people presenting with personality disorders or an anxiety disorder or depression and quite often it's a result of long term exposure... and they're normal people reacting to abnormal life circumstances. (RP7)

The participant places the mental health of Aboriginal peoples within its historical and social context and in this respect, several points are raised in this narrative: 1) the large institutions of mental health, both literally and figuratively, are reminiscent for many Aboriginal peoples of colonial and neocolonial practices, for example, the apprehension of Aboriginal children into care, their institutionalization within residential schools (and boarding homes), and the negative attachment to Aboriginality, (i.e., racism); 2) the invisibility of Canadian colonialist history to many Canadians, in this case, health care providers, leaves them unfamiliar with and unaware of important data that would inform assessment and treatment sessions; and, attached to this last point, 3) there is risk of pathologizing and/or misdiagnosis when mental health problems are assessed out of context and through cultural blindness, for example, failing to consider the natural consequences of a history of *group trauma* for Aboriginal peoples.

As Ponting (2001) asserts, "on a daily basis in society, the dominance of the dominant group's culture is expressed through various acts of omission or commission that redound to the detriment of those of other cultures" (p. 54). Mental health assessment and treatment are never neutral activities, however, in the context of Aboriginal mental health, the invisibility of Aboriginal histories and consequent social issues place many Aboriginal people at risk of not having their needs met.

As the participant above notes, the legacy of colonial violence has taken a serious toll on the mental health of many Aboriginal individuals, families, and communities through residential schools and the consequent disruption of family and loss of language; reserve life with unemployment rates as high as 90% in several locales, and disconnection from foundational cultural norms and practices and consequent loss of identity. Yet there is little

allocation of resources to develop innovative approaches to suicide prevention and health promotion programs that address these needs across Aboriginal communities. A non-Aboriginal policy participant, who was involved in the reform process, provides another perspective on this issue:

> P: When we identified the priority areas for reform, we purposely tried to steer around diagnostic [categories] and we identified the personal impact or degree of disability as the criteria. In that sort of approach, it's possible to look at other things like substance misuse, conceivably family violence. <u>So it doesn't fit quite so neatly and certainly risk of suicide [would be addressed], regardless of the cause and you can have an anxiety disorder which is leading to this (suicide)</u>.
>
> (P21)

The participant believes that the mental health system is able to accommodate the health concerns of Aboriginal peoples because the criteria for assessment and treatment is attached to level of functional *disability*, (i.e., "an emphasis on adults with the most disabling functional impairment due to serious mental illness," RRBC, 1998, p. iii), rather than to specific diagnostic categories. There is some latitude for interpretation in terms of the mandate of mental health.[125] At least some Aboriginal mental health issues could be accommodated within the mandate of the 1998 Mental Health Plan. But how can this arrangement attend to the unique understandings and needs of Aboriginal peoples? In the following interview excerpt, an Aboriginal participant, working as a director in an Aboriginal health program, comments on how the needs of Aboriginal peoples might be met:

> P: For Native people, especially now that they've lost their identity, their whole way of life, of being in this world that really matters, and losing their ways of

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[125] It is important to note that Aboriginal people *do* access the mental health system.

being role models as parents of children internally and quite often becoming addicted to alcohol or drugs and a lot of family violence and sexual abuse because of the government's policy regarding the residential schools - what Native people really need to get back to is their core and an understanding of themselves and an understanding of where they came from. [They need to understand]how to be able to get back to those places of pain but not be stuck in them and to be able to visit there but move out of it, move out of that pain. I think that through Aboriginal programs [they might do that]. We've designed ours around various ways of working with Native people because it may not be just one particular way. There would be, for instance, in our counseling program a component of family reconstruction. And I think that what has to be done is to make people realize that where they are from has been a place of power and that even though that's been lost, they can regain that. By working through those issues and looking at the strength that was there. When we first started our own programs, one of the things I realized was that (I was working strictly with suicidal teens whether they were native or non native but particularly the native youth) they may not even know what band they were from. They had no identity and the feeling was they were just condemned or there was really no hope, there was nowhere to go, all they'd ever seen was drunkenness and poverty and they felt that that was their lot in life and that's where they were going to go to and so when we started designing our program, we started designing around those issues - find out who your family is and where are you from and what language area you come from. Yes, there may have been abuse, but how do you deal with that abuse and that's where some of

those specific areas [of support] may or may not come from the Native
community. <u>It could be within our own programs but it could be also from outside
and we use a lot of skilled resource people in our programs that are both native and
non-native. It depends on if they're really well known in their field for doing that
particular kind of work that fits into that holistic program.</u> (RP8)

Prompted by the notion of *cultural safety*, this narrative raises questions in relation to the
previous excerpt: Although some Aboriginal people may be able to access the mental health
system, would its assessment and treatment modalities, which are most often tied to Western
biomedical approaches, fit with the needs of Aboriginal peoples? For example, would the
assessment include a history that was sensitive to asking about an individual's understanding
of family and community; and/or, would treatment options include approaches to family that
reflect an understanding of Aboriginal histories and social locations, for example, include the
possibility of engaging the client in repatriation or reconstruction processes if that were
deemed appropriate and possibly useful? Cultural safety reminds us that it is not enough to
be attuned to the health beliefs and practices of different ethnocultural groups, but that we
must also uncover the ways in which inequities are manifested at the institutional level
through, for example, discriminatory practices. An Aboriginal participant, working as a
consultant in an Aboriginal health agency, comments:

P:  <u>When you go to a mental health clinic or a mental health professional, they may
not [consider the residential school issue] as mental health…It doesn't fit into their
forms… that doesn't fit in one of their little boxes that they have.</u> I think that
Aboriginal people have a lot of problems with mental health services but it may not
be because they have [problems related to the residential school issue]. I think it's got

more to do with the fact that the people offering the services don't understand about Aboriginal people and their cultures. There's a lot of differences between a non-Aboriginal and Aboriginal person accessing services. A person in the profession may not see it as a mental health problem. But the person that's having the problem sees it as a mental health issue... <u>Also, if you go to a mental health professional, they'll look after your mental health, but they won't think about looking after your physical or your spiritual being or any of that and that's what makes us whole</u>. And when you look at the community as a whole, a community looks at everybody from young to old. <u>And, if you go to see a mental health professional, you may be looking after your nieces and nephews or you may be looking after children that aren't your own or you may be looking after an elder that's not part of you and they have a hard time understanding how that fits into [your definition of] family</u>. (RP11)

Here the interviewee describes the way in which Aboriginal people may be excluded from receiving services that fit for them and/or receive services that do not fit with their values and beliefs and thus seem "foreign" (P20) or "unsafe" (Wood & Schwass, 1993). Again, this narrative suggests a relationship between the dominant biomedical approaches, including "the little boxes," (i.e., relevant information that fits with those approaches), and the exclusion of data that is pertinent to Aboriginal understandings.

At the beginning of the research process, I was under the impression that the central disjuncture between Aboriginal understandings of and responses to mental health and illness and the current mental health system was the target population of mental health reform, those persons with serious and persistent mental illness – a focus that excludes the most serious mental health concerns of Aboriginal peoples. However, further analysis of the data suggests

that the issues of *access* and *fit* are both highly problematic. Although the criteria for admission is an issue because of the ambiguity created by the notion of "serious and persistent" and its consequent multiple interpretations, the most often cited problem in relation to the mental health system was access to treatments that fit for Aboriginal peoples. For example, assessments that begin from the place of "functional disability" or an "illness" perspective may run the risk of missing the stories that make the connection to Aboriginal histories and strengths. While it is recognized that there can be utility in treating *problems* as a pathway to wellness, the findings of the *Native Strengths Project*,[126] 1996, in the Downtown Eastside of Vancouver, B.C., suggests validity for an approach which begins with supporting the existing strengths of Aboriginal peoples in addressing mental health issues (VanUchelen, 1996; VanUchelen, Davidson, Quressette, Brasfield, & Demerais, 1997). Another Aboriginal participant, who works within an Aboriginal health board, shares a personal experience with healing that illuminates what this difference in perspective might mean:

> P: ...and I really couldn't deal with it, the context or what happened simply because there was no sense of connection and a big part of me needed to deal with the problems and to trust that I could deal with the problems. I needed to know what my resources were... And my resources, my *strengths* [emphasis mine] were those that came from my community, my family, my identity, my connection to nature and the spiritual part of me - just really knowing that I could do whatever I needed to do if I knew where I could draw my *strength* [emphasis mine] from.(RP2)

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[126] The purpose of the *Native Strengths Project* was to provide a research base for culturally appropriate 'First Nations' mental health initiatives in Vancouver's Downtown Eastside. A series of interviews with Native participants was the source of research information.

This sentiment was expressed by many of the Aboriginal participants in the study. Generally, they noted the need for mental health services to reflect an understanding of "group trauma," and its rather serious consequences such as "lost identities." In addition, the participants underlined the importance of Aboriginal notions of connection and strength related to family, community, and healing practices that honour the connection between physical, mental, emotional, and spiritual aspects of the self. Most of the Aboriginal participants stressed an understanding of individual mental health within the context of family mental health and, importantly, community mental health. Another Aboriginal participant, working as the director of an Aboriginal health agency offering mental health services in an urban setting, elaborates on this further:

> P: A lot of the programs were set up when I arrived and they're meant to be on a holistic level, in other words, <u>using the medicine wheel</u> concept. I really like that concept. <u>I believe in a mix of traditional, contemporary [practices], particularly for residential school survivors.</u> It's important because a lot of our target group..... have been removed from their communities for quite some time and they need some reconnection. I mean there are very, very glaring reconnection issues that need to be attended to. They're sent away from their home base or their home community for a number of years and so to utilize, if that's a word <u>we want to use, the elders in that way where they can begin the reconnection, repatriation process,</u> that would be wonderful, and we want to do that in a non-intimidating way.
>
> (RP10)

Regardless of whether or not the medicine wheel, braid, or other symbolic tool was used as part of the healing practices in the participants' community of origin, many providers saw

them as useful and several had adopted them into their life and/or work practices because of their fit with Aboriginal belief systems. For most of the Aboriginal people who access this particular program, the years of disconnection from family/community as a consequence of residential school experiences and/or intergenerational trauma had left them alienated from their own people and traditions. An Aboriginal participant, working as a consultant in an Aboriginal health agency, comments on the important connections in community:

> P:  I guess one of the things that comes to mind is that First Nation people for years have taken care of the problems... I listened to my grandfather and it's a wonderful, wonderful story and he talked about the problems that existed before the white man ever came and I know if he was consulted on matters, that he would have shared his knowledge openly and willingly... unfortunately he went to his grave with nobody ever considering that he was knowledgeable... And that his experiences and his awareness were worth so much... Being a person who has studied, I value my academic knowledge, however, that's not the only knowledge that exists about us and I really believe that we need to draw from the resources and the knowledge of all individuals especially those individuals who are out there and who know about First Nation needs. I don't think they're called when or if big decisions are made and that's the biggest tension - is not being included and not seeing what they have to offer as being as valuable as those people who are, again, you know, the so- called experts on mental illness... So that's the tension I see - the lack of inclusion and the lack of recognition of the incredible knowledge... We deal with mental illness in a different way. We have wonderful Aboriginal healers who will take people out to ceremonies and these individuals come back with a whole strong sense of relaxation and more....

You see these individuals come back and are feeling good about who they are.

(RP11)

This narrative, and many other similar accounts, suggest an important linkage to the knowledge of elders and healers in the provision of comprehensive mental health care. Healing is multifaceted but for many, the approach described above will be central to their well-being.

Along these lines, several participants noted that seeking *wellness* is incommensurate with accessing a clinic with the name "mental health." In the following interview excerpt, the participant, a director of an Aboriginal health organization notes this problem.

> P: ...I found in the survey that we did that people thought that if you had a mental health [issue/illness] that you're either insane or crazy and that the treatment didn't include examination of some of the other issues [for example, residential school trauma]. Maybe if we changed the name from mental health to something else. We even found that in our communities that if you have a mental health worker, people won't go to see them but if you change the name to something else that has a more positive connotation people are more apt to go ...
>
> R: Can you think of some names off hand that people think would be more helpful?
>
> P: ... One that comes to mind is family violence worker. We found it doesn't work but if you have changed it to a family support worker, or healthy families, or just changed into more of a wellness focus (RP11)

Many of the Aboriginal participants spoke about the way in which a label like mental health (and mental illness by association) is likely to alienate people because of the attachment it

has to being "crazy." The vernacular of mental health with its strong presence of psychiatry tends to be illness-centered and is often perceived as contrary to beliefs about health that are wellness-focused. The language of "illness" feels somewhat alien to those persons who are seeking assistance for mental health concerns created by "abnormal life circumstances" (RP7) rather than because of "serious and persistent mental illness." An Aboriginal participant who is a health provider working in an Aboriginal mental health setting comments on this further: "they're normal people reacting to abnormal life circumstances....You know, right now, here and now in this moment, mental health problems in the Aboriginal community are not because we're Indians, it's because of a community experience of trauma" (RP7).

Here, the participant is responding to the labels attached to mental health services and to the way in which ethno-racial identity has become an explanatory tool for the ills of Aboriginal people. In this case, the participant had noted the high incidence of sexual abuse amongst those in her program, not associated with being Aboriginal but rather understood as a consequence of a prolonged period of oppression, family disconnection, and consequent intergenerational trauma. According to this participant and others, many of their clients were not comfortable accessing mainstream mental health services because of labeling that ignored the complex problems associated with their various histories. Along the same line, another Aboriginal participant, working as a director of a mental health program in a rural setting, notes the problems associated with the language of mental health/ addictions:

> P: They should eliminate all alcohol and drug workers, the title alcohol and drug workers and convert them to community wellness workers... <u>Alcohol and drug has a defaming sound to it, you know, like, we're lower than</u> ... (RP1)

A protracted period of oppression and "status domination" which has occurred through "forcible ascription of negative identities" such as the "drunk Indian" (Furniss, 1999, p. 129) may, at least in part, be responsible for reaction to the alcohol and drug language used here. While there is also a stigma attached to this kind of service label for many non-Aboriginal people, the historical location of Aboriginal peoples stands to impede access further.

Without critical consideration of *difference*, the mental health care complex may remain impervious to meeting the unique needs of Aboriginal peoples (and other minorities) as located in their unique beliefs, values, organizations, and social histories. These differences are basic and powerful enough to define shared worldviews, interests, and even cultural norms among many Aboriginal peoples. Pal (1997), in considering "the politics of difference," notes the growing challenge for public policy to address the routine and systematic oppressions that are a consequence of a failure of social and political institutions to accommodate *difference*. The concern is that "the application of universal rules will only serve to further disadvantage these groups and suppress their individual differences" (p. 51).

## Summary

The analysis of the data suggests that the tensions and disjunctures are located in the relationship between federal, provincial, regional and Aboriginal governance bodies regarding *who is responsible* for Aboriginal mental health. Bureaucratic obfuscation regarding who has responsibility provides the opportunity for an abrogation of responsibility at structural, institutional, and practice levels. In addition, the inattention to worldview differences across ethno-cultural groups and the predominance of Western biomedical approaches to address "serious and persistent mental illness" within the mental health system unwittingly places Aboriginal people at risk of not having their most pressing mental health

concerns met and/or places them at risk for inappropriate diagnoses and treatment. The

jurisdictional divide intersects with the way in which *difference* is treated within mental

health institutions and policies to render invisible Aboriginality – to support the

embeddedness of colonial ideologies and, in particular, an assimilationist ethos.

In the next chapter, I examine the everyday practices within the mental health care

system that act as barriers to access for many Aboriginal peoples (i.e., to the tensions and

disjunctures).

# CHAPTER SEVEN

## EVERYDAY PRACTICES IN MENTAL HEALTH:
## THE TENSE THINGS THAT HAPPEN

### Introduction

In this chapter, the focus of the analysis shifts to the everyday practices within mental

health service delivery that shape and are shaped by ideologies and taken-for-granted

assumptions embedded within mental health institutions and structures. I examine how the

treatment of Aboriginality, culture and differences are interwoven and reproduced in the

routine everyday world of mental health service provision from the perspectives of

Aboriginal and non-Aboriginal people in their various roles as grass-root providers, healers,

educators, program directors, and policy-makers. Health care settings are not neutral

apolitical institutions but rather must be understood as microcosms of the social world

(Browne, 2003). As Anderson and Reimer Kirkham (1998) argue, "Health care systems

reflect the cultural values and the status of individuals within nations. As such, a health care

system is a product of a country's history and culture... [I]t is also instrumental in

constructing nation by shaping identities and experiences, institutions and policies,

oppressions and inequities" (p. 245).

Informed by postcolonial perspectives and the notion of cultural safety, I pose one

central question in this chapter: what are the everyday practices that act as barriers to access

to mental health services for Aboriginal peoples? – i.e., What are the tensions and

disjunctures between Aboriginal understandings of and responses to mental health and illness

and the current mental health? Polaschek (1998) redefines cultural safety as follows:

Nursing practice that is culturally unsafe includes "any actions that diminish, demean

or disempower the cultural identity and well-being of an individual." Culturally safe

nursing practice involves "actions which recognize, respect and nurture the unique

cultural identity of the Tangata Whenua,[127] and safely meet their needs, expectations

and rights." (p. 453)

Here I use the concept of cultural safety from its New Zealand context to examine the

tensions and disjunctures that occur in the everyday world of mental health service delivery.

As the analysis unfolds, it becomes apparent that there are serious barriers to access to mental

health services and as such, mental health care, for Aboriginal peoples. Some of the most

poignant accounts from providers reveal how everyday practices[128] in mental health are

experienced as paternalistic *and/or* exclusionary. In relation to cultural safety, while

Polaschek has outlined what should be considered "unsafe" *nursing* actions, this study

focused on everyday actions across the mental health care system at large. Participants'

accounts typically reveal a general failure of mainstream mental health services to provide

accessible and equitable services to Aboriginal peoples,[129] and although this also is

reportedly the case for many non-Aboriginal people (Hall, 2001), Aboriginality clearly

attracts another level of prejudice and consequent harm located in a long history of collective

oppression and marginalization.

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[127] Referring to the Indigenous peoples of New Zealand, the Maori.

[128] Here I am referring primarily to everyday practices in mental health service delivery, sometimes noted in the interactions between people but most often here referring to the ways in which services are offered (or not offered).

[129] The Aboriginal participants in this study who work within mental health or related fields (RP) are familiar with issues of access to the mental health system in a number of ways. Firstly, they may be troubleshooting for resources for the agencies in which they work. Secondly, they may be assisting with access to services for their clientele and/or thirdly, liaising with other mental health service providers across the continuum of care. In addition, as mentioned earlier, several of the participants in this study have accessed mental health and/or addiction services at one time.

The failure of traditional, mainstream social and health care agencies to provide accessible services to racial and ethno-cultural client groups has been well documented and several authors contend that it is a manifestation of individual, cultural, and/or institutional racism (Armitage, 1999; Essed, 1990, 2000; Henry et al., 2000; Ponting, 1997, 2001). In their work, Henry et al. note that

> [s]ome of the barriers to health and social services identified by minority-group clients were lack of information about the services provided, the unavailability of service, the service providers' lack of knowledge of the linguistic and cultural needs of different groups, and the inappropriateness of treatment modes and counseling. ( p. 210)

In addition to these findings, the analysis of the data in this study revealed a lack of educated Aboriginal health care professionals working in the field.

The participants' accounts of their current experiences with mental health services were constructed somewhat differently depending on whether they were talking about services in the urban or the rural setting. For those in the urban centers, the issues were primarily related to the lack of appropriate/"culturally relevant" services, whereas for those in the rural areas, (i.e., reserve), it was more about an absence of resources and services and/or whether an existing service was appropriate.[130] Common to all participants was the

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[130] For example, in the rural reserve setting, the issue of confidentiality was an often cited problem – the counselor you may need to see could be part of your extended family or be connected in some way with the issue of concern (for example, the sister of an abuser). The "fishbowl' quality of community life in and of itself raises a particular set of issues which makes access to outside resources a more urgent concern. Even in a larger community of approximately 1700 people, this issue was raised by several community members in a workshop regarding the development of an *Integrated Mental Wellness Program* within that community (Jorgenson & Smye, August, 2000). The concern about accessing someone who is known (perhaps an Auntie or a friend's mother) is compounded by the politics of reserve life in some communities – mistrust created from *within* community through the workings of internal colonialism adds to this complexity. Although beyond the scope of this dissertation, it is an important issue when thinking about access to mental health services for Aboriginal peoples living on reserve and one worthy of further consideration.

expressed need for services that fit with the primary mental health concerns and needs of Aboriginal peoples.

An examination of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system in the everyday of mental health care delivery reveals how some of the issues associated with Aboriginal mental health that are often ignored or rendered invisible can be illuminated as inherently linked with the ideological and structural aspects addressed in Chapters Five and Six – the ideological both shapes and is shaped by the social relations of the everyday.

## Everyday Life

In developing my analysis and interpretation, I move beyond describing the context of the participants' accounts and their experiences to explore how these might be influenced by wider social relations extending well beyond limited resources, communication difficulties, or cultural differences. For purposes of this discussion, three overlapping categories of *everyday life*[131] have been identified: a) acts of omission, b) colonial ambivalence: hypervisibility and invisibility, and c) normalization and resistance.

In the next section, I move on to the accounts of providers and policy participants as they reflect on other barriers to mental health treatment. Although Aboriginal peoples are a heterogeneous group with diverse acculturation histories, languages, customs, and cultural norms, the analysis of this data reveals several striking points of continuity across the interviews related to what participants saw as serious omissions in the mental health system.

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[131] I am using *everyday life* in the same way as Essed (1991) referring to the world in which we are located both physically and socially. Notably, "everyday life is not only reproductive of persons but also the positions of persons in social relations and of social relations themselves" (p. 48).

## Acts of Omission

The following interview excerpt with an Aboriginal policy participant, working within a government institution, provides the point of entry for the analysis of the data in this section:

> P: I suppose the simple things like staffing patterns and just the overall welcoming factor or lack thereof that you would feel as an Aboriginal person walking in to a community mental health team or something like that to say, does this look like a place where people like me hang out.... No, it doesn't, you know, it really doesn't.... I mean I suppose you'd have to imagine yourself in a foreign country where you were really one of the few people who was different from anyone else and if you're thinking about some things that are deeply personal and central to your feeling of yourself as a person and then you walk in and everybody looks and acts and speaks so differently from you, what are you going to think? Well, you're going to think, I want to shut up and get out of here (laughing) that's what you're going to think, (laughter) basically..... You know it's so hard for anybody to go into get mental health services in the first place. You need to be doing anything you can to facilitate that person showing up, support that person staying because it's a difficult thing. People always are going to be there at the worst possible time in their lives when they're presenting themselves in the worst possible way, - and then to already have a funny relationship historically say with the people that you're trying to interact with - to come to them in that state of weakness is probably not the thing that you want to do in the first place.... You know, it makes you too vulnerable to a group that you've come to expect attack from rather

than assistance, you know. (P20)

Here the participant transports us into the waiting room of a mental health clinic, likening the experience to that of a foreigner walking into a strange land: Aboriginal identity may mean "looking and acting differently" than everyone else, including the staff; and the individual may feel at odds with a dominant cultural system which, historically, has created a mistrust between parties. In addition to these relational issues, the person is in a particular state of vulnerability related to the stigma[132] attached to dealing with a mental health issue. From the outset, *difference* has negative connotations. The following interview excerpt with an Aboriginal participant, who directs an Aboriginal health program in an urban setting, provides an exemplar of the sentiment expressed across the interviews as participants spoke about the response of the mental health system to Aboriginality:

> P: And, you know, what's really disheartening is that it's a system that seems not to care about [the history of colonization]....So you've got the onus on Aboriginal people trying to make some sort of sense out of a system that wasn't designed for their needs and on the other side, you've got a [mental health] system that doesn't really give a damn overall about the needs of Aboriginal people when it comes to mental health issues. (RP5)

What is it about the everyday practices in the mental health system that made this participant conclude "they don't give a damn?" The following interview excerpts provide a glimpse into

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[132] Stigma as defined by Goffman (1990) is an attribute or characteristic that is considered deeply discrediting by the society or culture to which the individual possessing the attribute belongs. Stigma not only refers to the trait itself but to the outcome of being known to possess the trait. Stigma is a discrepancy between the expected and the actual that 'spoils' the social identity. Goffman identified three types of stigma: abominations of the body, blemishes of the individual character and tribal stigma. Abominations of the body include the various physical deformities that constitute a visible stigmatizing mark. Individual character blemishes include any personal characteristics deemed deviant by a society or culture such as addiction, mental illness, homosexuality or unemployment. Tribal stigmas are the stigmas of race, nation and religion that are transmitted through lineages and equally contaminate all members of a family or group (McCall, 2003, p. 4).

the everyday absences in the mental health care system revealed in the analysis of the data in this study.

In the following interview excerpt, an Aboriginal policy participant, working in a large health organization in an urban center, remarks on the barriers to access related to language:

> P:...How many information pamphlets go out from organizations that are published in many languages? - but let me ask you this, how many do you see here in Vancouver that are published in a Native language? (P17)

This participant was not aware of any mainstream health agency that publishes materials in any of the local Aboriginal languages. This narrative reveals the way in which dominant culture vocabulary is privileged within the mental health system. Importantly, several participants note this absence in the interviews. The challenge for programs in BC is the number of languages spoken across the province.[133] However, colleagues working in remote areas of BC, where fewer different Aboriginal languages are spoken, also note this absence (Fieldnotes, RP6, October, 2003). Another Aboriginal participant, working as a director of an Aboriginal mental health program in a rural setting, remarks: "Our immigrants get more respect than the First Nations people" (RP1), making the observation that many mental health settings carry brochures in other languages, for example, Punjabi, Cantonese, and Mandarin.

This latter notation draws attention to the issue of *respect*, common across the interviews as a reported absence between parties, generated by this kind of omission within the mental health care system, and acutely felt by many Aboriginal peoples (Royal

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[133]" Linguists concur that there are at least eight language families represented among the First Nations of British Columbia." Notably, languages belonging to the same language family may be as similar as Spanish is to French. "Language families include Algonquian, Athapaskan, Haida, Ktunaxa, Salishan, Tsimshian, Tlingit, Wakashum" (Muckle, 1998, p. 35).

Commission on Aboriginal Peoples, 1996a, 1996b; Browne, 1995, 1997; Haig-Brown &

Archibald, 1996). In addition, several participants in the study referred to the ways in which

immigrants are better treated. Consistently, this sentiment was not conveyed as a disregard

for the needs of immigrants, but rather, as expressed intent to draw attention to the "non-

place" of Aboriginal peoples in Canadian society (P19) and the dismissal of Aboriginality.

Another Aboriginal participant, working as a director of a mental health program in

an urban setting, describes several other absences that were felt to be barriers to access:

> P: ... Well I know for one thing many First Nations people do not go to the
>
> facilities and stay in them. One of the reasons they don't go into the facilities is
>
> that the facilities are not culturally sensitive to the needs of First Nation people, <u>the</u>
>
> <u>food there is very different, they don't have a First Nation person on staff, they</u>
>
> <u>don't allow for having a First Nation person come into the facility</u>...

The participant then goes on to explain the context in which these absences were described:

> There's a house and [the health council] identified a need because there was a high
>
> rate of suicide attempts, depression was high and they wanted a half way house or
>
> a facility and they decided to put the dollars into building a facility, having a psych
>
> nurse, having all these employees and I said, you know, probably most of those
>
> dollars come from the stats and probably if you go back to those stats, I would say
>
> that one third of the individuals who had attempted suicide were probably First
>
> Nations. So the dollars come available through the stats but they don't identify that
>
> the person may have been of Aboriginal descent. <u>So they get a lot of dollars and</u>
>
> <u>the dollars do not reflect the true need of Aboriginal people even though many of</u>
>
> <u>them are part of those stats and probably make up a large number</u>. (RP9)

The general lack of acknowledgment of Aboriginality within mainstream treatment facilities was a common story across the interviews. For example, here, the participant describes an absence of familiar foods, a lack of First Nations staff, and a problem of access to supports within First Nations communities, for example, elders. The narrative reveals a failure within the mainstream to consider the diverse cultural experiences of people in spite of the identified need in this community to create a safe place for Aboriginal peoples with mental health needs – commonly, Aboriginality is erased. In this instance, the issue of suicide generated support for a facility but without acknowledgement in practice of its potential Aboriginal residents – the participant notes, "where are the services that acknowledge the existence of Aboriginal practices?" Here decision-making regarding food, treatment models etc. was based on dominant culture need and perspective underpinned by notions of a *universal* subject. The lack of acknowledgment of Aboriginality in this facility makes it a difficult place for many Aboriginal people to be comfortable and, perhaps, safe. Several authors have documented the unease Aboriginal peoples often experience in accessing mainstream health services (Browne & Fiske, 2001; O'Neil et al., 1999).

In a similar vein, but along a slightly different line, an Aboriginal participant, working as a counselor in an Aboriginal mental health program in an urban setting, comments on the issue of the actual provision of counseling:

> P: And even myself, I've got lots of formal training and you do need some of that, you do, there is that fine line but then I also like to meet people in the spiritual level as well…. And allow them to have our traditional ways of seeing the spirit world in counseling too, taking into consideration, people's experiences with visitations, with ancestors, with feelings, that something bigger is happening, you

know, that it's not labeled paranoid or labeled as, you know, whatever. But then, you know, it doesn't take much brains to figure out when someone is trying to incorporate their spirituality - and it is quite an anchor in counseling…"An Inuit mother came and she showed up at the end of the bed and I was awake"…I mean those are anchors for therapy… They don't have to be seen as like a person is going nuts…. that's an Aboriginal way of seeing the world - we're living in a spirit world as well, right? And there are animals and the animals have meanings and our grandparents have meaning….. it's integral [spirituality], if you want to work with healing and Aboriginal people, no matter how cuckoo they present, you have to be willing to talk with them about what they're seeing…And have some belief in them…some of the craziness actually goes away – and then there are those clients who are struggling with mental illness…You know who they are. (RP7)

This participant and several others recounted stories of patients who were mistakenly diagnosed with a psychotic illness and therefore treated inappropriately. In the treatment domain, Duran and Duran (2000) caution against a reenactment of epistemic violence from which Native Americans have suffered for many generations. They note, "[i]f Western categorization of illness is falling short of the mark in the white community, then these categories must obviously fall much shorter when applied to the Native client" (p. 99). The subjugation of Indigenous knowledge in treatment environments remains embedded in ideological frameworks of the dominant culture that discounts the knowledge and worldviews of Others.[134] Warry (1998) notes that

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[134] I do not mean to imply here that because the system per se is underpinned by these ideological frameworks that the people working in them are necessarily insensitive to the needs of the Aboriginal people treated there. As noted previously, ideologies are ever present.

culturally relevant approaches to Native mental health stress that assistance to the clients must be situated in the context of Aboriginal community life. The likelihood of misdiagnosis or inappropriate therapies increases whenever counselors or therapists fail to account for the nature of family or community life, or when they ignore cultural beliefs and values. (p.133)

The many participants in the study who were mental health program leaders and/or clinicians, all concern about the lack of appropriate treatment modes and counseling[135] for their people, a general lack of fit. Another Aboriginal participant, working as the director of an Aboriginal health agency, discusses this further in the following:

P: ....I went and I was taking reflexology and all these different kinds of counseling courses and sometimes they really felt like - this is really interesting, some of it is really relevant for me and my people and some of it is just like trying to fit square pegs in round holes and it would make me angry, you know, I'd [think] you know this isn't going to work and this isn't going to fit, you know.... Why are we doing this and in other things it was like, oh yeah, I know this, I learnt this a long time ago... I think it was the idea that everybody is the same kind of [person] and the treatment is going to be all the same... And it's very clinical, it's ....we've researched this and this is the way it is so this is the only way that it can work....Whereas, to balance that each person is an individual and you, no matter how good a model is, it won't fit for everyone, and you have to actually do

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[135] Several participants in the study identified the absence of adequately educated Aboriginal mental health providers, both on the reserves as well as in the urban centers, as a serious obstacle to mental health care. For example, while the community health representatives (CHRs) have played a pivotal role in providing services in some communities for several decades, many are feeling overwhelmed by the lack of fit between the enormity of the scope of practice in mental health and their level of skill and education, placing them in a rather vulnerable position within their communities. Although there are an increasing number of Aboriginal providers in the field, need and availability remain grossly out of balance.

<u>research for each person that you're working with in order to see what really fits</u>

<u>for them</u>. (RP8)

This participant is challenging the everyday practice of using *Best Practice*

therapeutic models without individualizing those to fit with the client. Many participants

spoke of the need for health care providers, in particular, therapists, to tailor their approaches

to their clientele, keeping in mind the notion of differing worldviews across and within

ethno-cultural groups. According to Warry (1998) attachment to the hegemony of medical

and psychiatric institutions that dominate the field of mental health runs the risk of

continuing the colonization of community life. Although psychiatry can be useful and

certainly has its place, "there is a subtle difference between creating a supportive atmosphere

for healing – that is, an environment that promotes self-reliance – and promoting approaches

that 'institutionalize' the healing process...." (Warry, p. 162).

In addition to the issue of safety within the environment in which mental health

services are delivered, several participants spoke about the difficulty in accessing information

about available services and resources. In the following interview excerpt, an Aboriginal

participant, working as a director of an Aboriginal mental health program in a rural setting,

discusses one such resource issue:

> P:....the mental health services don't distribute all the information to every band
>
> within BC,.... where I'm from we don't receive a lot of information that's made
>
> available or any services or programs that are made available from the mental
>
> health program. (RP1)

Here the participant had been discussing the challenge presented by living in a rural

community where information about services in the urban centers often is not made

available. Physical distance from agencies and costly transportation also seriously inhibited

access for the community. Although this is also true for non-Aboriginal people living in

those regions, many authors (Fanon, 1967; Daes, 2000; Kelm, 1999) have identified isolation

as an important tool of colonization that has devastating results. As Daes writes,

> A fundamental weapon used by most colonizers against colonized peoples is to
>
> isolate the colonized from outside sources of information and knowledge – and
>
> then bombard them with propaganda carefully aimed at convincing them that they
>
> are backward, ignorant, weak, insignificant and very, very fortunate to have been
>
> colonized. (p.7)

In using this rather poignant quote, I am not suggesting that the mental health establishment

is deliberately setting out to isolate Aboriginal peoples, rather, I am attempting to uncover the

places and ways in which these practices remain embedded and unexamined. To many of the

participants this is not just about geographic location but about absences and erasures that

have occurred historically and often have serious consequences. Reserve life has isolated

many Aboriginal peoples from the knowledge of what might be available to them. Along

these lines, the Chief of a rural reserve relayed the following story to the researcher:

> P:...<u>A couple of years ago we had a homicide here. We didn't know that Victim</u>
>
> <u>Services was available for our community.</u> We didn't know where to turn to
>
> because of the trauma that hit our community .... It was about a week later that we
>
> find out Victim Services could have had a team down here to help us out. We got a
>
> hold of *name of Aboriginal organization* and got a hold of *name of person* and he
>
> came down and we went to medical services there to find out about getting some
>
> resources to help our community but by then the big wave was over and nobody

wanted to talk about it. But it's awful when a siren comes by the reserve, everybody jumps up and looks out the window to see where, it's not stopping here is it, on the reserve? So that trauma is still there, you know, and it has been over a year now.... When you hear a siren go by or come down, you wonder what's going on, what happened now? And we still haven't been able to resolve the whole thing and when you hear a car backfire it sounds like gunshots and you say, oh no, what happened now?... But, you know, we could have had somebody in here to help us through that whole process and to be able to talk it out or do whatever had to be done to deal with it. So our community is still suffering from that. (RP4)

The narrative provides an exemplar of harm done when communities are not aware of the services that they can access. Unfortunately, this was not an isolated incident for this community but rather one in a series of tragic events that placed the community at serious mental health risk. This challenge, coupled with the lack of a funded mental health program, creates a serious obstacle to mental health care in this community and many others like it across the province. Importantly, when trauma occurs in this kind of environment it does not simply affect one or two people, rather it becomes an experience of group trauma – a recreation for many of a colonial past. In the following interview excerpt, the same participant reports on mental health service delivery:

> P: I think one of the big ones that comes to mind is when our people have problems, they know what those problems are, they don't know where to find the services that they need.... You know like I said earlier, when a person knows that they've got abuse issues, they want to get out of that abuse and there's no place for them to go..... You know, so where do they turn then?...... And I think that's the

biggest one is that there's a lack of services to our people and when there are

services, there's such a long waiting list that then discourages people to make those

changes that they need in their lives. (RP4)

All of the participants in the study, regardless of geographic location, spoke about the lack of

mental health programs and services (including addiction services), Aboriginal and

mainstream. However, this was more apparent in the rural and remote areas. In the following

interview excerpt, the participant, an Aboriginal director of an Aboriginal mental health

program, describes the plight of the youth in a rural reserve community in BC:

> P: You have to take into consideration why the majority of our youth have
>
> developed mental health illnesses at such a very young age and one of the most
>
> important factors is the lack or non existence of mental health services in our
>
> community ... For youth, for anybody.... You have a big mental health program
>
> but where is it? In the lower mainland. We live a thousand miles away in the
>
> northern of BC and we don't have the technology, the majority of our people are
>
> on social assistance and, you know, the unemployment rate is so high, we don't
>
> have that technology [referring to telehealth].... So they die with a mental health
>
> problem without help.... You know, and the mainstream society doesn't
>
> understand that... Our lives are just as important as everybody else's but we can't
>
> access the mental health program services.... we don't have the dollars from
>
> medical services to bring out psychologists and psychiatrist - we don't have those
>
> kinds of services. Our nearest psychiatrist that is any good in the residential
>
> school issues, government or assimilation issues, is in North Vancouver and it

costs a thousand dollars a day for his services.... We don't have that, the

government won't give us money for that. (RP1)

Unfortunately, this experience is commonplace in all rural and remote communities. As

noted in Chapter Five, decisions about Aboriginal mental health are made at a regional level.

However, although the Ministry of Health has mandated that Aboriginal health is a regional

concern, the regional health authorities are relatively autonomous in relation to prioritizing

health issues. In the scenario above, the lack of service is located in an embedded ideology in

which adherence to notions of equality bracket out differences in health status. It is a

decision which fails to consider the socioeconomic reality of different communities. The

jurisdictional issue is also implicated here – federal ceilings on increasing transportation

costs (FNIHB) and federal-provincial wrangling over who ought to be responsible add a

significant layer of complexity to the problem.

Many of the participants were frustrated with the lack of allocated mental health

resources, programs, and services in their areas, given the burden of mental health crises. In

particular, they expressed concerned about the plight of the many youth and families who are

often mired in hopelessness and despair in the context of high unemployment rates and

seemingly bleak futures in rural and remote areas of BC. Although the Mental Health

Evaluation and Community Consultation Unit (Mheccu)[136] has been successful in piloting

telehealth[137] in a couple of Aboriginal communities, the problems that Aboriginal youth and

adults face generally require a complex array of on-site health and social services.

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[136] Mheccu is attached to UBC, Department of Psychiatry, and in part, funded by the Adult Mental Health Division, Ministry of Health. Mheccu also is supported by granting agencies.

[137] Telehealth is found to be most successful in those communities with a well-trained on-site health professional. It also is not intended to replace services but rather enhance those already in existence (Fieldnote, P21).

Importantly, as this narrative reveals, some Aboriginal people want to be able to access mainstream services, for example, a psychiatrist, sometimes in addition to more traditional approaches and sometimes alone. As many in this study shared, they simply want to have that *choice* available to them.

The narratives here suggest serious omissions within the mental health system that create barriers to mental health care for many Aboriginal people, such as a lack of information in Aboriginal languages; lack of programs and services that fit with the perspectives of Aboriginal peoples; lack of educated and trained Aboriginal and non-Aboriginal health care providers, including psychiatrists and the availability of (paid) healers and elders; and the availability of <u>mental</u> health and addictions resources in and for rural and remote communities, including information about what is available outside the community.

In addition to these acts of omission, the data from this study suggests that everyday practices are tied to the way in which Aboriginality renders one *seen* or *not seen*. Participants relayed a range of examples about how Aboriginal identity either excites processes of surveillance and paternalistic kinds of interventions, or, more commonly, discriminatory practices which exclude Aboriginal patients and/or their concerns. In this study, Aboriginality was constructed in three rather distinct ways: as that which is indicative of someone "childish" and therefore requiring "care," as that which is "inferior" and therefore dominated by the "superior," if you will, and as something that does exist but does *not* warrant special privilege.

### Colonial Ambivalence: Hypervisibility and Hyperinvisibility

The following interview excerpt with a Chief of a small Aboriginal community provides an entry point to this section of the chapter:

P:  My daughter was on a tribal journey this year and she went into labour early and gave birth in the local hospital. She spent just about a week over there because it was a high risk birth and they transferred her, flew her and the baby over by helicopter and when my daughter was going to feed the baby, breast feed, the nurse said you can't do that and she said, why?  She said, well, you've got to be tested for Hep C and HIV and everything else. I think that was just because she was an Indian. I think they assumed that because she was flown in from the city, they assumed she was a needle user or alcoholic or something. So she told the nurse I've already been through that testing. She said, it doesn't matter, we've got to do the test here. So before she could feed her, feed my granddaughter [she was tested]. It's those kinds of things that upset you. I wanted her to go to the hospital and just Raise Cain with them – but it shows the ignorance that people have when it comes to Indian people, the racist attitude out there. <u>That's what we've got to deal with everyday whether it is in the hospitals or with the doctors or whatever, you know, there's no trust in that system anymore</u>. (RP4)

This narrative suggests that this young woman was transformed into an "at risk" patient, having been rendered hypervisible by her appearance – Indian and pregnant – an identity which, in this case, translated to a connection with substance abuse and/or HIV illness.[138] Although this incident did not occur in the mental health system per se, it has everything to do with mental health. It is also symptomatic of a neocolonial gaze that often defines the social relations between Aboriginal peoples and health care providers. Here the notion of

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[138] The testing of women for Hep C and HIV is *not* mandatory practice in this province (Obstetrician, personal communication , November 20, 2003).

being "unsafe," (i.e., demeaned, Wood & Schwass, 1993), was associated with surveillance structures that intruded into the life of this family in a violent fashion.

As noted by other authors in the area of Aboriginal health, power continues to operate through surveillance mechanisms to regulate seemingly dangerous behaviours (O'Neil, Reading & Leader, 1998). Although Foucault's work does not always fit with postcolonial interpretations, it offers a perspective on power relations that I find useful here. Foucault (1973) described the potential of surveillance mechanisms[139] within the institution to objectify the Other, yet at the same time, nurture self-discipline, causing individuals to *gaze* upon themselves, to evaluate their own behaviour, with the consequence of becoming *docile* or *rebellious* subjects. In the case of the narrative above, this was translated into "I wanted her to go to the hospital and just Raise Cain with them." In the above scenario, it would seem that a modification of the panopticon is operating as a kind of filter for what is deemed dangerous and requiring intervention (or not); in particular, decisions have been made based on a reading of identity as the inferior Other in need of care.

Here the focus of the analysis shifts to a set of data from interviews with health care providers working with some of the most physically visible[140] Aboriginal people in BC – those persons who are homeless or near homeless and living with complex mental health challenges and/or drug abuse issues, and perhaps other health problem such as HIV illness and/or Hepatitis C. Mental health care providers, both Aboriginal and non-Aboriginal, in an urban center, discuss the issue of 'visibility' with the researcher:

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[139] Foucault borrowed the notion of the panopticon from the work of Jeremy Bentham "which involved maximum supervision with minimum effort" (Eckermann, 1997, p. 156) and he provides an analysis of how power operates through surveillance mechanisms in modern society to regulate populations (Foucault, 1973, 1977).

[140] Furniss (1999) notes the high visibility of this population in her study in a central interior community in BC in terms of public conversations etc. I am referring to the visibility of this group in much the same way.

P: <u>There's a terrible stigma attached to people that have mental health issues, have</u> <u>drug and alcohol issues, are HIV+ and are Aboriginal. "There goes that drunken</u> <u>Indian"</u> and I've heard people say that and it makes my blood boil [many in the group nod in agreement]. (F)[141]

and

P: [Racism] is a major source of the problem, not just on a personal level but on a collective level. Personally, the individual can leave counseling and get called a fucking Indian like three times walking down the street. So how is that going to affect your healing? (RP7)

The experiences of these participants call attention to the social stigma attached to mental illness, substance abuse, and HIV illness. In addition, the narratives suggest the additional assault of "everyday racism"[142]: In this context, intersecting layers of prejudice compound the problems of Aboriginal people with complex health problems. As noted in Chapter Two, according to Furniss (1999), one of the most common images appearing in Euro-Canadian discourse is that of the "drunk Indian." In her own study in BC, she found that regardless of the widespread alcohol problems in the Cariboo-Chilcotin region among non-Aboriginal teens, an inordinate amount of public attention was focused on the problem of "drunk Indians" as the undeserving recipients of social benefits (p. 107). In the following interview

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[141] This is an excerpt from an interview with a team of providers in an urban setting offering services to persons with multiple diagnoses, all of whom are HIV+, have a mental health problem and/or diagnosable mental illness and/or a substance abuse problem. Sixty eight percent of the clientele in this setting are Aboriginal (approximately 884 persons).

[142] Here, I am using "everyday racism" in the same way as Essed (1991, 2002). It can be featured in several different ways, for example, as more blatant assault in the form of verbal (as noted here) or physical assault, or more insidiously, as racist talk, that is, racism expressed in casual conversations (1991, p. 257), or as "practices with racist implications" that become in themselves "familiar and repetitive." In this way, "underlying racist and ethnic relations become actualized and reinforced through these routines or familiar practices in everyday situations" (Essed, 2002, p. 190).

excerpt, the participant, an Aboriginal mental health care provider, shares a personal account that provides another level of insight into this issue:

> P: ...your secret voice, your quiet voice that speaks inside your mind, I mean I can't share with the people at work that I had a really nice bottle of red wine two months ago. I can't share that, it's a secret... You live a double life. [You are afraid] that somehow you're doing the wrong thing... I don't hide it. If someone asks me, I say, yes, I drink, but I say it and the voice in the back of my head says – well, now they're going to judge you. (RP7)

This participant's account points to the way in which the colonial gaze becomes internalized, in this case, casting a shadow over personal identity with powerful consequences for the relational aspect of this person's life, (i.e., *expecting* judgment from others). The same health care provider connects this experience to the clinical area:

> P: ... I just had a woman in here two weeks ago and she said, I'm on my fifth step at AA and I said, so you're an alcoholic? And she said, "I don't know." I said "what do you mean you don't know?" "Well, I drank a lot when I was a teenager." [I asked] "so you're an alcoholic?" "Yeah, that's what they tell me." And, you know, if she was a white woman, they would have said, "what the hell are you doing here?"... Because she was Native, oh yeah, okay, you drank a lot when you were a teenager so you probably are an alcoholic – and that becomes internalized....My mother said, where the missionaries left us, AA picked up.... In telling us who we are and what's wrong with us, basically telling us that's what our problem is. You see, first our problem is being an Indian, now our problem is that we're drunk and we're druggies, you know....or inhalant abusers, even people I work with here, I mean that's the first thing

they'll say to somebody, "so are you still drinking?"... and it is like "Fuck off." (RP7) The use of this narrative is not meant to impugn Alcoholics Anonymous (AA) programs per se but rather to illustrate a commonly conveyed theme in the data, that of an internalized concept of self as "inferior" in various forms and how that idea may be recreated or reinforced by mental health and addiction services. This narrative suggests that assessments tinged by preconceived notions of Aboriginal identity may fail to address Aboriginal mental health concerns and, in fact, unwittingly contribute to a reinforcement of negative self esteem/ identities. These last two narratives suggest the power of the neocolonial gaze: surveillance mechanisms operate from both *outside* and *within* the individual and collective to create new forms of oppression.

In a similar vein, one of the non-Aboriginal focus group participants points to the issue of access for those persons with multiple diagnoses[143]:

> P: ... I have worked in the mental health field for a long, long time and I've seen some Native people with severe psychotic disorders, hearing voices, responding to inner stimuli. You know that there's something very, very wrong and I've tried to get them assessed by their local mental health centers. I say this person is suicidal, they're psychotic, they're responding to inner stimuli ...and they're refused service at the mental health centers because quote: "they use drugs or they use alcohol, they don't fit our criteria". Even under the DSM IV, drug and alcohol is listed under the criteria to be assessed but they said no - only serious mental illness [Axis I diagnoses] and I'm saying, I do have a person with a serious mental illness, experiencing psychoses. They say - we're not going to deal with them unless they clean up or

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[143] Multiple diagnoses in this context usually means that the individual is living with mental illness, substance abuse issues and HIV illness and/or Hepatitis C.

unless they're not using grass or unless they're not using cocaine..... <u>How many of</u> <u>our clients actually receive mental health services that are Aboriginal? We know of</u> <u>one, two, three? Three out of thirteen hundred clients, sixty-eight percent of whom</u> <u>are Aboriginal are receiving mental health services</u> [3/884 Aboriginal clients]... That's pretty incredible when you look at the severe problems we see in this center...In that respect, I think we've made giant strides in this center, understanding our bi polar guys, you know....Understanding them, but none of them are getting mental health services.... (F23)

Here, the participant draws attention to a long-standing tension that exists between mental health and addiction services (i.e., a client may have difficulty accessing in one area if they have a problem in the other): these systems often work in isolation.[144] The participants in this clinic found that they had to provide most of the mental health support for their clients.

In a recent telephone conversation, an Aboriginal participant in this study reported that since joining national and provincial mental health and addictions committees it has become increasingly apparent to him/her that there is a dearth of services for both Aboriginal and non-Aboriginal peoples in these areas: "It is really quite appalling" (Fieldnotes, RP6, September 11, 2003). However, the above narrative suggests that there is something that makes access to services particularly difficult for Aboriginal people in this study – recall the clinic data, "<u>[t]hree out of thirteen hundred clients, sixty-eight percent of whom are</u> <u>Aboriginal are receiving mental health services</u> [3/884 Aboriginal clients]... That's pretty incredible when you look at the severe problems we see in this center."

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[144] While there are several dual diagnosis programs in the Lower Mainland, they are often difficult to access.

A non-Aboriginal participant from the focus group describes an observed outcome of this gap:

> I mean the clients use the hospital for primary care - a lot use the emergency even though we've got doctors all over. They wait until they're absolutely at death's door and then they take an ambulance to the hospital and that's their primary care, an emergency ward - in Canada, where we have a health care system and we're next to a clinic and there are free clinics all over the place. (F26)

The participants in the focus group were particularly concerned about this issue because for some of their clientele, waiting so long really could mean it was too late. In the following excerpt from the focus group interview, a non-Aboriginal participant shares the plight of a regular client, presented as "fairly typical" of this group of people:

> P: Personality disorders[145] cannot be seen [by mental health]. We have a lot of severe personality disorders especially with the Native population who have been through severe residential school abuse, their growth stopped maybe at age six when they were thrown down the outhouse toilet holes because they wet the bed and we have clients, we have one client, he's bi-polar, he's a Native client, he comes in here and he was so severely abused when he was in residential school. When he was six years old, they would pull him out of bed in the middle of the night, put him in a dress, make him stand out in the school yard, if he wet the bed again, the priest would come, take him out of bed in the middle of the night, put him down in what he calls 'the shit hole' in the outhouse and leave him standing in the shit hole all night. A poor little six year old and, of course, today he's got

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[145] "A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (DSM-IV-TR, APA, 2000, p. 685).

problems. He ran away to work with a group of men in the labour force when he was 13 years old – there he was treated like 'one of the boys'… So I said to him, "what did that do for you?" He said: "they made me feel like somebody" and he said at that time: "I started to drink because drinking made me one of the guys, made me feel good at age thirteen"…. Now he comes to us, he's HIV, he's swings from manic to severe depression. He still has terrible drug abuse problems, we all love him to pieces here. He has deadly depression but he cannot be seen by the mental health team. …. (F25)

The above narrative points to exclusionary practices attached to the criteria for mental health assessment and treatment for both Aboriginal and non-Aboriginal people. It is now recognized that childhood sexual abuse and extensive family violence can result in Post Traumatic Stress Disorder (PTSD). Unfortunately many people who have been traumatized in this way are misdiagnosed with a personality disorder and are improperly treated or not treated at all (Waldram, 1997, citing Herman, 1992). Because of the disturbing nature of the symptoms, many people find it difficult to establish relationships and maintain employment, and so on (Waldram, p. 44). As noted in Chapter Two, a number of *Aboriginal* people with these difficulties find their way into the prison system (Monture-Angus, 2000; Waldram). An Aboriginal health care provider, working in an urban Aboriginal mental health setting, further explains the exclusion from mental health services:

P: ….when you're looking at Native people down here, Native men, Native women who are in their forties and fifties or even thirties, the majority of them have been so sexually and physically traumatized from their childhood that drinking or using drugs is like self medicating… And so they're always going to be

<u>left out of the system because they're intolerable clients - because they're needy,</u>

<u>they're constantly making mistakes, they're constantly incapable of keeping</u>

<u>housing, of staying out of trouble, they're incapable of taking care of their children</u>

<u>– but it's because they were raped for, you know, ten years of their life</u>

<u>everyday…. But are those problems inherent to our race? – no, those problems are</u>

<u>inherent to our experience</u> and so it's about mental health programs [having an

opportunity of] creating a new experience for Aboriginal people based on love and

compassion and unconditional positive regard…

many of the people who experienced depression are often misdiagnosed, - maybe

because they're abusing substances and they're identified as needing substance

abuse treatment… <u>Well I believe that a lot of these people are unable to deal with</u>

<u>the substance abuse issue simply because they're experiencing depression</u> …...

(RP7)

This narrative suggests that the missed opportunity for accurate diagnosis and appropriate

treatment is created by the gap between service areas (mental health and addictions) and, as

noted above is a problem for both Aboriginal and non-Aboriginal peoples. However, the

participant also points to the danger created when mental health issues are attached to a

particular group of people rather than to the social and historical context in which those

problems have occurred - recollect: "But are those problems inherent to our race?, no, those

problems are inherent to our experience." As Duran and Duran (1995) write, "Many Native

American people are diagnosed based on erroneous criteria; the diagnostic process never

takes a historical perspective in the placing of a diagnosis on the client" (p.52). In this

context, Waldram (1997) also calls attention to the need for Post Traumatic Stress Disorder

(PTSD) to be reconceptualized from being understood simply as a "traumatic memory" to also being seen as a "lived experience," and in the case of Aboriginal peoples as a collective lived experience with consequences for a "whole culture." He asserts that the DSM-IV fails to reflect "the manner in which long-term exposure to traumatic events shapes personalities, attitudes, values and behaviours. It would seem that an individual who is exposed to prolonged terror, especially from a young age, is likely to develop into an anti-social being" (p. 46). Waldram then goes on to apply that notion to the collective stating: "A whole community or society which is victimized by trauma is likely to develop aberrant moral reference points for its citizens, leading to the intergenerational transmission of pathological behaviours. The experience of trauma then becomes the lived experience of a whole culture" (p. 46).

Notably, the exemplars above describe the effects of group trauma on the lives of a particular group of Aboriginal peoples: The hypervisibility of this population created by the way in which the sequelae of trauma intersects with issues of race, class, and gender, has ironically, often rendered their mental health concerns *invisible* to the mental health and/or addiction systems. In the approach to Native Americans that they describe as "postcolonial psychology," Duran and Duran (1995) "fantasize that one day the DSM will have diagnostic criteria such as 'acute or chronic reaction to genocide and colonialism'" (p. 53). The dominance of a medicalization discourse in mental health (in this case, diagnostic categories and consequent treatment) which ignores the social, political, economic, and historical context of people's lives shapes the delivery of mental health services and consequent everyday practices.

The exclusions described above have not occurred without casualties. The following fieldnote excerpt describes a personal account told in a public Aboriginal mental health forum:

> After lunch there were only about 20 people left in the conference room. An Aboriginal man in his middle years with sweeping long white hair stood up to address the group. He spoke about his adult son who he gestured to with his hand as sitting to his immediate left. He relayed a story about how his son had been having headaches and blurred vision for many months and had gone to the emergency department on several occasions to get pain medications and seek consultation. However, he believes because his son was an alcohol and drug user (presumably also suspected of trying to get medication to use and/or sell), and Aboriginal, his symptoms were ignored. Inevitably, he would be told to go home and sober up. After many months, a physician took him seriously (I'm not sure if this was a clinic or hospital physician) and a series of investigations began. He was found to have a large brain tumour which was now quite intrusive. This father was extremely angry and hostile towards the health care system, in particular, and I think non-Aboriginal providers, in general. His son has incurred fairly considerable residual damage post surgery, which this gentleman sees as a consequence of delayed treatment. (Fieldnotes, September, 2001)

This conference participant's account of his family's experience with the health care system had both personal and relational consequences. This father expressed a complete lack of trust in the health care system and an overwhelming sense of grief and anger. The narrative

suggests the possibility that negligence was a consequence of discrimination, perhaps at several levels. One of the Aboriginal focus group participants relays another personal story:

> P: Like when I had an experience about twenty-three, twenty-four and I really wanted to quit drinking. My friend took me to an AA center, the person at the desk (I was in line) said, no, he's not ready and so I said, no, I don't have to live with this so I just said to hell with it for another eight years. <u>You know these are experiences and one thing that maybe nobody really realizes is that these clients are looking and they see rejection right away</u>. (F24)

These kinds of narratives were relayed by many of the participants in this study. Often people living with mental health and addiction issues are rejected by programs on the basis of "not being ready" or because of long wait lists; however, for many Aboriginal people this kind of dismissal is not easily dislocated from societal judgments related to Aboriginal identities. Citing the work of Peter Conrad, Lock (1998) notes that although the medicalization of alcoholism has shifted it to "disease" status and, in theory, moralistic judgments have been superseded, a negative moral valence remains. In addition, as Furniss (1999) found in her research, the weight of the "drunken Indian" stereotype remains as a "physical burden, as something that Aboriginal people have to "pack" around, as an image that precedes them in their interactions with non-Aboriginal people" (p. 130). The negative moral valence attached to alcohol and drug abuse coupled with stereotyping of Aboriginal identities creates a "double whammy" for Aboriginal peoples. In the scenario above, the participant internalized a sense of inferiority and failure.

In mental health and addictions work, providers often refer to *the window of opportunity*, period of time (often very short) in which the client expresses or demonstrates a

willingness to enter pretreatment (such as detox) and/or treatment. Because this may be a brief period of time, the provider will try to access the system as quickly as possible. Delays generated by service gaps and long waitlists often mean missed opportunities.

Currently the mental health system is not well integrated with addiction services and although there are a few dual diagnosis settings,[146] these can be difficult to access and/or are not well integrated with the other treatment teams. As a consequence, everyday life in mental health and addictions care is fraught with the problem of people "falling through the cracks." Unfortunately, ignoring the most pressing mental health issues of these particular Aboriginal people runs the risk of recreating the trauma of the colonial past with profound consequences for mental health (Duran & Duran, 1995) of whole communities (Couture, 1994; Waldram, 1997). The therapeutic perspective that people need to be *dry* before receiving mental health treatment tends to decontextualize, individualize, and depoliticize the issue of Aboriginal mental health. Cultural safety reminds us that, when these mental health issues are treated as faulty individual traits and "personalities requiring therapy," rather than as a social problem requiring social and structural change, this is indicative of the way in which the unique historical, social, and political location of Aboriginal peoples shape their health and access to health care.

The omissions and erasures of Aboriginality or the tensions and disjunctures within the everyday of mental health service delivery prohibit adequate access to care for many Aboriginal people. Importantly, health services and health both shape and are shaped by the

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[146] These are clinics where persons with a mental illness and a substance abuse problem can be assessed and treated. Currently there are a several designated 'dual diagnosis' programs in the lower Mainland and Fraser Valley. Apparently 10% (35) of the clientele across the programs are Aboriginal (Personal communication, October 10, 2002). However, recently I have been warned about the inaccuracy of mental health and addiction information of this kind within the province at this time (R. Peters, personal communication, November 12, 2003).

ideological frameworks of the dominant culture. In the following section, I conclude this chapter with the inclusion of participants' accounts of *normalization* and *resistance* to further illuminate how ideological structures are played out in the enactment of everyday life for many Aboriginal people.

## Normalization and Resistance

Many of the participants in this study spoke about the way in which depression, anxiety, and suicide have become part of normalized existence for their people. In the following excerpt, a participant related a personal story in the context of discussing the profound effect of residential schools and consequent intergenerational trauma.

> P: Personally within my own family almost all of my brothers and sisters have had some experience of depression. I went through a lot of depression and have been on anti depressants for a good part of my life and I would say about one third of my life now I've been seeing a counselor to deal with some of the incredible confusion and the anxiety and the hypersensitivity that I experience. – for a long time not knowing that what I was living was abnormal or considered out of the norm…. So not knowing what normal was… (RP11)

This normalization *from within* scenario reveals how people can internalize a "way of being" as *normal* based on patterned experience. Many of the participants in the study noted how normal it was for people in their community to live with depression, anxiety, and hopelessness for extended periods of time.[147] Waldram (1997), in his study with prison inmates also found a preponderance of traumatic events in the lives of his participants

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[147] Here I am not intending to essentialize the varied experiences of Aboriginal peoples but rather attend to a common thread woven throughout the interviews.

normalized by some to such an extent that they became "almost oblivious to the carnage" (p. 55).

Normalization processes have not occurred in a vacuum; rather Aboriginal bodily health and representation have been shaped by the structures and social relations of everyday life. Although there is variability in the everyday, these structures and social relations cannot be reproduced without uniformity of practice within that heterogeneity (Essed, 1991). Perceived indifference both from within and from outside the individual (and community) to the conditions of everyday life for Aboriginal peoples over a prolonged period of time, has rendered these conditions *normal* for many. As the participant above later explained, it was not until that frame of reference shifted, for example, through her own education, that notions of normality also shifted for her and she began to question her internal experience as well as the prevalence of depression and anomie in her community.

The same participant goes on to explain the consequences of the high mortality rates as an *everyday* occurrence for many Aboriginal children:

> P:... [my former partner – non-Aboriginal] his father was the only death that she had ever suffered and that was in the last couple of years so she's forty something years old and she's never suffered a death. Well you turn around and you look at my son, he's lost two grandpa's, two aunty's, his babysitter that looked after him for his whole life, a sister and he's sixteen years old, right?... And you look at how many other Aboriginal people have suffered the same thing... Well to me it brings up the issue as to how we deal with that factor and how we make our children healthy... because when you talk about death, it has a huge impact on how they see life and with so much death around how can they look positively into the

future? … <u>You know, so somehow I think we have to get back to looking at our</u> <u>children and look at changing how they look at the future… and when we look at</u> <u>our youth suicides that's a major issue, it's like they don't see a future.</u> (RP11)

Here the participant moves the discussion to the *normalization* of frequent and early death in many Aboriginal communities and to the way in which this phenomenon fuels anomie and even occasionally suicide.

Last year in a BC Aboriginal community of approximately 1700 people, there were fourteen deaths in fourteen weeks. Of these, two were the suicides of young adults, two were teenage deaths by drowning attributed, in part, to alcohol, and several were the deaths of elders from natural cause (Fieldnotes, RP14, August, 2002). At the same time there were only two full-time mental health-designated employees in the community and although the health director was able to garner support from outside,[148] there was no critical mass to handle this crisis in an ongoing way. As noted in previous chapters, anomie and suicide are all too frequent in some Aboriginal communities, both rural and urban. For some children, this relays the message that there is no future. In addition, individual ties to family and community life and the close proximity to others, particularly notable on reserve in rural and remote settings, heightens the risk of the 'ripple effect' (Warry, 1998). However, regardless of the knowledge about the extent of suicide rates in Aboriginal communities and their devastating effects, there is apparent indifference, for example, in the lack of organized response to suicide and to the conditions that contribute to these horrifying deaths at the

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[148] Apparently the workshops that were set up were poorly attended, often a problem when bringing in people from outside the community (Fieldnotes, verbal communication, August, 2002).

federal, provincial, and regional levels.[149] In the following interview excerpt an Aboriginal policy participant, who works in a large mainstream health agency, notes this problem[150]:

> And I'm reminded of a First Nations community back east that's alleged to have had the <u>highest suicide rate in all of the world</u> recently and in speaking to one of the people involved there I was told that it's <u>because there's no sense of hope and instead an overwhelming sense of hopelessness</u>... (P17)

The same participant then went on to express the need for government support:

> P: And my voice and others need to be heard, these are big issues. Our people have one of the highest suicide rates..... Let me summarize the words of a very wise young woman who stood up in a national Aboriginal health conference and said, hear my voice, I'm one of the few young people in this room but I want you to hear my voice. You government people can give us all the money you want, you can build all the buildings you want and you can give us all the professional helpers you want. None of that is going to help as much as you just being there for us. <u>We just want someone to be with us and to hear us, we need that nurturing more than anything else, that's what's going to help us.</u> (P17)

How are we to read these narratives in the context of thinking about what is safe or unsafe? First, they suggest that the lack of organized response to Aboriginal concerns and, in

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[149] The Report of the Advisory Group on Suicide Prevention, *Acting on What we Know: Preventing Youth Suicide in First Nations* (FNIHB, 2003b), jointly commissioned by the national Chief of the Assembly of First Nations, Matthew Coon Come and former Minister of Health, Allan Rock, puts forward several recommendations for the prevention of suicide, focused on Aboriginal youth. The Advisory Group intended that some of the recommendations could be initiated immediately by the government and Aboriginal organizations, however, they have not yet been formalized into a strategic plan and/or trickled down to the level of the provinces.

[150] The interview with this participant was interrupted by a call from a community in crisis – directly related to this topic. It was in this context that worry was expressed about the sense of hopelessness being experienced in several communities across Canada (Fieldnotes, P17).

particular, to anomie and suicide, may put some Aboriginal people (notably youth) at further risk. Second, the participants are asking for someone to *listen to* and *hear* the problem, to be *with* them rather than objectifying them as the Other *who needs to be taken care of.* Many of the participants in the study expressed the feeling that for the most part the voiced concerns of Aboriginal peoples are largely ignored and/or remedied with short-term, bandage approaches and paternalistic kinds of offerings. Generally participants asked for recognition of the suffering of Aboriginal peoples and acts of reconciliation.

Along the same lines but in a slightly different direction, in response to discussing the alarming suicide rates in some communities, several of the participants in the study described the notion of "collective grief." In the following field note excerpt an Aboriginal participant, who directs a national health agency, provides an observation of this phenomenon in his community:

> He had wondered on many occasions about the numbers of people who were in the habit of attending funerals for people they didn't know or at least, didn't know well. He found this both interesting and puzzling – what would draw so many people to funerals? And then at his mother's funeral he thought about the following possibility. While giving the eulogy at the funeral and gazing out over the crowd of those who had come to celebrate his mother's life and grieve with the family he noted that there were several people who he did not know, and probably didn't know his mother (he knew his community very well). It occurred to him that perhaps they were there because they needed to grieve and had no other place to do it. "There has been such an accumulation of loss and hurt and no place to vent, to work through thoughts and feelings. And no recognition of the embeddedness of

that grief, of the history of that grief down through the generations. There have

been so many losses". (Fieldnote, RP6).

Similar responses to group trauma in the form of collective grief were described by several

participants. For example, another participant interpreted the above phenomenon as a

historical community response to the banning of rituals as a legitimate and collective way of

engaging in ceremony (RP14). In his work as an Aboriginal psychologist, Couture (1994)

notes "[b]ecause of acculturation pressures, Aboriginal communities present, in many cases,

a damaged collective self, reverberating through community and its component families" (p.

15). Another interpretation of this exemplar might be to consider it as a form of resistance

and ownership of grief.

In his later work, Foucault (1988) offers a perspective on the notion of resistance that

I believe again makes an important contribution to the understanding of power relations. In

his view, rather than being passive bodies totally inscribed by discourse, the individual (in

this case, the *colonized*) rewrites the self (identity) through various forms of resistance. As

Lupton (1997) comments, Foucault was careful to emphasize frequently that "where there is

power there are always resistances and that power inevitably creates and works through

resistance" (p. 102). Aboriginal peoples may be transforming the usurpation of personal

power as cultural beings into forms of collective resistance. They are not simply docile

bodies onto which power is inscribed but rather they are people engaged in covert opposition

which sometimes shifts power relations.

However, everyday experiences which prescribe particular Aboriginal identities as

less than/Other/different continue to infiltrate the Euro-Canadian – Aboriginal relational

equation, rendering resistance difficult (Essed, 2002; Furniss, 1999). In the following

interview excerpt with an Aboriginal policy participant working within the context of government structures, the participant provides a context for this difficulty:

> P:…there's a significant amount of individual staff perceptions and attitudes that we haven't had an impact on whatsoever and we never will… <u>I think there's still a belief that Indian people, Aboriginal people should be able to help themselves after all. "Look at the Japanese and how well they've done since WWII"</u>. You know, we get those kinds of statements (laughter)….. They [policy and other colleagues] do say stuff like that…more one to one …although we've had a few people in meetings, perhaps not quite so blatant, but almost….so you do get that. (P19)

Everyday racism is located within specific social relations (Essed, 1991). Euro-Canadians have exercised the power to assign negative identities in situations of everyday, informal Aboriginal/Euro-Canadian contact in the workplace. Warry (1998) notes how even mention of his work in Aboriginal communities often elicits remarks "rooted in racism or simple intolerance – remarks about 'free rides, tax exemptions, and land claims that will 'kill the country'"(p. 28), an experience shared by this researcher (Fieldnotes, April, 2003). According to Furniss (1999), "[t]hese processes constitute forms of 'status domination', modes of interpersonal violence that contribute to the personal and political disempowerment of the Aboriginal population" (p. 105) – one of the most menacing forms of colonial power. Regardless of whether or not they are intended as demeaning, continual casual remarks such as the above impose on Aboriginal people an inferior and degraded public status, often crippling the potential for forceful public resistance (Furniss). However, resistance does continue to occur in many forms. In the following interview excerpt, an Aboriginal participant working in a regional health body comments on his own experience:

P:  I think discrimination plays a big role in our lives all the time daily, almost

daily.  I think that with the younger people being more assertive and some of us

people who are now reaching middle age learning that assertiveness is okay, you

know, some of that might slowly begin to go away. My history of dealing with

white people initially was not good but as the years moved along I felt more and

more secure to say the kinds of things that I feel need to be said.  I mean if I were

back in the fifties growing up I wouldn't say some of the things I say today simply

because it wasn't only not acceptable, it was unheard of and you could get yourself

into a lot of trouble for doing that. (RP2)

Although most of the Aboriginal people in this study recounted incidents of everyday racism

within the health care field, their increasing unwillingness to tolerate such treatment was also

apparent. There are more instances of Aboriginal people claiming space, (i.e., refusing to be

rendered invisible). For example, several Aboriginal leaders in BC refused to take part in the

recent referendum on treaty rights and joined forces with others, Aboriginal and non-

Aboriginal, in acts of covert and overt resistance.[151]

## Summary

In this chapter, the focus shifted slightly to consider the perspectives of Aboriginal and

non-Aboriginal people who work in the area of mental health and related fields, as they

reflect on their experiences with the mental health system. Firstly, there were a number of

omissions noted in the mental health care system that create barriers to access for Aboriginal

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[151] In recognition of the importance of self-governance, many First Nations communities and political organizations have entered into treaty and land claims negotiations (Hylton, 1999). In this context, it has been both interesting and instructive to write this dissertation in the context of a "referendum" on Aboriginal Treaty Rights/Issues in BC (May, 2002). The "referendum" – instigated by the state – involved a call to the citizenship of BC to "vote" on decisions affecting future Aboriginal land, treaty and self-government rights. This process, vehemently debated in both public and private arenas throughout Canada, exacerbated tensions in Aboriginal and non-Aboriginal relations.

peoples. Examining mental health care experiences from the perspective of Aboriginal peoples focuses attention on the tensions and disjunctures in the everyday world of access to mental health care. It focuses attention on the complexities inherent in accessing the mental health system, particularly when these are contextualized within historical relations of power and paternalism. Secondly, the analysis exposed how Aboriginal identity has rendered the concerns of some Aboriginal people hypervisible and/or invisible, resulting in paternalistic interventions or at the extreme, in no intervention at all. Lastly, the analysis revealed how exclusions, including a general lack of attention to the most pressing mental health challenges of Aboriginal people such as suicide, alcohol and drug abuse, family violence, and sexual abuse, have seemingly resulted in both the normalization of these occurrences and continued Aboriginal resistance.

There are palpable tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system evident in the everyday practice of mental health service delivery. The legacy of colonial health care continues to be played out in various ways, particularly through taken-for-granted discriminatory practices and structural constraints that have marginalized many Aboriginal people from the dominant health care system. This tension has been heightened in the last decade by cost containment and massive health care restructuring driven by discourses of scarcity and efficiency (Anderson, 2000, p. 223; Evans, Barer, & Marmor, 1994; Storch, 1996; Varcoe & Rodney, 2001).

In the next and final chapter, I consider the broader implications of the findings sections of this dissertation. I discuss the relative lack of critical consciousness in nursing about Aboriginal mental health, and discuss recommendations for future actions.

# CHAPTER EIGHT

# THE NATURE OF THE TENSIONS AND DISJUNCTURES

The central line of argument in this dissertation illustrates how dominant culture ideologies, mental health institutions, policies, and everyday practices intersect to shape the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system. Current mental health care provision to Aboriginal peoples is complex, involving the interconnection of a myriad of factors: societal values and ideologies; the histories of Aboriginal peoples within society; the organization of mental health care institutions and the larger priorities of the mental health care system; the identities, values, beliefs, personalities and health care needs of individuals, families and communities; the disposition, competencies, identities, and commitment of mental health care providers; the community setting; and so on. Although not the only factor, access to appropriate, responsive mental health services is important to achieving overall improvements in mental health status among Aboriginal populations (BC, 2002).

The 1998 Mental Health Plan as it exists within current mental health reform in B.C. has tended to gloss over and/or ignore the broader sociopolitical and economic factors that shape the meaning and experience of mental health and illness for Aboriginal peoples. In light of these exclusions and the inequitable mental health status of Aboriginal peoples, the central problematic addressed in this study was the nature of the tensions and disjunctures between Aboriginal understandings of and responses to mental health and illness and the current mental health system. To address this problem, an ethnographic study informed by postcolonial and critical perspectives was conducted. Methods included in-depth individual interviews with six policy makers, both Aboriginal and non-Aboriginal; fourteen Aboriginal

people working in mental health field and related fields; and, two nurses working in a hospital setting. A focus group interview was conducted with nine health care providers working with Aboriginal and non-Aboriginal people with multiple health issues, including mental health and substance abuse. In total, thirty one participants were involved in this study. In addition, a review/critique of several current mental health policies was done.

In this chapter, I discuss the nature of the tensions and disjunctures in terms of the implications that can be drawn from the preceding analyses. The first half of the chapter provides an overview of the empirical findings of this dissertation and is organized into three sections corresponding to the previous chapters. The first subsection provides a summary of Chapter Five, that is, the ideologies or scaffolding underpinning mental health institutions, policies, and care provision, (i.e., why the tensions and disjunctures). The second examines how the mental health institutions and policies support the embeddedness of ideological frameworks, (i.e., the patterns of tension and disjuncture). In the third subsection, I provide a review of the tensions and disjunctures (i.e., the tense things that happen), within the everyday of mental health care delivery to Aboriginal peoples and examine how those shape and are shaped by ideologies and institutions and policies.

In the second half of the chapter, I examine more pointedly the relative lack of critical consciousness about Aboriginal mental health within the mental health system, as reflected in its absence in mental health policy, strategic planning, and services. As I explain, this lack of critical political and social consciousness about Aboriginal mental health is constrained by colonialist ideologies embedded within the mental health system that preclude legitimization of Aboriginal knowledge and practices and result in the erasure of Aboriginal identities, and consequently of their mental health issues from the provincial health agenda.

I then turn to recommendations arising from this study. In forming these recommendations, I am directed by the postcolonial theoretical perspectives informing this study. I argue that the notion of cultural safety embedded within postcolonial perspectives has the potential to shift how nurses (and nursing) think about Aboriginal mental health within the context of its social, political, economic, and historical location, to prepare nursing to live out its social and moral mandate. In closing, I challenge nursing to consider how we can more fully activate our social praxis in relation to Aboriginal mental health.

## Overview of the Empirical Findings

### *Ideologies and Structures: The Scaffolding*

Early in the colonization process an assimilationist ethos prevailed in which Aboriginal peoples as "wards of the state" were to be assimilated into the fabric of Canadian society. The fact that assimilation survived as the official policy for more than a century post confederation suggests a certain embeddedness of this ideology and today, many government officials, policy makers, and citizens have reiterated "the assimilation mantra as a self-evident truth" (Cairns, 2000, p. 77). For example, there is strong support for assimilation in the national Alliance Party, formerly the Reform Party, and, currently, the official opposition in Canada (p. 79). Although there has been considerable Aboriginal and non-Aboriginal resistance to assimilation and the old assimilationist paradigm is in retreat (i.e., it is no longer official policy), it has not yet been vanquished.

Theories of ideology have been helpful in drawing attention to how the dominant culture view becomes the scaffolding for the way in which ideas, specialized practices and social relations are organized and operate in everyday life. In the process of colonization, the construction of Aboriginal peoples as "inferior" and in need of "care" provided the moral

justification for controlling Aboriginal lives in the spheres of everyday life – literature, art, history, education, health etc. As Cairns (2000) notes, "we sent missionaries to Christianize, anthropologists to analyze and Indian agents – our version of district officers – to administer. In general, Aboriginal ways of life, and thus their bearers, were stigmatized" (p. 31). Here, the notion of hegemony assists in locating how the message of European superiority has been effortlessly imbibed by the dominant group – how it becomes a taken-for-granted assumption underpinning a way of life for both the colonizer and the colonized. The dynamism of hegemony also draws attention to the impact of various forms of resistance – to why there are tensions and disjunctures within *this* historical period. Aboriginal resistance to domination has been inherent to colonial relations and, over the past several decades, Aboriginal peoples have made great strides towards becoming a self-determining body.[152] Through the organized resistance of Indian peoples, the 1969 *White Paper* of the Trudeau government with its proposals for assimilation was thwarted, and since the 1970s, attention to Aboriginality (and diversity), has been on the Aboriginal policy agenda. However, remnants of the colonial past remain.

In this study, ideologies central to the process of colonization and the way in which Aboriginal has been constructed are identified as the basis of the tensions and disjunctures. The narratives of the participants suggest the continued embeddedness of colonial ideology and, in particular, assimilation – revealed as three broad interconnected categories: (a) paternalistic care, (b) ethnocentrism, and (c) [im]partiality.

In addition, this analysis is based on a review/critique of several documents of reform including the 1998 Mental Health Plan, *Revitalizing and Rebalancing British Columbia's Mental Health System* (RRBC) as well as seven *Best Practices in Mental Health in B.C.* – the

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[152] Indigenous peoples have become increasingly self-determining across the globe.

seven documents included Assertive Case Management (BC, 2000a); Consumer Involvement (BC, 2000b); Crisis Response/Emergency Services (BC, 2000c); Family Support and Involvement (BC, 2000d); Housing (BC, 2000e); Inpatient/Outpatient Services (BC, 2000f); and Psychosocial Rehabilitation (BC, 2000g).In addition a *Best Practices*, Rural and Remote document (BC, 2000h) and a draft document, *Guidelines for elderly mental health care planning* (BC, 2001a) were reviewed/critiqued.

The overall tenor of the *1998 Mental Health Plan* and its accompanying *Best Practices* documents is reflective of Western understandings of health and illness. The mental health system continues to be strongly influenced by psychiatry with its attachment to biomedical traditions and individualistic approaches to treatment. Given this attachment, it is not surprising that the target population of reform is those persons with serious and persistent mental illness who meet the diagnostic criteria of the DSM-IV-TR (APA, 2000). Although there has been a general shift to the language of family-focused and community-based care, the mental health system remains largely aligned with an illness service model, which generally fails to address mental health within its sociopolitical, economic, and historical circumstances. In addition, the attachment of mental health reform to national *Best Practices* approaches is an attachment with *evidence-based* practice – in essence, assessment, treatment and research practices that fit with the biomedical tradition.

In this study, the participants revealed a lack of attention to *difference* within mental health institutions and policy that precludes attention to Aboriginality – for example, a chasm was articulated between mechanistic views of mental health (i.e., biomedical approaches), and more holistic approaches. Also, concern was expressed about what constitutes evidence – about assessment, treatment, and research approaches that might subjugate Aboriginal

knowledge. The data in this study revealed that mental health institutions and policies unwittingly contribute to the exclusion of Aboriginal perspectives – long-standing patterns of paternalism, authoritarianism, and ethnocentrism continue to shape the way mental health care is delivered to Aboriginal peoples.

Notably, although some Aboriginal people *do* access and benefit from the mental health system, this review/critique revealed a general lack of recognition of and consequent attention to the most pressing mental health concerns of Aboriginal peoples – depression, suicide, alcohol and substance use, family violence, and other forms of abuse – rooted in poverty, unemployment, hopelessness, and despair (anomie) in many Aboriginal communities. Generally, the poorer mental health status of Aboriginal peoples has been glossed over and/or ignored.

Historically, mental health services have been offered to Aboriginal peoples in the form of paternalistic care as per the conditions of the *Indian Act* – generally they were administered from outside, creating a tremendous dependency on the dominant system of care. However, as Aboriginal peoples have begun to recover from the trauma of colonization, increasingly, they have been seeking self-determining arrangements. Nevertheless, the mental health system continues to be shaped by the intersection of paternalism, ethnocentrism, and policy decision-making processes informed by notions of equality that privilege the needs of the dominant culture. In relation to the latter, whereas inquests into the tragic deaths of persons with schizophrenia, have in large part defined the target population of mental health reform, inquests into Aboriginal suicides have resulted in little change. The lack of organized response to the alarmingly high Aboriginal suicide rates suggests a *normalization* of Aboriginal suicide in this province.

To date, there is little resource, federally, provincially, and regionally, for Aboriginal peoples to design, implement, and administer mental health programs autonomously. Where there *is* support for Aboriginal mental health, it is generally fleeting. For example, although the provincial Ministry of Health largely funded the production of the discussion paper, *Aboriginal Mental Health: What Works Best* (Mussell & Smye, 2000), its planned dissemination across the province for input from Aboriginal communities and formulation into an Aboriginal Mental Health Plan was abruptly ended by a change in provincial leadership, the consequent reorganization, and a lack of designated funding. To date, there is no national or provincial Aboriginal mental health strategic plan. Young (1990) notes

> ...[A]ssimilation always implies coming into the game after it is begun, after the rules and standards have been set, and having to prove oneself according to those rules and standards. In the assimilationist strategy, the privileged groups implicitly define the standards according to which all will be measured. Because their privilege involves not recognizing these standards as culturally and experientially specific, the ideal of a common humanity in which all can participate without regard to race, gender, religion, or sexuality poses as *neutral* and *universal* [italics mine]. The real differences between oppressed groups and the dominant norm, however, tend to put them at a disadvantage in measuring up to these standards, and for that reason assimilationist policies perpetuate their disadvantage. (p. 164)

### Mediating Practices: Mental Health Institutions and Policies

Historically, the lack of clarity generated by the *British North America Act,* 1867, and the *Indian Act,* 1876, confers a certain degree of latitude for governments, federal, provincial, and regional, to vacillate on their position regarding who is responsible for

Aboriginal mental health, possibly unwittingly contributing to the mental health disparities among Aboriginal peoples and between Aboriginal and non-Aboriginal populations. The data in this study suggests that the jurisdictional debate intersects with the way in which the Western worldview dominates mental health institutions and policies to support the invisibility of Aboriginality (i.e., the embeddedness of colonial ideologies and, in particular, an assimilationist ethos).

Bureaucratic obfuscation regarding *who* has responsibility for Aboriginal mental health across the federal, provincial and regional divide provides the opportunity for an abrogation of responsibility at structural, institutional and practice levels. In addition, the inattention to worldview differences across ethno-cultural groups and the predominance of Western biomedical approaches to mental health within the mental health system, (i.e., psychiatry), creates barriers to access to mental health care for Aboriginal peoples. When Aboriginal people do access mental health care, they are at risk for misdiagnoses and inappropriate treatment (Duran & Duran, 1995, 2000; Sue & Zane, 1987; Waldram, 1997).

As noted earlier in this chapter, the mental health system's strong attachment to biomedical traditions, in particular to psychiatry, creates problems of access for those persons struggling with issues that do not fit with the mandate of mental health. For example, the manifestations of group or collective trauma do not necessarily fit neatly within the diagnostic categories of DSM-IV-TR (APA, 2000). In addition, for many Aboriginal people, their worldview perspective encompasses more holistic understandings of health, healing and wellness. Even more insidious are the exclusion and, in some cases, the danger imposed by assessment, diagnostic, and treatment practices that do not fit well with Aboriginal perspectives. For example, assessment questions (and forms) that do not reflect an

understanding of the histories, social positioning, and unique cultural values and beliefs of an Aboriginal person can have serious implications for diagnosis and treatment. In this study and in the literature (Duran and Duran, 1995, 2000; Good, 1993; Lopez, 1989) accounts of overpathologizing and misdiagnosis are common. Also, a lack of understanding of Aboriginal notions of family, community, and healing often preclude involvement of family, community, and in particular, elders and healers, in meaningful ways.

Without critical consideration of *difference* and resolution of the jurisdictional issue, the data from this study suggests that mental health institutions and policies will continue to support the embeddedness of a colonial ideology that renders Aboriginality invisible. By remaining impervious to these issues, the mental health system colludes with the overall failure of social and health policies to address the routine and systematic marginalization of Aboriginal mental health concerns and contributes to the poorer mental health status of Aboriginal peoples.

### *Everyday Practices in Mental Health: The Tense Things That Happen*

There are serious barriers to access to mental health care for Aboriginal peoples. In this study, three overlapping discourses informed issues of access in 'everyday life': (a) acts of omission, (b) colonial ambivalence, and (c) normalization and resistance. Undergirded by several common assumptions, these discourses formed the framework within which Aboriginal peoples found it difficult to access mental health services. Analysis at the micro level illuminates how ideological structures play out in the enactment of the everyday for Aboriginal people.

As noted in Chapters Five and Six, a Western worldview in the form of biomedicine infiltrates the mental health system. This dominance was notable in terms of the everyday

omissions of Aboriginality including Aboriginal languages; a lack of familiar foods and practices in residential settings, such as space for acknowledging the "spirit world," attachment to elders and healers and respect for the unique aspects of family and community connections; a lack of knowledge and connection to resources of support; and a lack of educated and trained Aboriginal mental health providers. Dominant cultural frameworks are interwoven and reproduced in the everyday context of mental health service delivery. Recall the Aboriginal policy participant who stated: "...imagine yourself in a foreign country where you are one of those few people who was different from anyone else..." (P20).

Racism is an undeniable social fact of life in Canada (Henry et al., 2000; Waldram, 1997). It was not surprising, therefore, that both Aboriginal and non-Aboriginal participants expressed views on and detailed experiences of racism. Images and discourses of Aboriginal peoples as getting a "free ride" and as the "drunken Indian" are pervasive in the media, on "the streets," and in public conversations (Browne, 2003; Furniss, 1999; Ponting, 2001). In the absence of strategies or perspectives that might challenge these notions, they are taken up within institutions. For example, institutional surveillance structures that scrutinize [Aboriginal] identities prompt various inclusions and exclusions: On the one hand, surveillance of the new mother who was (wrongly) perceived as drug using resulted in institutional control over the relationship between mother and baby. On the other hand, the "Indian" with a substance use issue on the street is often rendered invisible and/or chooses to self-exclude because of a sense of mistrust, lack of fit, and so on, with the health system.

The negative assumption made about the new mother did not arise from the misinformed opinion of a health care team – this assumption is ingrained in the Canadian consciousness and supported within the dominant culture discourse. In another clinical

context, Aboriginal peoples with mental health and/or substance abuse issues often struggle with issues (and symptoms) related to severe childhood trauma that do not fit neatly into the assessment, diagnostic, and treatment modalities of the current mental health and addiction systems. This, coupled with the way in which Aboriginal identity is constructed, may serve to further disadvantage an Aboriginal person. When Aboriginal mental health issues are dislocated from their social, political, historical, and economic realities and instead are seen uncritically through the lens of dominant culture frameworks, there is a risk of misdiagnosis and/or inappropriate treatment or *no* treatment.

In addition, in this study, it was not uncommon for the Aboriginal participants to talk about how suicide, depression, and anomie have become normalized within the everyday lives of many in their communities, both urban and rural, and to draw attention to collective trauma and consequent grief. *Normalization* responses have not occurred in a vacuum. They have occurred in response to how Aboriginal peoples have been and continue to be constructed in Canada, coupled with how their concerns are or are not addressed. Consistently, the participants in this study refer to the way in which the treatment of Aboriginal peoples as "inferior" vis à vis paternalism and/or neglect has been integrated into Aboriginal identities as a kind of internalized standard or norm. The cycle of depression, substance use, violence, and despair has become a *way of life*[153] for some Aboriginal people. The aspiration to assimilate Aboriginal peoples assists in producing the self-loathing and double consciousness characteristic of oppression – "to participate means to accept and adopt an identity one is not, and to try to participate means to be reminded by oneself and others of the identity one is" (Young, 1990, p. 165). As a result of cognitive imperialism, colonized peoples have been led to believe that their poverty and impotence are a result of their race

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[153] Obviously, not intentional.

(Battiste, 2000, p. 198). However, it should also be noted that, in the space where normalization occurs, there are also powerful points of collective resistance and healing.

The structure of the everyday world of mental health service delivery is part of the matrix of social relations present in and produced by everyday practices (Essed, 1991). By framing the tension and disjunctures as a reflection and function of a socially shared construction of "Aboriginal" as it intersects with relations of power, we can more easily locate the problem as socially organized and mediated, and seek socially transformative solutions.

## Implications: Developing a Critical Consciousness in Nursing

Without tools or strategies for thinking critically about issues of culture, history, or race, evidence of discriminatory policies and practices in the health system goes largely unrecognized by most health professionals (Anderson, 2000a, 2000b; Anderson & Reimer Kirkham, 1998, 1999; Browne, 2003; Reimer Kirkham, 2000). For example, in this study it became apparent that the lack of attention to Aboriginal mental health within the mental health system was related, at least in part, to the way in which dominant discourses – now taken-for-granted – factored into institutional policies and practices. An assimilationist ethos continues to prevail, in large part masked by the seemingly neutral and universal aspects of institutional structures, policies, and practices that both mediate and support its existence. However, as long as the institutions, policies, and practices remain unexamined, discourses operating as social practices will continue to reinforce the status quo (Henry et al., 2000).

This does not imply that there is *no* awareness or concern for the issues that Aboriginal peoples face, but rather that there is a lack of consciousness about how institutional policies and practices unwittingly support the embeddedness of an

assimilationist ethos with consequent disadvantages for many Aboriginal peoples. It is beyond the scope of this dissertation to engage with how the mental health system per se might tackle this problem. Instead, I examine how the domain of nursing might be readied to address the inequities in mental health care delivery to Aboriginal peoples.

As Starzomski and Rodney argue, intervention by nursing in sociopolitical structures is as essential to promoting health and preventing illness as are nurses' activities with the individual client (1997, p. 232). By shifting the locus of change in nursing from the individual to focus on uncovering and critiquing the oppressive social structures that constrain persons' health (Butterfield, 1990; Stevens, 1989), nursing is better positioned to meet the needs of the client.[154] As Stevens argues, "the more actively and extensively nurses are able to perceive and reflect upon their social, political, and economic environment, the more effective they become in their interactions, a condition that is the essence of health" (p. 63). This point was illustrated quite poignantly by a colleague working in community health as she relayed a story about the seemingly mundane topic of diaper rash. She was working in an Aboriginal community at the time. Apparently, on a regular basis, nurses had been giving mothers a salve to apply to babies' bottoms as treatment for recurring diaper rash. However, as the nurses came to know the mothers in the community better, and as they sought to understand why the pervasiveness of diaper rash, they came to realize that a lack of clean water for many of the residents was the most likely source of the problem. The outcome was twofold: (1) there was a shift to an upstream approach – the formation of an alliance with the mothers to advocate for clean water; and (2) this shift in the nurses' focus dispelled any

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[154] Client is defined here broadly as considering the needs of the aggregate as well as the individual (Starzomski & Rodney, 1997, p. 227).

thoughts that the mothers might be at fault. Thus, health was affected at both the relational and structural levels.

Because of the profound but often invisible or taken-for-granted influences on mental health institutional policies and practices uncovered in this study, I argue that special attention must be directed toward fostering critical consciousness among nurses.[155] Critical consciousness, characterized by self-awareness, insight into societal ideologies, mainstream stereotypes, and social agency, is required to understand the influence of one's own social identity and interpretive lens to challenge sustaining ideologies, institutional discourses, and predominating practices (Reimer Kirkham, 2000) that act as barriers to access to mental health care for Aboriginal peoples and other racialized groups. Critical consciousness is marked by insight into one's own complicity in racializing practices and discourses, and into how one is caught up and participates in power situations and consciously or unconsciously reproduces patterns of dominant society (Lather, 1991; Reimer Kirkham).

To develop critical consciousness in nursing requires educational strategies and frameworks that focus on the responsibilities and implications of practicing nursing in a postcolonial context where race and power continue to create patterns of inclusion and exclusion in health care settings (Browne, 2003). According to Anderson (1998) transformative knowledge is defined as knowledge that is "undergirded by critical consciousness on the part of the healthcare providers and that unmasks unequal relations of power and issues of domination and subordination, based on assumptions about 'race,' 'gender,' and 'class relations'" (p. 205). Social transformation, then, can occur at the level of the individual or group.

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[155] Ideally, all nurses – front line nurses, educators, administrators, academics, researchers and policy analysts – would demonstrate critical consciousness. Students would demonstrate an increased ability for critical consciousness as they charter their way through the educational process.

In this postcolonial context, nursing is challenged to remain cognizant of "how domination and resistance mark intercultural health encounters at individual, institutional and societal levels" (Reimer Kirkham & Anderson, 2002, p. 10). A deep understanding of Canada's colonial history and the current workings of internal colonialism might result in more subtle understandings of the history of Aboriginal-state relations (Kelm, 1998, xxiii), the embeddedness of ideologies, and the way in which institutions, policies, and practices mediate and support colonial structures. These are not, however, typical areas of study within nursing: Aboriginal health courses are generally not found within the nursing curriculum. Instead, the issue of Aboriginal health is often subsumed within other courses, for example, "Culture and Health" or the "Sociopolitical Determinants of Health" etc., or is missing altogether.

The findings of this study demonstrate the need for tools that will help nurses and other health care providers to situate patients' experiences in the larger context of mediating sociopolitical, economic and historical forces, to avoid the trap of making sense of difference in ways that "succumb to racialization, Othering, and reinforcement of existing power inequities" (Reimer Kirkham & Anderson, 2002, p. 9). While not intended as such, the erasure or rendering invisible of Aboriginality is a political act (Young, 1990). Therefore, fostering an understanding of the political nature of our institutions, policies, and practices – particularly in relation to peoples who are disproportionately disadvantaged by politically mediated social conditions – will be required to shift entrenched attitudes. In addition, strategies will be needed to make transparent the political ideological underpinnings of discourses and practices related to Aboriginal peoples, even when we assume a seemingly neutral, apolitical position (Browne, 2003; Young, 1990). For example, nurses need to be

prepared to question decision-making processes, to query the absence of Aboriginal peoples at the decision-making table and the invisibility of Aboriginality in practice settings. They need to be aware that policy discourses support the embeddedness of ideologies – that they signify particular aspirations, fears, beliefs, values, and the importance placed on events and objects by society at large. Policies determine who has authority and who accepts it, and some areas such as Aboriginal suicide can become invisible or immune from concern because they are not seen as problems (Edelman, 1988, pp. 12-13).

As I have attempted to show through the analysis presented in this dissertation, mental health care delivery systems are not ahistorical, apolitical, or transparent. Rather, the lack of attention paid to examining the sociopolitical and historical positionings of particular groups results in discourses that unwittingly support further disadvantage, oppression, and marginalization. If, as Essed (2002) claims, access to knowledge about the nature of domination and inequities leads people to accept more responsibility for changing their practices, nursing must view critical analyses of these issues as central aspects of nursing education, research, theory, and practice. However, before nurses can critically engage within the wider context of politically charged health care relations – including health policy and policy making – there is a need for critical engagement with nursing knowledge that is focused on the historical context of Aboriginal mental health and ongoing processes of colonialism.

In the following section, I engage with the notion of cultural safety as a means of fostering a critical political and social consciousness in nursing to create an opportunity for social transformation.

**Fostering Critical Political and Social Consciousness in Nursing:
Applying Postcolonial Perspectives from Cultural Safety**

It seems brutally evident that "if present trends in [Aboriginal] unemployment, social exclusion, and anomic conditions continue unchecked, the results for both Aboriginal and non-Aboriginal peoples will be catastrophic" (Cairns, 2000, p. 208). If this is the case, then how can nursing assist in creating a health care environment in which Aboriginal poverty, social malaise, and high suicide rates become priority issues; and how do we assist in creating a moral bond that remains sensitive to Aboriginality, promotes a united responsibility, but does not create prospective cultural imperialism or *new* colonialisms, for example, assimilation in a new guise. To form my responses, I return to the postcolonial theoretical perspectives discussed in Chapter Three. In particular, I put forward an analysis of how the theory of cultural safety embedded within postcolonial perspectives can assist nurses to critically engage with their practice whether it be clinical, education, policy or further research. Conceptualizing the challenge from the cultural safety perspective opens up the possibility for and fosters critical engagement.

Cultural safety is linked to the postcolonial project, with its recognition of power imbalances and inequitable social relationships, a legacy of the postcolonial past and neocolonial present. It was never intended to be a "cataloguing of culture-specific beliefs" of the Maori people (Anderson et al., 2003, p. 197; Ramsden, 1993), but rather, was meant to provide a critical lens through which to examine health care relations within the context of wider historical, social, and political forces. As Ramsden (1993), a Maori nurse scholar, writes,

> .....Nurses in New Zealand, without the benefit of a broadly based social
>
> education, were confusing the cultures of indigenous people with the culture of

poverty into which the indigenous people have been driven. It follows then that cultural safety requires nurses to become expert in understanding the poverty cycle and the various histories and socio-political conditions which establish and maintain it (p.3).

Cultural safety provides direction for the development of sociopolitical insights about the disparate power relations within and beyond health care, and the historical and social processes that organize these relations (Reimer Kirkham et al., 2002, p. 227). Importantly, cultural safety reminds us that individual health problems are located within the domains of historical and structural disadvantage that shape them, and requires us to unmask the ways in which racism and unequal power relations have resulted in marginalization and poverty with its associated illnesses. For example, incorporating perspectives from cultural safety into Canadian nursing discourses would draw attention to how the history of relations with Aboriginal peoples has been lived out within the mental health care system and how the legacy of colonialism continues to be embedded in the form of an assimilationist ethos – paternalism, ethnocentrism and democratic decision-making processes that disadvantage Aboriginal peoples.

Increasingly, nurses are taking up the discourse of cultural safety to analyze the complexity of Aboriginal health care delivery. In a Canadian context, Browne and Fiske (2001) use cultural safety as an interpretive lens for connecting the dynamics of everyday health encounters involving Aboriginal women to wider social issues related to Aboriginal-State relations, dominant conceptualizations of Aboriginality, and routine racializing practices. In another study, Browne and Smye (2002) use the concept of cultural safety to examine how discourses perpetuated in the health care literature continue to represent

Aboriginal women as objectified Other despite researchers' efforts to mobilize notions of

cultural sensitivity. In their research, Reimer Kirkham et al., (2001) recognized that cultural

safety was not in fact an entity, fact, or process that could be identified in any realist sense.

Instead, they saw it as being constructed though interactions within particular contexts, with

recipients and providers of health care, as well as researchers and participants, all continually

appraising exchanges as culturally *safe* or *unsafe*, depending on their individual perceptions

(Reimer Kirkham et al., pp. 228-229). Together these studies illustrate how cultural safety

can be conceptualized as a theoretical lens for examining how the politics of history, race and

sociocultural and political positioning are played out in the everyday practices of the mental

health care complex to sustain or disrupt relationships.

### *Cultural Safety as a Moral Discourse*

Because cultural safety links us to the broader sociopolitical context in which health

and health care are shaped and prompts us to ask questions about how systems of dominance

permeate, sometimes unwittingly, institutions, policies, and everyday health encounters. It

raises a set of ethical questions about processes and practices (Anderson et al., 2003, p. 212):

it engages us in a moral discourse. Conceptualizing the problem from a cultural safety lens

reminds us of the moral goal and therefore provides direction to practitioners, educators,

researchers, and policymakers to identify and alter any practices or policies that make people

feel demeaned or that extend colonizing influences to them as individuals or groups.

Speaking directly about the responsibility of scholars to address issues of colonization,

oppression, and domination, LaRocque (1996) asserts

> I find it impossible to study colonial history, literature, and popular cultural
>
> productions featuring Native peoples, particularly women, without addressing the

social and ethical ramifications of such study. To study any kind of human

violation is, *ipso facto*, to be engaged in ethical matters. And we must respond –

as scholars – as men and women, Native and white alike (p. 12)

Querying what is moral and just prompts us to interrogate the assumptions that might,

unwittingly, underpin our research, policies, and practices. For example, in an analytic sense,

in this study, cultural safety prompted me to think about *institutional racism*, about which I

had a priori assumptions. How was I to read the lack of attention to Aboriginal suicide? –

was it an example of institutional racism with its adjunct, long-term disregard for notions of

difference, *and/or* was it related to the jurisdictional issue, *and/or* how democratic decision-

making processes and *class* intersect to further disadvantage oppressed and marginalized

peoples. Considering this erasure of Aboriginal suicide from the policy agenda as related to

multiple intersections which create a situation of deep-disadvantage and *unsafety* takes us to

a different place in terms of action than reading it as institutional racism, period.

In keeping with the above sentiments of LaRocque, Anderson (2000a) argues that

research for praxis aimed towards helping participants to understand their situation is the first

step toward policy change. In short, the empowerment[156] of people that allows them to

engage with policy-makers which will have the most profound impact on policy change.

Notably, this does not imply that Aboriginal peoples, as an example, are not aware of the

structural inequalities that shape their experiences of health and illness, but rather, it suggests

a particular level of engagement – to make explicit the forces that have an influence on our

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[156] The term empowerment is used with some reticence. The concern Anderson (1996) suggests "is that the politicizing of 'empowerment' could provide the rationale for 'off-loading' of responsibilities to people who have been made vulnerable through illness, who have few resources, and who are least able to assume the responsibilities that the empowerment movement suggests" (p. 703). Lather (1991) defines empowerment as "analyzing ideas about the causes of powerlessness, recognizing systemic oppressive forces, and acting both individually and collectively to change the conditions in our lives" (p. 4). Importantly, people come into a sense of their own power – it is not something we do 'to' or 'for' someone.

health. In addition, the development of local and global networks to articulate clearly the nature of these oppressive forces is a good starting point towards effecting change (Anderson).

Critiquing/analyzing research, institutions, policies, and practices from a postcolonial vantage point using a cultural safety lens has the potential for revealing the taken-for-granted processes and practices that continue to marginalize Aboriginal voices and needs – it provides us something to look through. As noted in Chapter Four, in my commitment to research as praxis, I am committed to join forces with the participants to use this research as a resource in collective action in advocacy with policy makers. Raising critical consciousness in the area of policy is crucial to addressing the broader sociopolitical and economic determinants of Aboriginal mental health. Given the seriousness of the issue of Aboriginal suicide and the deeply felt concerns expressed by the participants in this study, it might be a place to begin. *Choosing Life* (Royal Commission on Aboriginal Peoples, 1995), a special report on suicide among Aboriginal people, contains many recommendations for government action as a response to a systematic review of the issue of suicide in Aboriginal communities across Canada. I briefly list the elements of this report which are useful as starting points for action, for example, the framework for action includes plans and programs aimed at three levels of intervention: 1) those that focus on building direct suicide crisis services; 2) those that focus on promoting broadly preventive action through community development; and 3) those that focus on the long-term needs of Aboriginal people for self-determination, self-sufficiency, healing, and reconciliation within Canada (Royal Commission on Aboriginal Peoples, p. 75). Seven key elements to achieve health are included: cultural and spiritual revitalization, strengthening the bonds of family and community, a focus on children and

youth, incorporation of the notion of holism, whole-community involvement, partnership arrangements, and community control (p. 78).

While these actions are well intended, Chartrand (1995) a Métis lawyer and RCAP commissioner, responds to the report with some reservations. Although he unequivocally supports the need for action, he also points out that the actions in the *Choosing Life* report fail to address the underlying social, economic, and political determinants of poor mental health in many Aboriginal communities. He asserts that the hope for change in the health status of Aboriginal peoples rests in changes in social policy at the government level (and in particular at the federal level). The danger in accepting interventionist actions without the accompanying policy change is that the marginalizing and racializing views which currently remain embedded within social policy will continue to act as barriers to the implementation of the solutions proposed by the report. For example, the fact that federal-provincial jurisdictional issues have not been resolved at a policy level might result in interventions only being available to those individuals with Indian status as well as the Inuit (and only to those persons living on-reserve).

Chartrand (1995) also calls attention to the fact that social policy related to Aboriginal health needs to reflect the strengths that exist within Aboriginal community, i.e., that the report ought to start from a position of what Aboriginal peoples are doing well and build on that experience and knowledge. Although the report contains testimony from many groups who are currently involved in offering innovative ways of dealing with mental health issues, its programs are not linked at a policy level with a commitment to better education, economic opportunities, and other initiatives that would strengthen individuals and

communities. Because there is an inherent danger in using suicide as a focus for change,[157] Chartrand suggests that interventionist strategies need to be focused around parallel processes in which Aboriginal and non-Aboriginal groups work to shift policy in the areas of education, economic opportunities etc.

Given the findings of this study, I would agree with Chartrand that transformative social change needs to occur at the level of policy in order to address the poorer mental health status of Aboriginal peoples. In this regard, I would argue that using a cultural safety lens provides direction for raising the critical political and social consciousness of nurses across a wide range of practice – clinical, education, research, and policy – to support the social and moral mandate of nursing.

### Overall Recommendations Arising from the Study

As nurses, we must make space for analyses of politics and history, and the ways in which these have variously positioned us, shaped people's health, and structured our relations with one another; only then will we be able to transform those relations.

Based on the outcomes of this study, the following recommendations have been formulated. These are suggested to provide direction to nurses in clinical, education, research, and policy areas as they work towards transformative change in the area of Aboriginal mental health.

### Clinical

- Provide tools for nurses and other health care providers to attend to issues of *difference* without giving way to stereotypes (Ramsden, 1992).

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[157] Attention to suicide runs the risk of further stereotyping Aboriginal communities and through media attention to it, increase the likelihood of more suicides (Chartrand, 1995).

- Raise consciousness about the how colonizing images continue to pervade mental health service provision.

- Provide opportunities for [mental] health nurses and other health care providers to examine the ways in which they experience *safety* and *unsafety* – to help develop a language for discussing the tensions and disjunctures that arise in their relations with patients/clients and one another.[158]

**Education**

- Although there are an increasing number of Aboriginal providers in the field, need and availability remain grossly out of balance.[159] Therefore, in collaboration with Aboriginal peoples we must develop access supports for Aboriginal students within the educational complex, not only addressing how to assist students with entry requirements but also to assist with creating a learning environment conducive to supporting comfort and *safety* while the student is in the nursing program to support successful completion. Therefore Faculties and Schools of Nursing must set up structures such as Aboriginal Access Committees and engage in initiatives such as ensuring "reserved seats" for Aboriginal students.

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[158] The narratives with the one of the nurses in this study and the cultural safety literature (Kearns & Dyck, 1996; Stabb, 1995) suggest a need to examine the issue of *safety* and *unsafety* from the perspective of both patients/clients and health care providers. Although beyond the scope of the analysis here, the issue of *reversed racism* is worthy of ongoing discussion and investigation. In the context of sometimes strained Aboriginal - non-Aboriginal relations, we must work to create a climate conducive to developing a language for engagement with another to discuss these issues. As Ahuarangi, a Maori nurse argues: "Cultural safety is about keeping one's culture intact but this does not imply stasis. Transformation, the ultimate rite of passage implies that all within the shared space are agents of each other's transformation" (1996, p. 15).

[159] Getting to post-secondary education presents a whole set of other challenges beyond the scope of discussion in this dissertation but one of the key issues here is that many students find when they apply to the universities and colleges that their secondary education has not adequately prepared them to meet entry requirements. This was commonplace in the communities where participants lived and/or worked (Fieldnotes, RP14).

- Post-secondary institutions can provide many of the forms of education and training which Aboriginal students need to survive. However, as Ponting (1997) notes, serious consideration needs to be given to the ways in which these institutions recruit students and inhibit or facilitate their success.

- Develop partnerships with Aboriginal communities to incorporate and teach content related to Aboriginal mental health within the nursing curriculum – a curriculum which includes *Aboriginal Mental Health* and *Cultural Safety* to provide a window to examine the limitations of biomedical approaches, critique mental health institutions and policies, and examine the burden of history as it is played out in relation to the mental health of Aboriginal peoples.

- Provide opportunities for non-western critical pedagogies to emerge (LaRocque, 2001).

- Provide opportunities for nurses and students to visit and interact with Aboriginal communities or agencies as a way of challenging assumptions, stereotypes, and dominant images (Ramsden, 1992).

- Provide resources for nursing faculty to focus on assisting students to further develop methods for *influencing change* within the mental health care system, for example, curriculum development and student projects in partnership with Aboriginal communities.

**Research**

- In research involving Aboriginal peoples we must be vigilant to the dangers of any "cross-cultural" gaze. For example, Duran and Duran (1995, 2000) assert that "cross-cultural" implies that there is a relative platform from which all observations are to be

made, and that the platform that remains in place in our neocolonial discipline[160] is one of Western subjectivity (Duran and Duran, 2000, p. 87). Such vigilance would require that the researcher be fully engaged with the ongoing process of reflexivity (Anderson, 1991a; Reimer Kirkham & Anderson, 2002; Lather, 1991) and to a scholarship committed to re-evaluating frameworks of interpretation, conclusions, and portrayals (LaRocque,1996) and to building ongoing partnerships with Aboriginal researchers and communities. We must abide by the ideology of self-determination (Duran & Duran, 2000).

**Policy**

- Facilitate the empowerment of Aboriginal peoples that supports a process of engagement with policy-makers. As Ahuarangi, a Maori nurse notes: "Institutional changes must begin in the highest echelons of power, where mana Maori motuhake [Maori independence, autonomy and self-determination] and crown sovereignty are in partnership within judiciary, executive and legislature" (1996, p. 15).

- Raise the consciousness of policymakers to the failure of current mental health policy to meet the most pressing mental health concerns of Aboriginal peoples.

- Raise the consciousness of policymakers to the impact of its broader health, social, and economic policies on the mental health and well-being of Aboriginal peoples.

- In partnership with Aboriginal peoples, work to provide of an organized response to Aboriginal suicide and more broadly, Aboriginal mental health in this province.

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[160] Duran and Duran (2000) are Aboriginal psychologists speaking about psychology. However, as noted earlier, I think this is also applicable to nursing.

## Concluding Comments

Duran and Duran argue that "as we move into the next millennium, we should not be tolerant of the neocolonialism that runs unchecked through our knowledge-generating systems" (1995, p. 6). Explicating the nature of the tension between Aboriginal understandings of and responses to mental health and illness and the current mental health system contributes to the process of unmasking the taken-for-granted assumptions embedded in and supported by institutional polices and practices. Nursing as a discipline is challenged to critically engage in the process of social transformation, which, as Paulo Freire (1970) suggests, must start within each and every one of us: we need to reflect within ourselves and then take action on our individual realities. The ways in which we perceive the world, relate to the world and to one another, will be altered forever (Hingley, 2000). LaRocque (1993) argues that there is a role for both Aboriginal and non-Aboriginal peoples in such social transformation: "The onus for change cannot rest solely on Aboriginal shoulders. White people in positions of power must share the burdens of finding answers, as they have been part of the problem" (p. 76).

Contextualizing the delivery of mental health care in today's postcolonial climate will allow us to confront deep-rooted attitudes and relations of power. By locating mental health care delivery within these wider historical, political, and social contexts, nurses (and other providers) can more fully contribute to social justice in the realm of Aboriginal mental health. As a psychiatrist who provides consultation and counseling to Aboriginal people on reserve recently said: "racial bias against Native peoples seems to be built into the fabric of the system... and people need to understand the consequence of that for Native people" (C. Bawden, personal communication, November 28, 2003).

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# APPENDIX A

## Informational Pamphlets for Participants

# APPENDIX B

## Consent Forms for Participants

# APPENDIX C

Interview Guides

## Interview Guide for Aboriginal Participants

1. Do you think there *is* a tension between Aboriginal understandings and responses to mental health and illness and the current mental health system?

2. Tell me a little about the tension.

3. Given your understanding of the current mental health system and policies, what do you see as some of the barriers that Aboriginal people face in achieving their optimum mental health? or What are some of the barriers you and/or others you have known have faced in terms of achieving your/their optimum mental health?

4. What do you think has been beneficial for Aboriginal people in terms of mental health services? Tell me about the barriers to access.

5. Do you think that racism or other forms of discrimination has affected Aboriginal access to mental health services in any way? If so, how?

6. Is there something I haven't asked you that you might want to discuss? or Would you like to add something?

If cultural sensitivity or relevance is discussed – ask about how the participant understands it - discuss the notion of cultural safety – what it might have to offer – suggestions etc.

## Interview Guide for Policy Participants

1. Do you think there *is* a tension between Aboriginal understandings and responses to mental health and illness and the current mental health system?

2. Tell me a little about the tension.

3. Can I ask you a question here? How much was the latest reform prompted by the BC Schizophrenia Society (BCSS) and the crises that occurred.

4. What do you perceive as the barriers to pushing forward the Aboriginal Mental Health agenda? For example, Aboriginal suicide hasn't reached the mental health agenda – what are the barriers? Are there areas of mental health policy you would change in relation to Aboriginal people?

5. Do you think that racism or other forms of discrimination has affected what mental health services are offered to Aboriginal people? If so, in what way?

6. What might you want to add to this topic that I haven't asked you? or Would you like to add something we haven't discussed?

## Interview Guide for the Focus Group

1. Do you think there *is* a tension between Aboriginal understandings and responses to mental health and illness and the current mental health system?

2. Tell me a little about the tension.

3. Tell me about your work with patients in this setting – what are their most pressing concerns?

4. Tell me about accessing mental health services.

5. Do you think that racism or other forms of discrimination have affected what mental health services are offered to Aboriginal people? If so, in what way?

6. Is there anything else that you would like to comment on or ask?

## Interview Guide for the Nurses

1. Do you think there *is* a tension between Aboriginal understandings and responses to mental health and illness and the current mental health system?

2. Tell me a little about the tension.

3. Tell me about the patients you care for here.

4. Tell me about your experiences caring for First Nations patients.

5. What kinds of mental health issues present here?

6. Do you see any issues related to access to mental health care? If so, could you describe them?

7. Is there anything else that you would like to comment on or ask?

# APPENDIX D

## Description of Federal and Provincial Mental Health Services

## Description of Federal Mental Health-Related Services
## for First Nations and Inuit Peoples

The First Nations and Inuit Health Branch (FNIHB) has the mandate to deliver a number of programs, which include a mental health component. Currently, the four FNIHB funding streams for mental health-related services are: 1) Brighter Futures Initiative (BFI), 2) Building Healthy Communities (BHC), 3) National Native Alcohol and Drug Abuse Program (NNADAP) and 4) Non-Insured Health Benefits Program –Crisis Intervention/Mental Health Counselling (NIHB). Various mental health services for First nations peoples are provided through one or more of these programs.

1) BFI was implemented in 1993 and is delivered by First Nations at the community level. It is intended to support community-based activities, within a community development framework that fosters the well being of the First Nations children, their families and communities. BFI provides programming such as mental health, child development, parenting skills, healthy babies, injury prevention and solvent abuse treatment. It is intended to support the development of specialized community-based mental health treatment services, crisis intervention services and solvent abuse programming (FNIHB, 2003b).

2) The BHC was initiated in 1994 and provides Mental Health Crisis Management. This component presents an opportunity to First Nations to take a proactive approach in planning early intervention and crisis response activities in the community which are integrated with and complementary to other locally designed and managed mental health services. The development of a Crisis Management and Response Plan that integrates all existing programs and services provided by caregivers is intended to enable the local communities to respond to urgent or unforeseen needs (Jodoin, 1998).

| Mental Health Services | First Nations on reserve | Inuit in Inuit settlement/ community | First Nations off reserve | Inuit (on/off settlement) | Métis | All Aboriginal People (on/off reserve and status non-status) |
|---|---|---|---|---|---|---|
| **Brighter Futures** (*Mental Health*, Child Development, Healthy Babies, Injury Prevention, Parenting Skills) | x | x | | | | |
| **Building Healthy Community** *Mental Health Crisis Intervention* | X | X | | | | |

Table I - Source: Health Canada, 2001; Romanow, 2003, p. 215

3) NNADAP began in 1984 and in the majority of First Nations communities there is at least one NNADAP worker. The Residential Treatment Component has a national network of 53 treatment centers (695 treatment beds) operated by First Nations organizations and/or communities to provide culturally appropriate in-patient and out-patient treatment services for alcohol and other substance abusers (FNIHB, 2003b).

| Addiction Services | First Nations on Reserve | Inuit in Inuit settlement/ community | First Nations on/off reserve | Inuit (on/off settlement) | Métis | All Aboriginal People (on/off reserve and status non-status) |
|---|---|---|---|---|---|---|
| National Native Alcohol and Drug Abuse Program (NNADAP) Residential | X | X | X | X | | |
| (NNADAP) Community | | | X | | | |

Table II - Source: Health Canada, 2001; Romanow, 2003, p. 215

4) NIHB Program funding is intended to provide limited funding of last resort for *professional* mental health treatment for individuals and communities in at-risk, crisis situations. The objective of the NIHB Mental Health Crisis Intervention Service is to provide mental health treatment on an early crisis intervention, short-term basis when comparable services are not available or accessible elsewhere through Federal/Provincial Ministries, other Medical Services Branch programs, or other insured health plans. Benefits under the NIHB Program include: pharmacy (including prescription and over-the-counter medications, medical supplies and equipment), dental care, vision care, transportation to access medical services, health care premiums in Alberta and British Columbia only, and other health care services including crisis intervention mental health counseling (Jodoin, 1998; FNIHB,2003b).

To maintain quality of care and accountability of service, NIHB-funded mental health services are provided by mental health professionals, including those in disciplines of psychology, psychiatric nursing and social work.

The NIHB guidelines allow for a maximum of twenty individual therapy sessions and physician assessments and referrals are desirable in order to access the services. However, in situations where this is not possible, screening by approved allied health professionals may be accepted. For circumstances where long-term care is recommended, appropriate treatment plans will be prepared by the health professional and alternate referral to Provincial or other services arranged (FNIHB, 2003b).

| Non-Insured Health Benefits (Dental, Medical Transportation, Drugs, Medical Supplies and Equipment, Vision Care, *Mental Health*) | First Nations on Reserve | Inuit in Inuit Settlement/ Community | First Nations on/off reserve | Inuit (on/off Settlement | Métis | All Aboriginal People (on/off reserve and status non-status |
|---|---|---|---|---|---|---|
| | x | x (recognized Innu) | x | x (recognized Innuit) | | |

Table III- Source: Health Canada, 2001; Romanow, 2003, p. 215

## **Description of Provincial (BC) Mental Health Services**

The mandate of the Adult Mental Health Division, Ministry of Health, B.C. is:

> To ensure the provision of core mental health services which include clinical services (assessment, treatment and consultation), support, psychosocial rehabilitation and outreach services and emergency response and short-term intervention services for people with *serious and persistent mental illness* (Jodoin,1998, pp. 3-4).

Mental Health Services in B.C. consist of the following:

- *Clinical services* – includes primary community-based intake, assessment, treatment, consultation and case management (e.g. by mental health centres established throughout the province); secondary psychiatric services in general hospitals; and tertiary psychiatric services (Riverview Hospital, Vancouver);
- *Support, psychosocial rehabilitation and outreach services* – includes community residential services; community rehabilitation /support services (e.g. club houses); respite for primary caregivers; community outreach services; and
- *Emergency response and short-term intervention* – includes triage; crisis intervention; short-term assessment and treatment; coordination; and referral and consultation (Jodoin,1998).

There are several mental health centres across B.C. which can be accessed without referral. Each of these centres provides a broad range of services:

- *Community mental health* which includes assessment, treatment and follow-up of major mental illness suffered by adults and the elderly;
- *Psychiatric consultation* provided by outreach psychiatrists who fly in and provide consultation on complicated cases;
- *Residential services* – some of the mental health centres contract with other agencies to support independent living and residences; and
- *Rehabilitation services* – support is provided to assist clients in developing club houses, life skills training etc. (Jodoin,1998; Rahim-Jamal, 1995)

Provincial mental health services and programs are available to First Nations communities as they are to all residents of B.C. However, the majority of these services are provided off-reserve and timely access and/or availability may be problematic for First Nations given geographic, cultural and economic realities (Jodoin,1998).

Regional Health Authorities who administer provincial funding across the province operate under the jurisdiction of the Health Authorities Act.