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Community Wellness and Control in the Canadian Arctic: Collective Agency as Subjective Well-Being

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In the 1970s, following decades of outside influence and intrusion, Inuit in Canada began a social movement toward reclaiming their land and forming an independent political territory. The years 1993 saw the establishment of an Inuit land claim agreement and 1999 a new territorial government in the eastern Canadian Arctic called Nunavut, or “our land” in Inuktitut. The effects of colonialism run deep, however, and social problems continue to take a toll on Inuit well-being. These problems include poverty, drug and alcohol abuse, domestic violence, and suicide (Bjerregaad & Young, 1998; Burkhard 2004; Griffiths, Wood, Zellerer, & Saville, 1995; Haggarty et al., 2000; Kirmayer, Fletcher, & Boothroyd, 1998). Injuries accounted for about 30% of all deaths in Nunavut in the 1990s, and most of these deaths were by suicide (Injury Surveillance Online 2004). The suicide rate among young Inuit between the ages of 15-24 has been increasing dramatically in Nunavut since the 1980s, bringing the total rate across all ages to 122.5 per 100,000 for 1999-2003 (Nunavut Bureau of Statistics, 2003) – ten times the rate for Canada. In Nunavik of northern Quebec this rate is even higher (Boothroyd, Kirmayer, Spreng, Malus, & Hodgins, 2001).

These social problems are a sad pattern existing among many indigenous peoples who have been colonized and have experienced much upheaval in their lives in recent decades. In some countries such as Canada, governments have made efforts to ameliorate this suffering. Although well-intentioned, many such efforts take the form and function of the dominant, colonizing society with little substantive involvement in their development by the indigenous communities so served. In this chapter, we review community wellness programs, policies, and actions among the Inuit in Nunavut. We examine in particular differences between approaches to wellness and mental health from outside versus inside Inuit communities, and argue for an urgent need to continue support for the latter.

A Brief Colonial History

Nunavut has had humans living on the land for over four thousand years. The Inuit stem from the Thule people (about 1000 years ago), who replaced or absorbed the Dorset (about 2,500 – 1,200 years ago) who followed the Pre-Dorset (about 4,500 years ago). Inuit oral history describes finding a people they call the *Tuniit*, who were the late Dorset people (McGee, 1981). Today the population of Nunavut is about 27,000, and, save for its capital Iqaluit where half the population may now be non-Inuit or *Qallunaat*, the typical community of between 350-1200 people is about 95% Inuit.

Nunavut, like much of the circumpolar north, has been a more recent colonial frontier of the 20th century. Yet the Inuit had earlier visitors. Inuit had Nordic occupants between AD 1000-1400, however the first contact with *Qallunaat* of Western written and Inuit oral historical note began with fighting and capture by English in the sixteenth century, first by Sebastian Cabot in 1501 or 1502 and then by Martin Frobisher between 1576-78. Visits by Danish-Norwegian and Dutch ships between 1605-1660 resulted in about 30 Inuit being captured, most of them for exhibition in Europe. Inuit captives were occasionally brought to Europe over a period of a few centuries (Idiens, 1989; Sturtevant & Quinn, 1989). The eighteenth century saw some trade but increasing hostilities between Inuit and European explorers seeking a Northwest passage, minerals, and fur (Williams, 2003 [2002]); Fossett, 2001). The eighteenth century also saw fighting between Inuit and French off the southern Labrador coast (Taylor, 1984), with Inuit taken as slaves in New France (Trudel 1994). Scottish and American whalers began to have some effect on Inuit lives between approximately 1860-1915, as many Inuit moved near their ships and worked in exchange for food and some European material goods (Damas, 2002). This adaptation to Europeans and Americans continued with trading fox furs with the Hudson's Bay Company beginning in the early twentieth century. The Royal Canadian Mounted Police (RCMP) began to arrive in the 1920s. Christian missionaries began conversion of Inuit in Greenland in the eighteenth century, however they were not in Nunavut until primarily in the 1920s and 1930s. While much traditional lifestyle remained, religious conversion was relatively swift in the context of epidemic diseases that took many lives; some estimate that most Inuit were killed by disease by the early twentieth century (Crowe, 1991). Missionaries stopped shamans, or *angakuit*, from their public spiritual practices. After 1941, Canadian and US soldiers established meteorological and radar stations throughout the Arctic into the Cold War, and the government era began (Wenzel, 1991). Social change after the establishment of the Department of Northern Affairs and Natural Resources in 1953 was massive.

The Canadian government became involved in the creation of settlements, including relocations of families in the 1950s and 60s in the midst of a severe tuberculosis epidemic (Grigier, 1994). This relocation and migration is of concern given that place has had a critically important function for indigenous peoples' identities, including Inuit (Basso, 1996; Dorais & Searles, 2001; Rasing, 1999). Inuit had been living primarily in extended family camps on the land until the government era. The aggregation of many unrelated extended families in one location, often different from the place where they had been living, had a disruptive effect on kinship and social organization (Condon, 1988; Graburn, 1969). Mandatory schooling began for Inuit children with residential and Federal Day schools (Milloy, 1999). Residential schools were opened in five communities in the Northwest Territories between 1955-1971, and day schools began in 1957 (Crandall, 2000; King, 1999). By 1964, three-quarters of Inuit children between the ages of 6-15 were enrolled in school (Duffy, 1988). Rhoda Kaukjak Katsak recalled her experience:

“When I went to school, when I came off the land, everything changed for me all at once... When I came off the land, the people with any type of authority were *Qallunaat*. The teachers were

Qallunaat, the principals were *Qallunaat*, the RCMP were *Qallunaat*, the administrators were *Qallunaat*, the nurses were *Qallunaat*, it was them who told us what to do... It was difficult for me to learn when I was a child that there are other races, like the *Qallunaat*, who have the power, who have the authority. It was difficult for me” (Wachowich, Agalakti Awa, Kaujak Katsak, & Pikujak Katsak, 2004: 208).

Municipal governments were established by the federal government and were run by *Qallunaat* for many years, further disrupting and changing Inuit social patterns and taking away Inuit control over their decision-making (Brody, 1991 [1975]; McElroy, 1975, 1979; O’Neil, 1983). The new wage economy began to show some growth with the seal industry of the 1970s, but its collapse in the early 1980s following the European boycott and anti-sealing campaigns turned *Nunavummut* (Inuit of Nunavut) into poor welfare recipients (see Wenzel, 1991). The last half of the twentieth century has seen the most profound and rapid social change in Inuit history.

Community Wellness

In April 1995 the Government of the Northwest Territories (GNWT), Canada, released a document entitled *Working Together for Community Wellness: A Directions Document* (Northwest Territories, 1995). Developed with input from Inuit communities and several government departments, the document was a proposal for a “new vision” of healthier communities across the Canadian Arctic, a region at that time called the Northwest Territories. In 1998, the GNWT developed a Mental Health Framework to begin planning for integration of mental health services. Inuit had begun serious discussions with the federal government about land claims and self-determination in the 1970s, and with a land claim being signed in 1993 and Nunavut coming into being with its own government in 1999. Nunavut residents chose to use the public style of governance as opposed to an Aboriginal government. Since the creation of the government of Nunavut, discussion surrounding community wellness has been taken more seriously.

Although there is evidence that some nationally known determinants of health are also valid for Native peoples in Canada (Wilson & Rosenberg, 2002), it is vital to understand mental health and well-being from local and indigenous perspectives. The Bathurst Mandate (Nunavut, 1999a) appears to have defined the Inuit perspective on mental health as *Inuuqatigiitiarniq*¹, “the healthy interconnection of mind, body, spirit, [people], and the environment.” Studies of suicide among Native North Americans have shown a relationship between community ties to traditional values and practices and attenuated suicide rates (Berlin, 1987), and between fewer suicides and community/tribal control related to education, health services, police and fire services, self-government, and cultural facilities (Chandler & Lalonde, 1998; this volume). In a review of suicide

¹ *Inuusiqatigiitiarniq* translates into English as “to have life as a positive state of being.”

prevention programs for Native American and Alaskan Native communities, Middlebrook and colleagues (2001) concluded that programs work best if they are both culturally relevant and developed with major community input. Community involvement in and control of policies and programs, commonly referred to as community empowerment, has thus been shown to make a significant difference in subjective well-being. Below we will try to show that it is community control that is the determining factor in successful suicide prevention and mental health outcomes in indigenous communities.

Well-being among Inuit in the Canadian Arctic has been moving in the direction of local control. The devolution or transfer of power of health services from the federal government to the Northwest Territories began in the 1980s, culminating with the transfer of health care from the federal government to the GNWT in 1988. Little impact of this change, however, was felt at the community level (O'Neil, 1990). The bureaucracy was not working, and new ideas were needed (Waldrum, Herring, & Young 1995). The 1995 GNWT report on community wellness, referred to earlier, resulted from concern over the continuing rise of social problems within Inuit communities. These problems have included intergenerational segregation or the weakening of traditionally strong bonds of affection, respect, and teaching roles across generations; family and interpersonal violence; alcohol, and drug abuse; child abuse and neglect; suicide; Fetal Alcohol Syndrome; high rates of teen pregnancy; and sexually transmitted diseases including HIV/AIDS. The programs and services addressing mental health were not working, and there was a lack of coordination across the relevant government departments. By 1993, a GNWT working group had been established to develop a community wellness strategy for Inuit communities. It was resolved that communities would be responsible for their own healing and wellness strategies, and that the government would assist and support as was seen fit by the communities. It was a strategy of community empowerment and shared responsibility, replacing one of external control and authority by a largely *Qallunaat* government. The seat of the northern government was still in the western Arctic, or Denedeh, while many of these problems were significantly worse in the central and eastern Arctic, or Nunavut. While the population of the western Canadian Arctic is almost twice that of Nunavut, for example, over 70% of suicides were taking place in Nunavut by 1997. The western Arctic is comprised of mostly the Dene First Nation, while the east is almost all Inuit.

In two important community-based workshops and numerous meetings organized by the GNWT in 1994, the first order of business in the development of a community wellness strategy was agreement on a definition of a healthy community. It is noteworthy that the Inuit "community" before the government era was the extended family camp, and the settlements that are now called communities are of a very different order. They are a mixture of multiple extended Inuit families and Canadian bureaucracy. Several GNWT departments jointly sponsored these 1994 meetings in Yellowknife and Rankin Inlet. The departments included Education, Health and Social Services, Culture and Employment, Justice, Municipal and Community Affairs, and the NWT Housing Corporation, with Aboriginal and community participants attended these meetings. The following characteristics of a "healthy community" were agreed upon: having a strong sense of

community; having a strong sense of family life; an emphasis on personal dignity; a state of well-being; a strong sense of culture and tradition; zero tolerance for violence, substance abuse, and child abuse/neglect; and integrated services. Attention was then directed toward four areas of planned change: (1) prevention, healing, and treatment, (2) education and training, (3) interagency collaboration, and (4) community empowerment. Government money was spent, action was taken. Three crisis lines were established or further supported; women's shelters were set up in a number of communities; an alcohol/drug rehabilitation clinic was opened in Iqaluit; suicide prevention training workshops were held over a three-year period for selected representatives of communities; additional training programs were established or further supported, some within Nunavut Arctic College. These programs were to provide training in nursing, community health, social services and social work, teacher education, general counseling, and drug/alcohol counseling. Frontline health and social service workers began to receive additional training.

Top-down training opportunities

Community empowerment meant significant involvement in the planning and administration of members' own health and social services based on these guidelines. Youth Committees were established or further supported in each community, beginning in the Baffin Region. Each community in Nunavut had, in addition to a Hamlet Council with elected representatives, an education committee, housing committee, elders society, hunters-trappers organization, and numerous other committees or groups overseeing the broad spectrum of health and well-being. Controlled drinking communities, ones where a limited amount of alcohol can be ordered every month, had active alcohol committees who reviewed all orders for alcohol and the people doing the ordering. The members of these committees were exclusively or almost exclusively Inuit. Health remains, however, in the control of the territorial government, as do social services in most Inuit communities.

The new Nunavut government has since 1999 incorporated the administrative and service models of the previous GNWT and the federal government, however it has declared as its mandate the incorporation of traditional knowledge or *Inuit Qaujimagatuqangiit* (IQ) into this model (Nunavut, 1999a). Forms of this incorporation have begun to take place in education, corrections, health, social services, and the Departments of Sustainable Development and Environment including the 2003 Nunavut Wildlife Act, for example. Yet this blending of Inuit and Euro-Canadian philosophy and social organization remains a major challenge. Individually-focused Western health services, including mental health, can be at odds with the family being at the centre of Inuit well-being (Kral, 2003). Inuit knowledge emphasizes the particular and personal, the practical and functional, and the relational and reciprocal, while scientific-Western knowledge is general, abstract, and hierarchically authoritative (Kublu, Laugrand & Oosten, 2004 [1999]). The challenge stems, in part, from what kind of community is imagined and by whom.

Health and wellness remains, however, in the control of the territorial government, as do social services in most Inuit communities. Communities are still given programs by the government with virtually no opportunity to determine or contribute to their content. Furthermore, these programs continue to create some divisions between Inuit communities and government, and within communities, because they are usually administered by community-based government workers. Knowledge from elders, the traditional teachers of lifeways, is usually taken as advice in a superficial manner. The Government of Nunavut has “IQ² Committees” with advisory meetings which are usually restricted as to what information is provided to the elders.

The Canadian government has been making an effort to improve the well-being of indigenous peoples in this country. One example is the blending of Western and indigenous wellness approaches under a program called Brighter Futures (2006). Brighter Futures was developed in 1992-93 to develop culturally sensitive, community-based health programs for First Nations and Inuit in Canada, directed primarily for young children but designed for family and community health and wellness. Based in the First Nations and Inuit Health Branch of Health Canada, Brighter Futures has been a financial resource supporting communities seeking funding for projects directed toward the improvement of “physical, mental and social well-being.” Program elements have included community mental health (e.g., hiring counselors, suicide or violence prevention workshops, healing), child development (e.g., pre-school programs, youth programs), solvent abuse (e.g., peer counseling, education), injury prevention (e.g., first aid or safety courses), healthy babies (e.g., Fetal Alcohol Syndrome awareness workshops), and parenting skills (e.g., parenting and communication workshops).

Brighter Futures in the Nunavut government is administered through the Department of Health and Social Services, and in keeping with the original goal of the program, it is strongly community-based. By 2000, most of the projects funded in Nunavut were in community mental health (107), followed by child development (76), parenting skills (12), injury prevention (7), and solvent abuse (3) (see www.gov.nu.ca/hsssite/hssmain.shtml). Separate funding has been available for solvent abuse through the federal government National Native Alcohol and Drug Abuse Program (NNADAP). Project examples have included the hiring of community wellness coordinators, teaching youth traditional hunting and language skills, providing breakfast to schoolchildren, holding a youth/elder conference, healing sessions for sexual abuse survivors, a bible study camp, drug/alcohol healing sessions, hockey skills development, student filmmaking, mathematics and language tutoring, a men’s self-help group, suicide prevention training, and recording oral histories from elders. It is important to note that these projects were designed and/or managed within the communities. Other programs funded through the same branch of Health Canada are the Building Healthy Communities Initiative, directed at increasing community services in mental health, home care nursing, and solvent abuse; Non-Insured Health Benefits funding, mainly for dental, vision, and prescription coverage, which also provides some coverage for one-on-one professional

mental health treatment; and the National Native Alcohol and Drug Abuse Program supporting community-based prevention program and residential treatment centers.

Although the concept is well-intentioned, Brighter Futures remains with many administrative challenges. Funding is allocated to a community project for one year starting April 1, yet it can take up to six months before a community is able to receive the money. Then in order to continue funding, communities must submit an evaluation report which itself takes much time. This means that communities might only have three to four months instead of one year to actually run their program. Unused money must be returned at year end, with often insufficient time to spend it. Brighter Futures can thus become administratively complex at both government and community levels.

Yet Inuit communities in Nunavut are increasingly taking wellness into their own hands, and it is here where we are seeing the first significantly positive outcomes. Recent examples can be found in many Inuit communities, but given space constraints we will mention only two concerning suicide prevention.

Mental Health from the Inside

Community empowerment can become personal empowerment through community discourse on healing, argues Catherine Degnen (2001). She points to the importance of Aboriginal communities initiating their own healing, one way they are regaining control over their lives. Many communities have begun to address the problem of suicide through such local discourse. Suicide has continued to increase among youth in Nunavut in spite of the recent government initiatives, however with wide variation in suicide rates across communities. We will briefly describe activities that began in two Nunavut communities just before each experienced a decrease in suicide, activities that community members attributed to the saving of lives.

The first community is Qikiqtarjuaq, formerly called Broughton Island, with a population of about 500. It is an island off the eastern coast of Baffin Island, above the Arctic circle. In 1994, it had the highest suicide rate of any community in the Canadian Arctic, with 12 youth suicides taking place between 1986-1993. Then the suicides stopped for several years. Inuit in other communities were saying that the people of Qikiqtarjuaq did something “from within” that had worked. In 1998, one of us was conducting fieldwork in that community and inquired about what they had done (Kral, 2003). Inuit there, including a few who had helped organize local suicide prevention activities, reported that two related events had taken place. One was the gathering of community members, regularly over a period of time, in the gymnasium located in the basement of the Hamlet Council building. The Council brought people of all ages together there. The local Youth Committee also gathered youth under the age of 24 to meet independently in the same place but at different times. These groups talked about suicide, and about wanting the suicides to stop. Suggestions were made, including having people stop and speak to anyone they saw who appeared sad, worried, or whose behavior had changed (e.g., social withdrawal). The local Anglican minister in this highly Christianized community also had people meet in the church to discuss suicide. The first

event thus centered on talking. There may have been a cathartic effect to this talking, but its purpose was one of synchrony – identifying shared feelings, ideas, concerns, and motivations about suicide and its prevention in the community. A second activity related to suicide prevention in this community was organized by the local Housing Committee. All houses were publicly funded rather than privately owned, so this committee removed from each house the number one method of suicide in the Nunavut: the closet rod. The primary suicide script here is hanging oneself from this rod in the bedroom at night when the family is asleep, usually facing the wall on the left side of the closet. Every closet rod was removed from every house, and locks were removed from bedroom doors. It was their version of ‘means restriction’, analogous to gun control, which has had an effect of decreasing suicide where shooting oneself is the primary method for death by suicide (Carrington & Moyer 1994; Lester & Murrell, 1982). This effect has been found for the restriction of any suicide method that is a culturally popular choice (Clarke & Lester, 1989). Individuals do not tend to change the method when the script for it is broken, suggesting that imitation and the internalization of cultural scripts play a significant role in suicide (Kral 1994,1998).

The second community example comes from Igloolik, an island in Foxe Basin above Hudson Bay and also above the Arctic Circle, with a population at this time of about 1300. Up to 1994 this community had had one of the lowest suicide rates in the Arctic. There had been one in the previous ten years. Within the next four years Igloolik had a large number of suicides: eight youth and one elder. Yet this community recently celebrated the occasion of not having had a suicide for an entire year. Two events had taken place that community members talk about in relation to suicide prevention. The first was Igloolik’s Youth Committee taking a major proactive step. The Youth Committee, about eight or nine young Inuit, held meetings every two weeks in response to a large number of recent suicides in the community. Young people came together at these meetings to discuss what they viewed as important, including ways to improve community life and what young people can do to help elders. This Committee developed, together with the Igloolik film company Isuma, a drop-in Youth Centre. During the day, two elders were there to teach youth about traditional ways of life, and in the evenings youth had a place to be with other youth. Elders provided separate group counselling sessions for young women and men. The Youth Committee also developed a local crisis helpline, and had six youth serving as peer counselors who received training through the community-controlled Department of Social Services. The Youth Committee also organized two spring camping trips with elders and youth through the Youth Centre, something they had begun prior to its development. The Youth Committee also produced a video on suicide prevention with Isuma. Another video was made of a play they produced on the subject of suicide prevention. Older Inuit became further involved in the Centre when it organized weekly board games such as chess and scrabble. Finally, the Centre was actively promoting the learning of Inuktitut and its dialects. The financial picture, unfortunately, became problematic and these services and activities stopped for a number of years. Indeed, a lack of continued funding and financial management, in addition to problems with the building itself, was the major reason for the closing of the Youth Centre after only one and one half years of operation.

The other event related to suicide prevention in Igloolik was more indirect: the making of a film by Inuit filmmakers and actors, all from Igloolik and centred in the Inuit film company in this community, Isuma Productions. The film was *Atanarjuat: The Fast Runner*, which was released in Canada in 2001 and the US in 2002, and has won numerous international awards including the Caméra d'or at Cannes. It was Canada's official selection for the 2003 foreign language Oscar. The film is about an ancient Inuit legend, and the story takes place before contact with *Qallunaat* (see Apak Angilirq, Cohn, & Saladin D'Anglure, 2002). A shaman disrupts the stability of two families and conflict ensues across a vast landscape and time. It is the story of Atanarjuat, a man on a journey of tremendous spiritual importance in the restoration of harmony for his family. Inuit of Igloolik were involved in the making of this film, from writing, directing, acting, and filming, to sewing caribou parkas and designing and making the traditional *kamutiq* or sledges from whalebone and sealskin. Inuit of Igloolik have prided themselves for upholding their traditional culture.

Inuit spoke during the film's initial stages of the importance of their involvement in its production. In discussing his sense of belonging, of feeling a part of the community or *ilagiittiarniq*³ one 19-year old Inuk talked about the importance of young people working together with adults and elders on the making of this film. This young man told of how being involved in the making of the film made him feel good about himself, "because it tells me how my ancestors used to live, and I see it with my own eyes and I see the environment how it was before." Lucy Tulugardjuk of the Youth Committee was ecstatic when she learned that she was given a lead role in the film. She soon helped youth develop theatre in Igloolik, while another Igloolik actor from *Atanarjuat*, Natar Ungalaq, helped youth develop film and video productions.

In a second major film production that finished shooting in 2005, Isuma involved Inuit youth in an apprenticeship program. This was on-the-job-training during the filming in filmmaking, television, and website design. One of these youth, Jason Kunnuk, spoke about how being on the sets and working with Inuit filmmakers and actors strengthened his sense of belonging, and had a profound and positive effect on him. "I can't find the words to express how I really felt looking at the people, my history, and how they worked so hard for us to be here." He reported feeling encouraged and motivated to "maintain my culture." He added that the experience made him aware that suicide "is not the Inuit way." Meeting the challenge of blending two cultural worlds together was made more clear to him, Jason said, and he shared a metaphor he has found helpful through the image of the *kamutiq* or sled. The sled, historically, was made of "organic material. Right now it's [made of] wood, plastic, rope... [yet] it still has the same purpose. We know where we came from. We know pretty much where we're going. But sometimes when

³ *Ilagiit* means family, *tiar* means to try to be in a good position of, and *niq* means actually doing. *Illagiittiarniq* thus means the practice of being in good relations, or of belonging.

you get lost, you could look back, behind your tracks, to see which mistakes you did. And mainly to look forward, to going on forward... it always goes forward.” Youth were also hired by Isuma to help elder women experts make fur clothing for the sets and learn this important traditional skill. One young woman learned to prepare and sew caribou skin for the first time, and with a smile said that she and her mother are now spending a lot of time talking about this. It was something her mother has done throughout her life, but a skill they were never able to share with each other until now. Here was an important bolstering of family ties. Leah Angutimarik, who at age 21 played a lead role in the new film, talked about the positive impact this experience had on her shortly after the shooting was completed. She learned, hands-on, various traditional Inuit practices such as lighting the *kulliq* or oil lamp, and spoke of the older Inuit in the film as role models. She came away from the film with a better sense of herself, saying “I want to be me more. I want to be myself more.” She said that she was a stronger person because of it. It created a desire in her to learn even more about her culture, and to help other young Inuit like herself learn the same. “We’re losing our history,” Leah indicated, and said she believed that this loss of history and identity is related to current problems of suicide and anger among Inuit youth.

The director of these two films, Zacharias Kunuk, is committed to bringing his people back in touch with who they are and always have been (personal communication, October 2002). There is good evidence that learning about one’s culture enhances self-esteem (Phinney 1991). The film *Atanarjuat* sings of reclamation and recovery. The concurrent activities of the community and Youth Committee, and the production of the two films, were constructed by the community; they were home-grown. Isuma received funds to open the Youth Centre toward an initial film/video project, and was thus directly tied to the larger project of community youth wellness. Suicides stopped for a noticeable period of time in a community that had been beset by too-frequent suicides. The tipping point, as the saying now goes (see Gladwell, 2000), for the reduction of suicide was not likely any one factor in the communities but a spread of wellness that coincided with and, we believe, is directly related to community control.

Programs bringing youth and elders together are being developed in many northern communities, in response to the increasing intergenerational segregation mentioned earlier and the centrality of family and community to Aboriginal life. One such program took place in the Kitikmeot region of Nunavut in the central Arctic (Eyegetok, Thorpe, & Iqaluktuuttiaq elders, 1998; Thorpe 1998). A small group of youth and elders spent time on the land in the summer where the elders taught traditional skills and knowledge in the context of storytelling and practice. “The elders gave skills, culture, experience and knowledge as gifts. The youth showed enthusiasm, cooperation and an eagerness to learn which was noticeable in their attempts, attitudes and morale... Together, these positive elder-youth experiences and Inuit knowledge recordings will provide a legacy of memories that will last well beyond the camp.” A similar “culture camp” took place in southwestern Alaska among the Yup’ik, where elders passed on their stories to youth, “teaching nothing less than how to learn” (Fienup-Riordan, 2002: 173). Youth themselves are involved in and often organizing these activities across communities. Intergenerational experiences of trauma and loss are well-known in

Aboriginal country, and this form of negative mimesis or transmission can be countered by today's young people (LeVine, 2000).

The Statewide Suicide Prevention Council of Alaska (2002, 2003) has implemented a strategy that appears to be working. A set of general principles for suicide prevention was produced, such as having a crisis team in each village, yet each participating community developed its own program. This was based in a shared belief across the Council and Alaska Native communities that imported suicide prevention programs could not address local place and culture. The Council, which includes youth and elders, conducted "listening sessions" where it learned from community members, including survivors and professionals, while local tribal councils were involved in training their own suicide prevention coordinators. Not training sessions, but listening sessions. Several villages with higher-than-Alaska-average suicide rates established their own prevention projects, and between 1990-1997 showed a decrease in these rates while villages without their own projects saw an increase in suicide rates. One of the plans of the Council is to have communities share with each other their particular projects. The essential feature of these successful prevention projects is that they are community owned to their core.

Warry (1998) has pointed out that Aboriginal community control over health and mental health activities and programs has been central to their success. This can also be seen in Australia's National Aboriginal Community Controlled Health Organization (NACCHO). Established in the 1970s, the philosophy behind NACCHO is for each Aboriginal community to control its own health and mental health service delivery, including the initiation of such services. An increase has been seen in not only a wide variety of needed services being provided across communities, but an increase in member utilization of these services (OATSIH-NACCHO, 2003). The Health Transfer Agreements being signed between Canadian Aboriginal communities and Health Canada of the federal government, begun in 1989, are similar to the Australian model, designed to allow communities to determine their own health priorities and establish culturally appropriate programs. In Canada this is further supported by the government's 1995 Inherent Right to Self-Government Policy for First Nations and Inuit, recognizing their constitutional right to self-governance. It should be noted that once community action begins, it can be catching. The opportunity to develop programs and activities toward well-being within a community can itself lead to further solidarity and commitment to these goals by its members, as it has been shown that social action itself is a determinant of such commitment (Kelly & Kaplan, 2001; Passy, 2003).

Nunalingni Silatuningit/Community Wisdom

We would like to go beyond possible remedies for Durkheim's *anomic suicide*, which include the restoration of social regulation, the meeting of expectations, the feeling of normative belonging, and the stabilizing of runaway social change (Durkheim, 1951 [1897]), and also beyond the idea of *social capital*, the newer term used to describe social membership and exchange, trust, and "collective action for mutual benefit" (Galea, Karpati, & Kennedy, 2002: 1374). While these constructs address the important benefits

of solidarity for individuals and groups, they do not focus strongly on the idea of social action, of collective agency and control as producing such social well-being. Personal control has been identified as an important factor in mental health across cultures (Grob, 2000; Vaillant, 2003). Among Inuit, as for other Aboriginal peoples, decision-making was taken away from individuals, families, and communities. There is good reason to believe that collective control is important for collective mental health, and Bellah and colleagues (1991) have argued that decentralized power is necessary for communities to thrive. As noted above, such control appears to be the critical feature in suicide prevention in Aboriginal communities (e.g., Chandler & Lalonde, 1998; this volume).

We are here discussing the idea of community or collective agency. The term “agency” in its modern sense refers to the individual and is founded in Protestantism, capitalism, and liberalism (Asad, 1996). Indeed, it has been traditionally pitted against the collective (Bakan, 1966; Fuller, 1998). Collective agency, however, can be viewed as an internal locus of control felt by individuals that is at once shared around both activity and identity—the two being interdependent. Collective agency takes place when members of a group or community participate in an activity that they have created themselves, that is “theirs” over time and recognized as positive. Agency is here seen as a quality of action, a process, rather than a bounded, internal force. Yet knowing and believing that one can execute a particular action is the self-efficacy tied to mental health. Much has been written on the beneficial psychological effects of internal locus of control and self-efficacy on individual well-being (Grob, 2000), and we extend these concepts to the community. Collective efficacy, “a group’s shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainments,” is predictive of such attainments (Bandura, 1997: 477). It is here that the personal/subjective and the collective share a common ground. Collective agency becomes directly tied to personal agency. It is ownership and control tied to the human need to belong (Baumeister & Leary, 1995). This may be especially relevant to indigenous peoples, who have historically been kinship-based cultures (Demallie, 1998; Miller, 2002). Family-centred interdependence may be one type of collectivism that is relevant to Inuit within the multidimensionality of the idea of collectivism that is relevant to Inuit within the multidimensionality of the idea of collectivism (see Ashmore, Deaux, & McLaughlin-Volpe, 2004). While individual autonomy has always been highly respected among Inuit, kinship and interdependence have historically been the basis of their social organization.

Consensus without Coercion

Inuit communities today comprise multiple families and are increasingly mobile, which presents an organizational challenge. Yet a community can become a social network whose members work toward collective goals, even as cooperative smaller social networks within the community (e.g., Wetherell, Plakans & Wellman, 1994). Community action becomes the route to collective ownership and responsibility.

Personal and collective agency does not need to be contradictory. Sampson (1988) adds a dimension to power and control that is on the other side of the internal, self-

contained individualism common in Western society that he refers to as field control. Here power and control is located in “a field of forces that includes but goes well beyond the person” (1988: 16). It is a control within what he calls ensembled individualism, an inclusive indigenous psychology that captures a more fluid self-other boundary. Autonomous selves are experienced as such even in collectivist cultures like Hindu India (Raval & Kral, 2004), and in the ensembled individualism of Aboriginal societies the locus of control is both personal and collective. Indigenous community control is a kind of field control that integrates personal and social responsibility.

Yet cultures and communities that have lost much control over their lives, e.g., via colonialism and state control, manifest significant social problems. It is a basic collective human need to have self-determination, and we have learned much about this from world history when this need has been taken away from a people. Peter Penashue (2001: 29), the President of the Labrador Innu Nation, writes about the need for control based at the community level: “I think that we have learned now that when people are oppressed, when people are not involved in determining the direction of their lives, they are deeply damaged.” Perceived control is especially important to well-being when the domain under control is highly salient (Grob, 2000). It would be important to understand and explore what domains are salient for different peoples, generations, contexts, and communities. Community control over mental health resources thus becomes an efficacious route that focuses on local salience. Services, programs, and activities become tailored by and for the people who most understand themselves.

Mason Durie (1998) has highlighted that for the Maori of New Zealand, *mana* or sovereignty has become salient in the context of colonialism, and is now directly related to the well-being of his people. These are the types of narratives and histories that help locate the meaning of agency in the plural. The reclamation of collective self-determination is never a smooth process. The Innu, Maori, Inuit, First Nations, and other indigenous and tribal peoples have struggled, even staggered, but they have not fallen (Amagoalik, 2000).

Returning to our critique of unidirectional, top-down knowledge transfer from governments and agencies to communities, we hope that we have made clear an awareness of the importance of knowledge transfer going in the other direction. The most important knowledge is already in the community. Chandler and Lalonde (2004) have recently made this same argument, adding that lateral knowledge transfer *between* communities is another important route. This is also beginning to take place in Nunavut. The *Isaksimagit Inuusirmi Katujjiqatigiit* or Embrace Life Council, a newer organization in Nunavut dedicated to suicide prevention and community wellness, organized its first conference in early 2005 that was attended by 59 representatives of every Nunavut community. The conference was titled *Avamut Iqajuktigiit Katimavikjjuanignat* – Conference of Helping One Another, and among its objectives, the central feature was the sharing among communities of their own wellness activities and programs, ones believed locally to be directly responsible for youth well-being and suicide prevention. A primary theme that emerged from the meeting was that Inuit communities need to be in control of their own wellness strategies (Embrace Life Council, 2005). This is one form

of lateral knowledge transfer that becomes a larger collectivity of social action toward well-being, a widening of the circle of sharing.

While the examples of local, community-based suicide prevention and mental health presented in this chapter are brief and few, they speak to something much more important than a well-intentioned mental health program being passed on to or imported for Inuit and other indigenous communities. The Inuit communities mentioned here did something unique. From our knowledge of these communities, it seems likely that these actions fit with a deeper and very local sensibility of how and what things work. They did something that came from within, something that they created. The successful Inuit community and Alaska suicide prevention projects are likely that because *it does not appear to matter so much what the project is, as much as that it is the community's own program or initiative*. This is in line with the move toward community empowerment of the GNWT in the mid-1990s, and fits with the Nunavut Government's mandate to have each community develop its own plans for wellness (Nunavut, 1999b). We are suggesting that internal community control or collective agency is responsible for the positive outcomes discussed above, however short-lived they may be so far. This is a critically important point. Joseph Gone (2004; this volume) has argued that Western clinical mental health practices can incur an invisible cultural proselytization, replacing local knowledge about wellness and healing with models that are not based on the cosmology of the people living there. The new knowledge is historically and experientially incongruent. It is a form of the state's standard grid of top-down legibility that excludes local knowledge (Scott, 1998). Top-down, outside-in approaches to substance abuse prevention still appear to be the norm for Native American communities, for example (Hawkins, Cummins, & Marlatt, 2004). O'Neil (1988) referred to this as a form of colonization by Western medicine, complicit with the larger colonial subordination of indigenous values and practices. In her chapter in this volume, Mary Ellen Macdonald (this volume) shows that culture has yet to find a place in Canadian federal health care policy. Yet we know that community is an essential cultural concept for Aboriginal mental health (Manson, 2000; Waldram, 2002). Culture can become realized in mental health initiatives through community power and control.

Inuit elder Mariarno Aupilardjuk stated recently that "We need to implement the Inuit counseling and healing practices with Inuit approaches" (Nunavut Social Development Council, 2001). These practices must start with local control and local planning if they are to be Inuit. There is a crucial difference between a community deciding how to implement and control a program of the government and a community *designing its own plans*. The latter engages and empowers the community in ways that remedies applied from the outside cannot. On suicide prevention, an Inuit woman elder from Igloolik stated, "We have to look at what the community wants," and a 17-year old Inuk from the same community emphasized, "Just a whole community working together can make a difference" (Kral, 2003). Writing about hunting societies including Inuit, Hugh Brody (2000: 148) emphasizes:

Elders in many indigenous societies are clear about the benefits of their way of life... Their argument is that the 'traditional' system secured important benefits

and could continue to do so. Change, they say, is for the most part a result of pressure and invasion rather than an expression of preference. Of course they want to be modern – but on their own terms.

Philip McMichael (2000) has argued that the broader development and globalization projects have not included the empowerment of local cultures. He believes that such projects need a rethinking about priorities toward long-term improvement of the human and environmental condition. These priorities will include, at their base, what Arturo Escobar (1995) was told by the Organization of Black Communities of the Pacific Coast of Columbia: a people's own "life projects." The Mental Health Working Group (2001: i) of the Assembly of First Nations/Inuit Tapirisat of Canada has made it clear that "the most important thing about mental wellness is that it must be well defined in terms of the values and beliefs of First Nations and Inuit communities."

Self-determination at the community level is not simple. Rather, new levels of complexity arise as, for example, some indigenous communities have experienced internally regarding disagreements about specific goals, people, and methods. The local also cannot always or even easily be independent of the regional, territorial, or federal in Nunavut in terms of activities and programs related to health, education, and social services, even if these activities and programs are created by the community. Not at this time. What we are writing about in this chapter is a form of indigenous anarchism in cooperation with the state; a contradiction, yet currently developing, not without struggle, in Canada (see Graeber, 2004). In addition to community control, and just as important, is a focus on sustaining community-developed action over time. Suicides resumed in the two Inuit communities discussed above as the activities/programs begun by each community came to an end. A major reason for this in at least one of the communities was a lack of sustained funding. Program continuity must also incorporate flexibility at the community level, where changes in personnel are common. A topic beyond the scope of this chapter, the continuity of truly community-based actions and programs toward well-being/mental health is in need of serious attention. This new complexity of community self-management is, we believe, worth the effort of time and money.

Local conceptions of indigenous mental health must be made clear and utilized. This will likely be some form of blending between Aboriginal and Western approaches. Such a convergence needs critical attention and dialogue. Yet this also needs to be in the context of the further identification and sustaining of local endeavors toward and control of psychological and community wellness, at the site of the community itself. The tool for community wellness is a respect for and listening to *nunalingni silatuningit*, or the collective wisdom of a community.

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