The Wharerata Declaration – the development of indigenous leaders in mental health

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This article has been written on behalf of the International Initiative for Mental Health Leadership (IIMHL). The IIMHL is a 'virtual' membership agency that works to improve mental health services by supporting innovative leadership processes: www.iimhl.com. The IIMHL contributes an article to every issue of *The International Journal of Leadership in Public Services*.

Abstract
Indigenous populations and communities around the world confront historical, cultural, socioeconomic and forced geographic limitations that have profound impacts on mental wellness. The impacts of colonialism and, for some indigenous populations, forced residential schooling and the resulting loss of culture and family ties, have contributed to higher risks of mental illness in these groups. In addition, there are barriers to healing and mental wellness, including inconsistent cultural competence of mainstream mental health professionals, coupled with the limited numbers of indigenous mental health professionals. The Wharerata Declaration is a proposed framework to improve indigenous mental health through state-supported development of indigenous mental health leaders, based on a new indigenous leadership framework. Developed by the Wharerata Group (original membership noted in the acknowledgements section at the end of this article), the framework will be presented for support to the member countries of the International Initiative for Mental Health Leadership (IIMHL) in 2010.

Key words
Indigenous; aboriginal; First Nations; Inuit; Maori; mental health; leadership; cultural competence.

10.5042/ijlps.2010.0275

Introduction

Almost 400 million indigenous people reside across the inhabited continents of Earth. Some are easily identified, such as the First Nations and Inuit in Canada, the American Indians and Alaska Natives in the United States, the Maori in New Zealand, and the Aboriginals in Australia. Some indigenous peoples are less visible, and some are not officially recognised by the governments of their countries. Indigenous people come from thousands of cultures and are over-represented among the poor and disadvantaged. Overall, their health compares unfavourably with their non-indigenous counterparts (Gracey & King, 2009). A generally agreed upon definition of indigenous peoples has been set by the United Nations:

> *'communities, peoples and nations… …which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or part of them. At present they form non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as a basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.'* (United Nations Permanent Forum on Indigenous Issues, 2004)

Indigeneity encompasses the diversity of indigenous groups and cultures, as well as their similarities.

- Indigenous peoples share a longstanding and enduring relationship with the natural environment, such as the 14,000 years of history for First Nations in the northwest of Canada, and 50,000 years for Aboriginal Australians.
- Indigenous peoples have distinctive languages, such as Inuktitut for the Inuit in Canada's north, and nine large language families in the United States plus a number of smaller distinctive languages.
- Indigenous peoples share a worldview that is derived from ecological associations and are spiritually-based. Indigenous peoples commonly have sacred stories and traditions that have been passed down for generations and which tie their culture to the land.
- Indigenous peoples share experiences that threaten their language, land, customs and social organisation. Colonialist governments have sometimes ignored indigenous peoples' rights, including the right to practice their own culture or raise their children within their culture.
- Indigenous peoples share a determination to survive and prosper as indigenous peoples – and as global citizens.
- Indigenous peoples share an aspiration that indigenous families and communities should have optimal health and well-being.

Indigenous perspectives and definitions of health are often different than the mainstream or Western definitions.

> *'Western definitions are exemplified through the disciplines of psychology, social work and psychiatry, and which tend to focus on pathology, dysfunction or coping behaviours that are rooted in the individual person. Aboriginal mental health is relational; strength and security are derived from family and community. Aboriginal traditions, laws and customs are the practical application of the philosophy and values of the group. The value of wholeness speaks to the totality of creation – the group as opposed to the individual.'* (Little Bear, 2000)

Unfortunately, indigenous peoples continue to face the challenge of retaining their indigeneity in the face of racism in the current day. Yet the resiliency of indigenous peoples, rooted in culture and community, has carried them through tremendous challenges throughout history. This strength continues to form the basis of community wellness and well-being (Durie, 2001). Despite this history, Indigenous culture and community cohesion are commonly overlooked health determinants in mental health practice, research, and policy development.

Mental wellness challenges

Data regarding the mental health and well-being of indigenous peoples is lacking, partly

because of challenges in the identification of indigenous clients, mistrust of mainstream mental health, frequent absence of culturally competent care, and lack of access to indigenous healing options and services. Despite an absence of large-scale data, such as found in census or surveys, indigenous peoples indisputably face higher risks of mental illness.

According to the Te Rau Hinengaro (New Zealand Mental Health Survey), Pacific peoples in New Zealand (NZ) experience mental illness at higher levels than the general population: 25% compared with 21% of the overall NZ population, and close to half had experienced a mental illness at some stage during their lifetime (Oakley & Wells, 2006). Research has found that First Nations people living on reserve face higher rates of depression by 1.5 times, and suicide rates of five to six times higher (Mood Disorders Society of Canada, 2009). Surveys suggest that Aboriginal people are more likely than other Canadians to seek help for mental health problems: whereas eight per cent of all Canadians had consulted a mental health professional in the previous year, in some First Nations groups the proportion seeking help was as high as 17% and would probably have been even higher if more mental health professionals were available in northern and isolated areas (Government of Canada, 2006). Data on mental health challenges has also been collected for American Indians and Alaskan Natives, and driven by extraordinarily high levels of exposure to trauma, the rates of post-traumatic stress disorder are three to four times higher than that of national comparators (Manson *et al*, 2005). It is not surprising, then, that in many tribes alcohol abuse and/ or dependence and suicide risk far exceed national norms (Beals *et al*, 2003; LeMaster *et al*, 2004).

Culturally adapted approaches to mental health and wellness are based in cultural identity and spirituality as the primary framework for treatment approaches, aimed at restoring balance of the individual with family and community. Because this framework emphasises indigenous values (spirituality, cultural identity as a source of strength, family and community), many believe the ensuing therapeutic work to be more effective than conventional approaches, which typically emphasise 'illness' and 'individuality' without regard for the broader social and cultural determinants of health.

While there are instances where indigenous peoples may choose to rely solely on indigenous mental wellness interventions and support, there are also instances where indigenous peoples choose to access mainstream mental health services (Gurley *et al*, 2001; Novins *et al*, 2004). This experience is not always positive for the indigenous client. The most significant mental health challenge is the potential conflict between indigenous worldviews and western worldviews. The legacy of colonialism, such as forced residential schools, is a heavy burden. But indigenous peoples may continue to face intentional or unintentional racism in everyday life, and may also encounter a lack of cultural competence in the mental health system. Indigenous peoples may still face inequitable response from the mental health system, ranging from a lack of respect for the client's culture, to lower rate of referrals, to disproportionately higher rates of diagnoses for more severe mental illness. The conflict between indigenous cultures and mainstream cultures continue to play out in the field of mental health, to the detriment of indigenous clients. The Wharerata Declaration sets out two complementary approaches to address this: supportive learning environments for mainstream mental health practitioners and leaders to strengthen indigenous cultural competency, and state supports for the development of indigenous mental health leaders and policy-makers.

The holistic nature of indigenous approaches is fundamental to practice and theory. The concept of holism would appear on the surface to be similar to other mainstream constructs. But indigenous languages offer a unique vehicle for communicating an understanding of indigenous worldviews on concepts of health and mental health. As we attempt to link indigenous concepts of health with western paradigms, there is always a risk of parsing or breaking down the indigenous construct into manageable parts, which better aligns to a western paradigm. In retaining the holism intrinsic to indigenous perspectives, we hope to communicate the points of compatibility between indigenous knowledge and western thought. For example, 'Le Va' is an indigenous Pacific Island term

that articulates an understanding of the 'space that relates' or often referred to as the negotiated space that exists between relationships (Mila-Schaff, 2009), and is used in treatment and support as a fundamental way to reconnect those suffering mental distress to relationships with others. This example is one of many that unveils the differences between cultural views on individualism and collectivism.

Wharerata is not about a minority approach to cultural safety. The Wharerata Declaration defines best practice for mental health practice and leadership as the strategic use of both indigenous cultural and clinical approaches in structure, process and outcome. We advocate that it is time that the mental health system meets indigenous clients on indigenous ground, and makes intentional space for indigeneity.

The Wharerata Declaration

The Wharerata Declaration was prepared by the Indigenous Leadership Group, assembled and supported by the International Initiative for Mental Health Leadership (IIMHL) in February 2009; the authors are referred to as the Wharerata Group. The Group met in the Wharerata building at Massey University in New Zealand, and included indigenous mental health practitioners and leaders from Canada, the US, Australia, Samoa, and New Zealand.

As presentations were given and discussions unfolded, four common challenges emerged. First, the mental health status of indigenous peoples lags behind non-indigenous populations. Second, indigenous perspectives and ways of healing are not always afforded equity in mainstream mental health systems of care. Third, indigenous mental health human resources are greatly under-represented throughout these systems (from practitioners to policy development). Finally, the influence of indigenous peoples with their representative countries' governments is inconsistent. The emerging consensus was that the development of indigenous mental health leadership naturally offers a foundation by which to address these four challenges (Durie, 2001).

The result was the Wharerata Declaration, a model to frame and advance indigenous mental health leadership in the IIMHL countries. While the Declaration specifies mental health, the Group believes that the principles also apply to the broader field of health.

> The word ***Wharerata*** is Maori in origin and was used as a name for one of the University's original buildings. *Whare* translates to 'house', and Rata translates to 'a tree with bright red flowers and a large canopy'. *Whare rata* is 'a house of wisdom and understanding, a house of shelter and protection'.

In health and mental health, indigenous perspectives are worthy not only of inclusion, but they also add value to western and medical perspectives. Indigenous perspectives on health are properly conveyed by indigenous practitioners and leaders. The creation of a cadre of indigenous health leaders is essential for inclusive conversations on health as well as culturally competent health indicators, and is essential to closing the gap in indigenous mental health (Durie, 2001; 1999).

Developing indigenous leaders necessarily differs from more conventional approaches to preparing mainstream health leaders. Business models are plentiful in leadership development theory, but none enshrine culture and community as essential components to build and sustain the indigenous leader.

The Wharerata Declaration articulates five themes for balancing indigenous and mainstream approaches to develop indigenous mental health leaders. These themes revolve around the following:

1. Indigeneity
2. Best practice
3. Best evidence
4. Informed, credible, strategic, connected, sustainable leadership
5. Influential and networked leadership.

Theme 1 – Indigeneity

Certain values and perspectives about life and health are shared by all indigenous peoples. Indigenous cultures retain sophisticated systems of healing and well-being developed prior to contact with colonising bodies.

> *'Aboriginal ideas about the body, disease, and medicine, then, were not just remnants of some pre-contact past but were living ways of viewing the world, ways of viewing that contested the colonizing discourse of Western medicine as it came to be articulated… …during the first half of the twentieth century. Through their very presence,*

Aboriginal conceptions of the body disrupted the intended medical dialogue of non-Native doctors and missionaries and forced, instead, a terse, discordant dialogue.' (Kelm, 1998)

Indigenous health and mental health are specialised areas of practice. Indigenous peoples understand that culture is inherently bound to complex social and community relationships, which include health and well-being. Given differences in health definitions, one incorporating culture and one not, it is not unreasonable to expect practitioners to include cultural competence and safety among the services provided to indigenous clients. There is a growing understanding that cultural competence takes us far beyond a simple awareness or acknowledgement of differences of 'other' cultures, even beyond recognising the importance of respecting differences. The concept has evolved to include the skills, knowledge and attitudes of practitioners (Indigenous Physicians Association of Canada & Association of Faculties of Medicine in Canada, 2009). Cultural safety is an intentional construct that acknowledges the experience of the patient as the evaluator of the degree of safety provided by the practitioner.

The development of culturally safe or culturally competent mental health practice is a lifelong journey. There are standards of cultural competence, one being Canada's First Nations, Inuit and Métis Cultural Competence Standards for Physicians and Psychiatrists by the Indigenous Physicians Association of Canada. Opportunities for learning more about cultures and how they relate to mental health are encouraged at community, academic, programme development and policy levels.

Theme 2 – Best practice

Mainstream or clinical practice has a major focus on the change within the individual, with a focus on psychological and biological dimensions, so treatment and care are primarily structured around individual patients, often on the premise that bio-medical perspectives are sufficient for the process of recovery. Yet there is growing recognition that culture and cultural approaches are achieving results, so the question then becomes: how do we combine clinical and cultural approaches in a meaningful and respectful manner?

If mental health systems are to improve the well-being of indigenous peoples, then we must strengthen understanding of indigenous perspectives as equally relevant as clinical perspectives, and recognise both the similarities and differences. For example, when using an indigenous values-based health outcomes perspective, it would be important to measure outcomes such as:

- has the intervention enhanced the individual's *relationship with their family?*
- has it enhanced their capacity to function as *part of their community?*
- have their *spiritual beliefs been considered* as part of the outcome assessment process?
- has the relationship between their *physical health and mental well-being* been considered?
- has the intervention considered their *cultural needs?*
- has the intervention process and outcome increased a *well-ness* orientation?

The Wharerata Declaration asserts the combination of cultural and clinical approaches as the best practice. Indigenous and clinical perspectives together have cumulative benefits that outweigh those deriving from a single track. A combined approach that explores the biological and psychological functioning of an individual, and at the same time locates the individual within the broader landscape, is the heart of an indigenous contribution to best practice. There is responsibility for both indigenous and mainstream practitioners to come together to find common ground and best practice.

Theme 3 – Best evidence

Evidence in mainstream health and mental health tends to be based in a positivistic approach, which sets out that '*phenomena are separate, self-contained, simple, and homogeneous*' (Ratner, 2006). Many factors restrict the inclusion of indigenous knowledge into the accepted body of knowledge in mental health. The holistic nature of indigenous knowledge almost defies a positivistic approach, and therefore is less likely to be published in peer-reviewed journals. Indigenous world views emphasise an ecological perspective that locates wellness and

Table 1: Comparison of indigenous and mainstream assessments of intervention (Kelm, 1998)

Inclusive of indigenous perspective	Clinical/mainstream
As a result of the intervention do you feel:	As a result of the intervention are you:
a) more valued as a person	a) more able to set goals for yourself
b) stronger in yourself as a Maori	b) more able to think, feel and act in a positive manner
c) more content within yourself	c) more able to manage unwelcome thoughts and feelings
d) healthier from a spiritual point of view	d) more able to understand how to deal with your health problem

illness within a broad landscape of spiritual, social, economic, customary and environmental dimensions. Following the point that best practice combines both cultural and clinical approaches, then how is evidence collected that upholds a culturally competent approach?

The Wharerata asserts that best evidence is based within the intervention – if the intervention is clinical, then the assessment or evidence should also be based in clinical perspectives. If the intervention is cultural, then the evidence of success should also be based in cultural perspectives. The sourcing of evidence from one epistemology to assess the other does not follow cultural competence standards. Determining outcomes is not solely about resolving the symptoms of an individual – there are broader changes based on the holistic health definition that should also accrue from programmes and services:

- functional outcomes: family functioning, a capacity to work, involvement in tribal or community life, and a sense of contentment are relevant to health gain
- clinical outcomes: personal insight, the absence of psychopathology, and sound reality testing are also markers of health gain
- indigenous research increasingly points to advantages accruing from traditional healing and cultural affirmation.

The combination of evidence and measures of success from clinical and cultural perspectives opens the door to an inclusive perspective on the inputs and products of change for the individual and community. A holistic approach to evidence is inclusive of the wider array of societal variables, including the supports or systems that surround an individual and community (see ***Figure 1,*** opposite). If 'it takes a village to raise a child', then it possibly takes the village to measure a child's success.

Theme 4 – Indigenous leadership

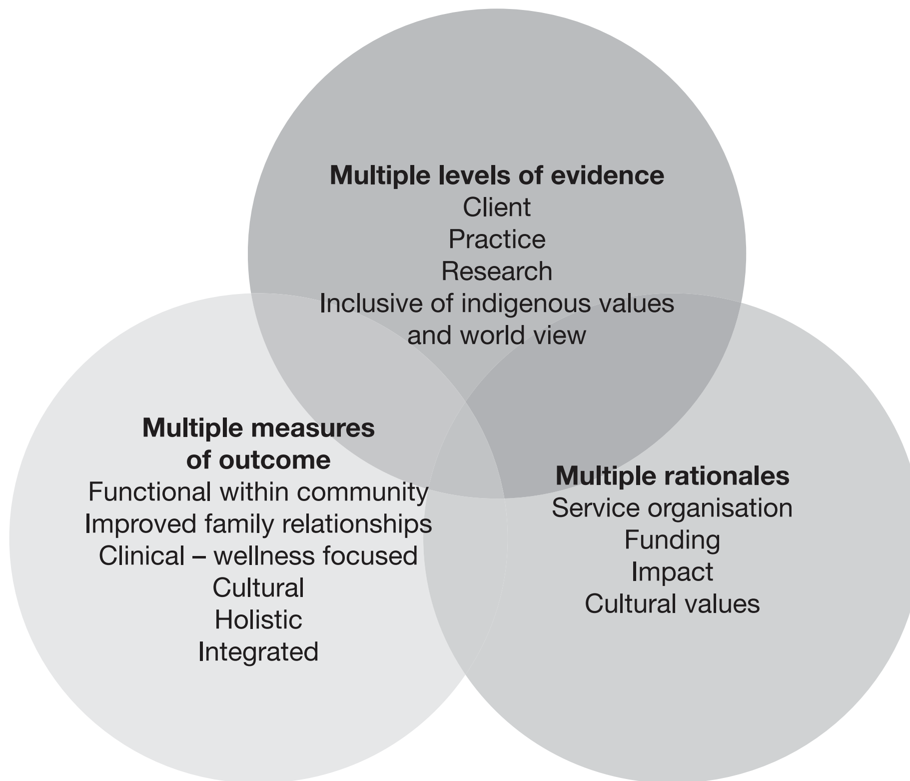
The Wharerata Group discussed possible reasons why there are so few indigenous leaders in mental health, and considered that the training programmes for leadership and mental health may not be inclusive of indigenous perspectives. Currently, most literature and discussions on leadership within health are based on corporate business models. There are few, if any, that examine this issue from an indigenous framework. However, most Maori organisations would agree that the following saying is one of the better indications of the core values of tribal leadership.

> *'Taku ate hoki ra,taku rata tutahi, taku whakamarumaru, taku whare kii tonu, taku tiketike ka riro, unuhia noatia te taniwha i te rua.'*
>
> *'You were my heart, my solitary rata tree, my sheltering place, my house of plenty, my elevated one now departed, withdrawn now is the dragon from its lair.'*

In this chant a leader is compared to a large tree in a forest that provides protection and sustenance for the community.

The practical application of best practice requires representation of, and participation

Figure 1: Best practice and best evidence



by, indigenous mental health practitioners and leaders throughout the mental health system, especially within policy areas. It is equally important that indigenous peoples share their world views and perspectives on mental health and culture, as this role cannot be given over to non-indigenous people.

The World Health Organization asserts that

> '*community empowerment is a major structural driver of health inequities when talking about indigenous communities. Health equity depends vitally on the empowerment of individuals and groups to represent their needs and interests strongly and effectively and, in so doing, to challenge and change the unfair and steeply graded distribution of social resources. Inequity in power interacts across four main dimensions – political, economic, social, and cultural – together constituting a continuum along which groups are, to varying degrees, excluded or included*' (World Health Organization & Commission on Social Determinants of Health, 2009).

The Wharerata is a strong declaration that the development of indigenous leaders must be supported by states as one of the five ways in which to address positive change for indigenous mental health. This needs to be accomplished by respecting unique indigenous leadership theories and perspectives.

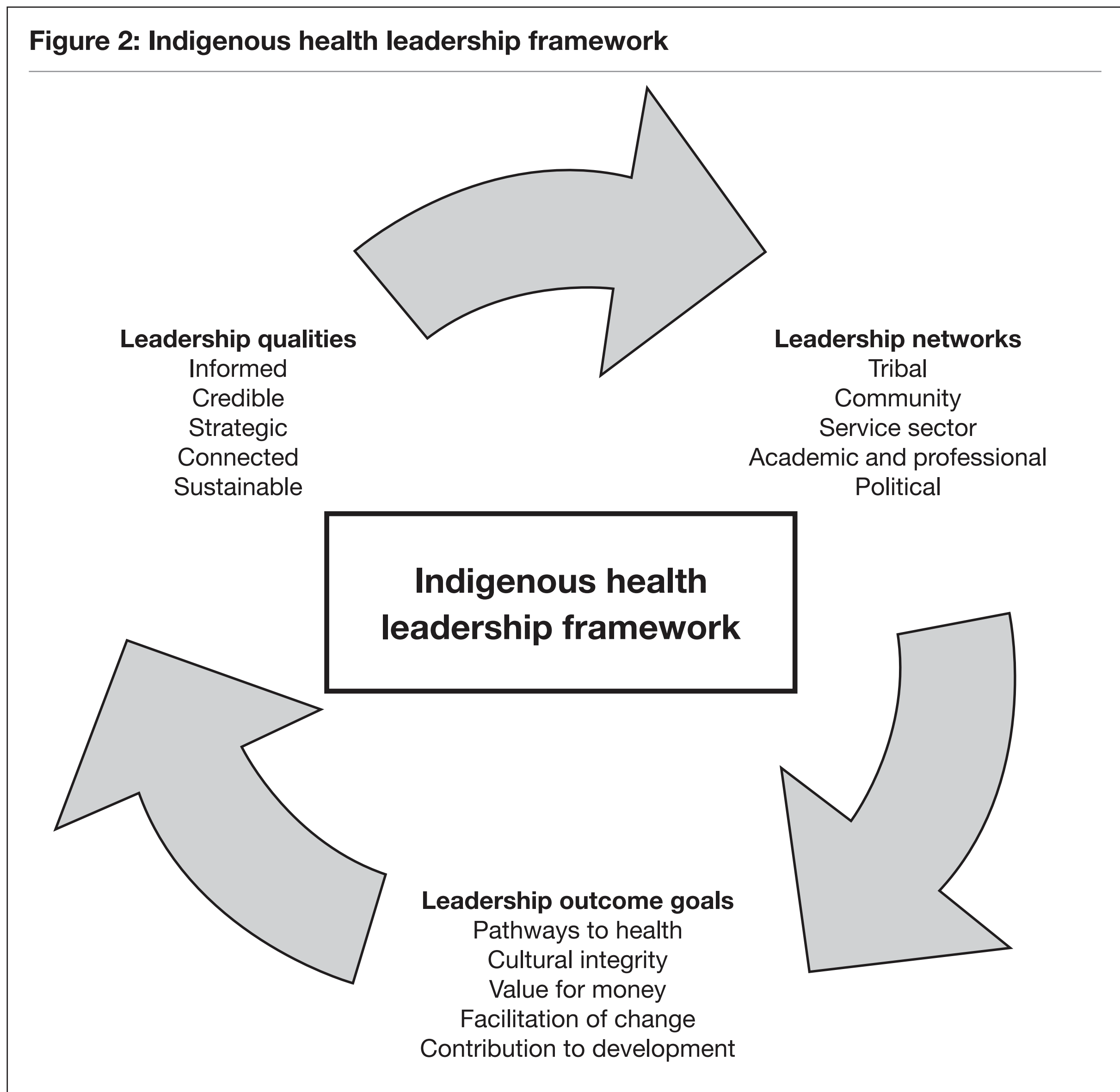
Indigenous mental health leaders must develop and maintain credibility from indigenous community; from mainstream peers; and are expected to advocate and effect change on a systems level.

The three domains of indigenous leadership are each characterised by five qualities, some of which are similar to mainstream leadership development theory, however some qualities are uniquely indigenous (see ***Figure 2***, overleaf).

Leadership qualities

1. **Informed** by both conventional wisdom and new knowledge
   - able to move between disciplines to uphold the principle of holistic health (such as addictions and mental

Figure 2: Indigenous health leadership framework



health, qualitative and quantitative data, etc)
- able to work at the interface between indigenous and mainstream worldviews
- comfortable with ambiguity and the unknown
- able to use and select appropriate language and vocabulary for the audience in order to build bridges, without risking integrity or reputation – an indigenous leader chooses the appropriate communication style to talk to his or her own community, mainstream funders, and the country's elected officials.

2. **Credible** leadership that enhances the leader's influence
- credibility within indigenous circles
- credibility within peers in the mainstream mental health system and health sector
- personal credibility – values such as integrity, creativity, self-reflection, humour, empathy, vision, capacity to care for others.

3. **Strategic** leadership is future-oriented
- creative leadership is able to move beyond convention and status quo in order to advance the cause, and is able to bring others with them

- able to facilitate and empower others
- able to promote consensus through skilled negotiation, for immediate and longer-term goals.

4. **Connected** leaders maintain their network, 'He toa takitini'

- tribal and community connections
- sector connections in health and professional peers
- policy and government connections
- part of a leadership network.

5. **Sustainable** leaders maintain work–life balance in order to protect their own contribution and relevance

- maintenance of supportive operating environment – social, work, family
- intentional planning for career succession pathways
- access opportunities for ongoing training
- awareness of, and contributing to, wider development goals of tribes, of communities.

Effective leadership encompasses all of the above, yet without influence there will be little impact on the mental health system and outcomes for indigenous clients and communities. Therefore, the Wharerata Declaration places unique value on the next dimension of 'influence'.

Theme 5 – Influence

Leadership is about the ability to influence change, and to raise awareness of indigenous health perspectives in such areas as: mental health development, political purchase, contracting for outcomes, population health, primary mental health care, relationships and boundaries, and workforce development initiatives. Indigenous leaders have visible and active networks, through which change can be influenced: tribal and indigenous communities, service sector, professional peers, and the political realm.

Influence is particularly important for indigenous mental health to overcome the historic invisibility of indigenous peoples, perspectives and holistic health. Mental health systems themselves are sometimes the barrier to mental wellness for indigenous peoples, so the ability to influence a wide variety of government policy-makers and service providers is a critical skillset.

Conclusion

Mason Durie (2001) wrote that

> *'often Maori [and indigenous] health is best understood, and improved, by targeting the lifestyles and dilemmas that face people in the course of their day-to-day encounters. The task then is to build strong foundations so that the demands of an unfriendly environment and the scars of unkind relationships can be softened, and the opportunities to be well can be enhanced'.*

The challenge facing us all is the reality that indigenous peoples continue to suffer from higher rates of mental illness than non-indigenous populations, and for some indigenous populations the rates are still increasing. The Wharerata Declaration, along with national initiatives to support mental wellness in indigenous communities, could contribute to a shift in momentum. The Wharerata Group envisions a world in which indigenous mental health is achieved.

- The negative effects of colonialism and residential schools are reversed, and indigenous people have renewed pride in their culture and their ability to succeed in wider society, and have visibility as contributing members in their countries.
- Mental health and addictions services and training programmes purposefully make space for cultural approaches to mental health, collaborate towards dual competency of clinical and cultural approaches and successfully build relationship with indigenous individuals and communities.
- Indigenous mental health leaders take their place alongside non-indigenous leaders, and together contribute to both indigenous and mainstream mental health systems.
- Indigenous people achieve mental wellness similar to their non-indigenous counterparts, and given the historical strengths of culture and social cohesion, may actually achieve more than parity.

This is a collective vision, one that requires a collaborative approach involving a number of partners, including community, providers and

government. But, like all collective action, it starts with individuals, and this vision starts with mental health leaders using their influence and networks to contribute to positive indigenous mental health, locally, regionally and nationally.

What are the next steps?

The Wharerata Group is currently building support for the Declaration in their respective IIMHL countries and indigenous peoples. The Declaration will be presented for support by all IIMHL countries at the IIMHL 2010 conference in Ireland. After that, IIMHL countries will be encouraged to find ways to resource and support implementation of the Declaration, specifically around the development of cultural competence in mainstream mental health systems, and to increase indigenous mental health leadership in policy and practice. We recommend that each country negotiate the target numbers of indigenous leaders to develop within a set time period with its respective indigenous groups.

> *The Wharerata Declaration is an organic document, and intended to be as inclusive as possible of indigenous perspectives. The Wharerata Declaration represents an additional tool to be used by indigenous groups in building their influence in their local mental health systems. Nothing in this plan should be interpreted as binding on indigenous groups, or restricting indigenous groups' work within their respective countries.*

Implications for leadership in practice

- The Wharerata Declaration is intended to spark discussion on the real-world application of the principle of best practice within the mainstream mental health field. Please join in the discussions on the Wharerata online home at www.indigenous-mental-health.ca, and share your thoughts on the Declaration.
- Develop your own knowledge of indigenous cultures, and your country's mental health system, and consider how to build bridges between the two.
- Share the vision of mental health in indigenous communities, and for indigenous peoples around the world.
- Consider how you can use your networks to build support for the Wharerata Declaration.

Acknowledgements

The original membership of the Wharerata Group is listed below.
Sir Mason Durie – Maori, Professor at Massey University, New Zealand
Ray Watson – Maori, Commissioner at the Mental Health Commission, New Zealand
Carole Maraku – Maori, Te Upoko o Te Rae, New Zealand
Dr Rees Tapsell – Maori, Director of Midland Forensic Mental Health Services, New Zealand
Dr Te Kani Kingi – Maori, Director of Academy of Maori Research, New Zealand
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