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Article abstract

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# Applying a Critical Policy Lens to Contracting in Indigenous Mental Health Care: An Ethnographic Study with Urban Indigenous Providers

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# Applying a Critical Policy Lens to Contracting in Indigenous Mental Health Care: An Ethnographic Study with Urban Indigenous Providers

## Abstract

This article reports on the findings of a larger study that explored urban Indigenous providers' experiences with contracting in mental health and addictions care. The study was undertaken with seven Indigenous and one non-Indigenous non-profit organizations based in diverse large and mid-size cities (off reserve) in British Columbia, Canada. Indigenous and critical theoretical perspectives provided the lens for this ethnographic inquiry. In-depth interviews were the primary data source. Participants' narratives provide an account of the ideological embeddedness of contracting and how a New Public Management operates to perpetuate colonial power imbalances and structural barriers to culturally safe and equity-oriented care within urban Indigenous communities. Policy and practice implications for government funders are discussed.

## Keywords

Indigenous health services, Canada, mental health, cultural safety, contracting

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## **Applying a Critical Policy Lens to Contracting in Indigenous Mental Health Care: An Ethnographic Study with Urban Indigenous Providers**

In many settler states, such as Canada, New Zealand and Australia, governments contract<sup>1</sup> with local Indigenous agencies and organizations to provide a range of health services and programs to their respective communities (Dwyer et al., 2014). Contracting for Indigenous health care creates space for increased Indigenous self-determination in health service delivery and “by Indigenous for Indigenous” models of care, and thus, has been advocated for as a means to improve access to culturally safe care and health outcomes for Indigenous populations (Dwyer et al., 2014; Lavoie, 2004). In Canada, urban Indigenous peoples<sup>2</sup> continue to face significant inequities in mental health and well-being (Allan & Smylie, 2015; Gone, 2013; Nelson & Wilson, 2017; Public Health Agency of Canada, 2018). The causes of these inequities are a direct result of past and ongoing colonial practices, racism, discrimination, and structural violence, including a lack of culturally safe care (Allan & Smylie, 2015; Truth & Reconciliation Commission [TRC] of Canada, 2015; Turpel-Lafond et al., 2021). Colonial policies, such as the imposition of state-defined Indigenous identities under the Indian Act (1985), the residential school system, the appropriation of Indigenous Land, and the prohibition and/or criminalization of traditional practices severely disrupted Indigenous ways of life with direct implications for Indigenous Peoples’ mental health (Czyzewski, 2011; Nelson, 2012). The lasting and intergenerational effects of the trauma caused by colonial violence continue to be evident in the disproportionate rates of post-traumatic stress disorder, suicide, violence, and other mental health concerns prevalent in many Indigenous communities in Canada (Kirmayer et al., 2014; National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG], 2019; TRC, 2015).

These inequities are perpetuated by a chronically underfunded mental health care system (Morrow, 2017), and a general lack of culturally safe care (Allan & Smylie, 2015; National Inquiry into MMIWG, 2019; Nelson, 2012). Although Canada has a publicly funded health care system, dedicated funding for comprehensive mental health services has been lacking (Morrow, 2017). Under the current legislation, universal coverage only extends to medically necessary health services provided by physicians or in a hospital, making psychiatric services the default form of treatment for the majority of people in Canada (Chodos, 2017). This concentration of state resources on biomedical and clinical rather than community-based forms of mental health care persists despite a shift from a highly centralized in-patient psychiatric model to a more decentralized and regionalized model of health care in most provinces, and

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<sup>1</sup> In this paper, contracting for Indigenous health care refers to the process of governments engaging Indigenous providers for the delivery of publicly funded health services and programs to a primarily Indigenous constituency.

<sup>2</sup> In the Canadian context, urban Indigenous Peoples include Métis, Inuit, non-status First Nations and status First Nations living in urban (off-reserve) areas. While Canada’s constitution recognizes that Metis, Inuit, and First Nations peoples as the Indigenous Peoples of Canada have distinct cultural origins and rights, “status” First Nations is a state-identified identity under the Indian Act. Under the current legislation, the federal government only extends its fiduciary duty to First Nations whose status is recognized under the Indian Act (1985). This includes a limited number of mental health services and benefits.

is largely a reflection of biomedicine's ideological embeddedness in public and policy discourses around mental health (Morrow, 2017). Even when available, mental health services that are aligned with biomedical traditions of psychiatry are often ineffective for and underused by Indigenous populations (Gone, 2013; Rowan et al., 2014). The longstanding marginalization of alternative, more holistic models of mental health care within the Canadian mental health care system, including Indigenous approaches to healing, and the systemic failure to account for the historic and ongoing impacts of colonization are barriers to accessible and culturally safe mental health services for many Indigenous Peoples (Tait, 2008; Turpel-Lafond et al., 2021). These barriers are compounded even further for Indigenous Peoples living in urban areas because of the continuing jurisdictional divide between provincial and federal governments regarding the provision of Indigenous health services (Dinsdale, 2014). Despite increasing efforts to address jurisdictional barriers over the past ten years, many urban Indigenous Peoples still have limited or no access to Indigenous-led approaches to mental wellness, such as land-based or traditional healing activities (Auger et al, 2016; British Columbia Aboriginal Association of Friendship Centres [BCAAFC], 2020; Snyder et al., 2015).

The pervasiveness of racism and other forms of discrimination against Indigenous Peoples and other racialized groups within the health care system exacerbate access barriers to culturally safe mental health care further (Browne, 2017). There is no question that Indigenous-specific<sup>3</sup> racism and discrimination remain deeply entrenched within Canada's healthcare system (Allan & Smylie, 2015; Browne, 2017; Browne et al., 2021; Turpel-Lafond et al., 2021). The troubling death of a 37-year-old woman from the Atikamekw FirstNation, a woman who died not long after recording the racist and abusive treatment she received from hospital staff, is only the most recent incident of a long list of unjust and avoidable deaths that Indigenous individuals have suffered in the care of hospital staff (Shingler, 2020). A recent government-issued independent investigation into accusations of racism within British Columbia's (BC) healthcare system (Turpel, 2020) found that 84% of all Indigenous respondents reported experiencing discriminatory treatment when accessing care based in racist assumptions and/or cultural disrespect. These findings are consistent with the wider research literature documenting Indigenous Peoples' experiences of healthcare across a wide range of settings, including mental health care (Allan & Smylie, 2015; Browne, 2017; Browne et al., 2011; Kurtz et al., 2008; McCallum & Perry, 2018).

Given these socio-historical and political realities, it is not surprising that many Indigenous Peoples are reluctant to seek mainstream care, and if care is accessed, often perceive that their needs are not fully met (Auger et al. 2016; Smye et al. 2020; Turpel-Lafond et al., 2021). Improved access to culturally safe care is key to enhancing mental health and mental health care equity for Indigenous Peoples (Assembly of First Nations & Health Canada, 2015; Browne et al., 2016; First Nations Health Authority et al., 2013;

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<sup>3</sup> As defined by Turpel-Lafond et al. (2021), "Indigenous-specific racism refers to the unique nature of stereotyping, bias, and prejudice about Indigenous peoples in Canada that is rooted in the history of settler colonialism. Stereotyping and profiling of Indigenous peoples springs from the historic beliefs cultivated about Indigenous peoples' genetic, cultural, and intellectual inferiority that enabled settlers and their governments to expropriate Indigenous lands and resources" (p. 84).

Mental Health Commission of Canada, 2009). While the concept of cultural safety has its origins in the Māori nursing context of New Zealand/Aotearoa (Papps & Ramsden, 1996), the concept has since been taken up internationally where it continues to evolve. The Canadian literature (Auger et al. 2019; Browne et al., 2016; Greenwood et al., 2017; Fast et al., 2017; Smye et al., 2010) identifies several key features of culturally safe mental health care involving Indigenous Peoples that include strengths-based and relational approaches to care that are informed by a wholistic understanding of mental health (i.e., wellness perspective) and responsive to the unique needs, priorities and wider historical and social contexts that shape Indigenous Peoples' and communities' mental health and wellness.

To increase cultural safety in health service delivery, governments in Canada, Australia, and New Zealand contract with Indigenous providers for the provision of Indigenous health and mental health services (Dwyer et al., 2011; Josewski, 2012; Lavoie, 2004; Lavoie et al., 2018). Many Indigenous communities have seized the opportunity to become contractors to develop and administer their own health programs through their own organizations (Dwyer et al., 2011). In Canada, Friendship Centres, among other Indigenous organizations, have taken leading roles in providing a wide range of community-based culturally informed mental health and wellness programs and services to off-reserve and urban Indigenous peoples (BCAAFC, 2020).

Empirical evidence on state-Indigenous contracting as a mechanism for improving cultural safety and equity in mental health services delivery is lacking. Informed by neo-classical contract theory, contractual analyses have “generally side-stepped the context in which purchasers and providers operate,” and have focused instead on examining single contracts from the perspective of funders (Lavoie et al., 2010, p. 667). This analytic reduction limits our understanding of the factors that influence contracting, and how different “contractual arrangements may favour or impede the implementation of Indigenous models of health service delivery” (Lavoie, 2004, p. 20). Conceiving of contracting in Indigenous health as divorced from its contexts not only ignores the past and ongoing impacts of colonialism on Indigenous-state relations, including health care, but also fails to consider concerns about the exigencies of contract reform influenced by neo-liberalism.

Ideologically speaking, neo-liberalism implies “new forms of political-economic governance” (Larner, 2000, p. 5) premised on a set of beliefs and values which emphasize the adoption of the efficiency of the free market, individualism, free choice, autonomy, and the idea of a minimalist state (Evans et al., 2005). The pursuit of these values in the public sector through new public management (NPM) reforms is linked to the adoption of market-based technologies into the public sector (Evans & Fanelli, 2018; Lorenz, 2012), and the creation of social structures and inequities that contribute to the social suffering of individuals and communities (Rylko-Bauer & Farmer, 2016). Given the effects of structural violence and inequities on Indigenous peoples' health (Browne et al., 2016; Hole et al., 2015; Jacklin et al., 2017; Kurtz et al., 2008; Smye et al., 2020), this is a considerable oversight.

To account for the contextual embeddedness of contracting in Indigenous health and to better understand how these contextual factors enable and hinder culturally safe mental health care, we

conducted a community-based ethnographic study grounded in the experiences and perspectives of urban Indigenous non-profit providers and policy decision-makers across BC. Our research aimed to move beyond a neo-classical analysis of contractual relations by examining contracting for Indigenous mental health care through a critical policy lens informed by Indigenous and critical theoretical perspectives and constructs. In this paper, we are reporting on the findings of this community-based ethnographic study. “We” are a small team of settler and Indigenous researchers, all of whom are involved in anti-colonial scholarship and activism in lands known to many as Canada.

### **Contextualizing Contracting for Culturally Safe Mental Health Care in BC**

Indigenous and non-Indigenous scholars who work with and through anti-oppressive and decolonizing theories have consistently shown that colonialism continues to structure Indigenous-state relations within and beyond health care, materializing in access barriers, health care encounters, and treatment approaches that are unsafe and ineffective (Browne et al., 2016; Hole et al., 2015; Jacklin et al., 2017; Kurtz et al., 2008). For this reason, health researchers, health care administrators, and decision-makers “must grapple with and firmly understand the workings of colonialism, both historically and into the present” (De Leeuw et al., 2010, p. 286). Raising critical consciousness of the ongoing impacts of colonialism on health and health care must begin with a recognition that health care has been instrumental to the process of colonization in Canada (O’Neil et al., 1999). By fostering racist and sexist stereotypes of Indigenous Peoples as naturally “diseased” (Kelm, 1998), “inferior,” and “incapable” (Turpel-Lafond et al., 2021), colonial health care served to provide the “moral” and “scientific” justifications for subjecting Indigenous Peoples to policies of assimilation and unethical, inhumane medical treatment (e.g., forced sterilization and medical experimentation) (Allan & Smylie, 2015). In addition, the model of colonial health care was expressly paternalistic and authoritarian, cultivating and entrenching lasting relationships of disempowerment and dependency on a regime of colonial medicine intent on establishing Euro-Canadian medical superiority (Greenwood et al., 2017; Smye, 2004).

The continued dominance of Western biomedical knowledge and marginalization of traditional Indigenous health knowledge and healing practices within Canada’s contemporary mental health care system serves as another manifestation of the legacy of colonial health care (Allan & Smylie, 2015; Allen et al., 2020; Nelson, 2012). To redress this legacy and improve health and health care equity for Indigenous Peoples, the 2015 Calls to Action of the TRC of Canada underscore the urgent need “to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders” (p. 210). Repeated calls for a deliberate de-centering of the dominant culture of the mental health system are supported by a growing evidence base suggesting that Indigenous-led traditional approaches to health care can play an important role in improving access and wellness outcomes for Indigenous Peoples (Allen et al., 2020; Efimoff et al. 2021, Firestone et al, 2019; Graham et al., 2021; Greenwood et al. 2022; Hole et al., 2015; Kirmayer et al., 2014; Rowan et al., 2014; Tu et al., 2019; Venugopal et al., 2021). An important theme emerging from this literature is “culture as intervention,” which posits Indigenous traditional culture as a treatment for

addressing the mental health concerns experienced by Indigenous Peoples as a result of colonialism (Gone, 2013; Rowan et al., 2014). A central feature of Indigenous cultural interventions is that they address mental wellness in a wholistic sense (inclusive of social, emotional, physical, and spiritual), in contrast to the individualistic and mind/body dualism that underpins Western psychiatric treatment approaches to mental health and addictions issues (Rowan et al., 2014). This reductionism means that Western treatment approaches fail to address the historical and ongoing root causes that underpin Indigenous Peoples' mental health experiences (Allan & Smylie, 2015).

Over the last decade, some relevant efforts toward reconciliation and transformative change with Indigenous Peoples, including a Canada-wide commitment to implement the TRC Calls to Action as well as several noteworthy Canadian examples of Indigenous-led health service partnerships, have emerged. Unique to BC are the creation of a First Nations Health Authority (FNHA) in 2010 and, more recently, the adoption of a Declaration of Commitment (2015) to advance cultural safety and humility by all health authorities and the BC Ministry of Health, and legislation to implement the United Nations Declaration on the Rights of Indigenous Peoples (2007) in 2019.<sup>4</sup> These developments have led to the formation of new cross-jurisdictional partnerships as well as the adoption of a First Nations wellness framework, which aims to ensure that cultural knowledge, values and traditional health practices and medicines are emphasized in health care planning, programming and service delivery (O'Neil et al., 2016). In January 2021, FNHA released a new framework specifically for and addressing the health care needs and rights of the urban First Nations population in BC. The Urban and Away-From-Home Health and Wellness Framework (FNHA, 2021) expands the narrow scope of FNHA's inherited federal service mandate by moving beyond the jurisdictional divide between on- and off-reserve First Nations health service delivery.

With few exceptions, health care for Indigenous Peoples living in urban environments has been treated as falling outside of the federally defined mandate of FNIHB (Lavoie et al., 2015). Instead, within Canada's decentralized model of health care, the responsibility for addressing the mental health needs of a growing urban Indigenous population has historically been under the purview of provinces, which have largely overlooked the distinct needs and rights of Indigenous peoples (BCAAFC, 2020).

Regionalization of healthcare, a process that began in BC in the 1990s and ultimately resulted in the creation of one provincial and five regional health authorities, created new pathways for Indigenous delivery of mental health care within urban Indigenous communities through government/health authority contracting with urban Indigenous service organizations (Josewski, 2012; Lavoie et al. 2015). Urban Indigenous communities in BC seized the opportunity to become service providers of community-based mental health and wellness services. However, given the absence of self-government

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<sup>4</sup> Of particular relevance is United Nations Declaration Article 24, which sets out that Indigenous Peoples must access health and social services without discrimination.



pathways for urban (off-reserve) Indigenous communities in BC,<sup>5</sup> government/health authority contracting with urban Indigenous service organizations has so far remained the only pathway for urban Indigenous self-governance in healthcare (Lavoie et al., 2015).

Increased opportunities for contracting in health are not merely a response to Indigenous demands for increased control over health service delivery but are also a hallmark of the global rise of neo-liberalism (MacDonald, 2011). However, while NPM-inspired practices continue to pass as best practices within North America and elsewhere (Simonet, 2008; Siltala, 2013), the adverse impacts of NPM reforms on non-profit and public sector organizations, labour force, quality of public services, and equity are well documented (Evans et al., 2005; Lapuente & Van de Walle, 2020; Siltala, 2013; Tenbensen et al., 2013). NPM's ideological commitment to individualism, managerialism, and free-market capitalism is fundamentally at odds with substantiating Indigenous individual and collective rights and other social justice claims. Rather than advancing Indigenous health care rights, neo-liberalism, it is argued, fosters relationships based on principal-agency thinking (Dwyer et al., 2014; Josewski, 2012) while promoting the "marketization of Indigenous citizenship" (Altamirano-Jiménez, 2004, p. 349) along with "a politics of privatization" (MacDonald, 2011, p. 258), "blame" or "responsibilization" (Orsini, 2007, p. 354). Adding to these relational concerns are critiques that show how neoliberalism's propensity for individualism promotes depoliticized (i.e., biomedical) understandings of and responses to complex social and health inequities (Morrow, 2013; Morrow, 2017).

The juxtaposition of the ascension of neoliberalism within Canada and BC's neo-colonial context provides therefore a crucial point of inquiry into Indigenous contracting for mental health service delivery. While recent developments in BC indicate renewed public commitments to advance reconciliation, cultural safety, and health equity for Indigenous Peoples, it is also an example of a jurisdiction that has followed closely the political doctrine of neoliberalism (Morrow, 2017). Without further exploration, it remains unclear to what extent current approaches to contracting may hinder the delivery of culturally safe mental health programs and services within urban Indigenous communities.

### Methodology and Methods

The research aimed to (1) examine Indigenous providers' experiences with contracting in relation to mental health and/or addictions care; (2) analyze the sociopolitical, economic, historical, and institutional contexts that mediate these experiences; (3) explicate the specific institutional structures, policies, and practices that support and/or impede the delivery of culturally safe mental health and addictions services and equity; and (4) generate recommendations for the promotion of culturally safe

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<sup>5</sup> With the exception of Ontario, which is the only province with a comprehensive policy framework for ensuring engagement of urban Indigenous communities in health care planning and delivery, formal mechanisms for self-government in Canadian provinces only exist for First Nations on-reserve (Lavoie et al., 2015).

and equity-oriented practice in contracting with urban Indigenous providers of mental health and addictions care.

### **Indigenous and Critical Theoretical Perspectives**

Indigenous and critical theoretical perspectives, and the constructs of cultural safety and equity informed our approach to research and analysis. These theoretical perspectives and lenses were chosen to foster an intersectional, multi-level, and praxis-oriented approach to inquiry that is grounded in the everyday realities of community life, from the perspective of urban Indigenous Peoples. Aimed at disrupting the inequitable social and power relations that organize health and healthcare experiences within contemporary settler states (Papps & Ramsden, 1996), the concept of cultural safety fits well with Indigenous decolonizing perspectives (e.g., Tuhiwai Smith, 2012) and postcolonial and feminist theorizing (e.g., Battiste, 2009; Reimer-Kirkham & Browne, 2006). Indigenist and decolonizing perspectives advance an Indigenous social justice agenda that supports Indigenous self-determination and seeks to disrupt the dominance of Eurocentric systems of knowledge production by foregrounding Indigenous knowledges, voices, and experiences (Battiste, 2009; Grande, 2004; LaRocque, 1996; Tuhiwai Smith, 2012).

The centrality of relational epistemologies represents a significant point of convergence between Indigenous and feminist thought that is particularly salient in the scholarship on intersectionality (Dhamoon & Hankivsky, 2011). Rooted in Black feminist thought (Collins, 2002, 2004; Crenshaw, 1989), intersectionality offers a powerful analytical framework that has been effectively used by both Indigenous and non-Indigenous researchers to advance the operationalization of equity in health services and policy (Clark et al., 2017; De Leeuw et al., 2011; Smye et al., 2020). However, as an analytical framework intersectionality does not necessarily include a critique of colonial power (Clark, 2012). To address this concern, post-colonial scholarship as informed by Indigenous (e.g., Battiste, 2009; LaRocque, 1996) and non-Indigenous feminist (e.g., Browne et al., 2007; Reimer Kirkham & Anderson, 2002) thought also provided direction for analyzing contractual relationships as extensions of wider social and structural relations, including past and ongoing colonial and neo-liberal relation.

### **Data Collection**

In keeping with this theoretical framework, the study was conducted in partnership with eight urban non-profit organizations (seven Indigenous and one non-Indigenous) using a participatory design and ethnographic in-depth interviews. The research team was guided by an Indigenous advisory committee including leaders in Indigenous mental health, one of whom is a co-author on this paper. The Research Ethics Board at Simon Fraser University and the two partnering health authorities provided ethical approval. In addition, research agreements were sought with the participating community partners.

Using purposive sampling, we conducted in-depth, semi-structured individual interviews with a total of 33 participants. Of these, 23 were conducted with “Community-based Provider Participants” (CPP)

representing: (1) community-based providers of mental health and addictions services and programs (e.g., Peer Support Workers, Drug & Alcohol Counsellors, Professionally Trained Mental Health Clinicians, and Indigenous Elders), (2) mental health program managers, and (3) senior administrators (e.g., Executive Directors and Board Members). In line with the wholistic and contextualized conceptualizations of mental health that underpin Indigenous worldviews, the operational definition of “mental health and addictions” services and supports was deliberately broad, ranging from preventative medicine and health-promotion-based programming to group and individual interventions and support services. The nature of identified “mental health and addictions” services and supports also included cultural programming and circle work, mental health and addictions counselling, Elder support programs, peer support, psychological and psychiatric care, outreach support, and community-building. In addition, we interviewed 10 “Policy Participants” (PP)—individuals with past and/or present experiences pertaining to Indigenous mental health and addictions policy and funding decision-making and programming. This group was sampled for the purpose of contextualizing CPPs' interviews.

For the purposes of this research, an Indigenous Non-Profit Organization [NPO] was defined as an organization governed by a predominantly Indigenous board, which self-identified as Indigenous and served a primarily Indigenous constituency. The non-Indigenous NPO was included because it served a large proportion of the local Indigenous community and had a high proportion of Indigenous employees. While NPOs were primarily selected on the basis of researcher pre-existing relationships, in keeping with the requirements of one of the research agreements, the researchers took pains to sample organizations from three different health regions.

Overall, just over half of all participants self-identified as Indigenous ( $n = 18$ ) including 11 out of 23 CPPs. Almost three-quarters of CPPs self-identified as female, highlighting the significant role gender plays in the Indigenous non-profit sector in BC. Across CPPs, senior administrators had been in their positions for the longest with an average of 15 years and a mean of 20 years. Mental health providers had been in their current position between two and 15 years with a mean time of four years—yet all had extensive working experience in their area, with an average of 19 years. This compared to an average of 4.7 years and a mean of 1.75 years for program managers.

## Data Analysis

After obtaining informed consent, participants were invited to interviews that lasted between 60 and 90 minutes and focused on exploring participants' experiences with contracting within the context of their everyday work. With permission, interviews were audio-recorded and later transcribed. Cleaned and anonymized interviews were then uploaded into NVivo®, a qualitative software program for data management, organizing, and coding. Analysis followed an iterative and nonlinear approach to interpretive thematic analysis (Thorne, 2016) moving back and forth between interviews, coding, and analysis. We coded data using cultural safety as an ethical/interpretative lens (Smye & Browne, 2002) identifying both social and structural barriers and enablers to the delivery of culturally safe mental health and addictions care. Guided by multi-level, intersectional frameworks for policy analysis (Hankivsky et

al., 2012), we mapped emerging themes across the macro, meso and micro levels of Indigenous health contracting. Analytically, this process helped us to explore relationships and interactions within and between different system levels (i.e., macro, meso, and micro) and data sets (e.g., interview data from PPs versus CPPs), and identify inconsistencies, contradictions as well as commonalities. At the macro-level, analysis focused particularly on the everyday experiences of PPs, while analysis at the meso-level and micro-levels centered predominantly on CPPs' accounts and examined community- and organizational-level factors as well as day-to-day practice relating to, for example, securing program funding, contract management, programming, and care.

To foreground Indigenous voices, we paid particular attention to the accounts of Indigenous participants and brought emerging themes and findings back to community partners that had expressed interest, as well as to members of the Indigenous advisory team. Through this process, several higher-level themes and broader conceptual propositions were generated, which we further explored in relation to the literature and Indigenous scholarship. This step also helped to ensure authenticity and credibility of the findings (Thorne, 2016) and provided guidance on when to terminate data collection. We then continued the analysis until there was a compelling basis for drawing the conclusion that the findings generated did justice to the research questions.

## Results

Results are presented using a multi-level framework to shed light on some of the key structural and social barriers and enablers across the macro-, meso- and micro-levels of contracting in Indigenous mental health care within urban Indigenous communities in BC. To help contextualize participant quotes, excerpts from interviews held with CPPs and PPs are marked accordingly; quotes that are from participants who identified as Indigenous are indicated by the additional letter "I" (i.e., ICPP and IPP).

### Macro-level Factors

Analysis at the macro-level illustrates how ideologies central to contemporary health policy and the culture of health care, organize PPs experiences of health policy and funding decision-making and contracting, and provide a contextual foregrounding for the findings at the meso- and micro-levels.

#### *Neo-liberal Dynamics*

Regionalization, although accomplished in the early 2000s, had an ongoing impact on contracting. Referring to the way regionalization unfolded in BC, one Indigenous PP observed that healthcare reform and government's approach to contracting often takes the form of "a political dance" adding that during their 30 plus years of working with government, "I've gone through several cycles where . . . everything is contracted out, everything is pulled back" (IPP-05). Rather than evidence-based policymaking, from the perspective of this participant, it is the prevailing political ideology of the "particular government in

power” that shapes “whether they want to have community services provided or they want to centralize community services” (IPP-05).

As the following excerpt from an interview with an Indigenous PP highlights, participants at the policy level were also highly critical of neoliberal-inspired policy and practices changes:

[W]e have to have a zero budget at the end of the fiscal year . . . Population health outcomes are twenty-five years long; why are we tied to this crazy service industry? I understand why a hospital does or whatever but we . . . have to fit into the same mold. (IPP-02)

As suggested by IPP-02, the narrow concern of NPM with achieving fiscal accountability is at odds with a population health approach which emphasizes long-term goals and upstream investments in primary prevention to address the determinants of Indigenous mental health and well-being.

Unsurprisingly perhaps, many Indigenous PPs criticized the equity work undertaken by government funders as superficial and falling short of addressing those structures, policies, and practices that produce and reproduce colonial and neo-colonial relations within health care institutions. As IPP-02 noted:

I know the population public health peoples at [health authority] and the Ministry of Health are very interested in doing equity work but their equity work is quite superficial. They always want to go for the easy win like “oh let’s just put a training thing up on the pod, it takes half an hour and then peoples know more about equity.” (IPP-02)

### *Colonial and Neo-Colonial Dynamics*

PPs offered multiple examples of how colonial and neo-colonial relations continue to shape institutional structures, policies, and everyday practices including their day-to-day struggle of gaining recognition and funding for Indigenous approaches to mental health. One Indigenous PP recalled developing a culture-based mental wellness program that “was integrating sewing, . . . button work, [and] weaving” and being told by Mental Health & Addictions, “oh well you’re just paying for crafts” (IPP-05). For IPP-05, this interaction was indicative of how the ongoing dominance of Western biomedicine within mental health continues to discredit and de-value Indigenous approaches. As IPP-05 explained, the program was “well-designed” and yet, it never received the necessary structural support and resources to evolve into what IPP-05 had “hoped the . . . program to be.” Lacking support for and recognition of the value of Indigenous approaches to mental health and healing led this participant to conclude that “we don’t have a health system, we have an illness system, an illness management system and anyone who thinks it’s anything other than that doesn’t understand the system” (IPP-05).

Another Indigenous PP stated, Indigenous Peoples “don’t want to fit in the same old government model . . . we are trying hard to focus on wellness, which is a . . . major paradigm shift in the way we imagine, think and do” (IPP-06). To change the way “mental health and addictions” care is delivered, this and

several other Indigenous participants emphasized “a big part of that public narrative . . . [has] to come from the Indigenous Peoples themselves.”

Accounts of how paternalistic governance structures within government and health authorities contributed to the marginalization and subjugation of Indigenous voices and expertise were also woven through the interviews. As one Indigenous PP reflected, within the policy making process Indigenous health is “never at the forefront, it’s never at the beginning of anything, it’s always been an afterthought” because “it is not hard wired” into the system:

Hard wiring it would mean changing the way we do business, changing the way we make decisions . . . at least put me in a position where . . . when these decisions and thoughts are being first discussed I can go [and say] “hey, hold on, this applies to the Aboriginal population and I would recommend you to do this, this and that” . . . but it’s not that way right now. (IPP-07)

Lacking support for Indigenous issues and authority assigned to Indigenous Peoples’ voices within the health care system was intrinsically linked to an institutional culture in which racism and discrimination towards Indigenous Peoples remained prevalent. Many Indigenous participants recounted confronting racist and colonial attitudes in their day-to-day interactions, describing how their efforts to apply an Indigenous lens or advocate for more resources are commonly met with responses ranging from “contempt” (IPP-01) to “resistance and backlash” (IPP-02). This Indigenous PP recalled how one person responded to their plans of rolling-out cultural competency training in the health authority with such irritation that “she started banging her head on the table” based on what she seemed to perceive was a misplaced priority setting, stating: “Are you kidding me? We can’t even get . . . this . . . emergency skills training out and you’re going to make them take cultural competency?” (IPP-01). These types of responses are reflective of implicit yet “prevalent attitudes in Canadian society where Aboriginal Peoples are sort of a subspecies of humanity . . . we don’t really count” (IPP-01).

### **Meso-Level Factors:**

At the meso-level, PPs’ and CPPs’ accounts provided important insights into how funding structures, contractual policies, practices, and relationships mediate between these dominant ideologies and the micro-level of care. Findings are discussed in relation to the three intersecting dimensions of social justice: participation, recognition, and redistribution (Reimer Kirkham & Browne, 2006).

#### ***Issues of Redistribution: “We have to beg and fight for every single dollar” (ICPP-09)***

While a comparative analysis of public investment in Indigenous versus non-Indigenous mental health care was beyond the scope of this study, both CPPs and PPs in this study strongly believed the funding distribution of mental health care resources to be inequitable. There was consensus among participants that the level of funding continued to fall short of meeting the communities’ needs, and that mainstream mental health services were significantly better resourced than Indigenous providers of community-

based mental health programs even though, they argued, the need for mental health related services and support in urban Indigenous communities was significantly higher.

While most organizations, though not all, had been successful in “protecting” what they considered their “core services,” participants described how the “clawing back of money” by government funders had led to a dismantling of programs as well as organizational and administrative infrastructure. One CPP who was working for a smaller Indigenous NPO observed that program funding used to be “stable” and comprehensive “enough to pay for the staffing, . . . location” and “admin fees which covered the overhead” so that the organization “didn’t have to worry about . . . getting funding from someplace else” whereas “now it seems like you’re getting little pieces” (CPP-19). Other CPPs recounted similar experiences. As their accounts revealed, government funders’ increasingly compartmentalized and instituted competitive approaches to contracting, within an already jurisdictionally complex and siloed policy and funding environment, meant that the finding, obtaining, and administering of program funding had become increasingly more difficult and taxing for Indigenous NPOs. This reality led some to question whether the distribution of resources was more a function of organizations’ administrative capacity than a reflection of communities’ needs. As many participants explained, the administrative burden imposed by this funding regime simply surpassed their organizations’ existing administrative capacities. This, they argued, created differential access to funding, especially for smaller organizations and when Indigenous and non-Indigenous NPOs had to compete for the same funding. These tensions were compounded further by a perceived lack of transparency and inconsistencies in how funding decisions were reached, as one CPP who worked for an Indigenous NPO remarked, “where it becomes frustrating is how to kind of break into these pools and try and do new things when the funders have basically already established, or it seems like they’ve already established, who their funding is going to” (CPP-19).

Another source of tension described by CPPs was the prevalent use of short-term contracts, which created significant liabilities for NPOs, their staff and the communities they served. As one participant noted, often “what happens [is] we get some of the programs up and running and then the . . . funding would [be discontinued].” Many Indigenous health funding programs were structured so that organizations could not receive contract renewals that would provide continuity of the service they provided. This taken-for-granted practice led to the paradoxical situation in which Indigenous NPOs saw their programs terminated even though their success had been demonstrated, as one Indigenous CPP shared:

It’s really tough to get any money and so they cut the [name of program]. . . . They just said that they don’t have the dollars . . . but yet it was very successful. We were just getting off the ground and momentum was going. So . . . maybe they didn’t want us to become successful [laughing].” (ICPP-17)

Interactions with funders whose approach to contracting was governed by abstract rules, arbitrary funding caps and unanticipated funding cuts provoked not only feelings of frustration but also reinforced

historical mistrust towards government among Indigenous NPOs. As one ICPP put it, “clawing the money back and then giving it back, the same money” may serve funders “making themselves look good” but

we want to stop violence and poverty . . . and . . . substance misuse and so how are we going to make that work in regard to offering programs when the systems keep going back and forth? (ICPP- 21)

Even where the funding terms allowed for the possibility of renewal, the uncertainty associated with the constant churning of short-term contracts created numerous structural barriers for Indigenous NPOs that undermined their ability to ensure high-quality mental health services and relational accountability to clients, staff, other community partners, and the communities at large. This included obstacles to recruitment, training, and maintenance of high-quality staff as one Indigenous community-based senior administrator explained,

It’s really, really challenging to recruit and retain staff, you know, because we’re not able to pay them the same kind of money that they might get if they’re working for a mainstream organization or a union organization . . . and when you’re recruiting you’re having to say to staff members that this is an annual contract . . . So that impacts the quality of staff that you get in the organization as well. (ICP- 09)

As the same participant pointed out, what funders don’t seem to realize is that “there’s a cost to close down programs just like there is to start programs.” To a large extent, this cost was borne by staff, who faced the stress of potential and real “layoffs” and the challenge of scaling down of client caseload to ensure continuity of care to the extent possible all the while being paid less than what would be expected in the public sector. As participants reported, these costs were often exacerbated further by unduly delays in the approval of funding renewals, which kept organizations and providers in a perpetual state of “trying to catch up” in terms of staffing levels and “client caseload.”

***Issues of Participation: “I’ve yet to really negotiate a contract” (ICPP-10)***

Another potent theme across participants was connected to the ways in which current approaches to contracting enabled and constrained opportunities for urban Indigenous self-governance and meaningful urban Indigenous involvement in policy and funding decision-making. At a fundamental level, CPPs noted a significant power imbalance between Indigenous NPOs and their funders. Speaking to issues of resource allocation and priority settings, one Indigenous CPP with twenty plus years working in the Indigenous non-profit sector remarked,

the problem is there’s never any real negotiation in contracting when it comes to government funding. . . . Contracting usually comes out of a process where people . . . at some level of government have decided they’re going to make a certain amount of money available to, to tackle a certain problem . . . and so left



out of that process is the discussion . . . with people who are on the ground trying to deal with problems. (ICPP-10)

Most CPPs concurred that contracting typically followed a top-down process with RFPs that too often reflected funders' rather than local needs and priorities. As they argued, funders "don't . . . know what happens . . . [at] the grass roots levels, they just work from an ivory tower and wield their power" (ICPP-17) and so "they don't have any firm notion or firm understanding of what the problems actually are" (ICPP-10).

Focusing the discussion on the power dynamics within contractual relationships, one Indigenous PP described government funding of community-led programs as a "double-edged sword" noting that once "they'll start funding" all too often Indigenous NPOs are "co-opted by government" (IPP-06). This perception was shared by many other Indigenous participants in this study who described how government funders and contract managers retained an increasingly large degree of control over Indigenous NPOs' internal operations through increasingly stricter financial and program-related performance monitoring and regulations. As the following account highlights:

Their rules are too strict or they have never been in the trenches themselves or got their hands dirty; they just sit at the table and decide. That's for the most part what happens that I've seen . . . "this is how it's done" and there's no ifs, ands, or buts . . . And on top of that . . . they want the whole ten yards to every penny . . . which is their right but they're so strict they want pages and pages of everything. (ICPP-21).

While participants understood the importance of being accountable, many CPPs found this approach to accountability to be counterproductive and interfering with their ability to effectively deliver services because it constrained them in their ability to be responsive to communities' changing needs and priorities and required excessive documentation, which tied up already scarce human resources. Moreover, they were critical of the presumed authority of government funders over them, with one Indigenous CPP identifying this approach to accountability as a re-enactment of paternalistic policies of the past: "It's like Ottawa running Aboriginal people for all those years" (ICPP-21).

While the relations of control and surveillance enacted under performance management triggered a deep sense of un-safety and mistrust among some participants, not all experiences with funding relationships were negative. This study confirms that long-term funding relationships, contractual flexibility and comprehensive block-funding can play a positive role in overcoming historical mistrust and enhancing Indigenous NPOs' ability to respond safely and effectively to the needs and priorities of communities.

***Issues of Recognition: "Culturally appropriate kind of services . . . is a right for First Nations people, . . . it's not a gift that non-native people are giving us" (ICPP-04)***

CPPs described many different ways in which their mental health and wellness programming blended Indigenous and Western ways of healing and emphasized the difference these programs made in peoples' lives. At the same time, CPPs repeatedly voiced concern that their efforts and achievements were not adequately supported through their contracts, even when RFPs and contractual agreements explicitly stated "culturally appropriate" programming as a key deliverable. Recounting an all-too-common experience, one CPP who was working for an Indigenous NPO shared that while the organization used to have an Elder on site, the funding for this position and other things "Indigenous" had been lost in the process of continual program cuts:

We try and do the canning of the salmon, we do berry canning, we do different types of things like that . . . [but] those are things that are the first to get cut back when there's no funding. So, the programs would still be able to maintain themselves, [but] . . . [w]hat is the quality of the programs . . . going to be like? (CPP-19).

Indigenous NPOs were left to fill the resulting gaps and often relied on volunteer labour and contributions by their staff, including Elders, to ensure their programs integrated Indigenous cultural traditions and healing knowledge.

Another source of tensions that CPPs discussed arose from the challenge of reconciling Indigenous understandings and approaches to mental wellness with funders' piecemeal approach to contracting for Indigenous mental health and addictions care. Several CPPs described a process of attempting to create a collage of mental health and addictions services by piecing together different contracts with multiple government funders in an effort to sustain and/or create wholistic care that is responsive to the unique cultural, social, and mental wellness needs and priorities of the populations they served. As participants reported, the transaction costs of weaving together multiple separate contracts from various funders were high, sometimes higher than the value of the contract.

Yet another pertinent subtheme that emerged from across interviews was the notion of accountability, which conveys CPPs' concern with the often too narrow scope of performance measures, which failed to account for those program aspects and outcomes that participants considered culturally meaningful and relevant, such as building new connections with family, culture, land, and community and across generations, or involving Elders and spiritual advisors in designing their programs. As a non-Indigenous administrator with an Indigenous NPO pointed out, "it's not about quality, it's about quantity" . . . "the numbers don't reflect a lot for us: we just hit the quota and do our own thing" (CPP-04). The majority of performance-based indicators and targets, participants argued, were skewed towards achieving gains in cost-efficiency, constraining their ability to provide funders with an authentic and meaningful account of their work and the impact this had on individuals, families, and communities.

Participants also provided several illustrative examples demonstrating that funding arrangements often have paradoxical and potentially harmful consequences for urban Indigenous NPOs, staff, and community members accessing these services with one Indigenous PP observing,

The MCFD [Ministry of Children and Family Development] process in managing those contracts—it's kind of a catch 22. For child and family service agencies the federal funding formula is that the more children you apprehend the more money you get. Aboriginal agencies don't want to apprehend children, they want to prevent them from being apprehended but there's no money there for their services. (IPP-01)

This example demonstrates how models of performance contracting can create a serious ethical double-bind for Indigenous providers when they are not aligned with the principles of cultural safety and equity-oriented care.

***Micro-Level: "So . . . we still need to be providing our own services but . . . we're not really supported to be successful at that" (IPP-01)***

At the micro level of care, CPPs discussed how neo-liberal contracting and accountability policies and practices mediated their ability to deliver culturally safe care that is responsive to the unique mental health needs, concerns, and contexts of the Indigenous clients, families, and communities they served. One source of tension was bound up with diverging funders' and providers' approaches to accountability as evident in the following comment by one non-Indigenous mental health provider:

it's always cost efficiency . . . And that's not always the best way to look at things . . . we deal with Peoples here [and] that's not what we're thinking about. . . . We're thinking about how we can best serve the client. (CPP-08)

Providers repeatedly contrasted funders' narrow understanding of accountability in terms of cost-efficiency with what they described as their relational accountability to clients, families, and communities. For providers, enacting culturally safe practice involved working the spaces in between their accountabilities to the funder and the clients and community, and navigating the ethical tensions and paradoxes that arose within and between these spaces. This often led to the acceptance of compromises that did not always feel "right." In the voice of one Indigenous provider:

I have to meet a certain number of clients, a certain amount of hours, [and] do a certain amount of programming . . . which can also be helpful for keeping on track . . . [but it] . . . doesn't feel good . . . like for me I'd want to give priority to clients but if there's certain objectives I need to meet how do I achieve that? (ICPP-22)

Operating under these divergent accountability obligations, many reported feeling pressured by funders to prioritize administrative needs over those of clients. Rather than investing their time in relationship-

building with clients, providers reported having to ration the time they could spend with each client in order to meet and report on their contractually defined performance targets.

The intrusive impact of performance-based accountability mechanisms on how to provide care distressed many providers, who consistently asserted the need to “slow it down and build relationships” (CPP-05) to create emotionally and culturally safe health care encounters. There was consensus among providers that the pace of care needed to reflect an understanding that most of their clients lived with past and ongoing experiences of trauma, violence, racism, and other forms of discrimination. As one provider remarked, “most . . . of the women we work with have concurrent disorders, most of them have trauma histories. And so . . . you’re not going to get anywhere if they don’t trust or feel safe . . . so what we’re trying to do is just engage with the client to get them to a place where they feel safe, where they can start making the changes that they want to make, that takes time” (CPP-07). Practices that fostered safety and a sense of empowerment included creating warm and welcoming spaces where clients can talk to somebody and can have a cup of coffee without feeling ostracized. Creating culturally safe and trusting environments also involved being able to connect Indigenous clients with Elders, medicines for smudging, and ceremony. Others described how respectful engagement and empowerment of clients was fostered by “using more non-directive approaches where you assume the client is the expert on their experience” (CPP-04), and a pragmatic approach to care focused on addressing those concerns that are taking priority in clients’ lives. As one provider reflected, “so many times people aren’t ready for counseling because there’s poverty-based issues, they haven’t had any nutrition, . . . they don’t have a good place to stay” (CPP-05). Based on their experiences, providers in this study agreed that to successfully engage clients in programs, clients’ most immediate needs and concerns had to be attended to first, which included taking the time to build relationships of trust and addressing basic social determinants of mental health. As a result, CPPs described investing extensive amounts of time focused on building trust with clients, often over the course months and even years as one administrative leader explained, “some kids . . . we’ve been working with . . . for five years since the program started . . . they’ve had their trust broken so many times” (CPP-04).

Yet, under the current contracting and accountability regime, participants argued that the needs, rights, and social suffering of those most marginalized by social and structural inequities are often rendered invisible and left unaccounted for. While CPPs stressed the positive benefits of stable program funding on providers’ capacities to successfully engage clients in the long-term and support healing and recovery in mental health and addictions, funding arrangements even for three to five years were the exception rather than the norm. In particular, CPPs were critical of funders’ failure to provide adequate funding for Elders’ involvements, ceremony, and other cultural interventions, as well as the narrowness of funders’ concern with quantitative assessments of care utilization and imposed eligibility criteria that governed program accessibility. Underpinning CPPs’ expressed concern was a view that these practices objectified clients and clients’ needs rather than promoting care informed by understanding that, as one provider put it, “this is a real person with a real issue with real family members . . . with real trauma” (CPP-05). Reflecting the impact of the jurisdictionally complex and fragmented nature of the funding environment

in which Indigenous providers of mental health operated, another participant described how, out of four mental health and addictions contracts that the organization held, only one did not require Indigenous people "to fit into . . . [a] box to get service" while the other three were "very specific . . . [to] child youth, mental health or . . . addictions" (CPP-04).

The resulting practice tensions were compounded by the "increasingly astronomical . . . reporting" requirements (ICPP-09) that participants across all interviews described, and the predominance of short-term, multi-funder contractual arrangements as demonstrated in the organizational scenario described by CPP-04 above. While piecing together a range of different mental health contracts can be an effective strategy to fill the gaps in mental health programming and promote equitable access, the attendant increase in administrative burden weighed heavily on the organization and individual providers. This kind of experience contrasted starkly with that of another organization that received block-funding under the terms of one comprehensive contract and consequently, experienced a much higher degree of flexibility in program design and delivery without the attendant administrative burden. As expected, funders' increasing unwillingness to cover costs not considered directly related to the delivery of care, such as "administrative costs" and "food," magnified these tensions even further. The cumulative effect of these changes in funding and contractual arrangements was that providers reported finding themselves in an ethical double-bind whereby they were held accountable to provide culturally safe and responsive care under contractual conditions that made it increasingly difficult to do so.

### Discussion

The research presented in this paper provides new evidence on the contextual factors that support and hinder the implementation of government contracting with urban Indigenous NPOs as a mechanism for promoting equity and cultural safety in mental health care. Our analysis highlights the centrality of the local and wider socio-cultural, political, historical, economic, and institutional contexts in shaping government contracting in Indigenous mental health. Specifically, our findings suggest that taken-for-granted NPM-inspired policies and practices serve to reinforce, perpetuate, and obscure ideologically and historically mediated colonial relations with potentially harmful and unintended consequences for urban Indigenous NPOs, providers, and recipients of care.

As this study demonstrates, conceptualizing contracting in Indigenous mental health from such a cultural safety lens informed by a relational conception of social justice draws attention to the relational and ethical dimensions of contracting, and is useful for making linkages between Indigenous CPPs' experiences, and the micro, meso and macro structures, policies and practices of government contracting in Indigenous mental health. The findings described in this article fill an important gap in the literature concerning the lack of evidence on contracting in Indigenous mental health with the expressed purpose of enhancing equitable access to culturally safe care.

While there are analyses of the impact of neo-liberal reforms on contracting with the non-profit sector (Evans et al., 2005; Hasenfeld & Garrow, 2012; Smith & Smyth, 2010), few studies have considered the

intersections of neo-liberalism, racism, colonial power relations, and other axis of discrimination and their implications for contracting in Indigenous health care. This is especially true within the Canadian context, and in relation to mental health and urban Indigenous communities. Bringing a cultural safety and critical social justice lens to the analysis of contracting in Indigenous mental health broadens the analytical focus in ways that extend beyond the political economy of contracting and thus helps healthcare decision-makers and administrators in funding institutions to more fully understand the complexities embedded in contracting as reflected in the contradictory experiences of participants.

Participants' accounts reveal that rather than promoting contractual relationships based on mutual respect, responsibility, reciprocity, and local relevance, performance-based contracting promotes paternalistic relations of governance and a culture of compliance with performance measures. The normalization of performance-based accountability mechanisms pressures and, in some cases, might silence urban Indigenous providers and presumably clients, through its narrow focus on efficiency and cost-effectiveness. As a result, evidence of those aspects of care that made a difference in peoples' lives as well as those that placed Indigenous Peoples at continued risk of harm tend to remain largely unrecognized. For example, consistent with the literature on culturally safe and equity-oriented care involving Indigenous Peoples whose lives are shaped by structural inequities (Browne et al., 2015; Browne et al., 2016; Browne et al., 2012; Ford-Gilboe et al., 2018), CPPs emphasized the need to foster trust and long-term relationships with their clients, to provide care that is responsive to clients' self-identified priorities (e.g., ceremony, housing, or access to food) rather than those defined within their contracts, and to work with families and in community-based settings rather than providing individualized care during traditional office hours. Yet, contractually defined parameters, such as volume-based performance targets, short-term contracts, and cuts to administrative expenses and food budgets, often produced ethical practice tensions for providers who felt that they had to choose between their accountabilities to the clients and the funders. For example, long-term and trust-based provider-client relationships are central to culturally safe care (Browne et al., 2015; Browne et al., 2016; Smye et al., 2010), yet, ill-supported by short-term contractual arrangements.

The same body of literature (Browne et al., 2015; Browne et al., 2016) also highlights the need for flexible approaches to program delivery to ensure programs and care are responsive to the most salient and emerging needs and priorities of clients and communities. The impacts of recent events on Indigenous communities in Canada, such as the COVID-pandemic or the shocking discovery of the hundreds of unmarked and undocumented graves in BC and other former residential schools, serve to magnify the significance of supporting the capacity of Indigenous organizations to contextually adapt and tailor their programs and services. However, rather than enhancing organizational and program flexibility, CPPs' accounts highlight the extent to which neoliberal approaches to contracting obstruct Indigenous self-determination and ability to respond to communities' needs. Performance management practices and monitoring extend funders' and contract managers' regulatory power and reach far into the internal operations of urban Indigenous organizations. Increasingly stricter rules and regulations on how organizations are allowed to spend their funding, tight monitoring, along with efficiency-focused

performance targets have created a culture of compliance that serves to reinforce and perpetuate the embeddedness of assimilationist ethos. While further research is needed to more fully understand the role and effects of colonial beliefs and racism in shaping the uptake and implementation of contracting in Indigenous health, the findings of this study echo other research evidence (De Leeuw et al., 2010; McKenzie et al., 2016; Turpel-Lafond et al., 2021) of how colonial and racist assumptions and stereotypes about Indigenous inferiority and incapability continue to be (perhaps unwittingly) enacted within health care, including health care policy and funding. Considering the evidence of ongoing racism and historical mistrust that shape Indigenous-state relations, it was not surprising that several participants in this study interpreted funders' increased concern with monitoring and performance regulation as discriminatory and a continuation of paternalistic and colonial approaches to policy and health service administration.

Colonial power relationships and culturally unsafe conditions were also reinforced in more subtle ways through the embeddedness of a deep-seated ethnocentrism that was reflected in the dominant influence of biomedicine in shaping contractual arrangements in Indigenous mental health. Participants' accounts of the changes in funding, including funders' reluctance to cover costs that are not directly related to the delivery of the service being contracted out, as well as the increasingly fragmented nature of contracts, imply that biomedicine continues to serve as the dominant lens for funders when faced with the questions of what counts as care and what services they are willing to pay for (and which are considered expendable). The consequences of this "continued legacy of epistemic racism" (Allan & Smylie, 2015, p. 5) are evident in community-based provider participants' reports of the difficulty of finding adequate funding for comprehensive mental health programming, and, in particular, mental health program aspects that were culture-specific or oriented to address the social inequities shaping community members' everyday lives. In keeping with the literature (Browne et al., 2016; Fast et al., 2017; Graham et al., 2021; Rowan et al., 2014), integrating Indigenous knowledge and cultural practices into program design and delivery was considered an essential feature of culturally safe and equity-promoting health care involving Indigenous Peoples.

While many of the observed tensions are consistent with international literature (Chouinard & Milley, 2015; Lapuente & Van de Walle, 2020; Siltala, 2013), the findings take on a particular meaning within the wider historical, political, and social and local context shaping Indigenous health contracting in BC. As previously mentioned, Indigenous self-determination, racism, and ongoing colonialism are increasingly recognized as distal determinants of Indigenous mental health and wellbeing (Allan & Smylie, 2015; Fast et al., 2017; Greenwood et al., 2015; Greenwood et al., 2022). Indigenous Peoples have the right to exercise self-determination over health programs affecting them, and maintain and strengthen their own institutions, cultures, and approaches to healing (UNDRIP, 2007). BC is the first jurisdiction in Canada to formally adopt UNDRIP through legislation, and committing its government to work with Indigenous Peoples to align its institutions, laws, policies, and practices with Indigenous Peoples' rights to advance reconciliation and address the legacy and harms of colonialism. Bringing contracting in alignment with these rights is thus not only an ethical but also a legal imperative.

## Moving Towards Cultural Safety and Equity in Contracting

The evidence produced in this study is not meant to inform an argument against government contracting in Indigenous mental health; it does, however, underscore the urgency for structural and systemic change. While contracting has created opportunities for urban Indigenous communities to reclaim control over how mental health programs are designed and delivered, Indigenous NPOs and providers cannot fully operationalize their commitment to culturally safe and equity-oriented mental health programs and care without better alignment of contractual arrangements, policies, and funding environments. Further attention to the structural and cultural dimensions of contracting and the implications this has for Indigenous Peoples at individual, community and system-levels is therefore needed. While political neutrality is a purported core value of public administration (Chouinard & Milley, 2015), the findings of this study make it clear that administrative policies and practices cannot be deemed neutral technocratic processes but, rather, must be understood as social practices that both mediate and support historical power-laden relations within health care and beyond. By remaining impervious to how NPM approaches to contracting colludes with ongoing colonial policies and practices and forms of racism, government funders and health authorities will continue to unwittingly place Indigenous Peoples at harm, most notably through compounding access issues to mental health services for urban Indigenous Peoples. To mitigate these inequitable power relationships that permeate contractual relationships and ultimately relationships of care, we argue that contracting needs to be embedded in an administrative policy framework that is politicized and oriented to “hardwire” cultural safety and health equity through action at the micro, meso, and macro levels of the system. Bringing a macro-, meso-, and micro-level framework to contracting provides important considerations for how and where to intervene in the contracting process to create policy and funding environments and contractual approaches that are aligned with the principles of cultural safety and equity.

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