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Reconciling indigenous need with the urban welfare state? Evidence of culturally-appropriate services and spaces for Aboriginals in Winnipeg, Canada

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ABSTRACT

Despite the increasing urbanization of the Aboriginal population in Canada over the past 50 years, most municipalities have not developed services and programs designed to meet their unique social and cultural needs. Faced with numerous health and social problems, the Aboriginal population is mainly forced to rely on the non-Aboriginal social services sector. However, little is known about the extent to which such sectors seek to accommodate Aboriginal populations in their programming. We examine the extent to which the recovery system makes space for Aboriginal healing through the provision of culturally-appropriate services and programming. Through the use of 24 in-depth interviews with staff members at seven treatment facilities in Winnipeg (Canada), we find an entrenched reluctance, indifference and lack of desire to create Aboriginal spaces of healing in treatment, save for one facility where Aboriginal healing spaces serve as a focal point of treatment. We discuss the implications in terms of the effectiveness of the non-Aboriginal recovery system (along with other social services) in meeting the needs of Canada's urban Aboriginal population.

1. Introduction

According to the 2006 Census of Canada, over 1 million people self-identified as Aboriginal[1] (representing 3.8% of Canada's total population) (Canada, 2008). The Canadian Aboriginal population is usually classified as residing on-reserve (i.e., living on land set aside by the Crown[2]) or off-reserve (i.e., in urban or rural locations). Since the 1960s, the Canadian Aboriginal population has extensively urbanized. While much of the writing on the Aboriginal population is focused on the reserve-based population, the dramatic reserve-to-urban demographic shift eventually engendered a burgeoning literature on the experience of urban Aboriginal peoples (Anderson and Spence, 2008; Benoit et al., 2003, 2005; Cardinal, 2006; Holmes et al., 2002; Klos, 1997; Peters, 2000, 2005a,b; Skelton, 2002; Walker, 2003, 2006). This resonates with indigenous urbanization in other settler societies, including New Zealand (Barcham, 1998; Kearns et al., 2009; O'Connor, 2007) and Australia (Byrne and Houston, 2005; Paradies and Cunningham, 2009).

Despite the increase in size and scope of this body of research, very little attention has been directed towards the degree to which non-Aboriginal social services are responding to and coping with the (relatively recent) surge in urban Aboriginal populations. This is an important area of investigation, for several reasons. As Peters (2000) notes, most municipal and provincial governments have not developed Aboriginal-specific policies and programs in Canada (see also Barcham, 1998). As a result, urban Aboriginals are frequently forced to use the non-Aboriginal social service system where their special status, cultural beliefs and traditions may, or may not, be acknowledged (e.g. Walker, 2006). Moreover, this tension has a parallel geographical expression, in terms of the degree to which non-Aboriginal social services are "making space" for Aboriginal needs in urban settings.

In this paper, we seek to investigate the process of *reconciling* Aboriginal special status with the realities of non-Aboriginal urban welfare states. We frame our investigation through the concept of "culturally-appropriate services", which Trudeau (2008, p. 682) defines as "services that create a social environment that observes and respects the cultural beliefs and practices of the individual receiving services". We apply this concept to the creation of

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[1] In Canada, the term 'Aboriginal' is used to refer to the descendants of the original inhabitants of Canada. The Constitution Act of Canada (1982) recognizes three broad Aboriginal identity groups: North American Indians (i.e., First Nations peoples), Métis, and Inuit (Canada, 1982). Each group is distinct in their histories and relationships to the nation state; moreover, each group can be further subdivided into tribes and so forth (see also Cardinal, 2006).

[2] The Canadian Federal government provides services and programs to 'Registered Indians' (those registered under the Indian Act of Canada – also referred to as 'status Indians') residing on reserves but assumes little or no responsibility for the urban Aboriginal population. In fact, only a few Federal services (e.g., non-insured health benefits) are provided to Registered Indians living off reserve.

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cultural spaces for urban Aboriginals within non-Aboriginal social service systems–in this case, the addiction treatment system, which is designed to manage and treat substance abusers (DeVerteuil and Wilton, 2008). Through the use of in-depth interviews with staff members at seven treatment facilities in Winnipeg (Manitoba), we tease out the extent to which programs are making space for Aboriginal clientele by providing services in a culturally-appropriate manner. We find a deep reluctance, indifference and lack of explicit accommodation/creation of Aboriginal spaces across most services, save for one facility where Aboriginal healing spaces have thrived. We pay particular attention to this sole facility, tracing its accommodation to its Aboriginal clients culturally and spatially, and we suggest the need for the emergence of hybrid institutions that combine Aboriginal needs with mainstream capacities.

2. Culture/place/health and indigeneity

Our investigation draws inspiration from recent research on the intersections of culture, place and health (Gesler and Kearns, 2002; Jayne et al., 2008; Kearns 1993). In particular, the cultural turn in medical geography yielded a paradigm shift from quantitative, location-based studies of disease diffusion and the spatial distribution of health care to qualitative examinations of place (see Kearns, 1993). This shift was associated with "increasing interest in the way cultural beliefs and practices structure the sites of health experience and health care provision" (Gesler and Kearns, 2002, p. 1). The importance of culture for understanding the links between health and place has been made especially evident through the emergence of the therapeutic landscapes concept. Positioned between the new cultural geography and health geography, Gesler (1991, p. 84) defined therapeutic landscapes as those places that have "an enduring reputation for achieving physical, mental, and spiritual healing". Gesler stressed that adopting ideas from cultural geography (e.g. sense of place, symbolic landscape) would enable in-depth investigations of places as sites of meaning and further understanding of how the "healing process works itself out in places (or situations, locales, settings and milieus") (Gesler, 1992, p. 743). Since its introduction almost 20 years ago the concept of therapeutic landscapes has been applied to demonstrate the healing properties of places such as nature, parks and wilderness areas (Conradson, 2005; Hall and Page, 2002), spas (Geores 1998; Gesler, 1998) and sites of formal health care delivery (e.g., hospitals and treatment centres) (Andrews, 2004; Andrews et al., 2005).

In terms of indigenous[3] health, a small but growing area of research has demonstrated that sites of health and healing hold specific meaning for the health of indigenous populations. Research has demonstrated that physical, symbolic and spiritual connections to the land/nature support indigenous health in a number of important ways (e.g., provision of traditional food and medicines, traditional healing practices such as the sweat lodge[4]) (Gone, 2008; Panelli and Tipa, 2008, 2007; Schiff and Moore, 2006; Wilson, 2003). Exploring the interconnectedness of culture, health and place also reveals that cultural differences in health status and health care experiences exist within and between populations and places. In this vein, research by Adelson (2005) and Ring and Brown (2003) has demonstrated the existence of health disparities between indigenous and non-indigenous populations worldwide. The literature points to a strong link between health inequalities and the ongoing effects of colonization, including loss of land, culture and language along with persistent socioeconomic and political marginalization (Chandler and Lalonde, 1998; King et al., 2009; Adelson, 2005; Smylie, 2001). While the impacts of colonization vary across places and cultures, as King et al. (2009, p. 76) note, "the principles are the same. Indigenous health inequalities arise from general socioeconomic factors in combination with culturally and historically specific factors particular to the peoples affected."

As such, indigenous claims for healthy environments that respect their culture must necessarily operate within a larger system of race and racism, a developing area of interest within culture, place and health (Kearns et al., 2009; Krieger, 2003; O'Connor, 2007). The colonization, containment and exclusion of indigenous peoples in most settler societies – in the form of dispossession from traditional territories, suppression of cultural beliefs and practices, the creation of isolated reserves, chaining benefits to reservation status (in Canada for instance), and high levels of segregation in most cities – have resulted in a host of persistent social, economic and health inequalities (Kearns et al., 2009). This has also resulted in the alienation of indigenous cultural conceptions, spirituality and spaces from mainstream society, a fact reflected in discriminatory institutional practices across health, educational, legal and criminal justice systems in settler societies such as Australia, Canada and New Zealand (O'Connor, 2007; Paradies and Cunningham, 2009). One way to capture the range of discrimination is to articulate the concept of "white privilege", which refers to the advantages that whites enjoy through the largely unquestioned "whiteness" that pervades settler society, including their naturalized ability to exclude racialized others from prime spaces (Wilton, 2002). White privilege can therefore exclude, even unknowingly and without intent, certain cultural practices among indigenous populations. That said, little attention has focused on indigenous encounters with institutional spaces and the extent to which such spaces may constitute landscapes of healing that incorporate culturally-appropriate beliefs and traditions.

3. Indigeneity and culturally-appropriate services/spaces

We can frame indigenous encounters with non-indigenous institutional spaces through the concept of "culturally-appropriate services". While a complex term, as noted above, we employ Trudeau's (2008, p. 682) definition of culturally-appropriate services as those "that create a social environment that observes and respects the cultural beliefs and practices of the individual receiving services." While drawing inspiration from the therapeutic landscape concept, culturally-appropriate services are an apt vehicle to explore culture, place and health at the institutional level, thereby linking to the increased decentralization of primary health services and avoiding the rather individualistic accounts of experiencing therapeutic landscapes. With respect to indigenous health, culturally-appropriate services may incorporate a number of factors including language, traditional healers, elders, traditional healing practices (e.g., sweat lodges or healing circles among some groups in Canada) and an understanding of the impact of colonialism on health (see Browne, 2007; Bucharski et al., 2006; Smylie, 2001). It has been argued that the creation of culturally-appropriate services, especially as they pertain to indigenous health and well-being, is key to ensuring both the relevance and effectiveness of any service provided (Giger and Davidhizar, 2007; Poonwassie and Charter, 2001; Wilson, 2008).

In the context of substance abuse treatment, anthropological work has documented the beneficial role of indigenous healing practices (Waldram et al., 2006). However, some leading researchers

[3] Indigenous is used in this paper as a broader term that refers to indigenous populations worldwide.

[4] A sweat lodge is a dome-like structure, which is often constructed using saplings or long, thin branches. In the middle of the sweat lodge there is pit in which heated rocks are placed. Sweat lodges have multiple functions and are used for prayer, healing and overcoming social problems, such as, alcoholism and drug addictions (see Waldram, 1993, 1997).