IMPLEMENTATION OF TRADITIONAL KNOWLEDGE IN MENTAL HEALTH POLICY
Learning from the cases of the Inuit, the Haida and the Maori

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Melissa
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Dedication

This thesis is dedicated to my family who saved my life 12 years ago; I am only here today because you made me confront the disease that would have consumed me. It is also dedicated to mental illness survivors everywhere: the people who get up every day and face their sometimes very visible flaws even though it can be very scary and very painful. You are all the bravest people in the world. I never thought that I would be grateful to be among your number; there is a part of me that will always wonder why, but I will never give up or fall off my path again. It is my sincerest hope that you all find your own peace.

Abstract

This paper considers the Aboriginal population in Canada (composed of First Nations, Métis and Inuit peoples) and explores the hypothesis that the degree to which traditional knowledge concepts, specifically in the area of mental health, is impacted by the extent to which a given population has achieved self-government. Additionally, from a public policy standpoint, this study – using a single case comparison methodology – examines the gap between intentions outlined in policy formulation stage guidance documents, indicating that the Canadian federal government intends to incorporate traditional knowledge to a greater degree, and evidence present at the policy implementation and budgeting stage, where it is clear that the application of the guidance does not always result in the stated outcome. By looking at similarities and differences between the case populations, this study will highlight some successes in the field of mental health policy, assess the challenges that policymakers face in the area of Aboriginal health, and offer suggestions to arrive at a place in the future where fundamental mental health disparities have been reduced for Aboriginal people in Canada.

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Introduction

As the West is engaging in a profound revisiting of its own colonial past, ancient and new experiences of identity seem to emerge. Under colonial rule, indigenous identities have been repressed and subjected to the presence of an "other", which had a structuring effect on how and what was proper material for identity construction. Alienation of indigenous identities have been the result of the cultural upheaval that has resulted from the Aboriginal experience of colonialism, which has been articulated through such well documented experiences as forced migration, residential schools and the vicious cycle of drug and alcohol abuse that has lead to "severe consequences in terms of community and individual mental, social, spiritual and physical health" (Frolich & Poland, 2007).

For the last twenty to thirty years, initiatives have been put in place as a way to both repair injustice and as a method of providing services that are more responsive to the needs of indigenous populations. Among the areas of public policies that have been more prone to experiment with postcolonial perspective, healthcare is undoubtedly an area that has raised attention because it is relevant to all Canadians. This thesis is rooted in the context of public health disparity and proposes to shed light on the fact that the Canadian Inuit population has experienced marginalization in terms of health and what efforts have been made in recent years to improve these inequalities.

The Inuit are the population of interest for this thesis rather than another Canadian indigenous population because they are the most isolated from the rest of Canada and have been able to preserve many of their traditions. They are a population that has certainly been touched by Canadian colonialism in many ways. However, as the North is so isolated, the Inuit are a difficult group to access and have been able to preserve their knowledge to a

greater extent than many other Aboriginal groups. As such, this population is of special interest. The Haida and the Maori are populations brought in to the study in order to highlight the way that the Inuit are unique in comparison. Through a case study comparison method these populations, in concert, will help identify some of the key successes and problems in the way that traditional knowledge is applied in mental health policy for the Aboriginal populations in Canada, specifically the Inuit.

This thesis focuses on the place that knowledge occupies in health policy. In particular, it addresses the increasing interest (from policy makers, experts, members of native associations) for aboriginal knowledge in health policy. In Canada, as well as in many other countries, a number of initiatives have been developed in order to assess a cultural gap or a culture shock provoked by the encounter (and sometimes the omission of respect) with and for traditional knowledge. More importantly, this thesis is based on the assumption that the different types of knowledge present within the traditional communities of the Inuit entertain different notions of many concepts – governance, interpersonal relations, nature – so differently from the dominant 'white Canadian' ideas that it has been extremely challenging to reconcile the concept of health care as something universal. There is an important ethical dimension to these policy claims. In fact, should and could Aboriginals implement or adhere "more closely" to the dominant expert-based health policy paradigm sustained by the Canadian State and its officials. Perhaps this is not actually possible, as the goal should not be to ensure that Inuit adhere to a 'rest of Canada' conception of health and health care. The goal of many of these approaches is to find a way to balance understandings so that both cultural groups can have a definition of health and/or health care that is an honest reflection of the values of the cultures. Given that the two cultures are so wholly dissimilar and that there is very little in terms of a framework within which the cultures can

relate to one another, it is a challenge that the Canadian government must address. What is now sure is that the current arrangements seem to have failed, and that current health problems are ever increasing. Among the myriad of ideas and solutions that have been proposed to solve this problem, one of the strategies that is most promising has been to revalue and re-legitimize indigenous knowledge.

The idea of legitimizing knowledge and arriving at an understanding, or at least a respect for, the differences in interpreting interactions is crucial in order for progress to be gained within an environment of cultural hostility. Sometimes it is difficult to see how to arrive at a neutral space where decisions can be made without further repression or without re-enacting colonialism. The question of knowledge is interesting, as it has opened a base for valuing indigenous input (and sometimes even autonomy) in the governance of their health services. Knowledge, and indigenous knowledge in particular, has been identified as a positive strategy to repossess one's own community future. A definition of what is considered knowledge within the framework of this study is provided in a subsequent section.

The aim of this thesis is to explore the place dedicated to indigenous knowledge in Canadian healthcare policies and strategies in order to understand the place of knowledge in the indigenous/white articulation of healthcare policy in Canada over the last twenty to thirty years. In addition, the Inuit experience will be assessed in light of comparative material brought from different, yet comparable, contexts. These include the experience of the Haida in Western Canada – a First Nations people that are currently making progress in settling their claims to land and are actively engaged in the journey toward at least partial self-governance – and the Maori in New Zealand, who have, over the past 15-20 years, articulated their governance well and set themselves up as something of a separate nation

operating within the greater context of New Zealand as a whole. The Haida experience will provide a Canadian experience that contrasts with that of the Inuit, while the Maori will provide an international comparison group.

The inclusion of these three groups, common thematically, but disparate in their outcomes, will help to illustrate the breadth and complexity that is the theme of Aboriginal knowledge. Additionally, these comparisons will help to convey the Aboriginal context overall, encompassing the First Nations, Métis and Inuit communities and establishing these as unique entities; too often we speak about Aboriginal communities without defining our parameters appropriately. The Inuit context will be introduced and the details of why this population is unique and different in this policy context will be made clear.

It is important to be clear about the population under discussion because there is a true diversity amongst different groups of Aboriginal people and "this diversity makes lumping people together under generic terms like 'Aboriginal' or 'indigenous' profoundly misleading" (Kirmayer, 2000). For the ease of reading and the lack of accepted alternative terminology, this paper utilizes these words; however, it is important to acknowledge the limitations of language up front. Establishing the specificity of the population will set up the first part of this exercise of defining the population and explaining the overall problem that will be investigated over the course of the research.

In other words, the thesis aims at shedding light on the consideration of indigenous knowledge in Canadian healthcare policy formulation/implementation by focusing on one health policy subsector: mental illness. The specific question under consideration is: How has traditional knowledge been implemented in mental health policy? Areas of exploration under this umbrella question include how the Canadian government and the Aboriginal self-governing bodies have (or have not) worked together to implement space to include

traditional knowledge in health care practices; where these policies have been best and worst applied; and, the extent to which Canada can learn from other countries, such as New Zealand, in terms of inclusive health policy implementation and the operationalization of culturally appropriate practices.

There are several examples of where Canadian policy documentation indicates that the guiding philosophy is that the federal government wants to follow through on the requests of Canadians and work to incorporate more traditional knowledge in health policy and specifically mental health treatment protocols. The policy formulation documents and budget statements indicate that will be the direction taken; however, in the implementation phase it appears that the communications get disconnected and the same solutions end up on the table, resulting in the same, typical, outcomes. These outcomes include inequitable mental health treatment for Aboriginal Canadians, culturally inappropriate care, and the continuation of existing disparities. As such, the question of the impact of self-government will be crucial; the hypothesis here is that there is a correlation between the degree of governance power and the degree of traditional knowledge incorporated into treatment. Additionally, the way that different policies have been applied amongst different domestic Aboriginal populations as well as compared to an international case will be explored in order to assess the potential learnings that Canada could apply, in general. This will be done through a case study approach, which will be detailed in Chapter II.

Among the multiple areas of health policy and intervention, mental health has been one of the most problematic and significant evidence of this is present amongst Canada's Aboriginal communities. Because it relies heavily on communication with the patient or with the patient's family, mental health is more prone to cultural misinterpretations or to clashes in cultural understanding. The increasing presence and prevalence of issues such as

addictions and suicide in Aboriginal communities illustrates the importance of finding culturally appropriate ways to deal with mental health issues and the need to involve Aboriginal knowledge as a way of increasing community ownership of solutions.

This study will address these issues in a linear fashion and will attempt to address multiple facets to the story behind the gap between policy formulation and implementation. Chapter I will provide some background on the health inequities in Canada and outline the differences in health outcomes between Aboriginal and non-Aboriginal populations. Addressing the thorny issue of post-colonialism briefly, this section provides context for the relevance of this study in today's policy environment. Chapter II features the methodological framework of the study and provides a high level of detail around case selection, data collection, and analysis, while Chapter III outlines the theoretical framework and key authors that guided the composition of the hypothesis and informed the direction of this work.

Chapter IV takes a broad look at the Canadian health policy system and outlines some of the critical principles with respect to the establishment of our health system overall and the role of the federal government in their fiduciary responsibility for Aboriginal populations (despite that health is considered a matter of provincial jurisdiction). Chapter V summarizes the particulars on how each of the case study populations has experienced the journey towards self-government and how this has influenced the presence of traditional knowledge in relevant policy. Chapter VI looks at the implementation of mental health policies through an assessment of two "cases within the case", which addresses components with the Maori and Inuit cultures that have helped to operationalize the construct of applying traditional knowledge practices to care and treatment. Additionally this chapter covers the perspective of care providers in the field who must operationalize policy decisions; having

this understanding allows for a clearer interpretation of the amount of needs that must be taken into consideration where good policies are being considered.

Chapter VII takes the specific lens of knowledge use as applies it to mental health policy. Looking at the when, where, and type of knowledge, this chapter focuses specifically on examples of how knowledge is used domestically as well as internationally to guide policy choices. Chapter VIII addresses the challenges inherent in this type of work and contains a bit of an analysis about how funding traditional knowledge is difficult. Of late, it has added that, in policy documentation and in actual spending, there appear to be two different theses in the field. The goals of strong Canadian health care being argued at the same time and the challenges to both sides are great. Finally, Chapter IX covers the challenges about studying knowledge, with specific attention to health policy as an object of study. Together, these chapters tell the story of the gap between policy formulation and implementation when it comes to the application of traditional Aboriginal knowledge in the Canadian health care context.

Chapter I: Background

This introductory section will look broadly at the concept of health disparities and address the perception of culture as a determinant of health. Introducing this idea, it will be linked to that of the diminished health status of the Inuit population. A brief background on the social determinants of health concept is provided below in order to clearly identify what the determinants concept looks like (Evans & Stoddart, 1990). Despite that the determinants concept is inherently biased against the Aboriginal population and comes from a non-inclusive theoretical underpinning, it is an important premise for context. Subsequent sections will address the flaws of this generally accepted approach. From this foundation, the goal will be to set up a definition of *implementing* indigenous knowledge. Several indicators of this process will be explored through a review of the literature comprising indigenous knowledge and healthcare policy. As well, specific questions around legitimization will be addressed in order to create a real understanding of the necessary terminology and the precise research question.

a) Healthcare services and underprivileged populations

Important to the context of this paper is the overall discussion about health disparities in general and how, within Canada, Aboriginal people are at higher risk for health impacts, especially related to mental health, due to several socioeconomic factors present in the living situations many Aboriginal Canadians have been faced with (Adelson, 2005). To understand this link is will be important to define what it means to be underprivileged in Canada in relation to health. To be clear, the Aboriginal population in Canada is not the only segment with disparate health outcomes; many minority populations and recent immigrants also have a difficult time getting culturally appropriate care. Much of this has to do with how the

majority population in Canada understand the concept of knowledge and what kind of knowledge is appropriate for health. The notion of a science-based or evidence-based discipline is a way of knowing that many Canadians privilege; they have a difficult time conceptualizing other knowledge constructs, like Chinese medicine, for instance. The Eastern concept of understanding health as a more subtle series of states rather than the binary Western notion of health or illness as mutually exclusive concepts is difficult for most minds raised in the Western tradition to frame (Kaptchuk, 2000). Other authors such as Mehl-Madrona (2009) and Hunter (2006) explore this notion of cultural understandings of health and health care; the bridge between the different ways of knowing is, as yet, underdeveloped between Aboriginal and non-Aboriginal populations within Canada. As such, understanding the place of traditional knowledge in health policy is useful to increase understanding between these populations within Canada.

The guiding literature that sets the standards around who is healthy and who is not can be explained through the concept of health determinants. This is a concept that was first introduced in the late 1970s and further elaborated in foundational documents relevant to Canadian health care, such as the 1986 Ottawa Charter, an oft-cited document by scholars of health promotion and the health determinants perspective. Determinants of health are set up as a framework within which one can understand the concepts of disease and health care, and crucial to this is the notion of health as more than just the absence of disease (Evans & Stoddart, 1990).

The ideas present within health determinants theory come from a democratic sense of health as a necessity for all. The notion of health determinants and their place in indicating the overall health of a population or sets of populations will really inform what this paper posits about health and specifically the ill health that is seen amongst Aboriginal populations

in Canada, primarily among the Inuit. Evans and Stoddart (1990) articulated a series of 14 factors that impact individual health; some are negative impacts while others provide positive impacts. The list of variables is as follows: income, education, unemployment/job security, employment/working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, Aboriginal status, gender, race and disability.

The fact that Aboriginal status is present on the list of determinants is alone a strong reason to put forward the idea that Aboriginal people (including First Nations, Métis and Inuit) fall into a special category within the underprivileged sector of society. While many of the other categories apply – for Inuit in the North the issues of housing and food insecurity are paramount – the fact that their very background is itself a risk to health helps to make the case of this component of this study quite clear. This fact helps to direct attention to the next phase of this investigation: the framing of 'the native' in health care and health policy.

While the determinants of health may be a useful lens through which to view the Aboriginal population for some studies, it is profoundly lacking from this perspective because it sets up the Aboriginal populations as an "other" to Canadians; instead of making them a *part* of the theory, it sets them up as though the entire population is some sort of observable variable in a laboratory experiment. As a result, given that it leaves no room for true Aboriginal *participation*, the health determinants theory is not a useful basis through which Aboriginal people can engage with for the purposes of health promotion or health policy improvement.

Stemming from the fact that indigenous populations are seen to be at risk for poor health simply by virtue of their existence, it is important to understand that this is relevant beyond the Canadian context alone. While there is much documentation about the disparities

and inequalities that exist between Aboriginal and non-Aboriginal populations in Canada, there is also documentation of these imbalances internationally. This section will look slightly more pointedly at Canadian indigenous populations as well as those in countries around the world that are similar to Canada for comparative purposes, specifically the Maori in New Zealand.

There are biases in terms of the determinants of health and the unique perspective that evaluates Aboriginals as opposed to non-Aboriginal Canadians. Data from the 2001 Aboriginal People's Survey shows stark disparities in terms of many variables that are represented in the social determinants theory; for example, 53% of Inuit live in crowded conditions[1] compared to 7% of all Canadians and Inuit of both genders had the lowest life expectancy when compared to all other populations in Canada, including First Nations (both on and off-reserve) and Métis (Adelson, 2005). Unemployment rates for Aboriginal people are higher than for non-Aboriginals – more than three times higher in 2001 – and Aboriginal people are overrepresented in both prison populations and the HIV and other STI epidemics. All of these examples are poor indicators for health (Tang & Browne, 2008) and they are also poor indicators for mental health.

These statistics present a very clear picture that there is a great disparity in the health of the Aboriginal population and in the way that health policy theorists view the population. What is unclear is how Aboriginals experience health differently and deal with the different needs they face. The factor that becomes important here is the racialization of health care and how individuals are treated when race is incorporated as a factor. Additionally, when speaking in terms of mental health care specifically, there are several underlying factors present within the Northern context that must be understood to fully grasp the difference in

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[1] "Crowded conditions" is defined as 1 or more people per room in a dwelling.

the possibility for health. As evidenced in the work of Kirmayer and his team, the experiences that many Aboriginal peoples and certainly Inuit have of "cultural discontinuity and oppression have been linked to high rates of depression, alcoholism, suicide and violence in many communities" (Kirmayer et al, 2000).

Knowledge about care and acceptance of treatment is crucial to understand as things are framed in the different discourses of knowledge between Inuit and the dominant population within Canadian culture. Additionally, there is the issue of the different debates that are becoming more relevant as the changing Canadian population illustrates that the dominant culture is now becoming less dominant due to immigration and other factors. While investigating this issue deeply is largely outside the scope of this study, the understanding that the face of the 'dominant' Canadian culture is changing may mean that the future of understanding the Aboriginal population as just one of many diverse components of the Canadian population is closer than it currently seems.

b) *Self-governance and policy making*

Political sovereignty has been and still is a dominant issue among First Nations, Métis and Inuit people in Canada, (Henderson, 2007) thus, it is important to provide space for Aboriginal people to build institutions of government that include their tradition and style of governance. As a population, Aboriginal leaders have striven to successfully implement the concept of self-government, in the Canadian context. As such, the question of how to truly incorporate a post-colonial approach to health governance such as the respect for traditional indigenous knowledge into policy-making is a very important one. Specifically around policies dealing with health care, and even more specifically, mental health, it is the duty of policy-makers to protect the interests of those who are most vulnerable such as the

sick and those whose faculties are temporarily compromised by the use of drugs and/or alcohol.

It is difficult enough to design a strong health policy for the protection of those in the "dominant" part of the population; mental health is still viewed with a keen stigma. Coming from a minority culture that has been viewed as second-class in decades past and coming out of a system that has set this culture up to be assimilated, the design of strong policy for Canadian Aboriginal populations is even more difficult. As well, policy is difficult to design when the population of concern has very different ideas about the way to construct the problems at issue. For example, the work of Kirmayer's team addresses the idea that "[specifically in the case of the] Inuit concepts of mental health and illness and attitudes toward deviant behaviour suggest that cultural factors play a role [as] Inuit tend to label states rather than people, allowing for the possibility that someone whose behaviour is bizarre today may be ordinary tomorrow" (Kirmayer et al, 2000). This kind of framing of a mental disorder as something that is *part of* a person but does not *become* a person is very different than the framing of the same disorder in the non-Aboriginal or "western" context where there is a tendency to be more judgmental of the individual, framing the mental disorder as a weakness or defect.

It is possible that this is an example of the postcolonial influence that separates the ideas of the Aboriginal from the 'white' population. As discussed in the work of Bhabha, "postcolonial criticism bears witness to the unequal and uneven forces of cultural representation involved in the context for political and social authority" (2004). While postcolonial theory is not defined as part of the framework supporting this paper, it is important to acknowledge the influence of postcolonial thinking on the way, subconsciously, that Canadian Aboriginal people might interpret mental health issues.

c) Defining the Research Problem

The object of this thesis, then, is to explore Aboriginal knowledge in policy formulation and implementation and to understand how this knowledge is, or is not, used in the field of health, specifically mental health. The position taken, through evidence put forth from the literature and a look at three case studies, is that policy can be effective when there is community ownership and that this community engagement is most often achieved after an effective self-government process. Community involvement in policy implementation can, "contribute to a climate of self-empowerment in the community and can improve access to services through a supportive, culturally-appropriate environment" (Lemchuk-Favel & Jock, 2004).

One component that this study explores is the apparent gap between the intentions behind policy formulation, including the documentation provided in policy handbooks and federal level accountability documents like Reports on Plans and Priorities (RPP) or Departmental Performance Reports (DPR), and the implementation of sound mental health policies that consider traditional knowledge. From the evidence that this study has accessed, the implementation stage is where policy intentions get muddled and the result is that the Canadian government, to this point, has not done well at "walking the talk", so to speak, in terms of operationalizing the policy language they use to make meaningful steps towards a practice of mental health practice (resultant from guiding policy) that considers traditional knowledge concepts.

Chapter II: Methodological Framework

The case study approach taken for this study allowed the author to engage with the literature to a great extent from day one of the data collection phase. This approach, described in more detail below, allowed for an increased understanding of the population of interest based on comparisons to two contrasting populations. In this way, both similarities and differences of context, culture, continents, and contacts with colonial oppressors are highlighted and can be presented in a concise fashion. Chapter VII illustrates in a synthesis chart format the high level findings that can be drawn from the literature.

a) Research strategy

The case study format suited this research because cost and time constraints did not allow for in-person structured interviews with Inuit populations. Travel to Nunavut is prohibitively expensive and during the time that the research phase of the project was taking place, it was the dead of winter, leaving the flight schedule largely unpredictable. To avoid the risk of planning an expensive research trip that had a great likelihood of cancellation, the case study approach was deemed appropriate. This also allowed other populations to be assessed to the same degree; it would not have been equitable to do structured interviews and focus groups with one case population and not engage to the same degree with the other two populations under consideration.

The single case study approach, as defined by Robson, is a "well established research strategy [that] typically involves multiple methods of data collection [and] can include quantitative data, though qualitative data are almost invariably collected" (2002). In this study, the 'case' or the group of interest is Aboriginal populations, illustrated by the Inuit and the Haida (domestically) and the Maori (as an international comparison case). Through

assessing the varying attributes of these three populations, this study is able to make some comments on the topic of interest, the implementation of traditional knowledge in mental health policy. This application of the method of single case comparison – called single case, because despite that the study assesses three comparison cases they are all part of a larger single group – is exclusively qualitative, as comparable quantitative data on the case components were not available. This is not to say that the study was conducted without rigour; in fact, the opposite is true and the details are described below.

b) Case selection

The Inuit were selected as a case in this study due to the status of Nunavut Territory as a self-governing territory within the federation of Canada. The concept of *Inuit Quajimajatuqangit* (IQ), which is an Inuit concept referring to the importance of traditional knowledge held by Elders, was enshrined in the foundational documents of the territory and all policies established in the territory have to illustrate how they address the IQ principles. The fact that this exists led to further questioning about whether other cultures have established systems to codify abstractions like traditional knowledge and how relevant that would be as Aboriginal populations in Canada attempt to assert increased control over their governance. This line of thinking led to the hypothesis that there would be a positive correlation between the degree to which a given population incorporated traditional knowledge concepts into their health care and the degree to which they had control over their governance as a population within the federation.

The comparison cases of the Maori in New Zealand and the Haida in British Columbia are the method that will locate this thesis and ground it in practice and help to access indirect information about the population of interest. The comparison cases will

highlight the differences between minority cultures located within the general population of their respective countries, like the Maori and Haida, with the Inuit who are very physically separated from the dominant discourse and are the majority on their land. The fact that the Maori also have different ways of knowing and understanding health does not seem to place them at the same kind of disadvantage as the Inuit. The specific case that will be considered is that of *Inuit Quajimajatuqangit* (IQ) in Nunavut, which is the process of engaging traditional knowledge of the Inuit Elders. This policy/practice will be compared against the similar guiding principles present in New Zealand. They rely upon a completely different set of principles to legitimate traditional knowledge, engage and provide quality care to the Maori people and they are much more entrenched within New Zealand as a whole country. Most Canadians are not affected nor consider Inuit policies on a regular basis; in fact, it could be proposed that the Inuit are so separate from the 'south of 60' Canadian reality that Nunavut is almost a separate nation. The other two Northern territories have considerably more engagement with the south and also have considerably better road and communications access with Canadian population centres.

Against this contrast, the third case study provides a counterpoint; the Haida people in British Columbia provide an example of an Aboriginal population in Canada that has undergone, and is continuing to undergo, a different and more convoluted self-determination process. They are one of over 200 tribal groups of varying background and claim to certain lands in British Columbia; treaty negotiation has been complicated in recent years by overlapping lawsuits and varying levels of federal engagement. The residential school apology to all Canadian First Nations, Métis and Inuit peoples by the federal government in June 2008 stirred up a lot of sentiments and created difficulties for many treaty negotiations. The Council of the Haida Nation (CHN) entered the treaty process in December 1993 and

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eight years later, in April 2005, stage 2 (determination of the readiness of the parties to negotiate) of the British Columbia Treaty Council (BCTC) process was complete and treaty negotiations began in earnest (Government of British Columbia, 2007). The CHN was established in 1974 with an extensive mandate, key among which is to, "strive for full independence, sovereignty and self-sufficiency of the Haida Nation" (CHN, 2003).

c) Data selection and analysis

The data selection began with a few key texts such as Adelson (2005), Henderson (2007), and Martin (2009) and from there, extensive literature searches were conducted in Scholar's Portal and Web of Science databases on fields such as "traditional knowledge", "holistic care", "Aboriginal mental health" and "Nunavut health policy". Initially, the potential of doing a press review was considered but the Nunatsiaq News, which is the local paper in Iqaluit, NU, did not have an extensive online search capacity with enough history to make the press review worthwhile. As such, the literature search developed it was clear that there was significant data on all three populations of interest to do a single case comparison on several key factors that are similar and/or different between the three populations.

Additionally, the literature was informed by a review of policy documentation and federal government accountability documents; these are all public documents, accessible online. They were extremely helpful in assessing the intentions behind some of the policy guidance information that would show up in the academic literature. The transparency provided by these documents, including Departmental Performance Reports (DPR) and Reports on Plans and Priorities (RPP) allows for comparison between multiple fiscal years and, through an investigation of this, a picture can be

established of the ongoing budget decisions that allow information about policy

direction to be ascertained.

Chapter III: Theoretical Underpinnings

This section covers the definition and explanation of the critical discourse theory and the public participation theory that will be used to support the discussion within the paper itself. Too often issues concerning any of the indigenous populations in Canada are approached only through a post-colonial framework, which, while valid and continually relevant, does not provide enough of an opportunity to raise questions about the words used to frame the problems under discussion. As such, there are several authors from various schools of thought incorporated into this section; this is to provide a broad map of the current literature with regard to this topic and to locate my position within this framework.

a) Public policy

The concepts of "knowledge", whether 'Aboriginal', 'traditional' or simply the 'construct of being aware of a body of facts', has a place in public policy. Canadian health policy research, in particular, relies upon a scientific tradition to inform the choices that are "best practices" because when health policy is on the table, decision makers really do hold the fates of citizens in their hands. Listing and de-listing care is a subject that is passionately argued on both sides (example: Peterson, 1993; Manga, 2000; Armstrong, 2001) but regardless of which perspective is correct, both work from an evidence base. For this reason, traditional knowledge can be difficult for policy makers to process, as it is less tangible. Oral tradition and other ways of knowing can be very challenging for health care policymakers, as their decisions are based on a specific framework of understanding how 'knowledge' applies to the science based field.

At the same time, researchers in health policy have been raising alarms over recent years about the "failure of policy makers to recognize the imperative of reducing inequities

for promoting health" (Low & Thériault, 2008). Additionally, there is a "commitment to the ideas of individualism and individual responsibility as opposed to communal responsibility" present in the dominant Canadian culture that does not exist to the same degree within the Inuit context (Raphael et al, 2008). The notions of community that the Inuit understand and prioritize greatly influence their ideas of what kinds of social policies are appropriate. This section investigates territorial and provincial mental health policy literature from Nunavut and a cross-section of other Canadian jurisdictions. By this means, it will be possible to compare and contrast the different framing of policy issues. In this way, and through the application of a critical discourse lens, conclusions will be drawn about how different types of policy structures work in jurisdictions with different dominant cultures.

b) *Knowledge and public policy*

In this section the connection will be made between the relevant public policy documentation and the theories of traditional knowledge. It is very difficult to establish a strict definition of traditional knowledge as it applies to health because, "cultural and spiritual practices in many cases cannot be separated from Aboriginal concepts of health and healing practices and are as diverse as the many Peoples that utilize them" (NAHO, 2008). For the purposes of this study, 'traditional knowledge' is defined as per the description provided by the National Aboriginal Health Organization (NAHO), a custodian of much of the First Nations, Métis and Inuit knowledge within Canada:

"[It is] the collection and use of natural remedies as well as some fundamental concepts of public or population health which flow naturally from Aboriginal concepts of land, languages and relationships within communities." (NAHO, 2008)

The notion of traditional knowledge is a familiar concept in environmental or educational contexts. Thus far, application to health has been relatively limited and the

volume of literature on the subject is lacking. However, as environmental and land tenure issues are receiving increased attention and achieving resolution, there is available space to address the relevance for traditional knowledge applications in the field of health care policy.

Looking through the lens of critical discourse, some of the literature that bridges Aboriginal knowledge with policy is presented below. The linkages between these authors and the concepts that my thesis will explore are clear, as the map of the literature will indicate. Considering Raphael and colleagues first, their perspectives on the positivist approaches to health and the dominant concepts of individualism present in the common Western idea of health illustrate that this concept of knowledge is at odds with the more community focused idea of health held by traditional Aboriginal communities (Raphael et al, 2008). This concept is of interest, as their position is that this individualism is a barrier to implementing Canadian policy that properly addresses the determinants of health for all. The underlying idea is that individualism "leads to a strong bias towards understanding health problems as individual problems rather than societal ones" (Raphael et al, 2008). The idea of taking a more community-focused lens, present within the Inuit traditional knowledge framework, is supported here.

Despite the fact that Canada has a fiduciary responsibility in the area of health for most Aboriginal people living in the country, it is important to understand that policy that will work for Aboriginal communities cannot be implemented in the same way as for the rest of Canada. There is a need to avoid the "bureaucratic efficiency" model of policy making (Weissert, 2002). Instead, a pluralist approach, which "sees policy development as driven primarily by the quality of ideas" (Raphael, 2008) and "values democratic decision making involving extensive consultation with stakeholders" is key to successful implementation in Aboriginal communities (Weissert, 2002). This idea of attachment to the result of the policy

working after implementation and achieving a goal, instead of attachment to the work in place in the original policy is essential. For mental health policy implementation to be successful, these authors illustrate that it is necessary for there to be willingness for flexibility and adaptability. These authors support the notion of buy-in, which is paramount. Incorporating traditional knowledge concepts, such as consensus, into policy implementation is a way to achieve this.

c) Critical discourse, post-colonialism and democratic theory

Given the research question described above, it is a challenge to best align the discussion within the frame of one theory. The culture and power dynamic that is present needs to be effectively addressed in order to move the discussion forward. It must be acknowledged, but at the same time it is important not to dwell on the fact that it is an issue. There is a cultural bias that is very strong in the Canadian context between the 'white' and 'Native' that requires exploration in terms of the reasons of the "health for some" approach. The critical discourse theory perspective will help to break down the barriers that terminology can provide and neutralize the issues of racialization that often become present in a cultural dialogue.

Critical discourse, as a theory within which to couch the dialogue, can help with this as a way to mitigate the 'white' vs. 'indigenous' slants and access the crux of the issues, clearing away all the baggage that comes with these kinds of questions. We cannot shy away from the cultural aspect of the problem but it is often a good idea to step back and assess the situation without the complications of wondering who is buying in and who is not. As such, critical discourse theory is a framework that will provide part of the necessary support to this study. As evidenced in the work of Fiske and Browne, "critical discourse analysis usefully

takes up theoretical constructs derived from postcolonial theory that are pertinent to examination of health policy" (2006).

As well, when thinking about the self-governance aspect of this work, the writings of post-colonialist theorists can help to inform the perspectives. For example, in terms of understanding the nation and framing the Aboriginal population in Canada, many Aboriginal actors see themselves as something of a separate nation governed by illegitimate actors. It brings to mind writing that was intended for a different oppressed population, that of the African nations. One can understand the parallels in experience, when we consider how "preceding generations have simultaneously resisted the insidious agenda of colonialism and paved the way for the emergence of the current struggles" (Fanon, 2004). Reading these critical perspectives facilitates a comparison between Aboriginal governing bodies in Canada, such as the Assembly of First Nations (AFN), the Métis National Council (MNC) and the Inuit Tapriirit Kanatami (ITK), and marginalized governing bodies of minorities in their own homeland in other countries such as Wales, Scotland, and Israel/Palestine.

Another necessary part of the framework supporting this study is that of democratic theory, specifically dealing with public participation and deliberative democracy. This part of the theoretical framework is important to build upon the idea that as different types of knowledge become legitimated and reflected in the dominant culture, those who are part of the non-dominant population are more likely to subscribe to the proposals put forward by the dominant population for various reasons including coercion. In this case, within Canada specifically, the dominant population is the white Southerners and the non-dominant are the Aboriginal populations. In this aspect of the work, the label of population is outside of the cultural context and is simply a representation of majority and minority.

The ideas present within public participation theory links back to the concept of legitimation of knowledge, as it expresses the idea in truly valid processes of policy making and agenda setting, all parties, even the non-dominant, are needed to participate. The key problem here is not how to increase the participation of the non-dominant population but "how those who typically dominate might be made to attend to the views of others" (Sanders, 1997). In other words, it is more difficult to get the members of the dominant population to listen than it is to get the members of the non-dominant population to speak and participate.

Before delving into the specific issues that are at the core of this study, it is important to pull back and investigate the roots of the disunity that has prefaced Canada's current context, as well as that in New Zealand. While the relationship dynamic between each group of Aboriginal populations and their respective colonial oppressors is different, the ways that the relationships have evolved have determined the successes or lack thereof in terms of presence of traditional knowledge in mental health policy. The next chapter will present a historical look at how health policy overall has developed in Canada and New Zealand and will set the context for understanding each country's Aboriginal populations' journey to self-governance over health and incorporation of traditional knowledge concepts.

Chapter IV: Looking Broadly at Health Policy

Stepping back for a broader view, it is important to situate the larger context within which the discussion of traditional knowledge implementation takes place. Both countries under consideration here have an existing health system and it is only under this umbrella that the issues relevant to this paper can be framed. As a result, this section will focus on knowledge from a policy angle and will address a certain extent of the formulation side of the policy story to provide an underpinning for dealing with the fundamental discord between the Aboriginal and non-Aboriginal ways of knowing. Some history and background on Canadian mental health policy in general will help to establish the boundaries for the conflicting knowledge bases that must be bridged to operationalize any effective discussion on the issues.

a) Brief history of health policy in Canada

Western health policy, and provision of health services in general, privileges science based on empirical ideas and the notion of an evidence base; something is only true based on observable properties repeated in standardized settings (Durie, 2004). This idea is in direct counterpoint with the overall concept of traditional indigenous knowledge that is more connected to neither colonization nor socio-economic disadvantage but to the social and cultural identities connected with the most primary linkages to the Earth in a four-pronged approach, most often symbolized for Western understanding by the medicine wheel (King, et al, 2009). This concept is evidence supporting Durie's suggestion that, "the defining characteristic of indigenous peoples is therefore not necessarily premised on colonization or sovereignty or a prior claim to settlement, but on a longstanding relationship with land, forests, waterways, oceans and the air" (Durie, 2004).

The Kirby Report, produced in 2004 to report the findings from the federal

Commission on the subject of mental health in Canada, had this to say about the roots of the

inequities seen between the different segments of the Canadian population:

> "Experts in the field suggest that, while many of the causes of mental illness, addiction and suicidal behaviour in Aboriginal and non-Aboriginal communities may be similar, there are added cultural factors in Aboriginal communities that affect individual decision making and suicidal ideation. These cultural factors include past government policies, creation of the reserve system, the change from an active to a sedentary lifestyle, the impact of residential schools, racism, marginalization and the projection of an inferior self-image."

This statement is not to suggest that mental health is a problem that is somehow tied to being

Aboriginal; that is where the concepts expressed in the determinants of health as illustrated

by Evans and Stoddart (1990) are limited. They place a skewed lens on the data and suggest

that because mental health problems express themselves in certain ways and have a greater

incidence rate in the Aboriginal population that there is something inherent in 'Aboriginal-

ness' that creates these problems. This is a very Western approach to explain the observable

details but it is not culturally sensitive and neither are the resultant foundations of health

policy in this country.

Canada has been viewed as progressive for instituting universal health care, first in

Saskatchewan in 1947 and then nation-wide in 1966 (Armstrong, 1998). However, the

constructs available to the Aboriginal population to access this care were often, and continue

to largely be, provided in a completely foreign way. Health Canada, as the federal

department with fiduciary responsibility of the health care of Aboriginal people, operates a

Branch to deal exclusively with this responsibility; the First Nations and Inuit Health Branch

(FNIHB) is the most current incarnation.

b) *Federal structures for Aboriginal health*

To access services writ large (not just limited to mental health services, but health services of any kind), Aboriginal people who reside in Canada and are either a) registered Indians according to the *Indian Act, 1985* (the amendment that was debated as Bill C-31, which returned status to many Aboriginal women)[2] or b) Inuks recognized by one of the Inuit Land Claim Organizations (i.e. Inuit Tunngavik Corporation, etc) must apply for benefits through Health Canada's Non-Insured Health Benefits (NIHB) program (Health Canada, 2012). Despite the goals statements in many current policy documents, including Departmental guidance documents such as the Report on Plans and Priorities (RPP), that indicate a primary Departmental goal is to transfer ownership and decision making about health care back to Aboriginal populations and incorporate traditional principles, the actual receipt of services for this population requires the Crown to assess applications and determine what services are necessary[3]. In practice, the operation of the current NIHB appears to be more about keeping the Aboriginal population in line with a Western model of health care and less about operationalizing stated policy goals.

For example, Health Canada's RPP for 2011-12 lists, under its third Strategic Outcome of "*First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status*", there is a performance indicator (a way of measuring progress towards the stated outcome) that states: "*# of First Nations and Inuit engaged in the control, design, development and delivery of health programs and services based on their own identified needs*". The target attached to

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[2] For more on the health impacts of Bill C-31: Non-Insured Health Benefits Program Annual Report 2004-2005 (2005).
[3] Health Canada, NIHB Program, Benefits Information, March 13, 2012 http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/index-eng.php#qalipu

this indicator – the amount by which the Department hopes to achieve progress towards attaining the outcome goal – is listed as 5% over 5 years (Health Canada, 2011).

At the same time, public financial documentation indicates that, of the entire Departmental budget ($3,448.5 million forecast for 2010/11[4], with plans to spend $3,345.7 million in 2011/12 and $3,272.8 million in 2012/13),[5] Health Canada forecast spending $2,402.4 million in 2010/11 and planned to spend $2,180.7 million in 2011/12 and $2,171.3 million in 2012/13 on the First Nations and Inuit Health Branch alone. This means that over 66% of Departmental spending is directed toward this Branch, while the outcomes expected around empowerment, self governance and incorporation of traditional knowledge concepts are minimal at best. This analysis suggests that perhaps funding should be directed towards change rather than maintaining the status quo because, as subsequent sections will illustrate, the status quo is not a status in which Canada as a country can take great pride. It appears that dollars are available; the question is about the relevance and creativity of the ends to which they are put.

To summarize in very basic terms, the Department has set a goal for itself to progress towards achieving more Aboriginal control of health services, based on the needs the population feels are important, at a rate of 1% per year. The percentage *of what* is unclear; it may mean percentage of the Aboriginal population overall, or it may mean percentage of Aboriginal communities who are in discussions currently to attempt to gain governance rights over their health services. It may even mean percentage of the Aboriginal population who currently utilize the NIHB program. One thing that is not unclear is that 1% per year is

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[4] Treasury Board of Canada, Reports on Plans and Priorities, 2010/11, November 13, 2009 http://www.tbs-sct.gc.ca/rpp/2010-2011/inst/shc/shc01-eng.asp
[5] Treasury Board of Canada, Reports on Plans and Priorities, 2011/12, June 9, 2011 http://www.tbs-sct.gc.ca/rpp/2011-2012/inst/shc/shc01-eng.asp

a very slow rate and leaves us looking at the year 2112 when 100% of health services for Aboriginal people will be directed by Aboriginal populations and determined by needs that Aboriginal people feel are most relevant. That seems like too long to wait, especially given the urgencies these populations are facing around many issues, not least of which is mental health.

Chapter V: Paths to Self-Government

Each of the three populations under consideration in this study followed a unique path to a varying stage of self-government. Currently, the Inuit in Nunavut are technically self-governed through an extremely complex agreement between several land claims organizations and the Canadian federal government. The Maori in New Zealand have a slightly different situation, as illustrated in the previous chapter, but are considered largely self-governed within an overall Government of New Zealand framework. The Haida in British Columbia are in the process of self-determination and they are in the midst of land claims negotiations with the province of British Columbia to obtain a level of self-government, along with several other Aboriginal groups in that area of Canada.

Each of these three Aboriginal populations, two domestic and one international, have also obtained varying degrees of implementation of their respective traditional knowledge concepts into policy. This study argues that there is a correlative relationship between the level of self-government (actualization as a people in relationship to former colonial oppressors) and degree of traditional knowledge concepts articulated clearly in mental health policy documents. There are theoretical roots to this hypothesis, as evidence by the Canadian sociologist Raymond Breton (1964) who coined the term "institutional completeness" to describe the process of community development that happens with immigrants. At its roots, the theory is that institutional completeness quantifies an immigrants' sense of ethnic community and it influences the direction of their social integration (Breton, 1964). This theory has developed into a theory that, "plays an important role in the study of ethnic communities in Canadian sociology" (Goldenberg & Haines, 1992); however, there are clear linkages between this theory and a main hypothesis

of this study, the connection between articulated self-governments and real implementation of traditional knowledge concepts in mental health care.

The idea of the Aboriginal concept of self-government and governance as a whole resembles the 'institution' that Breton described as the collective that immigrants seek out when they arrive in a new country. The concept here that positions institutional completeness in a new way is that there are parallels between newcomers to Canada and Aboriginal populations; despite that they were the first peoples in this country, they have been other-ed to such a great extent by the impacts of colonialism that they have more in common with newcomers than they do with citizens. This study proposes that institutional completeness provides theoretical support for the hypothesis.

This is not the first time that the theory has been positioned to look at situations within the Canadian Aboriginal context; Winter (2011) incorporates institutional completeness in her analysis of how multiculturalism is delegitimized in multicultural societies. The theory has been incorporated in other studies on First Nations language, governance and multiculturalism (Kymlicka, 2003) but there is very little developing the relationship between this theory and the health of Aboriginal populations. A 2007 paper on the alcohol use habits of the Sami (native population of Norway) briefly cites the theory in a reference from a person other than Breton (Spien, Sexton, Kvernmo, 2007) but the review of the literature did not turn up additional sources making the link between institutional completeness and applications, through governance, to health.

This section will provide a description of processes that each population underwent to get where they are today and will provide evidence to both support and refute the correlation hypothesis. While attribution is extremely difficult in cases such as this, due to the wide variety of factors involved in a relationship between multiple populations, there is still a

great deal support for the correlation theory. Further research would be necessary to determine causal linkages and the methods that would involve were beyond the scope of this study.

a) Nunavut: an Inuit story

The Canadian North has experienced a long history of colonial misdeeds – this includes residential schools, forced resettlement, astonishing suicide rates and rampant alcohol and drug abuse. From an ethical and social perspective, it is important for the future of policy-making to ensure that the people for whom the policies are written are able to see themselves reflected accurately in the policies that are written, ostensibly to protect and to provide for them. More importantly, it is crucial that the entire population is given the chance to thrive and evolve in the best of the conditions, and past experience in public policy – in relation to the Aboriginal population – has shown that some of the measures formulated and implemented – sometimes in the worst and even with the best intentions – may have unforeseen consequences, and proper awareness of the impact of colonialism is necessary.

To provide some background on the population of interest, it is important to understand how significant the creation of Nunavut Territory was and the extent to which it has brought about several positive outcomes for the Inuit in Northern Canada. The 1993 Nunavut Land Claims Agreement (NLCA), signed by the Inuit of the eastern Arctic of Canada, the territorial government of the Northwest Territories (NWT) and the federal government of Canada, awarded the Inuit with 350, 000 square kilometres of land; mineral rights; $1.1 billion dollars to be transferred from the federal government over a period of 14 years; royalties from oil, gas and mineral development on Crown land; hunting and fishing rights; as well as participation in land and resource management (Henderson, 2007).

However, perhaps the most important aspect of the NCLA is the political accord, which enabled the Inuit to govern themselves through a distinct and representative government. It is this idea of self-governance and the path by which each of the comparison populations within this thesis achieve (or are in the process of achieving) their ability to self-govern or share governance responsibilities with the federal government that impacts the extent to which traditional knowledge is or has been implemented in the mental health policies for that population. Understanding this connection is crucial to understand how to best serve Aboriginal populations with regard to mental health and community ownership of health policies.

The Government of Nunavut is defined as a non-partisan, public government, based on a consensus model (O'Brien, 2003). Although the government is structured in the same manner as other provincial and territorial governments, (Premier, Cabinet and Legislative Assembly) there are no political parties and the proceedings in the Legislative Assembly are calm, respectful and rather civil compared to legislative proceedings in Southern Canada (O'Brien, 2003). Moreover, the absence of political parties and party line loyalty, promotes an environment where the ministers can work in cooperation with ordinary members of the Legislative Assembly. The government is also sensitive to the strong Inuit presence in the territory and thus reflects the culture, customs and traditions of the Inuit peoples. For example, government proceedings take place in the traditional Inuk language, Inuktitut, and government representatives are encouraged to wear traditional Inuk clothing (O'Brien, 2003). Whether this respect for Inuit traditions is reflected in actual policies, especially those related to mental health, and is operationalized in practice will be addressed in subsequent sections.

Acquiring government autonomy was not an easy feat for the Inuit. Discussions began in the 1950s when it was clear that the western and eastern populations of the NWT had vastly different interests; people in the west were mainly interested in developing commercial opportunities such as mines and gas pipelines while the people in the east were more concerned with establishing self-government (Dickerson, 1992). At the time, the NWT was the largest political jurisdiction in Canada and was comprised of various indigenous groups, including Dene, Métis, Cree, Inuvialuit, and Inuit (Henderson, 2007). Therefore, there were many opposing opinions and thus, in 1963 the Canadian federal government established the Carrothers Commission (Parker, 1996). The purpose of the Commission was to examine the issues of territorial division, provincial status and institutional development; however, the Commission recommended that the NWT remain united, that acquisition of provincial status be delayed and that institutional development would be fostered through the transfer of certain provincial responsibilities and by generating a system of democratic accountability (Henderson, 2007).

Despite the outcome of the Carrothers Commission, Inuit in the north persisted with their proposals as they viewed separation as the only means of achieving political development. However, the federal government was very resistant as they foresaw many problems. A major concern with regards to the division involved two constitutional factors: "the creation of an ethnically defined political jurisdiction and the transfer of control of non-renewable resources to a polity less developed than the existing NWT" (Henderson, 2007). The federal government's response to Inuit demands was the Drury Commission, mandated to discuss the same issues as the Carrothers Commission: division, provincial status, and decentralization of federal authority (Henderson, 2007). The Inuit viewed the Drury Commission as an appeasement rather than a genuine attempt to negotiate Inuit interests, as

they were not consulted with regards to the set up or terms of reference of the commission (Henderson, 2007). Nevertheless, the commission proceeded and although it has been characterized as being more engaged with local institutions, councils and Inuit people than the Carrothers Commission, it concluded with recommendations that advocated against division of the NWT (Henderson, 2007). Throughout the 1980s and early 1990s, discussions and debates resumed but with regards to the process, ownership of non-renewable resources, power-sharing, the role of municipalities, the presence of political parties, the meaning of consensus, institutional design, and so on (Henderson, 2007). Eventually, in 1993, the negotiators reached a consensus and on April 1, 1999, Nunavut Territory was born.

The creation of Nunavut established a third northern territory in Canada, which includes half of the land of the NWT, pre-1999, and most of the Northern Arctic islands (White, 2009). As demonstrated, the establishment of the Nunavut Territory was a culmination of a long struggle for self-government for Northern Inuit. In addition to being able to shape their government institutions and processes, the Inuit in Nunavut enjoy a government that is also representative as 85% of Nunavummiut are Inuit peoples (Marecic, 2000).

b) New Zealand: a Maori story

The Maori, on the other hand, certainly had a more conventional colonial conflict period than did the Inuit in Nunavut. First contact happened in the late 18th century and by the mid-1800s British colonialism had taken hold; however, the constructs of Maori social life held and remain to this day. The society was organized in a complex lineage based manner, "divided into groups called *iwi* (tribes) which traced their descent to a common ancestor, and were politically and militarily coordinated; these consisted of a number of *hapu*

(subtribes)… usually numbering a few hundred. The *hapu* in turn, consisted of a number of *whanau* (extended families), which were the units of social life" (Sachdev, 1990). There are three key cultural constructs - *wairua*, *mauri* and *hau* - that are important in understanding the Maori concepts of self and ideal health. In terms of mental health, *wairua* is the most relevant and is considered a necessary determinant for physical and mental health. It is a spiritual principle and can be understood as the "Maori equivalent of a soul" (Sachdev, 1990).

While Maori principles are coming back into use in New Zealand and working alongside 'mainstream' care, it has only been within the last 30 years that the rejuvenation of Maori values has taken place. The onset of colonization reduced the autonomy of the Maori substantially and it took nearly 150 years for the Maori people to organize and assert their self-determination rights (Durie, 1998). Like the Aboriginal populations in Canada, the European colonists in New Zealand privileged written documents and rejected the traditions of oral history regarding concepts like land use and health practices as inadequate. As a result, treaties, which were misunderstood and foreign concepts to the native populations, were signed and meaning was attached to them by the Europeans that was not shared by the Maori. However, unlike the situation in Canada, land tenure was not the dominant issue for the Maori so instead of getting into disputes with the colonial governments over geography and physical concepts, the Maori worked within the constructs put in place by their colonizers to eventually establish an ideal of a Maori nation operating within the state of New Zealand. A crucial turning point was in 1984:

"A new Labour government formally recognized the Crown's obligation to Maori under a Treaty signed in 1840. The Treaty of Waitangi was the instrument that allowed Great Britain to assume sovereignty over New Zealand on the condition that tribal property and culture would be protected and individual Maori would have full rights of citizenship" (Durie, 2011).

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This treaty was a game changer in the course of Maori self-determination as, through the late 1980s and 1990s, the Maori developed self-government ideologies that were less about tangible results and more about goals for the population as a culture. They were as concerned about the *spirit* of development, ensuring that the guiding principle was not to hang onto the past but instead to move forward thoughtfully and sustainably, as they were about approaching the situation from a 'rights-based' perspective (Durie, 1998). The resultant situation is that the current relationship between Maori and New Zealanders of other background is quite settled.

The Maori are farther ahead on both the self-government and knowledge incorporation fronts than are the Inuit, and certainly the Haida, in Canada. They are unique populations and the intention of comparing the groups is not to undermine their differences at all, but simply to highlight where it is possible for the Canadian Aboriginal peoples and their supporters to see where there are some lessons to be learned and some mistakes to learn from and avoid as well. The experience of the Maori in seeking respect for their knowledge in terms of policy, specifically in the realm of health policy, may not be in precise parallel with the journey of the Canadian Inuit and other Aboriginal populations but it has a lot of use, viewed through the right lens.

Mason Durie and his colleagues have written much about the indigenous population in New Zealand and the ways their health care needs are being met. There are many similarities in the populations of Canadian First Nations, Métis and Inuit and the New Zealand Maori. There is a very similar demographic discrepancy in terms of health inequalities: the life expectancies for Canadian non-Aboriginal males and females are both higher than for Aboriginal males and females (Durie, 2005). This is the same pattern with

Maori and non-Maori in New Zealand. Additionally, the infant mortality rate for

Aboriginals is double that for non-Aboriginals, with the same applying between Maori and

non-Maori and there is a much greater percentage of the population of Aboriginal and Maori

who are under 15 years old (Lavoie, 2004). These figures are all indicators of an unhealthier

Aboriginal and Maori population in the two countries under consideration. The question

becomes what is different about the way these two populations have been treated in the last

10-15 years that has allowed Maori to have improved health outcomes?

There is much to be said for the implications of place; in New Zealand the Maori are

largely blended in with the urban population, while in Canada the First Nations, Métis and

Inuit populations can be very separated, specifically those members of each population that

live on reserves. The population with the clearest separation is the Inuit, whose traditional

lands in the Arctic are very distant from the dominant Canadian population numbers. This

creates a lack of connection in the ability of the general population to understand the health

care challenges and also the traditional way of life of the Inuit people. The Maori have access

to most of the systems of power in New Zealand and despite their unique cultural perspective

they are able to carve out spaces of authority for themselves.

It is not uncommon for Maori to be university educated and to be a part of the

medical community themselves so that they are able to participate as providers (Lavoie,

2004). Having a role as a health care provider, coming from the minority culture, allows for

a sense of legitimacy to grow within the population and the fact that a Maori individual can

seek care from someone of their own background establishes a sense of trust. Patients are

able to feel confident that their provider understands their cultural framework and

understands their needs. For youth, specifically, this presence opens up possibilities for role

models, sets examples, and encourages the idea that Maori youth are capable of working in

an area of authority like medicine or any area of their choosing. This kind of empowerment present within a culture does a good deal to improve intangible qualities like pride and sense of self that have an indirect but profound impact on the health status of a population. These results build the case for more engagement of this kind within the Inuit framework as well; while outside the scope for this study, it is important to address the possible impact that these 'softer science' initiatives have.

The Maori are very inclusive in terms of which of their members benefit from New Zealand government benefits in terms of things like resource sharing and profits from fishing and other traditional industries (Durie, 1998). As such, most of the governance systems align smoothly and systems like education and health operate with the Maori being considered as one part of a larger whole. In general, New Zealand provides a healthy example of biculturalism and diversity management, not only in terms of health policy, but also in terms of how a relationship between a colonial party and the natives of a country can develop and function well.

c) British Columbia: a Haida story

The Haida, despite being a Canadian case, have more in common with the case of the Maori than they do the Inuit, largely because their journey towards self-government, which remains ongoing to this day, has many similarities to that of the Maori. British Columbia is a diverse province, the 7th to join Confederation in July of 1871, and the land it includes is the ancestral home of several First Nations peoples. On the whole, there are nearly 250 separate tribes/bands in the province and they are at varying stages of self-determination.[6] The BC Treaty Commission (BCTC), established in 1992, is the independent organization that

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[6] Government of British Columbia, http://www.gov.bc.ca/arr/treaty/regional.html

facilitates treaty negotiations between the governments of Canada, British Columbia, and the

First Nations; it is important to note that the BCTC does not actually negotiate, as that is up

to the three parties involved. The BCTC explains self-government as follows:

"Self government is the principal means by which First Nations formalize their relationship
to those lands and resources today and preserve their traditions, language and culture …
Under the BC treaty process, it is intended that each First Nation has the opportunity to
negotiate a self government arrangement to meet its unique social, cultural, political and
economic needs." (Poelzer, 2002)

Due to the three-pronged nature of the required negotiations and the competing desires

and constraints of each level of government, treaty negotiations can last a very long time.

However, considering how many interests are at competing and the stakes that each player

holds, it is a true success when an agreement is reached. In this way, the process creates the

basis for future relationships; during stressful negotiations, the players learn a lot about each

other and often arrive at a heightened appreciation for the diverse viewpoints once the dust

has settled. As such, acting upon the treaties does not produce the same types of difficulties

and subsequent actions, such as drafting frameworks and implementing policy ideas, become

more straightforward.

Since Nunavut was created as a self-governing territory from the start, the governance

bodies did not carve out a relationship at the negotiating table with the Government of

Canada. The people who did the negotiating for the most part did not stay involved with the

governance process after the territory was formally established in 1999. Given this, the

methods that many of the Inuit leaders want to use to communicate policy goals and needs

do no resonate with the non-Inuit decision makers in Ottawa. It is almost as though the

strain and battle at the negotiating table is a necessary step for the eventual articulation of

policy that reflect the needs of the population; without that time to get a sense of the other

party at the table, the Inuit leaders have not created a situation where they are speaking

(literally and figuratively) in a language that the party they most need to engage can

understand.

Chapter VI: Health Policy through a Mental Health Lens

This chapter will more directly problematize the argument illustrating a correlation between progress towards self-government and the uptake of traditional knowledge concepts in policy documents. The sections below outline two key examples that will act as a 'cases within the case' to facilitate the drilling down to a focus on specific operationalization of mental health policies. Combined with the field perspectives, this comparison on a more intimate scale will attempt to provide a more level field for looking at the three distinct populations. The intention is that these more qualitative comparisons will facilitate conclusions about whether progress towards self-government correlates with increased uptake of traditional knowledge concepts in policy making around mental health.

a) Guiding policy structures: Inuit Qaujimajatuqangit & Kaupapa Maori Health Service Teams

The concept of citizen participation in Nunavut is strong and well developed despite that the territory is very young. It is easy to see how strong participation from the community is a driving force behind the concept of government in the territory. One of the concepts that illustrate the desire for strong participation in the sphere of government is "Inuit Qaujimajatuqangit" (IQ). The direct translation of IQ is "things of which Inuit knew about all along" and encompasses all aspects of traditional Inuit culture including values, world views, language, social organization, knowledge, life skills, perceptions and expectations (Owlijoot, 2008).

This concept is very difficult to define; a policy analyst for Qikiqtani Inuit Association (QIA) said that it is "a set of teachings on practical truisms about society, human nature and experience passed on orally from one generation to the next" (Jaypetee Arnakak,

quoted in Martin, 2009). Respect for IQ is inherent in the mandate of many diverse

departments within the Government of Nunavut; for example, the web site of the Department

of Human Resources says "it is the department's mandate to incorporate IQ in the delivery of

our programs and services. Our policies and practices must be consistent with the beliefs,

customs, values and the language of Inuit" (Martin, 2009) and that notion is applied equally

in departments across the territorial government.

The importance of citizen participation was born out of the needs of the land claims

negotiators, who wanted to ensure that Nunavut would not be governed in the same way as

the Western Arctic. The government in the NWT is firmly based in administrative models

that come from Southern Canada (i.e. European governance models that do not reflect First

Nations, Métis or Inuit cultures). The negotiators knew that the traditional "Canadian"

governance models would not function for Nunavut and would not allow for the kind of

cultural representation they were trying to ensure. They knew that they had to enable the

voices of the Inuit people to be privileged in the system "so that it would not simply be a re-

run of well meaning whites turning Inuit lives upside down with their bright ideas" (Peter

Jull, quoted in Timpson, 2006). In this way, the development of Nunavut is unique because

it was established so recently out of the lessons learned through colonialism by an Aboriginal

group. Nunavut is something of an embodiment of "best practice"; however, it remains to be

seen whether the future leaders of the territory will remain true to the intentions of the

territorial founders, specifically when it comes to concepts like preserving knowledge and

traditional practices.

In Nunavut it is written into the governance framework that IQ must be implemented

when new policy is developed. IQ is one of the core traditional knowledge concepts that

illustrate the hypothesis that, while there are barriers to full integration, the will to

incorporate and create space for this type of knowledge is very strong. However there is a limitation to the extent of consultation that is possible with elders and a limitation on the engagement that they truly feel with the process. There is also a balance that must be achieved for students coming into the practice of care between learning 'modern' practices and applying traditional practices as well. Realizing that "Indigenous worldviews could be as valid as those of contemporary social and medical science, and they may be more valid for those people who hold them" is an important insight for new medical practitioners in Aboriginal communities to grasp (Mehl-Madrona, 2009).

The experiences and memories of Elders are respected within Inuit culture and this "recognition of Elders as scholar of an intellectuals tradition marks an important step in the dismantling of cultural hierarchies" (Martin, 2009). The problem with this policy has been that it is difficult to operationalize; Elders must be willing to share their knowledge with policy makers and in this context, Elders will only "speak about things that they had personally experienced, rather than things that they had only heard about" because to do otherwise would be inappropriate (Martin, 2009). The desire to pay respect to the elders' knowledge is present but the people of Nunavut lack a way to fully operationalize this desire. This barrier to transferring the social knowledge of elders and respected individuals in the community to the language of policy is unique; usually it is the other way around and social communities face barriers to incorporating scientific research into their sphere.

Despite the fact that the policy came into effect in Nunavut in 2004 (Timson, 2006), there are members of the Inuit community that do not see IQ as appropriate for an official government policy. They feel that "separating IQ from the contemporary realities renders something that is profound, enriching and alive into something that is meaningless, sterile, and awkwardly exclusionary" (Arnakak, 2000). This idea that IQ comes from a completely

different philosophy creates it as very distant to "white" knowledge and separates it into

something completely unique.   The understanding of the concept as going beyond

knowledge about Elders and into the whole way of life of the Inuit as separate and distinct is

clear; however, it is difficult to theorize about another way to respectfully incorporate Inuit

knowledge into policy or involve other methods of thinking about decisions if they are going

to be considered invalid by the very individuals that the majority want legitimized.

The idea that something is being 'done to' as opposed to 'done with' is difficult to

escape when talking about sensitive issues like ways of knowing. Beyond this is the idea that

making IQ part of a governance model that is not seen as necessarily legitimate by all parties

under the ruling umbrella. Perhaps this is another reason why there has been difficulty in

gaining traction for implementing policies according to IQ. The recently released Mental

Health Strategy for Canada from the Canadian Mental Health Commission is promising; the

fifth strategic direction for the Strategy is to, "work with First Nations, Inuit, and Métis to

address their distinct mental health needs, acknowledging their unique circumstances, rights,

and cultures" (Kirby, et al., 2012).   The strategy acknowledges that, "First Nations, Inuit,

and Métis cultures and holistic understandings of the world have much to contribute to the

transformation of the mental health system in Canada," thus illustrating the importance of a

wide-ranging perspective on mental health care that values the diverse wisdoms and

strengths that Aboriginal groups can provide to support their own healing (Ibid, 2012).

The Kaupapa Maori health service teams are a strong example of how Maori care is

incorporated within the larger health system in New Zealand; the lens appears to be strictly

about a component of diversity. The Maori are not considered as a 'abnormal' population,

just one with particular needs, and the evidence of the operationalization of the relevant

policies takes place in authoritative documents such as provisional data on service usage for

2009/10 that was released earlier in 2012 by the Government of New Zealand. These data define the Kaupapa Maori health service as care teams that, "provide assessment and treatment services to clients within a Māori cultural context" (Ministry of Health, 2012). These teams can be inpatient, residential or community-based and can deal with one of four classifications: Maori kaupapa, alcohol and drug, children and youth, or dual diagnosis, meaning mental health and alcohol and/or drug (Ibid, 2012).

These teams facilitate things like contact with the family of the person in crisis, coordinate additional contacts, hold family face-to-face interventions, and other navigation of the New Zealand health system for Maori families. The ability of the care teams to function at an intimate level and keep the family involved as the unit of support for the patient is crucial to provide culturally appropriate care. Perhaps not attributable to the Kaupapa care teams themselves, but certainly evidence that care is moving in a positive direction in New Zealand, is that overall bednights in inpatient or residential settings for mental healthcare decreased by 14% from June 2001 to July 2010. The number of contacts, care provided in a community or outpatient setting, increased 49% in the same time period (Ministry of Health, Manatu Hauora, 2012). This could be seen as a negative but it likely means that more people are getting access to help and are not having to undergo trauma (forced confinement, psychiatric hold, etc), instead accessing needed care at home and with family support.

b) *Reconsidering the hypothesis*

Does the evidence from the section above prove the counterfactual of the hypothesis this study proposes? The evidence from policy documents indicates that BC has a strong provincial government stance on facilitating treaty negotiations, and that traditional

knowledge is reflected well in Haida-centered documents, specifically those pertaining to health promotion and care. After assessing the available literature, it appears that the Haida First Nation is doing a better job, in the absence of a governance system that dictates respect for traditional knowledge, than Nunavut, where IQ is mandated. If this is true, why in a territory developed by Inuit for Inuit is mental health still such a problem? It is no secret that rates of suicide, depression, alcoholism and several other social problems that can be linked to mental health issues are glaringly high in Nunavut. How is it that traditional knowledge concepts, spoken about and written about extensively, can be included in policy discussions but not in terms of implementation? Going back to the example of Ilisaqsivik and the difference between intended actions and funding received, why is policy being appropriately formulated but inappropriately implemented?

The problem of location must not be understated. There are many socioeconomic concerns that make creating Northern infrastructure difficult and there are limitations to how many family resource centres can be funded for towns of 800 people; the underlying problem is place. Nunavut could not be further from the federal government both literally and figuratively and because the parties have never really had to negotiate with one another since the territory was created – transfer payments go through land claims organizations – implementation of Inuit frameworks and ideas by federal governance structures is challenging. The Government of Nunavut may recognize the need to take IQ into consideration when designing a hospital but unless those IQ principles are communicated to the policy maker at the Department of Aboriginal and Northern Affairs or Health Canada or Heritage Canada, the concepts will not last into implementation.

It is also extremely difficult to attract staff from outside Nunavut due to the weather, the accessibility and the quality of life; there are many things that make Nunavut a beautiful

place to live but the fact that fresh food is prohibitively expensive[7] does not attract people like medical practitioners and teachers from the South to stay for very long. Until Nunavut builds professional capacity among its residents and creates a strong link between policy formulation and implementation by inviting further engagement with federal departments it will be difficult to implement IQ as it was intended. The bigger problem, on a more philosophical scale, is what the failure to articulate a territorially mandated concept into appropriate policy reveals for Canada as a federation. Can we really allow our responsibilities to diminish because of the fact that the country is large and diverse? The Constitution Act applies just as much to the self-government of Nunavut as it does to the governments of other provinces and territories; all those living in Canada should have the ability to access services they need in the way they want to receive them. For the Inuit in Nunavut that means health policies that are implemented according to the precepts of IQ.

It is clear after having seen the differing paths to self-government laid out in the previous sections that the Haida, who have taken a similar path to the Maori and have engaged with the existing governance networks in Canada to arrive at an articulated set of policies documented in the grey literature, have a more comprehensive implementation of strategies that have been crafted to take traditional knowledge into account. The Inuit in Nunavut have the guiding principle of IQ to steer their policy direction but they do not have the same enunciated implementation documents. With a comparison in this regard it is tempting to conclude that the case of Nunavut proves the counterfactual of the original hypothesis and that, in fact, the territory that was founded "by Inuit for Inuit" has not done a good job of implementing the policy concepts present in their guiding literature. It may be tempting, but it may not be accurate.

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[7] In April 2010 one green pepper was over $7.00 in Iqaluit, less than $3.00 in Ottawa (Author's note)

One thing that this analysis has not yet considered is the means by which the evidence was gathered; this study was conducted, for reasons of time and cost, largely by a review of the literature. The very notion of making conclusions about a population that is consistently defined by its respect for the oral tradition and resistance to colonial methods of privileging text over speech based on a review of literature may be fundamentally flawed. What becomes clear is that the heart of the comparison only corresponds if the case populations are related by means of evidence from the method of recording information on which each places the highest value. For the Inuit that would be spoken word and, as such, without extensive interviews it is not legitimate to say that the cases of the Haida and the Maori prove the counterfactual of the hypothesis expressed in this study.

To address this gap, the following section describes the practitioner perspective, consisting of the thoughts and ideas of those in the health care field. This cannot replace the depth that key informant interviews would bring to this study, but given the physical and monetary barriers to fieldwork in Nunavut, a perspective from a practitioner is an attempt to provide evidence that is difficult to obtain in the literature. It is important for an author to recognize when their work unconsciously supports their own cultural privilege and values and it can be remarkably unsettling. Confronting inherent prejudices in work designed to be open and objective can be challenging and can destabilize confidence in the underlying research assumptions; however, equally important is to address existing biases in order that they not be used as a method of illegitimizing a strong hypothesis.

c) Perspectives from the Field

Understanding the perspectives from a clinical practitioner on traditional knowledge in the health care field allows insight into the real locus of policy implementation. This helps

to establish a case for the legitimacy of the attempts to incorporate traditional knowledge and

for the dangers of applying traditional principles without respecting the wisdom. Traditional

knowledge concepts are not tangible things that can be coopted by well meaning policy

makers and used to attempt to gain buy in from a marginalized population. In order to

approach including traditional principles in policymaking there has to be actual buy in from

those writing the policy. This is where the value of participatory action research and

immersion research comes in; to truly understand the needs of the population and accurately

articulate it into a roadmap to results via policy, the researcher/policymaker has to engage

with their population of interest and access

Several nurse practitioners and academics in the field of psychiatric nursing have

populated the literature with information about how to properly provide culturally

appropriate care. One non-Inuit counselor wrote about her experience providing care

without an empirical basis for knowing what was 'right'. She found herself noticing that

both Inuit and non-Inuit clients valued,

"… relationship qualities of warmth, caring, non-judgmental acceptance, and trust in both confidentiality and belief in the counsellor's ability to help are common to elders and contemporary Inuit views of good counselling; these are also essential elements of generic Western counseling" (Korhonen, 2004).

Recognizing the foundations that this provided, it became easier for her to adjust her

worldview and adapt to individual cultural needs.

Chapter VII: Uses of Indigenous Knowledge

As evidenced by the analysis in the preceding chapters, a body of traditional knowledge exists within the various Aboriginal populations in Canada. This chapter covers the application of traditional knowledge in practice; traditional knowledge is not merely a concept that reminds people of previous times, it is a lived experience. From both a domestic and international perspective this chapter provides concrete examples of the application of traditional knowledge in the modern world.

a) Knowledge use domestically: mechanics of care

Until very recently, health policy on the whole in Canada was largely unconcerned with mental health. Health care was structured less as disease prevention and wellness stimulation and more as dealing with sickness after it already developed or injuries after they were already suffered. Not until the Lalonde Report and the Ottawa Charter in the early to mid-1980s did Canadian health policy take a turn towards a holistic approach, turning away from the focus on disease treatment and looking up the chain towards health promotion and preventative care. Ironically, these 'revolutionary' health promotion ideals are a lot more aligned with traditional Aboriginal knowledge concepts that were subscribed to by that population long before these recent decades.

From the beginning, organized health care in Canada privileged the medical model of doctors in an authoritative relationship to the patients they served. An example of one area where this relationship links to traditional knowledge is childbirth. Starting in 1865, doctors (all male) in Ontario succeeded in obtaining the exclusive right to attend childbirths; this meant that women who traditionally practiced (largely unorganized and unpaid) as midwives suddenly became seen as unfit to provide care. This is despite the fact that a report came out

in 1919 stating, "maternal mortality was much higher in the 50 per cent of confinements attended by medical men" (Armstrong, 2003).

This 'medical-izing' of a process that had, until that point, been something women experienced, guided and supported by other women, marked a real shift in what was considered appropriate. This happened in a similar way at a later date for the Aboriginal population; however, traditional knowledge concepts around childbirth are still present today, especially in recordings or transcriptions of conversations with Elders. The following is a transcription of a discussion between a student at Nunavut Arctic College and an Inuit Elder named Ilisapi Ootoova on the subject of traditional childbirth:

> "The midwife would keep a close eye on the woman in labour. She would make sure her legs were positioned properly. She would make sure her legs were not spread too wide. The midwife would keep the position of the spine in mind, as well as the tailbone. The spine is connected to the pelvic area so they paid attention to this. … I have delivered eleven children, two in the hospital, and nine in the traditional way. … When I delivered in the hospital, I thought it would be better if the nurses were not around constantly. I tended to close up when they were too near. The foot stirrups are painful too. It seems as if your *kuuttinaak*, your pelvis, is positioned the wrong way." [Translated from Inuktitut] (Therrien & Laugrand, 2001)

It is clear from the Elder's comments that she considered the traditional methods more suitable; however, today childbirth is a procedure that, for most Inuit women, takes place in hospitals. Qikiqtani General Hospital, the single full service hospital in the entire territory of Nunavut, located in the capital, Iqaluit, has the capacity to deal with most uncomplicated births; however, in any situations where complications are foreseen, Inuit mothers are sent to hospitals in the "south" (meaning South of 60, most often cities such as Winnipeg or Ottawa)[8]. This situation is not specifically related to the mental health policy that is the focus of this study but it emphasizes the breadth of health issues that are touched by the deterioration of traditional knowledge and the decreased value placed on these concepts.

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[8] Personal communication with an Iqaluit City Councillor, April 2012.

The fact that the options for a mother in Nunavut do not really encourage having an Elder midwife, but only include a hospital birth in Iqaluit (which may be quite far and difficult to access from their home town) or a distant city in the south (when they may never have previously left their hometown), seems to contradict the spirit of IQ based health policy.

An example more relevant to mental health about the capacity of the hospital in Nunavut's capital is that it has a mental health ward for emergencies, such as suicide watch and the like, but has little capacity for long term mental health interventions or continued care. However, it may be that hospital centred care is moving by the wayside and the ideas around the benefits of community-based care will get more exposure. The Mental Health Commission, funded in 2007 with a ten-year mandate out of the Kirby report recommendations, released a new strategy on mental health on May 8, 2012 that specifically cites a small family resource centre in Clyde River, NU (Nunatsiaq News, May 9, 2012). The Ilisaqsivik Family Resource Centre is referred to in the strategy document as "innovative" and reference is made to, "a hip hop program that is helping to reduce self-harm, smoking, and marijuana use, and is contributing to an overall decrease in crime rates and suicidal thoughts" (Kirby, et al., 2012). For a hamlet of 820 people, where just over 100 receive services every month, recognition on this scale is crucial; however, just five months previously the Centre was in the news due to lack of financial stability (Nunatsiaq News, December 16, 2011). These kinds of juxtapositions between service usefulness and funding received will be discussed in a subsequent section. The central idea to remember is that the current policy environment – despite policy intention documents to the contrary – seems to privilege perceived "value for money" over service uptake, results for clients and implementing existing policies to encourage the application of traditional knowledge.

Effectively straddling the line between devoting sufficient energy and time to both community development goals and accountability is a perennial problem for small community based social service agencies like Ilisaqsivik, the social service centre in Clyde River, NU, discussed in an earlier section.   When the agenda is more abstract and concept-based, such as promoting traditional knowledge concepts and community capacity, it can be difficult for agencies to transition into a tangible responsibility-based mindset. This very contradiction is itself an example of the different ways of communicating knowledge between agencies that are knowledge and culture based (Ilisaqsivik) and those that often fund them (governments). The power dynamic here is notable in that those with the power – in this case the funding dollars – are asking for accountability mechanisms while those with the topic specific knowledge want to be measured by their results.

The situation in British Columbia (BC), the province within which the Haida are mostly located, is similar. The province as a governance construct provides a second level of Canadian bureaucracy that the Haida must navigate; however, provincial governments have jurisdiction in the area of health under the section 92 of the *British North America Act, 1867*, which can mean that strengthening relationships with the respective province can help Aboriginal groups achieve their goals in terms of incorporation of traditional knowledge concepts and operationalizing existing policy according to their needs. Granted, the fiduciary relationship around health between the federal government and Aboriginal populations remains for those populations who live on reserve, but by interacting with the province, many Aboriginal groups in BC have been able to develop partnerships to move their goals of ownership over health forward.

Currently, the Haida First Nation are just one of many Aboriginal groups working in partnership with the BC Provincial Government on a *Transformative Change Accord*, which

is an action plan for First Nations health in the province that was negotiated in 2006 to be

implemented between 2005-2015. The goal was to lead to a tripartite agreement with the

federal government by 2007 (this goal was reached on June 11, 2007[9]) and to the

implementation of several Aboriginal centred health policies in the province by 2015. This

Accord was developed in response to several key indications that the, "difference in health

outcomes between First Nations and other British Columbians [was] unacceptable and

unsustainable" (Government of British Columbia, 2005). Data from Provincial Health

Officer reports in 2001 and 2004 indicated that:

- status First Nations lived 7 years less than other British Columbians;
- status First Nations had a diabetes rate that was 40% higher than the general population; and
- 49% of Aboriginal youth smoked, which was more than double the rate of other BC youth.

To address these, and other, discrepancies, the First Nations Leadership Council partnered

with the Government of BC to create the Accord and it is currently two years from the end of

its mandate. Just recently, in October 2011, the BC Tripartite Framework Agreement on

First Nation Health Governance was signed. This action sets up a timeline for the federal

government to transfer the planning, design, management and delivery of First Nations

health programs to a new First Nations Health Authority over the next two years, allowing

for a great increase in Aboriginal controlled health services by 2013 (FNHC Update,

December 2011).

One of the outcomes of the Tripartite Health Plan - which covers the period between

June 1, 2007 and May 31, 2017 - that has been especially promising for the Haida First

Nation was the development of Community Engagement Hubs, which "creates space for

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[9] Tripartite First Nations Health Plan, 2007.

First Nations communities to take greater control over their own health services."[10] This is

tangible evidence that the goal of putting the direction and development of Aboriginal health

services back in the hands of Aboriginal people is gaining traction. These Health Hubs are

supported by the BC First Nations Health Council (FNHC) due to their focus on reclamation

and promotion of traditional practices. In addition, they improve service accessibility for

First Nations like the Haida. As the FNHC explains:

"Collaboration and joint planning create efficiencies, and will provide better health services
for BC First Nations people. For example, where it may not be feasible to have a mental
health expert in every community, the hub concept would allow for planning to have one
expert available to serve the member communities of the hub. In this way, collaboration and
resource sharing between the nations in a hub can fill health gaps that otherwise would not
be addressed."[11]

The Haida Health Hub is an example of positively implemented traditional knowledge-

focused policy designed in partnership between all levels of government. The results include

a Community Wellness Plan, which has a specific objective on mental wellness that began its

implementation process in Summer 2011.

b) *Knowledge application abroad: comparing the policies towards care*

The current health care policy landscape in New Zealand has the interests of Maori very

much constructed as part of the mainstream; while there are some policies that are

specifically geared towards respecting the Maori worldview and particular concepts that

Maori people privilege, the health system is quite open to Maori as simply New Zealanders

with different needs. That said, there are some disparities in terms of health indicators that

have persisted. For example, in terms of mental health, the rate of first admissions to

psychiatric hospitals in New Zealand in 1992 was 18/10, 000 for female and 23/10,000 for

male Maori. The rates for non-Maori were 10/10,000 and 12/10,000, meaning that the Maori

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[10] Haida Health Hub – Background, 2011 http://www.haidahealthhub.com/information/
[11] http://www.fnhc.ca/index.php/engagement_process/community_hubs

rate was nearly double in both genders (Durie, 1998). Alcohol and drug issues remain a key reason why Maori men and women enter psychiatric care, with first-time rates of admission to psychiatric units increasing significantly from 1965 to 1995, mainly for alcohol and drug disorders, while rates for non-Maori remained stable (Ebbett & Clarke, 2010).

In terms of mental health policy in particular, the recent focus has been on the "Let's Get Real" campaign that was developed in 2005 as a Maori-centred Mental Health and Addictions Framework. This Framework has a 10-year mandate (2005-2015) and currently, at the 7-year mark, implementation of this framework is progressing in a positive direction. Within the Framework there is a full section of measureable performance indicators on working with Maori, at several different levels of engagement - the 'essential', the 'practitioner', and the 'leader' – and each has different performance expectations (Ministry of Health, Manatu Hauora, 2008).

The expectation would be that an upcoming implementation evaluation would provide evidence of progress; however, since only 4 years have passed since implementation began, results of a project of that kind would not be expected at this juncture. Perhaps in coming years there will be empirical documents available that will speak to achievements or setbacks in the implementation process. The fact that a Framework exists at all is extremely promising.

The construct here parallels the Haida experience of setting up measureable goals using templates from the colonial governing bodies to establish their own unique measures. As a result, conventional decision makers are more easily able to understand these measures and thus, the Haida and the Maori have been able to work within existing governance structures to establish their governance direction. The Inuit in Nunavut have no need to establish their governance because they are already self-governing; however, in terms of policy

Population	Factors				
	Self government	*Delivery of Care*	*Policy*	*Implementation*	
Inuit	High	Low-med	High	Med-low	Rating
Haida	Low – medium	Low-med	Low-med	Medium	
Maori	Medium	High	Med-high	High	

communications and ability to address needs, it might be useful for the health policy decision makers to consider expressing their needs in language that conventional governing bodies can more easily comprehend, if for no other reason that to get results for their population.

The synthesis chart above illustrates two very interesting relationships that this study has determined between self-government and the existence of culturally appropriate policy. First, there is a positive correlation between the degree of control a population has over their governance and the extent to which policy that incorporates traditional knowledge exists. Second, this study has determined that there is little correlation between the existence of policy documents that describe policy intentions to incorporate traditional knowledge and the actual implementation of intended policies. Further study is necessary to determine the rationale for these findings; however, it is interesting to consider the communications, or lack thereof, that must exist in the policy sector for Aboriginal health if these findings could be empirically proven.

Chapter VIII: Challenges for knowledge in health policy

Health policy poses many challenges, both within the policymaking framework and raises many strong opinions both inside and outside the House of Commons. One of the greatest challenges faced by decision makers is to decide what groups seeking funds get to receive them and use them to deliver health policy in the form of services. This paper alluded earlier to the situation currently facing the Ilisaqsivik Centre in Clyde River, NU; their funding circumstances are not positive this fiscal year (2012/2013) and further description of that, as well as several other challenges facing the uptake of traditional knowledge in health policy, will be covered in this chapter.

a) Dollars and deliverables – at cross-purposes?

Despite being cited in a nationwide mental health strategy and being listed by Tides Canada, the country's largest public foundation dedicated to the environment and social justice, among its Top 10 recipients for 2011, the Centre is at risk for closure (Nunatsiaq News, December 7, 2011). Tides recognizes Canada's "most innovative and forward-thinking projects and organizations that have demonstrated outstanding leadership, vision and real-world impact in addressing today's most pressing environmental and social problems," and Ilisaqsivik was chosen in the area of community development (Tides Canada, 2011). The Executive Director of Ilisaqsivik, Jakob Gearheard, who has been with the organization for eight years, is frustrated with the funding issues and says:

"As of right now, we are running a budget deficit. This is normal in the sense that every year we run a deficit until about November through January when (if we are lucky) we can break even. This situation exists every year because we have zero core funding… this should be a warning signal for government or *group that wants to promote wellness and IQ* [emphasis added] and Inuit empowerment." (Nunatsiaq News, December 16, 2011)

Examples like this one illustrate the difficult position community based mental health efforts face because despite the fact that they operationalize established policy goals, such as promoting the concept of IQ and traditional knowledge, funding does not appear to be derived from impact. However, it is difficult to establish how the $2 million of funding Ilisaqsivik receives is spent; after establishing in 1997 and receiving Government of Nunavut funding, the Centre's public accounting of their spending is somewhat lacking[12].

Given that the Centre is trying to fund many disparate services and receive funding from many funders (several different Departments within the Government of Nunavut as well as some direct program funding from both Health Canada and the Public Health Agency of Canada) it can be difficult to track spent funds back to the original pot they came from. As a result, it is understandable that the Territory would not want to provide a funding increase. If the reason for the deficit is fund mismanagement, increasing the funding amounts will not solve the root problems; however, it may simply be that there is a lack of effective tools for tracking spending to illustrate more clearly where funding is needed.

Another example relates to the National Aboriginal Health Organization (NAHO), a wellspring of data and literature on many topics relevant to Aboriginal health and certainly traditional knowledge. Many researchers use NAHO resources on a daily basis and several pieces of literature cited in this study were either commissioned, or partially funded, by the organization. In another example of short term cash flow gains being privileged over following through on policy promises, the staff of NAHO were informed on April 4, 2012 that the decision had been taken to cut the $4.4 million of federal funding the organization receives through Health Canada. Resultantly, the 12-year-old organization will shut its doors

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[12] Ilisaqsivik Programs and Services
http://www.ilisaqsivik.ca/eng/about/programs.html

on June 30, 2012.[13]   Arguably, funding an organization with the breadth of mandate NAHO

has in 'times of austerity' is difficult to justify; however, in this case there are many ripple

effects that will result from this simple funding cut and the impact on actual health outcomes

for many Aboriginal people will be negative. This political decision will have great

influence in coming years on the distribution of Aboriginal health research, despite that the

decision has been marketed as a move towards redirecting the monies to direct services;

indirect services that NAHO provided, such as a repository of research and data, a

centralized information hub and a promoter of Aboriginal health, are also crucial to ensure

that Aboriginal health outcomes continue to improve in Canada.

b) Beyond the money – further challenges

While funding is a significant challenge to traditional knowledge being integrated into

policy there are many other challenges that must be overcome in order to arrive at a place, in

Canada, where traditional knowledge is fully embraced. The critical issue is that in this post-

colonialist period, all parties in the Aboriginal governance problem feel wronged. Clearly

the part of the colonized is understandable, as they want to be able to govern themselves and

make the choices that are culturally appropriate for their experiential perspective, which is

difficult to accommodate without weakening the federal government construct. The part of

the federal and provincial power structures is also well defined; given that there is no single

person in a position of power who actually enacted legislature to colonize and remove power

from the Aboriginal population in Canada, the governing parties wonder why they must

continue to display contriteness for the mistakes of their forefathers. Regardless of the

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[13] CBC News, April 9, 2012 http://www.cbc.ca/news/politics/story/2012/04/09/north-naho-funding-cut.html

perspective one holds, one thing that is impossible to disagree with is that the problem is multifaceted and complex.

Adding a further layer to the complexity is the fact that the Aboriginal population is not unified. While organizations like the Assembly of First Nations (AFN), Métis National Council (MNC) and Inuit Tapiirit Kanatami (ITK) claim to represent their respective populations of Aboriginal people in the country, they are never the claimants in a treaty negotiation. Individual bands of Haida, for example, are in negotiations with the province of British Columbia and the negotiations, even just for the overall land claim of the Haida Gw'aii have gone on for upwards of 15 years. This is an expensive and time consuming process, but the federal government has not come up with a more effective way to deal with land claims. These claims are only the beginning of the governance issue – one claims are settled, then the problem of fostering the local economy and following the transition to a self-governed body must take place. In all of this, it is easy to lose sight of the issues of day-to-day importance, such as reducing disparities in standard of living, education and health policies. For the necessary work to be done in shifting the balance, these larger, conceptual problems with the return of governance to Aboriginal populations must be addressed.

Chapter IX: Reflections on Theory and Literature

After spending a lot of time on assessing factors of disparities, governance, mental health, and the use of knowledge, this study ends with a final analysis on traditional knowledge, with specific attention to mental health policy as an object of study. Returning to the significance of the topic that has been developed through a case study approach, and relying on the exploration of the academic literature, policy documents and some broader federal accountability and budget documents, this study has made the case that traditional knowledge can only be effectively implemented into mental health policy when Aboriginal peoples achieve ownership over their own governance. In order to summarize the many theoretical perspectives and findings from the literature, it is important to reflect on the interpretations this study has provided and consider how to frame the results in a conclusive way.

Considering the theoretical approach, something that may be useful for the future would be to assess the relationship that this study has posited between governance and the presence of traditional knowledge in a systems theory perspective. There is a great degree of interconnectedness between the analysis present in Chapter VII and the different theories presented in both Chapters III and IX. Instead of a synthesis chart to explain the different findings, one could conduct an analysis of the theoretical model using a matrix approach. This would illustrate the many linkages between the different types of theory and the different findings. Systems theory, defined by Laszlo in the early 1970s, is considered by many scholars to be more of a meta-theory than an individual body of theory in it's own right, that consists of "a set of common sign posts for systems theorists to follow" (Gunaratne, 2008).

Looking at the findings of this study from a systems perspective, it is possible to construct a visual representation of the current state of Aboriginal health policy, along the lines of a traditional systems approach, looking at the sociological continuum of chaos at one end of the spectrum and agreement at the other end. A matrix could illustrate the current policy situation with respect to traditional knowledge incorporation as it relates to mental health along this framework. The findings of this approach, reflecting the findings of this study would illustrate that the environment is presently at a point much closer to chaos than agreement. This, however, is not necessarily a negative, as the closer a system is to chaos, the more opportunities and windows there are for change, which is something that the Canadian Aboriginal community urgently needs.

The Aboriginal population exists as the minority in their own land. They are compared in this study to the case of the Maori in New Zealand who were also governed by a European oppressor and managed their transition to government differently. One could also think of other nations governed by a colonizer such as Wales and Scotland, both governed by the UK, or the minority populations in a country like India who are not well represented in their own parliament. The crucial concept to take away here is the governance: being governed by a power that removes community ownership and individual pride and/or culture renders populations disenfranchised and frustrated and this is the root of disparity in many areas; most relevant for this particular study is the impact on health outcomes and the lack of incorporation of traditional knowledge concepts based on a framing of health that is culturally different. The non-Aboriginal science based perspective has proven to be insufficient to address the needs of Aboriginal populations and, with much evidence and theoretical support, a more holistic approach is recommended.

Conclusions and Next Steps

The preceding pages have endeavoured to link two domestic cases and one international case to facilitate an understanding of a large idea that is difficult to limit to one policy angle. This concept of implementing traditional Aboriginal knowledge into mental health policy in Canada is quite specific but brings into consideration many broad policy and philosophical points. Within this study the Canadian health policy context has been explored in light of the specific issue of mental health. The population of interest – Aboriginal people, both in Canada and abroad – has been drilled down in a linear fashion to three very specific comparison groups and parameters have been set up within which to contain the analysis.

The table below concisely illustrates the ways that the case studies differ from each other and the way they relate to each other on a variety of variables that compose the concept of "Aboriginal knowledge".

Aboriginal Knowledge	Haida	Inuit	Maori
Initiation	combative	administrative	collaborative
Creation (encapsulation)	ownership	holistic	intrinsic
Validation	assertive	consultative	integrative
Circulation (dissemination)	formal sphere	political sphere	intellectual sphere
Implementation	negotiated	managerial	supportive
Cultural relationship between knowledge and health	re-building	fundamental	worldview ("Maori" is not linked to place)
Conceptions of mental health	extensive	inclusive	societal/familial

Policy documentation has been the source of key interest to arrive at these conclusions, but historical context setting and present social factors have all contributed to the analysis. Additionally, the theories of critical discourse, colonial oppression and public participation have been connected in a framework to support the study. As well, normative

power relationships have been examined in the context of the relationships between the Aboriginal populations under consideration and their historical persecutors. However, despite that this study has arrived at certain well supported conclusions about the implementation of traditional knowledge concepts into Canadian mental health policy, there are many avenues of this work left to explore.

It is clear that there is plenty of room for further study on this basket of issues; through the course of conducting the research and performing the analysis, the sensation of standing on the tip of an iceberg was tangible. The potential for determining a causal relationship between self-government and the implementation of traditional knowledge concepts exists and in future study I would propose to narrow the population of interest to the Inuit alone but widen the number of variables to include other social aspects that have an affect on how mental health policy is implemented. These could include variables like mother tongue, to make a case that Inuit speaking Inuktitut alone are not served as well as Inuit with a reasonable level of official language (English or French) comprehension. Another option would be variables to proxy community connections, to make the case that those with family members/friends available to advocate for them in a mental health crisis situation fare better than those without that support. Another interesting angle would be to look at the prevalence of mental illness diagnoses within the prison population in Canada and assess the relationship between Inuit heritage, mental illness and criminality. It is plain that there are many ways that continued work could add to the body of knowledge and build the case for further, creative, investments in Aboriginal mental health.

Work such as this is relevant as Canada marches on into the second decade of the 21st century; for too long the acknowledgement has been made that a discrepancy exists between the mental health outcomes of Aboriginal and non-Aboriginal people living in Canada

without adequate action to impact that discrepancy in a positive direction. Both the implementation and the outcomes of health policies need to provide backbone to support the hopeful, 'blue skies' approach that policy formulation can often take. The arguments presented within this study not only provide a launching point for a more in depth analysis but also provide some evidence about the current state of the policy playing field and articulate some thoughts towards better approaches for the future.

Canada has a lot to be proud of but the level of variance between the health of our diverse population sets, specifically in the area of mental health, leaves much to be desired. There are many positive goals that have been set out in relation to current frameworks and strategies; over the next five years Canadians will, if all goes as written, see the outcomes of those strategies in action. Hopefully future researchers will look back on this decade as one where real progress was achieved towards narrowing gaps in mental health between populations in Canada. In closing, let the words of Tommy Douglas resonate on this issue:

"Courage, my friends, 'tis not too late to build a better world."

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