MAKING HISTORY HEAL:
SETTLER-COLONIALISM AND URBAN INDIGENOUS HEALING IN ONTARIO,
1970s-2010

by

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Abstract

This thesis focuses on the interrelationship between Canadian colonial histories and Indigenous healing. I begin by problematising how colonialism is invoked in contemporary scholarship on Aboriginal health and healing, and arguing for more precise historical methods and a more relational understanding of colonial processes. Historicising Indigenous agency is integral to this analysis. Whilst colonial continuities in contemporary Canadian public policy discourse is an important theme, I also attend to social movements, institutions, professions, and political and economic forces beyond the state.

Indigenous healing as a socio-political movement itself has a history dating at least to the late 1960s. Urban Indigenous healing discourse is characterised by linking present-day suffering to collective historical losses, and valorizing the reclamation of Indigenous identity, knowledge and social relations. Drawing on urban Indigenous social histories from Kenora and Toronto, I consider the urban healing movement as an example of Indigenous resistance influenced by the international decolonization and North American Red Power movements, but which over time has also engaged with dominant institutions, professions, policies, and discourses, such as the concept of trauma. My analysis considers professionals and patients invoking historical trauma as political agents, both responding to and participating in broader shifts in the moral economy. These shifts have created the
conditions of possibility for public victimhood to become a viable strategy for attracting attention and resources to suffering and injustice.

The thesis highlights the centrality and complexity of self-determination in urban Indigenous healing, drawing on historical and ethnographic analysis from three southern Ontario cities. I analyse how the liberal multiculturalism paradigm dominant in health policy and health care settings contributes to mental health professionals’ failure to recognise Aboriginal clients and issues. I argue that characterising pan-Aboriginal and ethno-national healing as approaches in opposition to one another produces an insufficiently nuanced analysis in the context of urban Indigenous subjectivities and social relations, where both approaches are valuable for different reasons. The thesis urges greater attention to the role of Indigenous languages and local histories, and to the threat which dominant policy discourses on residential schools and mental health pose to the maintenance of distinct ethno-national histories, epistemologies and traditions in urban Indigenous healing.
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Many different terms are used to identify and self-identify the original peoples of Canada and their descendants. Indigenous scholars and others supportive of Indigenous self-determination increasingly use Indigenous-language terms of self-identification for Indigenous peoples as a gesture of respect. For example, Anishnaabeg is the term used by Anishnaabe people to describe themselves, meaning “the people”. I follow this practice where relevant, whilst also referencing the collective nouns traditionally used by scholars for a particular ethno-national group (in this case Ojibwe) where such a name is likely more familiar to many readers. A wide range of spellings are currently used for Anishnaabe, so whilst I try to remain consistent in my own usage the reader will note variations in spellings between place and programme names employing this identifier, such as Anicinabe Park.

In discussing public policy and referring to diverse Indigenous populations such as those in urban settings – two focal points of this thesis – broader terms of identification are also required. I use the terms ‘Aboriginal’ and ‘Indigenous’ more-or-less interchangeably, whilst recognizing that they have slightly different associations: Aboriginal is currently the dominant term in Canadian policy and therefore often associated with government, whereas Indigenous suggests a political consciousness of the global existence of peoples whose lands have been colonized and the possibilities for solidarity across contexts. The term ‘Native’ was more commonly used in policy discourse during the 1970s and 1980s, and continues to be used by both Indigenous and non-Indigenous peoples, particularly by older people and in northern Ontario; I use it here occasionally and particularly in relation to these periods and settings.

Canada’s 1982 Constitution Act recognised First Nations, Métis and Inuit as having distinct entitlements. The terms ‘status Indian’ and ‘non-status Indian’ result from the 1876 Indian Act, which created deliberate political and administrative divisions amongst First Nations Peoples. ‘Status’ describes individuals recognized by the Canadian government as having ‘Indian status’ under the Indian Act, historically based upon membership of an ‘Indian
Band’, an administratively created unit typically based on a land reserve. However, not all ‘Status Indians’ have band membership. The government does not recognize non-status Indians as having distinct political or legal entitlements. Non-status applies to those of First Nations ancestry who are not registered under the Indian Act, those enfranchised as Canadian citizens who thereby lost their Indian status, and until 1985, women who were born with Indian status who married non-Indians and thereby lost their status.

Terms of identification for non-Indigenous Canadians are also not straightforward. I avoid ‘non-Indigenous’ and ‘non-Aboriginal’, terms which contribute to the collective denial of Canada’s colonial history. Settler and settler-descendant are useful for the opposite reason, but exclude those who came to Canada as slaves, indentured labourers and refugees. However, I follow Bonita Lawrence and Enakshi Dua in arguing that members of racialised groups also be recognised as settlers.  

I use elder to refer to an older person, and Elder to refer to an older person who has been recognised by his or her people as having exceptional knowledge, life experience and leadership qualities.

1 Whilst the United Nations has decided against adopting a universal definition of indigenous peoples, the understanding commonly accepted by the Secretariat of the Permanent Forum on Indigenous Issues is based on the International Labour Organization’s 1989 Convention concerning Indigenous and Tribal Peoples in Independent Countries, No. 169. The following is excerpted from this working definition: “Indigenous communities, peoples and nations are those 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 parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.” Secretariat of the Permanent Forum on Indigenous Issues Division for Social Policy and Development, United Nations, "The Concept of Indigenous Peoples," (2004).

2 I use ‘Aboriginal’ as a descriptor rather than a proper noun; whilst recognizing that the latter is a common usage by some Aboriginals, it is also considered offensive by some in both Canadian and international contexts. National Aboriginal Health Organization, "Terminology Guide,"(2003), http://www.naho.ca/english/pdf/terminology_guidelines.pdf.

Introduction

Canadian Colonialism & Urban Indigenous Healing: (Re)Conceptualising the Relationships

Mohawk scholar Gerald Taiaiake Alfred recently described Indigenous healing programmes in Canada as “problematising [Indigenous] people and not the state’s behaviour”. Further, he argued that “such approaches are not intended to alter the underlying, colonial, causes of unhealthy and destructive behaviours in First Nations communities”.

I share Alfred’s perceptions and concerns regarding the problematic discursive effects and limited material impact of contemporary Canadian public policy on “Aboriginal healing”. But the need to critique recent policy developments should not obscure scholarly attention to the different meanings attached to “Aboriginal healing” or “Indigenous healing” by different groups over time and in different contexts. Historicising the concept and practice of Indigenous healing highlights its emergence through Indigenous-led discourse and, in this context, its close relationship with the socio-political movement towards self-determination. In historicizing the development of healing discourse in urban Ontario since the late 1960s and critically analysing how it has been taken up by the state since 1998, I draw attention to how Indigenous healing discourse both influences and is influenced by broader Canadian public policy, and has become increasingly contested domain with its incorporation into state policies and projects.

This thesis foregrounds the social history of Indigenous healing as a socio-political movement in selected Ontario cities between the late 1960s and the late 2000s. Anthropologist James Waldram has noted, “[Indigenous] healing seems to be a metaphor for socio-political change as well as personal recovery and includes both processes of cultural repatriation or revival and political self-determination”. My interests are in how Indigenous healing is framed in social and political terms, and particularly how it is discursively connected to broader discussions of colonial history and relations between Indigenous peoples, the Canadian state and settler society. By anchoring my explorations specifically in urban settings -- where the majority of Indigenous people in Canada currently live -- I aim to contribute to addressing the neglect of urban Indigenous histories
and experiences by scholars in the fields of public health, history and anthropology. Further, this work is intended as a partial response to a gap in the scholarly literature on the relationship between Canadian colonialism and Indigenous health and healing, in which colonialism is often insufficiently historicised and under-theorized, whilst Indigenous people’s resistance to and engagement with colonial ideologies and structures is obscured. Research in the field of “Aboriginal health” commonly invokes colonialism as a generalized experience of “culture loss”, with a particular emphasis on residential schools as the ultimate experience of colonization, in ways which convey a misleading impression that widely diverse peoples endured identical experiences which have rendered them helpless victims in the present.

Thus my research objectives are first, to provide an account of the social history of Indigenous healing in selected Ontario cities since the late 1960s, with attention to Indigenous agency and engagement with dominant institutions and discourses. Second, I aim to explore the tensions which have emerged since the late 1990s as the Canadian state has increasingly engaged in public discourse and policy addressing colonial history and Aboriginal healing. Third, I historicise the ascent of ‘Aboriginal mental health’ as a paradigm for making sense of Indigenous suffering, and consider the implications for urban Indigenous healing. And fourth, I intend to sketch a conceptual framework for understanding Canadian colonialism as a set of dynamic social and political structures, ideologies, practices and relations which continue into the present, in interaction with other historically-determined social forces. In other words, I seek to move beyond the universalizing and inadequate formulation that Aboriginal people are suffering in the present as a result of Canadian colonial history. I propose to analyse how local Indigenous social histories are intersected by colonial relations of domination, appropriation, marginalization and assimilation, which have disrupted Indigenous social relations in complex and multiple ways, and which Indigenous people have engaged with, challenged, subverted and resisted in multiple ways. By tracing these social processes and locating them in specific geographic and temporal zones, one can see more clearly both the continuities between historical and contemporary colonialisms, and how these intersect with broader social and political processes. One can also begin to understand the depth
and complexity of contemporary Indigenous experiences of suffering and healing, including a more nuanced understanding of inter-relationships with colonialism.

My interests in this work are personal and political as well as intellectual. I am new to the field of Indigenous studies. My return to Canada after nearly two decades living elsewhere provided an opportunity to examine Canada’s colonial past and present with fresh eyes. The interests and questions I bring are inspired by longstanding observations of how expatriate officials and professionals in the fields of international health and development hypocritically represent Canada as an international champion of peace and human rights untainted by an imperialist past. I also draw on two decades of intellectual engagement with the complex interrelationships among individual healing, social and political transformation, and health care systems. These experiences have led me to understand the latter as sites which simultaneously reproduce dominant modes of power and hold the potential to effect profound transformations in social relations. In my Masters thesis, I examined how the pain experiences of people living with sickle cell disorders are shaped by historical and contemporary discourses of racialisation in the British National Health Service. Working as a medical anthropologist in a donor-funded health project in Nigeria during the late 1990s and early 2000s, I was fascinated and disturbed to observe how colonial discourses and relations continued in international health work in the context of a putatively postcolonial nation. Professional training in Europe is proffered in attempts to buy the allegiance of key officials and professionals, and programming is subject to the whims of political agendas in distant foreign capitals whilst autonomous and accountable local decision-making is undermined. I bring these experiences and interests to the current project. As a Canadian-born settler-descendant who grew up largely ignorant of the country’s colonial history, I appreciate this opportunity to engage with the historical and contemporary experiences of Indigenous peoples and their relationships with the Canadian state and settler society.

In Section One of this introductory chapter, I shall explain why Canadian colonialism is a central analytic concept in this work, elaborate on my critique of existing approaches to colonialism and Indigenous health, and clarify my own theoretical approach to this
relationship. In Section Two I review anthropological and other approaches to the study of Indigenous social suffering and healing, and consider what is distinctive about these social phenomena in urban settings. Section Three focuses on urban Indigenous relationships with biomedical institutions and professions as an important dimension of urban Indigenous self-determination. In Section Four I discuss my methodological approach, and the fifth and final section provides an overview of the rest of the thesis.

1. Recognising Canadian colonialism: theoretical underpinnings

My analysis begins with the premise that how colonialism is conceptualized is crucial to the productive critical analysis of its relationship with Indigenous suffering and healing. Scholars’ narrow and unreflective invocations of colonialism as a determinant for contemporary health problems and social suffering, increasingly prevalent in the literature on Aboriginal health, are problematic in several ways. Firstly, simplified framings tend to universalize Indigenous peoples’ significantly varied experiences of colonization, eliding temporal, geographic, ethnic and gendered differences with a homogenizing portrayal of colonialism’s effects. Secondly, some accounts imply that colonialism is a completed project firmly located in the past, thereby foreclosing considerations of how colonial relations and practices continue in the present. Thirdly, some commentators have represented colonial power as universally hegemonic and Indigenous peoples as passive victims of historical forces, a representation with a long history in the Canadian social science literature. And finally, calls for health and social programmes to redress the damage inflicted by colonialism deny the central role which the Canadian health care and welfare systems have themselves played in colonization and the perpetuation of Indigenous suffering.

My approach to theorising Canadian colonialism draws on the rich body of interdisciplinary scholarship which has been produced at the intersections of anthropology, literary studies and history over the past three decades, a field sometimes described as “colonial studies” and which also overlaps with Native/ Indigenous/ Aboriginal studies. In this section I elaborate on two broad conceptual- methodological issues which are of particular relevance to this thesis: first, locating analyses of colonialism

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in time and space; second, modernity and health care as an important but neglected element of Canadian colonialism.

**Locating Canadian colonialism in time & space**

As the critique above indicates, I share historian Frederick Cooper’s concern that “a generic colonialism” is increasingly dominant in scholarly literature: “spatially diffuse and temporally spread out over five centuries; its power in determining the present can be asserted even without examining its contours”. As Cooper observes, this tendency to over-generalize the workings and effects of colonialism leads to a narrow critical stance and multiple methodological weaknesses. An essentialised experience of colonization becomes the central analytic focus, whilst context and social processes --including resistance-- are neglected. This approach dominates current literature addressing contemporary Aboriginal health and social suffering in Canada. In an effort to move beyond these limitations, I intend to heed Cooper’s call to “a more thorough and critical engagement with other fields, a more rigorous and wider reading of social theory that both reconfigures and deepens methodological understandings”, and “a more precise historical practice”.

I engage with the question of how Canadian colonialism has shaped contemporary Indigenous suffering and healing by integrating two approaches: a Foucauldian approach to analyzing public policy discourse, now commonplace in colonial studies, and attention to local social histories and how they intersect with broader social and political processes. Meghan Vaughan’s dismissal of Foucault’s concepts of governmentality and biopower as irrelevant to colonial regimes, based on her work on British colonial medicine in sub-Saharan Africa, is widely cited. Vaughan identifies three limitations to the applicability of Foucault’s conceptualisation of modern power to colonial government. First, she argues that colonial states cannot be considered ‘modern’ in the sense of European nation-states, but rather were characterized by pre-modern, repressive forms of power more typical of sovereign regimes. Second, Vaughan emphasizes the overwhelming significance of racial difference in colonial power regimes. This prominence, she argues, eclipses other forms of difference such as those on which Foucault focused (insanity, criminality, sexual
perversion), and renders “the medical power/ knowledge complex...much less central than it was in the modern European state”. Third, Vaughan questions the extent to which colonial power operated through the creation of individual subjectivities, suggesting that group classification (which she terms “unitization”) was more significant than Foucault’s subjectification.

Other scholars have since provided evidence of the coexistence of sovereign/coercive forms of power and the cultivation of governable colonial subjects, as well as the salience of “colonial governmentalities” in twentieth century colonialisms. As I discuss further in the next chapter, governmentality, bio-politics and mechanisms of subjection become increasingly central to Indigenous relations with the Canadian state with the rapid growth of Indian health services and Native welfare programmes after the Second World War. Whilst my orientation is primarily anthropological, I draw heavily on historical approaches which provide a valuable methodological check on the tendency to over-generalise and over-simplify which a Foucauldian approach to discourse analysis sometimes inspires. By focusing on urban social and institutional histories and public policy discourse, I trace how colonial discourses continued and changed over time and, crucially, interfaced with other social and political forces.

Conventional definitions of colonialism stress the integrity of a relationship with a “parent state”, an understanding which suggests that Canada’s colonial period ended with the British North America Act in 1867 and shores up the Canadian government’s periodic description of Canada as “a non-colonizing” nation. During the 1970s and ‘80s, scholarly work addressing relations between Indigenous peoples and the Canadian state in the latter half of the twentieth century commonly employed the concept of “internal colonialism”. This framing is intended to distinguish the experience of Indigenous peoples who are numerical minorities within nation states such as Canada, from that of other colonized peoples. This distinction is important but from an Indigenous perspective, the concept of “internal colonialism” does not sufficiently challenge dominant understandings of Canadian state’s borders -- both geographic and metaphorical -- thereby disregarding the claims of Indigenous peoples who argue they have never surrendered their sovereignty or
Further, it underplays the significance of the origins of the Canadian nation-state as an outpost of French and British empires. These origins are important for understanding the historical emergence of particular forms of colonial governmentality, relations and subjectivities.

Writing from a Marxist political economy perspective, Canadian sociologists Terry Wotherspoon and Vic Satzewich make several important points regarding the limitations of ‘colonialism’ as an analytic category in their critique of the (pre-1990) literature on Indigenous peoples’ relations with the Canadian state and settler society. They argue that the suggestion that colonization began with contact neglects the significance of the shift towards agriculture and industrial capitalism during the 19th century which ushered in a period of more profound and systematic disruption and oppression. In other words, it is misguided to generalize the effects of all post-contact relations under the banner of colonialism; rather, scholars ought to consider the particularly devastating effects wrought by colonial-capitalism. Further, they argue that the role of the state is under-theorised in this approach, and that public policy development is insufficiently linked to social, political and economic interests, implying that state actions are simply the result of a pervasive failure to consider Indigenous interests. The need to attend to how colonialism interfaces with changing forms of capitalism as well as other social and political forces is a concern which I intend to take seriously in my analysis. However, Wotherspoon and Satzewich’s argument neglects Frantz Fanon’s early critique of Marxist analyses of colonialism (reiterated by many others in the interim): the failure to attend to the lived experiences of the colonized. As I shall argue below, literature which takes settler colonialism as its focus offers new approaches for theorizing the colonial state in the context of international imperial movements and discourses, whilst also attending to the subjectivities and social relations of settlers and Indigenous peoples.

A second critique of settler colonialism as a central analytic concept comes from Frances Abele and Daiva Stasiulis, who argue that a too-narrow focus on settlement obscures the centrality of the fur trade in Canadian history, from which the Métis emerged as a people, and a period during which 'Native societies presented a commercial opportunity and a
military challenge for the merchants and the colonial elite who controlled the state apparatus'. But this concern has apparently been overtaken by historical scholarship in the interim, as historians Mary Jane McCallum and J.R. Miller have each noted separately that the fur trade has been given disproportionate attention in the history of European-Indigenous relations in Canada. Instead, McCallum observes that Indigenous histories during the later periods of European settlement are relatively under-explored in the scholarly literature, an omission which she attributes to historians’ pervasive discomfort with Aboriginal modernity:

The gap in our history which exists after the so-called closing of the frontier, the disappearance of the buffalo, the signing of the numbered treaties, the plotting of reserves and the consolidation of the Indian Act (each usually described in similarly passive ways) makes it appear as if Native people retreated from ‘planet earth’ only to appear again, angry and tardy, in 1969.

My review of the secondary literature concurs with McCallum, as I have noted the small volume of scholarly work addressing Canadian colonialism in the twentieth century and particularly for the years after World War Two (this period is the focus of the next chapter).

Scholars have expressed another set of concerns regarding the effects of the reification of categories of settler/ Native, colonizer/ colonized into opposing binaries. Wotherspoon and Satzewich argue that applying the concept of colonialism in the Canadian context overstates the homogeneity of interests within the categories of “Aboriginal” and “white”, “colonizer” and “colonized”, neglecting both important internal divisions, and the fact that not all white people have benefitted equally from the exploitation of Indigenous peoples and lands. In a related critique, Frances Abele and Daiva Stasiulis are concerned that the concept of the “white settler colony” “is dangerous because it carries an image of the "ideal" proletarian: white, mobile, literate, male, independent of family ties and supports”, whereas in reality “few workers match this image [...] in Canada at any period”. Some scholars have recently begun to address this problematic by both attending to mixed populations, and considering white settlers’ racialisation of other immigrants and Indigenous peoples as inter-related processes. Renisa Mawani urges scholars to move beyond analyses of white Europeans as the basis for comparison with the colonized “other”. Her work on cross-
racial encounters in British Columbia in the late 19th and early 20th century includes Chinese migrants and “mixed-bloods” as well as European settlers and Aboriginal people, and shows that colonial anxieties extended beyond the white-Native binary which has been the focus on much work in colonial studies. Instead Mawani shows how "racial distinctions that were drawn between the colonized shifted the constitution and distribution of state racisms and their corresponding colonial policies”.\textsuperscript{21} The overarching desire to protect and promote white settlement motivated all colonial racializing rationalities and practices, which were structured by settler perceptions of the innate capacity of particular social groups to “enhance or inhibit the settler population”.\textsuperscript{22}

Over the past two decades a burgeoning literature in anthropology, history and social geography has focused on settler colonialisms, providing an important corrective to formulations which focus narrowly on colonialism as the imperial state’s economic exploitation of other peoples’ lands, resources and labour without attending to the implications for social relations and subjectivities.\textsuperscript{23} This analytic focus supports a deeper understanding of colonialism as both a set of historically-determined social relations and a social force which continues to structure relations in the present. Thus this framing both addresses and goes beyond the concerns raised by Wotherspoon and Satzewich. As Annie Coombes argues in the introduction to a recent collection, it is the relationships with Indigenous peoples in any given locality which determine distinct forms of settler colonialisms. South Africa, Australia, Aotearoa New Zealand and Canada were all colonies and later ‘Dominions’ of the British Empire, all settled in the early twentieth century by predominantly English, Irish and Scottish peoples. What was distinct about each white settler community was

\textit{fundamentally contingent on their relationship to and with the various Indigenous communities they necessarily encountered. In other words, the colonisers’ dealings with Indigenous peoples – through resistance, containment, appropriation, assimilation, miscegenation or attempted destruction – is the historical factor which has ultimately shaped the cultural and political character of the new nations, mediating in highly significant ways their shared colonial roots/ routes.}\textsuperscript{24}

Thus comparative analyses of the workings of particular institutions and cultural processes can provide valuable insights into imperial commonalities and locally distinct patterns of
colonial socio-political relations. For example, historians Adele Perry and Sylvia Van Kirk, anthropologist Ann Laura Stoler and literary studies scholar Mary Louise Pratt have led calls for scholarly attention to how the ‘intimate domains’ of gender relations, colonial domesticity and parenting are significant sites for the construction of colonial relations and racialized categories.\(^{25}\) Such cultural practices interface with broader political and economic interests in important ways, whilst also constituting space shared by colonizing and colonized subjects with the possibility of mutual social transformations. Transnational comparative analyses of humanitarian social movements within and across empires have provided important insights into the former’s important role in the development of colonial discourses and practices, as well as commonalities and divergences in how these are taken up in strategies of colonial governance. Margot Hillel and Shurlee Swain have shown how British ‘child rescue’ discourse, itself shaped by the imperial concept of the ‘civilizing mission’, was employed by child welfare activists and eventually colonial authorities in Canada and Australia in the late nineteenth and early twentieth centuries, with profound and enduring effects for both Indigenous and poor settler families.\(^{26}\) Grimshaw explores how settler anxieties about Indigenous political rights shaped the trajectories of women’s campaigns for suffrage in Australia, Hawai’i and New Zealand in the late 19th and early twentieth centuries.\(^{27}\) Colonial suffrage activists such as the World’s Women’s Christian Temperance Union promoted a discourse of racial equality which both challenged white settler values of the period, and reinforced social hierarchies based on a Euro-American moral framework.

**Medicine, Modernity and Colonial Subjectivities**

European imperialism and colonialism and the development of European scientific knowledge were historically interdependent processes. The application of this knowledge through colonial health care systems has been integral to colonial power in ways that were both coercive and productive.\(^{28}\) Ahistorical and positivist framings of western science as inherently progressive and aligned with humanitarian interests have frequently justified colonizing projects. The colonial state’s provision of health care to Indigenous peoples is held up as evidence of the modernity, technical superiority and beneficence of settler society, and imagined as both legitimization of, lure for and eventually evidence of the
assimilation of Native peoples into settler society. Such assumptions have historically been shared not only by colonizers, but by some anti-colonialists and colonized peoples who, believing in the superiority of European (or Euro-centric) scientific knowledge, have argued that it must be harnessed for the benefits of colonized peoples. A naïve view of biomedical healthcare as a benign, politically and culturally neutral intervention remains dominant in the contemporary field of Aboriginal health (and that of international/ global health) in Canada.

In contrast, critical anthropologists and historians have shown that medical institutions and professionals played a central epistemological role in constructing Indigenous peoples as diseased, impoverished, and culturally and morally inferior to European societies, thereby legitimising European (or later, Canadian) intervention, management and control. Colonial powers developed policies and programmes addressing Indigenous health not out of any sense of compassion or moral responsibility, but to further specific imperial interests, which varied over time and between geographic and institutional sites. These included protecting European settlers from Native epidemics; biomedical research and training for which colonized bodies provided “raw material” and Native settlements and Indian reserves, clinical laboratories; controlling and maintaining the health of Indigenous and other colonized laborers crucial to European economic interests; and demonstrating the technical superiority of Euro-American medical science.

Within the literature on colonial biomedicine, scholars have most often focused on European imperial powers’ relationships with geographically distant colonies, and given less attention to Indigenous health in the context of settler colonies and ‘Dominions’. The historiography on colonial medicine in Canada is narrow relative to work in other colonial settings, and has focused particularly on the histories of infectious disease epidemics and the regulatory aspects of the colonial healthcare system, with less attention to the micro-workings of power and Indigenous and settler subjectivities. In Canada, historians Mary Ellen Kelm and Mary Jane McCallum have begun to address this gap. During the last decade emerging work from New Zealand and Australia has provided useful comparative material. In the remainder of this section I discuss the important contributions of these
relatively recent approaches to the history of Indigenous health in the context of settler-colonial health care.

An overly simplistic framing of colonial medicine as an imposed modernist project misses the opportunity to examine how Indigenous people found spaces within the colonial health care system to make claims for the redress of inequities, to form alliances with external agents, and to appropriate and reinterpret colonial knowledge towards their own ends, as well as the extent to which settlers benefitted from Indigenous healing knowledge.\(^{35}\) For example, historian Mary Ellen Kelm’s work on the history of Aboriginal health and healing in British Columbia in the first half of the twentieth century challenges the widely-held perception that Indigenous healing practices were eradicated by European colonizers.\(^{36}\) Kelm demonstrates that whilst some who embraced Christianity did reject Aboriginal healing practices during the first half of the twentieth century, many others reconciled their adopted faith and their enduring commitment to their original healing systems, and continued to seek out Indigenous healers despite missionaries’ attempts at discouragement. Whilst many did visit non-Native biomedical practitioners, this was done strategically with an understanding that certain conditions were appropriately treated by European medicine, whilst Native medicine was more effective for other conditions. Perhaps most importantly, Kelm argues that Indigenous peoples’ use of European biomedicine “did not necessarily alter their ways of understanding disease and the body”, and that “rather than bringing about assimilation, non-Native medicine was itself assimilated”.\(^{37}\)

Until recently, scholars have paid little attention to Indigenous people’s roles in settler-colonial health care systems; historian Mary Jane McCallum has begun to address this important gap with her work on the social history of Aboriginal nurses and Community Health Representatives in Canada.\(^{38}\) Indigenous health professionals were conspicuous by their absence from the Canadian healthcare system until the 1950s, and continue to exist in disproportionately small numbers to the present day.\(^{39}\) The availability of education for is a major historical determinant of when and how Indigenous people gained access to the health professions in settler colonies. In Canada, most Indian residential schools provided
poor quality (if any) secondary school education, and settler public high schools did not begin to accept Native students until the 1950s, so Native graduates were effectively barred from pursuing higher education in the health professions. For those able to obtain the required prerequisites against the odds, anti-Aboriginal racism in nursing schools and hospitals meant that many would not host Indigenous nursing students or professionals, thus preventing many Aboriginal people from accessing higher education in medicine or nursing during the early decades of the twentieth century. Raeburn Lange reports that Māori probationary nurses experienced similar obstacles in New Zealand during the first decade of the twentieth century. Whilst the Department of Indian Affairs advocated for increases in the number of Aboriginal health professionals from at least 1946, lack of intervention to address poor educational standards and inaccessibility of higher education reveals the ‘hollowness’ of such discourse. In contrast, in New Zealand, the first Māori doctors qualified around the turn of the twentieth century and went on to play significant leadership roles in Māori health care.

Beyond the barriers to training presented by the colonial state and settler society, the many Aboriginal nurses who were motivated to work in their own communities faced an additional obstacle. Medical Services Branch had an unofficial policy of hiring settler women (including white and racialised women, settler-descendants and new immigrants) rather than Indigenous women for professional roles, which had the damaging effects of dividing Indigenous ‘families, resources and interests’. As late as 1983, Aboriginal nurses held just 4 percent of the 800 Medical Services Branch nursing positions. In McCallum’s analysis, this discrimination was based on assumptions that Aboriginal nurses’ professional training would inevitably distance them from their own people, whilst the modernising benefits of their training would risk being undone in the presence of familial and broader social influences. Scholarly discussions about the complex roles played by Black nurses in African-American communities in the United States during the pre-Civil Rights era suggest further questions regarding both colonial governance interests and Aboriginal nurses’ perspectives on their roles. For example, Evelynn Hammonds highlights how professional Black women who worked as nurses and social workers and teachers played significant roles in the lives of African Americans, as both mediators of and protectors from
racist white society. In contrast, Susan Smith suggests that the effects of professionalization and middle-class identity on Black health professionals who participated in the Tuskegee Syphilis Study were to render them blind to the ethical problems of the study’s victimization of poor black men, and therefore ultimately complicit.

Whilst Indigenous women and men gained access to the health professions very slowly and continue to be under-represented, the rapid expansion of Medical Services Branch immediately after the Second World War included the creation of low-status para-professional health care roles specifically for Indigenous workers. By the 1950s Indigenous workers constituted one quarter of Medical Services Branch’s support staff. Community Health Representatives (CHRs) were understood to play a mediating role to facilitate Indigenous communities’ necessary and inevitable progression towards modernity, which would ultimately lead to the latter’s assimilation within the Canadian nation-state and settler society. Assimilationist health policy through the 1950s and 1960s was predicated on the assumption that the provinces would eventually assume responsibility for Indigenous health care. Thus the CHR position ‘was conceived as a dead-end and precarious position low on the Indian Health Services hierarchy and [...] ultimately created with the intention of being phased out to provincial services’. But as McCallum highlights, this programme was distinct from other government labour programmes which tended to equate employment with assimilation; rather, a recognition of indigeneity was central to the work of the CHRs, as indicated by the job requirement of fluency in Aboriginal languages. The Medical Services Branch’s creation of the CHR position signals the central role envisaged for state health care in facilitating the process of Aboriginal assimilation into Canadian settler society.

Colonial health care was also an important site for the creation of settler subjectivities, most notably the construction of settler nurses and doctors as humanitarian and heroic. Canadian medical discourse from the late 1940s understood the isolation of Native people as partially geographic, but more particularly in terms of proximity to ‘civilization’.
Isolation was both central to medical understandings of Aboriginal people, and supported the construction of the health professionals providing their care as adventurous and self-sacrificing.\(^5^6\) As McCallum describes, 

*through concepts of isolation, medical professionals imposed their own ideas of primitive bodies and wilderness landscapes that informed their treatment of Aboriginal peoples as they followed through with policies of removal, relocation, surveillance and assimilation.*\(^5^7\)

In a parallel analysis, Kelm discusses how physicians employed by Indian Affairs in British Columbia during the first half of the twentieth century displayed a ‘strong man ethic’, the determination and derring-do characteristic of British colonizers ‘which sought to conceal the ambivalences of colonial relationships with bold action’.\(^5^8\)

Nurses have played a central role in Indian Health Services in Canada since the 1950s. The massive expansion of Indian Health Services during the 1950s included the hiring of large numbers of staff, among whom nurses (mostly female settler-descendants and new immigrants) were the most significant category.\(^5^9\) The Indian Health Services nurses of the 1950s were portrayed as modernizing heroic professionals:

*these women were the attractive face of the modern and expanding system of federal health care...they showcased their sacrificial, non-traditional yet feminized work as heroic because it suited national interests and expensively and attractively performed the work of the nation.*\(^6^0\)

Helen Gilbert’s analysis of contemporary Canadian nursing discourse of the 1970s through the 1990s demonstrates striking continuities with the earlier discourses on settler heroism and Indigenous primitivism, as well as Victorian imperialist discourses on nursing: the infantilisation of Indigenous peoples and the nurse as bearer of modernizing values.\(^6^1\)

Similarly, medical anthropologist John O’Neil has described the colonial maternalism which continues to characterize the attitudes of white nurses working in northern Inuit communities.\(^6^2\) Health professionals’ discourses and relations are clearly important sites for analyzing contemporary continuities with Canada’s colonial past. The next section considers colonial continuities in urban Indigenous health, alongside contemporary Indigenous understandings of suffering and approaches to healing.
2. Urban Indigenous healing in Canada: decolonization & colonial continuities

*Indigenous Healing and Social Suffering*

Mohawk Scholar Marlene Brant Castellano has emphasized the significance of political and historical analysis for understanding and addressing contemporary distress among Aboriginal people.\(^6^3\) She describes healing as

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*a powerful process of renewal of culture and community life.*[...]* The healing process gains strengths from many sources, but principally from rekindled confidence in traditional wisdom and a political-historical analysis of the genesis of present distress.*

The concept of ‘social suffering’, introduced by anthropologists Veena Das, Arthur Kleinman and Margaret Lock, has inspired a growing body of literature which resonates strongly with Indigenous understandings of healing.\(^6^4\) Unsurprisingly, anthropologists writing about Indigenous healing are among those who have employed the concept. Social suffering is useful in that it deliberately destabilizes the categorization of problems such as depression, suicide, alcoholism and addictions as ‘principally psychological or medical and, therefore, individual’.\(^6^5\) Rather, both social suffering and health are inherently political, cultural and social issues which cannot be separated from relations of power and historical context. Further, by insisting on locating contemporary distress in the historical context of colonialism, social suffering challenges dominant state-imposed models which attribute suffering in the present to Indigenous peoples’ failure to become modern self-governing subjects.\(^6^6\) Thus I use social suffering to describe the multiple individual and collective manifestations of Indigenous people’s distress which are increasingly subject to medicalisation, but are more usefully analysed in relation to colonial histories and continuities.

Of particular relevance to the current research are analyses of social suffering which attend to the historical antecedents of contemporary distress, and the social and political processes by which communities make meaning of and recover from individual and shared experiences of suffering.\(^6^7\) Veena Das and colleagues suggest that scholars investigate such processes through ethnographic explorations of the ‘relation between collective and individual memory’, ‘creation of alternate public spheres for articulating and recounting experiences silenced by officially sanctioned narratives’, ‘retrieval of voice in the face of
recalcitrance of tragedy’, and the ‘meaning of healing and the return to everyday’. I would add that for Indigenous peoples in settler colonies, the negotiation of representations of past, present and future relations with the colonial state and settler society are also a focal point in addressing social suffering. In what follows I discuss how anthropologists have used such approaches in analysing Indigenous social suffering and healing in the context of reserves and rural land-based communities in Canada, before moving on to focus on urban settings.

Historicisation is an important element of studies of Indigenous social suffering, allowing the analyst to describe a clear correlation between the workings of particular colonial institutions and practices and the emergence of distinct expressions of individual and collective distress in Indigenous communities. Anthropologist Adrian Tanner and sociologist Colin Samson both combine social history with ethnographic analysis in their accounts of the devastating impacts of sedentarization on the Cree and Innu, respectively. Tanner describes how assimilation policy contributed to increasing sedenterization and abandonment of traditional livelihoods of hunting and trapping among the east Cree in the late 1960s and early 1970s. Binge drinking became a significant social problem from the 1960s as involvement in hunting and trapping declined, disrupting the structure of social relations, and people spent more time in newly created settlements. Further, Pentecostal proselytization during the 1970s led many to abandon relationships with spiritual beings which had been central to their worldview whilst hunting remained the dominant livelihood. The Innu of Labrador and Quebec trace the emergence of serious social problems in their communities to the establishment of a ‘missionary-inspired’ government school in 1959, followed closely by Canadian government and Roman Catholic missionaries’ enforcement of Innu settlement in villages in Labrador in Quebec during the 1960s. Since this time Innu villages have experienced high rates of alcohol and solvent abuse, suicide, interpersonal violence, accidental deaths and sexual abuse, all contributing to a death rate among people under 30 which is more than 10 times that of the provincial and national averages. By incorporating historical context into their analyses, Tanner and Samson provide important critiques of dominant accounts identifying Indigenous peoples’ failure to modernize as the cause of their social suffering in the present.
Several anthropologists have explored the inter-relationship of political activism, identity (re)formation and healing in Indigenous initiatives addressing social suffering. Naomi Adelson was among the first to invoke the concept of social suffering to describe the multiplicity of co-existing, collective, inter-personal problems experienced in Indigenous communities in Canada as a result of historical and contemporary social forces.\textsuperscript{72} Her account describes how the Whapmagoostui Cree’s opposition to a hydroelectric project in the Great Whale river waterway of northern Québec spurred profound collective reflection on the meaning of Cree identity. Central to this process has been the creation of an annual summer Gathering which provides a carefully structured space for the cultivation of Cree sociality.\textsuperscript{73} Adrian Tanner also describes an emergent healing movement among the Cree of the eastern James Bay region of northern Québec.\textsuperscript{74} In response to growing problems of binge drinking and violence in their community following sedentarization and the concurrent repression of Cree spiritual practices, some Cree have initiated annual gatherings (known in Cree as ciiweydow meaning ‘going back home’), a conscious (re)enactment of traditional hunting camp and spiritual ceremonies located at former trade post and camp sites. The gatherings are explained as ‘efforts to overcome the disincentives to hunting’, ‘education for youth who otherwise experience discontinuities in their exposure to the traditional religion of hunting’, and ‘forms of healing to address social pathologies’.\textsuperscript{75} They are also a conscious effort at generational re-integration, an opportunity for community members to honour Elders and educate youth in Cree knowledge and practices.

Such accounts of contemporary Indigenous healing often emphasise the coexistence of resurrected local knowledge and borrowings from other therapeutic practices. For example, in Adelson’s analysis the Whapmagoostui Cree’s annual summer gathering incorporates both conscious learning of traditional local knowledge and its ‘intermingling’ with ‘new, adopted, and created Cree practices’.\textsuperscript{76} Similarly, contributors to a recent collection edited by James Waldram found common approaches to healing across five programmes studied, with Indigenous spiritualities as a central tenet supported by therapeutic borrowings from biomedicine, complimentary medicine and non-local Aboriginal traditions.\textsuperscript{77} At the same time Waldram stresses that definitions of healing were
firmly located in Indigenous social contexts and ‘about the reparation of damaged and disordered social relations’.

Other scholars have problematised the imposition of forms of ‘pan-Aboriginal’ healing on land-based communities. Colin Samson describes how the First Nations-run Nechi Institute, based in the city of Edmonton in western Canada, received public funding to develop treatment programmes for the Labrador Innu on the east coast in response to the alcohol and solvent abuse crisis widely publicized in 1992-1993. The programmes centred on techniques synthesizing ‘popular psychology, New Age thinking and Alcoholic Anonymous “addiction” models’ with ‘Plains Indian cultural practices’ such as smudging and sweat lodges. In particular, he reports that Innu elders objected to imported sweat lodge practices which were inconsistent with Innu values. Whilst acknowledging some positive effects from these interventions, Samson is concerned by

\[\text{a tendency to ignore that the culturally alien treatment methods have had the effect of pushing aside more genuinely indigenous healing techniques. Such interventions have been made at great expense and with few concrete results for non-urbanized Aboriginal peoples such as the Innu.}\]

This analysis draws attention to the fact that not only do Indigenous nations and communities have varied healing traditions, their respective relationships with the Canadian state are equally diverse and complex. The divergent interests of Nechi Institute and the Innu in increasingly dominant public policy discourses on Aboriginal healing have had significant implications for the Innu, as Samson shows.

**Urban Indigenous Healing**

Urban Indigenous healing remains an under-researched topic, despite increasing scholarly attention to Indigenous healing within the past decade and the fact that for several years, the majority of Indigenous people in Canada have lived in cities. In calling attention to this imbalance, I do not mean to dichotomise on-reserve/ rural and urban Indigenous experiences. As historian Mary Jane McCallum has noted, ‘the tendency remains to isolate urban and reserve history, rather than draw them both into the same temporal sphere’. In this thesis I strive to strike a balance between attending to the historical and continuing
interconnectedness of Indigenous communities in different geographic sites, and highlighting Indigenous people’s particular experiences and challenges in urban settings due to the historical and contemporary social and political factors structuring social relations in cities.

The small existing body of mostly anthropological literature on Indigenous healing in Canadian cities suggests that urban healing shares a broad paradigm with the depictions of rural and reserve-based healing summarized above. Accounts describe central themes of personal and collective loss, and reclamation of and reconnection with culture and community through education and ceremony, undergirded by an historical and political analysis of relations with the Canadian state and settler society. Healing practices are characterized by the resurrection and application of Indigenous knowledge, relationships with spiritual forces, and a reframing of individual suffering within a historical and political context. Elders often play a central role as teacher-healers. For example, in James Waldram’s ethnography of Elder-led spiritual healing in western Canadian prisons, he describes therapeutic work with an aim of

\textit{spiritual and cultural reintegration and the need for Aboriginal inmates to develop better identities as Aboriginal persons. This is an effort to undo the damage done to both Aboriginal society and the Aboriginal psyche by colonization and assimilation.}

Waldram contrasts the Indigenous healing frameworks with the conventional ‘assimilationist’ rehabilitation services within the prisons: the latter focuses on individual-level determinants of criminal behaviour, whilst the former accords primary explanatory power to history. Part of the transformative power of the healing process derives from reframing the patient’s understanding of their problem as beyond the realm of the personal, to include social and historical factors, particularly colonialism. This reframing has the effect of partially dispersing responsibility for the problem, and also of providing insight into the causes and possible solutions to the problem. Waldram notes that the qualification of ‘partially’ is crucial: since individual autonomy is a central value in many Indigenous cultures, the individual will always be expected to take some responsibility for his or her own actions.
Whilst urban and reserve/rural settings may share an Indigenous healing paradigm, anthropologists and others have shown how elements of that paradigm play out differently in urban centres. As Waldram’s work signals, urban Indigenous healing occurs in multiple sites: prisons and the justice system, the streets, women’s shelters, and from the late 1980s Aboriginal-controlled health centres. Less frequently urban Indigenous healing programmes have been located within dominant biomedical institutions – one such example, the Native Healers programme at the Lake of the Woods hospital in Kenora, will be discussed in Chapter Two. Below I provide an overview of how anthropologists and other scholars have approached the multiple distinct features of urban Aboriginal life in their accounts of urban Indigenous healing. I consider issues of identity and community membership; traditional healers’ trajectories and practices; Aboriginal women’s gendered experiences of suffering and their roles in developing institutional, discursive and programmatic responses; urban-reserve connections; and the policy context of intra-governmental jurisdictional conflict.

**Indigenous identity and healing in urban contexts**

The varied individual trajectories and ethno-national diversity of Indigenous urban residents may complicate assumptions of a straightforward relationship between Indigenous history, identity and community membership. Laurence Kirmayer and Gail Valaskakis note that ‘to a large extent, traditional healing draws its authority from its rootedness in a local community with a shared social life’. But in urban Indigenous communities, the content of the Indigenous identity that is to be reclaimed and the colonial history that is to be learned as part of the traditional healing process, is less self-evident than may be the case within a more ethno-nationally homogenous, land-based community. Southern Ontario cities in particular are home to people with a broad range of Indigenous ethno-national identities, each with distinct social histories and healing traditions, as well as large numbers of ‘culturally disenfranchised’ individuals with little or no knowledge of their family and community of origin. In many Canadian cities including Ottawa, Montreal and Vancouver the descendants of the original occupiers of the land constitute a minority of the total urban Indigenous population, and no single First Nation is in a numerical majority. Indeed, according to 2006 census data, the Métis now constitute 43% of the
urban Aboriginal population in Canada. A final factor complicating urban Indigenous identity is that many Aboriginal people have historically concealed their identities in urban settings to protect themselves and their children against everyday and institutional forms of racism.

Existing literature suggests that urban Aboriginal people and agencies have diverse perspectives on the linked issues of identity, healing, and pan-Aboriginal knowledge and practices. Métis anthropologist Craig Proulx analyses the centrality of community (re)integration to urban Indigenous healing in his ethnographic account of the ‘Community Council Program’ run by Aboriginal Legal Services Toronto. This programme aims to break the interactive cycle of addictions/ street life /crime/ prison through supporting participants in (re)claiming their Indigenous culture, developing a sense of personal responsibility in social relationships, renouncing violence, and (re)connecting with their community. Proulx emphasizes that the healing work is about a process of community (re)connection, never about an individual in isolation. What is crucial to the urban Indigenous setting is a flexible understanding of identity, which means that

urban Aboriginal people can begin to think of themselves as members of a community beyond, or without, band or nation affiliation.

But Jairus Skye’s study of Anishnawbe Health Toronto (AHT) suggests that some urban Aboriginal agencies may employ a less fluid understanding of identity. Skye explores the complexities of urban Aboriginal healing and identity-development as mutually constitutive processes, and indicates that urban Aboriginal institutions play a role in policing the boundaries of Indigenous identity. AHT’s policy requires that clients identify as Aboriginal in order to use the centre’s services. Skye explains, ‘Because [AHT] is intended to provide services strictly for the Aboriginal population certain measures have to be put in place to ensure that the rest of the population does not monopolize and exhaust services at the center’. Thus new clients are required to participate in an intake interview -- usually conducted by the most senior counsellor -- which includes questions about the prospective client's ancestry. The senior counsellor asserts
We have a lot of people who come through the door that think they are Native but they're not sure where they come from... we don’t judge that but we would like to know a bit about their history...I need to know if someone is telling the truth.98

Notwithstanding the counsellor’s claim that ‘we don’t judge’, she clearly describes a process of judgement, although the means by which authentic Native identity and truth-telling are assessed is not specified in Skye’s account. This process is justified by reference to the lack of resources and the burgeoning ‘wannabe’ population of ‘new age’ settler-descendants interested in Indigenous spirituality. The counsellor’s defensiveness may be a reaction against dominant liberal attitudes which consider Aboriginal-focused urban programming to be discriminatory.99 Nonetheless, the AHT perspective contrasts with the more open approach to Aboriginal identity described in Proulx’s account above. These issues will be discussed further in Chapter Six.

**Resurrection & synthesis of healing knowledge**

Studies of traditional healers and counsellors working in urban Indigenous agencies settings suggest fluid definitions of ‘healer’ and syncretic healing practices.100 In Skye’s account of healers and counsellors working at Anishnawbe Health Toronto (AHT), the distinction between the two categories is not entirely clear. Some of the healers were identified as healers from childhood and use plant-based medicines, but others work exclusively with energy and spirit and draw on healing traditions beyond Indigenous North America (such as shiatsu) in practices which appear broadly comparable to the work of the counsellors employed at the same centre.101 At Building a Nation (BAN) in Saskatoon clinical staff are described as ‘therapists’, do not use plant-based medicine but are trained in the use of the Cree Medicine Wheel, described as the centre’s ‘main therapeutic tool’.102 Therapists also incorporate smudging ceremonies, inner child therapy, couples counselling and bereavement counselling; Waldram and colleagues note that the ‘somewhat eclectic mix of techniques’ is strongly integrated.103 BAN therapists consider traditional healers as a distinct category and facilitate relationships between clients and healers or Elders from outside the centre.104 But interestingly, BAN’s clients don’t make a clear distinction between the work done by the BAN therapists and traditional healers or Elders working outside of the centre; indeed, many view the therapists as healers.105 Waldram et al frame
this as a case of misrecognition, indicative of the extent to which the clients are lacking cultural knowledge; it might also suggest the need for a sufficiently broad-based definition or spectrum of urban healing processes to recognize the perspectives and needs of the culturally disenfranchised.106

At both AHT and BAN, counsellors, therapists and some healers seem to have developed their knowledge and skills later in life and draw on their lived experiences of suffering and recovery in their therapeutic practice. Relevant lived experience including profound loss, addictions, interpersonal violence and incarceration is also an important characteristic of Elders in Waldram's account of healing in western Canadian prisons.107 Both therapists and clients at BAN emphasize the value of therapists who have “walked the road” of abuse and recovery' and “are on their own path” of healing'.108 In Skye’s account, several of the traditional healers working at Anishnawbe Health Toronto inherited a familial proclivity for healing, another became a healer later in life having recovered from an illness, and in two cases their healing capabilities were recognised by other, established healers. The theme of ‘the wounded healer’ is of course prominent in many therapeutic traditions across history and cultures, and particularly in shamanic practices.109

**Gender & healing**

Aboriginal women have played significant leadership roles in developing urban Aboriginal institutions and services, including gendered approaches to healing.110 Aboriginal women have historically outnumbered Aboriginal men in Canadian cities: some come to cities to pursue educational and employment opportunities not available on reserves or in small rural communities; others are pushed out of reserves by discriminatory enfranchisement policy and experiences of gendered violence.111 Nancy Janovicek’s history of Beendigen, an Aboriginal women’s shelter in Thunder Bay, Ontario, offers insights into how urban Aboriginal women organizing in the 1970s began to articulate their distinct, gendered needs for healing in the context of the broader urban friendship centre movement and discourse on Aboriginal rights.112 Urban Aboriginal women in Ontario developed a critique of dominant feminist understandings of violence which led to an important reframing of
Aboriginal violence in the context of colonialism, as will be discussed further in Chapter Three. ¹¹³

Some scholars have analysed urban Aboriginal women's experiences of suffering and healing in the context of a broader range of urban institutions. Working in Vancouver, Dara Culhane draws on urban Aboriginal women's autobiographical accounts to illustrate how existing services focused on addictions recovery have failed to respond to women's broad and complex needs, including safe housing, supportive social relationships and educational opportunities. She describes women's experiences of 'emerging from a treatment program hopeful and determined to change their lives, only to be undermined by problems in obtaining housing, in surviving on income assistance, or of being relied upon too heavily by others'.¹¹⁴

Also in Vancouver, Cecile Benoit and colleagues describe how poor Aboriginal women's healing and care needs remain largely unmet despite the presence of a putatively Aboriginal-focused health centre, the Vancouver Native Health Society. The original vision of a healing centre run by and for Aboriginal people with a 'commitment to revitalizing and implementing traditional Aboriginal healing and health practices’ has been lost in the face of inadequate public funding, regulations restricting hiring practices and traditional healing, the national shortage of Aboriginal health professionals and traditional healers’ reluctance to work in a clinical setting.¹¹⁵ Further, management and staff at the Vancouver Native Health Society (VNHS) largely support a liberal approach to service delivery which equates equal treatment with fairness. They therefore refuse to prioritise Aboriginal clients on the grounds that ‘health care services must not “ghettoize” Aboriginal people or “encourage a system of apartheid”’.¹¹⁶ As a result, at the time of Benoit’s research just 40% of VNHS clients were Aboriginal, and Aboriginal women were particularly underrepresented amongst the center’s clients. Women in the study described dissatisfaction with the dominance of biomedical approaches to care and the lack of Aboriginal staff at the VNHS, feeling unsafe in the waiting area, and desires for access to spiritual healing, traditional healers and more compassionate and supportive care providers.¹¹⁷
In contrast, a linked service for substance-using pregnant women, Sheway, comes closer to meeting the needs of Aboriginal women in Vancouver. Sheway provides a safer environment more focused on the needs of women and their children. In particular, staff employ a less medically-dominated approach characterized as a ‘non-task-oriented philosophy of care’, meaning that women may use the centre to gain access to food and interact socially with other women and are not required to share personal health information as a matter of course, in contrast to most biomedically-based services including VNHS. Similarly, Waldram and colleagues described the central importance of ‘fellowship and friendship’ at Building a Nation in Saskatoon, where people are free to use the centre’s facilities without necessarily engaging in a treatment programme.118

**The spatial organisation of healing: urban-land connections**
The interconnectedness of urban and reserve life remains largely unexplored in the anthropological literature on urban indigeneities, health and healing.119 Social geographers have made important contributions to scholarly understandings of urban Indigenous communities, introducing conceptualizations of spatiality which problematise the presumed bounded-ness (and indeed binary-relationship) of reserve and urban Indigeneities. Katheryn Graham and Evelyn Peters have stressed the need to recognize urban and ‘non-urban’ Aboriginal populations as ‘interconnected in terms of mobility, culture and politics’.120 Many Aboriginal individuals migrate between urban centres and reserves multiple times in the course of their lifespan. This conceptualization contradicts the pervasive understanding that urban Aboriginal people have abandoned their culture and become assimilated into non-Aboriginal society. Kathi Wilson and Evelyn Peters have shown how Anishnaabeg migrants to Ontario cities employ multiple strategies for maintaining a close relationship to the land in urban settings, for example creating ‘small-scale spaces, within which physical, symbolic, and spiritual relationships to the land can be expressed’.121 As well, some urban Indigenous residents regularly visit their home reserve to participate in healing ceremonies, underscoring the significance of geographic distance, transportation systems and individual economic resources for access to certain forms of healing.122
The ongoing jurisdictional conflict between federal and provincial governments over responsibility for urban Aboriginal programming presents distinct challenges for both developing and sustaining services, and advocating for Indigenous needs. Mary Ellen Macdonald provides a contextualized discussion of these issues in her account of diverse perspectives on the lack of programming for Aboriginal healing in Montreal, Quebec.\textsuperscript{123} Recent federal and provincial policy documents on Aboriginal communities in Quebec fail to mention the Montreal Aboriginal population, indicating the extent to which urban Aboriginal communities remain invisible in the province. (In contrast, in Ontario urban Aboriginal people have been both participants in and the objects of provincial health policy over the past two decades, as shall be discussed in subsequent chapters.) It is therefore unsurprising that the particular health and social service needs of Aboriginal people in Montreal are largely unmet. The dominant system of community-based health and social services, Centres Locaux de Service Communautaire (CLSCs), operate on a postal code-based definition of community which is inconsistent with Indigenous identities in the city and does not recognize the complexity and mobility of that population.\textsuperscript{124} Service providers suggest that the lack of both services in Indigenous languages and Indigenous healing programmes renders an Aboriginal person in Montreal ‘a refugee in his own land’.\textsuperscript{125} At the same time, Macdonald finds that there is no consensus amongst Aboriginal people in Montreal regarding either the need for, or the design of, Aboriginal-specific health and social services. Despite common desires for spiritual approaches to therapy, services in Indigenous languages and a comfortable and welcoming healing space, participants in Macdonald’s study recognised ethno-national heterogeneity, concerns about privacy and confidentiality, and a shortage of Indigenous health professionals as major barriers to the development of such programming.

Some critical anthropological analyses draw attention to the importance of examining urban Aboriginal healing practices over time and in the context of shifting political relations. Heather Howard examined recent practices in putatively Aboriginal-controlled diabetes prevention and management in Toronto, the legacy of work by the late Elder Joe Sylvester and many others which also led to the establishment of Anishnawbe Health Toronto (discussed in Chapter Two of this thesis). Howard found that the programme is
dominated by standardized biomedical understandings of diabetes, with only superficial use of Indigenous knowledge. There is little evidence of the critical historical and activist analysis which informed the birth of the programme. In Howard’s analysis, the political context of continuing lack of clarity regarding government responsibility for urban Indigenous health has constrained Indigenous control over the programme content. This example parallels that of the Vancouver Native Health Society described by Benoit and colleagues, discussed above. The next section considers the role of dominant biomedical institutions and discourses in urban Aboriginal people’s lives, and the salience of self-determination in discussions of Indigenous healing.

3. Challenges to self-determination in urban Indigenous healing: institutions, professions, & the ascent of ‘Aboriginal mental health’

In the context of continuing federal denial of urban Indigenous people’s inherent rights, the struggle for self-determination in Canadian cities plays out through Indigenous people’s efforts to develop and sustain their own institutions, disputes over the role and responsibilities of urban institutions in providing appropriate services for Aboriginal people, and tensions around accountability and competition for resources in delivering Aboriginal-specific programming. With regards to healing programmes in particular, the proximity of urban Aboriginal institutions to large numbers of dominant biomedical institutions and professionals has created both opportunities for collaboration, and conflict over roles and resources. Urban Indigenous groups invoking self-determination are beginning to demand accountability as well as cultural appropriateness from biomedical service providers. Aboriginal people have established dozens of Aboriginal-run healing institutions and programmes in cities in Ontario and elsewhere in Canada since the 1970s, including health centres, women’s shelters, and others. Regardless, dominant public policy discourse continues to discourage separate services, on the grounds that improving universal services should be the priority, and/or that separate services for Aboriginal people represent a form of discrimination. The persistence of this discourse means that urban Aboriginal people often have few or no alternatives to utilising dominant health and social service providers. Thus it is important to consider here Aboriginal people’s experiences of and relationships with urban biomedical services and the broader Canadian
healthcare system. Below I provide an overview of existing approaches to analyzing these experiences and relationships.

**Public health discourse on urban Aboriginal peoples**

Over the past twenty five years, public health analyses of urban Aboriginal health have reproduced stereotypical and stigmatizing discourses which portray Aboriginal people as riddled by social pathologies, and largely responsible for their own suffering due to their inability (or unwillingness) to access modern health care. As Waldram has pointed out, academic studies of urban Aboriginal peoples during the 1970s paid little attention to issues of health or use of health care services.\(^{129}\) When academic public health began to engage with urban Aboriginal health during the early 1980s, despite the dearth of relevant information, a public health discourse pathologising Aboriginal cultures and relationships quickly emerged. ‘Culturalist’ explanations for poor health have predominated, and public health researchers have characterised urban Aboriginal people as disorganized and irresponsible. For example, Shah and Farkas complain that ‘the use of medical services by Native single men and pregnant women in urban centres is often inadequate or inappropriate’, and cite ‘cultural barriers’ to service access, leading them to recommend ‘cultural sensitivity training’ for health care providers.\(^{130}\) Mears and colleagues note disapprovingly that ‘Indians living in the skid-row area of Vancouver tended to neglect their health even when they had the requisite information’ and further ‘they did not make good use of medical services other than hospital emergency departments’.\(^{131}\) Most assessments have been shaped by narrowly epidemiological approaches, and advocated biomedical interventions and programmatic resolution of problems, a pattern which continues in recent publications even as claims are made for greater ‘community participation’.\(^{132}\) Public health calls for the creation of urban Aboriginal para-professional roles in health care show marked continuities with Canadian colonial discourse on Native health. Shah and Farkas recommend the development of an urban ‘Native health care worker program’ based on the Medical Services Branch Community Health Representative programme, but do not articulate a need to train more Aboriginal health professionals.\(^{133}\)
Public health framings of urban Aboriginal people as incapable of using modern health services responsibly were challenged by James Waldram and Melissa Layman’s comparative research on the health care utilization patterns of Native and non-Native patients in the western Canadian city of Saskatoon. Waldram and Layman’s survey showed that there were in fact minimal differences between Aboriginal and non-Aboriginal poor people’s patterns of accessing primary health care services. Rather than the widely-cited ‘cultural barriers’ or inherent backwardness, the reasons why Aboriginal people generally preferred walk-in clinics over registration and appointment-based services were found to be lack of a home phone (due to cost), and difficulties in coordinating appointments with many young children, barriers common to other people with limited material resources.

**Analyzing colonial continuities in health services**

Anthropological and other literature since the late 1980s has moved beyond the ahistorical invocation of ‘cultural barriers’ and ‘poor communication’ in analyzing Indigenous experiences of healthcare, towards analyses which implicate biomedical institutions and health professionals as perpetuating colonial power dynamics in health care provision to Aboriginal people. Medical anthropologists John O’Neil and Patricia Kaufert’s work on Inuit experiences of biomedical care powerfully illustrated the continued dominance of colonial assimilationist ideology in the health care context, including the devaluation of the role of medical interpreters, infantilisation of Inuit patients, and failure to appreciate the sophistication of Inuit culture and its relevance to wellness. More recent qualitative studies provide evidence of the continuities of other colonial discourses, including an inherent proclivity to substance abuse and a preoccupation with Aboriginal peoples as vectors for infectious disease. Thus some scholars have identified colonial continuities which draw attention to the historical role of biomedical institutions and health professions in colonialism.

To deepen our understanding of how colonial discourses exert effects through the Canadian healthcare system, it is also necessary to analyse how continuing colonial discourses articulate with contemporary socio-political discourses in the healthcare system.
Few scholars writing on the substantive topic of Aboriginal health have attempted this approach; more often, contemporary dominant discourses are under-analysed and/or treated as benign. For example, Annette Browne’s ethnographic study of relations between First Nations women in hospital and their nurses identifies clinical practices which marginalize Aboriginal patients. In her conclusion Browne contrasts health professionals’ espoused ‘liberal ideals of egalitarianism’ and their actual behaviour, thereby missing an opportunity to consider how liberal discourse itself can function to exclude Indigenous subjects by perpetuating an ahistorical myth of equality. In contemporary Aboriginal health literature, dominant contemporary discourses are too often left unquestioned or taken as politically neutral. The population health model commonly espoused in Aboriginal health research and policy provides another example. This paradigm may at first glance appear to resonate with holistic understandings of health and healing consistent with many Indigenous perspectives. However, critical scholars have explicated how population health’s narrow conceptualization of the social constrains the analysis of social determinants of health, failing to attend to how structural forces shape the healthcare system and serving to justify reductions in state expenditure on healthcare.

Further, literature on Indigenous experiences of biomedical healthcare generally fails to articulate what is distinct about anti-Indigenous racisms in the settler-colony setting. Approaches to theorizing racisms are commonly borrowed from generic anti-racism discourse such as ‘white privilege’ or an ‘us and them’ binary. Such paradigms may have some applicability in northern Canadian settings but are of increasingly limited application in ethnically diverse cities such as those of southern Ontario, where a significant proportion of health care professionals belong to racialised groups. Other paradigms used for analysing relationships between biomedical practitioners and Indigenous patients such as ‘cultural sensitivity’ and ‘cultural appropriateness’, similarly fail either to draw on the insights into colonial subjectivities offered by the analyses discussed in Section One, or to recognize the extent to which such paradigms originate in multicultural discourse which occludes Indigenous peoples.
Below, the last part of this section considers the increasing prominence of mental health in discussions of urban Indigenous suffering and healing.

**The ascent of Aboriginal mental health**

Some of the major problems preventing the effective community integration of Native People [in Ontario cities] include: Discrimination; Alcoholism; Education; Unemployment; Housing; Health Care; and Cultural Reinforcement.

Ontario Federation of Indian Friendship Centres (1978) *Strangers in our own Land*

Assimilation policies and the genocide attempts on the Aboriginal population such as the 1960’s scoop of Aboriginal children as well as the intergenerational impact of Residential School attendance from 1831 through the 1990’s have resulted in widespread and chronic poor mental health in urban Aboriginal communities. Aboriginal people today suffer the long term effects of sexual abuse and violence as well as the underlying intergenerational effects of collective trauma. [...] Friendship Centre programme staff report that there are increasing numbers of clients who suffer from concurrent mental health disorders and/or multiple mental health problems. [Emphasis added.]

Ontario Federation of Indian Friendship Centres (2006) “Good Mind” Mental Health Strategy

These two excerpts from reports published by the same urban Aboriginal institution, twenty-eight years apart illustrate a marked shift in how the challenges facing Aboriginal people in urban centres are framed. The 1978 report focused almost exclusively (with the exception of alcoholism) on external structural factors shaped by the state and settler society. The 2006 report is centrally concerned with problems internal to individual Aboriginal people. Of course the later report also pays attention to structural factors including poverty, homelessness, incarceration and unemployment as determinants of Aboriginal mental health. But a major conceptual shift is indicated in that the point of intervention becomes quite different when the primary problem is located within the individual, rather than within social structures and processes. As David Mechanic points out, ‘the concepts of mental health and mental disorder are frequently used in an imprecise and ambiguous way and come to encompass a wide range of social problems’. 142 These framings of social suffering ‘implicitly suggest that these problems reside more in individuals than in the organization and patterning of the community itself’, and that ‘the
proper means of changing these conditions is through changing the personalities and inclinations of individuals rather than through changing the structure of the society itself.

The expansion of the field of mental health within the past two decades into terrain increasingly coterminous with that of Aboriginal healing has attracted critical attention from scholars. In a recent special edition of psychological anthropology journal Ethos guest-edited by Gros Ventre psychologist Joseph Gone, several scholars shared ethnographic analyses of how dominant mental health and addictions discourses and practices have imposed their ontologies in Indigenous communities, whilst offering little to alleviate local social suffering. In his introduction to the issue Gone characterizes the emergence and expansion of Aboriginal mental health programmes in the United States and Canada as ‘a cottage industry devoted to the surveillance and management of the “mental health” problems of North America’s indigenous peoples’ Further, he argues that the field of Aboriginal mental health ‘harbors the ideological danger of an implicit Western cultural proselytization’ which constitutes an emerging form of colonial violence:

*It may be that the missionary, military and anthropology vanguard of the historic “White-Indian” encounter has been displaced of late by the professional psychotherapists or credentialed counsellors of the “behavioural health” clinics who, armed with their therapeutic discourse and their professional legitimacy, are “using a more shrewder way than the old style of bullets” to resolve the age old “Indian problem”.*

It is pertinent here to briefly consider the broader literature treating the expansion of the field of mental health as a historical phenomenon resulting from social, political and economic processes. Psychiatrist and medical anthropologist Arthur Kleiman recently described how mental health has extended its reach

*to include both clear-cut disease, and vaguer, though no less serious, problems of everyday living, as well as the results of catastrophes [such that] the term “mental health” became an unwieldy, even an unbelievable odd lot. Now in DSM with hundreds of subcategories it seems to simultaneously trivialize the most serious of medical conditions, and to medicalize social problems.*

Over the past three decades mental health discourse has effectively medicalised social suffering, in North America and beyond. The massive expansion of the terrain of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in its third edition in 1980, and the increased availability and aggressive marketing of psychopharmaceuticals, have
driven the expansion of diagnostic boundaries, as exemplified by the dramatic increase in
diagnoses of mood disorders including depression and bipolar disorder over the past
twenty years.\textsuperscript{147} The rise of biological psychiatry and the linked growth of the
psychopharmaceutical industry have shaped mental health knowledge and practice
internationally, focusing attention on neurobiological models of causation of distress and
marginalizing social factors.\textsuperscript{148} At the same time, many consumer-survivor and family
groups have embraced neurobiological models as liberating those diagnosed with mental
illnesses and their families from the burden of guilt associated with implied
responsibility.\textsuperscript{149}

Significant shifts in the organisation and delivery of mental health services over the past
forty years must be contextualized against the broader erosion of the welfare state. The
proliferation of psycho-pharmaceutical prescriptions in the context of the retrenchment of
public healthcare is clearly not coincidental. Health practitioners lacking the time and
financial resources to offer sustained interpersonal support to distressed patients can
instead offer psychiatric medication. ‘In part, because they offer simple remedies to
problems with a host of complex, and often ill-understood, sources, psychiatric medications
often seem to be practical solutions to many forms of difficulty, distress and suffering’.\textsuperscript{150}
But as Kirmayer and Raikhel suggest, this very simplicity and relative inexpensiveness may
be invoked by policymakers to justify increasing reliance on psycho-pharmaceuticals and
continuing under-investment in community-based social support for suffering.\textsuperscript{151}

Broader social, political and economic forces also shape experiences and perceptions of
mental illness on the one hand, and policy responses to these on the other, as critical
anthropological and historical analyses illustrate. The interface between housing and
mental health is salient in urban settings, and of particular relevance for urban Indigenous
populations who are over-represented among the homeless in Canadian cities.
Anthropologist Kim Hopper has shown how the massive loss of affordable housing has
contributed significantly to the apparently burgeoning number of urban homeless people
with severe mental illness. Hopper argues that focusing too narrowly on the closure of
psychiatric hospitals as the main precipitating factor for the latter phenomenon obscures
the importance of housing policy and other, broader social context. Whilst he draws on ethnographic research in New York his analysis is applicable to many North American cities. Hopper points to the time-lag between the closure of local psychiatric hospitals during the 1960s, and a significant increase in apparent psychiatric problems among the growing homeless population in New York City years later, during the late 1970s and early 1980s. He argues that it is the combined effect of rapid gentrification, the state’s failure to curb landlords’ exploitative practices, and falling incomes among the lower classes, which has contributed most significantly to a growing population of homeless people suffering from severe distress including active psychosis. Hopper’s analysis demonstrates how structural shifts can precipitate significant increases in the suffering of vulnerable groups. Framing this as a simple increase in the prevalence of people with mental illness not only obscures these important contextual factors, but diverts attention from a broad-based policy response addressing housing and poverty, towards a narrow focus on mental health interventions.

This brief critical overview of how the contemporary field of mental health has been historically constituted stimulates questions regarding the emergence of ‘Aboriginal mental health’ in urban Indigenous healing discourse and Canadian public policy at this juncture in time. What is at stake, discursively and materially, in utilizing Aboriginal mental health as a framework for explaining and managing Indigenous suffering? Are there structural advantages, such as increased access to resources? Does this framing risk medicalizing suffering which is inherently social? What are the implications for Indigenous people’s experiences of healing and receiving care in urban settings, for Indigenous knowledge and subjectivities, for relations between Indigenous peoples and the Canadian state and settler society? I engage with these questions in Chapter Six.

4. Methodology
I began this project in 2005, inspired by my observations of how ‘Aboriginal mental health’ had recently risen to prominence in Canadian public policy discourse and was becoming a dominant framework for making sense of and responding to Indigenous social suffering.
This line of thinking was bolstered by my abiding interest in the literature on psychiatry and colonialism. Inspired by the trend in colonial studies and historical anthropology towards locating North American history in the context of international imperialisms, I set out to do an historical ethnography of the respective roles of the Canadian state and other actors in shaping public policy and discourse on Aboriginal mental health, imagining that I would draw on comparative material from other colonial sites in my analysis. My initial approach was also motivated by a desire to avoid reproducing the objectification of Aboriginal communities which continues to characterize much ‘Aboriginal health’ research in Canada, coupled with experience of the limitations of ‘community based’ research which optimistically frames ‘community participation as a simple route to emancipatory practice’. Further, I understood that Indigenous and other scholars have leveled similar critiques at anthropologists (who, to be fair, have gone much farther than public health researchers in reflecting on the historical and contemporary power implications of disciplinary practice).

Thus I was determined to make the Canadian state and public policy, rather than Aboriginal people, the objects of my analysis.

My initial conceptualization was complicated by my desire to focus on urban Aboriginal communities. I was aware that the concerns of urban Aboriginal communities had been neglected by public health research, and interested in the complexities and controversies of relations between urban Aboriginal agencies and dominant biomedical institutions. What I did not fully appreciate at that time was the extent to which the federal government’s abdication of responsibility for urban Aboriginal people meant that urban Aboriginal health and healing have only been recognised as policy issues by certain elements of the Canadian state (such as the Ontario government) within the past two decades.

Thus as with so many ethnographic projects, my focus shifted as my understanding of the issues developed. Two major developments are worth highlighting here. First and most significantly, my central focus migrated from ‘Aboriginal mental health’ to ‘Indigenous healing’. Following this shift, I began to appreciate that whilst archival sources are essential for analyzing the histories of policy discourse, they are of limited value for
understanding urban Indigenous healing as a socio-political phenomenon. Whilst I had always intended to incorporate oral history, with my emerging focus on healing I realized that urban Indigenous social histories in particular would need to constitute a major source. Below I provide an overview of the research process, including the major methodological choices I made, the constraints and opportunities I encountered, and reflections on the analytic consequences. The following sub-section discusses the details of sources and methods.

**Analytic Trajectory and Insights**

With hindsight, my original interests and motivations led me to focus disproportionately on the role of state at the expense of attending to the roles of Indigenous social actors. In particular, my interest in the role of psychiatry in colonial governmentality, inspired by a Foucauldian understanding of power-knowledge, drew my attention away from more subjugated knowledge, as I framed questions with a focus on the role of psychiatry and mental health institutions in the production of (urban) Aboriginal subjects. This was compounded by the misguided decision to familiarize myself with the political and policy context of urban Aboriginal mental health prior to commencing oral history interviews. This turned out to be a less fruitful line of enquiry than I had hoped given the Canadian state’s very limited recognition of this as a policy issue, as I noted above.

An important insight helped to reorient my analysis in a more productive direction, as I switched from interviewing national-level policy actors to those working in urban agencies. Whilst early interviews with policy-makers validated my impressions of Aboriginal mental health as a salient concern, interviews with Elders, directors and staff working out of urban agencies presented a much less consistent picture. I quickly became aware that not only had the Aboriginal mental health paradigm had not been taken up by urban agencies as consistently as national discourse suggested, but that there was an important history of healing as a socio-political movement which preceded the emergence of the Aboriginal mental health framing by several decades. My first oral history interview with Sylvia Maracle, Executive Director of the Ontario Federation of Indian Friendship Centres, facilitated a major shift in my thinking. Given her knowledge of urban Aboriginal
programming dating back to the 1970s, Sylvia’s account helped me to make connections between the early efforts of urban Aboriginal communities to address problems of alcohol abuse, child neglect and violence, and later discourses on mental health. In particular she drew my attention to the early harm-reduction work of the Kenora Street Patrol in the 1970s. Further, because Sylvia had been present as a young newspaper reporter at the 1974 Anicinawbe Park occupation in Kenora, she was also able to situate the emergence of the Street Patrol’s pioneering response to urban Indigenous suffering in the context of the Red Power movement and the broader political struggle for self-determination. Sylvia introduced me to Elder Joseph Morrison, who not only provided a detailed social history of the Indigenous healing movement in Kenora, but also made connections with community leaders’ experiences of residential schools. Oral history from Elders Vern Harper and Lillian McGregor in Toronto provided similar context for that city.

Unfortunately it was late in the research process when I developed insights about the centrality of local social history to my evolving research questions. This meant that I was not able to pursue particular lines of investigation as fully as I would have liked. For instance, I wanted to conduct further oral histories in Kenora (particularly relating to the Native Healer project at the Lake of the Woods Hospital, discussed in Chapter Two) but lacked either time to pursue the necessary social connections or, at that stage in the research, financial resources to travel the considerable distance from Toronto. This has become a priority direction for future research. I also didn’t have enough time to facilitate connections with Elders in Ottawa and Hamilton who could have provided detailed local socio-historical contexts for Aboriginal healing in those cities.

Fortunately, interviews with Directors and staff at multiple agencies in all three cities were somewhat easier to carry out, and enabled me to develop my understanding of the ideology and practice of urban Indigenous healing more fully.\footnote{159} (However my initial preoccupation with mental health limited the range of my questions during earlier interviews). Taken together, these interviews provide recent historical context (dating back to the early 1990s) and insights into the challenges and trajectories of healing practice in southern Ontario cities. Some participants also spoke frankly about how their personal healing
journeys have led to their current positions as workers in urban Aboriginal agencies. These generous contributions -- quite unsolicited as I had not intended to delve into the ‘personal’ to such an extent -- significantly enhanced my appreciation for the interconnectedness of individual recovery and collective community-building as important dimensions of urban Indigenous healing.

Sources
My analysis draws from three main categories of sources: national and Ontario provincial archival documents; transcribed oral history interviews; and ethnographic fieldnotes and interview transcripts based on limited participant observation in a clinical mental health setting. These major categories were supplemented by other sources including informal interviews with key informants, contemporary policy documents and grey literature, and published secondary analyses. Below I discuss each of the major categories in turn, incorporating a discussion of ethical considerations and informed consent processes where relevant.

Archival Research
As I worked my way through files at Archives Canada (the national archives) I realized that both Aboriginal mental health and urban Aboriginal peoples were marginal topics in the history of Canadian public policy on Aboriginal health. Whilst Medical Services Branch files contained some interesting correspondence indicating communication between psychiatrists and senior MSB officials during the 1940s and 1950s (discussed in Chapter Three) and regional reports included occasional references to mental health in the context of evidence of high rates of suicide on some Ontario reserves during the 1970s, I found little of direct implication for urban Aboriginal peoples. The files of the Native Alcohol Abuse Programme (later Native Alcohol and Drug Abuse Programme) were an exception, as this programme did fund some urban projects in Ontario and elsewhere.

I found more of relevance to my interests in the Ontario Provincial Archives, although nothing relating to urban Aboriginal peoples or Aboriginal health dating prior to the late 1980s. The Community Mental Health Services Program files (record group 10-76) from
1994 to 1996 included multiple files pertaining specifically to Aboriginal issues and others in which Aboriginal issues were addressed. Earlier Records of the Health Programs Unit (1989-1995) included some relevant material but one file of particular interest [Record group 10-259, Records of the Health Programs Unit, Minister/Deputy Minister/ Assistant Deputy Minister correspondence: Multicultural health – Ontario Métis and Aboriginal Associations [199-] B324291] was withheld in full.\textsuperscript{162}

**Oral histories**

Between September 2008 and April 2010 I conducted oral history interviews with thirty participants in Ottawa, Toronto and Hamilton.\textsuperscript{163} For analytic purposes the participants may be grouped into two broad categories: first, national policy actors, including people currently or previously working within the First Nations and Inuit Health Branch* of Health Canada, the Aboriginal Healing Foundation, leaders of national Aboriginal organisations and scholars involved in national policy; and second, urban programme actors (some of whom have also been involved in provincial policy-making), including Elders, directors and staff of Aboriginal agencies, and psychiatrists and psychologists. In addition to the thirty people interviewed, another two declined to participate, two did not respond to emailed invitations, and one national Aboriginal leader was willing to participate but was obliged to cancel two scheduled interviews at the last minute, after which I abandoned my attempts. In three cases the person I initially approached to participate delegated the invitation to another person within the same organisation. Most of the oral history interviews were digitally recorded and professionally transcribed. In three cases, participants were not willing to be recorded but gave permission for me to take notes, which I later word-processed. This component of the research was reviewed and approved by the University of Toronto Health Sciences Research Ethics Board.\textsuperscript{164} Where oral histories obtained as part of this research are cited or quoted in the text, the corresponding footnote provides the details of the interview including name of the participant, date, place of interview, reference number, and where relevant the section of the audio recording (minutes) which is being referenced.

\* Formerly Medical Services Branch
**Participant Observation**

I initially intended that long-term ethnographic research with a clinical mental health team in a large biomedical institution would constitute the major focus of this research. My proposal outlined multiple situations in which I hoped to observe and informally interact with clinical staff, including team meetings and clinical rounds, as well as key informant interviews. Several constraints prevented this part of the research from unfolding as I had expected. First, the institutional ethnics review board from which I was required to gain approval appeared to have little familiarity with or sympathy for either anthropological methodologies or research which took health professionals and their culture as its objects, rather than patients. The reviewer queried the description of the research as participant observation on the grounds that I was not ‘a qualified member of the group being observed’, i.e. a health professional. The idea of informed consent as something which may be continually negotiated in the context of ethnographic research was alien and unacceptable. Although I was not seeking permission to observe or interact with patients, because I would be privy to discussions of patients during rounds and meetings I was required to negotiate a process of obtaining informed consent from each patient in advance of each meeting/rounds. The entire process of negotiating approval from the institutional Research Ethics Board took approximately ten months and multiple rounds of revisions.

The second major challenge I encountered was resistance to the research from the clinical staff. I obtained initial permission to work with two clinical teams from the relevant directors and managers, facilitated by the programme’s partnership with an Aboriginal services agency (with whom I had a prior professional relationship). Henceforth I describe the two teams collectively as the ‘Mood Disorders Programme’, and where pertinent will distinguish between the inpatient or outpatient service. I participated in several lengthy team meetings and ‘behind-the-scenes’ discussions with individuals in order to work out the complex logistics of obtaining patient consent, and two separate version of clinician’s consent: first, consent to participate in a key informant interview and second, consent to have their contributions noted during rounds and meetings. It was the latter which turned out to be unacceptable to many clinicians, and ultimately I had to abandon this part of the
research. As the negotiation process itself illuminated clinicians’ perspectives, I have incorporated a more detailed discussion into Chapter Five. Key informant interviews conducted as part of this research are referenced following the same practice as that described for oral histories, except that the participant is unnamed.

**Learning to Listen**

I began this project confident of my interviewing skills, having many years of prior research experience to draw from. Although new to historical interviewing, everything I read convinced me that the basic approach was not so different from the ethnographic and semi-structured qualitative interviewing I was familiar with. I followed the excellent advice of my historian supervisor to prepare exhaustively for each interview, and during my first few interviews with senior policy makers, I felt gratified when I was able to effectively jog their recollection of the date or chronology of particular programmes.

My self-assurance dissolved during my first interview with an Elder. In two hours we covered barely two of my questions. Having previously taken pride in my ability to tolerate silences in interviews, I found myself literally biting my tongue to keep from interrupting or rushing him. Afterwards I was a bundle of nervous tension, frustrated by my inability to direct the course of the interview and deeply doubtful as to the relevance of what he had shared to my research question.

With a lot of reflection and a little experience I transformed my approach to interviews. Grafton Antone, resident Elder at First Nations House at the University of Toronto, gave me two excellent pieces of advice which complemented that of my supervisor. First, he helped me to understand the importance of ceremony to knowledge-sharing. I had previously understood tobacco-offering in a superficial way, a hurdle to be cleared in order to gain access, like an ethics review form based on a positivist research paradigm. With teachings from Grafton and others I came to appreciate that ceremony such as the offering of tobacco is central to structuring relationships in the context of research and an important first step towards building trust.167 Second, he helped me to develop greater patience and to overcome my anxiety about the possibility of becoming entangled in factionalism and
community conflict. His advice was to begin with clarity about both my own intentions and the social location of each person I am interviewing, and that this would allow me to ‘become’ each person in turn. Eventually I merged these ideas by developing a practice of deliberately reflecting on my current self-location and my prior knowledge and assumptions about each participant as I prepared the tobacco tie which I would present during our first meeting.\textsuperscript{168} This preparation helped enormously with temporarily setting aside my own research agenda and becoming fully present and engaged with the person sharing his or her knowledge with me.

5. **Overview of thesis**
The following chapters provide a multi-layered analysis of how ideas and forces have interacted to shape the contexts and practice of urban Indigenous healing in Ontario over the past four decades. The endurance of colonial discourses in and through public policy, institutions and professional knowledge is a prominent theme woven through the thesis. Indigenous peoples’ strategic engagement with and active opposition to colonial ideas and institutions is a second theme which appears throughout.

Chapter One provides essential socio-historical context for the chapters which follow by providing an overview of how Canadian colonial policies and discourses in the twentieth century have caused social suffering in Indigenous rural/ reserve-based communities, focusing on the period 1945-1969. This background provides insight into the linked phenomena of Indigenous social suffering and urban settlement from the post-war period to the present, and emphasizes the continuing interconnectedness of reserve and urban Indigenous lives. This chapter also introduces my historical-anthropological approach to understanding Canadian colonialism, which focuses on continuities and discontinuities in colonial discourses, policies and practices, and locally and regionally-located social histories. I interweave life-histories from three urban-dwelling Elders with archival and secondary historical sources.

In Chapter Two I foreground urban Indigenous actors and contextualize the emergence of urban Indigenous healing practices in relation to the broader political struggle for the
recognition of Native rights. Here I draw from oral histories and archival sources to discuss how Indigenous people experienced both challenges to and opportunities for social organizing in Ontario cities during the 1970s and 1980s, with detailed ethno-historical examples from the cities of Kenora and Toronto. I explore urban Indigenous self-determination in the context of political and economic constraints, and the conflicts inherent to working with and within dominant institutions such as prisons and hospitals.

Chapter Three is structured around the enduring theme of the colonial pathologization of Aboriginal parents and families, and Indigenous challenges to such framings. I consider the role of mid-twentieth century psychiatry in legitimizing assimilationist practices including the removal of Aboriginal children from their families, drawing on international historical literature and Canadian archival sources. Aboriginal critiques of and protests against Canadian child welfare practices from the 1970s led to the emergence of Aboriginal-controlled programmes during the late 1980s. The chapter then shifts to the 1990s when Aboriginal children became the focus of Canadian public policy, whilst ‘Aboriginal mental health’ assumed a totalizing definition, encompassing all aspects of social suffering whilst advocating individualistic behavioural interventions. Finally I discuss Indigenous leadership in developing the 1994 Ontario Aboriginal Healing & Wellness Strategy. This important policy named colonialism as a determinant of contemporary Indigenous suffering -- perhaps the first Canadian policy to do so -- and incorporated an Indigenous framing of family violence and articulation of healing as a collective, social process.

Chapter Four addresses the Canadian state’s engagement with ‘Aboriginal healing’ from the late 1990s, against the backdrop of emerging international discourses on trauma, reparations and reconciliation. The Royal Commission on Aboriginal Peoples, mental health professionals and Aboriginal political organisations adapted and leveraged these discourses to advocate for government and public attention to Indigenous suffering in Canada, forcing the insertion of colonial history into the domain of public policy. I draw on oral history interviews with policy makers and others, policy documents, media sources and research literature to analyse the discursive and material effects of policies on residential school reparations, reconciliation and Aboriginal healing. My analysis
problematizes assumptions about testimony as an inherently healing process, challenges the appropriateness of an individualistic model of reparations and questions the implications of recent policy developments for understandings of colonial histories. This analysis is juxtaposed with the recognition of the potentially powerful positive effects of policy as a catalyst for social processes of healing.

In Chapter Five I consider how Canadian multiculturalism conceals the existence of Indigenous peoples via an exploration of how mental health policy development and institutional practices in Ontario have marginalized Indigenous interests. I draw on archival material to show how community activists, health policymakers and institutions in Ontario began to embrace a liberal multicultural model during the late 1980s and subsumed Aboriginal issues within this paradigm. Indigenous peoples articulated their resistance to being subsumed within multicultural mental health policy and protested their exclusion from strategy development and funding opportunities. The second part of this chapter is based on ethnographic fieldwork in a biomedical institution, and shows how the dominance of ‘diversity’ and ‘cultural competence’ models in mental health, combined with discourses on professional excellence and best practice, have served to perpetuate the marginalization of Indigenous interests in this urban mental health care setting. Mental health practitioners have difficulty recognizing Indigenous clients and their needs, whilst professional and institutional pressures prevent them from admitting to their lack of knowledge.

Chapter Six discusses important developments in urban Indigenous healing since the mid-1990s, including how urban Indigenous peoples have engaged with provincial and federal policies addressing Aboriginal healing, and the marked increase in invocations of mental health as a framework for making sense of urban Indigenous suffering. It considers both momentum towards and obstacles inhibiting urban Indigenous self-determination and self-governance, in the context of a growing number of agencies engaged in healing and continuing funding constraints. Here I raise the question: if histories help make meaning of suffering in the present, what are the implications of how histories, including healing traditions, are framed in therapeutic settings? I explore the implications of healing programmes as sites for the assertions of distinct ethno-national histories and identities,
such as that of the Inuit in Ottawa, compared with generic ‘pan-Aboriginal’ approaches to healing, and the dominance of residential school experience as the ultimate symbol of suffering.

Chapter Seven concludes the thesis by reflecting on the contributions of historical analysis to understandings of urban Indigenous healing, and the implications of invocations of Indigenous and colonial histories by differently-situated social actors.

A central premise of this thesis is that location in time and space is important for understanding the interrelationships between colonial histories, colonial continuities in the present, and urban Indigenous healing practices. The chapters which follow are thus organized according to thematic focus and also, in some cases, historical timeframe and geographic focus. Chapters Two and Six focus particularly on urban Indigenous communities in Ontario, whilst Chapter Five is concerned with the urban backdrop as constituted by provincial mental health policy, social movements and urban biomedical institutions. Chapters Three and Four address issues (psychiatric discourse, Aboriginal parenting and family healing, and Canadian public policy on Aboriginal healing) which transcend a particular location, although I continue to draw out implications for urban Indigenous peoples and healing.
End-notes to Introduction

3 Krista Maxwell, "The Racialized 'Other' and Health Care in Britain: The Case of Sickle Cell Disorders" (School of Oriental and African Studies, University of London, 1997); K. Maxwell, A. Streetly, and D. Bevan, "Experiences of Hospital Care and Treatment Seeking for Pain from Sickle Cell Disease: Qualitative Study," British Medical Journal no. 318 (1999).
6 Ibid., 6.
10 Cooper, Colonialism in Question. Theory, Knowledge, History.
11 For example in 1995 a Department of Foreign Affairs document referred to ‘Canada's history as a non-colonizing power, champion of constructive multilateralism and effective international mediator, underpins an important and distinctive role among nations as they seek to build a new and better order’. Foreign Affairs and International Trade Canada, Canada in the World. Canadian Foreign Policy Review (Ottawa: Foreign Affairs and International Trade Canada, 1995).
12 See for example Noel Dyck, ed. Indigenous Peoples and the Nation-State: "Fourth World" Politics in Canada, Australia and Norway (St John's: Institute of Social and Economic Research, Memorial

13 These are not new claims. For example, Victoria Freeman provides an account of Mohawk (Kanienkeha) Chief Samson Green’s speech asserting his peoples’ status as ‘allies, not subjects of the crown’ at Toronto’s semi-centennial celebration in 1884. In 1914, the Six Nations Confederacy Council used the occasion of the outbreak of the First World War to assert their status as ‘allies of the Crown’ whilst denying Canadian military jurisdiction over Six Nations men. In 1921 and 1923 the Council sent Deskaheh, Cayuga Chief Levi General to represent the case for the Confederacy’s sovereignty in London and to the League of Nations in Geneva. Victoria Freeman, ""Toronto Has No History!" Indigeneity, Settler Colonialism and Historical Memory in Canada's Largest City.," Urban History Review 38, no. 2 (2010); Sally M. Weaver, "The Iroquois: The Grand River Reserve in the Late Nineteenth and Early Twentieth Centuries, 1875-1945," in Aboriginal Ontario. Historical Perspectives on the First Nations., ed. Edward S. Rogers and Donald B. Smith (Toronto & Oxford: Dundurn Press, 1994), 245; 47.

14 Their critique of the ambiguity regarding the timing of colonization, and implication of a consistent set of motivations and practices over time, foreshadows that of Cooper which I have discussed above. Unfortunately Wotherspoon and Satzewich have not updated their discussion of colonialism for the most recent (2000) edition of their book, so it is not clear whether they are insisting that their arguments still hold notwithstanding growing scholarly interest in North American colonialism through the 1990s. Wotherspoon and Satzewich, "Political Economy Versus the Chicago School and Internal Colonialism: Class, "Race", Gender, and Aboriginal Peoples."


18 Wotherspoon and Satzewich, "Political Economy Versus the Chicago School and Internal Colonialism: Class, "Race", Gender, and Aboriginal Peoples."

19 Abele and Stasiulis, "Canada as a "White Settler Colony": What About Natives and Immigrants?," 269.

20 Adele Perry includes a focus on mixed-race relations and cultural hybridity in Adele Perry, On the Edge of Empire: Gender, Race, and the Making of British Columbia, 1849-1871 (Toronto: University of Toronto Press, 2001).

21 Mawani, Colonial Proximities. Crossracial Encounters and Juridical Truths in British Columbia, 1871-1921, 12., emphasis added.

22 Ibid., 15.

23 For example, Wotherspoon and Satzewich question the relevance of colonialism to Indigenous peoples living off-reserve and in urban areas: 'it is unclear how the model applies to Aboriginal peoples who, while they may be subject to various forms of racist hostility and exclusion, are not subject to the social, economic, and political controls of INAC and the Indian Act. These groups have different relationships to the Canadian state than do reserve-based Indians'. This question is based on a narrow understanding of colonialism which neglects the social and cultural dimensions of colonial relationships
which apply equally to Indigenous people in various settings. It fails to recognize that ‘various forms of racist hostility and exclusion’ are structured by colonial ideologies and relations which go far beyond the practical workings of the Indian Act and government bureaucracy. Further, it reifies the distinctions created by the Indian Act, failing to recognize that off-reserve, non-status and urban Indigenous peoples maintain social relations with those living on reserves. Wotherspoon and Satzewich, "Political Economy Versus the Chicago School and Internal Colonialism: Class, "Race", Gender, and Aboriginal Peoples."


30 For discussions of colonial medicine and the protection of European settlers from 'Native' epidemics see Anderson, Colonial Pathologies. American Tropical Medicine, Race, and Hygiene in the Philippines; Rajnarayan Chandavarkar, "Plague, Panic and Epidemic Politics in India, 1896-1914," in Epidemics and Ideas, ed. Terence Ranger and Paul Slack (Cambridge: Cambridge University Press, 1992); John Farley, "'Bilharzia: A Problem of Native Health', 1900-1950," in Imperial Medicine and Indigenous Societies, ed. David Arnold (Manchester & New York: Manchester University Press, 1988); Mary Ellen Kelm,


36 Kelm, Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950.

37 Ibid., 172. For discussions of similar dynamics in colonial African settings see Vaughan, Curing Their Iills: Colonial Power and African Illness. and ; Gordon, "A Sword of Empire? Medicine and Colonialism at King William's Town, Xhosaland, 1856-91."

38 McCallum, Twice as Good – a History of Aboriginal Nurses; ———, "Labour, Modernity and the Canadian State: A History of Aboriginal Women and Work in the Mid-Twentieth Century".


40 Indian Affairs records show that until the 1930s, only a minority of hospitals were willing to host Indigenous student nurses, whilst hospitals in British Columbia were “reluctant” to accept Aboriginal students or employees as late as 1952. McCallum, "Labour, Modernity and the Canadian State: A History of Aboriginal Women and Work in the Mid-Twentieth Century", 246 f.n.60, 57 f.n.88.


44 McCallum, "Labour, Modernity and the Canadian State: A History of Aboriginal Women and Work in the Mid-Twentieth Century", 239-42.

45 Created as a division of the Canadian Department of Indian Affairs in 1927, Medical Services Branch (MSB) was transferred to the Department of National Health and Welfare (now Health Canada) in 1945. MSB is responsible for the health of status Indians living on reserve. Ibid., 242.

46 Ibid., 239.


50 McCallum, "Labour, Modernity and the Canadian State: A History of Aboriginal Women and Work in the Mid-Twentieth Century".

51 Ibid., 243.


54 Ibid., 163.

55 ———, "This Last Frontier: Isolation and Aboriginal Health."

56 The medical discourse on isolation also bolstered the dominant settler understanding of Indigenous peoples as vulnerable to disease, by virtue of both their geographic distance from modern European bio-medical facilities, and their (culturally and/or biologically) inherent ‘difference’. The continuing dominance of this discourse in contemporary Aboriginal health research is evidenced by the disproportionate concentration of research resources on ‘isolated’ communities, to the neglect of the

57 McCallum, "This Last Frontier: Isolation and Aboriginal Health," 107.


61 Gilbert, "Great Adventures in Nursing: Colonial Discourse and Health Care Delivery in Canada's North."


67 This is the focus of the second volume in the above-named series, Das et al., *Remaking a World. Violence, Social Suffering and Recovery.*

68 Ibid., 3.


71 Ibid., 110.


Tanner, "The Origins of Northern Aboriginal Social Pathologies and the Quebec Cree Healing Movement."

Ibid., 262.

Adelson, "Reimagining Aboriginality: An Indigenous People's Response to Social Suffering."


Ibid., 6.


Tshenut (older Innu people) objected to the Nechi Institute’s use of sweat lodges on the grounds that the participants ‘are not “sick”’, that the lodges should be situated in the country rather than in the village, and that participants were not showing due regard for the power of the spiritual forces invoked. Ibid., 112-13.

Ibid., 112.

To illustrate, in two important recently-published collections on Aboriginal healing and mental health in Canada, urban issues were the focus of two out of twenty and one out of five sections, respectively. Laurence J. Kirmayer and Gail Guthrie Valaskakis, Healing Traditions. The Mental Health of Aboriginal Peoples in Canada (Vancouver & Toronto: UBC Press, 2009); Waldram, ed. Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice.

Ibid., 74-75.

Regarding personal responsibility for healing, Métis psychologist Joseph Couture wrote, ‘one must keep in mind, because it has implications for therapy, that [...] there are unequivocal traditional teachings regarding personal responsibility for one’s actions and their consequences, as these guide the maintenance of essential life-giving and restoring connections.’ Similarly, Adrian Tanner notes that among the Cree of northern Quebec engaged in community healing activities, ‘regardless of who is to blame for causing the social pathology, it is those most directly concerned who must take responsibility for finding the solution’. Joseph E. Couture, "Aboriginal Behavioral Trauma. Towards a Taxonomy," (Saskatoon, SK: Corrections Canada, 1994), 5-6. Tanner, "The Origins of Northern Aboriginal Social Pathologies and the Quebec Cree Healing Movement," 267.

Aboriginal people founded their own urban health centres in some of the larger Canadian cities from the late 1980s, including the Aboriginal Health and Wellness Centre in Winnipeg in 1988, Anishnawbe Health Toronto in 1989 (discussed in chapter two of this thesis), and the Vancouver Native Health Society in 1992. (The establishment of urban Aboriginal health centres in Ontario from the mid-1990s is discussed in chapter four of this thesis.) See Cecilia Benoit, Dena Carroll, and Munnaza Chaudhry, "In Search of a Healing Place: Aboriginal Women in Vancouver’s Downtown Eastside," Social Science and Medicine 56(2003); Joséé Lavoie et al., "Community Healing and Aboriginal Self-Government," in Aboriginal Self-Government in Canada: Current Trends and Issues, ed. Yale D. Belanger (Saskatoon: Purich Publishing Ltd, 2008).
Anthropologist John O’Neil provides an account of how Native Medical Interpreters, employed in hospitals in the city of Winnipeg, Manitoba in western Canada since the 1970s, have played a crucial role in facilitating Aboriginal patients’ access to traditional healers.

Kirmayer and Valaskakis, Healing Traditions. The Mental Health of Aboriginal Peoples in Canada, 457.


The CCP is a diversion programme for Aboriginal adults and youth charged under the federal Criminal Code or Controlled Drugs and Substances Act, which emerged from the 1999 Gladue Criminal Code changes. The 1999 Supreme Court Ruling R. V. Gladue has led to changes in the Canadian justice system’s treatment of Aboriginal offenders, providing explicit direction that judges should consider ‘systemic or background factors’ contributing to the offender’s court appearance and sentencing procedures appropriate to the offender’s ‘Aboriginal heritage or connection’. For a detailed discussion see Craig Proulx, Reclaiming Aboriginal Justice, Identity and Community, Aboriginal Issues (Saskatoon, SK: Purich Publishing Ltd, 2003), 141-47.

The CCP is structured around hearings in which participants negotiate various conditions of community engagement as an alternative to a jail sentence. These may include working with a Native treatment centre, housing in a Native housing cooperative, receiving counseling from Elders and other Indigenous counsellors, and providing community service at a Native agency. Ibid., 140-41.

Jairus D. Skye, "An Orchid in the Swamp: Traditional Medicine, Healing and Identity at an Urban Aboriginal Community Health Center" (McMaster University, 2006).

Ibid., 70-71.

Quoted in Ibid., 71.


At the time of Skye’s study, AHT employed nine traditional healers and three traditional counsellors, in addition to biomedical practitioners. Skye, "An Orchid in the Swamp: Traditional Medicine, Healing and Identity at an Urban Aboriginal Community Health Center", 55-67.

Ibid., 61.


Ibid., 226.

Ibid., 232-33.

Ibid., 246; 48.

Ibid., 248.


Susan Applegate Krouse and Heather A. Howard, Keeping the Campfires Going. Native Women's Activism in Urban Communities (Lincoln & London: University of Nebraska Press, 2009); Heather Howard, "Dreamcatchers in the City: An Ethnohistory of Social Action, Gender and Class in Native Community Production in Toronto (Ontario) " (University of Toronto, 2004).


Benoit, Carroll, and Chaudhry, "In Search of a Healing Place: Aboriginal Women in Vancouver's Downtown Eastside," 824-5.

Quoted in Ibid.: 825. Similar views were expressed by health professionals in Macdonald, "A Jurisdictional Tapestry and a Patchwork Quilt of Care: Aboriginal Health and Social Services in Montreal."

Benoit, Carroll, and Chaudhry, "In Search of a Healing Place: Aboriginal Women in Vancouver’s Downtown Eastside," 827.


Existing literature does touch on this issue. Levin and Herbert note the social and economic challenges experienced by some urban Indigenous people in meeting social expectations of hosting visiting relatives. Waldram suggests that urban health centres might consider referrals to healing ceremonies on reserves in their proximity. Mary Ellen Macdonald mentions that Aboriginal people in Montreal commonly travel great distances outside the city in order to participate in ceremonies and meet with Elders and traditional people.


Macdonald, "A Jurisdictional Tapestry and a Patchwork Quilt of Care: Aboriginal Health and Social Services in Montreal."
Scholars have given little attention to analyzing how urban health and social service providers are meeting the needs of urban Indigenous people. One recent example investigating how effectively the addictions treatment system in Winnipeg is responding to Aboriginal service users' needs is Geoffrey DeVerteuil and Kathi Wilson, "Reconciling Indigenous Need with the Urban Welfare State? Evidence of Culturally-Appropriate Services and Spaces for Aboriginals in Winnipeg, Canada," Geoforum 41(2010).


James B. Waldram and Mellisa M. Layman, "Health Care in Saskatoon's Inner City: A Comparative Study of Native and Non-Native Utilization Patterns," (Instute of Urban studies, 1989); Waldram, "Physician Utilization and Urban Native People in Saskatoon, Canada."


Browne, "Clinical Encounters between Nurses and First Nations Women in a Western Canadian Hospital."


142 David Mechanic, *Mental Health and Social Policy. The Emergence of Managed Care.,* Fourth ed. (Boston: Allyn and Bacon, 1999), 44-45.


145 Ibid.: 312. Gone is quoting a Native respondent.


148 Wyatt and Midkiff, "Biological Psychiatry: A Practice in Search of a Science."

149 For an ethnographic account of how people diagnosed with mental disorders have embraced biological definitions of their condition and psychopharmacological treatment see Emily Martin, *Bipolar Expeditions. Mania and Depression in American Culture.* (Princeton and Oxford: Princeton University Press, 2007).


151 Ibid.


153 Competition for a dwindling supply of affordable housing intensified amongst low-income people, weakening poor households’ capacity to support a dependent and potentially disruptive family member. Further, New York City’s massive loss of single-room occupancy hotels -- a reduction of rooms by 87% between 1970 and 1982 -- has meant the loss of a major source of shelter for many former psychiatric patients.

Anthropology as a discipline has a history of reflexive analysis of how anthropologists and their work are implicated in colonialism and imperialism, the politics of ethnographic research and other aspects of power relations which is roughly coterminous with the period which this thesis addresses, i.e. the past four decades. A few key works are T. Asad, *Anthropology and the Colonial Encounter* (London: Ithaca Press, 1973); James Clifford and George E. Marcus, eds., *Writing Culture : The Poetics and Politics of Ethnography* (Berkeley: University of California Press,1986); Richard G. Fox, ed. *Recapturing Anthropology. Working in the Present* (Santa Fe, NM: School of American Research Press,1991); Arjun Appadurai, *Modernity at Large: Cultural Dimensions of Globalisation* (Minneapolis MN: University of Minnesota Press, 1996); Akhil Gupta and James Ferguson, eds., *Culture, Power, Place: Explorations in Critical Anthropology* (Durham, N.C: Duke University Press,1997).

On public health researchers' neglect of urban Aboriginal issues see Young, "Review of Research on Aboriginal Populations in Canada: Relevance to Their Health Needs." My budding interest in relations between urban Aboriginal and dominant biomedical institutions was inspired by volunteer work with the Aboriginal Services programme at the Centre for Addiction and Mental Health in Toronto during 2004.

These included the friendship and urban Aboriginal health centre in Hamilton, and Miinwashin Lodge, Odawa Native Friendship Centre and Mamisarvik in Ottawa. In Toronto, Directors of Anishnawbe Health and Native Child and Family services.

At Archives Canada I was able to digitally photograph documents of interest, but the Ontario Provincial Archives only introduced this privilege near the very end of my period of research. This meant that I was typing notes as I worked through documents and was thus able to cover less material within my time constraints.

My initial objectives were to trace the emergence of policy discourse on Aboriginal addictions and mental health, and to contextualize this discourse in relation to broader shifting relations between Aboriginal peoples and the Canadian State, with a particular focus on urban Aboriginal peoples. I reviewed files from a broad range of record groups including Indian and Northern Affairs, National Health and Welfare and Medical Services Branch, the Ministry of Citizenship and Immigration, and Federal Interlocutor for Métis and Non-Status Indians.

A list of oral history participants is in Appendix One. The one participant from Kenora, Joseph Morrison, travelled regularly to southern Ontario so I was able to interview him in Hamilton and Toronto.
details of which I noted. Ethical research practice dictates that researchers recognise a participant’s discomfort with a written contract and respect preferences for a verbal agreement.

165 Institutional Research Ethics Board reviewer comments, December 18th 2007.
166 The suggestion that informed consent in participant observation should be a ‘dynamic and continuous’ process is presented in a recent paper prepared for the University of Toronto Research Ethics Board by Professors from anthropology, geography and political science. University of Toronto Social Sciences and Humanities Research Ethics Board, “Guidelines for Ethical Conduct in Participant Observation,” (n.d.).
168 I followed instructions I was given by a kind woman working at the gift shop of the Native Canadian Centre of Toronto and used red cotton cloth torn by hand to wrap the tobacco and thread pulled from the cloth to tie it.
Chapter 1 Colonial Policies, Social Suffering & Indigenous Urban Settlement in Twentieth-Century Ontario

Introduction

Canadian colonial policies actively and deliberately undermined the social foundations of land-based Indigenous communities in pursuit of the over-arching goal of assimilating their members into settler society. During the middle decades of the twentieth century, such policies increasingly drew on and propagated a legitimating discourse on the necessity of the modernization and development of Indigenous peoples, a role which the Canadian state assigned to itself. Policies of enfranchisement (loss of Indian status), coerced relocation, suppression of ceremonies, forced removal and detention of individuals for compulsory medical treatment, residential schooling, and others caused extreme social suffering on reserves and in Inuit and other rural communities. Further, industrialised capitalism and the growth of the welfare state (particularly from the late 1940s) interfaced with continuing colonial ideologies during the post-war years, effectively constraining Indigenous livelihoods, and fostering the state’s increased intrusion into Indigenous lives and growing Aboriginal dependency.

Dominant accounts of urban indigeneities which equate urbanization with assimilation are problematic on several counts. First, such portrayals conceal that settler cities in Canada and elsewhere were founded on lands already occupied by Indigenous inhabitants. Notwithstanding the fact that many Aboriginal settlements were forcibly displaced to make room for settler towns and cities, Indigenous peoples have long and complex histories with early colonial urban settlements which scholars have only recently begun to acknowledge. Second, representations of reserve-urban migration as an inevitable and progressive process further evolutionist colonial understandings of Indigenous communities as pre-modern and destined for obscurity. Instead, in this chapter I argue that the phenomenon of increasing numbers of Indigenous people living and working in cities in Ontario (and elsewhere in Canada) during and after the Second World War can be partially understood as a response to intensified social suffering in reserve and rural communities, subsequent to specific historical developments elaborated below. In particular, the depletion of
traditional food sources due to the combined effects of the fur trade and settler encroachment on Indigenous lands, coupled with growing provincial restrictions on wild harvesting activities, caused widespread deprivation and food shortages. Such conditions undoubtedly intensified the appeal of labour market participation for Aboriginal people. This framing situates Canadian colonial policies as the major structural forces shaping urban Indigenous settlement, rather than deficiencies in Indigenous cultures and communities. Further, it begins to situate the mid-twentieth century emergence of urban Indigenous communities in global historical context, opening up the possibility for comparisons with the colonization and subsequent transnational migrations of other peoples.

The following sections provide historical context which is essential to the analyses I present in subsequent chapters. I am particularly concerned here with the temporal period from 1945 to 1969, but invoke earlier history as needed to explain the origins and contexts of relevant policies and practices. As much as possible, I use illustrations and examples drawn from Ontario, and from the regions surrounding the four cities which are discussed in the thesis: Kenora, located in traditional Anishnaabe territory in northwestern Ontario, and Hamilton, Ottawa and Toronto, southern Ontario cities on Haudenosaunee, Algonquin and Anishnaabe territories. I also include some discussion of Métis and Inuit histories. Inuit did not begin to settle in Ontario in significant numbers until the 1970s, but subsequent chapters discuss the healing activities of the Inuit community recently established in Ottawa. Thus this chapter provides some necessary historical context for my later analysis of contemporary Inuit healing which engages with the fallout of colonial history. Here I draw mainly on secondary sources but also make use of certain archival sources and oral histories contributed by Indigenous Elders as part of this research. The Elders are introduced in the first section.

1. Conceptualising urban Indigenous communities

Whilst my focus in this chapter is on the post-war years, a farther-reaching historical perspective challenges depictions of Aboriginal people as newcomers to urban areas. Rather, as social geographer Evelyn Peters and others have argued, Canadian colonial
policies actively displaced Indigenous peoples from developing urban settlements to make space for settler communities. But Indigenous peoples’ presence in Canadian cities was rendered invisible by scholarship through most of the twentieth century. Historians and colonial studies scholars have belatedly recognised colonial cities as important sites for the analysis of colonial relations. Accounting for the lack of earlier scholarly attention, Penelope Edmonds notes that

*issues of sovereignty are at stake here, and recognition of Indigenous people’s historical presence would be an admission that Indigenous peoples are not newly arrived immigrants to cities – they owned and occupied the land well before settler cities were established and were implicitly part of their physical and imaginative creation.*

Histories of Indigenous-settler relations in urban settings offer important insights into the construction of Indigenous and settler subjectivities and relationships, how space and racialised categories are mutually constitutive, and how public memory shapes power relations over time. For example, Victoria Freeman discusses how the historical performance of public memory surrounding Toronto’s semi-centennial celebrations in 1884 served to both obfuscate the city’s Indigenous past and present a romanticized vision of the harmonious coexistence of settlers and Aboriginal peoples, two themes which continue into the contemporary period. Discourse framing ‘Indigenous vanishing as a natural and inevitable phenomenon’ belied the coercion and complexity inherent to the Mississauga’s dispossession of lands occupied along Lake Ontario’s northern shore prior to British control of the region in 1760. The very decision to identify Toronto’s incorporation in 1834 as the city’s foundational event, rather than the purchase of Mississauga land in 1787, rendered the previous occupants of the land irrelevant. Further, as Freeman describes, ‘in most nineteenth-century historiography of Toronto, the Toronto Purchase would be characterized more as a beneficent formality than a legal necessity, and was often not mentioned at all’.

*Migration in Historical Context: Introducing the Elders*

Three Elders have contributed significant oral histories to this thesis: Anishnaabe Elder Lillian McGregor of Toronto, Anishnaabe Elder Joseph Morrison of Kenora, and Cree Elder Vern Harper, also of Toronto. All three have provided significant leadership in urban Indigenous communities in Ontario over several decades. They have generously
shared family histories which provide a historical backdrop to the social phenomenon of Indigenous urban settlement; further details of their distinct trajectories are interwoven through subsequent sections of this chapter.

Lillian McGregor is the third of ten children, born in 1924 on Whitefish River Reserve on Birch Island, near Manitoulin Island in Georgian Bay, Ontario. Lillian’s grandmother Miigwas (Little Feather) was a midwife and healer; she was born around 1882 and grew up on Manitoulin Island. Her people were Potawatami who were driven out of the United States and came to Canada via Sault Ste. Marie. Lillian’s father ran a store and post office on the reserve. Lillian moved to Toronto to work as a nanny in 1939 and has lived there ever since, although she regularly visits her home reserve.

Joseph (Joe) Morrison was born in 1941 at Naongashiing (Big Island reserve – see Map 1.1 below) in Lake of the Woods, northwest Ontario, where his mother was a registered Indian. Generations of his mother’s people were trappers. Joseph’s great-great-great grandfather on his father’s side, Anton Morriseau, was a French fur trader who first worked for the Northwest Company at Trois Rivières in southern Quebec, later for the Hudson’s Bay Company. (The family name was changed to ‘Morrison’ whilst Joe’s father was a student at Cecilia Jeffrey residential school during the 1930s). Morriseau eventually settled at Lake St Joseph in Anishnaabe territory, on the present-day border between the provinces of Manitoba and Ontario. All eight of Morriseau’s children married Aboriginal spouses; many became registered Indians and were party to the signing of Treaty 3 in 1873. Joseph is not sure why the Commissioner excluded his great-great grandfather’s name when drawing up the original list of registered band members, but Joe’s branch of the family has been non-status ever since. Joe’s grandfather ran a commercial fishery in the Lake of the Woods and fought with the Canadian military during World War Two. Except for periods spent in the military and working in Fort Frances, Joe has lived in and around Kenora -- adjacent to his mother’s reserve of Naongashiing in the Lake of the Woods -- for most of his life.

Vern Harper was born in Toronto around 1934, to a Cree mother and a ‘mixed-blood’ father. He is a fifth-generation grandson of Cree hereditary Chief Mistawâsis (Big Child), who signed Treaty 6 in 1876. After his mother died when he was four years old, Vern and
his twin brother were fostered by a white family in Toronto. Vern reconnected with his Cree family in Saskatchewan in the mid-1950s, and he lived with them for a few years, learning from his uncles about Cree traditional knowledge and practices. During this period he spent two years living alone on the traplines. From Saskatchewan Vern settled in San Francisco and Los Angeles for a few years, where he became involved in the ‘hippie scene with Janis Joplin and Jim Morrison’, travelled with the American Indian Movement (AIM), and struggled with drug and alcohol abuse. In 1967 Vern was detained by the Royal Canadian Mounted Police (RCMP) after a violent fight in the western Canadian city in Lethbridge, Alberta. He was committed to Ponoka Mental Hospital, ostensibly for a thirty day observation period but was not released until 1969. Vern re-settled in Toronto in the early 1970s and has been actively involved with the Aboriginal community there ever since.

When Lillian, the oldest of these three Elders, first settled in Toronto in 1939 she met few other Aboriginal people, but the Aboriginal community in Toronto and other cities grew rapidly during the 1940s, 1950s and 1960s (see Chart 1.1 below). The proportion of Aboriginal people living in Canadian cities nearly doubled during the 1940s and again during the 1950s, and more than doubled during the 1960s, according to census data. Like Lillian, many Indigenous people migrated to urban centres to pursue the education, training and employment opportunities perceived to exist there. At the same time, the decision to leave one’s home community to pursue actual or imagined opportunities elsewhere is necessarily always shaped by a consideration of the social and economic conditions at home. As I discuss in this chapter, these conditions were made profoundly more difficult by public policy and other developments during this period.
It is also important to recognize that individuals seeking education and employment in urban centres did not necessarily equate such desires with abandonment of their Indigenous identity, as will become clear in the discussions of urban Indigenous community organisation in the following chapters. The intensive social disruption experienced by many Indigenous communities in Ontario and elsewhere during this period contributed to increasing numbers of people leaving their home communities to settle in cities, but not all Aboriginal migrants to urban centres left behind impoverished and dysfunctional communities. And as social geographer Evelyn Peters has noted, ‘like transnational migrants, many urban Aboriginal people maintain links with their communities of origin -- political, economic and cultural -- stretching out social relations and identities across urban and rural space’.

Indeed, I would argue that many urban Indigenous people do understand themselves to be transnational migrants. Thus it is important to appreciate the fluidity of the socio-spatial boundaries separating reserve/rural and urban Indigenous communities.
2. The Indian Act and enfranchisement

Many First Nations have long histories of diplomatic practices and alliance-building with other nations, and by the mid-nineteenth century looked to treaties with colonial authorities as the main instrument by which they might protect their dwindling lands and natural resources from settler encroachment and exploitation. Earlier legislation in Upper Canada, Nova Scotia and New Brunswick made provision for the creation of reserves, but it was the Robison treaties of 1850 which enshrined the practice of including provisions for reserves.\(^1\) In 1867 the British North America Act transferred responsibility for “Indians, and Lands reserved for Indians” to the new Dominion of Canada. Whilst Indigenous peoples might have expected this to mean the continuation of treaties as a means to establish respective entitlements to land and natural resources, Canada’s first Prime Minister, Sir John A. Macdonald declared that ‘the great aim of our legislation has been to do away with the tribal system and assimilate the Indian people in all respects with the other inhabitants of the Dominion as speedily as they are fit to change’.\(^2\)

Shortly after Confederation, the first Indian Act of 1869 made ‘Gradual Enfranchisement’ part of federal policy. Enfranchisement means that an individual lost their Indian status and linked entitlements and became a Canadian citizen, gaining the right to vote in Canadian elections (otherwise denied until 1960). Previously, Upper Canada’s 1857 Gradual Civilization Act had established the concept of Indian enfranchisement as central to assimilationist policy and a strategy for the gradual dissolution of reserves. One of the major Aboriginal objections to the enfranchisement policy was its provision for awarding parcels of land carved out of reserves as private property to those enfranchised.\(^3\) Until 1880 enfranchisement was compulsory for all Aboriginal men who obtained a university education or entered a profession, a vivid illustration of the extent to which Canadian policymakers viewed Native peoples as living in a pre-modern condition incompatible with European knowledge. Voluntary enfranchisement under the initial policy was very rare: only 102 Aboriginal men chose to become enfranchised between 1857 and 1918.\(^4\) Compulsory enfranchisement, introduced between 1920 and 1922 and reintroduced in the Indian Act 1933, became a powerful mechanism by which Indian Agents could exert control.
by promoting the enfranchisement of individuals seen as threatening to the colonial order.\textsuperscript{21}

New measures in the Indian Act of 1918 simplified the enfranchisement procedure, targeted off-reserve Indians, and gave unmarried Aboriginal women and widows the right to enfranchise.\textsuperscript{22} These developments contributed to a ‘minor wave of [voluntary] enfranchisements in the inter-war years, in which the First Nations of southern Ontario were over-represented’.\textsuperscript{23} Historian Robin Jarvis Brownlie notes that successful applicants received their share of band funds whilst renouncing claims to future payments, and suggests that a sense of entitlement to access these resources and pressing material need were factors motivating those seeking enfranchisement.\textsuperscript{24} Further, most applicants were already living off-reserve and obtaining few or no material benefits from their Indian status.

Involuntary enfranchisement has been particularly devastating for First Nations women and their descendants, and is an important historical factor contributing to the high ratio of Aboriginal women to men in urban communities.\textsuperscript{25} Bonita Laurence has argued that

\emph{loss of status because of gender discrimination in the Indian Act has had as assimilatory an effect on Native families as residential schooling, albeit in a different way [... ] loss of status is a central reason why significant numbers of Native people are permanently urban.}\textsuperscript{26}

Section 6 of the 1869 Indian Act removed Indian status for women marrying anyone who lacked Indian status. A woman who married a man with status but from another tribe would lose her own band membership. In 1874 a further amendment stipulated that Indian status could only be passed through men. From 1951 onwards women who lost status were automatically enfranchised. Loss of status translated into considerable social and financial losses: the loss of a home residence, share in collective property, and education and health benefits. Disenfranchised ‘non-Indians’ who were permitted to remain on reserves were not eligible for support from either federal relief programmes, nor for provincial assistance as the province considered all residents on reserves to be a federal responsibility.\textsuperscript{27} In Lawrence’s assessment, the social losses were even more significant.\textsuperscript{28} Between 1876 and 1985, 25,000 Aboriginal people -- mostly women and their children -- lost their Indian status and their entitlement to live in their home.
community; factoring in the descendants of these people increases the figure to between one and two million.²⁹

In 1985 the federal government made amendments to the Indian Act (commonly known as ‘Bill C-31’) which aimed to remove gender discrimination and restore status to those who had lost it, thus theoretically rendering the Indian Act compatible with the Constitution Act of 1982, which took effect in 1985.³⁰ Bill C-31 also strengthened Band control over membership. By separating Indian status and band membership this policy change had the effects of creating new divisions amongst First Nations people. It is now possible to hold status and be denied band membership, and vice versa. Bands have developed their own rules of membership which are widely divergent, some emphasizing social and cultural connections to the reserve communities, others including a biologically-based ‘blood quantum’ requirement – most famously the Mohawks of Kahnawake, located near Montreal in southern Quebec.³¹ Approximately 127,000 individuals had regained status under C-31 as of 2004, but many more non-status Indians and Métis did not.³² Further, whilst Bill C-31 expanded restrictions on inter-generational transmission of status to include men, it continues to discriminate against women with a ‘second-generation cut-off’ which prevents reinstated women from passing status to their grandchildren.³³ Thus the grandchildren of women who ‘married out’ have fewer rights than do those of men. The overall effect is that intermarriage ‘represents a “ticking time bomb” in Native communities, inexorably removing Indian status from the descendants of anybody who chooses to marry somebody without Indian status’.³⁴ But as Lawrence notes, Aboriginal opposition centred on Bill C-31 has largely failed to acknowledge how gender discrimination has been central to the Indian Act throughout its history – ‘the gendered violations of sovereignty that occurred in successive Indian Acts since 1869 have been virtually normalized as the problems of individual women’.³⁵ These historical dynamics have contributed to some Aboriginal women’s estrangement from their home communities, and help to explain both the high ratio of Aboriginal women to Aboriginal men in urban centres, and why some of the earliest examples of social and political mobilization in urban Aboriginal communities were led by women, as will be discussed in the next chapter.³⁶
3. Colonial suppression of Indigenous healing knowledge and practices

The suppression of Indigenous healing constituted an important strand of Canadian assimilationist policy and practice, but with uneven results. Legislation banning Indigenous ceremonies was not repealed until the 1951 revisions to the Indian Act. The Potlatch Law of 1885 banned the ceremonial redistribution of wealth as practiced by Indigenous inhabitants of the west coast, and was the first of multiple legislative attempts to suppress aspects of Aboriginal culture deemed threatening to the assimilationist goals of the Canadian government. For many western coastal First Nations Potlatch ceremonies constituted a central institution, structuring social status and moral relations, and providing an important mechanism for sharing material goods and passing on rights to valuable resource sites. In 1895 the Sun-dance practiced by the plains Cree and other prairie First Nations was prohibited, and in 1906 this prohibition was extended to all forms of Indigenous ceremonial dance. In a 1914 measure intended to strengthen the powers available to Indian Agents in western Canada with the decline of the pass system, ceremonial dress was also prohibited and any form of public performance, including at fairs and stampedes, required advance written approval from Indian Affairs.

Historian Katherine Pettipas presents evidence that government agents and missionaries recognized the centrality of spirituality to Aboriginal cultures, including its interdependence with Indigenous political, social and economic systems. Thus repressive legislation including the Potlatch Law and various subsequent amendments to the Indian Act should be interpreted not simply as Christian intolerance, but as official attempts to destroy Indigenous cultural systems. Pettipas’ analysis of the Plains Cree’s extensive responses to government repression of Sun Dances and other ceremonies demonstrates the impact of this legislation.

Whilst the colonial suppression of Indigenous healing is commonly associated with western Canada -- and it was western Indigenous peoples’ ceremonies which were the particular target of the Indian Act ---colonial ideology legitimised comparable practices elsewhere, including Ontario, leading to the disruption and loss of healing knowledge and practices. Proselytizing missionaries, residential schooling, language loss, disruption of
social and particularly intergenerational relationships, incorporation into the capitalist wage economy, and the loss of access to animal and plant sources of medicines due to physical relocation and settlers’ destruction of natural habitats all combined to undermine epistemologies of healing central to Indigenous cultures and sovereignties, well beyond the 1951 repeal of relevant sections of the Indian Act.

In an oral history interview conducted as part of the current research, Sylvia Maracle spoke of how her grandmother used to keep a beautiful tobacco medicine bag hanging on a nail behind the wood stove. When she saw strangers approaching the house, Sylvia’s grandmother would quickly take down the bag and put it in a drawer. Having observed this as a young girl during the 1960s, Sylvia asked her grandmother “Why do you do that? Why do you hide the tobacco when people come?” Sylvia’s grandmother said,

Because in my lifetime, that’s been called witchcraft and other things, and it’s not been allowed. And there have been times in my life when the minister from the church came and took the things away.

During Sylvia’s berry fast around 1967 or 1968 -- probably the last to be conducted in her Mohawk community of Tyendinaga -- the old women who gathered in her grandmother’s house hung blankets over the windows, and her grandmother gathered ceremonial objects from hiding places in the root cellar. Much later, Sylvia’s grandmother told her of the time when the Indian Agent, the school superintendent, the nurse and the church minister had come to the community and removed all the drums, rattles, deer horns, wampum belts and other ceremonial items they could find, and burned them in a big fire.

In another example, anthropologist Adrian Tanner describes how the Pentecostal church suppressed animist practices among the East Cree of northern Quebec as recently as the 1970s. As Tanner indicates, the suppression of Indigenous spiritual knowledge and practices – whether by missionaries or government agents – not only threatened the survival of such knowledge and practices, it caused painful and sometimes permanent social divisions within families and communities.

Suppression by colonial agents was not the only threat to Indigenous knowledge and practice. In Lillian’s home community, the destruction of natural habitats and the disruption of social relations have been more salient. Lillian’s grandmother Miigwas was a
midwife and healer, and Lillian became her helper around age seven. From this vantage point Lillian acquired extensive knowledge of the natural world, healing including plant medicine, and other traditional teachings. She observed her grandmother successfully treat conditions ranging from serious injuries to post-partum psychological disturbance, as well as delivering babies. From Lillian’s perspective, the environmental degradation of her people’s lands presents a major challenge to the continuation of her grandmother’s healing practices:

*I’ve been back to where she used to pick medicines, now there’s a highway, electrical and telephone wires ... there’s not much medicine left, I only found a couple.*

Lillian left her home community at age fifteen, and is aware of only one very old woman still living in Whitefish River who has the kind of knowledge that her grandmother did.

Historians have described multiple situations in which colonial regimes have suppressed Indigenous healing knowledge and practices as a technique of colonial rule. At the same time it is important to recognise that such processes were often incomplete, as Sylvia’s oral history indicates, and Indigenous healing persisted in multiple forms despite colonization.  

Joseph Morrison’s maternal grandfather was actively involved with the Midewiwin Society in the Lake of the Woods area throughout his life, but because the activities are not discussed outside of the Society, Joe did not learn that his grandfather had held a high-ranking position until after the latter’s death in the late 1980s.  

Vern Harper’s Cree family in Saskatchewan retained substantial traditional knowledge, which his uncles shared with him when they reconnected in the mid-1950s.  

At that time Vern participated in Sun Dances, re-learned the Cree language and spent two years alone on the traplines. Due to Indigenous resistance and subversion and the unevenness of colonial biomedical domination, many Indigenous people have been able to retrieve, continue, and adapt their healing traditions in recent years.

4. Forced relocation of Indigenous communities
In 1996, the Royal Commission of Aboriginal Peoples identified the forced relocation of Indigenous communities as one of four colonial policies causing the most enduring harm to Indigenous peoples, alongside the Indian Act, residential schools and the treatment of war veterans. The practice of relocating Aboriginal communities has been widespread with varied rationales, ranging from the assertion of Canadian sovereignty claims in the Arctic,
to urban and capitalist developments, to the regulation and containment of Indigenous peoples. Regardless of the rationale, all such relocations were characterized by a lack of Aboriginal participation in decision making, and usually very little notice was given to the communities involved. In short, as the Commissioners, observed, ‘Aboriginal people were moved [...] because they were [...] moveable’.\(^51\)

The Canadian state has relocated dozens of Indigenous communities against their will during the twentieth century.\(^52\) The Mi’kmaq in Nova Scotia were ‘centralized’ from twenty small reserves to two large reserves, Eskasoni and Shubenacadie, between 1942-49. The Inuit of Hebron and Nutak, Labrador were relocated in the 1950s for similar reasons of streamlining government administration, and the Mushuau Innu were relocated twice, in 1948 and again in 1967.\(^53\) The Sayisi Dene of northern Manitoba were moved to North Knife River and Churchill without their consent in 1956, having been denied the land and natural harvesting rights they were promised under Treaty 5.\(^54\) In an example made famous as the subject of a Canadian Human Rights Commission investigation during the early 1990s, small family groups of Inuit who later became known as the ‘High Arctic Exiles’ were coerced into relocating from northern Quebec and Pond Inlet to Grise Fiord, Craig Harbour and Resolute Bay in the Arctic in 1951 and 1953.\(^55\) Government agents falsely promised families good hunting and better living conditions, and the option to return after one or two years if they chose. In actuality the uprooted families endured harsh weather conditions, an extremely reduced range of harvestable natural resources compared with their homelands, and a lack of appropriate supplies or support.

The multiple government relocations of the Inuit which took place between the mid-1930s and the early 1960s were influenced by a range of factors including the federal government’s desire to reduce relief expenses, anxieties about maintaining Inuit self-sufficiency and avoiding the perceived failures of Indian reserve policy, the commercial interests of the Hudson’s Bay Company, and, with the advent of the Cold War, Canadian sovereignty concerns.\(^56\) The Department of the Interior and the Hudson’s Bay Company jointly managed the ‘first official Eskimo relocation project’ which involved moving Inuit from Baffin Island multiple times between various sites on Devon Island over a period of 13
years from 1937. Many other Inuit communities were moved from the late 1940s onwards.

In Ontario, the Grassy Narrows reserve is perhaps the most widely-cited case of forced relocation. Between 1963 and 1972, the people of Grassy Narrows in northwestern Ontario were moved against their will from their original reserve located on islands and peninsulas to a new site closer to the city of Kenora. Whilst some community members speculated that the commercial interests of the Hudson’s Bay Company were the main motive for the relocation, Anastasia Shkilnyk locates the federal intervention within the broader policy of modernization and improving infrastructure in reserve communities during the 1960s, which also led to the relocation of several other Aboriginal communities in northern Ontario and northern Manitoba. The Grassy Narrows community was relocated to a new location linked by road to Kenora. Anastasia Shkilnyk’s detailed account of the relocation and its aftermath describes multiple problems with the new reserve. Community members found that the soil in the new location was too poor to grow produce and they were forced to become more dependent on store-bought food – which was of course more accessible given the road link to Kenora. Houses were built far too close together for a people whose social relations were structured around hunting and gathering and a widely-dispersed clan-based settlement pattern. Shkilnyk’s analysis links the relocation of Grassy Narrows to the extreme social suffering experienced by the community during the 1970s, including widespread alcohol abuse, interpersonal violence, and neglect of children and their forced removal by the Children’s Aid Society, which she documents graphically. In Chapter Two I discuss how these and related issues were taken up by Red Power activists and other Aboriginal people in Kenora.

Shkilnyk’s book was important in that it drew attention to how federal policy contributed to Indigenous suffering, thus providing an important corrective to overly-simplified socio-economic or racist culturally-based explanations. During an oral history interview for this research, Mike DeGagné, Director of the Aboriginal Healing Foundation, mentioned Shkilnyk’s book as significant in drawing attention to the scale and effects of alcohol abuse in northern Aboriginal communities at the time of its publication. However the book was also problematic on several grounds. Most fundamentally, the community did not
authorize its publication. Scholars have also criticized Shkilnyk’s romanticisation of pre-relocation life which underplayed the significance of other colonial policies; her overemphasis of the uniqueness of Grassy Narrows and inattention to similarities with other Indigenous communities; and the occasionally judgmental portrayal of the people and focus on representing social pathologies, with insufficient consideration of the range of historical and social factors shaping suffering.61

5. Suspect patients and noncompliant wards: colonial healthcare and tuberculosis in Indigenous communities

Historical evidence indicates that those First Nations who signed treaties with the Dominion of Canada understood that government provision of free healthcare was a term of their agreements. Treaty number 6 was signed with Cree leaders (including Vern Harper’s ancestor Chief Mistawâsis) in what is now Saskatchewan and Alberta in 1876, and included what is known as the ‘medicine chest clause’, which states “A medicine chest shall be kept at the house of the Indian agent for the use and benefit of the Indians”.62 Observers’ records confirm that Indigenous people present at the negotiations discussed the extent to which their people had been suffering from infectious diseases such as measles and small-pox, and specifically requested that the provision of free medicines be included in the terms of the treaty.63 Treaty commissioners’ documented assertions that all treaties would have equal terms imply that the medicine chest clause ought to have been incorporated into all treaties contemporary and subsequent to Treaty 6. Further, oral histories and Commission Reports describe Treaty Commissioners’ verbal assertions during multiple different treaty negotiations that free medical care would be provided.64

The Canadian government failed to honour both its explicit and implied commitments, and government health services for Aboriginal people developed slowly and erratically. The Department of Indian Affairs appointed their first Chief Medical Officer in 1904, but after the forced resignation of Peter Bryce in 1910, the post was not filled for 17 years.65 When the first federal Department of Health was established in 1919, its remit excluded Native health. It was not until 1927 that the Medical Services Branch was created within the Department of Indian Affairs. Eventually in 1945 the Department of Health assumed responsibility for Medical Services Branch, an arrangement which continues in the present.
The Canadian state’s gradual and grudging assumption of responsibility for Native health in the first part of the twentieth century was primarily motivated by the fear of Native disease infecting European settler populations. As discussed in the Introduction, settler anxieties about Native contagions have historically inspired health interventions in other colonial settings in Africa and Asia, as well as the development of public health services for former slaves and their descendants in the African-American population of the United States.66 But the Canadian state’s early interventions addressing Aboriginal health were complicated by a range of factors beyond anxiety regarding Natives harbouring contagions. These included federal government reluctance to acknowledge any legal responsibility for the health of Native peoples, concerns about the financial implications of providing health care, and the abiding belief that Native populations were ‘dying out’ – a self-serving discourse common to other settler colonies including Australia and the United States.67 The complex interplay of these motivations, against the backdrop of a more generalized laissez-faire policy regarding public health and welfare before the Second World War, contributed to the Canadian state’s slow and inconsistent response to tuberculosis epidemics amongst Indigenous peoples during the first three decades of the twentieth century.

When the federal government eventually developed policy addressing tuberculosis control in Aboriginal populations, it was among the most coercive of Canadian colonial policies. From the late 1930s, compulsory treatment and confinement severely disrupted many Indigenous communities, particularly those of Inuit and other northern peoples. By the beginning of the twentieth century, tuberculosis was a serious health problem for many Indigenous communities in Canada, with documented mortality rates nearly twenty times that of the settler population. Contrary to long-standing academic assumptions that Indigenous peoples were not exposed to tuberculosis prior to European contact, recent archaeological evidence suggests that forms of tuberculosis existed in the Americas prior to European invasion and settlement.68 Whilst the specific form/s, virulence and geographic reach of ‘New World’ tuberculosis continue to be debated, it is clear that particular social and economic conditions induced by colonization were the primary causes of the extent of tuberculosis epidemics amongst Indigenous populations in Canada during the late nineteenth and early twentieth centuries.69
First Nations in western Canada were particularly vulnerable to tuberculosis infection due to the combined effects of recent reserve settlement, declining nutritional standards and increasing contact with European traders, labourers and settlers. These factors also applied to many communities in northern Ontario. From 1871 onwards, following the signing of the numbered treaties, Indigenous peoples in western and northern Canada increasingly settled on reserves, typically in conditions of substandard, poorly-ventilated and overcrowded housing which facilitated transmission of infectious disease. The expansion of settler agriculture depleted hunting stocks and other traditional food sources, whilst provincial regulations increasingly restricted Indigenous peoples’ access to traditional hunting and fishing areas. These factors, together with the decrease of seasonal migration based on availability of food sources, led to growing rates of malnutrition in Indigenous populations, which compromised immunity to infectious disease. The westward migration of large numbers of traders and labourers associated with railway construction brought Indigenous communities into contact with large groups of settlers and indigent labourers, many of whom were carrying the tubercle bacillus.

Growing numbers of church-run industrial and boarding schools from 1883 also accelerated the spread of tuberculosis infection amongst Indigenous populations. Concerned to reduce the number of deaths within their institutions, schools discharged fatally ill children, who were returned homes and infected other members of their families and communities before dying. Randall Packard describes a similar policy in colonial South Africa during the first few decades of the twentieth century. The mining industry repatriated infected African miners to their home communities in rural areas, where they often infected their families and 60% died within two years of being sent home. This practice led to very high rates of tuberculosis in many rural areas of South Africa by the late 1920s. From 1906 Peter Bryce, first Chief Medical Officer of the Departments of Interior and Indian Affairs, led a campaign to improve the sanitary conditions of the residential schools, but the Department of Indian Affairs instructed Bryce to cease his annual medical reports in 1913, arguing that the cost was not justified. The Department of Indian Affairs and the churches only implemented the least costly of Bryce’s many recommendations.
Sanatorium treatment for Indigenous tuberculosis patients

From 1910 Canadian physicians and settler society began to favour sanatorium treatment in the management of tuberculosis. Many sanatoria did not accept Native patients with the rationale that they had insufficient beds for settlers. A small number of hospitals run by the Department of Indian Affairs were available from 1917, but these totaled only seven by the mid-1930s, with eight to forty beds per hospital. In 1935 the Canadian Tuberculosis Association complained to the government that the Indians’ “uncontrolled diseases are a menace to citizens generally and to the collective general health of the provinces”. Canadian settler society’s continuing anxiety regarding the “disease menace” posed by reserves contributed to the often coercive nature of sanatorium treatment for Indigenous people when it belatedly became available during the 1940s. A fully-centralized federal treatment system for Native tuberculosis was finally established by 1950. Between 1937 and 1953, the number of Native patients being treated for tuberculosis in institutions including sanatoria and Department of Indian Affairs hospitals increased from 100 to nearly 3000. One of these patients was Joseph Morrison’s mother: her confinement in Fort Williams Sanatorium between 1946 and 1948 meant that Joe was put into residential school in Kenora between the ages of five and seven.

Compulsory sanatorium treatment for tuberculosis was particularly devastating for Inuit communities and individuals. From the mid-1940s through the 1960s, Inuit were evacuated by medical ship and plane to be treated for tuberculosis thousands of miles away from their homes in southern hospitals and sanatoria, including the Mountain Sanatorium in Hamilton and the Toronto Sanatorium Weston, with stays averaging 28 months. Lillian McGregor did some of her nursing training in Hamilton during the early 1950s and recalled caring for Inuit children there:

*There was a lot of Eskimos in medical facilities at the time. I worked with the little ones. And I think the saddest part was seeing if they were exposed to anybody with measles or scarlet fever or anything like that. They didn’t last for any more than two days. [...] We lost some of them, we lost ten of them right there. I went in and I said ‘Where is everybody? Did somebody take the plane already?’ And they said, ‘They’re not coming back on their flight.’ ‘Oh,’ I said, ‘Great news. They’re all cured?’ ‘No Lillian,’ they said ‘They’re going on a flight they can’t come back from.’ [...] But it would just hit them so fast. I’ll never forget that. And of course they didn’t have a name like John or Nicholas*
or Luke or anything, just number 7774K or something. And I thought oh, goodness, when is this ever going to change? Lillian is referring to the federal administrative system of numbered discs by which Inuit were identified beginning in 1941.

Federal medical officers often employed deception and coercion in removing individuals from their families and communities. At the height of this practice during the late 1950s, up to one sixth of the total Inuit population was being treated in southern Canada; in some Arctic Inuit communities, up to 75% of the population was treated in the south at some point. Former evacuees’ oral histories tell how some were physically punished with straps, rulers and straitjackets, and shouted at by nurses for speaking Inuktitut. Most of those Inuit sent for treatment in the south were unable to communicate with their caregivers who did not speak Inuktitut, and often had no communication with their families. For those who survived and returned home, readjustment was often a prolonged and difficult process.

Federal health officials viewed this coercive practice, with its patently destructive impact on Inuit cultures and societies, as an opportunity to speed up the process of assimilating the Inuit into settler society - at that time seen as both desirable and inevitable. In 1969 the Inuit continued to experience rates of tuberculosis infection 40 times higher than the Canadian settler population, whilst the average figure for status Indians at that time was 10 times higher than the settler population.

**Indian Health Regulations**
Parliament passed the Indian Health Regulations as an amendment to the Indian Act in 1953 to authorise the already established practice of compulsory detention, examination and treatment of Indians suspected of carrying infectious disease. The regulations were finalized in 1954, in time for the Director of Indian Health Services to provide a copy in response to the 1954 June 15 letter from the Regional Superintendent of Saskatchewan, who reported ‘disciplinary troubles’ amongst Indian tuberculosis patients in the sanatorium, some of whom were running away.
The Indian Health Regulations continued to be invoked to authorize compulsory detention of Aboriginal people as late as 1969. In 1965, Dr H. Procter, Director of Indian Health Services speculated that the regulations were becoming outdated, and sought the views of the Regional Medical Services Branch Directors regarding their possible revision or even abolition. Whilst some Regional Directors agreed that the regulations should be abolished, those from Eastern Canada, Alberta and Saskatchewan indicated that the regulations were still being applied and insisted on maintaining the option for compulsory detention. The Director from Eastern Region indicated the potential power of threatened coercion in his comment that

*the very infrequency of their use is in a way evidence in favour of their retention. A single application of the regulations has, we know, been instrumental in preventing other cases of recalcitrance.*

Further, he expressed concerns regarding the ineffectiveness of provincial laws:

*as far as we are aware, provincial laws do not compel a suspect patient to submit to an examination [...] there are still some provinces in Eastern Region that do not have any legislation including compulsion, either for examination or treatment.*

These observations indicate the persistence of a racialised stereotype of Aboriginal people as reservoirs of disease warranting extraordinarily coercive measures. But ultimately it appears that the decision to maintain the regulations was rationalized by the concern that any new legislation would be seized upon by the provinces as evidence for federal responsibility for 'Indian Public Health', during the period when federal policy emphasized the necessary and inevitable devolution of Indian health care to the provinces.

The Canadian policy of compulsory detention and enforced long-term residential treatment of Aboriginal people with tuberculosis endured for decades after more humane forms of treatment were being practiced elsewhere. In African settings, village-based alternatives to sanatorium treatment for tuberculosis were proposed from as early as 1937, and from the 1950s the World Health Organization and UNICEF supported tuberculosis management based on outpatient treatment and training of Indigenous workers in various African settings, including Nigeria. The endurance of this draconian treatment model in Canada can be interpreted as deriving from both colonial anxieties regarding settler exposure to Native contagion, and the coercive treatment's perceived alignment with the broader goal of assimilating of Indigenous peoples into settler society.
6. Colonial education policy, assimilation and Indigenous suffering

Colonial regimes in Canada and elsewhere have practiced the coerced acculturation of colonized children as a central technique of colonial governance, removing them from their families and communities and placing them in boarding schools, orphanages, children's homes, and white settler families. First European missionaries and later colonial states in North America recognised education and the strategic targeting of children as central to the religious conversion and ‘civilization’ of Indigenous peoples. Indeed, as historian Hugh Shewell has argued, until the advent of the welfare state after the Second World War, education was the only practical means for operationalising Canadian assimilation policy, given the small number of individuals who chose voluntary enfranchisement.

Since the late 1980s, Indigenous and other scholars have been documenting the profoundly disruptive and often devastating effects of Canadian residential schools on Indigenous lives and societies, including the loss of Indigenous languages and knowledge, alienation of intergenerational relationships, and in some cases physical and sexual abuse. Some of this scholarship also considers the myriad ways which Aboriginal people resisted and opposed these colonial institutions, effectively limiting the extent to which the residential schools achieved their goals of assimilation. But as Mohawk psychologist Ed Connors describes, the present-day consensus among Aboriginal people is that the residential schools system undermined Indigenous parenting knowledge and skills and introduced ‘oppressive, controlling and abusive relationship patterns’ which contributed to the breakdown of family relationships and the loss of Aboriginal youth to ‘foster care, adoptive care, group homes, reform schools, training schools, and correctional facilities’. Residential schools experiences have been a central focus of Indigenous healing in policy discourse since the late 1990s, as will be discussed in Chapter Four.

My aim in what follows is to provide an overview of historical literature describing how Indigenous peoples in Ontario engaged with colonial education policy, including the establishment of residential schools, the emergence of increasingly coercive policy mandating attendance at these schools, and the multiple forms of resistance by children and their communities. I also include a brief discussion of the Inuit day schools; although these were outside of Ontario, this is important historical context to the healing work of
present-day Inuit in urban Ontario, particularly Ottawa, discussed in later chapters. Despite the proliferation of publications addressing residential schools and their legacies, little has been published on the local histories of individual schools in Ontario, though see Anishnaabe writer Basil Johnston’s autobiographical account of life at Spanish Boys’ School, and Elizabeth Graham’s oral history-based account of life at the Mohawk Institute and Mount Elgin Indian Residential School in southern Ontario.104 More accounts of individual schools in British Columbia have been published.105

English-language missionary education began in Upper Canada as early as 1784 when the Society for the Propagation of the Gospel, the Church of England’s missionary arm, established an Indian School for the Mohawks at the Bay of Quinte.106 Late eighteenth-century and early nineteenth-century schools in Upper Canada/Ontario were mostly voluntary day schools. From the middle of the nineteenth century there was a shift towards coercing Indigenous children to attend residential ‘Schools of Industry’ modeled on the Choctaw Academy for Indians in the United States:

\[A\]s the [nineteenth] century progressed, the “civilizing” mission of church and state was succeeded by the schools-of-industry concept with its aim of making Indians both useful and reasonably self-sufficient and thus “amalgamating” them [...] into the White economic system.107

By 1890 there were four industrial schools in Ontario, including the Shingwauk Industrial Home for Indians at Sault Ste Marie, established by the Anglican Reverend Edward Wilson who consciously styled himself after a leading English ‘child rescuer’, Dr Thomas Barnardo.108 Middle-class Christian men initiated the child rescue movement amongst the urban poor in late-nineteenth century Britain; its concepts and practices travelled quickly through the British settler colonies. Whilst highlighting the suffering of children, child rescue discourse also pathologised families -- inevitably poor and/or Indigenous families -- and romanticized alternative care.109 When the Catholics completed St Joseph’s at Fort William in 1936 there were fourteen residential schools in Ontario, half of which were administered by the Roman Catholics, the other half by the Anglican, Presbyterian and United Churches (see Table 1.1 below). The Mennonites opened the last school to be established in Ontario, Poplar Hill in the northwest, in 1962. As Table 1.1 below indicates, the province’s residential schools were disproportionately concentrated in northwestern
Ontario, and the city of Kenora had the dubious distinction of being the only urban centre to host two schools, with a third, McIntosh, about fifty kilometers outside of Kenora. Historian J.R. Miller provides an account of how the Anishnaabeg of Shoal Lake negotiated with the Presbyterian Church between 1898 and 1902 to establish what would become Cecilia Jeffrey School in Kenora. Mission correspondence and a contract between the Shoal Lake Band and the church provides evidence of the Anishnaabeg’s determination to protect their children from proselytization and hard labour, to resist any attempts at coerced attendance enforced by the police, and to retain their rights to remove children at any time to participate in ceremonies and to choose which children and how many would attend. Unfortunately their intentions were thwarted by legislative developments, as discussed below.

Despite the apparent interest of some Indigenous communities in establishing schools for their children, most schools experienced difficulties in recruiting children during the 1880s and 1890s. From the mid-1890s the federal government began to acquiesce to Church demands to make attendance compulsory. An 1894 amendment to the Indian Act authorized judges and Indian Agents to enforce attendance at industrial and boarding schools by Indian children under age sixteen. In 1920 an amendment to the Indian Act made school attendance compulsory for all Indian children aged 7 to 15, and gave authority to ‘truant officers’ to inspect residences and to penalize parents who refused to send children. The 1945 Family Allowance Act introduced a new form of coercion with its requirement that families keep their children in school, or risk losing the family allowance which many people had begun to rely upon as traditional livelihoods were eroded.

Both of Joseph Morrison’s parents attended Cecilia Jeffrey School in Kenora through the 1930s. Joseph’s father, Donald, was non-status and would not therefore have been legally required to attend, but Donald’s mother died when he was about ten, and Joe’s grandfather sent his four children to Cecilia Jeffrey in 1928. Joseph’s mother attended from 1931.
<table>
<thead>
<tr>
<th>Region</th>
<th>School Name</th>
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<td>Cecelia Jeffrey Residential School (Presbyterian), Kenora</td>
<td>1900 – 1977</td>
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<tr>
<td></td>
<td>St Mary's Indian Residential School (Roman Catholic), Kenora</td>
<td>1894-1962</td>
</tr>
<tr>
<td></td>
<td>Poplar Hill (Mennonite), Poplar Hill</td>
<td>1962-1989</td>
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<tr>
<td></td>
<td>Pelican Lake (Anglican), Sioux Lookout</td>
<td>1926-1979</td>
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<tr>
<td></td>
<td>McIntosh Indian Residential School (Roman Catholic – Oblate Missionaries), McIntosh (nr Kenora)</td>
<td>1924 – 1969</td>
</tr>
<tr>
<td></td>
<td>Fort Frances Indian Residential School (Roman Catholic – Oblate Missionaries), Fort Frances</td>
<td>1902-1974</td>
</tr>
<tr>
<td></td>
<td>St Joseph's Indian Boarding School (Roman Catholic), Fort William</td>
<td>1936-1964</td>
</tr>
<tr>
<td>Northeastern Ontario (west coast James Bay)</td>
<td>St Anne's residential school (Roman Catholic), Fort Albany</td>
<td>1904-1973</td>
</tr>
<tr>
<td></td>
<td>Bishop Horden Hall (Anglican), Moose Factory Island</td>
<td>1865-1964</td>
</tr>
<tr>
<td>Mid-Northern Ontario</td>
<td>St John's Indian Residential School (Anglican), Chapleau</td>
<td>1907-1948</td>
</tr>
<tr>
<td></td>
<td>Shingwauk Industrial School (Anglican), Sault Ste Marie</td>
<td>1873-1970</td>
</tr>
<tr>
<td></td>
<td>Wikwemikong* (Roman Catholic)</td>
<td>1879-1963</td>
</tr>
<tr>
<td></td>
<td>Spanish Girls’ &amp; Boys’ Schools (Roman Catholic), Spanish</td>
<td>1912 - 1965</td>
</tr>
<tr>
<td>Southern Ontario</td>
<td>Mohawk Institute (Anglican), Brantford</td>
<td>1828-1970</td>
</tr>
<tr>
<td></td>
<td>Mount Elgin Indian Residential School (United), Munceytown (near London)</td>
<td>1850-1946</td>
</tr>
<tr>
<td></td>
<td>Alexandra Industrial School for Girls, Toronto</td>
<td>1897 - unknown</td>
</tr>
</tbody>
</table>

Table 1.1 Residential Schools in Ontario

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*Wikwemikong was relocated from Manitoulin Island to Spanish on the mainland during 1911-1912.*
Joseph’s parents told him that they were abused at Cecilia Jeffrey, but ‘they didn’t talk much about it’. However both of them spoke Ojibwe fluently in adulthood despite long periods of residential school attendance. As mentioned above, Joseph himself was sent to Cecilia Jeffrey whilst his mother was being treated for tuberculosis during the late 1940s. Lillian McGregor’s parents both attended residential school: her father went to Wikwemikong initially and then transferred to Spanish, which her mother also attended. Lillian is not aware that her parents suffered any form of abuse at the schools, and like Joseph’s parents, both of them retained their fluency in the Ojibwe language. Lillian herself attended a church-run day school on her home reserve, although many of her siblings went to residential school.

Many children and parents resisted the coerced attendance of residential schools, as evidenced by both oral history and archival sources, to the extent that in Miller’s estimation residential schools failed to maintain more than about one third of children who were eligible to attend as resident students. However it is important to consider that Miller’s estimate is an average and that the proportion of children attending in any given area likely fluctuated significantly based on multiple local factors, including the history of relations between the Church and Aboriginal communities and, after 1894, the proclivity of local Indian Agents, judges and police officers to enforce attendance. Parents commonly withheld their children in protest at dangerous conditions, and Bands lodged formal complaints about deteriorating conditions at the schools. During the 1880s, Ojibwe boys at Wikwemikong school on Manitoulin Island frequently ran away from the school, and parents complained about corporal punishment, ‘excessive instruction in catechism’, and poor conditions including bed bugs and fleas in the dormitory. The Ojibwe at Couchicing, Ontario both withheld their children in protest, and made multiple formal complaints to Oblate officials about their dissatisfaction with the leadership and conditions of Fort Frances school between 1929 and 1940. In 1945, a majority of parents withheld their children from the Anglican school at Moose Factory in James Bay Cree territory in northeastern Ontario, in protest at an objectionable principal, who was then transferred to another school. In a rare example of parental protest via litigation, in 1913 the Six Nations Council backed parents in retaining a lawyer to pursue allegations against the
Mohawk Institute at Brantford in Southern Ontario. At the trial students described ‘wormy oatmeal, bad meat, whippings, and repeated runaways to escape the harsh regime at the school’.

Arson was one of the most dramatic forms of protest against the residential schools. Several schools in Ontario were partially or completely destroyed by fires, some of which were evidently set by students. Shingwauk at Sault Ste. Marie was destroyed by fire in September 1873 (just six days after it was completed), the Wikwemikong Girls’ School on Manitoulin Island had two unexplained fires in 1885 and another set by students in 1888, and boys attempted arson at Sioux Lookout school in 1931. In southern Ontario, a student at Mount Elgin Institute burned down a barn in 1907 in the hope that it would lead to him being ‘set free’, and students at the Mohawk Institute attempted several fires, some of which were successful, between April and June of 1903. As late as 1974, adults and children joined in the burning of the Mennonite school at Poplar Hill, northwestern Ontario.

Students commonly protested against untenable conditions by deserting the residential schools. This led to some successful escapes and in other cases, tragic deaths. Joseph Commmanda died in September 1959 after running away from Mohawk Institute in southern Ontario with his brother Rocky; he was killed by a train whilst escaping from police. In 1966 the national Canadian weekly Maclean’s Magazine covered the death of twelve-year old Charlie Wenjack, who left Cecelia Jeffrey school in Kenora heading for his home community of Martin Falls Reserve. Two more boys running away from Cecelia Jeffrey died of exposure in 1970.

**Inuit and Métis experiences of colonial education**

The Inuit’s experience of residential schools is shorter than that of many First Nations communities, but the effects on Inuit social life were severely disruptive due to the rapidity with which students were enrolled and the high proportion of children who attended. Missionaries established schools for Inuit in the Northwest Territory during the 1860s, but government-regulated schools, known as ‘federal day schools’ but comparable to the Indian residential schools, did not appear until the 1950s. The Department of Northern Affairs
took over the first, Turquetil Hall at Chesterfield Inlet (Igluligaarjuk), in 1954. Just 10 years later, three quarters of Inuit children aged 6 to 15 were enrolled in these schools, compared with historian JR Miller’s estimate of one third of status Indian children at the schools’ peak (but see my discussion above). Teaching was in English from the time children entered school (in contrast to practices in Greenland and Russia during the same period, where Inuit children were taught in their own language). This intensive assimilationist practice caused rapid loss of Inuktitut: just 50 years ago all Inuit spoke Inuktitut, whereas almost one quarter of the population has lost their language over just two generations.

Like many First Nations parents, Métis parents were eager for their children to acquire an education. Tricia Logan describes how Métis children were often rejected from attending provincial schools for being ‘too Indian’, and rejected by residential schools for being ‘too white’. The ambivalent status accorded to Métis children by the Canadian state contrasts with the Australian colonial context, where ‘half-caste’ children were more likely to be separated from their families to be placed in residential dormitories ‘because they were thought more likely to benefit and more deserving of a chance to enter the non-Aboriginal community than were full-blooded Aboriginals’. Indeed in some regions of Australia, including the Northern Territory, the colonial authorities established specialized institutions for children of mixed Aboriginal and white settler parentage. In Canada residential school was sometimes the only choice of formal education available to Métis children, but because the federal government did not acknowledge any responsibility for providing education to the Métis, permission for their children to attend was inconsistently given and depended upon local circumstances. Records of Métis attendance are less complete than those for First Nations children for the same reason. But because schools were reimbursed on a per capita basis, there was a strong incentive for school administrators to accept Métis children whose parents wanted them to attend, particularly where schools were threatened with closure due to low attendance.

In the wake of the movement for restitution for residential schools experiences, some Métis have argued that their communities experienced similarly damaging effects to those suffered by first Nations and Inuit communities, not only from attendance at residential
schools but also at day schools. As the 1920 Indian Act amendments mandated English language in all Indian day schools, it is clear that day school students may also have struggled to maintain their mother tongues.

The gradual closure of residential schools from the late 1940s onwards did not stop the damage inflicted by government education policy. Federal Indian education policy during the 1950s and 1960s centered on the construction of day schools on reserve, and in northwestern Ontario day schools were built as early as 1951 on reserves including White Dog. With the creation of day schools families were compelled to remain on the reserve for their children to attend school, which meant that many Anishnaabeg in northwestern Ontario abandoned the traplines which were central to their worldview. The repression of Indigenous languages was continued in the day schools. The 1951 Indian Act revisions facilitated federal-provincial agreements for Indian children to attend provincially-run schools together with settler children, and one quarter were doing so by 1960. However it was not until the 1973 agreement between the National Indian Brotherhood and federal government that Aboriginal peoples began to gain some measure of consistent control over the education of their children.

The history of residential schools and urban Indigenous communities are intertwined in multiple ways. In the most obvious manifestation, some parents relocated to towns and cities in order to be closer to their children attending residential school. A more complex issue is the effect of residential schools on intergenerational and familial relationships, with many Indigenous commentators and others arguing that the breakdown of these ties resulting from residential school attendance has contributed significantly to the historical trend since World War Two of young people moving away from their families on reserves and in rural communities to settle in cities. There is also some evidence that former students of residential schools (and their children) are over-represented amongst those in the care of child welfare agencies and foster families, and in prisons and mental hospitals, all experiences which would contribute to a general trend of urban settlement.
7. Child welfare and the removal of Aboriginal children

By 1980, most Indian residential schools had closed, and Aboriginal children were over-represented in the Canadian child welfare system by more than 600%, accounting for more than 20% of all children in care despite representing less than 4% of the population.\(^\text{152}\) There is a lack of reliable data regarding the exact numbers of Aboriginal children apprehended by child welfare services during the 1950s and 1960s. Patrick Johnston provides figures from British Columbia which indicate that the proportion of Native children apprehended in that province increased from less than one percent to over one third of all children in care between 1955 and 1964.\(^\text{153}\) In Canada, Australia and the United States, declining attendance of residential schools by Aboriginal children also coincided with an increase in white settler-descendant families adopting and fostering Aboriginal children.\(^\text{154}\) In Canada this practice intensified during the 1950s and continued through the 1960s and 1970s. Between 1971 and 1981, settler-descendant families were permitted to adopt 3,729 status Indian children, 76% of all state-facilitated adoptions of Aboriginal children during that period.\(^\text{155}\)

The over-representation of Aboriginal children in the Ontario child welfare system during the 1970s does not appear to be as dramatic as in western Canada: because the total Ontario population is much larger, Aboriginal children make up a smaller proportion of those in care than in the western provinces.\(^\text{156}\) But in the Ontario regions with a relatively higher proportion of Aboriginal residents, the over-representation of Aboriginal children was clear: in northwestern Ontario in 1981, 85% of the children in the care of the Kenora Children’s Aid Society were of Aboriginal ancestry, whilst the Aboriginal population constituted only 20% to 25% of the catchment population.\(^\text{157}\) In 1981, 73% of adoptions of Status Indian children in Ontario were by non-Native people.\(^\text{158}\) Some of these children were even adopted by families outside of Canada: Chief Moses Tom of Big Grassy Reserve in northwestern Ontario lost four children to Children’s Aid during the 1970s, two of whom were taken to the United Kingdom and never seen again by Tom and his wife.\(^\text{159}\)

These developments were the outcome of the post-war expansion of the welfare state and the linked ascent of the profession of social work; 1951 amendments to the Indian Act authorizing provincial child welfare systems to operate on reserves; and from the 1960s,
the ascent of a powerful new discourse on child abuse which encouraged a new form of interest in children on the part of the liberal state, and intensified the righteousness of those who would intervene to remove children from their families. These factors combined to facilitate provincial child welfare systems' increasing intrusion into Métis and off-reserve Aboriginal families and, eventually, encroachment onto reserves.

Prior to the 1950s, Aboriginal families had little or no contact with the provincially-administered child welfare system. Indian Agents had tremendous power to apprehend on-reserve children and send them to residential schools. In 1947, the Canadian Association of Social Workers and the Canadian Welfare Council petitioned the Senate/House of Commons Committee considering revisions to the Indian Act for the extension of provincial child welfare systems to reserves.\textsuperscript{160} The submission failed to recognize Aboriginal sovereignty and special relationships with the federal government. Instead, they argued that Indian children were insufficiently protected, criticized the role of the Indian Agent in current adoption practices, condemned the practice of placing “neglected” children in residential schools, and advocated that Aboriginal people on reserve should receive equivalent services to those of other Canadians. The federal government acted on these recommendations in 1951 amendments to the Indian Act. Whilst the federal government maintained the constitutional responsibility to provide services to Indians living on reserve, section 88 of the 1951 revisions states that this responsibility may be devolved to the provinces, whilst failing to specify the terms by which the provincial governments should be financially compensated in such cases.\textsuperscript{161} This ambiguity meant that, in practice, provincial welfare services were unevenly extended to reserves, reaching only some reserves in some provinces. Further, many status Indians and some provincial governments protested that the federal government must retain full responsibility for service provision for Indians on reserve, under section 91.24 of the British North America Act.

The Ontario government reached a bilateral agreement with the federal government in 1965, recorded in the \textit{Memorandum Respecting Welfare Programmes for Indians}, in which the federal government committed to reimbursing the province for a wide range of services provided to on-reserve status Indians including the extension of child welfare services to
reserves. (In contrast, other provinces’ resistance to such agreements meant that some provincial child welfare departments refused to deliver services on reserves.) The 1965 Memorandum also reinforced the standard federal expectation that all non-status Aboriginal people, and those living off-reserve, were eligible for standard provincial services. This meant that Métis and other Aboriginal people without Indian status were not recognized to have any particular entitlements with regards to child welfare provisions. Indeed, the provinces argued that such provisions would be discriminatory. This position became increasingly untenable following the 1981 constitution Act which recognized the special Aboriginal rights of Métis and non-Status Indians.

Whilst child welfare services in Ontario and elsewhere became more active on reserves, a major discursive shift regarding child welfare was occurring in North America. In the context of the 1960s “War on Poverty” in the United States, charities campaigning against child abuse found broad social and political support. Paediatricians introduced the concepts of the “battered child” and the “cycle of abuse” into the English lexicon in 1961. The resulting public policies, institutions and practices have constituted unprecedented level of state interventions in family life.

The moral certainty provided by child abuse discourse combined with racism, cultural distance and state-authorized power to fuel extreme levels of intervention in the lives of Aboriginal families. One can begin to understand how such processes are rationalized and perpetuated by considering how power works through the subjectivities of social workers and other professional carers. In Canada and other western liberal states, the expansion of the welfare state involved the increasing employment of women as professional carers in social work, education and health, as has been well documented by feminist scholars. In Canada the “helping professions” were dominated by white women until well into the 1970s. Sunera Thobani has discussed how professional discourses on caring which have emerged in the context of expanded state welfare programming and the mass entry of white women into the professional workforce have been closely linked to white women’s self-identification as agents of social reform and purveyors of necessary and valuable services. Further, the maintenance of a professional carer’s status is reliant on her state-authorized power over clients and their continuing dependence on her. Thobani argues
that “working in the caring professions has a profound influence on the self-constituting practices of the white women who work in them”.

This is vividly illustrated in author Patrick Johnson’s account of a conversation with a longtime staff of British Columbia’s Ministry of Human Resources in 1981:

*She admitted that provincial social workers would, quite literally, scoop children from reserves on the slightest pretext. She also made it clear, however, that she and her colleagues sincerely believed that what they were doing was in the best interests of the children. They felt that the apprehension of Indian children from reserves would save them from the effects of crushing poverty, unsanitary health conditions, poor housing and malnutrition, which were facts of life on many reserves.*

By understanding the professional and personal investments which individuals have in representing their work as valuable and necessary, we can become more sensitive to recognizing continuing colonial relations in the guise of contemporary public health and welfare policies and practices, which are framed as benevolent but have violently disruptive effects.

During the 1960s, policymakers and social welfare professionals developed a discourse which rendered alcohol-abusing Aboriginal parents *de facto* child abusers. State professionals perpetuated and elaborated discourses on Aboriginal people’s particular susceptibilities to alcoholism (and later, addictions and mental health problems) which combined with negative judgments about Aboriginal parenting to justify the removal of Aboriginal children. Ironically the loss of children to child welfare was sometimes a critical factor in exacerbating parents’ alcohol abuse, thereby increasing the likelihood that remaining children would also be apprehended.

The Canadian child welfare system's disproportionate apprehension of Aboriginal children is linked with Indigenous suffering and urbanization in several ways. The loss of children was profoundly destabilizing for families and communities, exacerbating parents’ prior suffering and contributing to social disintegration in some reserve-based communities. Parents whose children were taken sometimes relocated to urban centres in order to be near the foster homes or institutions to which their children had been removed. Aboriginal people raised by the child welfare system or adopted by settler families are over-represented in the penal system and among those seeking social services in urban
settings. Urbanization may also have contributed to the disproportionate apprehension of Indigenous children, as argued by Andrew Armitage in his comparative analysis of child welfare policies in Canada, Australia and New Zealand. First, parents moving to cities often lost the support of their extended families, and second, well-established child welfare and juvenile justice systems ‘assumed that Aboriginal children should be integrated into mainstream service patterns’.

Both dynamics applied in Vern Harper’s case. After his Cree mother died around 1940, he and his twin brother were fostered by a white family in Toronto. Had they been at their mother’s home reserve in Saskatchewan, Vern is confident that they would have been adopted by their uncles, one of whom was a hereditary chief and a decorated veteran of World War One. Provincial child welfare authorities were not involved with families living on reserves at that time and so would not have intervened in such an arrangement. But Susan Harper died in Toronto. Vern’s uncles, Samuel and Joseph Dreaver, requested that their nephews be returned to their care on the reserve, but the Toronto Children’s Aid Society refused. The Dreavers were told that their sister had converted to Catholicism and that Catholic children could not be adopted onto a Protestant reserve.

Vern describes his white foster mother as “a monster”. She refused to send Vern to school, labeling him as “retarded”; in an oral history interview Vern reflected, “that was the worst thing they did to me”. The foster mother punished Vern and his brother for speaking Cree. Vern enjoys relaying a conversation he and his brother had as adults, in which he asks, “Do you remember when our foster mother used to make us eat soap?” to which his brother replies “Yes, I don’t like to think about it”. But Vern persisted, “I liked Lux, which brand did you like?”. Notwithstanding the violence and oppression he experienced from his foster family, Vern also insists that his foster mother was instrumental in helping him to retain his identity:

*One thing that she did that made a difference, every day from when I was four years old, she would say ‘Vernon, you’re a good Indian boy’ or ‘Vernon, you’re a bad Indian boy’. The point is she was reinstating in me, every day of my life that I was with her, that I was an Indian. We lost the language, had no connection with our family, were totally isolated. I just clung to that ‘Indian’ because I was isolated from any Indian people.*
It is of course deeply ironic that Vern’s foster mother would encourage his identification as an “Indian” whilst sabotaging her foster children’s efforts to retain their Cree language. But unlike many foster and adoptive parents in this period, Vern’s foster mother provided him with enough basic information about his Aboriginal family, including photographs of his Cree relatives and the location of his mother’s reserve, to enable him to reconnect with them later in life.

Aboriginal children continue to be over-represented in the child welfare and juvenile justice systems in the present day in Canada, the United States and Australia. Further, the growing practices of transnational adoption can also be read as continuous with the colonial confiscation of Indigenous children, as Laura Briggs has argued. Participating professionals, officials and settler-descendant families continue to frame their actions as ‘rescue missions’ protecting the interests of Aboriginal children, whilst obscuring the colonial state’s role in creating the conditions used to justify the forced removal of Indigenous children from their families. In recent years, discourses on alcoholism and substance abuse have been supplemented by the growing use of psychiatric diagnoses as part of the process of judging Aboriginal mothers as unfit, leading to the removal of Aboriginal children to the custody of white Canadian parents.

8. **Indigenous livelihoods, industrial capitalism and waged work**

Eurocentric definitions of “real work” framed by the politics of modernity are central to colonial social histories including Canada’s. Whilst Indigenous trapping was central to the fur trade which drove initial European interest in North America, Indigenous livelihoods based on fishing, hunting, and gathering activities were not recognised as real work according to Eurocentric economic models. At the same time there is a pervasive misconception that after the demise of the fur trade Aboriginal people existed outside of the colonial capitalist economy. Historians have contributed to this distortion by neglecting Indigenous labour histories in Canada, and have only recently begun to address this gap. Historian Mary Jane McCallum argues that the trend among historians ‘to dissociate Canadian history from its colonial past’ has contributed to the dearth of scholarly writing on Indigenous labour in the twentieth century. She further explains the neglect
of Indigenous labour histories as a product of the ‘whiteness and indeed arrogance of the labour history field’ which frames Indigenous experiences as irrelevant. Existing work on Indigenous labour history in North America is dominated by research focused on British Columbia and western Canada, resource-based labour such as forestry and fisheries, and on Aboriginal men’s labour, whilst Ontario and eastern Canada in general, women and urban labour have been neglected in scholarship to-date. In contrast, McCallum’s work on the history of Aboriginal women’s labour challenges the dominant ‘narratives of Aboriginal displacement in the twentieth century’. As Renisa Mawani’s recent work has demonstrated, labour history is also an important perspective from which to analyse relations between Indigenous workers and racialised migrant workers, such as the Chinese labourers employed by British Columbia Salmon canneries from the 1870s, as ‘sites of interracial sociality’. As discussed in the Introduction to this thesis, Mawani’s work highlights the extent to which scholarship on Canadian history and the field commonly known as ‘Native-newcomer relations’ continues to be dominated by settler/Aboriginal and colonizer/colonized binaries, rendering invisible the roles and relationships of non-Indigenous racialised ‘others’.

Historian John Lutz’s work on Indigenous-settler relations in British Columbia aims to redress the invisibility of Indigenous peoples in twentieth century Canadian labour history. Lutz develops the idea that Indigenous people chose when and how to engage with the nascent capitalist economy in ways which would support the continuity of their own social structures. He uses detailed historical case studies of the Lekwungen and Tshilhqot’in First Nations to show how Indigenous wage labour has been central to both the development of British Columbia’s economy and to the dispossession of Indigenous peoples, who became ‘unwitting participants in the very process that was transforming and displacing their own economies’. At the same time, Lutz’s work demonstrates how the Lekwungen of Vancouver Island chose to engage with the colonial economy from the 1840s as a deliberate strategy aimed at maintaining their culture.

Robin Brownlie has cautioned against extrapolating the concept of Indigenous strategic and selective participation in wage labour, as epitomized by Lutz’s work. Whilst she concedes this analysis is applicable in British Columbia and Nova Scotia, Brownlie’s
research on Anishinaabe and Mohawk labour in southern Ontario during the inter-war period produced ‘little evidence that cultural preservation in itself was an objective’ of those participating in wage labour.\textsuperscript{187}

In the inter-war years, First Nations peoples living on reserves in some parts of Ontario could still rely on natural harvesting to resist full dependence on wage labour in the capitalist economy. The land in northwestern Ontario for example was not considered suitable for settler agriculture, so Anishnaabeg in this region suffered less settler encroachment during the first half of the twentieth century than did Indigenous people in southern Ontario. Joseph Morrison’s maternal grandfather, who lived at Naongashiing on the Lake of the Woods, survived as a trapper until his death in the late 1980s.\textsuperscript{188} But for those in southern Ontario, the large-scale privatization of land, commercialization (and destruction) of fisheries and depletion of game animals meant that wage labour and farming were the main choices of livelihood for many by the early twentieth century.\textsuperscript{189} Indeed, the Mohawks of the Bay of Quinte expressed concerns regarding the loss of Indigenous livelihoods due to depleted natural resources in southern Ontario as early as 1846.\textsuperscript{190}

First Nations people were employed in the forest, fishing and transportation industries in Ontario, all of which were hard-hit by the Great Depression.\textsuperscript{191} As economic hardship spread among the settler population in the 1930s, poor whites resorted to hunting and fishing further depleting these natural resources which many Aboriginal peoples still relied upon in areas less affected by European settlement. In the post-war years increasing recruitment of immigrant labour and industrial technological developments led to significant loss of work for Aboriginal people, particularly those who had relied on casual labour in the agricultural and natural resources sectors. The legal status of reserve lands meant that reserve residents were unable to secure bank loans for farm machinery and could not therefore compete with increasingly mechanised settler agriculture, leading to a decline in agriculture on Six Nations and other southern Ontario reserves.\textsuperscript{192}

Aboriginal people migrated to the large urban centres of southern Ontario seeking employment in increasing numbers during the inter-war years, with an even more
significant increase after World War Two. The emerging historiography describing Aboriginal women and men’s active participation in southern Ontario’s wage economy in twentieth century provides some important context for the development of urban Indigenous communities. For some of those residing on Haudenosaunee and Anishnaabe reserves in southern Ontario it was possible to commute to nearby urban centres for waged labour. Six Nations of the Grand River and Mississauga of New Credit are close to Hamilton; Mohawks of Tyendinaga could readily travel to Belleville and Kingston. Haudenosaunee men became renowned for their proficiencies as high steel workers in the construction industry. Haudenosaunee high steel workers not only built the Hamilton suspension bridge but also travelled widely throughout Ontario and New York State to work, typically returning to Six Nations on weekends or after completing a job.

Many Anishnaabeg from the Georgian Bay area migrated to southern cities, particularly Toronto. One of these was Lillian McGregor. Having attended school on the reserve up to grade eight, Lillian was working as a ‘cabin girl’ at a tourist lodge near Georgian Bay when the owner introduced her to the Gale family from Toronto who were looking for a live-in nanny. Despite her mother’s reluctance, Lillian went to Toronto to work for the Gales in November 1939. She completed high school whilst working for the Gales, and went on to study nursing. According to Lillian, it was common practice among the upper-middle class Toronto families who employed Aboriginal women as domestic workers to encourage the women to further their education. Lillian explained to me that because of her extensive experience gained from working with her grandmother the midwife-healer, ‘nursing was the easiest thing to do, because I had that grounding in medicine’.

Aboriginal women had fewer employment options than men during the early part of the twentieth century. During the 1930s the majority were employed as domestic servants or clerical workers, low-status work which Canadian-born white women avoided, reflecting the limited job options for working-class women at the time. Robin Brownlie’s research on voluntary enfranchisement in Ontario -- discussed in Section One above -- identified that 25% of enfranchisement applications were initiated by (single or widowed) women, and of the files reviewed, all female applicants were successful, unlike the men. Half of the women whose files were considered were destined for large cities of Toronto, Montreal and
Ottawa, and the majority employed as domestic servants or in clerical work, reflecting the limited job options for working-class women in the 1930s. In an early government programme promoting Aboriginal employment and urbanization, the Department of Indian Affairs facilitated Native women’s employment as domestic labourers in institutions and private homes, including one programme which placed women in wealthy Ottawa homes including those of highly ranked government officials and Senators during the early to mid-1940s.

Service in the Canadian military became an important occupation for many Aboriginal people in Ontario during the twentieth century. Both Vern Harper and Joe Morrison joined the military at age seventeen, and Vern fought with the United States forces in Korea. Joe’s father and Vern’s maternal uncles and some female cousins fought in the Second World War. One of Vern’s ancestors, Harry Dreaver, fought in the second Boer War (1899-1902). Lillian McGregor recalled that four men from her reserve fought in the Second World War; Lillian’s sister Colleen joined the Canadian Women’s Army Corps and later worked as an officers’ cook. Oral history interviews with veterans indicate a range of motivations among which loyalty to Britain and the opportunity to earn a decent wage were prominent. Across Canada the proportion of Status Indians who enlisted equaled and often exceeded the proportion of non-Aboriginal Canadians who volunteered, despite racist opposition from some recruitment officers and instituted in military policy. More than 4,000 status Indians enlisted during the First World War (1914-1919), 35% of those eligible; the largest number came from Ontario. Over 3,000 enlisted during the Second World War (1939-1945) including over 1,300 from Ontario, with high numbers of volunteers from Six Nations, Manitoulin Island, Parry Sound and Tyendinaga. Aboriginal women participated in both World Wars, and the Ontario Native Women’s Association has recently published an account of their experiences.

Veterans’ experiences of participation in the wars, and the subsequent lack of recognition and continuation of racist colonial relations upon their return to Canada, motivated some (such as Fred Loft of Six Nations in southern Ontario) to play leading roles in the political mobilization for Indigenous rights, beginning in the interwar years. Others suffered disappointment and discouragement:
their exposure to the broader world had changed them profoundly, but they returned home to the same patronizing society that they had left. Although eligible for the vote overseas, they lost their democratic rights after the war. [...] Although they had fought overseas, their legal status had not changed: they continued to be wards of the Crown.  

The Department of Indian Affairs administered a post-war soldier settlement programme in which many Aboriginal veterans in Ontario participated, but it failed miserably. The general market decline was exacerbated by the government's allocation of insufficient resources and poor quality land to participants in the programme. As historian Robin Brownlie notes,

Although their status as former soldiers had initially elevated them above the ordinary category of “Indian”, their position as aid recipients undermined the image of competence and bravery they had earned in wartime.

Surprisingly little scholarly attention has been given to the psycho-social effects of Aboriginal people’s military participation and subsequent return to family life. Joe Morrison described how his father Donald returned home after fighting in the Second World War ‘with a different outlook, more rough, violent’. Donald began to abuse Joe’s mother and to drink excessively. Eventually Joe’s parents separated and Donald lived on the streets of Kenora for a while. The story of how he recovered and led the development of the healing movement around Kenora is told in Chapter Two.

**Disruption of Anishnaabe livelihoods in northwestern Ontario**

During the first few decades of the twentieth century many Anishnaabeg in northwestern Ontario continued to sustain themselves as they had done for centuries prior to colonization, with livelihoods based on wild harvesting from forests and lakes, including hunting, trapping, fishing, and the cultivation of wild rice. The Anishnaabeg were centrally involved in the fur trade and the Hudson Bay Company was a dominant paternalistic force in Anishnaabe lives. Nevertheless increasing settler activity and growing provincial regulation of natural resources from the mid-twentieth century constituted the most profound disruptions of Indigenous livelihoods in this region.

The rapid expansion of state regulation and programming, combined with the growth of capitalist industry, constituted a violent assault on the social fabric of Ojibwe life. To
appreciate the scale of the disruption, it is necessary to understand that wild harvesting activities embody complex social and cultural meanings for Indigenous peoples, with profound implications for kinship and broader social relations, spirituality, and individual personhood – in short, all aspects of health, holistically defined.\[210\] Settlers began to construct dams to power saw mills and generators from the late 1880s, causing environmental disturbances and disrupting Indigenous livelihoods.\[211\] The resulting flooding reduced wild rice yields and damaged fisheries and the muskrat population, an important trapping species.

Some Anishnaabeg found work as guides for tourists from the 1930s; several hunting and fishing lodges opened in the region during the mid-1940s and offered seasonal employment. By the late 1960s, a majority of the households on Grassy Narrows reserve had at least one family member working at a lodge.\[212\] In an analysis which parallels Lutz’s argument about Indigenous peoples’ strategic engagement with wage work, Anastasia Shkilnyk describes how work in the tourist lodges complemented traditional economic practices by providing seasonal employment, and minimally disrupted social relations by providing opportunities for families to work together. However, anthropologist Krystyna Sieciechowicz cautions against an overly-benign representation of the tourist lodges.\[213\] In her research with Anishnaabeg in south and northwestern Ontario over several decades she has collected numerous accounts of intensely discriminatory practices at such lodges. Sieciechowicz described how Anishnaabeg were treated in a most servile manner or degrading manner, often given the poorest quality food, were not permitted to leave the compound, and had their wages withheld, etc. In her analysis, the Anishnaabeg stuck with these jobs in the 1940s because there were so few other sources of cash income.

From 1947, the Ontario government’s natural resource management policy began to undermine Aboriginal livelihoods in the region, contra to treaty agreements, by restricting trapping, hunting, fishing, and wild-rice harvesting.\[214\] Industrial pollution and disruption of the natural environment also undermined traditional economic practices in the region. Power stations intensified fluctuations in the English-Wabigoon river system in the late
1950s, decimating the muskrat population already reduced by the effects of earlier damming.

Some Aboriginal fishers including Joe Morrison’s grandfather and great-grandfather participated in the commercial fishing industry which developed in the region, and grew in scale during the 1950s when regular air transport to northern Ontario began. In 1971 surveyors found that the freshwater system of northwestern Ontario, and particularly the English-Wabigoon river system, had been severely poisoned with methyl mercury from pulp and paper industry emissions. This discovery led to the collapse of the commercial fisheries and significant job losses in sports fishing with the closure of tourist lodges. The contamination continues to constitute a serious health threat to Aboriginal people of the area, particularly Grassy Narrows and White Dog.
Map 1.1  City of Kenora and surrounding reserves (1974)

Notes:
1. See Table 1.2 for 1974 and current reserve names
2. Map is illustrative only. Locations are approximate.
<table>
<thead>
<tr>
<th></th>
<th>First Nations reserves in the Kenora area: 1974 Indian Affairs-assigned names</th>
</tr>
</thead>
</table>
| 1. | Islington No. 29  
(Wabasseemoong, White Dog) | 12. Eagle Lake No. 27 |
| 2. | Swan Lake No. 29 | 13. Lake of the Woods No. 31G |
| 3. | English River No. 21  
(Grassy Narrows) | 14. Lake of the Woods No. 31C |
| 4. | Wabaskang No. 21  
(Wabauskang) | 15. Lake of the Woods No. 37B |
| 5. | The Dalles No. 38C  
(Ochiichagwe’Babigo’ining) | 16. Big Island No. 31D, E, F, & 37  
(Naongashiing) |
| 6. | Shoal Lake No. 39A  
(Iskatewizaagegan No. 39) | 17. Obabikong 35B |
| 7. | Shoal Lake No. 40 | 18. Lake of the Woods No. 37 |
| 8. | Northwest Angle No. 34C & 37B | 19. Yellow Girl Bay No. 32B  
(Naotkamegwanning Anishinabe) |
| 9. | Northwest Angle No. 33B | 20. Whitefish Bay No. 33A & 34A  
(Naotkamegwanning Anishinabe) |
| 10. | Rat Portage No. 38A  
(Washagamis Bay) | 21. Big Grassy River No. 35G (Big Grassy) |
| 11. | Kenora No. 38B  
(Wauzhushk Onigum) | 22. Sabaskong Bay No. 32C, 35C, D, F & H  
(Ojibways of Onegaming) |

**Table 1.2**

**Notes:**
1. Numbers correspond to locations on Map 1.1 (above)
2. Current/Anishnaabe & alternate names are in brackets
9. Indigenous people and alcohol in Ontario
The suffering wrought by alcohol abuse is perhaps the most widely written-about
dimension of Indigenous post-contact experience. Much scholarly writing on Indigenous
peoples and alcohol in North America reproduces conceptual weaknesses identified by
anthropologist James Waldram: assumptions of Indigenous peoples’ biological and/or
cultural inferiority, Arcadian notions of pre-contact Indigenous life as lacking any social
conflict or change, and the reinforcement of constructs of Aboriginal people as inherently
‘traditional’ and ill-equipped to cope with the stresses of ‘modern’ life.217

The biological essentialist paradigm is based on the assumption that Aboriginal peoples are
genetically predisposed to metabolise alcohol differently than other ‘races’. Whilst this
understanding was popularized in contemporary health science by an Edmonton-based
study conducted in 1971, the idea of Indigenous peoples possessing an inherent
susceptibility to alcohol dates back to at least the early 19th century and continues to
circulate, propagated by Indigenous as well as non-Indigenous commentators.218

The theory that ‘acculturative stress’ and loss of meaningful cultural roles caused by rapid
cultural change induces anxiety which drives people to drink in order to ease this suffering
is problematic: it perpetuates an understanding of pre-contact Indigenous societies as
timeless and Indigenous individuals as therefore incapable of withstanding social
change.219 The same colonial discourse underlies the idea that rapid social change resulting
from colonial contact would precipitate high rates of mental illness, as discussed by Megan
Vaughan in the context of British-colonised sub-Saharan Africa.220

At the same time though, it is clear that historically different societies have suffered from
widespread alcohol abuse during periods of rapid social change, such as the “gin craze” in
mid-18th century England, which has been linked both to the increasing availability of
stronger alcohol and the social upheaval brought about by the beginnings of the industrial
revolution.221 The challenge is to discuss Aboriginal alcohol abuse in a socially and
historically-situated way which avoids perpetuating stereotypes and incorporates a full
range of contextual considerations. My starting point, then, is the recognition that alcohol
has been a central feature of Indigenous social suffering in Ontario and elsewhere,
tempered by an awareness that Aboriginal experiences of alcohol are complex, varied, and
not universally destructive. Here I focus on alcohol prohibition as a technique of colonial governance with wide-ranging social effects; the significance of regionally-specific histories within Ontario for patterns of alcohol consumption; and the interface between alcohol abuse and urbanization.

**Colonial Prohibition: ‘No minors, no dogs and no Indians’**

Vern Harper recalls returning from the Korean War and being refused service in a bar in Saskatchewan in 1954:

> I came back from Korea, a decorated veteran. [...] I was in an American uniform and I was decorated and I met some Canadian Indian soldiers that came back from Korea, just young men, we were young men. [...] We went into a hotel in a place called Shellbrook, Saskatchewan. [...] We went inside and we sat down, we’re all in uniform and we’re, you know, we’re like really proud and happy to be home and everything and the owner of the hotel came and said, he made us look, it was bigger than that billboard, that board there, bigger than that, and on that sign it said, ‘No minors, no dogs and no Indians’.222

The history of Aboriginal alcohol consumption in Canada needs to be understood in the context of the colonial Canadian state’s Aboriginal-specific prohibition of alcohol. Canada and other settler colonies including Australia and the United States enacted Aboriginal-specific prohibition laws aimed at ‘protecting’ Aboriginal people from the effects of alcohol. Canada’s Aboriginal-specific prohibition laws were in place from the time of the first Indian Act in 1868 until 1985.223 Such laws were founded on the assumption that Aboriginal people had insufficient self-control to consume alcohol without harming themselves or others. As Mariana Valverde has noted, regulation of alcohol consumption was an important mode of governance in many colonial states but approaches varied across settings.224 For example, colonial administrators in former British colonies in Africa, including South Africa and Ghana, exploited colonized populations as consumers of beer manufactured by British-controlled industries, whilst suppressing Indigenous industries producing alcoholic beverages such as palm wine.225

Aboriginal commentators and others have argued that Canadian colonial prohibition has profoundly affected Aboriginal drinking behavior. In particular, prohibition laws effectively compounded practices of binge-drinking.226 But Aboriginal-specific prohibition
was also a technology of colonial governance with social effects extending far beyond alcohol consumption; these are just beginning to be explored in the academic literature.\(^{227}\) Some Aboriginal people who could pass as white chose to do so in order to access alcohol, creating further social divisions.\(^{228}\) Bootlegging industries provided sources of income for settlers and Aboriginal entrepreneurs. Local-level enforcement of prohibition, in Ontario and elsewhere, produced and elaborated racializing discourses which purported to define Indian-ness, enforced racial segregation, and perpetuated stereotypes of Aboriginal people as inherently irresponsible, lacking self-control and prone to violence.\(^{229}\) And the prosecution and conviction of Aboriginal people for liquor-related offenses criminalized large proportions of many communities.

**Aboriginal communities and alcohol in northwestern Ontario**

As has been widely noted, Aboriginal peoples were often exposed to alcohol through social interactions with early European traders and the work-crews constructing roads and railways, men who were accustomed to binge-drinking.\(^{230}\) In northwestern Ontario, the completion of the Canadian Pacific Railway in the mid-1880s brought a new wave of fur traders independent to the Hudson’s Bay Company, which had banned alcohol in the areas it controlled after its amalgamation with the North West Company in 1821.\(^{231}\) The independent traders typically brought strong alcohol which they traded with Aboriginal fur traders, and were commonly known as “whisky pedlars”; soaring fur prices towards the end of the First World War provoked a major influx of new traders.\(^{232}\)

Anthropologist Adrian Tanner makes an important argument regarding the historicisation of Indigenous alcohol abuse in his discussion of social suffering among the east Cree in northern Quebec. Tanner points out that although the Cree first encountered alcohol in their interactions with European fur traders many decades previously, binge drinking only became a significant social problem from the 1960s, as assimilation policy contributed to declining involvement in hunting and trapping, disrupting the structure of social relations, and people spent more time in newly created settlements.\(^{233}\) This analysis has important implications for understanding alcohol abuse in Aboriginal communities in northwestern Ontario, for whom the disruption of traditional livelihoods and social structures (discussed
above), coincided with increased access to Kenora via government roads constructed during the 1950s for people living on reserves such as Grassy Narrows and White Dog.\textsuperscript{234} During the same period, some First Nations located on islands in the region voluntarily relocated to the mainland, in order to access electricity and services.\textsuperscript{235} These were likely significant factors shaping drinking behaviour in Kenora and the region more generally. A 1958 provincial proclamation allowed for reserves to hold referendums whereby a majority vote would legalise bringing alcohol onto the reserve. The threat of provincial police maintaining a stronger presence to enforce provincial liquor laws on “wet” reserves was a disincentive to many reserves, and by 1962, only forty reserves had voted in favour of allowing alcohol, meaning that residents of many reserves were obligated to travel to cities to buy and consume it.\textsuperscript{236}

**Aboriginal people and alcohol in urban Ontario**

Elder Lillian McGregor recalls that it was unusual for Aboriginal people in Toronto to drink alcohol during the 1940s and ‘50s:

> I don’t remember anybody saying ‘Oh let’s go have a beer, oh let’s go have a drink’ at that time. There was nobody making a rush just to go and drink. There was only, you had to have a card if you were ever going to do that. You had to have a blue card it was called. Even to buy booze, the men had to have a card, but you didn’t see anybody staggering on the street, like I see my people now.\textsuperscript{237}

Lillian is referring to the enfranchisement cards (‘blue cards’) issued by Indian Affairs, which vendors commonly used to identify non-status Aboriginal people who were allowed to purchase alcohol.\textsuperscript{238} According to Lillian, conspicuous Aboriginal public drunkenness was a social phenomenon which emerged in Toronto in the late 1960s, much to the embarrassment of older Aboriginal people in the city.\textsuperscript{239} Mark Nagler’s late 1960s study *Indians in the City* includes a short section on ‘Alcohol Consumption’, in which he reports that ‘in the lower-class bars of the Jarvis-Church area of Toronto, one frequently finds Indians drinking’.\textsuperscript{240}

From the 1950s, changing prohibition policy and the growth of urban Aboriginal populations, as well as increased travel between reserves and cities in northern Ontario, contributed to gradually increasing Aboriginal alcohol consumption in Kenora, Toronto and other Ontario cities. Some of the new urban residents and alcohol consumers were
Aboriginal veterans from the Second World War, who often settled in cities upon their return. Those who had acquired the habit of drinking whilst serving abroad commonly shared this habit with friends and family. As discussed above, Joe Morrison’s father Donald began to abuse alcohol after returning from the Second World War, and Joe’s mother acquired the practice from his father. Joe himself also started to drink when he joined the military.

But Aboriginal veterans could not legally be served alcohol in Canada, and after the Second World War, increasing numbers of status Indians were convicted for illegal alcohol consumption. Settler society became increasingly uneasy with Indian prohibition regulations during the 1950s, which came to be seen as discriminatory rather than protective. In the conclusion to Vern Harper’s account, local farmers, themselves veterans of the Second World War, intervened to ensure that Vern and his friends were served:

*They told the owner, they said ‘You better serve these men or we’ll tear this place apart.’ So we all got drunk.*

The Canadian state gradually lessened restrictions on Aboriginal alcohol consumption from 1951, when the Amendment to the Indian Act allowed for provincial legislation permitting Aboriginal people to buy and consume alcohol in licensed public venues. The government of Ontario made this change in 1954. The Liquor Control Board of Ontario continued to ban Indians from buying liquor from stores until 1959, and it remained an offense for Indians to be intoxicated outside of a reserve until 1967 (at which time section 94 of the Indian Act was struck down by the Supreme Court). Thus the criminalization of Aboriginal people for consuming alcohol continued, resulting in disproportionate numbers of alcohol-related charges in Kenora and Toronto during the 1960s and continuing into the 1970s, the implications of which shall be discussed further in Chapter Two.

10. Native welfare
After the Second World War the rapidly developing Canadian welfare system became an important site for the emergence of contemporary public policy discourses on Indigenous peoples. This historical development is crucial to an understanding of how the state’s efforts at subjugating and assimilating Indigenous peoples led to the intensification of Indigenous social suffering in the latter half of the twentieth century. By the late 1950s the
federal government’s goal in establishing a Native welfare system was clearly articulated as facilitating the assimilation of Aboriginal people into dominant settler society. This goal was intimately linked to the financial motivations of opening reserve lands to capitalist development, and increasing Indigenous access to white settlements where Indians would become consumers of settler-produced and controlled goods and services.

In this section I discuss how emerging welfare programmes for Aboriginal people were characterized by an expanding bureaucracy and extreme levels of surveillance and intrusion into Indigenous lives, whilst a powerful emergent liberal discourse on ‘equality’ actively obfuscated understandings of the historical context of Indigenous-state relations. The size of the Indian Affairs bureaucracy more than doubled between the late 1940s and the late 1950s, incorporating increasingly specialized professional roles and developing new discourses and practices aimed at reconstructing Indian recipients of government relief into liberal self-governing subjects. Alongside this new focus, the longstanding colonial understanding of Indigenous peoples as pre-modern and incompetent persisted in official discourse and practices.

Social work philosophy emphasizing individual responsibility for self-management was increasingly evident in late 1950s Indian Affairs discourse. Social workers and economic development officers were added to regional offices, and an Economic Development Division was created in 1958. Relief payments to status Indian families increased significantly over the course of the 1950s and food vouchers gradually replaced the previous rations system. Recipients were provided with ‘a guide to good nutrition “based on Canada’s Food Rules” and developed with the cooperation of the Department of National Health and Welfare’. Meanwhile the role of the Indian Affairs superintendents evolved “from administrator to educator (nutrition – proper use of the food dollar – wise purchasing, etc.)”. The new approach to welfare also incorporated the 1950s Indian Homemakers’ Clubs, and a Leadership Training Program delivered seminars to individuals whom Indian Affairs staff identified as exhibiting leadership ability.
Community Development emerged during the 1960s as a more sophisticated version of social work’s self-help model. A Liberal government came to power under Prime Minister Lester Pearson in February 1963, and the new Deputy Minister of Indian Affairs was familiar with community development concepts being promoted by the United Nations.252 By 1963 the rate of welfare dependence amongst status Indians was over ten times that of the general Canadian population, thus an anticipated reduction in welfare costs was a major rationale for adopting the community development approach.253

In March 1964 Indian Affairs submitted a proposal to Cabinet for a community development programme on reserves. In a supporting memo, Minister of Citizenship and Immigration Rene Tremblay described ‘a pressing need for further measures designed to bring Indians into the twentieth century’, and goes on to argue that ‘experience in the under-developed areas of the world and current trends in Canadian public opinion support a community development approach as one effective way of achieving this aim’.254 Tremblay describes how ‘Pilot projects conducted by Indian Affairs Branch have demonstrated that an inverse relationship exists between welfare costs and investment in community development programs’. Historian Hugh Shewell cites archival evidence in arguing that the model developed by Indian Affairs Branch was influenced by British approaches, which involved the application of adult education principles in social and economic development work with former colonies.255 The British paradigm contributed to IAB’s emphasis on ‘developing and supporting Indigenous leaders, who would organize the community around key issues, identify strategies for resolving those issues, and take constructive action based on those strategies’.256

Early Aboriginal welfare policy spawned a powerful ahistorical discourse on equality which has persisted into the present day. Federal desires to shift responsibility for Indian welfare to the provinces drove the emergence of this discourse, which framed Aboriginal people as ‘equal’ to the settler population and therefore entitled to receive public services in the same manner, i.e. delivered by provincial governments.257 Indian status and special entitlements derived from historical rights were framed as ‘segregation’ and an obstacle to citizenship and full participation in Canadian society.258 This formulation obscured
outstanding historical issues pertaining to Indigenous peoples’ collective rights and entitlements and their dispossession by the Canadian colonial state and settler society, as Shewell describes:

*Instead of acknowledging the unresolved historical issues, it was easier to deny or ignore them, to depict Indians as still engaged in learning the ways of modern society, and to equate their situation with questions of labour market opportunity. Social assistance [...] was [...] a method of instruction in liberal political economy and hence integration.*

The government was only partially successful in establishing such arrangements, which further reduced the autonomy of First Nations who would ‘become third-party objects of contractual arrangements between Ottawa and the provinces’. However the province of Ontario and various national non-governmental organisations, including the Canadian Welfare Council, the Anglican and United Churches and the Indian-Eskimo Association, all endorsed the underlying analysis. The willfully ahistorical framing of Indigenous ‘special entitlements’ as the problem and ‘equality’ as the solution to Indigenous suffering remains dominant in the present-day, as shall be discussed in subsequent chapters.

Shewell discerns three broad and somewhat contradictory social patterns among Indigenous people during the 1950s which he links to the growth of welfare programming. The first two are based on his comparative analysis of First Nations' testimonies and written submissions to the joint parliamentary committees on the administration of Indian Affairs of 1946-48 and 1959-1961 respectively. Firstly, he describes evidence of the emergence of ‘feelings of inferiority to whites and a negative, collective self-image’. Shewell links this disturbing development to increasing pressures to integrate in the context of continuing deprivation and marginalisation and increased exploitation. Welfare administration facilitated increasing intrusion into lives of Indigenous communities and families and promoted liberal, middle-class Eurocentric values at every turn, such as the dominant model of single-resident nuclear family headed by a dominant male breadwinner. A second difference between the two sets is that in the latter submissions, some Bands employ a ‘language of integration’, that is, they embrace the liberal economic model and welfare bureaucratic terms, absent from the earlier submissions which focused more plainly on material deprivation on reserves.
Shewell’s third observation regards the social significance of Indian Affairs Branch’s community development programme. Whilst Indian Affairs and the Liberal Cabinet had conceived of community development as a tool of assimilation, the programme provided a forum for the articulation and development of arguments around Indigenous rights which contributed to the formation of a national Indigenous movement. Emerging Indigenous political leaders participated in leadership and community development training and regional and national Indian advisory committees: some of the community development officers appointed under the new programme from 1965, and nearly all of their assistants, were Indians. One of the officers was George Manuel who later became the leader of the National Indian Brotherhood and spearheaded the successful opposition to the 1969 White Paper on Indian Policy, which will be discussed in Chapter Two.

11. Conclusion
This chapter has provided socio-historical context for the phenomenon of contemporary Indigenous social suffering in Ontario. Here I have begun to address two of my stated research objectives. First, I have provided historical context for forthcoming chapters which focus on the social history of urban Indigenous healing in Ontario from the late 1960s. My aim in providing this broader background is to emphasise the shared colonial histories of urban, rural and reserve based Indigenous peoples, as well as to contextualize increasing Aboriginal migration to urban centres after the Second World War. Second, I have set the scaffolding of my historical-anthropological approach to understanding Canadian colonialism. In tracing the trajectories of colonial ideologies, policies and practices through the middle decades of the twentieth century, I have shown the significance of continuities and discontinuities in colonial thought, and of attending to convergences with historical developments such as the intensification of industrial capitalist development, the growth of welfare bureaucracy and the rise of the associated ‘helping’ professions, as well as continuities such as those between residential schools and the child welfare system, and Indian Act suppression of Indigenous spiritual practices and contemporary missionary activity. I have also begun to illustrate the relevance of geographically-located analyses of colonialism and Indigenous social suffering and healing, by drawing on local and regional historical analyses which distinguish how Indigenous
peoples in southern and northwestern Ontario engaged with particular policies and other social and political developments.

In Chapter Two I focus on the Ontario cities of Kenora and Toronto to explore how urban Indigenous communities organized themselves socially and politically from the late 1960s, both protesting and addressing the social suffering in their midst, and spawning a discourse and practice of urban Indigenous healing.
End-notes to Chapter One


2 James Clifford suggests that in the context of ‘the relentless assault on indigenous sovereignty by colonial powers, transnational capital, and emerging nation states’, Indigenous ‘practices of long-term dwelling away from home’ may be regarded as diasporic: although Indigenous peoples’ usual attachment to a land base disqualifies them from being defined as a diaspora, his analysis suggests important points of convergence with contemporary diasporic experience. James Clifford, "Diasporas," *Cultural Anthropology* (1994): 309-10.

3 The end of the Second World War marked the intensification of a series of social and political trends among Indigenous peoples including increasing settlement in urban areas and renewed political organisation often spearheaded by returned veterans. Also in 1945, Indian and Northern Health Services were transferred from Indian Affairs to the newly-created Department of National Health and Welfare and the provision of state programmes and services to status Indians and Inuit gradually intensified.

4 Peters cites several specific examples including the forced removal of First Nations people from what is now Vancouver, the destruction of a Cree community opposite the city of Edmonton in the 1880s, the removal of reserves to make way for urban settlements in Saskatchewan in the early 1900s, the removal of the Songhees Indian reserve to accommodate the city of Victoria, and the forced relocation of various Métis communities. Evelyn Peters, "Conceptually Unclad: Feminist Geography and Aboriginal Peoples.," *The Canadian Geographer* 48, no. 3 (2004): 255.


7 The colonial government employed deliberate economic and political interventions to weaken Mississauga control over the lands, which was further undermined by settler agriculture and poaching which depleted hunting and fishing resources. The naturalization of Indigenous ‘vanishing’ from Toronto also concealed the Mississauga’s efforts at advocacy for the return of lands which they had not voluntarily relinquished, including an 1860 petition to the Duke of Newcastle which addressed their former “Council Grounds’ on the site of the Provincial Lunatic Asylum (now the Centre for Addiction and Mental Health on Queen Street West). Freeman, ""Toronto Has No History!"" Indigeneity, Settler Colonialism and Historical Memory in Canada's Largest City.," 24.

8 Ibid.: 28.

9 Lillian McGregor was involved in early social organizing in the Aboriginal community in Toronto from the 1940s onwards (see Howard, "Dreamcatchers in the City: An Ethnohistory of Social Action, Gender and Class in Native Community Production in Toronto (Ontario) "; Heather A. Howard, "Women’s Class Strategies as Activism in Native Community Building in Toronto, 1950-1975," in *Keeping the Campfires Going. Native Women’s Activism in Urban Communities.*, ed. Susan Applegate Krouse and Heather A. Howard (Lincoln and London: University of Nebraska Press, 2009). Lillian joined the Elders’ Council at the Native Canadian Centre of Toronto in 1989. In 1993 she became the first Grandmother and Elder-in-residence at First Nations House, University of Toronto. Lillian was Elder to the Ontario Federation of Indian Friendship Centres between 1990 and 1995, when she was seconded to the Ontario Aboriginal Healing and Wellness Strategy (discussed in Chapter Three), where she was Elder until health problems forced her to step down in 2006. In 2002 the University of Toronto awarded Lillian an Honourary
Doctorate of Laws in recognition of her service in the Aboriginal community, and in 2006 she was awarded a membership of the Order of Ontario. At the time of writing (early 2011), Lillian is about to be awarded a prestigious National Aboriginal Achievement Award. Vern Harper, *Following the Red Path: The Native People’s Caravan, 1974* (Toronto: NC Press, 1979).

Joseph Morrison was active in the Aboriginal community in Kenora during the 1970s, helping to establish the Ne’Chee Friendship Centre and the Kenora Street Patrol, discussed in Chapter Two. Between 1989 and 2007 he worked as a Justice of the Peace for Ontario. Since retiring from that role he has been President of the Board at Ne’Chee, second Vice-President of the Ontario Federation of Indian Friendship Centres (OFIFC), and OFIFC representative to the Nationals Association of Friendship Centres.

10 Joseph Morrison was active in the Aboriginal community in Kenora during the 1970s, helping to establish the Ne’Chee Friendship Centre and the Kenora Street Patrol, discussed in Chapter Two. Between 1989 and 2007 he worked as a Justice of the Peace for Ontario. Since retiring from that role he has been President of the Board at Ne’Chee, second Vice-President of the Ontario Federation of Indian Friendship Centres (OFIFC), and OFIFC representative to the Nationals Association of Friendship Centres. Vern Harper has been an active contributor to the Aboriginal community in Toronto since the 1970s, and a significant participant in the Red Power movement in Canada and the United States. He was an organizer of the Toronto Warriors Society, the Toronto chapter of the American Indian Movement (AIM), and the Native People’s Caravan to Ottawa in 1974, discussed in Chapter Two (and see Harper, *Following the Red Path: The Native People’s Caravan, 1974.*) Together with his second wife Pauline Shirt (now an Elder), Vern co-founded the first Aboriginal school in Toronto, the Wandering Spirit Survival School, and was involved in the establishment of Pedahbun Lodge and Anishnawbe Health Toronto, discussed in Chapter Two. During the 1960s he struggled with drug and alcohol abuse, and in the late 1960s was incarcerated in two psychiatric institutions in Alberta, experiences which he has written about (see Vern Harper, "Them Crazy Indians," in *Shrink Resistant: The Struggle against Psychiatry in Canada*, ed. Bonnie Burstow and Don Weitz (Vancouver: New Star Books, 1988). Vern was elected Vice-President of the Ontario Métis and Non-Status Indian Association in 1972. He worked with Millie Redmond at the Native Canadian Centre as the second Native Court Worker (Millie was the first), and went on to work for Aboriginal Legal Services for over a decade during the 1980s and 1990s. In 2002 Vern received the Centre for Addiction and Mental Health’s ‘Courage to Come Back’ award, which honours ‘people who have overcome addiction or mental illness and have used their experience to contribute to the community’. Abigail Pugh, "Urban Elder Brings Traditional Healing to the Twenty-First Century," *Cross Currents: The Journal of Addiction and Mental Health* 6, no. 4 (2003).


13 Harper, "Them Crazy Indians."

14 Adapted from Leo Driedger, *Multi-Ethnic Canada. Identities and Inequalities* (Toronto & Oxford: Oxford University Press, 1996). Source: censuses of Canada 1871-1991. The figures for different years are not directly comparable because of shifting definitions, but taken together they provide a basic illustration of patterns of population change. The definition of ‘urban’ is that in effect at the time of the particular census. Definition of ‘Aboriginal’ varied from year to year based on legislation then in force: 1901 included Indians and half-breeds with mixed Native and non-Native ancestry traced through either parent; 1911 included Indians only, with ancestry traced through the mother’s side; 1921 added Inuit to the 1911 formulation; 1931 added persons of mixed Native and non-Native ancestry traced on the mother’s side; 1941 included Native Indian, Inuit, and persons of mixed ancestry traced on the father’s side; 1951 and 1961 included Native Indian, Inuit, and persons of mixed ancestry living on reserves or traced on the father’s side; 1971 included Native Indian and Inuit only, traced on the father’s side; 1981 onwards included Native Indian, Indian and Métis ancestry traced through both parents. Peters, "Conceptually Unclad: Feminist Geography and Aboriginal Peoples.," 253. Notes to Table 1.

15 Peters, "Conceptually Unclad: Feminist Geography and Aboriginal Peoples.," 256.

Compulsory enfranchisement was not repealed until the 1951 Indian Act. Ibid., 32.


Lawrence, "Real" Indians and Others: Mixed-Blood Urban Native Peoples and Indigenous Nationhood, 54-55.

Ibid., 55-56.

Fiske, "Constitutionalizing the Space to Be Aboriginal Women: The Indian Act and the Struggle for First Nations Citizenship," 312.


Lawrence, "Reconfiguring Colonial Gender Relations under Bill C-31," 67.
35 Ibid., 69.
36 In 1966 16.4% of status Indian women lived off reserve, compared with 15.4% of status Indian men. By 1986 this difference had increased from 1% to 6.4%. Janovicek, ""Assisting Our Own". Urban Migration, Self-Governance, and Native Women's Organizing in Thunder Bay, Ontario, 1972-1989."
38 Dickason and with McNab, Canada's First Nations. A History of Founding Peoples from Earliest Times, 254; 84.
39 The pass system was imposed in the prairie provinces in the wake of the 1885 North-West rebellion to prevent status Indians in western Canada -- particularly the Cree -- from leaving their reserves. It was officially in force until 1941 but residents on northern reserves reported the system continued to be enforced into the 1960s. Ibid., 297-98; 517 f.n. 23
41 Ibid.
42 Sylvia Maracle, oral history, July 9th 2010, Toronto. OH9.5, 6-9m.
43 The berry fast is a puberty rite for young women involving ceremony and mentoring from older women in the community (‘aunties’), and teaching self-respect and self-restraint. Kim Anderson, "Honouring the Blood of the People: Berry Fasting in the Twenty-First Century,” in Expressions in Canadian Native Studies, ed. Ron F. Laliberte and et al. (Saskatoon: University of Saskatchewan Extension Press, 2000).
44 Tanner, "The Origins of Northern Aboriginal Social Pathologies and the Quebec Cree Healing Movement," 261; 64-5.
47 See also Kelm, Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950; Gordon, "A Sword of Empire? Medicine and Colonialism at King William's Town, Xhosaland, 1856-91."; Lambert, "Plural Traditions? Folk Therapeutics and 'English' Medicine in Rajasthan."
48 Joseph Morrison, oral history, November 26th 2010, Toronto. OH20.3.
52 Ibid., 411-90.
53 For a discussion of the historical process and social effects of the relocation and sedentarization of the Innu see Samson, "A Colonial Double-Bind: Social and Historical Contexts of Innu Mental Health."


Ibid., 169-70. Shkilnyk cites an interview with a former DIAND official who invokes the case of the Dene Seal River band in northern Manitoba, who were relocated to Churchill during the early 1960 on the grounds that it would be too difficult to extend services to the fly-in community. 255-6, f.n. 6.


Ibid.: 6-8.

Sproule-Jones, "Crusading for the Forgotten: Dr Peter Bryce, Public Health, and Prairie Native Residential Schools."


Ibid.

Waldram, Herring, and Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives,* 62.

Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950.*


Sproule-Jones, "Crusading for the Forgotten: Dr Peter Bryce, Public Health, and Prairie Native Residential Schools."

As with other forms of healthcare at the time, early sanatoria were mostly privately-run. Though initially inexpensive, the costs of running a sanatorium increased quickly due to treatment innovations,
leading many to close during the depression. Hodgson, "The Social and Political Implications of Tuberculosis among Native Canadians."

76 Lux, "Perfect Subjects: Race, Tuberculosis, and the Qu’appelle B.C.G. Vaccine Trial."; Kelm, Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950.

77 Young, "Indian Health Services in Canada: A Sociohistorical Perspective."

78 Hodgson, "The Social and Political Implications of Tuberculosis among Native Canadians."

79 As Lux is careful to emphasize, this increase reflects the availability of treatment facilities for Aboriginal people, rather than actual need. Lux, "Perfect Subjects: Race, Tuberculosis, and the Qu’appelle B.C.G. Vaccine Trial."

80 Joseph Morrison, oral history, November 26th 2010, Toronto. OH20.3


82 Waldram, Herring, and Young, Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives, 170; Olofsson, Holton, and Partridge, "Negotiating Identities: Inuit Tuberculosis Evacuees in the 1940s-1950s."

83 Lillian McGregor, oral history, June 12th 2009, Toronto. OH13.2, 15m.

84 See Valerie Alia, Names, Numbers, and Northern Policy. Inuit, Project Surname, and the Politics of Identity (Halifax: Fernwood Publishing, 1994). Waldram, Herring, and Young, Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives, 168-69.

85 Hodgson, "The Social and Political Implications of Tuberculosis among Native Canadians."

86 Olofsson, Holton, and Partridge, "Negotiating Identities: Inuit Tuberculosis Evacuees in the 1940s-1950s."

87 Grygier, A Long Way from Home: The Tuberculosis Epidemic among the Inuit.

88 Olofsson, Holton, and Partridge, "Negotiating Identities: Inuit Tuberculosis Evacuees in the 1940s-1950s."

89 Waldram, Herring, and Young, Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives, 169-70.


91 Indian Health Regulations were established by Order in Council P.C. 1953-1129, 17 July 1953

92 Library and Archives Canada, Record Group 29, Volume 2625, File 800-6-5, Part 2: Medical Services – Indian Act and Regulations.

93 Library and Archives Canada, Record Group 29, Volume 2625, File 800-6-5, Part 2: Medical Services – Indian Act and Regulations, various correspondence.

94 Library and Archives Canada, Record Group 29, Volume 2625, File 800-6-5, Part 2: Medical Services – Indian Act and Regulations. Memo from Regional Director, Eastern Region to Director General Medical Services, Nov 26 1965

Lindsey Harrison makes a similar observation regarding Australian assimilationist policy after the Second World War: that imposing increasing controls and restrictions over Indigenous peoples, such as compulsory mass feeding programmes, were seen as the necessary means to achieve assimilation.


Johnston, Indian School Days.


Ibid., 73.

Ibid., 74-75.

On child rescue discourse in Britain and its settler colonies see Hillel and Swain, Child, Nation, Race and Empire: Child Rescue Discourse, England, Canada and Australia.


In addition to the Shoal Lake Anishnaabeg, Miller describes petitions for schools from a Native community near Alberni on Vancouver Island and Coast Salish people at Sechelt, also in British Columbia. Ibid., 117-18.

Ibid., 129.
In 1930 compulsory attendance was further extended to age 16 and Indian Affairs was given the authority to insist that children remain until age 18 in some cases. Ibid., 169-70.


http://www.anglican.ca/rs/history/schools/pelican-lake.htm


Aboriginal Healing Foundation, "A Directory of Residential Schools in Canada."

Shkilnyk, A Poison Stronger Than Love. The Destruction of an Ojibwa Community.


http://www.anglican.ca/rs/history/schools/bishop-horden.htm

http://www.anglican.ca/rs/history/schools/st-johns-chapleau.htm

http://www.anglican.ca/rs/history/schools/shingwauk.htm


Adapted from http://www.trc.ca/websites/trcinstitution/index.php?p=12 which lists the schools recognised in the Residential Schools Settlement Agreement, and Aboriginal Healing Foundation, "A Directory of Residential Schools in Canada." The latter includes at least one additional school. End-notes for individual schools indicate the source(s) used for opening and closure dates and any additional sources about that school.


Ibid., 345; 56.

Ibid., 346; 516 f.n.13; 353; 519 f.n. 52.

Ibid., 355.

Ibid., 357.

Ibid., 357.


Medical Services Branch, Ontario Region. 1975 Annual Report


Ibid., 286-87.


Ibid.


Larry N. Chartrand, Tricia E. Logan, and Judy D. Daniels, *Métis History and Experience and Residential Schools in Canada* (Ottawa: Aboriginal Healing Foundation, 2006); Logan, "A Métis Perspective on Truth and Reconciliation."


Ibid.

For example a 1977 survey of household heads on Grassy Narrows reserve found that 18% moved to McIntosh whilst their children were at school there. Shkilnyk, *A Poison Stronger Than Love. The Destruction of an Ojibwa Community*, 121-22.


In the western provinces, Aboriginal children constituted between 40% and 60% of all children in care. In Ontario, the percentage of Aboriginal children as a fraction of the total number of children in care was smaller, but only because the settler-descendant population was so much larger. Patrick Johnston, *Native Children and the Child Welfare System* (Ottawa: The Canadian Council on Social Development, 1983).

Ibid., 23.


For example, between 1977 and 1981 Aboriginal children (including status Indians, non-status and Métis) represented between seven and eight percent of all children in the care of provincial Children’s Aid Societies, whilst status Indian children comprised just 1.1 percent of the provincial population aged under 20. (Figures are not available for non-status and Métis populations but likely would not total more than an additional one percent). Total numbers of Aboriginal children in care in Ontario during this period ranged from 998 in 1981 to 1,134 in 1977. Ibid., 43.

Ibid., 115.

Ibid., 44.

Ibid., 61. Aboriginal children from Manitoba were sent to the United States as late as the 1980s. Fournier and Crey, *Stolen from Our Embrace. The Abduction of First Nations Children and the Restoration of Aboriginal Communities*, 88-89.


In Saskatchewan for example, Department of Indian Affairs and Band Council staff (lacking relevant training, resources, and the apprehension powers of provincial officials) delivered child welfare services.
on reserves into the 1980s, and provincial officials became involved only in the most extreme cases.


166 Ibid., 126.


169 This discourse has an historical antecedent in late-19th century British child welfare discourse, which treated poverty, alcohol abuse and child abuse as interchangeable conditions. Hillel and Swain, Child, Nation, Race and Empire: Child Rescue Discourse, England, Canada and Australia.

170 For example, in 1981 the Indian Homemakers' Association of British Columbia identified alcohol abuse as a factor in the majority of apprehensions of Aboriginal children. Quoted in Johnston, Native Children and the Child Welfare System, 76-77.


174 Armitage, Comparing the Policy of Aboriginal Assimilation: Australia, Canada and New Zealand, 213.


178 Bill Nelson, a social worker who has worked in the child welfare and mental health systems in Alberta and British Columbia for over thirty years, describes 'Seven Steps to Child Removal' which commonly ensue after a mother has sought help for substance use, spousal violence or poverty. Step two is 'the mother/parent is assigned a diagnosis in accordance with the DSM IV'. Richardson and Nelson, "A Change of Residence: Government Schools and Foster Homes as Sites of Forced Aboriginal Assimilation - a Paper Designed to Provoke Thought and Systemic Change," 78.

179 Lutz, Makuk. A New History of Aboriginal-White Relations.
Bryan D. Palmer, "The 'Discovery' of the 'Indian'," in Canada's 1960s. The Ironies of Identity in a Rebellious Era. (Toronto: University of Toronto Press, 2009); Brownlie, "Living the Same as the White People': Mohawk and Anishinabe Women's Labour in Southern Ontario, 1920-1940."


Ibid., 4-6. Scholars have also given little attention to the history of Indigenous slave labour in British colonies in the Caribbean – see Max Carocci, "Written out of History. Contemporary Native American Narratives of Enslavement.,” Anthropology Today 25, no. 3 (2009).


More complex than the European concept of private property, in Lekwungen culture, overlapping forms of ownership are intimately connected with family relations, social status and the spiritual realm. The potlatch ceremony is an important practice involving the ceremonial redistribution of wealth through valued goods, with implications for social status and spiritual power. The Lekwungen’s central concern with material acquisition – motivated by social and spiritual concerns - combined with their settled lifestyle, facilitated their consumption of European manufactured goods and motivated their participation in the wage economy. Ibid.

Brownlie, "Living the Same as the White People': Mohawk and Anishinabe Women's Labour in Southern Ontario, 1920-1940," 43.

Joseph Morrison, oral history, November 26th 2010, Toronto. OH20.3.

Brownlie, "Living the Same as the White People': Mohawk and Anishinabe Women's Labour in Southern Ontario, 1920-1940," 44.

Quoted in Wilson, "'No Blanket to Be Worn in School': The Education of Indians in Nineteenth-Century Ontario," 72.

Brownlie, "Living the Same as the White People': Mohawk and Anishinabe Women's Labour in Southern Ontario, 1920-1940," 60-61.

Weaver, "The Iroquois: The Grand River Reserve in the Late Nineteenth and Early Twentieth Centuries, 1875-1945."


Weaver, "The Iroquois: The Grand River Reserve in the Late Nineteenth and Early Twentieth Centuries, 1875-1945," 250.


Brownlie, "Living the Same as the White People': Mohawk and Anishinabe Women's Labour in Southern Ontario, 1920-1940," 55-56.

Ibid.

McCallum, "Labour, Modernity and the Canadian State: A History of Aboriginal Women and Work in the Mid-Twentieth Century", 73-76.

The Royal Canadian Navy maintained a ban on participation by anyone not “of pure European descent and of the white race” until 1943. The Royal Canadian Air Force had a similar policy but in 1939 the Chief of Air Staff issued an instruction that an exception was to be made for Aboriginal people. However the RCAF required a high level of educational qualifications which effectively excluded many prospective Aboriginal participants at that time, thus there were only 29 Aboriginal servicemen reported in the RCAF


201 Lackenbauer and Mantle, *Aboriginal Peoples and the Canadian Military: Historical Perspectives* 139-42.


205 Brownlie, "Work Hard and Be Grateful: Native Soldier Settlers in Ontario after the First World War." Ibid., 196.

206 Joseph Morrison, oral history, November 26th 2010, Toronto. OH20.3.


210 Taylor, "Northern Algonquians on the Frontiers of "New Ontario", 1890-1945."

211 Shkilnyk, *A Poison Stronger Than Love. The Destruction of an Ojibwa Community.*

212 Krystyna Sieciechowicz, personal communication with author, July 6th 2010.


215 Research conducted by Masazumi Harada in 2002 and 2004 ‘found the effects of mercury poisoning on residents of Grassy Narrows and Wabaseemoong Aboriginal communities about 80 kilometres northeast of Kenora to be worse than previously suspected. Although concentrations of the toxic chemical found in the hair of residents had gone down significantly since samples were taken in 1975, symptoms of mercury poisoning and Mirmata, a neurological disease associated with the chemical, had risen significantly’. Anna Mehler Paperny, "Ontario Natives Bear Mercury's Toxic Legacy," *The Globe and Mail*, April 7 2010; See also n.a., "Grassy Narrows Native Protest a Toxic Legacy," *The Globe and Mail*, April 8 2010.


Mancall, "I Was Addicted to Drinking Rum". Four Centuries of Alcohol Consumption in Indian Country," 100.

Elder Vern Harper, Oral history, Toronto, OH 11.1, 20m


Ibid.: 162

B. Maracle, Crazywater: Native Voices on Addiction and Recovery (Toronto: Viking, 1993); Richard W. Thatcher, Fighting Firewater Fictions: Moving Beyond the Disease Model of Alcoholism in First Nations. (Toronto: University of Toronto Press, 2004).


Maracle, Crazywater: Native Voices on Addiction and Recovery.

Thompson and Genosko, Punched Drunk: Alcohol, Surveillance, and the L.C.B.O., 1927-75

Maracle, Crazywater: Native Voices on Addiction and Recovery; Thatcher, Fighting Firewater Fictions: Moving Beyond the Disease Model of Alcoholism in First Nations.


Shkilnyk, A Poison Stronger Than Love. The Destruction of an Ojibwa Community.

Joseph Morrison, Oral history, Hamilton. OH20.2.


Lillian McGregor, oral history, Toronto, June 12th 2009, OH13.2, 26m

Scott Thompson and Gary Genosko provide an interesting discussion of the role of ‘blue cards’ and other criteria used by Ontario alcohol vendors in assessing ‘Indian’ identity and entitlement to purchase alcohol. Their analysis shows how the Liquor Control Board of Ontario developed an extensive discourse constructing ‘the Indian’ through specific directives and instructions circulated to staff. Multiple circulars issued by the LCBO during the 1920s and 1930s directed that enfranchisement cards were the means by which LCBO vendors were to identify ‘non-Indians’ allowed to purchase alcohol by virtue of their non-status. Whilst recognizing that not all non-status Indians were eligible to carry enfranchisement cards – for instance, the children of disenfranchised Indians – the LCBO maintained that the “appearance” of Indian identity and recognition of such by local people should be the over-riding criteria in determining whether or not a potential customer should be served.

Thompson and Genosko, Punched Drunk: Alcohol, Surveillance, and the L.C.B.O., 1927-75

Nagler also notes that, unlike Vancouver at that time, there was no visible use of other (illicit) substances in Toronto’s Aboriginal population. Mark Nagler, *Indians in the City. A Study of the Urbanization of Indians in Toronto* (Ottawa: Canadian Research Centre for Anthropology, Saint Paul University, 1970), 77.


242 Elder Vern Harper, Oral history, Toronto, OH 11.1, 20m


244 Ibid.


246 Ibid., 278.

247 Ibid., 260.

248 Ibid.

249 Ibid., 262.

250 Ibid., 264.

251 Ibid., 283.

252 Ibid., 309.

253 Ibid., 308.

254 March 17th 1964 Memorandum to Cabinet from Minister of Citizenship and Immigration, Rene Tremblay: ‘Community Development Indian Affairs Branch’. Archives Canada Record Group 2, Volume 6259, file C-20-5, CAB DOC 111-64


256 Ibid.

257 May 8th, 1964 Memorandum to Cabinet Committee on Social Security and Labour. From: Minister of Citizenship and Immigration (Rene Tremblay): ‘Extension of Provincial Services to Indians’. Archives Canada Record Group 2, Volume 6260, File C-20-5, Cab Doc 204-64


259 Ibid., 283-84.

260 Despite initial federal confidence regarding provincial co-operation, only Ontario was willing to negotiate a formal cost-sharing agreement for the provision of services to on-reserve Aboriginal communities – the 1965 Memorandum of Agreement Respecting Welfare Programs for Indians. In practice other provinces became more involved during the 1960s and 1970s. Ibid., 271; 321.

261 Ibid., 282.

262 Ibid., 287.

263 Ibid., 311; 21.

Introduction
In 1980, the Union of Ontario Indians led a policy initiative to develop capacity for health planning at the grassroots level.\(^1\) Professor Marlene Brant Castellano, a Mohawk woman from Tyendinaga in southern Ontario and University of Toronto-trained Master of Social Work (MSW), was invited to facilitate a Health Steering Committee as part of this initiative. Professor Castellano recalls how Mrs. Pine, a participating Ojibwe Elder, introduced her to an Indigenous understanding of health and healing:

\[
I \text{ had been reading about the work of the World Health Organization and the Alma Ata Declaration, Health for All by 2000. I spoke to the group about how the world’s understanding of health was really coming around to recognize that health was more than the absence of disease and the germ theory – this was really the beginning of discussion about social determinants of health. Mrs. Pine, an old Ojibwe woman in her 70s, said “I think the World Health Organization has some very good ideas, but they’ve left out the spiritual”. This was mind-blowing for me. Here was a 70+ year old Ojibwe woman with maybe an elementary school education and broken English, doing a critique of the World Health Organization’s ‘Health for All’ campaign as incomplete. This was a dramatic revelation to me: all my book-learning, even when informed by momentous international developments, still needed improvement by an Elder. That was my introduction to wholism [...] , the beginning of a learning path towards understanding the role of spirit, understanding just what Mrs. Pine meant by the engagement of the spirit in healing.}^2
\]

Mrs. Pine’s succinct comment conveys the essence of an Indigenous discourse on healing which became increasingly prominent in Aboriginal communities in Ontario cities from the late 1960s. This discourse reflects a conscious response to individual and community suffering in Aboriginal communities, and has a distinct focus on historical consciousness and the spirit. Important elements of this healing discourse include a reframing of individual problems as attributable to historical and ongoing social and political forces, (re)locating the Indigenous individual in relation to the ethno-national collectivity, and resurrecting Indigenous knowledge, including relations with spiritual forces.

Growing Aboriginal political organization and activism in North America during the 1970s and the broader international decolonization movement provide important context for these local developments. Whilst Indigenous healing in North American emerged in the
context of international decolonization, as historian Scott Rutherford has noted, Indigenous intellectuals identified their own priorities which did not always align with the international movement. In particular, the value accorded to Indigenous knowledge systems by activists in Canada was not always shared internationally, given that some anti-colonial movements uncritically embraced modernization and development and deprioritised local traditional knowledge.

To make sense of why the discourse on Aboriginal healing emerged in Ontario cities when it did, we must consider the historical context of multiple overlapping and intersecting social and political forces, including developments in health and social policy. Chapter One discussed the intensification of poverty and social suffering in many Aboriginal communities between the 1940s and 1960s, and the concurrent changes in Aboriginal-specific prohibition laws which increased the visibility of Aboriginal alcohol consumption in Ontario cities. This chapter foregrounds urban Aboriginal actors who articulated connections between Aboriginal alcohol abuse and the harmful effects of colonial state policies for Indigenous individuals, families and societies.

Urban Indigenous people initiated healing programmes outside of and separate to the Canadian healthcare system, but began to engage with dominant discourses on health, mental health and addictions as funding opportunities emerged. In this chapter I explore how such opportunities both afforded access to resources, and presented potential challenges to Indigenous autonomy. Community mental health, and to a lesser extent addictions, were becoming increasingly important areas for health services development in North America during the 1970s and 1980s. State investment in community mental health services increased exponentially during this period, as the process of closing long-stay mental health institutions, begun in the 1950s, continued apace. The Ontario government launched its ‘Community Mental Health Services Program’ in 1976. By the late 1980s, Ontario was funding 337 community mental health programmes with a budget of 83.4 million dollars, and an additional 150 addictions programmes at 36.8 million dollars. The Ontario provincial government became increasingly engaged with Aboriginal issues, including health, following the election of a Liberal government in 1985 after many decades of rule by the Progressive Conservative Party. The new Liberal government developed a
'Policy Framework for Native Affairs', and in 1988, the Ministry of Health appointed the first Coordinator for Aboriginal Health.

In what follows I consider how an Indigenous healing movement developed in Ontario cities during the 1970s and 1980s, focusing on how Aboriginal people developed frameworks for making sense of and responding to suffering in urban settings: within dominant institutions, as part of conscious community-building in the context of newly-established friendship centres, and emerging out of political protests. I have selected these particular examples because they vividly illustrate how urban Indigenous peoples experience both opportunities and challenges as a result of the proximity of dominant institutions and professions.

Over the course of the 1970s and 1980s, urban Aboriginal programmes in Ontario transitioned from volunteer services offering generic social support, to professionally-staffed programmes with missions and objectives, some of which explicitly identified the improvement of health, healing and recovery. In their ongoing pursuit of resources, fledgling Aboriginal organizations formed strategic relationships with dominant institutions (including large charities such as the YWCA, and public service providers, predominantly hospitals), and professionals including social workers, psychologists and psychiatrists. Whilst the number of Aboriginal social workers grew during the 1970s and ‘80s, to the present day there remain very few Aboriginal psychiatrists and psychologists. As discussed in Chapter One, the colonial Canadian state created multiple social, economic and political barriers to Aboriginal participation in higher education, some of which persist into the present day.

The remainder of the chapter consists of four sections. The first section draws on original archival research and secondary historical sources to provide an overview of the national political context to the emergence of urban Indigenous healing. This includes a discussion of the divergent perspectives on Indigenous healthcare entitlements which arose during the 1969 federal White Paper ‘consultations’, the establishment of national Aboriginal political organisations during the 1970s, and broader political protest during the 1970s and early 1980s. Section Two discusses the intersections of the Red Power movement,
early alcohol abuse interventions, and Ojibwe cultural revival in the city of Kenora, north-western Ontario. This discussion is informed by oral histories and archival sources. Section Three looks at the emergence of programmes addressing Aboriginal healing and health in the context of intensive Aboriginal institution-building in Toronto during the 1970s and 1980s, again drawing on both oral histories and archival sources as well as secondary anthropological and historical literature. In Section Four, I focus on Toronto-based Aboriginal community activists’ practice of prison-visiting in southern Ontario, and this practice’s transformation from a charitable act to a politically-informed process of bringing Indigenous healing knowledge into a state institution, and reconnecting culturally dispossessed individuals with their Indigenous heritage. This section draws particularly on oral history interviews.

1. Indigenous protest, healthcare and healing in Canada, 1970s

During the 1960s, headlines such as “This is Our Alabama” drew Canadians’ attention to the racism and poverty experienced by Indigenous communities, whilst media commentators began to draw parallels between Native political protests and the Civil Rights movement in the United States. Growing public concern regarding the conditions of Aboriginal peoples in Canada provoked the federal government to intensify its policy of modernizing and assimilating Indigenous peoples into settler society, discussed in Chapter One. Indian Affairs initiated a range of programmes intended to accelerate these processes, including community development, the provision of self-administration grants to some Indian Bands, and the devolution of some education and social programmes to some provinces, including Ontario. In the late 1960s and 1970s, the conflict between Indigenous commitments to self-determination and state interests in assimilation came to the fore.

**Health care in the 1969 White Paper ‘consultations’**

During the 1960s the growing cohort of public health professionals and policy makers birthed by the expansion of the Canadian health care system from the 1950s began to wield their influence on Indian health policy. Shifts in civil service culture under Liberal Prime Ministers Lester B. Pearson (1963-68), and particularly Pierre Trudeau from 1968, contributed to a new understanding of civil servants as ‘agents of social change’. Health
professionals and other policymakers within Health Canada became increasingly vocal in advocating ‘integration’ of Indigenous peoples into Canadian society as a solution to state-defined Native health and social problems. Liberal civil servants envisaged a central role for the health care system in facilitating this ameliorating integration, via the reformulation of the terms under which Indigenous people accessed health care and the eradication of Indigenous special status and treaty rights.

As anthropologist Sally Weaver showed in her important analysis, Indian Act reform was conceived in the context of senior federal officials’ mounting concerns about public criticism of the government’s management of Indian affairs during the late 1960s. In particular, the Privy Council’s special ‘War on Poverty’ unit and the three Western provinces exerted pressure on the government to reassess its Aboriginal programming. These interests converged in the 1967 cabinet decision to pursue systematic consultation with Indians regarding potential revisions to the Indian Act; the 1968 election of Pierre Trudeau as Liberal Prime Minister meant that the ensuing process was strongly shaped by Trudeau’s political ideology and culture.

Indian Act consultation meetings were organised by Department of Indian Affairs and Northern Development (DIAND) officials during latter part of 1968 through 1969. Having recognised that Indigenous leaders considered health to be a priority issue, the Deputy Minister of DIAND, Mr. J.A MacDonald wrote to the Deputy Minister for National Health, Dr. JN Crawford, in September 1968 to extend his ‘warm invitation to send a senior official of National Health’ to attend the outstanding meetings, explaining that ‘in the discussions which have already taken place matters pertaining to health have been frequently raised.’ But National Health was most reluctant to participate. In an earlier hand-written note attached to the press release for the Indian Act consultations dated six months prior, Crawford had indicated to a colleague that the consultations ‘will be an uncomfortable session for our men, and an unproductive one as well. The Honourable Andros has as much as indicated that his intent is to “shake up the bureaucrats.” Observer status only?’ Thus Crawford quickly declined Deputy Minister MacDonald’s invitation, explaining that
it would be in my opinion a serious retrograde step for the federal government to enact in the field of health on the basis of one ethnic group. Doing so would certainly perpetuate segregation in an area where it is of our utmost concern that this should not happen. Official attendance at discussions to include health provision [in the revised Indian Act] would imply acquiescence.¹⁴

Crawford’s representation of Indigenous Peoples as ‘one ethnic group’, and invocation of ‘segregation’ in his dismissal of the proposed consultations, display a striking denial of Indigenous treaty rights, histories and diversity. This is entirely consistent with the liberal ideology of the period which understood justice to mean equality, and equality to mean treating everyone the same. As we shall see in subsequent chapters, this is a framing which endures in Canadian health services discourse to the present day.

Undeterred by Crawford’s firm refusal, the Deputy Minister for DIAND persisted with a second, more forceful letter, invoking the instructions of his Minister, Jean Chrétien, and the newly emerging ideology of participatory democracy - a central, if ambiguous, concept from Trudeau’s electoral platform:

*I believe you have misunderstood the purpose of the consultation meetings. These meetings are to listen to what the Indian people have to say about the way legislation affects their lives. It is important that those who prepare that legislation should listen to them.*¹⁵

Crawford was obliged to acquiesce (although internal communication shows that he made no attempt to conceal his reluctance from his staff), and the Director General for Medical Services, Dr Procter, proceeded to instruct the Regional Directors for Medical Services to attend subsequent consultation meetings.¹⁶

Indigenous leaders who participated in the ensuing consultations viewed the issue of their peoples’ entitlements to government-provided healthcare very seriously indeed. Native representatives at more than half of the sixteen consultation meetings held during 1968 and 1969 expressed demands that their entitlement to federal provision of free healthcare be honoured; at several meetings motions to this extent were passed. During at least two meetings, Native leaders invoked the treaty basis of their people’s healthcare rights.¹⁷ In Regina, ‘extensive discussion’ of healthcare included references to Treaty Six. At the meeting in Prince George, Mr. Harry Dickie of Slave Bay cited the ‘medical treatment
promises contained in a Report of the Commission which led to the signing of Treaty No. 8 in 1899’, and read aloud a detailed quotation from the signed Report of the Commission dated 22 September 1899, which promised free medicine and treatment by the government physician.\(^\text{18}\)

In their reports of the meetings, Medical Services Branch (MSB) officials were both dismissive of and defensive towards Indigenous leaders’ claims. Some were apparently concerned that Indigenous leaders’ assertive articulation of entitlements and demands for greater participation in healthcare planning would undermine MSB control. Regional Director Dr Savoie expressed indignation and alarm at the concerns raised by the Kahnawake Chief Mr Delisle at the October 1968 consultation meeting in Québec. The latter, determined to obtain federal support to improve conditions at Kateri Memorial Hospital in the Mohawk territory of Kahnawake, announced plans to go directly to parliament. Savoie complained that

\[we \ had \ started \ interesting \ Bands \ in \ taking \ more \ responsibilities \ in \ their \ own \ affairs \ and \ were \ starting \ to \ get \ results \ [...]. \ We \ were \ disappointed \ to \ note \ that \ Mr \ Delisle \ [...] \ warned \ Bands \ against \ such \ cooperation \ [...] \ the \ net \ result \ [will \ be \ that] \ our \ negotiations \ with \ the \ different \ Bands \ will \ be \ more \ difficult \ than \ ever.\]^\text{19}

The Director General for Medical Services Dr Procter attended the Toronto meeting in January 1969, at which forty-five ‘Indian community representatives’ were present. He reported to Crawford that

\[there \ was \ an \ undercurrent \ that \ it \ was \ a \ poor \ health \ service; \ that \ we \ thought \ of \ everything \ in \ terms \ of \ dollars \ rather \ than \ human \ values; \ that \ answers \ to \ questions \ were \ always \ hedged.\]

Procter does not acknowledge the possible validity of Native concerns, but rather concludes that ‘the young representatives are militant, radical and unrealistic’, noting that ‘all this protest tends to suggest that under existing treaties the Indians don’t have a legal leg to stand on’.\(^\text{20}\) But the DIAND’s report of the Indian Act consultation meetings clearly conveys the Indigenous demands: that their inherent rights - including the right to healthcare - be reinstated and effectively protected by the Federal Government, and that Indigenous peoples be permitted to participate actively in policymaking.
Despite Trudeau and the DIAND’s earnest rhetoric about consultation, the White Paper on Indian Policy presented by Chrétien to the House of Commons in June of 1969 bore no resemblance to Indigenous peoples’ documented priorities. Instead, the document blamed the government’s historic ‘special treatment’ of Indigenous peoples for current suffering, and advised abolition of the Indian Act and the removal of Indigenous peoples’ special status and rights: in short, assimilation into Canadian settler society.

**Opposition to the White Paper and the emergence of National & International Indigenous Organisations**

Native leaders’ united opposition to the 1969 White Paper contributed to the gathering momentum towards growing Native political solidarity and organization, at both provincial and national levels. Responses ranged from political protests to articulate written rebuttals. Six Nations of the Grand River in southern Ontario issued an Iroquois Declaration of Independence. The Chiefs of Manitoba produced *Wahbung, Our Tomorrows* (with input from Cree public health nurse Jocelyn Bruyere who later helped to found the Aboriginal Nurses Association of Canada). In 1970, the National Indian Brotherhood adopted the Assembly of Indian Chiefs of Alberta Chiefs’ detailed refutation of the White Paper known as the ‘Red Paper’, and presented it to Trudeau in Ottawa in June 1970. Massive opposition ultimately forced the government to withdraw the White Paper in 1971 – although its philosophy has continued to inform policymaking into the present. Within Medical Services Branch, discussions continued unabated regarding how best to transfer health care responsibilities for Indians to the provinces. A Policy Review Group established in 1972 identified “securing Indian and Provincial agreement to the principle that Indians should receive services from the same sources and in the same way as other provincial residents” as a priority issue.

The first leader of the National Indian Brotherhood, George Manuel, prioritized the development of an international Indigenous rights movement. Manuel travelled widely during 1971 and 1972, meeting with Māori MPs and Māori Council leadership in New Zealand, Aboriginal leaders in Australia, Tanzanian President Julius Nyerere, Sami representatives in northern Sweden, and many international organizations. Under Manuel’s leadership, the United Nations accepted National Indian Brotherhood’s
application for membership with NGO status in 1974. In 1975, Nootka First Nation on
Vancouver Island hosted the founding convention of the World Council of Indigenous
Peoples. Indigenous delegates and official observers from nineteen different countries
participated, and Manuel was elected, unopposed, as first president of the World Council of
Indigenous Peoples.

Other national Indigenous organisations emerged alongside the National Indian
Brotherhood (NIB) during the 1970s, although none has exerted the same degree of
influence over federal policy as the NIB (which became the Assembly of First Nations in
1982). The Native Women’s Association of Canada was established in 1974 to represent
the interests of women whose concerns were not always aligned with those of the NIB
leadership. By the late 1970s NWAC’s leadership was lobbying government officials for an
active role in health policymaking and the recruitment of health professionals by Medical
Services Branch. A memo from Lyle Black, Director of Medical Services Branch advised
Regional Directors to ‘meet with the Provincial Indian Association to determine their views
on the Native Women’s Association being represented on selection boards’. This
reluctance to accord due authority to the NWAC is likely shaped by concerns regarding the
presence of non-status Indians in the NWAC and MSB’s continuing vigilant protection of its
narrow mandate to serve only status Indians as well as, one may speculate, the enduring
patriarchal values which shaped the Indian Act’s gender discriminatory content.

Six regional Inuit associations founded a national organisation to represent their peoples’
interests, the Inuit Tapirisat of Canada (ITC), in 1971. The ITC described its focus in 1975
as ‘development, education and cultural preservation’, whilst maintaining that ‘we Inuit
have never surrendered our traditional territory’. Initially based in Edmonton, the ITC
moved its offices to Ottawa in 1972 to facilitate access to federal government. By the late
1970s, ITC had identified constitutional change towards recognition of Inuit rights to self-
governance as a top priority. As Graham et al note, Inuit understanding of self-government
is distinct from the meaning held by other Indigenous groups, and has focused on the
establishment of ‘public governments in [Inuit] traditional territories, where they form the
majority of the population’. The Inuit Women’s Association was formed in 1983, and in 1984 the ITC formally transferred responsibility for Inuit health issues to that organisation.

**Indigenous political protest and organisation**

Of course Indigenous peoples began to organize protests against their mistreatment by the Canadian state, in Ontario and elsewhere, long before the emergence of a unified national leadership in the 1970s, and protests continued outside of the national organisations during this period. Mohawks in southern Ontario and Quebec have protested the imposition of the band council system since the 1880s. Sally Weaver provides an account of political activism on the Six Nations reserve in southern Ontario from the late 19th century, which included multiple petitions to the Canadian and British governments and the League of Nations, as well as campaigns for public support. An early example of political organization with a broad base of support was the League of the Indians of Canada, established by First World War veteran Fred Loft of Six Nations in southern Ontario. This early pan-Indian political organization faced active opposition from local police and Indian Affairs which led to its demise by the early 1930s.

The 1960s and 1970s saw a marked intensification in Aboriginal protest in Canada, influenced by the Civil Rights and Red Power movements in the United States as well as international decolonization movements (see Table 2.1, below). Historian Bryan Palmer argues that, ‘few [...] pre-1950 Aboriginal movements and political bodies embraced tactics of militant opposition’; such approaches began to appear most clearly amongst Iroquois activists in southern Ontario and Quebec and the border States during the late 1950s.
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950s</td>
<td>Iroquois activists protest land expropriations and relocations associated with the development of St Lawrence Seaway in southern Ontario and Quebec</td>
</tr>
<tr>
<td>1959</td>
<td>Iroquois associated with the Onondaga Longhouse occupied the Ohsweken Band Council building on Six Nations reserve, southern Ontario, declaring themselves the authorised rulers of Six Nations and independent of federal and provincial governments.</td>
</tr>
<tr>
<td>1965</td>
<td>Over 400 Aboriginal people marched to Kenora City Hall demanding the preservation of Anishnaabeg treaty rights in northwestern Ontario</td>
</tr>
<tr>
<td>1967</td>
<td>Indian Pavilion at EXPO '67, Canada’s 1967 Centennial Celebration in Montreal highlighted broken treaty promises and the colonial oppression of Indigenous spiritual practices and governance, and attracted international media attention</td>
</tr>
<tr>
<td>1968</td>
<td>Mohawk protestors from Akwesasne on the Canada-US border blockaded the international bridge at Cornwall, southern Ontario in protest at levy of duties on small articles</td>
</tr>
<tr>
<td>1969</td>
<td>American Indian Movement activists occupied Alcatraz Island in San Francisco, USA – many Aboriginal activists from north of the border participated</td>
</tr>
<tr>
<td>1972</td>
<td>Coalition of status Indians and Inuit from northern Quebec sought injunction against James Bay Corporation’s construction of dams and power generating stations</td>
</tr>
<tr>
<td>1973</td>
<td>First Nations convoy from Winnipeg, Manitoba in western Canada carried supplies to American Indian Movement activists at Wounded Knee</td>
</tr>
<tr>
<td></td>
<td>Native Youth Association organised peaceful 24-hour occupation of Indian Affairs building in Ottawa (Canada’s federal capital) in protest at James Bay hydro-electric project in northern Quebec and stalling on British Columbia land issue</td>
</tr>
<tr>
<td></td>
<td>Ojibway Warriors Society organised occupation of Indian Affairs Offices in Kenora, northwestern Ontario</td>
</tr>
<tr>
<td>1974</td>
<td>Ojibway Warriors Society and supporters occupied Anicinabe Park, Kenora following Ojibwe Unity Conference, July 20-21</td>
</tr>
<tr>
<td></td>
<td>Protests against James Bay Hydro-electric project, Northern Quebec including fundraising concert in Montreal attended by Aboriginal people from across Canada</td>
</tr>
<tr>
<td></td>
<td>The Native People’s Caravan travelled from Vancouver on the west coast culminating in a protest at Parliament Hill which was violently attacked by police</td>
</tr>
<tr>
<td>1980</td>
<td>British Columbia Native Women’s Society and other Aboriginal groups in BC organized a ‘Indian Child Caravan’ to protest mistreatment of Aboriginal children and families by provincial welfare agencies</td>
</tr>
<tr>
<td>1983</td>
<td>AIM activists led incarcerated Aboriginal men at Oakalla Regional Correctional Centre in British Columbia in a spiritual fast, in protest of denial of Indigenous rights to inmates</td>
</tr>
</tbody>
</table>

Table 2.1  Selected Aboriginal political protests in Ontario and elsewhere in North America, 1950s-1983
Members of the Ojibway Warriors Society in northern Ontario and the Mohawk Warriors Society in southern Ontario and Quebec, both formed during the early 1970s, were active in leading regional protests, as well as participating in political actions elsewhere in Canada and the United States. According to Howard Ramos, the period between 1973 and 1976 saw twice as many Indigenous protests and legal challenges as the whole of the 1960s. A timeline of major protests up to 1983 is in Table 2.1. Of course Aboriginal people continued to organize political protests in subsequent years; those at Kanehsatake (Oka) in 1990, discussed in Chapter Four, and Ipperwash provincial park in Ontario in 1995, were of particular political significance.

Both media coverage and historical literature on Indigenous activism in North America has focused primarily on male activists in the Red Power movement. Some scholars have argued for greater attention to Indigenous leadership as gendered and the essential but under-recognised roles played by Aboriginal women in political struggles. These include conventional leadership roles, but also ‘incipient activism’ and ‘low-keyed activism’ which contrasts with the more flamboyant and media-friendly roles often played by male leaders in Red Power. For example, anthropologist Heather Howard gives an account of the varied and crucial contributions of Aboriginal women in developing Indigenous community in Toronto during the 1950s, 1960s and 1970s. Such contributions ranged from economic development activities, including teaching and selling crafts, to networking and fundraising with wealthy white women who provided significant financial support to early friendship centres, to the development of early social services for urban Native people.

Whilst friendship centres are commonly cited as the earliest example of Indigenous people’s social organizing in Canadian cities, Indigenous women’s histories of organizing to establish shelters and women’s centres in many cities, often shortly after friendship centres, are less widely acknowledged (see Table 2.2 below). Some of these organizations became important providers of healing services, as I shall discuss further in Chapter Six. In Ontario, the many Native women’s groups who had been organizing in both on and off-reserve communities came together in Thunder Bay, northern Ontario, in May 1972 to form the Ontario Native Women’s Association.
Anduhyaun House, Toronto 1969
Native Women’s Community Resource Centre, Thunder Bay 1974
Hamilton Native Women’s Centre 1976
Beendigen Native Women’s Crisis Home, Thunder Bay 1978

| Table 2.2 | Early Native women’s shelters and centres established in Ontario cities |

Conflict over the gendered effects of the Indian Act has been a divisive force in First Nations political mobilization. From the perspectives of First Nations women, Native leaders’ vehement opposition to any changes to the Indian Act was problematic: thousands of women had lost their status under section 12(I)(b), as described in Chapter One. In 1971, Jeannette Corbiere Lavell from Wikwemikong Reserve in Ontario launched a legal challenge to the gender discrimination perpetuated by the Indian Act. The National Indian Brotherhood opposed this action and the Supreme Court of Canada ruled against her in 1973. Other individual Aboriginal women also lodged legal challenges both within Canada and with the United Nations Human Rights Committee during the 1970s. In 1971 non-status and Métis women in Alberta founded Indian Rights for Indian Women to raise support for legal challenges to the Indian Act.43 Despite the 1981 UNHCR ruling that the Indian Act constituted ‘an unjustifiable denial’ of Aboriginal women’s rights and contravened the International Covenant on Civil and Political Rights to which Canada was a signatory, the Act was not amended until 1985. The Indian Act created divisions amongst First Nations people which persist to this day.44 Aboriginal women’s profound awareness of the damaging and divisive effects of the Indian Act influenced their commitments to provide universal services which did not perpetuate such divisions, an approach with significant implications for healing programmes in urban settings, as we shall see in Chapter Six.45

The child welfare system also became an important object of organized political protest during the 1970s and early 1980s. In 1979, the British Columbia Native Women’s Society described the child welfare system as an “agent of cultural genocide” in its practices towards Indigenous children.46 In 1980, together with other Aboriginal groups in BC they
organized a protest which became known as the ‘Indian Child Caravan’ in 1980. The Canadian Indian Lawyers Association made child welfare the focus of their first national conference in Winnipeg in April of that year, with participation at full capacity.\textsuperscript{47}

\textbf{Self-determination & healing}

Some Native activists embraced the recovery and revival of Indigenous knowledge as an approach to addressing social suffering in keeping with the principles of decolonization and self-determination. In an interview in 1974, Louis Cameron, founding leader of the Ojibway Warriors Society in northwestern Ontario, spoke about Anishnaabe traditional knowledge and particularly the Midewiwin tradition as the basis for Native political action:

\begin{quote}
what we mean by spiritualism [...] it’s just going home, going home and working at home with your people and going through deep ceremonies, learning about our families and the traditions or history – not going backward but going forward – to practice the ceremony.\textsuperscript{48}
\end{quote}

Within this context of political protest, the assertion of Native rights to land and self-determination, and the recovery and application of Indigenous knowledge, Aboriginal commentators and others began to articulate a causal relationship between colonial policies and cultural disenfranchisement, and troubling behaviour in many Aboriginal communities. Some community leaders began to discuss their observations that many Aboriginal communities were suffering disproportionately from alcohol misuse, interpersonal violence, suicide, neglect of children and fatal accidents. Emerging discourse linked such problematic and anti-social behaviors to the effects of colonialism, including the Indian residential schools and widespread forced adoption and fostering of Aboriginal children from the 1950s onwards.

\textbf{Prisons, protests and healing}

Justice and healing are inextricably linked for Aboriginal peoples in Canada, and prisons became important sites of both political protest and Indigenous healing during the 1970s and 1980s. Until the middle of the twentieth century, many Aboriginal people were imprisoned for participation in healing ceremonies, because Indigenous spiritual practices were criminalized under the Indian Act until 1951, as we saw in Chapter One.\textsuperscript{49} The disproportionate incarceration of Indigenous people continues to be a major contributor to
individual and community suffering. To the present day, Aboriginal men and women are grossly over-represented in prison populations in Canada as well as in other settler-colonies.\textsuperscript{50} Between 1978 (when statistics were first disaggregated) and 2001, Aboriginal admissions to custody represented between 14\% and 19\% of total admissions (the majority of which are to provincial institutions), whilst Aboriginal people were estimated to represent 3.3\% of the general population in 2001.\textsuperscript{51}

During the 1960s and 1970s Aboriginal inmates in Canadian penitentiaries began to form support groups which played an important role in facilitating access to traditional healing for incarcerated men and women.\textsuperscript{52} There is almost no scholarly literature regarding the formation of these groups. American Indian Movement (AIM) activists led a series of protests in western Canadian prisons during the early 1980s, eventually leading to state approval for Indigenous healing programmes in Canadian prisons.\textsuperscript{53} Anthropologist James Waldram provides an account of how Darelle (Dino) Butler and Gary Butler, AIM members from the Siletz Nation in Oregon state, initiated protests against the state’s denial of their right to spiritual practices in prison which gained momentum across western Canada. In 1981, Dino and Gary sought permission through the British Columbia Supreme Court for the return of a sacred eagle feather, pipe and medicine bundle. Their request was denied, prompting the Butler brothers to commence a hunger-strike. Twenty days into the hunger-strike, the Judge’s decision was reversed, and the Oakalla Regional Correctional Centre allowed for the development of Aboriginal Services. The next year, the Native Brotherhood at Kent Institution in Agassiz, British Columbia was denied permission to hold pipe and sweat lodge ceremonies.\textsuperscript{54} After being denied access to a lawyer they contacted the Canadian Human Rights Commission, and lawyers developed arguments for Aboriginal spirituality to be seen as "Aboriginal rights" under the Constitution section 35, as well as freedom of religion under the Charter of Rights and Freedoms. In 1983 the Butler brothers and other inmates began a 'spiritual fast' in protest, which quickly spread to other prisons, including Oakalla and the Regina Correctional Centre. Métis psychologist Joe Couture facilitated discussion between the Brotherhood and the prison wardens, and in 1985 Correctional Service of Canada developed a policy on Aboriginal spiritual practices in prison, based on Couture’s earlier work.\textsuperscript{55}
2. Ojibwe activism, harm reduction and healing in 1970s Kenora

Aboriginal people living in Kenora, northwestern Ontario during the 1970s had a settler problem. Kenora was widely known to be a violently racist place, where one Native person would die under questionable circumstances each week, on average.\(^{56}\) Anishnaabeg from the many nearby reserves increasingly made use of businesses and services in the town with improved road access from the 1950s, and some settled in Kenora (see Map 1.1 for the locations of reserves in relation to the city). But pervasive racism in the dominant pulp and paper industry meant that finding employment was a challenge for many.\(^{57}\) Exploitative landlords let their most decrepit properties to Aboriginal people at inflated rates. Police routinely harassed and arrested people drinking and socializing on the streets. The local court sentenced an average of more than twenty Aboriginal people per day on charges of public drunkenness, whilst the accused were denied legal aid and, as the court did not employ a translator, were regularly required to translate for one another.\(^{58}\) Some Anishnaabeg and Métis in the town concealed their identities in order to protect themselves and their families from prevalent anti-Aboriginal racism.\(^{59}\) Euro-Canadian town residents would (apparently without irony) tell Aboriginal people to “go back home”.\(^{60}\)

These challenges, combined with the loss of traditional livelihoods and the social disruption inflicted by residential schools, exacerbated some community members’ longstanding struggles with alcohol abuse.\(^{61}\)

G.W. Mercer, a researcher from the Addiction Research Foundation in Toronto visited Kenora in May 1970. In his report he provided an account of ‘what the Kenora townsfolk have labeled their “Indian Problem”’, the brazenly public nature of Aboriginal alcohol consumption:

*Reserve Indians may not be legally allowed to drink at their home on the reserve. Once drunk in town they may be 20 or 50 miles from home with all their money spent buying “rounds” at the pub. They have nowhere they can easily go to extract themselves from the public eye and further do not seem to be ashamed of being drunk. [...] As a consequence, many of the inebriated Indians loiter about the streets of Kenora, sleeping in alleys, and generally causing the “respectable” citizens some small amount of concern and discomfort.*\(^{62}\)
Settler and Aboriginal communities in Kenora, and addictions experts such as Mercer, all recognized Aboriginal drinking as an issue. However their analyses of the problem and approaches to addressing it were different, as we shall see.

In oral history shared as part of this research, Elder Joseph Morrison noted that Aboriginal people have struggled with alcohol problems since the town of Rat Portage (which became the city of Kenora in 1905) was first established in the 1870s. As discussed in Chapter One, the availability of alcohol in the region increased significantly after the mid-1880s, when the completion of the Canadian Pacific Railway facilitated an influx of independent fur traders many of whom also plied hard liquor. Joseph also described a long history of bootleggers operating in the Kenora area. He recalls that it was often people who attended residential school who later had problems with alcohol. Joe described how his father, Donald Morrison, attended Cecilia Jeffreys residential school from about age nine, and later struggled with alcohol abuse for much of his adult life: ‘he was known as a town drunk in Kenora’.

As discussed in Chapter One, provincial prohibition policy changes and increasing migration and travel from reserves meant that Aboriginal alcohol consumption both increased, and became more visible to settler society, in urban centres from the late 1950s. Alcohol consumption remained illegal on most reserves, whereas consumption in licensed venues in Kenora and elsewhere became a legal option from 1954. During the 1950s and 1960s, many previously inaccessible reserves gained access to Kenora, due to government road construction projects and the involuntary relocation of communities such as Grassy Narrows. Also during this period, some reserve communities voluntarily relocated from islands to the mainland in order to access electricity and services.

The criminal justice system, central to the enactment of colonial prohibition policy, has been an oppressive force in many Aboriginal lives in Kenora, as elsewhere in Canada. Like other settler colonies, the Canadian state has incarcerated Indigenous people at a hugely disproportionate rate. Mercer reported in 1970 that the Kenora court was sentencing more than 20 Aboriginal people per day on alcohol-related charges. In his analysis of Kenora court statistics from February 1966 to January 1969, Mercer found that of 1,573
convictions of Aboriginal people during this period, 94% were for alcohol-related offenses. Further, he noted that court procedures were ‘only vaguely legal’, and ‘the Indians on drunk charges are refused legal aid and seem to have no idea of their rights’. As Aboriginal people in Kenora began to engage in organized political protest during the 1960s, systemic changes to curb police harassment and reform the racist justice system were prominent amongst their demands.

**Ojibwe healing in Kenora: The Waystation & the Lake of the Woods Powwow Club**

Aboriginal people’s attempts to mitigate the damage inflicted on individuals and communities by alcohol abuse were among the earliest healing interventions in urban communities. As Joseph’s father Donald Morrison recovered from his struggles with alcohol, he became one of the people responsible for raising up the drum in the Kenora area in the 1970s. The suppression of Indigenous ceremonial practices through most of the twentieth century had led to the ‘drums falling silent’ in Native communities throughout Ontario. ‘Raising up the drum’ describes the social and ceremonial processes by which people retrieved drums and other ceremonial objects which had been hidden in closets and basements, held feasts and offered tobacco and brought the drums and other sacred items back into use. The bigger drum is literally raised up and positioned on the four directions. Sylvia Maracle explained to me that when the drums were ‘raised up’ they became visible symbols of an Indigenous way of life prior to colonial oppression, which people could then consciously choose as an alternative to alcohol abuse.

Joe described to me how his father first came to work as a Native addictions counsellor in Kenora:

> then he sobered up and they had a Waystation in Kenora, which was like an overnight place where, you know, they looked after people that were intoxicated and had no place to go, eh, a place to sleep, a place to get out of the elements and a place for safety. And, so he’d started there, and he sobered up and then eventually he was sober long enough to be able to be offered a job by the Addictions Research Foundation as a counsellor. [...] I think he enjoyed it, you know. He liked going out and talking about his experiences with alcohol, with the AA philosophy, but with the traditional aspect of it involved, eh. He had the drum, and the singing, and he shared that with people, with the different communities that he visited. He was asked to go to a lot of the places that, to share that.
The Addiction Research Foundation established the ‘Kenora Waystation’ in February 1967, in a two-storey building in central Kenora, just off the Trans-Canada highway.\textsuperscript{76} According to Mercer’s account, the Waystation was a response to requests for assistance from the Kenora municipal authorities and Aboriginal community leaders, who in 1966 had contacted the Addiction Research Foundation in Toronto to ask for assistance with Aboriginal public drunkenness.\textsuperscript{77} Managed by white social workers, the Waystation provided several different services. The ground floor served as a ‘flophouse’, a grubby and poorly-furnished space where inebriated Aboriginal men and women could take shelter, access washroom facilities and sober up. Ojibwe staff such as Donald Morrison hosted biweekly Alcoholics Anonymous (AA) meetings in the cleaner upstairs space, and visited reserves around Kenora, screening films, distributing literature and delivering what Mercer describes as ‘AA confessional style’ lectures in Ojibwe.\textsuperscript{78} The Waystation workers also provided individual support to those struggling with alcohol abuse, including assistance with court attendance, transportation, and finding employment.

During the late 1960s the Ojibwe addictions workers at the Kenora Waystation began to link recovery from alcohol abuse to the reclamation of cultural knowledge, thus anticipating an analysis which became central to the broader Indigenous healing movement which gained momentum across North America during the 1990s.\textsuperscript{79} In their visits to Treaty 3 reserves, Ojibwe workers from the Waystation screened films depicting Aboriginal cultural revival and political protest.\textsuperscript{80} These included a documentary about the ‘Indian pavilion’ at Canada’s Expo ’67, an exhibit which conveyed profound anger at broken treaty promises and articulated demands for self-determination.\textsuperscript{81} The visiting researcher from the Addictions Research Foundation in Toronto was seemingly mystified as to the connection between Indigenous cultural knowledge, political protest, and healing from alcohol abuse, and commented in his report, ‘How [such films] will affect the Kenora area Indian’s drinking problem is a bit obscure’.\textsuperscript{82} Instead, he advocated a more conventional health promotion approach, urging that the Waystation develop media specifically about ‘Indian drinking’ in Ojibwe and ‘simple English’.\textsuperscript{83} As we shall see, it remains common for non-Aboriginal health professionals to fail to appreciate the significance of Indigenous political-historical analyses of suffering to contemporary healing strategies.
In the early 1970s, a group of Ojibwe people in Kenora including Donald Morrison founded the Lake of the Woods Powwow Club. They began meeting as an Aboriginal Alcoholics Anonymous group around 1972, but soon decided that whilst the AA philosophy provided some relevant guidance, they were more interested in resurrecting their own knowledge and practices in support of healing. As Mariana Valverde has discussed, AA ideology insists on its members' primary allegiance to a universal alcoholic identity, whilst ‘those aspects of one’s life that distinguish one from other alcoholics are to be kept firmly in the background’.

Thus the founding members of the Lake of the Woods Powwow Club developed a new focus: to recover from alcohol abuse through resurrecting and applying traditional Ojibwe knowledge. Such knowledge had been suppressed, but not entirely lost, due to missionary and Indian Agent opposition to Aboriginal ceremonies, and the social disruption caused by the residential schools, which all but two of the Club members attended.

When I asked Joseph how it was that his father and others who had attended residential schools were able to access traditional knowledge, he explained that they had acquired a sufficient grounding in such knowledge when they were still living with their families prior to being sent away to school. Cree/Métis historian Kim Anderson’s account of childhood in northern Algonquian communities provides important insights into how it was that such individuals were able to recollect traditional teachings and ceremonial practices later in life.

Drawing on oral histories shared by elders, she describes how early childhood was described as “the good life” in Midewiwin teachings. A sense of collective responsibility to nurture and care for children was extended to particularly close relationships between grandparents (and great-grandparents) and young children, particularly those under the age of seven or eight. Here the concept of grandparent was not confined to one’s parents’ parents; rather, the participants in Anderson’s research recollected grandparent relationships with a range of older adults in the community. Whilst parents were preoccupied with work, grandparents often had sufficient time to be the primary caregivers for young children. As Anderson notes, ‘this arrangement was also important because it facilitated traditional education’. The time young children spent with grandparents was often a time for teachings, including storytelling and locating medicines.
Some children worked as helpers for grandparents who were healers, giving them privileged access to healing knowledge and practices. Thus some of the children who attended residential school clearly had intensive exposure to traditional teachings in their early years, to the extent that they could resurrect such knowledge in later life.

Joseph joined the Lake of the Woods Pow Wow Club in 1975. He explained to me how the group expanded from the mid-1970s:

*The group progressed further that their children got involved, and it then became a family … activity, I guess, without the use of alcohol or drugs. Then pretty soon it kind of took off into the other communities. […] They revived their traditional beliefs, people, they got other tribal people who were coming in sharing their traditional beliefs, and the important thing that people in that area were able to look back to their own history, how things were done as Ojibwe people, taking that step further to being to develop a sense of pride of who they were, who they are.*

Thus initial efforts at developing an Ojibwe approach to healing focused on resurrecting knowledge and practices to restore individual and collective identities undermined by colonization, including experiences of residential schools, relocation and disruption of livelihoods. This approach was complemented by the critical analysis of ongoing colonial relations with the Canadian state and settler society which Aboriginal activists were developing during the early 1970s, in the context of the international decolonization movement.

*Activism and Healing*

Around the same period when the Lake of the Woods Powwow club was being established, Ojibwe people were also voicing their anger and frustration via political protest (see Table 2.1). In an event described as ‘Canada’s first “civil rights” march, about 400 people from six reserves in the Kenora area participated in a peaceful march through Kenora in November 1965, protesting racism in the city and the state’s failure to honour their treaty rights. During the early 1970s, younger Aboriginal people across North America increasingly took on leadership roles organizing political protest, and the Red Power movement emerged. Louis Cameron, an Ojibwe man from Whitedog reserve north of Kenora and a member of the Lake of the Woods Powwow club, established the Ojibway Warriors Society with other young Anishnaabeg in 1972. This was clearly a trans-local
movement: members of the Ojibway Warriors Society and others from the Kenora area took part in political actions elsewhere in Canada and the United States, whilst activists from elsewhere, including members of the American Indian Movement from the United States and Red Power activists from Toronto, visited Kenora to offer support to the local protestors. The 1973 occupation of the Kenora Indian Affairs office occurred shortly after activists had occupied Indian Affairs offices in Ottawa, and some of the same activists took part.

Ojibwe activists’ occupation of Anicinabe Park in 1974 provided significant impetus to community mobilization around issues of Aboriginal health and healing in Kenora. Louis Cameron and other members of the Ojibway Warriors Society, organized an ‘Ojibwe unity conference’ and powwow in Anicinabe Park in Kenora during the weekend of July 20-21, 1974. Approximately five hundred people, including those local to the Kenora area and Red Power activists from elsewhere in Canada and the United States, discussed alcohol problems and the lack of health and dental care for Aboriginal people, alongside concerns about mercury poisoning of the Wabigoon-English river system, police harassment, substandard housing, and the reserve system. Discussion during the weekend conference highlighted participants’ frustration about the lack of progress on Indian rights, and inspired between one hundred and two hundred people to occupy the park for thirty-nine days. Protestors argued that the park was Ojibwe land, and accused the Federal government of illegally selling it to the city of Kenora. Specific demands were made of federal, provincial, and municipal governments, including improvements in health care, public transport linking Kenora to nearby reserves, employment of interpreters at government agencies serving Aboriginal people, an end to discrimination against Aboriginal workers by unions and businesses, action against police brutality towards Native people, creation of a local human rights committee, and the removal of Provincial Judge SJ Nottingham from the bench in Kenora. The Canadian state ultimately met many of the demands, including the transfer of Judge Nottingham, who was inflicted on the unfortunate residents of Thunder Bay. At the conclusion of the occupation, fifteen people were charged with offenses, including possession of dangerous weapons, but all charges were eventually dropped.
The occupation had far-ranging social effects, including the establishment of several important Aboriginal-led projects in Kenora, and an outpouring of increasingly blatant racist rhetoric from some segments of settler society in the city. The local newspaper ‘Miner & News’ printed letters and articles promoting crude colonial stereotypes of Aboriginal people as aggressive, dangerous and dirty, whilst white settlers were portrayed as ‘victims’.98 At the same time the paper’s editors declined to engage seriously with the demands presented by the Ojibway Warriors Society.99 The theme of white settlers as ‘victims’ of ‘discrimination’ was further developed in the noxious self-published tome written by Kenora resident Eleanor Jacobson, ‘Bended Elbow’.100

More positively, the Ojibwe occupation of Anicinabe Park led directly to the establishment of the Ne’Chee Friendship Centre and the Kenora Street Patrol. A group of volunteers began to organize the Ne’Chee Friendship Centre during 1975, and it was incorporated May 31, 1976.101 The Kenora Native Women’s Association (now Kenora Anishinaabe Kweg) was founded around the same time, and the two organizations shared a building for several years from 1978. The Kenora Street Patrol, one of the very first harm reduction programmes in North America and the first such initiative by urban Aboriginal people, originated from a proposal made during the Anicinawbe Park Occupation.102 Sylvia Maracle, Executive Director of the Ontario Federation of Indian Friendship Centres, recalls,

> there were people in Kenora, as a result of addictions, who were freezing in the winter time or under boats or drowning or whatever, and the community got together and it began with a couple of people who were Elders and who were sober, and teams of men and women walking around at night, with black coats on that said ‘Street Patrol’ in bright letters on the back, and they’d call the police when they needed support or an ambulance. And eventually, you know, ended up saving people’s lives. But not just saving people’s lives, having real impact on those lives.103

Joseph Morrison and Richard Green began the Kenora Street Patrol in 1976. Between 6pm and 2am, the volunteers would walk the streets. In his typically modest and understated manner, Joe described the work thus:

> We didn’t have any powers to arrest anybody, we were just two individuals that were working to patrol the streets of Kenora and ensure that people that were in need were escorted to a place of safety, or we’d inform the police of persons causing difficulties, youth intoxication or, or come across children that were on the street, you know, without parental involvement.104
The Street Patrol went on to be funded over many years by the Ontario Ministry for Community and Social Services. People working in Friendship Centres and homelessness programmes from Toronto and Winnipeg visited Kenora to learn about the Street Patrol model, and programmes for homeless Aboriginal people, which emerged in many Canadian cities during the 1980s, were heavily influenced by their work.105

In 1980, members of the Lake of the Woods Powwow Club collaborated with physician Dr Allan Torrie to establish the ‘Lake of the Woods Native Healers’ programme at Kenora’s Lake of the Woods Hospital.106 Through the programme traditional Anishnaabe practitioners provided healing and support to both inpatients and outpatients at the hospital, and visited reserves in the surrounding area. By honouring and applying Indigenous knowledge within an institutional space historically controlled by the European biomedical paradigm, this programme embodied a powerful challenge to continuing colonial domination of Indigenous people in the region. George Councillor was the first healer to be hired, and he was able to recruit the support of a group of other healers, including his brother, Randy Councillor. Joe explained how, as word spread about the ceremonies, people from outside the hospital began to come to participate. Many different healers from across North America also visited Kenora to take part in the programme. Two years after the programme began, George Councillor drowned in a boating accident, and Madeline Skead, a member of the Lake of the Woods Powwow Club, was hired as coordinator.

The Native Healers programme enjoyed substantial community respect and support for many years and was consistently funded by the Ontario Ministry of Health, but in recent years healers have stopped visiting the hospital, and fewer ceremonies are being held outside of the hospital. Joe attributes these changes to shifts in hospital and provincial government policy.107 Archival records also suggest that increasing bureaucratic scrutiny and monitoring demands from the late 1990s may have undermined the program. Under Premier Mike Harris, between 1995 and 2002 the Ontario provincial government implemented wide-ranging cuts to health and social programmes. In 1996, Ontario Ministry of Health staff expressed concerns regarding the lack of ‘appropriate and acceptable parameters’ defining the work of the ‘Native Healer program’, and the
unavailability of quantitative data with which to ‘measure actual program activities and services delivered to clients’. The programme was funded under the Ontario community mental health services programme, and in her ‘program plan/ report for 1996/97’, Madeline Skead asserted:

the spirit of the [recent provincial] mental health reforms will be implemented through the guidance of the [Ontario] Aboriginal Health Policy. The Native Healer Program has been at the forefront in this area, since healers associated with the program provide the bulk of primary mental health services to traditional people on Kenora area reserves.

The Ministry of Health Consultant approved the submission for further funding but challenged Madeline’s claim regarding the program’s leading role in community mental health, noting that ‘this program does not provide community mental health services; a good review is needed.’ These conflicting perspectives vividly illustrate the extent to which colonial relations continue in the contemporary Canadian health care system, characterized by prevailing assumptions regarding the superiority of biomedical and bureaucratic knowledge over Indigenous knowledge, and legitimized in the name of bureaucratic efficiency and financial accountability. Further, this exchange foreshadowed the significant gap between biomedical and holistic models which increasing Aboriginal engagement in the field of mental health since the late 1990s has highlighted.

The discourse on urban Indigenous healing in 1970s Kenora emerged from a confluence of local and international, social and political concerns and actions. The Ojibwe addictions workers and the protestors at Anicinabe Park were both motivated by the imperatives of Indigenous suffering and oppressive state and settler racism in the Kenora area, and inspired by broader examples of anti-colonial critique and struggle. The developments discussed in this section illustrate the possibilities of alliances with and initiatives based in dominant institutions, in support of urban Indigenous healing. At the same time, this account has shown that even the most patently successful and established urban Indigenous initiatives are vulnerable to being undermined by shifting dominant political and institutional regimes.
3. **Institution-building & healing in Toronto**

Descriptions of activist responses to self-evident community needs are insufficient to fully account for patterns in the development of urban Indigenous institutions and programs over time. A more thorough analysis of the emergence of Aboriginal-run organizations in Canadian cities needs to take into account the contextual factors shaping access to resources, and the social and political complexity of urban Indigenous communities. As anthropologist Weibel-Orlando has discussed with reference to the development of Indigenous organizations in Los Angeles, 'Institutions are [both] structural indicators of community cohesiveness, completeness, and inclusiveness', and also indicators of resource availability: 'patterns of organizational continuity and change appear to be associated with the relative local control of resources that sustain such ethnic organizations.' Further, as we saw in Kenora in the previous section, Indigenous actors draw on a range of discourses in defining, framing and responding to problems. These may include broad psycho-social and moral discourses such as Alcoholics Anonymous, ideologies drawn from international political movements, and Anishnaabe and other Indigenous bodies of knowledge. Such discourses constitute another important element of a considered analysis of the development of Indigenous-directed programming. In this section, I trace the historical emergence of Indigenous healing programs in Toronto from the late 1960s, with reference to these contextual factors.

*Emergence of Indigenous-led programmes on alcohol, addictions, mental health & primary health care*

During the 1960s, Aboriginal community leaders in Toronto began to provide basic social services to meet the perceived needs of new arrivals and the urban Aboriginal community at large. These were initially generic social services relying heavily on volunteer resources and addressing the most urgent needs of Aboriginal people arriving in the city: basic counselling, orientation to the urban setting, and referrals to other agencies for housing, employment and health care. Friendship centres provided this function in many cities, and are widely cited as the earliest examples of urban Indigenous community organising in Canada. Certainly the Native Canadian Centre in Toronto, established in 1962, has historically been the hub of community organizing in Toronto, leading to the founding of dozens of other agencies, as anthropologist Heather Howard has documented.
Community groups’ development of specific programming to address issues of alcohol abuse, addictions, mental health and healing can be understood as responses to the growing visibility, awareness and discussion of alcohol abuse, individual distress and health problems such as diabetes within the Toronto Native community. The emergence of such programmes must also be interpreted in the context of increased availability of funding with the establishment of the federal Native Alcohol Abuse Programme in 1975, and the Ontario Community Mental Health Services Programme in 1976.

Indigenous-specific programmes on alcohol abuse developed in Toronto and other Ontario cities during the late 1960s and early 1970s, often operating out of friendship centres. Some of the early friendship centres served alcohol at weekend fundraising dances during the 1960s and ‘70s, which often led to fall-out, as Sylvia Maracle wryly observed: “We could guarantee our own work on Monday”.114 Thus friendship centres began to host alcoholism recovery groups, often known as ‘Native AA’, or sometimes ‘Birds of a Feather’.115 As with the Kenora group which was the precursor to the Lake of the Woods Powwow Club, these groups were based on the Alcoholics Anonymous model, but often incorporated strong elements of cultural revival, including singing and drumming, ceremonies, and teachings from Elders.

In 1975, Pedahbun Lodge in Toronto submitted the first Ontario application to the newly-established federal Native Alcohol Abuse Programme.116 A group operating out of the Native Canadian Centre established the Lodge as a ‘halfway house’ for Native people struggling with alcohol abuse in 1974. Pedahbun was the first urban residential alcohol abuse treatment centre for Aboriginal people in Canada, housed in a former nursing home on King Street, downtown Toronto. Indigenous groups in Los Angeles established similar programmes – known as the ‘Indian Men’s Lodge’ and ‘Indian Women’s Lodge’ – during the early 1970s.117 Elder Vern Harper recalls that the idea for an Aboriginal-run alcohol treatment centre in Toronto came out of meetings of the ‘Native Concerned Citizens Committee’, a group formed around 1970.118 In a 1980 oral history interview, Pedahbun Lodge founder, recognized Elder and former alcoholic Joe Sylvester described how he’d had a vision about the need for an Aboriginal-controlled rehabilitation unit.119 As an
Addictions Counsellor at the NCC, Sylvester experienced challenges in supporting clients who were struggling with alcohol abuse whilst referring them to white-dominated treatment settings:

*I was finding that I was not helping the Indian people at all. I was trying to help them stay sober but I was not helping them at all. Then I thought to myself, then we must have our own rehabilitation unit. I put them in halfway houses here in the white setting. They did not respond to that treatment.*

In addition to Sylvester and Harper, members of the founding group included Art Solomon, an Elder from Sudbury and former mine worker and union activist, Pauline Shirt, Jim Dumont, and Roger Obonsawin, Executive Director of the NCC from 1974 to 1981 and first president of the National Association of Friendship Centres.

Community leaders developed the first Indigenous-led mental health and primary health care programmes in Toronto during the 1980s. The Native Community Crisis Team was the first Aboriginal-specific programme in urban Ontario to be described as a “mental health” intervention. The Native Canadian Centre, in collaboration with the Department of Psychiatry at Toronto East General Hospital, established the programme in 1982. The Native Community Crisis team was one of hundreds of projects funded under Ontario’s Community Mental Health Services Program during the 1980s, including a growing number of programmes founded by immigrant groups in southern Ontario cities who contributed to an emerging ‘multicultural mental health’ paradigm. Aboriginal community leaders took pains to distance themselves from this discourse as it gained prominence; I shall discuss this issue in detail in Chapter Five.

Anishnawbe Health Toronto, the first urban Indigenous health centre in Canada, emerged from community leaders’ work on diabetes education at the Native Canadian Centre during the early 1980s. Representatives from four Toronto Aboriginal agencies - Anduhyaun (Stella Johnston), Council Fire (Millie Redmond), the NCC (Roger Obonsawin) and Pedahbun Lodge (Joe Sylvester) - formed a committee in 1980 with the aim of initiating a diabetes education programme for Toronto’s Aboriginal community. With support from the Faculty of Nursing at the University of Toronto, the group developed the ‘Native Diabetes Program’, an action-research education programme with Elder Joe Sylvester as its spiritual advisor. Rebecca Hagey, an anthropologist and professor of nursing at the
University of Toronto, became an important collaborator, and published several papers on
the action-research programme. The work of the Native Diabetes Program inspired Joe
Sylvester and others to develop primary health care services for Indigenous people in
Toronto. To this end, they established Anishnawbe Health Resources, incorporated in 1984
with an objective “to recover, record and promote traditional Aboriginal practices where
possible and appropriate”. Participants at a three day conference and visioning
workshop at the Native Canadian Centre in January 1986, reached a consensus regarding
the need to establish an Aboriginal health centre in Toronto.

The Ontario government formally announced funding for Anishnawbe Health Toronto
under the provincial Community Health Centre programme in 1988, and the centre opened
in 1989. The Liberal provincial government which came to power in 1985 had established
a ‘Policy Framework for Native Affairs’ that same year, encouraging provincial ministries to
‘provide “Native-specific” services in a way that protects the culture’. In her public
announcement of provincial funding for Anishnawbe Health Toronto, Minister of Health
Elinor Caplan expressed the emergent liberal discourse on multiculturalism and health
which was to become increasingly dominant over the next two decades:

We want to ensure that people make use of health services that are available. We want
to ensure that cultural beliefs are understood and respected, that language is not a
barrier to health care. [...] we must be ready to respond to the differences among us, the
differences that make us a more interesting, more vital society.

The issue of self-determination for urban Indigenous peoples was conspicuously absent
from her remarks (although it was referenced in the Liberal’s policy framework). But
Caplan went on to emphasise her government’s ‘commitment to improving Native health’,
as further evidenced by the Ministry of Health’s recognition of ‘Native people’ as one of
several ‘special target groups’ assigned their own Coordinator within the Ministry. She
pledged that the newly appointed Native Health Coordinator, Mr Don Stuart, would be
seeking ‘advice and ideas’ from Anishnawbe Health Toronto and would be developing new
Aboriginal health initiatives. Despite these encouraging remarks, formal collaboration
between the Ministry of Health and Aboriginal groups in Ontario did not begin until 1990,
as discussed in the next chapter.
Discourses on tradition, community and healing: consensus and conflict

Aboriginal people involved in healing programmes in Toronto during the 1970s and ‘80s developed and elaborated a discourse on healing explicitly linking current individual distress to collective historical suffering and the loss of individual Indigenous identity. Participants in this discourse understood the resurrection, re-learning and celebration of traditional Indigenous knowledge to be integral to individual and collective healing processes. The ubiquity and persistence of this discourse is noteworthy given the significant diversity within the Aboriginal community in Toronto. Most members of the Aboriginal community in Toronto during the 1950s and ‘60s were of Ojibwe origin, and according to Vern Harper, Anishnaabe knowledge and traditions have provided the dominant framework for community organizing in the city. But by the early 1970s agencies were staffed by Cree, Métis, Mi’qmak and Iroquois, and by 1991 census data showed that people of Ojibwe origin represented 55% of the First Nations population in Toronto (these data exclude Métis and Inuit), as shown in Table 2.3 below.

In contrast, Anishnaabeg have continued to constitute a large majority of Aboriginal populations in northern Ontario cities such as Sudbury, Thunder Bay (shown in Table 2.3 below) and Kenora. I have encountered little published or informal discussion regarding the implications of the growing ethno-national diversity of urban Indigenous populations in southern Ontario, although a couple of participants made oblique, good-humoured references to the historical Anishnaabe dominance of programming in Toronto. Chapter Six considers the more recent emergence of distinct Inuit and Métis healing programmes in Ontario cities.
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Table 2.3  Aboriginal Population by Nation of Origin in Selected Ontario Census Metropolitan Areas, 1991\textsuperscript{129}
Community leaders’ central concern with the revitalization of Indigenous knowledge did not preclude their strategic engagement with dominant biomedical discourses and practitioners. Indeed, a willingness to invoke dominant models likely enhanced the chances of accessing state funds for programmes. For example, Pedahbun Lodge’s early funding application to the Native Alcohol Abuse Program invoked a biomedical model of alcoholism in policy statements such as ‘We strive towards the eventual eradication of the disease of alcoholism’ and ‘We support research into the problems of the Native alcoholic and the seeking of better solutions to the disease alcoholism’. At the same time, the Pedahbun treatment model explicitly emphasized the distinct nature of Indigenous people’s struggles with alcohol abuse:

*A lack of self-esteem and a negative identification with being Indian is at the root of the problem in many cases [therefore] all programmes will attempt to awaken in the individual a sense of pride and dignity.*

In practice, elements of biomedically-informed practice were clearly in operation at Pedahbun, such as admission criteria restricting clients to those for whom alcohol abuse was the ‘primary’ problem, and excluding those who ‘appear... to require psychiatric treatment (ie: cases where alcohol is obviously a secondary problem only)’.

The discourse on healing seems at times to convey a reified understanding of culture as timeless and bounded, which is understandable in a social climate of massive cultural loss and ongoing threatened assimilation. But in practice, healing programmes such as Pedahbun Lodge did not simply import Indigenous ceremonies and teachings into a treatment environment. Rather, the treatment model involved extensive participation in community events, an active celebration of living, dynamic Aboriginal cultural practices and social networks. As well as participating in traditional ceremonies including sweat lodges at Pedahbun Lodge, residents regularly attended social and cultural events in Toronto, including the weekly drumming group at the Native Canadian Centre. Staff and residents also travelled farther afield, participating in powwows and visiting the rehabilitation centre at Wikwemikong Reserve, and attending spiritual ceremonies at Cape Croaker Reserve, led by the Lodge’s own Elder.

In 1977 a group of residents, staff and volunteers embarked on a road trip through western Canada and the northern United States, the declared purpose of which was to ‘further the spiritual awareness of the
Pedahbun group'. The group visited Cree reserves and a powwow and conference hosted by the Stoney community at Morley, Alberta, and the Chicago Indian Friendship Centre en route back to Toronto.

Controversy over the sweat lodge built in the grounds of Pedahbun Lodge provides further evidence that cultural healing practices in Indigenous Toronto during the 1970s and 1980s were contingent and subject to negotiations. Lillian McGregor, who visited Pedahbun Lodge several times to share traditional teachings with the residents, described her concerns at the time that an urban-based sweat lodge violated the basic principle of being in contact with the earth. Further, McGregor explained the specific ethno-national origins of the sweat lodge and its traditional identification as a ceremony for men:

*The sweat lodge is not for every group of Native people. It’s basically an Ojibwe or a Cree ... teaching, I call it. And then when I heard the women [were] doing sweat lodges, I said “Women can do their own, but you’re not supposed to have a sweat lodge. You have your ceremonies, your moon ceremonies, that’s your sweat lodge ceremony”*. Whilst women, Indigenous people of all ethnicities, and even non-Indigenous Canadians have continued to participate in sweat lodges, community leaders eventually reached a consensus that sweat lodges do not properly belong in the city.

**Health professionals, healers, & Indigenous self-determination**

With the growth of a discourse on community mental health and the parallel growth in state funding, Indigenous organizations began to form alliances with the credentialed experts in the field, psychologists and psychiatrists. The women’s shelter Anduhyaun employed a ‘psychiatric consultant’, a Dr. J.L. Whitton, to advise on residents’ ‘problems [...] that present as psychiatric and emotional difficulties.’ Whitton was also part of the University of Toronto psychiatric team employed by Medical Services Branch in the Sioux Lookout Zone, northwestern Ontario. When in 1978 the Ontario Regional Advisory Board of the Native Alcohol Abuse Programme threatened not to renew funding for Anduhyaun’s alcohol and drug abuse programme, Whitton sent a detailed four-page letter to the Board strongly recommending the refunding of Anduhyaun’s programme with an increased budget.
Whitton’s description of the programme merges Indigenous healing discourse with medical-psychiatric vocabulary, and provides an early example of the invocation of ‘trauma’ as an explanation for Indigenous suffering:

*The program […] proposed that drug abuse in the Native women served by Anduhyauan was a symptom, pathologic in mode and self-destructive in effect – a symptom of a traumatic loss of self-worth, dignity, self-competency, personal identity – a symptom exhibiting the compulsivity of personal needs terminally frustrated by the environment – a symptom indicative of exhaustion of inner resources.*

The participation of non-Indigenous regulated health professionals in Indigenous healing programmes was countered by an emerging discourse on the value of Indigenous service providers treating Indigenous clients. Whereas early friendship centre programme models focused on referrals to mainstream agencies and provided services only where they did not already exist, this discourse affirmed the value of a ‘shared past’ in establishing empathy in a therapeutic relationship. Steve Koptie, a Métis counsellor with the Native Community Crisis Team (managed by a psychologist) in the early 1990s, asserted the crucial role of the Native counsellors:

*Our growing caseloads and wide range of presenting problems confirm the growing number of Native people engaged in a healing process. The growing need to share “collective pasts” makes Native counsellors a valuable and rare commodity as they play a very necessary role in offering guidance and direction as people move back to their cultural traditions. Healing circles, teaching circles with elders, as well as individual counseling are part of the therapeutic strategies we promote at the Native Community Crisis Team.*

This discourse’s emphasis of the historical distinguishes it from concepts of ‘ethnic matching’ and ‘cultural congruence’ which have featured in North American and British mental health services since the 1990s. The role of Native counsellors goes beyond understanding based on shared cultural values. Rather, urban Indigenous healing is often about the community reclaiming its members who have been alienated from their Indigenous heritage through the child welfare system and broader disintegration of social relations associated with colonialism. Native counsellors thus facilitate both individual reconnection with cultural identity and community, and the individual and shared coming-to-terms with multiple significant collective losses.
During the late 1980s Indigenous community leaders in Toronto both developed formal structures to protect and promote traditional knowledge, and opposed state control of traditional healing practices. Following a major restructuring at the Native Canadian Centre (NCC) in 1984, the Centre’s new administration established an “Elders and Traditional Teachers Advisory Council” (later renamed Taamkadinakegig, ‘the first people who lived here’) in 1986, and hosted the first annual Elders and Traditional Peoples’ Conference the same year. In 1988, the NCC Board passed a resolution to incorporate traditional cultural practices into all administration and programming. Also during the latter part of the 1980s, Indigenous community leaders and healers coordinated resistance to provincial regulation. In 1983, the Ontario government appointed a Health Professions Legislation Review Committee to review and recommend revisions to legislation governing all health professions in Ontario. Whilst some traditionally marginalized practitioners such as midwives and chiropractors took the opportunity to pursue state regulation, Indigenous community leaders led by Anishnawbe Health Resources in Toronto opposed the inclusion of Aboriginal healers and midwives under state regulation, and refused to participate in the Ministry of Health’s consultation process. In the final legislation, Aboriginal healers ‘providing traditional healing/midwifery services to Aboriginal persons or members of an Aboriginal community’ were exempted from regulation. The protection and promotion of Indigenous knowledge had become a clear priority for the leaders of Toronto’s Aboriginal community.

4. Indigenous healing in southern Ontario prisons
About a decade before the American Indian Movement protests in western Canadian prisons described in Section Two, women from the Toronto Native Canadian Centre’s Ladies’ Auxiliary began visiting Aboriginal women in southern Ontario penitentiaries, one of a range of volunteer activities which anthropologist Heather Howard has characterized as middle-class activism. An emerging middle-class of urban Aboriginal women was central to the establishment of the Native Canadian Centre of Toronto in 1962; several of these women went on to found the Ladies Auxiliary in 1963. The prison visiting seems to have been conceived not so much as healing as charity work, alongside other charitable activities such as hospital visiting and clothing and food-drives. An oral history
interview with Millie Redmond, first president of the Auxiliary and a Potawatomi from Walpole Island First Nation, suggests an element of moral judgement, or blaming of Aboriginal women for their incarceration:

_Sometimes I’d get a little downcast because I’d find so many Native women sitting in the cells, and the same women... and Major Worthy who was a Salvation Army person would say to me, ‘Millie, remember, today may be the day they change. One word from you just may cause them to change’. And not long after, about a year, I hardly saw any of those women there._

Howard argues that, over time, “the social conditions that put the women in jail in the first place became a central concern for the Auxiliary”. Such an analysis is indicated in another interview quoted by Howard, this time with Josephine Beaucage of Nipissing First Nation. Beaucage described teaching craftwork to women in Kingston penitentiary as contributing to a “mission to bring traditional practices and elements of Native culture to spaces where they might re-affirm Native identity and forge links of cultural solidarity”.

Millie Redmond became the first Native Court Worker in Toronto, and the work of this programme eventually led to the establishment of Aboriginal Legal Services of Toronto in 1990.

Vern Harper and Jim Mason, both Aboriginal men born in Toronto who went on to be recognized as Elders, also worked extensively with Aboriginal people in southern Ontario prisons from the 1970s onwards. Their trajectories illustrate the influences of both the Red Power movement and local community development in fostering the development of Indigenous healing practice and the role of Elders in urban settings. Vern was actively involved with the Red Power movement, including the founding of the Toronto Warriors Society in the wake of the Anicinawbe Park occupation in Kenora, and the development of Aboriginal community agencies and services in Toronto. He was a Native Court Worker under Millie Redmond at the Native Canadian Centre in Toronto when he began visiting Aboriginal people in Guelph Provincial Correctional Centre and Kingston Penitentiary. In the early 1980s, Vern was determined to establish a sweat lodge for use by the Native Sons group at Guelph. He made an arrangement with Father McCarthy, a priest with a Jesuit order who owned a farm outside of Guelph, to use some of the Jesuit’s land as a site for the sweat lodge, with the understanding that neither party would interfere with the work of the other. Elder Art Solomon cautioned Vern against forming a close alliance with the
Jesuits on the basis of his own negative experience of working closely with the Anglican Church. But the arrangement endured, and the sweat lodge continues to be used by Aboriginal groups from Toronto in the present day.

Born in Toronto in 1919 or 1920, Jim Mason was the son of an Ojibwe mother and a Mohawk father from New Credit reserve. His mother died in childbirth; his son reports that Jim knew little about his parents. Jim was raised by family members in Toronto in difficult conditions, and left home at age 12. Jim worked at a range of occupations including farm labour, high steel construction work (a common occupation for Mohawk men throughout the twentieth century, as discussed in Chapter One) and truck driving, before coming to work at the Native Canadian Centre during the 1970s. Initially acting as driver for the Native Centre’s Ladies’ Auxiliary during their prison visits, Heather Howard describes how Jim came to be considered an ‘honorary member’ of the Ladies’ Auxiliary, and eventually undertook his own prison visits. Jim was also involved in the Ontario Métis and non-Status Indian Association, and in early Red Power protests, often driving people to events.

Leslie Saunders, a white addictions counsellor who has worked with Aboriginal people in Toronto for several decades and worked closely with Jim at the Don Jail during the late 1980s and early 1990s, described his work thus:

\begin{quote}
[Jim] was fabulous. The men could relate to him and he provided a grandfather-type of role and the men instantly respected him and he brought culture to them in the jail. I think he related to the lived experience of the men and he made access a little less formal. [...] He could really relate to the men’s experience of being criminalized and he knew that it was a tough road in the jail. He knew what these guys were having to do to survive in there. And he was almost like one of the boys, that’s how he would approach them, and they respected him.
\end{quote}

In addition to visiting Kingston Penitentiary and Wentworth with the Ladies’ Auxiliary, Saunders described how Jim worked in particularly challenging settings including the Ontario Correctional Institute, which treated sex offenders and those with drug and alcohol problems, and Guelph Provincial Correctional Centre, which was ‘supposed to be a correctional centre but had this terrible reputation as being very high security’, and commonly hired untrained farmers as guards.
Formalisation of traditional healing through ‘Native Sons’ at Toronto’s Don Jail

During the late 1980s the Native Sons group at the Don Jail (‘the Don’) in Toronto was struggling to function, apparently due to the active resistance of prison staff. Ursula Jocko of the Chaplaincy Department was providing some limited programming for Aboriginal men in response to individual requests. Jocko, an Aboriginal woman and a devout Catholic with “her feet in both worlds” worked at the Native People's Parish, a Catholic church in Toronto’s West End. Jocko was actively engaged in learning about traditional teachings at the time, and whilst her knowledge was limited, her efforts to engage with the men helped to sustain the Native Sons group:

[Ursula] did some really good work. [...] She didn’t even really know that much about traditional culture herself, but she would come in and she’d bring medicine cards in and she’d do that kind of thing with the men, you know, they’d draw the medicine card and she’d talk to them about whatever that animal was that they had pulled.

In 1989 addictions counsellor Leslie Saunders began working to formalize and legitimize the Native Sons group, facilitating regular meetings, making individual referrals to Jocko, and inviting Aboriginal Elders and traditional people into the institution to work with the Aboriginal men. In her analysis, Saunders was able to facilitate the reinvigoration of Native Sons at the Don by building on the groundwork she had laid as an addictions counsellor with the St Leonard’s Society, a federal half-way house, earlier in the decade. As addictions counsellor with St Leonard’s, Saunders delivered group and individual counselling sessions at the Don Jail and the East Detention Centre as part of an ‘Addictions Education Program’, and strived to build relationships with prison staff as well as inmates. The addictions counsellors recognized the importance of earning the respect of the institutional staff, given the latter’s absolute power to effectively obstruct activities which they were opposed to:

The reality is if [the guards] don’t support your program, you’re basically not going to have a program. Because they can find a myriad of ways to interfere with you getting to your client or pulling your group together. And I’ve experienced some of those, I mean, stuff like waiting in the stairwell for them to unlock the door for half an hour. And they just come and say “Look, we’re busy, you’re gonna have to wait.” And there’s nothing you can do.
The majority of the Aboriginal inmates Saunders worked with at the Don had a history of drug and alcohol abuse and had been convicted on minor charges such as theft and assault, all of which were committed whilst drunk and/or using drugs. Most had been through the child welfare system and/or raised by settler-descendant families from whom they were typically estranged. This contrasts with Waldram’s account of the Aboriginal inmates he worked with in the western prisons, the majority of whom he described as having a ‘traditional’ or ‘bicultural’ orientation, rather than ‘Euro-Canadian’. It is not clear from these sources why this pattern should be so different, although from Saunders’ account, most of the Aboriginal men at the Don during the late 1980s were of northern Ojibwe origins. As we saw in Chapter One, over one thousand Aboriginal children were in care in Ontario during any given year during the 1970s, hundreds were adopted by non-Aboriginal families, and Aboriginal children constituted the large majority of those in the care of Children’s Aid Societies in northern Ontario. Surveys in various parts of Canada have identified the over-representation of Aboriginal people who have been through the child welfare system or non-Native adoptions amongst Aboriginal prisoners, street kids and residents of homeless shelters.

Because the men had so little experience with Aboriginal people and practices, they were often highly reluctant to participate in the Native Sons activities, as Saunders described:

*I’d have to discuss with them for a long time to get them to come to the program. Because if I’d go up to them and say ‘Do you want to go to the Native Sons Program tonight?’ they’d say ‘Oh, I wasn’t raised with Native people. I don’t know anything about it.’ And this shame, this veil of shame would come over, because they felt they weren’t worthy of being in that room. They wouldn’t know how to behave. They wouldn’t know what to say.*

She was usually able to persuade the men to participate despite initial reluctance, and described how many of them experienced a transformative realization of the commonality of their personal history:

*Once they got up there, just even the first time, there was no more fear. They were very comfortable, because they quickly realized that they did not have to be an expert in Aboriginal culture. And they were welcomed and their [personal] history seemed to already be known by the person facilitating the program and they thought this was miraculous.*
Despite Saunders’s persistent efforts at building relationships with prison staff, she and the Elders and traditional people she invited were repeatedly and deliberately obstructed by the Don Jail guards. Jim Mason, the first visiting Elder after Ursula Jocko’s departure, eventually stopped visiting the Don due to the strain of relentless obstruction and harassment from the guards.

We did have problems. I would find that, you know, [Jim] would come to the door and they would turn him away. They would say things like ‘There’s no note here that you’re supposed to be coming in’, that was a frequent explanation given. I would go out of my way to create this paper trail, I’d prepare the memo every week. It never ended. It had to be done every week: ‘Jim Mason is a traditional elder, blah, blah, blah, he’s coming in on such and such a date at such and such a time. He’ll be leaving at such and such a time. He’s to be on such and such a floor. If you have any questions, please call me.’ I changed my hours so that I was there until like ten o’clock on Friday nights, because the programs would start at about seven and I’d have it signed by security and I’d leave it at the front door, but when he’d show up, it wouldn’t be there. They couldn’t find it. It was just a nightmare. So it got to the point where I’d have to physically stand and wait for him and still hand in the paperwork and then say, you know, ‘Here he is’, and drop the memo. Still they’d be saying things like ‘Well, we can’t find it’, but I would have a photocopy, you know, so. It was just unbelievable.

Saunders’s account is consistent with Waldram’s description of how entrenched racism and opposition from staff undermined traditional healing work in western Canadian prisons during the latter 1990s. Saunders was able to arrange for Vern Harper, and later Jackie Alton, to facilitate the group after Jim’s departure, but after Saunders left her position at the Don in 1995, the obstruction worsened, until eventually the guards prevented Jackie Alton from visiting altogether. Similarly, Waldram describes how Elders suffered ongoing harassment from staff, including invasive searches of sacred objects leading to desecration, and deliberate restriction and sabotaging of ceremonies, despite policy directives from senior penitentiary administrators authorizing Aboriginal healing practices. As a result, Waldram notes that (like Jim Mason) many Elders working in prisons have suffered ‘stress leading to burn-out’.

The Don Jail staff’s continuing obstruction of the work of Aboriginal healers through the mid-1990s is particularly striking, given that from 1992 the federal ‘Corrections and Conditional Release Act’ required that “reasonable steps” be taken to allow Aboriginal inmates access to ‘Aboriginal spiritual leaders and Elders’, who were accorded status
equivalent to other religious leaders. Saunders recalls that a Ministry of Corrections pamphlet explaining the use of herbs such as sweet grass and sage, and medicine bundles, designed to educate guards and facilitate Elders’ healing practices, was in circulation whilst she worked at the Don Jail.

Saunders shares Waldram’s analysis of the inappropriateness of Elders working under the auspices of the prison chaplaincy. Waldram criticizes the conceptualization of Aboriginal spirituality as parallel to Christianity which has dominated policy on Indigenous healing in Canadian prisons. Whilst recognizing that this framing has been strategic in ensuring the ‘constitutional protection of Aboriginal spirituality as a form of religious practice’, it fails to acknowledge the significant therapeutic implications of spiritual practices, as articulated in an Indigenous healing paradigm. Thus Correctional Services Canada’s policy on mental health services for Aboriginal inmates denies a role for Aboriginal Elders and healers by restricting mental health service providers to "professionals/practitioners currently registered/licensed [...] in Canada". Whilst institutional opposition to Indigenous healing may be particularly blatant in prison settings, there are parallels in other dominant urban institutions, as we shall see in the coming chapters.

5. Conclusion
During the 1960s and’70s, Indigenous and settler societies became increasingly conscious of the scale and extent of Indigenous suffering caused by Canadian colonial policies, and Indigenous community leaders began to articulate a discourse on healing informed by historical consciousness. Although the early Red Power movement did not prioritise health and healing to the extent of issues of land and treaty rights, Red Power ideology undoubtedly shaped the development of urban Indigenous healing discourse and practices. The principle of self-determination was adopted by community leaders advocating Indigenous control of spirituality, child welfare and health care. The reclamation and revitalization of traditional Indigenous knowledge became central to the enactment of healing across all of these domains. Many people experienced a transformation in consciousness through recognizing shared histories and implications for present-day suffering. Such transformations must have been particularly profound for those previously ignorant of the historical antecedents of their individual trajectories, such as the
young Ojibwe men, raised in institutions and settler-descendant foster families, who participated in the Don Jail’s Native Sons programme during the 1980s. Such experiences contributed to a growing sense among many Native people in urban Ontario that Indigenous suffering was best alleviated by Indigenous healers.

Compared with reserve-based communities at this time, Urban Indigenous groups were in some respects better situated to develop healing programmes. Being unencumbered by the Indian Act administrative bureaucracy, the latter had both greater autonomy, and closer proximity to certain resources. In particular, ready access to dominant biomedical, academic and charitable institutions enabled both financial support and collaborations with credentialed professionals. Such collaborations led to many long-running programmes and agencies, including the Traditional Healers programme at Lake of the Woods Hospital in Kenora, Anduhyaun Native women’s shelter, and Anishnawbe Health Toronto. Off-reserve Indigenous agencies had access to municipal funding – particularly in Toronto – and, as a result of the 1965 Welfare agreement, provincial resources. The Ontario Ministry of Community and Social Services was the most important source of funding for urban Indigenous community programmes during the 1970s and ‘80s, supporting over thirty such initiatives by the late 1980s.167 The provincial Ministry of Health began to sponsor urban Aboriginal projects through the community mental health programme during the early 1980s. Provincial engagement in Aboriginal health intensified after the election of an Ontario Liberal government in 1985, and again under the New Democratic Party government during the first half of the 1990s, as will be discussed in the next chapter.

The presence of large numbers of culturally-disenfranchised individuals of Indigenous origin was also distinct to urban centres. Residential school survivors, those raised by settler-descendant foster and adoptive families, and those released from long-stay institutions, including child welfare programmes, tuberculosis and mental health hospitals, and prisons, commonly settled in cities. Some of these individuals -- such as Vern Harper and Jim Mason, both strongly influenced by Red Power -- were so successful in their personal journeys of cultural reclamation that they became recognized as Elders.
In this context, Urban Indigenous communities developed a discourse on healing with three prominent elements: the development of historical consciousness; the resurrection and reclamation of traditional knowledge, particularly in relation to the spiritual; and the reframing of individual experience and identity within a collective whole. The therapeutic models developed were eclectic, synthesizing the revival of cultural practices, Alcoholics Anonymous ideology and individual and group counseling, usually by minimally trained volunteers or para-professionals. Given the prominence of historical experience in urban Indigenous healing discourse, it is perhaps surprising how rarely colonialism was invoked. The focus was primarily on loss of culture, with significantly less attention given to the processes by which disenfranchisement and assimilation occurred. This de-politicising of Red Power’s anti-colonial discourse may have been pragmatic, given the strategic value of collaborations with dominant institutions and professionals. But as we shall see in the next chapter, it was in the context of closer collaboration between Indigenous groups and the state that colonialism was first named in public policy discourse.
End Notes to Chapter Two

1 The Union of Ontario Indians is the secretariat of the Anishnaabeg (Ojibwe) Nation, and represents 42 First Nations across Ontario. It was incorporated in 1949 and traces its roots to the pre-contact Three Fires Confederacy. 
http://www.anishinabek.ca/index.php?option=com_content&task=view&id=56&Itemid=37
accessed May 19, 2010

2 Professor Marlene Brant Castellano, Oral history, March 22nd 2010, Tyendinaga. OH27: from pre-recording notes.


4 Anthony Hall, The American Empire and the Fourth World: The Bowl with One Spoon (Montreal & Kingston: McGill-Queen’s University Press, 2003); Cited in Rutherford, "Canada’s Other Red Scare. The Anicinabe Park Occupation and Indigenous Decolonization." The extent to which Indigenous knowledge has been maintained despite missionary and state officials’ concerted efforts at its eradication varies between communities and regions. The traditional knowledge on which Indigenous healing practices are based may be adapted for use in contemporary settings, often draws on more than one ethno-national healing tradition, and sometimes incorporate contemporary complementary therapies as discussed in the Introduction. These qualifiers notwithstanding, I use the term ‘resurrecting’ as a deliberate alternative to ‘constructing’ in recognition of Indigenous efforts to protect and pass on healing knowledge as a valued cultural resource.

5 Cf. Joan Weibel Orlando’s account of Aboriginal organisations in Los Angeles, which explains how President Johnson’s ‘Great Society’ social welfare programmes made unprecedented funds available to community-based social service organizations in the United States, leading to a mushrooming of Aboriginal social service agencies in American cities such as Los Angeles. Joan Weibel-Orlando, Indian Country, L.A. Maintaining Ethic Community in Complex Society. (Urbana and Chicago: University of Illinois Press, 1999).


7 Several social work training programmes aimed particularly at attracting Aboriginal students were launched during this period, such as the ‘Native Social Work Education Project’ at the University of Regina.


10 Ibid.

11 Ibid.

Prime Minister Trudeau appointed Robert Andros to be Minister without Portfolio, with the specific assignment of ‘working with Mr Chrétien on the consultations with Indians in developing new legislation’. Sally Weaver, *Making Canadian Indian Policy. The Hidden Agenda, 1968-70.* (Toronto: University of Toronto Press, 1981).


MSB officials attended consultation meetings held at Yellowknife, Moncton, Toronto, Sudbury, Regina, Quebec, Prince George and Edmonton during late 1968 and early 1969. *Ibid.*, memorandum ‘Indian Affairs Meeting with Indian Groups – HIS Attendance’ from Dr Crawford, Director General Medical Services to Regional Directors, October 7 1968.

Treaty number 6 was signed with the Cree in what is now Saskatchewan and Alberta in 1876, and included what is known as the ‘medicine chest clause’, which states “A medicine chest will be kept at the house of each Indian agent in case of sickness amongst you.” Waldram, Herring, and Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives*, 14; 141-49.

Observers’ records confirm that Indigenous people present at the negotiations discussed the extent their people had been suffering from infectious disease such as measles and small-pox, and specifically requested that the provision of free medicines be included in the terms of the treaty. Historical evidence indicates that other treaty First Nations also understood that government provision of free healthcare was a term of their agreements with the Dominion of Canada. Rene Fumoleau, *As Long as the Land Shall Last* (Toronto: McClelland and Stewart, 1973), cited in Waldram et al, 1995; Barkwell, "The Medicine Chest Clause in Treaty No. 6." This evidence includes the documented assertions made by the Treaty Commissioners that all treaties would have equal terms – with the implication that the medicine chest clause ought to have been incorporated into all treaties contemporary and subsequent to Treaty 6 - and oral histories and Commission Reports describing Treaty Commissioners’ verbal assertions during multiple different treaty negotiations that free medical care would be provided. ———

Treaty 8 covers parts of what are now British Columbia, Alberta and the Yukon. The report quoted by Mr Dickie was to the Honourable Clifford Sifton, Superintendent of General and Indian Affairs, Ottawa, and signed by David Laird and JAJ McKenna of the Indian Treaty Commission.

*Ibid.*, Memorandum ‘Meetings of Indian Representatives in the province of BC to consider change in the Indian Act, Prince George Oct 15 to 18, 1968’, from Regional Director Medical Services Branch, Pacific Region memo to Director General Medical Services, Oct 25 1968; Memorandum ‘Indian Affairs Meetings with Indian Groups, Prince George Oct 14-18’ from Zone Director, Miller Bay Zone, Prince Rupert To Regional Director Medical Services Branch, Pacific Region, Oct 30 1968.

*Ibid.*, Memorandum ‘Indian Affairs’ Meeting with Indian Groups – Quebec Meeting’, From Regional Director Québec (M. Savoie, MD) to Director General Medical Services, October 8, 1968.

*Ibid.*, MSB Handwritten note attached to p. 16 of ‘Résumé of Reports of the Indian Act Consultation meetings, DIAND, March 1969’, sent to Dr HA Procter, Director General MSB, from Assistant Deputy Minister Social Affairs, DIAND


McCallum, "Labour, Modernity and the Canadian State: A History of Aboriginal Women and Work in the Mid-Twentieth Century".

The National Indian Council, formed in 1961 with leadership drawn largely from urban areas, was disbanded in 1968, and from its ashes emerged the National Indian Brotherhood, with a mandate to
represent the interests of status Indians, and the Native Council of Canada, representing Métis and non-status Indians.


27 Archives Canada, Record Group 29, Volume 2659, File 801-1-1, part 10. “Medical Services: Conferences, Committees and Meetings, General”. Memo to All Regional Directors from Director General, Program Management, Medical Services Branch, Re. Native Women’s Association of Canada, March 13th 1978.


31 Weaver, "The Iroquois: The Grand River Reserve in the Late Nineteenth and Early Twentieth Centuries, 1875-1945."


33 For an analysis of relationships between Indigenous protests in Canada during the 1970s and the international anti-colonial movement, see Rutherford, "Canada's Other Red Scare. The Anicinabe Park Occupation and Indigenous Decolonization."

34 Palmer, "The 'Discovery' of the 'Indian'," 396.


37 Palmer, "The 'Discovery' of the 'Indian',' 403.


41 Howard, "Dreamcatchers in the City: An Ethnohistory of Social Action, Gender and Class in Native Community Production in Toronto (Ontario)"; ———, "Women’s Class Strategies as Activism in Native Community Building in Toronto, 1950-1975."


44 Lawrence, "Real" Indians and Others: Mixed-Blood Urban Native Peoples and Indigenous Nationhood; Fiske, "Constitutionalizing the Space to Be Aboriginal Women: The Indian Act and the Struggle for First
Nations Citizenship."


49 Murray Sinclair, former co-Chair of the Manitoba Aboriginal Justice Inquiry and Current Director of the Truth and Reconciliation Commission, has written 'statistical evidence available [...] for Stony Mountain Penitentiary in Manitoba at the turn of the century shows that most of the Indian people who were incarcerated at that time were sentenced simply for practicing their traditional religions.' Murray Sinclair, Dealing with the Aboriginal Offender. Presentation to New Provincial Court Judges (Val Morin, Quebec, 1990), 5. Cited in Waldram (1997). See also Thomas Fiddler and James R. Stevens, Killing the Shamen (Moonbeam, ON: Penumbra Press, 1985).


51 It is not possible to provide useful comparative data on the total Aboriginal population over this time period due to changes in both census definitions and patterns of self-identification.


54 Ibid., 11.

55 Ibid., 14.


57 Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton

58 Mercer, "The Kenora Waystation." Centre for Addiction and Mental Health Archives, Box 41-03. Cited with permission from the archivist.

59 Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton

60 Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton

61 According to Elder Joseph Morrison, some Aboriginal people in the Kenora area had struggled with alcohol problems since the town was first established. Bootleggers were prevalent in the area prior to the Ontario government’s relaxation of prohibition laws in 1954. Morrison noted that alcohol
problems were particularly common amongst those who had attended one of the two residential schools in Kenora. Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton

Mercer is referring to reserve-based prohibition laws in effect on over 80% of Ontario reserves at this time. Mercer, "The Kenora Waystation."

Kenora began life as the Hudson’s Bay Company trading post of Rat Portage, established in 1861. As noted in Chapter One, the availability of alcohol in the region increased significantly after the mid-1880s, when the completion of the Canadian Pacific Railway facilitated an influx of independent fur traders many of whom also plied liquor.

Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton. 40m.

As discussed in Chapter One, changing prohibition policy and the growth of urban Aboriginal populations during the 1950s contributed to increasing alcohol consumption in Ontario cities. The Canadian state gradually lessened restrictions on Aboriginal alcohol consumption from 1951, and in 1954 Ontario legislation permitted Aboriginal people to buy and consume alcohol in licensed public venues. The Liquor Control Board of Ontario continued to ban Indians from buying liquor from stores until 1959, and it remained an offense for Indians to be intoxicated outside of a reserve until 1967 (at which time section 94 of the Indian Act was struck down by the Supreme Court).

Ojibwe leaders participating in the 1873 negotiations had specifically requested that Treaty 3 include a provision banning alcohol on reserve lands. A 1958 provincial proclamation allowed for reserves to hold referendums whereby a majority vote would legalize alcohol on reserves. But the threat of provincial police maintaining a stronger presence to enforce provincial liquor laws on “wet” reserves was a disincentive to many reserves, and by 1962, fewer than twenty percent of the reserves in Ontario had voted in favour of allowing alcohol.


Genosko and Thompson confirm that from the time Indians were given the right to drink in Ontario in 1954, they were over-represented in convictions related to ‘interdiction’ – ‘the process of listing “risky” individuals and groups found or believed to have immoderate drinking behaviours’. Indeed interdiction-related convictions did not occur in Ontario until 1949, and their increase overlaps with the period during which Indians were acquiring more rights to purchase and consume alcohol. Thompson and Genosko, Punched Drunk : Alcohol, Surveillance, and the L.C.B.O., 1927-75 16.

Mercer does not provide either population data or comparative figures for the settler population. Mercer, "The Kenora Waystation," 14.

Ibid.p.7


Sylvia Maracle, Oral history, July 9th 2010, Toronto. OH9.5.

Sylvia Maracle, Oral history, July 9th 2010, Toronto. OH9.5.

Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton


Mercer, G.W. 1970 The Kenora Waystation. Addiction Research Foundation

Mercer, "The Kenora Waystation." p.7 Autobiographical narratives are typically a central element of AA meetings, but Mariana Valverde disputes the characterization of such accounts as ‘confessional’, given the equally prominent tenet of non-judgement which determines the tone of meetings. Valverde
suggests that storytelling in AA is more about building a sense of community than about individual exoneration, and likens it to queer coming-out stories and personal narratives in support groups for survivors of abuse. Valverde, "The Power of Powerlessness: Alcoholics' Anonymous Techniques for Governing the Self," 130-33.


Mercer, "The Kenora Waystation."

Canadian Broadcasting Corporation, "Expedition. Expo '67's Indians of Canada."

Mercer, "The Kenora Waystation."

Other founding members, as recalled by Joseph Morrison, included his mother Ada Morrison, Bill Skead and Julia Skead, Doug Skead and Madeline Skead, Alex Skead and Elizabeth Skead, Robin Green and Mabel Green, and Sam Copenace and Mabel Copenace. Joseph Morrison and Louis Cameron joined the group around 1977, about five years after it was first formed.


Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton


Ibid., 99.


Burke, "Confrontation at Anicinabe Park."


Burke, "Confrontation at Anicinabe Park", 354-56.

Mark Anderson and Carmen Robertson, "The "Bended Elbow" News, Kenora 1974," American Indian Quarterly 31, no. 3 (2007); Burke, "Confrontation at Anicinabe Park."

Burke, "Confrontation at Anicinabe Park."

Anderson and Robertson, "The "Bended Elbow" News, Kenora 1974."

Ibid.


Nee’Chee is Ojibwe for “a close friend or brother”. Ontario Federation of Indian Friendship centres website, http://www.ofifc.org/ofifchome/page/Office.asp?FCID=16 accessed November 27th, 2009. Ne’Chee’s first Directors were Sam Copenace Sr., Joseph Morrison, Kitty Everson, Steve Skead, Christine Gordon, Len Hakenson (of the Addictions Research Foundation) and Derick Pitawanakwat.

Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton. OH20.1:2m.
According to Joseph Morrison, Allan’s daughter Jill also played a central role, developing the successful funding application to the Ontario Ministry of Health. Both Allan and Jill had long histories of involvement with the Native community in Kenora, and Joseph described Dr Torrie as someone who ‘always treated Native people with respect’, and had a good understanding of the challenges people faced in the urban setting and in seeking medical care. Elder Joseph Morrison, Oral history, November 28th 2009, Hamilton.


Rutherford, "Canada's Other Red Scare. The Anicinabe Park Occupation and Indigenous Decolonization."


Howard, "Dreamcatchers in the City: An Ethnohistory of Social Action, Gender and Class in Native Community Production in Toronto (Ontario) " See also Roger Obonsawin and Heather Howard-Bobiwash, "The Native Canadian Centre of Toronto: The Meeting Place for the Aboriginal Community for 35 Years," in The Meeting Place. Aboriginal Life in Toronto, ed. Frances Sanderson and Heather Howard-Bobiwash (Toronto: Native Canadian Centre of Toronto, 1997).

Sylvia Maracle, Oral history, OH 9.1, p.2

Sylvia Maracle, Oral History, OH9.2, 12m

Agenda, Seventh Meeting of the National Advisory Board on Native Alcohol Abuse, 23 June 1975. Archives Canada, Record Group 29, Volume 2684, File 801-2-N13 pt 9: ‘National Advisory Board on Native Alcohol Abuse’. Anduhyaun, the Native women’s shelter in Toronto, also received financial support from NAAP to establish an ‘Alcohol and Drug Abuse Program’ in 1976, but their funding was not renewed after the first two years.


Elder Vern Harper, Oral History Interview, May 5th 2009, Toronto, OH11.1. See also Howard, "Dreamcatchers in the City: An Ethnohistory of Social Action, Gender and Class in Native Community Production in Toronto (Ontario) ".

Joe Sylvester, "Oral History Interview Transcript (from a Videotaped Interview by Duke Redbird),"

Dimensions 1980.

Ibid.


Council Fire is the second friendship centre in Toronto. It was founded in 1978 by a group dissatisfied with programming at the Native Canadian Centre. Unlike the NCC, it is affiliated with the provincial umbrella body, the Ontario Federation of Indian Friendship Centres. Rebecca Hagey, "Anishnawbe Health Resources and the Indirect Approach," Nutrition Newsletter 1986.
The Phenomenon, the Explanations and the Responses: Metaphors Surrounding Diabetes in Urban Canadian Indians,

Social Science and Medicine 18, no. 3 (1984).


Anishnawbe Health Toronto, "About Anishnawbe Health Toronto."

King-Hooper and Hagey, "Control Issues in Native Health Care: Perspectives of an Urban Community Health Centre."
———, "Dreamcatchers in the City: An Ethnohistory of Social Action, Gender and Class in Native Community Production in Toronto (Ontario) ": 154


Howard, "Dreamcatchers in the City: An Ethnohistory of Social Action, Gender and Class in Native Community Production in Toronto (Ontario) ".

Toronto Native Oral History Project 1983c, cited in Howard

Howard, "Dreamcatchers in the City: An Ethnohistory of Social Action, Gender and Class in Native Community Production in Toronto (Ontario) ".

Elder Vern Harper, Oral History Interview, Toronto. OH11.1, 57m.

Jay Mason (son of Jim Mason), personal communication with researcher.

Howard, Heather ibid.: 245-46

Jay Mason (son of Jim Mason), personal communication with researcher.

Leslie Saunders, Oral history, OH24.1, 13m

Leslie Saunders, Oral history, OH24.1, 11m

Leslie Saunders, Oral history, OH24.1

Leslie Saunders, Oral history, OH24.1, 30m

Leslie Saunders, Oral history, OH24.1, 6m


Fournier and Crey report the results of a survey in Prince Albert penitentiary where over 95% of Aboriginal prisoners had been through the child welfare system. Fournier and Crey, Stolen from Our Embrace. The Abduction of First Nations Children and the Restoration of Aboriginal Communities, 90. See also PM Menzies, "Orphans within Our Family: Intergenerational Trauma and Homeless Aboriginal Men" (University of Toronto, 2005).

Saunders Saunders, Oral history, OH24.1, 37m


Ibid.:121-122

Ibid.: 123


Ibid., 15-18.

Cited in Ibid., 18.


Chapter 3 From Mental Hygiene to Family Healing: Mental Health Professionals, Aboriginal Parenting and Indigenous Resistance

Introduction

Colonial regimes around the world have historically expressed deep and abiding interest in Indigenous family relations, parenting practices and children. These issues have constituted an important site for the legitimization of colonization through discourses which construct colonized peoples as morally inferior. Such discourses then justify interventions by the colonial state, religious authorities and/or settler society into Indigenous family life. Anthropologist Bonnie McElhinny has noted that in colonial studies, ‘Childhood has more often been considered as a discursive symbol than as the substance of imperial policy’. Colonial studies scholars are belatedly analysing what Indigenous peoples have been arguing for several decades: how colonial regimes, in Canada and many other parts of the world, have practiced the coerced acculturation of colonized children as a central technique of colonial governance, removing Indigenous children from their families and communities and placing them in boarding schools, orphanages, children’s homes and white settler families. As discussed in Chapter One, such practices continue to the present day through child welfare systems’ treatment of Aboriginal families in settler states including Canada, the United States and Australia.

The striking historical endurance of practices of ‘rescuing’ Indigenous children, across different settler colonies and over periods of profound political and social change, should prompt us to analyse how legitimizing discourses shifted over time, in concert with dominant interests and a changing moral economy. In this chapter I approach this by considering the role of mental health knowledge and professionals, and Canadian public policy and programming in constructing Aboriginal parenting and childhood as legitimate sites for state intervention. As discussed in Chapter One, the rise of the profession of social work which accompanied the expansion of the Canadian welfare state post-World War Two was a crucial factor in the development of child welfare services and the professionally-legitimated large-scale removal of Aboriginal children from their families. In Section One of this chapter I draw on Canadian archival documents and international secondary sources.
and consider the role of psychiatry in legitimizing state interventions in Aboriginal families, including how psychiatric discourse has been taken up by other ‘helping’ professions within state systems of health care and child welfare.

Dominant discourses rooted in psychiatric knowledge have continued to frame Aboriginal family relations as a ‘mental health’ issue. In Section Two, I provide a detailed analysis of a transcript from a 1983 meeting of the Canadian Psychiatric Association Section on Native Mental Health, which vividly illustrates how psychiatric and allied professionals at that time continued colonial framings of Aboriginal parenting practices as pre-modern, potentially harmful and urgently in need of adaptation. At the same time some of the Indigenous people present at the meeting challenged the dominant accounts and assumptions about the legitimacy of state-authorised professionals’ interventions in Indigenous family life.

Such challenges coalesced in organized Aboriginal protests against state and professional interventions into the lives of parents and children. In Chapter One we saw how from the late nineteenth century onwards, many Aboriginal parents actively pursued educational opportunities for their children via the colonial and missionary systems, whilst protesting aggressive proselytization, poor living conditions and maltreatment in the residential schools. In Section Three, I consider Aboriginal activist, legal and scholarly perspectives on child welfare from the late 1970s onwards. Activists framed child welfare as an issue with the power to unite diverse Indigenous interests, and multiple Aboriginal organisations in Ontario and elsewhere challenged and opposed the assimilationist and racist assumptions underlying dominant discourse on Aboriginal children, developing their own approaches to the issues of family violence which centred on family healing.

In the wake of the International Convention on the Rights of the Child, adopted by the United Nations General Assembly in 1989, the well-being of children emerged as an issue which could potentially unite diverse political and policy perspectives, as well as activists. The political currency of children’s rights shaped Canadian federal policy in the early 1990s, even whilst international media accounts of the acute social suffering experienced
by Indigenous children (such as the Labrador Innu) were shaming and embarrassing Canada. These dominant political interests converged with the ascent of a mental health framework for explaining Indigenous distress, propelled by the Medical Services Branch first ‘mental health needs assessment’ of reserve communities, conducted between 1988 and 1991. This convergence produced the first Canadian policies to explicitly address Aboriginal mental health which, unsurprisingly, focused on children: Brighter Futures and Building Healthy Communities.

Aboriginal women in Ontario initiated their own analysis of family violence in the late 1980s, employing an explicitly political and historical perspective and profoundly challenging dominant representations which pathologised Aboriginal people and relationships. In the political context of a receptive new provincial government and unprecedented unity between provincial Aboriginal organisations, the Ontario Native Women’s Association’s work precipitated a transformative policy development process, which made inroads against state dominance and led to the Ontario Aboriginal Healing and Wellness Strategy in 1994. This was the first public policy in Canada to address Aboriginal healing, and was particularly significant in that it named colonialism as a major determinant of Indigenous social suffering in the present.

1. “Problem cases with no solution”: colonial psychiatry, Aboriginal parenting and children’s mental health

If the forced separation of Indigenous children and parents was a central practice of settler colonialism, psychiatric discourses both legitimized the continuation of this practice, and developed new forms of intervention to achieve the assimilation of Indigenous children. In his analysis of the career of John Cawte, pioneer of “Australian ethnopsychiatry”, Edmund McMahon demonstrates how psychiatric discourses can be read as part of broader socio-political discourses on assimilation, including the restructuring of Indigenous parenting practices and family relations. In his 1964 psychiatric field survey at Kalumburu, Western Australia, Cawte identified Aboriginal parenting practices as a source of mental disorders, arguing that Aboriginal practices of “group teasing and ridicule [...] inculcated narcissistic dynamics of fear and shame rather than ‘a constructive sense of guilt’.” Further, the
psychiatrist criticized Aboriginal parents’ excessive indulgence and failure to adequately discipline their children or ensure timely weaning, vaccinations and homework completion. Such critiques echo colonial medical discourses in multiple international settings which blamed Indigenous children’s health problems on the ignorance, moral weakness and overly indulgent behaviour of their parents (particularly their mothers), necessitating colonial interventions to “modernize” childrearing practices and ensure the appropriate development of children into governable colonial subjects. As McElhinny points out, such interventions “required scientific child-raising practices that increasingly drew on the opinions of male experts rather than mothers”.

Mid-twentieth century Canadian psychiatrists were also concerned with the perceived shortcomings of Aboriginal parenting practices. Archival documents show that psychiatrists in the ‘Mental Hygiene’ Division of the Canadian Department of National Health and Welfare were in regular dialogue with Indian Affairs during the late 1940s and 1950s regarding the ongoing project of assimilating Indigenous children. Dr Charles Stogdill, Chief of the Division of Mental Hygiene in the Canadian Department of National Health and Welfare, visited a residential school and an on-reserve day school at Shubenacadie, Nova Scotia in 1946. He later wrote to the Superintendent of Welfare and Training at Indian Affairs that the schools ‘impressed me very favourably indeed’. He was particularly delighted that the syllabus was organized to compensate for what he imagined to be the deficiencies of the Aboriginal children’s home environments:

*I was very pleased to see manual training and domestic science as part of the course even from early grades in the residential school, and that provision is made for such in the day school. In my opinion, that type of training is especially suitable for Indian children, as they will be helped in their grasp of abstractions by the use of materials, in measuring, etc., and as they haven’t the home background of verbalizing and reading that most white children have.*

Stogdill further commented, ‘it would not surprise me if Indian children on the whole have more trouble with academic work of the higher elementary school grades than white children’. Thus psychiatric discourse bolstered the assumptions embedded in educational policy of the inferiority of Indigenous parenting practices and family life, and the pragmatism of preparing Native children for work as manual labourers rather than careers requiring higher education.
Bureaucrats and professionals alike were so confident of the inevitability and desirability of assimilating Aboriginal children via the residential school system, that children who would not be assimilated were pathologised as abnormal. In 1947, Mr GH Gooderham, regional supervisor of Indian Agencies in Alberta, wrote to the Director of Indian Affairs Branch, on the topic of Aboriginal ‘juvenile delinquents’. In his letter Gooderham proposes a role for psychiatrists and sociologists in the diagnosis and treatment of Indian children’s failure to assimilate.

*There is an ever increasing need for psychiatrists and sociologists to study the history of and to advise on the treatment, care and education of Indian children, who for some reason cannot be properly adjusted to our present school set-up. There are no reform schools in this province and therefore no place for the incorrigibles. [...] Qualified sociologists and psychiatrists would study the cause of the unbalanced mental and physical condition in early life when it would be possible to correct it. It would be our recommendation that, before recommending the establishment of reform schools for Indian children, that trained sociologists be added to our school section and qualified psychiatrists to the Indian Health Service Branch of the Department of Health and Welfare. Problem cases with no solution have instigated this letter.*

These sources indicate that policymakers found psychiatric knowledge to be relevant and valuable in the management of Aboriginal assimilation via education and healthcare during the middle decades of the twentieth century. In my research I did not encounter primary or secondary sources which suggested a more significant role than this for psychiatry in shaping colonial policy and discourse on Aboriginal peoples during this period. However, with the expansion of the healthcare and welfare systems through the 1950s and 1960s, growing numbers of medical, social and ‘helping’ professionals including psychiatrists became increasingly significant participants in analyzing, explaining and addressing Aboriginal peoples’ ‘failure’ to modernize and assimilate as anticipated by policymakers.

In 1969 authors of the ‘Booz-Allen-Hamilton Report’ speculated that ‘there may be significant amounts of depression, despondency and neurosis among Indians’, and a 1976 memo from the Regional Director of MSB in Ontario noted a ‘greater than expected incidence of minor mental problems’ attributable to ‘the rate of cultural change and resulting huge generation gap, along with a different culture-related alcohol use’. From the late 1960s, Medical Services Branch regions across Canada began to send psychiatric
teams from southern universities to assess and treat Indigenous communities in northern regions, beginning in the Northwest Territories and the ‘Baffin Zone’. In northern Ontario the only psychiatric hospital, Lakehead in Thunder Bay, was far from accessible to most northern Aboriginal communities. Thus the ‘University of Toronto Sioux Lookout Zone Mental Health Programme’ was established in 1972 to provide the services of visiting psychiatrists to Native communities in the northwestern region of the province, which encompasses Cree and Ojibwe traditional territories and overlaps with Ninshnawbe-Aski Nation and Grand Council Treaty #3.

By the mid-1970s, increasing numbers of Canadian psychiatrists were treating Native patients on reserves and referring them to urban psychiatric hospitals for treatment. Perhaps reflecting this growing professional engagement, in 1972 the Canadian Psychiatric Association (CPA) notified Medical Services Branch of their interest to become more involved in policymaking for Aboriginal people. However it was not until the late 1980s that Medical Services Branch began to actively develop policy addressing Aboriginal mental health. In the interim, psychiatrists within the CPA initiated their own programme of activities under the auspices of the ‘Native Mental Health Section’, discussed in the next section.

2. The Canadian Psychiatric Association’s Native Mental Health Section & Aboriginal families, 1983

This section focuses on the Canadian Psychiatric Association Native Mental Health Section’s first annual meeting ‘The Native Family: Traditions and Adaptations’, held in Ottawa in 1983. I intend to show the extent to which psychiatric and associated professional discourse in the early 1980s continues to convey the colonial imperatives for Aboriginal people to modernize and assimilate, even whilst Indigenous activists and community leaders were challenging such assumptions in broader social and political fora. As we see below, Indigenous voices do challenge psychiatric dominance in the context of the meeting, but the enduring power of professional authority is also clear.

Psychiatrist Wolfgang Jilek started an informal group on ‘Native Mental Health’ within the Canadian Psychiatric Association (CPA) in 1975. Jilek was both studying and practicing
‘Native healing’ in British Columbia, and in 1973 published a book *Salish Indian Mental Health And Culture Change: Psychohygienic And Therapeutic Aspects Of The Guardian Spirit Ceremonial*. By 1978, the Native Mental Health group had 35 members, enough to become formally established as a ‘Section’ of the Canadian Psychiatric Association.

Dr Clare Brant, widely recognized as the first Aboriginal person in Canada to train as a psychiatrist, was appointed Chair of the CPA Section on Native Mental Health in 1982. Brant grew up in Tyendinaga Mohawk Territory in south-eastern Ontario, and trained as a physician at Queen’s University, graduating in 1965. He worked in geriatrics in Montreal and as a GP at Tyendinaga until the mid 1970s, when he ‘had some mental health issues of his own’ for which he sought treatment in London, Ontario. Thus began Brant’s abiding interest in psychotherapy. His sister Marlene Brant Castellano quotes Brant as saying that after years of intensive training to become a medical professional, it took more years of psychoanalysis to recover his identity as a Mohawk. During the latter part of the 1970s, Brant pursued training in traditional Freudian psychoanalysis, completing a four-year residency at the University of Western Ontario (U.W.O.). He was admitted to the Royal College of Physicians (Canada) in 1983 and took up an appointment as Assistant Professor at U.W.O. School of Medicine in the same year. Brant began to attend the Native Mental Health Section meetings with Jilek whilst still in training during the 1970s.

Under Brant’s leadership, the Native Mental Health Section expanded its focus from raising awareness about Native mental health among psychiatrists, to providing education for the growing numbers of Aboriginal para-professionals working on (broadly-defined) mental health and addictions issues at the grass-roots level, most of whom were Community Health Representatives and workers in the National Aboriginal Alcohol and Drug Addiction Programme (NAADAP). Annual meetings from 1983 onwards provided a forum for psychiatrists (at this meeting, all settlers with the exception of Brant), other health and social service professionals, and Aboriginal para-professional frontline workers to share ideas about Aboriginal suffering and healing. In 1990 the section became independent from the CPA and was incorporated as a non-profit organisation, the Native Mental Health Association of Canada, with Clare Brant as its first Chairman.
**Psychiatrists and ‘the Native Family’: assimilation, resistance and healing**

The Native Mental Health Section’s first annual meeting was held in Ottawa in 1983. Participants’ contributions reflect divergent interpretations of Indigenous experiences of modernization and assimilation, including the antecedents and processes, inevitability and desirability of these social processes. The psychiatrists, including Clare Brant, and a white children’s services coordinator participate in a colonial evolutionist discourse in which Aboriginal parenting practices are temporally located in a pre-modern period and judged to be of limited value and relevance in contemporary Canadian society. As child psychiatrist Paul Patterson explained on the subject of ‘Native child rearing practices’,

> All these [Indigenous] values had their function and had their purpose but I am also suggesting that some of them at this particular time in evolution may in fact be dysfunctional and maladaptive and, in fact, dangerous for our children.\(^{20}\)

From this perspective, Aboriginal people must ‘adapt’ their parenting practices if they are to raise their children to be functional members of dominant settler society. Failure to do so could, in fact, be seen as irresponsible. Clare Brant articulated this point in his discussion of how Native ethics shape child rearing practices. He identifies these ethics as respect for individual autonomy leading to non-interference; suppression of anger; withholding praise; instruction by modeling; and withdrawal in response to social stress.\(^{21}\) Brant shares the case of Steven, an Aboriginal teenager on his second admission to psychiatric hospital for a suicide attempt, describing the patient as ‘a delinquent adolescent characterized by lying, stealing, and aggressive behavior with minimal or no provocation’. According to Brant, the patient’s parents exhibited classical Native parenting behavior which is not effective in the context of Canadian society, and which was responsible for Steven’s social problems:

> [Steven’s parents’] opposing values to the larger culture easily explained the difficulties Steven is having in coping with the majority white society and attempting to find a place in it. In this particular case one must wonder whether the exercising of Native ethics and rules of behavior are a method of achieving personal enrichment and growth or whether or not they are used to sidestep responsibility for parenting which is to prepare the youngster for life in Canada in 1983.\(^{22}\)

Mr Winston Brant, a Mohawk probation office and a colleague of Brant’s from London, seems to support Brant’s analysis, pointing out that “it is hard to set up a behavior contract or whatever for the child when the parents don’t want to be interfering with them”.\(^{23}\)
In what can be read as a respectful critique of the psychiatrists’ decontextualised accounts of Native parenting values, George Desnomie, a counsellor from Winnipeg and a panelist at the meeting, spoke about the need to understand the social context of the value of non-interference, including the importance of grandparents, aunts and uncles, and the significance of changing livelihoods for family life:

*Child rearing is and was a community event or a community problem or it was a community involvement. Everybody had a hand in everybody’s children. [...] The child was not reprimanded for making mistakes, but it meant a great deal of involvement for us as adults. That meant we had to have a relationship with this child. When I asked people in Winnipeg, when I told them I was going to do this [presentation] they said “make sure you mention that the relationship was an ongoing everyday practice”. It wasn’t just in the evenings or after work of whenever things were appropriate with the child. It was an ongoing practice and they said to mention that love came from that ongoing involvement with the children.*

Whilst the session focuses on Aboriginal families’ experiences of ongoing and significant social disruption as a result of colonization, participants show surprisingly little interest in the actual historical processes whose effects are being discussed. Indeed, “colonization” is not named, and the psychiatrists convey an understanding of processes of modernization and assimilation as implicitly neutral or explicitly desirable. For example, in discussing Inuit settlement patterns in the Baffin region of the eastern Arctic, psychiatrist Eric Hood fails to mention the forced relocation of families whose sled-dogs were slaughtered to discourage them from returning. Rather, he represents urban settlement as the Inuit’s free, rationale and *correct* choice in favour of a modern lifestyle:

*Those communities began with the governments putting in some services, establishment of air bases, bringing in health services, schools and various other organizations. The people were naturally attracted to those places because they brought some benefits, especially in relation to health and survival.*

Despite the “naturalness” and desirability of urban settlement, Hood argues that it inevitably had negative implications for Inuit parenting: “some families still look after their children very well and others haven’t learned how to care for them in communities of several hundred or a thousand people”.
Psychiatrists at the meeting were also silent on the question of how the Indian residential schools and large-scale fostering and adoption of Aboriginal children by white families might have affected contemporary parenting practices. In his account of the work of Australian psychiatrist John Cawte, Edward McMahon similarly observes that Cawte completely failed to consider the possibly damaging effects of settler-colonial practices, such as the forced separation of parents and children via the "dormitory system" in mission communities, on Aboriginal family relations and mental health. Instead Cawte identified Indigenous culture and social relations as the source of pathology.

Other participants were less reticent in articulating the impact of residential schools on Aboriginal family life. George Desnomie noted that

> Native parents that are in practice right now, being parents right now are mostly parents that have come from a residential school education system, so I think it would be fair to say that the majority of parents now are learning on the job.

Maureen MacMillan, a settler-descendant panelist, was also moved to raise the residential schools issue. MacMillan was a coordinator of children’s services in Moosonee, with responsibility for probation, Children’s Aid and mental health programming. The schools in the Moosonee area of James’ Bay, St Anne’s and Bishop Horden Hall, closed in 1973 and 1964 respectively. MacMillan must have been aware of this very recent history in the communities where she worked. Whilst acknowledging that “some really horrific things [...] occurred at the residential schools” she is eager to explain away this pillar of Canadian colonial policy as simple human error:

> We all know that some very terrible errors have been made in the past regarding Native children. [...] Over the years I have looked at this and indeed the errors have been made, but I am not certain that you can say these bad things were done because those people are white, they did these bad things to the Indians. I think a very large element of it is those mistakes were made simply because they were human beings and human beings make mistakes.

This analysis exonerates those who participated in the colonial education and child welfare systems imposed on Native people by universalizing their behaviour as “human”, whilst obscuring the historical and continuing political, economic and professional interests at stake in the residential school system and other forms of colonial governance.
Some Aboriginal participants at the meeting affirmed the value of Indigenous parenting practices in contrast to those of the dominant society, and strongly articulated their concerns about the ongoing negative impact of dominant institutions on Aboriginal families. John Childs, Elder from Big Trout Late and former community health representative, described how ‘the educated Indians’ in his community were the ones struggling with parenting. In his view, white education had undermined parenting practices, and those who maintained their language were receptive to Elder teachings on family relations:

They don’t seem to listen to the Indian Elder because they have been taught by white people, white teachers and that is why they don’t listen to us. [...] The lower class ones, the non-educated ones they stick together and work together.31

Childs explained further,

the other non-educated people, these people understand me better than the ones that are educated because I talk Indian to them and I have a hard time trying to explain this in English, but I could do it in Indian just like that and I think that is the reason why these non-educated couples understand me better when I am talking Indian to them.32

Similarly, Mohawk Elder Ernie Benedict observed that ‘those that follow the traditional manner of living that these people have more stable marriages’.33 Benedict was also concerned about the increasing emphasis on competitiveness:

The cooperative lifestyle seems to be losing ground to this new competitive, this new aggressive kind, you might say confrontation kind of world view [...] and this has an effect on our young people and an effect upon the lives of young people and it really worries me.34

Another Aboriginal participant also emphasized the many strengths of traditional child rearing practices, and argued that Aboriginal parents’ excessive ‘borrowing’ of dominant parenting practices was causing harm in Indigenous communities. She cited multiple examples of colonial social practices which she believed were contributing to abusive parenting: a lack of value for elders, unrealistic behavioural expectations of very young children, expectations that biological parents (including single parents) should assume sole responsibility for children, corporal punishment and maintaining a rigid feeding schedule.35

Mr Sam Gargan, a Deh Cho man from Yellowknife, delivered one of the strongest critiques of ‘outside institutions’ dominating Indigenous lives. Gargan spoke in response to a story
shared by Children’s Services Coordinator Maureen Macmillan about Betty, a young woman in Moosonee with a history of having her children removed by Children’s Aid. Macmillan described how Betty called her one Saturday night and asked her to take the children while she was drinking. Macmillan refused, telling Betty that she was not a bad person but was behaving badly, and that she needed to take the children to their grandmother. In Macmillan’s account, by reframing the situation and by setting limits on her willingness to intervene, she helped Betty to positively change her behavior.

But Gargan challenged Macmillan’s portrayal, insisting on a broader frame of reference which problematised the very presence of Macmillan and her programmes in Betty’s community:

*I guess what the girl in her mind thought at that time presumably was that you were assuming the responsibility of that child, for that matter any social problems that happen. I guess what is happening now in the communities is that among the Native people there are too many outside institutions that are assuming responsibility for the Native people. [...] The institutions that are now in place, I guess it is not working, both for the Native people and for the white people. They are creating too much of a dependency. I guess what I just wanted to direct you in is that if you left the Native people alone, you will find out how responsible Native people are.*

Other Aboriginal participants also raised important critiques about the effects of colonial institutions and practices, but stopped short of questioning the value and relevance of colonial professional knowledge for resolving the challenges faced by Indigenous families, suggesting the enduring authority of medical professionals.

For their part, the psychiatrists alternated between emphasizing the importance of Aboriginal people taking on frontline roles in the delivery of mental health services, and reinforcing the inherent value of psychiatry, which Eric Hood described as ‘special kinds of knowledge’. In Hood’s view, the ‘role for the outside professionals is to try to be the consultants and have ideas and discuss cases with people as they carry on case responsibility’, whereas ‘local Native workers’ were best equipped for service delivery. Maureen MacMillan also emphasized that Native people’s problems were often of an innate nature requiring biomedical expertise:

*I don’t think if everyone just picked up and walked away, that all of a sudden Native people would solve their problems. There are genuine mental health problems, that are
Notably absent from the psychiatrists’ contributions was any suggestion that settler professionals should change their ways of working with Indigenous families. Early research on ‘cultural competence’ was beginning around this time. Mary Louise Evans, a nurse from Vancouver with a recent degree in medical anthropology and health services planning, raised a lone voice to advocate for ‘culturally appropriate education of professionals’, referring to her experience of teaching nursing students ‘culturally appropriate psychiatric care’. Evans argued that ‘this is an area as professional people that we need to see as vital in the preparation of professionals who will be working amongst other cultures.’

This contribution frames conflicts between white professionals and Aboriginal communities as a problem of inadequate expertise, rather than resulting from colonial policies and the illegitimacy of interventions. Reverend Cuthand, an Aboriginal pastor from Regina, appeared to support Evans’ point, by emphasizing the time and training required for an outsider to build ‘rapport’ and ‘empathy’ with any Indigenous community. Apart from these two contributions, the idea that professionals might require additional knowledge, skills and experience beyond their conventional training to work effectively with Aboriginal families was not entertained in the meeting.

There seemed to be a consensus amongst participants regarding the value of Native workers in providing child and family services, and the need for more of them in Aboriginal communities. But challenges were identified during the course of the meeting. First, some participants observed that Native people don’t always respect Native workers. Maureen MacMillan put it thus:

I often got a sense among the Native people, not necessarily clients, but broader, that if it was a Native person who was in that job, in that position, be it a probation officer, Children’s Aid worker, mental health worker, then he really couldn’t be very good, because he was Indian or she was Indian.

Bernice Desnomie shared her own experience of having her expertise devalued by Native people who appeared to favour white professionals: ‘sometimes that is a real sadness about being Native is that we don’t have confidence in our own people and our own ability to do things’.

These comments highlight the particular challenges for Indigenous helping
professionals and paraprofessionals in the context of a continuing racist hierarchy within the health professions. Psychiatrist Paul Patterson thought this problem might be related to Native workers assuming ‘white mannerisms’:

Particularly with Native counsellors [...] in trying to train them sometimes we induce them to model themselves after us. Thus instead of being able to process and assimilate the information that we have and then impart it as one Indian talking to another Indian they take on the mannerisms of the white man and collect some of the resentment properly due us in that regard.43

Further, participants did not have a shared view of the type of knowledge needed nor of the most appropriate way for it to be conveyed. Cynthia Sewell, an Aboriginal alcohol and drug worker from New Brunswick spoke strongly against removing Aboriginal people from rural and isolated communities for university education, arguing that ‘on the job training is the way to do it.’ In her experience, those who traveled out of the community for long-term training were often ostracized upon their return, and at any rate the education received was typically of limited relevance:

They have been away a long time, their ways have changed but boy you are looking at three years to unlearn a bunch of stuff that is not helpful and to learn the hard way the helpful stuff that is pertinent to their particular community.44

This analysis has shown that in the early 1980s, some Aboriginal workers and community leaders articulated resistance to dominant professional portrayals of Indigenous families as pathological, and assimilation as positive and necessary. Whilst Mohawk psychiatrist Clare Brant attempted in his work to locate Indigenous values and practices in social and environmental contexts, he also participated in the dominant psychiatric discourse at this time regarding the imperative for Indigenous people to adopt the values of Canadian settler society. To resist this inevitable process is presented here as not only futile but, particularly for Indigenous parents, irresponsible. As the next section shows, many Indigenous people opposed this framing.

3. Indigenous & academic critiques and the emergence of Aboriginal-controlled child welfare services
As described in Chapter Two, Indigenous organizations in Ontario and elsewhere in Canada began to assertively protest and re-shape child welfare practices towards Aboriginal
families during the late 1960s and 1970s. Two reserves in Rainy River District (northwestern Ontario) facilitated a reorganization of the relationship with child-welfare agencies, recognising the entire community as responsible for child welfare and providing support to all parents. These reserves were able to recover children who had been removed and placed in institutions, and to halt the removal of further children. Aboriginal communities in Manitoba and Saskatchewan established child-welfare committees to enhance local decision-making and control. The Sandy Bay Child Care Committee in Northern Saskatchewan was so effective in their community organizing that they were able to halt the removal of children from their community within a few years.

At the Canadian Indian Lawyers Association’s first national conference in Winnipeg in April 1980, participants spoke passionately about how the issue of Aboriginal children’s rights and welfare should unite status and non-status Aboriginal groups, a recognition of the disproportionate number of Métis children in care. Mr Doug Cuthand, a Cree man from the Federation of Saskatchewan Indians, described the loss of children suffered by Aboriginal communities:

We have lost more people through child welfare than through marriage. Children are adopted and taken off band lists. So then Indian people have non-Indian last names: German, Ukrainian, etc. And Indian Affairs strikes them off the list. We don’t know who they are. How can we find them?

The conference produced many ideas for change, centred on increasing Aboriginal control over child welfare. The next year (1981) Dakota-Ojibwe Child and Family Services in southern Manitoba became the first state-recognised, Aboriginal-controlled child welfare agency in Canada, and assumed responsibilities previously carried by three Children’s Aid Societies.

Critical voices also emerged from the social work profession. The Canadian Council on Social Development (previously the Canadian National Council on Child Welfare, founded in 1919) published studies in 1980 and 1983 describing serious problems with services for Native children, in particular the over-representation of Native children in provincial and territorial welfare systems. In 1981, University of Manitoba Social Work Professors Pete Hudson and Brad McKenzie published an important paper entitled ‘Child Welfare and
Hudson and McKenzie argued that the child welfare system was an agent of colonization, assuming the role previously performed by the colonial education and health care systems of removing children from their home communities and cultures. Dominant approaches in child welfare were systematically undermining Indigenous cultures and parenting practices, and obscuring the importance of land claim resolution and economic control in shaping social conditions in Aboriginal communities. Hudson and McKenzie also cautioned that Indigenous control of child welfare is not a panacea, and that efforts to promote decolonizing practices, adequate allocation of resources, and concomitant progress on land claims and economic self-sufficiency, would be essential to avoid the replication of existing problems within Aboriginal agencies.

Kenn Richard, a Métis social worker who studied with Pete Hudson at the University of Manitoba, recalls that Gus Ashawasega invited him to get involved with a group in Toronto who were meeting to discuss issues around Aboriginal families’ experiences of child welfare and Children’s Aid in the mid-1980s. In Ontario, the 1985 Child and Family Services Act proclaimed “Indian and Native people should be entitled to provide, wherever possible, their own child and family services, and that all services to Indian and Native children and families should be provided in a manner that recognizes their culture, heritage and traditions and the concept of the extended family”. The Aboriginal group meeting in Toronto was able to persuade provincial officials that child welfare programming specifically for Toronto was warranted, although the Act only made provision for reserve-based communities. In 1987 the group successfully lobbied the Ontario government for a moratorium on all adoptions of Aboriginal children by non-Aboriginal families. The Toronto-based group of volunteers developed Native Child and Family Services of Toronto (NCFST) between 1985 and 1988, and provincial funding commenced in April 1988. Gus Ashawasega was the founding president, and Kenn Richard continues to be Executive Director to-date. NCFST is the only off-reserve child welfare agency in Ontario directly controlled and managed by the Native community. During the 1990s, staff at NCFST developed innovative programmes aimed at supporting Aboriginal families and preventing the apprehension of children, based on an historical analysis of
contemporary challenges. In 2001 NCFST launched a successful legal case against the provincial government which led to the agency being granted a child protection mandate in 2004, the first and only off-reserve agency to-date to have that statutory responsibility.

4. Canadian policy, mental health & Aboriginal children
The early 1990s saw the emergence of ‘Aboriginal mental health’ in Canadian public policy discourse, with a specific focus on Aboriginal children. In 1988 Medical Services Branch initiated a two year national ‘mental health needs assessment’ which expanded the definition of Aboriginal mental health, previously invoked most often in relation to Indigenous suicide in northern and reserve communities. The needs assessment also led to the first federal policy initiative to employ the language of Aboriginal mental health, ‘Brighter Futures’. The assessment was conducted in First Nations reserve-based and Labrador Inuit communities, and so excluded other Inuit communities, off-reserve and urban First Nations peoples, and Métis communities. In Ontario despite the existence of ‘Native mental health workers’, Medical Services Branch (MSB) had no regional staff with responsibility for mental health, so four or five staff were seconded from Ontario’s Community Mental Health Programme to lead the development of a model for a continuum of on-reserve mental health services. According to one of those seconded, social worker Frank McNulty, the goal of the needs assessment and subsequent consultation was to provide sufficient evidence to convince the federal Treasury to fund comprehensive Aboriginal mental health programming.

The resulting 1991 report Agenda for First Nations and Inuit Mental Health acknowledges suicide as ‘the symptom of malaise which has attracted the most attention [to Aboriginal mental health], in part because it is the one, countable, unarguable demonstration of a problem situation’. But the report goes far beyond suicide in its broad definition of the emerging field of Aboriginal mental health. One of the first policy documents to invoke an Indigenous understanding of social suffering, this holistic conceptualization is then used as an entry point to establish a broad definition of mental health as encompassing every imaginable expression of individual and collective distress. Thus the report begins by asserting that
Among the First Nations and Inuit communities the term mental health is used in a broad sense of describing behaviours which make for a harmonious and cohesive community and the relative absence of multiple problem behaviours in the community, such as family violence, substance abuse, juvenile delinquency and self-destructive behaviour. It is more than the absence of illness, disease or dysfunction – it is the presence of a holistic psychological wellness which is part of the full circle of mind, body, emotion and spirit, with respect for tradition, culture and language. This gives rise to creativity, imagination and growth, and enhances the capacity of the community, family group or individual to interact harmoniously and respond to illness and other adversity in healing ways that resolve conflicts constructively, promote improved function and the healthy development of children.  

Note that this wide-ranging definition bears some resemblance to the Indigenous concept of healing discussed in previous chapters, but lacks the latter’s explicit analysis of historical factors shaping suffering in the present. This expansive conceptualisation of mental health, attributed to First Nations and Inuit communities, then provides the basis for the report’s authors to stake out a broad range of experiences of social suffering as the domain of mental health: accidents, violence, homicide, suicide, over-representation in prisons, family violence, child sexual abuse, children’s ‘failure to achieve’, depression, children in the care of child welfare, substance abuse, and neurological damage resulting from impaired births are all defined as ‘mental health problems’. Further, the report observes that mental health problems must be related to broader social economic context, but rather than urging action to address Indigenous peoples’ economic inequities, argues that poor living conditions and high rates of unemployment render ‘assistance to the behavioural area the more imperative, for it will significantly affect the ability of the communities to use economic opportunities’ [my emphasis]. Despite the authors’ presumably good intentions, compared with earlier Indigenous analyses of suffering and healing, this discourse presents a de-politicised analysis focused on individual-level interventions whilst bracketing the need for fundamental change in social and political structures.

Aboriginal children’s mental health in Canadian policy and programming

Brian Mulroney’s Conservative government subsequently produced the policy ‘Brighter Futures’, which bore little resemblance to the mental health report’s recommendations but was entirely consistent with an emerging focus on children in domestic and international policy discourse. Mulroney’s government had a strong rhetorical focus on ‘child poverty’: 
in 1991 it ratified the United Nations’ 1989 Convention on the Rights of the Child, and controversially redirected $50 million from a promised national childcare programme to address child poverty and the prevention of child abuse. Announced in May 1992, Brighter Futures focused on Aboriginal child development and included elements addressing mental health and injury prevention. Regional Medical Services Branch staff who had worked on the mental health needs assessment were reportedly dismayed by this outcome. In an interview conducted as part of the current research, MSB social worker Frank McNulty described Brighter Futures as an ‘ill-conceived, politically motivated initiative that sabotaged a lot of the work that we had done and our plans’ and ‘watered down the mental health movement’. In effect, Brighter Futures replicated the National Aboriginal Alcohol & Drug Abuse Programme (NAADAP) model by creating a federally funded, community-based para-professional position in the complete absence of service infrastructure:

The whole continuum of services... assessments, diagnosis capacity, intervention capacity, case management follow-up capacity: those dimensions weren’t conceptualised at all. So you created a position. You gave some money to them and so you had a Brighter Futures worker and a NAADAP worker.

In an oral history for this project, Sylvia Maracle recalled how urban Indigenous agencies participated in discussions in the early 1990s which began to focus on mental health, against the backdrop of the MSB mental health consultation and Brighter Futures (both of which excluded urban and off-reserve populations), and in the context of the work on the Ontario Aboriginal Healing and Wellness Strategy:

Culture was very much part of our consciousness now, we were sort of in full recovery mode, [...] so let’s talk about holistic approaches, [...] words we used in Ontario were ‘Family Healing’, [...] how do we support the person with the problems in the context of his or her family and that environment. [...] There was a lot of emphasis in the mental health strategy talking about how important this was to improve the lives of children and there are huge costs of course, [...] in apprehending children. So people who wanted to go to treatment, right, ended up losing their kids because there’s nobody, how do you take care of them when you’re going into treatment? (By the way, that’s still an issue). And so part of this notion in the mental health discussion [...] was how good would this be for our kids, how amazing would it be for children to be raised in homes where there wasn’t addictions, where there wasn’t family violence, where there wasn’t, you know, issues in terms of related behaviours, of criminal justice and things like that, right. And so that seemed to be a very powerful motivator, and maybe it was sort of articulated too well. And the fact of the matter is that’s what Cabinet did grab on to, right. So we’re
trying to say, there are all these savings to the system if we look at treating people from a mental health perspective, and I remember using the analogy of [...] the onion, you know, you peel back one thing and it’s the next, you peel back, you peel back, let’s get right to the core of some of these things and try to deal with them.64

Thus from Indigenous perspectives, community-based addictions and social programmes established through the late 1970s and 1980s both generated momentum towards healing, and drew Aboriginal communities’ attention to a host of inter-related and complex social problems, particularly family violence, sexual abuse, and the neglect of children. ‘Mental health’ held out the promise of a comprehensive framework which would validate the seriousness of suffering in Aboriginal communities and respond holistically to these interrelated forms of social suffering. And as Maracle articulates, centering this model on the well-being of children and getting ‘right to the core’ of complex social problems created a ‘powerful motivator’, and the basis for an apparent consensus which, superficially at least, appeared to respond to the needs of both cost-cutting governments promoting emotive rhetoric about child welfare, and Aboriginal communities seeking financial resources to support healing programmes.

Whilst ‘Brighter Futures’ was exclusively for reserve-based First Nations communities, the federal government allocated resources for parallel programmes for urban children, the Community Action Plan for Children and the Canada Prenatal Nutrition Programme. The federal government has consistently abrogated responsibility for urban Aboriginal programming, so it is unsurprising that the needs of Aboriginal children were not addressed in these policies. However the Ontario Federation of Indian Friendship Centres (OFIFC) negotiated with the NDP provincial government for 30% of the federal funds allocated for Ontario to be set aside for urban Aboriginal children.65 The resulting programmes continue in the present day, administered through Ka:Nen (Mohawk for ‘seeds’) out of Thunder Bay, and supported by the Métis Nation of Ontario, Ontario Native Women’s Association and the OFIFC. Ka:Nen oversees the management of approximately ninety off-reserve Aboriginal Community Action Programs for Children (CAP-C) and Canada Prenatal Nutrition Programs (CPNP).66 During the same period the Ontario government created a pilot programme called ‘Better Beginnings’. Under this provincial
programme *N'Swakamok* was established in the Friendship Centre in Sudbury, which had 'twenty staff one day and fifty staff the next day'; this programme also continues to function under Aboriginal direction. Described as a 'prevention programme for high risk communities', its goals are:

Prevention: To reduce the incidence of serious long-term emotional and behavioural problems in children. Promotion: To promote the optimal social, emotional, behavioural, physical and educational development in children. Community Development: To strengthen the ability of communities to respond effectively to the social and economic needs of children and their families.

On one level, the discursive focus on promoting 'optimal development' and preventing behavioural disorders in individual Aboriginal children responds to Indigenous commitments to improving the quality of children's lives in the context of the ongoing suffering of families and communities. At the same time, such discourse diverts attention from the state's responsibility for perpetuating historical and contemporary structural contributors to Indigenous suffering.

Further, as Susanne Miskimmin observes in her analysis of an urban Aboriginal Head Start programme, interventions with Aboriginal families structured around concepts of risk management and prevention have certain continuities with colonial relations and practices. Miskimmin notes that the community-based programme developed its own culture and practices influenced by dominant values and institutional goals which were sometimes at odds with those of the community members using the service. In particular, her analysis reveals a tension between caregivers' prioritisation of cultural education, and programme goals of fostering normative (dominant society) parenting and identifying 'high-risk children' for treatment. Health Canada aggressively promoted a construction of "family" which implicitly privileged the nuclear family, for example restricting participation in the programme's social activities to those residing with the child. Miskimmin notes that the programme's conception of participation often manifested as 'education' with a goal to correct assumed deficiencies in the mothers', and that caregivers often resisted professional evaluations aimed at assessing children's 'special needs' which might impact 'school readiness'. She interprets some caregivers' non-involvement in the programme
as a form of resistance to the imposition of dominant social values and attempts at molding parental behaviour.

‘Communities in Crisis’: suicides, solvent abuse and Aboriginal mental health

Inconsistencies between Canadian political rhetoric on children’s rights and children’s welfare on the one hand, and the extreme suffering experienced by many Aboriginal children and youth on the other, became increasingly public during the early 1990s. In January 1993 -- the year in which the federal government designated a ‘National Children’s Day’-- Innu children sniffing gasoline in an unheated shack in Davis Inlet were recorded on video which was aired internationally. International headlines such as ‘Davis Inlet: Canada’s Third World’ were profoundly embarrassing to the government. An addictions counsellor who had resided in Davis Inlet for two years told CBC radio:

*The level of mental health here is extremely low, it’s scary. We know what the problem is, we live in it every day, and we also know the solutions, and the solutions are treatment for these children, for their primary disease, and their families.... The primary disease is addictions: these children are addicted to solvents.*

Such framings call attention to extreme forms of Indigenous suffering, underscore the need for urgent intervention, but offer an astonishingly narrow analysis, establishing the inevitability of an individualistic, medicalised and short-term response. In a contrasting analysis, anthropologist Colin Sampson (whose historical analysis of Innu sedentarization and social suffering was discussed in Chapter One) discusses the extent to which health professionals working with the Innu systematically deny the historical and political contexts of Innu suffering. He concludes that these health professionals ‘either cannot or will not acknowledge the larger contexts of the misery occurring all around them’. Rather, health professionals routinely employ a discourse which blames parents and other individuals for making bad choices, with the implication that ‘these troubled Innu could extricate themselves from their afflictions through taking positive actions, exercising restraint, and facing up to their personal problems’. Samson also illustrates how workers in the healthcare system have launched verbal attacks on the characters of local Indigenous leadership without acknowledging how colonially-imposed system of governance and the broader political context have created exploitative power relations within communities.
In addition to widely-publicised cases of Aboriginal children abusing solvents in reserve-based communities across Canada, a series of ‘suicide clusters’ drew further domestic and international attention to Indigenous suffering in 1993. Shortly after the Innu children’s solvent abuse was publicized, the media reported that nine young people in the Aboriginal community of Big Cove, New Brunswick had committed suicide since July 1992; a further 75 people within the same community had attempted suicide, all within a period of less than one year. The inquest report identified a ‘lack of adequate housing ... as one of the major factors in the suicides’.77 In June 1993, the Department of Indian and Northern Affairs added funding for nine new houses in addition to the ten already promised for 1993 -- approximately 70 less than the number of houses identified by the people of Big Cove as urgently needed.78 By 1995, Canadian smugness induced by the United Nations’ description of Canada as “the best place in the world to live” was undermined by the UNICEF report *The Progress of Nations*, which reported that the suicide rate among Aboriginal people in Canada was the highest in the world at 100 per 100,000, and that 105 Aboriginal youth had taken their own lives between 1986 and 1990.79

In June 1994, the fledgling policy paradigm of Aboriginal mental health was given additional impetus when the recently-elected Liberal federal government announced Building Healthy Communities, presented as a policy response to suicide and solvent abuse in on-reserve First Nations communities. In an oral history Al Garman of First Nations and Inuit Health Branch (formerly Medical Services Branch) confirmed that

*the pressure [for Building Healthy Communities] came from suicide, suicide rates, because we’ve always had the impression that it was horrendous. We’ve really never had good solid data, but there was a growing concern about this and I think it was a grass roots growing pressure.*80

The programme’s focus is to provide support for First Nations and Inuit communities to develop ‘community-based approaches to mental health crisis management’.81 Building Healthy Communities formalized the role of ‘mental health workers’, whose remit includes ‘assessments, counseling services, referrals for treatment and follow-up treatment, aftercare and rehabilitation to individuals and communities in crisis’. As with Brighter Futures, there remained a lack of corresponding infrastructure to support the workers.
Also in the early 1990s, ‘short-term emergency mental health counseling’ was added to the list of ‘non-insured health benefits’, such as medical transportation, dental care and prescriptions, which the federal government would subsidise for First Nations people with Indian Status and Inuit. This service has a ‘very small budget’ attached, and guidelines specifically exclude psychiatric services and psychoanalysis. Social workers and psychologists provide most of such services and coverage typically does not extend beyond twelve visits.

Other federal initiatives responding to Aboriginal ‘crises’ and focusing on children in reserve communities followed during the mid-1990s, including the creation of eight youth solvent abuse treatment centres, and a national Aboriginal youth suicide strategy. In some regions government officials began to involve Aboriginal leaders in co-management and programming decisions during this period. For example, Al Garman as Director of Atlantic Region began to work directly with the Atlantic Policy Congress, a forum of First Nations Chiefs, from 1994; Alberta followed suit shortly after. The growing involvement of Aboriginal leaders contributed to an increasing realization amongst policy makers that existing addictions services were inadequate: the long-running NAADAP focuses too narrowly on addictions and Medical Services Branch does not provide detox services, considered a provincial responsibility. At the same time the concept of ‘concurrent disorders’ was beginning to circulate in policy circles: as Al Garman described it, a “newfound understanding that people with addictions sometimes have other mental health issues”. With the growing prominence of mental health in policy discourse, policymakers began to acknowledge that despite the existence of some programming through Brighter Futures, Building Healthy Communities, and counselling services through Non-insured Health Benefits, there was a lack of long-term professional mental health care for on-reserve Aboriginal communities. According to Al Garman, during the late 1990s, Health Canada officials intended to press Cabinet to commit six or seven million dollars towards this development, but in 1998 those funds were reallocated to the Aboriginal Healing Foundation. Garman speculated that the work of the Aboriginal Healing Fund may have ‘in a sense offset the need for professional services’. These and subsequent policy developments are discussed in Chapter Four.
5. Reframing Aboriginal family violence: invoking colonialism in healing discourse

In 1990, the Ontario Native Women's Association (ONWA) released its report *Breaking Free: A proposal for change to Aboriginal family violence*, the first attempt by an Aboriginal organisation to initiate a research-based public discussion of the issue of family violence in Indigenous communities. This report was one of several important precursors to unprecedented changes in provincial policy facilitated by Aboriginal organizations in Ontario during the early 1990s, which succeeded in establishing Aboriginal healing as a responsibility of the provincial government. The 1994 Ontario Aboriginal Healing and Wellness Strategy resulted from the merger of two initially distinct policy processes: the Aboriginal Family Healing Strategy (inspired by ONWA's report) and the Aboriginal Health Policy. Urban Aboriginal groups led by the Ontario Federation of Indian Friendship Centres were centrally involved in the processes which led to the Ontario Aboriginal Healing and Wellness Strategy in 1994. Below I analyse the significance of the ONWA report and describe important political context to the Aboriginal Healing and Wellness Strategy, before focusing on the policy development process, including the shifting relationship between Aboriginal organizations and the Canadian state (as manifest in the provincial government of Ontario), and the emergent policy discourse on Indigenous suffering and healing.

ONWA's report locates the reportedly intensifying problem of interpersonal violence in Aboriginal families in the context of Indigenous peoples’ subjugation to foreign dominance and lack of control over their own lives, highlighting the need for an Aboriginal justice system and self-government. Whilst not naming colonization, the report discusses the effects of particular colonial policies, including how residential schools undermined parenting skills, the disruptive and destructive effects of the disenfranchisement of Aboriginal women and the bureaucratic domination of everyday life. Poverty, unemployment and alcohol abuse are also identified as important factors influencing family violence, but is the lack of self-government which is identified as the core problem.

The ONWA report recognizes that increasing willingness to publicly discuss family violence (and public funding to facilitate such discussion) in Canadian society contributed to Aboriginal communities acknowledging that this issue was also a problem for them.
Across North America and Western Europe, politicians and publics were paying increasing attention to issues of domestic violence by the mid-1980s.88 Funding for ONWA’s research was provided by the Ontario Women’s Directorate, which from 1986 led a five-year provincial strategy on domestic violence and sexual assault, including funding to community organizations for research and programming. At the same time, the ONWA report insists on the need for a distinct approach to Aboriginal family violence, and discusses the limitations of dominant feminist and state framings of the issue. In particular, the authors question the implications of the criminalization of family violence for Aboriginal communities, citing Aboriginal people’s lack of trust in Canadian police forces and the broader justice system, which are permeated by ongoing racism.99 Further, they object to the practice of isolating the perpetrators of family violence: whilst recognizing that the safety and well-being of those abused must be paramount, they emphasise that (usually male) perpetrators also need care, and the issue must be viewed as a collective problem.

In addition to the ONWA report, other contextual factors contributed to the emergence of Aboriginal healing as an object of public policy in Ontario. First, the centre-left New Democratic Party (NDP), elected to power in Ontario for the first time in October 1990, showed an early commitment to developing more collaborative ways of working with Aboriginal groups. The NDP government expanded substantially on the previous Liberal government’s tentative efforts at developing relationships with Aboriginal organizations during the late 1980s, which in the health sector resulted in funding support for Anishnawbe Health Centre in Toronto and the establishment of a Native Health Coordinator in the Ministry of Health in 1988 (discussed in Chapter Two).90 The NDP had shown a commitment to Aboriginal health prior to election with their influential January 1990 report ‘First Come, Last Served: Native Health in Northern Ontario’.91 The new government produced convincing evidence of their commitment to broader Aboriginal issues with the 1991 ‘Statement of Political Relationship’, the first formal recognition by any Canadian government of Aboriginal peoples’ inherent right to self-government, which had the important effect of raising Aboriginal political players’ expectations of a more respectful relationship with government.92
The on-reserve impact of federal cuts from the 1980s onwards was a second factor facilitating the unprecedented collaboration of Ontario Aboriginal groups with divergent interests. With the resulting severely diminished services on reserves, First Nations leaders in Ontario overcame longstanding anxieties about the federal government off-loading its responsibilities and became more receptive to engaging with the provincial government.\textsuperscript{93}

\textit{Changing dynamics in Indigenous-state relations}
These processes of policy development incorporated new, often unprecedented, and at times transformative levels of collaboration between Aboriginal peoples and the Canadian state. This was particularly evident in the work of the Joint Steering Committee on Aboriginal Family Violence, formed in 1991 by seven Aboriginal organizations and nine provincial Ministries.\textsuperscript{94} Suzanne Dudziak’s 2000 PhD thesis provides a detailed account of the history of these processes and their eventual merger into the Aboriginal Healing and Wellness Strategy.\textsuperscript{95} I draw on her work and on sources obtained through my own research in the following analysis.

Dudziak describes how from the outset, Aboriginal participants in the Joint Steering Committee on Aboriginal Family Violence conveyed a clear set of principles and practices which were to form the basis of a changed Indigenous-state relationship. One of these was the need for Aboriginal leadership: this was achieved partially through the appointment of Sylvia Maracle as Aboriginal Co-Chair of the Steering Committee. Another was the establishment of an Aboriginal caucus which met separately before all joint meetings, fostering unity amongst the diverse Aboriginal organizations participating. The need for government to commit sufficient resources for meaningful consultation with Aboriginal communities was clearly conveyed and accepted by government participants.\textsuperscript{96}

Government acceptance of consensus-based decision making as part of the Committee’s terms of reference was fundamental to the shift in power dynamics which occurred during this process. In Dudziak’s analysis this approach presented major challenges for government participants, who were accustomed to working in a more hierarchical manner, and who lacked both the clarity of vision and delegated authority of the Aboriginal
participants. One of the government participants in Dudziak’s study recalled the extent to which she and her colleagues had to learn to take individual responsibility for decision-making, and Aboriginal Co-Chair Sylvia Maracle’s effectiveness in facilitating this:

*I think the Aboriginal Co-Chair just made us feel so guilty (laughter) [for not being able to commit to a decision] that we would go around again to do something about it. Even that was valuable because just the big ability that she had [...] especially when you had sat in a caucus meeting on hour before, “We can’t give in this way, and we don’t have that money and there’s no way they’re even going to consider doing that.” And then you come out of the joint meeting, yes, in fact you were now going back and doing a briefing note saying, “We need to do such and such and so and so.” [...] that was important because I think we learned to do more, we wouldn’t have stretched that far had we not had to reach consensus and look good to everybody, because you know when you sit in a government meeting all you have to do is impress X ministry or whoever else you’re working with, but here you had to make sure that all these Aboriginal agencies were happy too. [...] It was really a significant period for me. I learned a great deal.*

Government participants also expressed appreciation for the value of Indigenous knowledge in enhancing both the process and content of policy development. An informant in Dudziak’s study described how the Elder Lillian McGregor’s participation not only ‘brought dignity and respect’ to the process, but also ensured that the historical, political and cultural contexts of the work remained prominent in the minds of those involved.

Another major ideological shift for government participants was the acceptance of a non-standardised process for community consultation. The Aboriginal organisations were able to persuade government of the importance of each of them following their own distinct consultation process, in order to best meet the needs of their respective constituencies. Dudziak argues convincingly that political will at the senior level enabled government support for this decentralized approach. The process of consultation was also facilitated by Aboriginal organisations’ generosity in sharing resources with one another, in order to meet the different needs of the many different Aboriginal groups in Ontario and ensure marginalized voices were given the opportunity to speak. The resulting consultation in 1992 was the largest ever undertaken with Aboriginal people in Ontario, involving over 7,000 participants from 250 communities.

Finally, Sylvia Maracle described to me how, in a powerful expression of the extent to which participating civil servants’ consciousness had shifted over the course of the process,
they agreed that they were not entitled to speak to Cabinet on behalf of Aboriginal people. In an unprecedented development which violated the principle of Cabinet secrecy, not only was the submission jointly drafted by all members of the Joint Steering Committee, but Sylvia Maracle, an Aboriginal community leader and someone completely outside of the structure of government, attended three Cabinet committee meetings and a Cabinet meeting to present the proposed strategy on behalf of Aboriginal Committee members.

**An Indigenous re-framing of violence and suffering**

In discursive terms, the Aboriginal Healing and Wellness Strategy was significant for its framing of Indigenous suffering as the legacy of colonialism, and its definition of family violence and healing in Indigenous terms. In an oral history shared as part of the current research, Sylvia Maracle recalled the process by which this occurred after the community consultation was completed. At that time the Committee was floundering: it was a particularly challenging stage in the work and many members were falling sick. The pervasive expressions of pain conveyed during the consultation were overwhelming:

> 7000 community people telling us, every one of them, men women and children, that they had been a victim of violence in their life, and that that violence came in many forms, including how we see ourselves on television and how we read about ourselves in books and how we’re taught about ourselves in school.

Recognising that they were having difficulty in moving forward with the work, Committee members agreed that Sylvia Maracle would take tobacco to four traditional people to seek their guidance on how to move forward with the strategy. The traditional people whom she consulted each offered similar advice to the Committee: “make what you are doing positive”. They should not dwell on interpersonal violence, but rather focus on healing. Recognition of the colonial origins of contemporary violence and suffering was a crucial part of this analysis: “there are roots that go back a long way: those are the roots of the colonizer. They don’t have to do everything forever, because we’ve learned to emulate them”. With the help of Elders Edna Manitowabi and Kathleen Green, Sylvia conveyed this message to the group during a three-day retreat of all members of the Joint Steering Committee at Elmhurst, at which the Aboriginal organizations were sharing the contents of their respective consultations. Discussion at this event constituted a significant turning
point: participants were now able to move beyond the experience of processing the enormous outpouring of pain provoked by the consultation. Sylvia reflected to me, “it was very cathartic. We really did purge ourselves of pity and fear.”

Dudziak’s account confirms that it was at this retreat that the Committee first conceptualized the central role of colonization in understanding contemporary interpersonal violence. The group took the time to develop meaningful definitions of family healing, community membership and wellness, which moved away from the dominant terms and concepts used by the Ontario Women’s Directorate as well as the broader social discourse of the time, such as ‘assault’, ‘abuse’ and ‘perpetrators’, which were perceived as too narrowly negative and not encompassing Indigenous experiences.

The 1993 strategy document “For Generations to Come” reflects this analysis, with a definition of family violence as

\[
\text{consequent to colonization, forced assimilation, and cultural genocide, the learned negative, cumulative, multi-generational actions, values, beliefs, attitudes and behavioural patterns practiced by one or more people that weaken or destroy the harmony and well-being of an Aboriginal individual, family, extended family, community, or nationhood.}
\]

Meanwhile, work on the Ontario Aboriginal Health policy had progressed in parallel to the development of the Family Healing Strategy. As Dudziak describes in her account, although the two policy development processes were different in some respects, both were characterized by unprecedented levels of collaboration between First Nations and off-reserve groups.

**The Ontario Aboriginal Healing and Wellness Strategy**

In 1994, whilst both the Aboriginal Family Healing Strategy and the Aboriginal Health Policy were in the final stages of approval, the political climate shifted. With the end of their term in sight and opinion polls indicating rapidly declining popularity, the New Democratic government moved into pre-election mode and a “growing mean-spiritedness” began to prevail. The latter was likely exacerbated by the newly-elected Liberal Federal government’s aggressive discourse on state cost-cutting in the name of deficit reduction. In these charged circumstances, the Ontario Cabinet took a unilateral decision to merge the
two Aboriginal initiatives. Whilst Aboriginal participants accepted the pragmatism of this decision as an alternative to axing both initiatives, the government’s utter failure to involve the Aboriginal organisations in this decision-making process constituted a serious breach of trust and undermined the substantial good will that had been accrued through the join processes to that point. This last-minute shift reflects both the intractability of a political culture which reverted to form under pressure, and a failure in leadership on the government side, such that no senior person emerged to champion the floundering policy. Given these conditions, the Ontario cabinet’s approval of the Aboriginal Healing and Wellness Strategy in June 1994, with a budget of $49.5 million over five years, is probably the best outcome that could have been hoped for.

Despite the significant discursive shift represented by the explicit recognition of ‘colonization’ and ‘cultural genocide’ in the new policy, its Ministerial announcement in the legislature signaled the continuation of an ahistorical neoliberal discourse on Aboriginal victimhood and economic solutions. Minister for Native Affairs Bud Wildman’s announcement of the new policy to the Ontario Legislative Assembly invokes neither colonization nor history in general, beyond self-congratulatory references to work initiated at the beginning of his party’s term in government. Rather his 2.5 page speech focuses on establishing the ‘tragedy’ of Indigenous suffering in Ontario, the ‘shared grief and frustration’ at the ‘waste of human potential’, and asserting that ‘programs to deal with family violence, mental health, substance abuse, crisis prevention and training of Native health care professionals’ are the appropriate solutions to these problems. At the same time he makes repeated references to the goal of Aboriginal self-government, for which ‘healing’ is seen as a necessary prerequisite. Wildman also is careful to note the ‘favourable economic impacts’ of the strategy, including the creation of 600 service jobs and 195 construction jobs.

These themes are equally taken up by Dalton McGuinty in his response for the Liberal opposition. McGuinty is quick to reinforce Wildman’s account of ‘very serious social problems’ in Aboriginal communities, ‘conditions you can only categorize as desperate’, and ‘the terrible realities facing our first nations people’ (my emphasis), shored up by
invocations of grim statistics (relating to the whole First Nations population in Canada) regarding suicide rates, alcoholism, and foetal alcohol syndrome.\textsuperscript{116} He notes that the new policy represents a precedent in the level of control exerted by Indigenous community leaders: ‘I think we have to capitalize on the expertise, so to speak, of the Aboriginals themselves and to give them more control – that’s the long and the short of it – in terms of dealing with and addressing their own particular problems’. McGuinty simultaneously minimizes Indigenous knowledge with the qualifier ‘so to speak’, and frames it in financial terms, revealing that the instrumentalist approach to ‘partnership’ promoted by the increasingly dominant neoliberal ideology of the day is less about respecting Aboriginal sovereignty than it is about cost-saving.

So whilst the content of the Aboriginal Healing and Wellness Strategy shows a reframing of historical context in public policy, the official discourse surrounding the launch indicates that concepts of reconciliation and reparations were not yet politically salient in the Canadian context in 1994. The policy did however have important discursive and material effects, in combination with the preceding 1991 Statement of Political Relationship, signaling Ontario’s commitment to support self-government and recognise the distinct entitlements of Indigenous peoples, beyond assimilationist and liberal multicultural models.\textsuperscript{117} And the policy supported the establishment of multiple new sites for Indigenous healing, including eight new Aboriginal health centres in cities, which will be discussed in Chapter Six.

\textbf{6. Conclusion}

Their children’s suffering became a powerfully unifying concern for Indigenous peoples in Canada from the late 1970s onwards. The management and assimilation of Indigenous children has been a focal interest of the Canadian state and settler society throughout the twentieth century, as for many other colonial regimes. From both Indigenous and dominant settler-colonial perspectives, mental health knowledge, discourses and practices have been invoked in discussions of Indigenous children’s well-being. In this chapter, I have both historicized and problematised such invocations, with particular attention to how mental health discourses serve to legitimize state interventions into Indigenous lives,
focus on individual behaviour at the expense of structural factors, and privilege biomedical discourses and western psycho-social models over Indigenous knowledge.

As we saw in Section One, mid-twentieth century psychiatric discourse validated and reinforced colonial perspectives of Indigenous family life as inherently inferior to Euro-Canadian social relations, insufficient to prepare children for assimilation into Canadian society, and potentially inducing mental disorders. By the early 1980s, some Canadian psychiatrists had learned to speak more respectfully about Indigenous values and parenting practices. Mohawk psychiatrist Clare Brant made important contributions in locating Native ethics in their social, historical and environmental context, challenging earlier, more blatantly racist framings. But the over-arching assumption among psychiatrists and other ‘helping’ professionals continued to be that Aboriginal people must ‘modernise’ on the terms of dominant society: to resist the forces of assimilation was not only futile, but irresponsible to one’s children. As shown in Section Two, this professional discourse is strikingly ahistorical and apolitical, framing coerced assimilation as ‘cultural change’, and continuing to view resistance to assimilation as abnormal, even pathological.

From the 1970s onwards, Indigenous activists and some community leaders and paraprofessionals began to publicly oppose dominant framings of Native child welfare. Like some of the participants at the 1983 meeting of the Canadian Psychiatric Association Section on Native Mental Health Association in Ottawa, they articulated valid and valuable critiques of dominant models for familial relations, asserting the legitimacy of Indigenous parenting practices and calling attention to the ongoing damage to Native lives caused by dominant institutions and professions. Aboriginal people established their own organisations, such as Native Child and Family Services in Toronto, asserting their right to oversee the well-being of their children and maintain Indigenous values whilst doing so. Whilst naming colonialism as the force behind the child welfare system’s treatment of Native families, Hudson and McKenzie cautioned in a 1981 paper that Indigenous control of child welfare is not a panacea, and that the challenge of supporting Aboriginal families must be framed in the broader political context of self-determination.
The field of Aboriginal mental health claimed new ground during the early 1990s by co-opting Indigenous perspectives on the interconnectedness of various forms of social suffering. At the same time the emerging discourse on Aboriginal mental health failed to incorporate the historical analysis central to Indigenous healing models. The resulting paradigm identified behavioural interventions as paramount, whilst neglecting the historical and structural factors underlying Indigenous social suffering. Nevertheless, the Aboriginal mental health model appealed to many urban Indigenous agencies because of its value in both calling attention to social suffering and recognizing that issues such as addictions and children’s well-being were inter-related. Thus mental health discourse became an important component of urban Aboriginal family healing projects. But as we have seen, such projects may continue to implicitly promote parenting models based on dominant values, thereby undermining Indigenous ontologies.

In Ontario, the development of the 1994 Aboriginal Healing and Wellness Strategy reflected significant shifts in power relations between provincial Aboriginal organizations and the state, and the growing recognition of colonialism as an important determinant of contemporary suffering. Whilst these shifts were in some senses transient, there have also been some lasting effects in the province, most notably in the ongoing joint management of the Aboriginal Healing and Wellness Strategy. This policy process also involved an unprecedented (although ultimately unsustained) degree of collaboration between diverse Aboriginal organizations representing different constituencies and interests. Whilst Indigenous knowledge influenced both the development and the content of the policy, culminating in the reframing of dominant concepts of ‘family violence’ and ‘health’ in Indigenous terms, political discourse affirmed the continuing dominance of ahistorical colonial models of Aboriginal suffering. In the next chapter we consider the definitive emergence of Indigenous history and healing into the realm of Canadian public policy in the late 1990s.
End-notes to Chapter Three

1 McElhinny, ""Kissing a Baby Is Not at All Good for Him": Infant Mortality, Medicine, and Colonial Modernity in the U.S.-Occupied Philippines," 183.


5 Ibid.: 33.

6 McElhinny, ""Kissing a Baby Is Not at All Good for Him": Infant Mortality, Medicine, and Colonial Modernity in the U.S.-Occupied Philippines."  

7 Ibid.: 189.

8 Archives Canada, Record Group 29, Volume 333, File 436-3-4: 1945-1956, Mental Health Division.


11 This is not to say that the interface between psychiatry and Canadian settler colonialism is not a fruitful topic for historical research, but rather that sources seem to be lacking regarding this interrelationship in the context of national policy discourse. For researchers interested in this issue a more productive direction might be to focus on psychiatric institutions, i.e. provincial psychiatric hospitals. According to archival documents 296 Indian patients were treated in 35 different provincial institutions over 79,820 patient days during 1947-48. An institutional focus has been used in historical research in African colonial settings. See for example Jackson, Surfacing Up: Psychiatry and Social Order in Colonial Zimbabwe; Sadowsky, Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria. See also Vaughan, "The Madman and the Medicine Men: Colonial Psychiatry and the Theory of Deculturation." Archives Canada, Record Group 29-Vol 333-File 436-3-4: 1945-1956, Mental Health Division.
Division. Memo Feb 8th 1949 to Dr Stogdill from Dr PE Moore, Director of Indian Health Services, Dept of National Health and Welfare.


14 Aboriginal people in need of mental health care in the densely urbanised region of southern Ontario were presumed to benefit from 'easy access to the medical centres and well known institutions of Southern Ontario'. Medical Services Branch Ontario Region 1977 Annual Report, p.4

15 The programme was added on to a pre-existing University of Toronto programme providing medical services in the region, established in 1969.


17 Professor Marlene Brant Castellano, oral history interview, March 22nd 2010, Tyendinaga. OH27: 8m.

18 Professor Marlene Brant Castellano, communication with researcher, January 30th 2011.

19 Professor Marlene Brant Castellano, oral history interview, , March 22nd 2010, Tyendinaga. OH27. Following the death of Clare Brant in 1995, Bill Mussell became the Chairman of the NMHA and continues in that position at the time of writing. The association has moved away from its origins in psychiatry and the current Board is comprised of psychologists and social workers.


21 Ibid.: 30-34

22 Ibid.: 36


24 Ibid.:46-48


27 Ibid.
29 Canadian Psychiatric Association Section on Native Mental Health, The Native Family: Traditions and Adaptations. Transcribed and Edited Proceedings of the 1983 Meeting of the Canadian Psychiatric Association Section on Native Mental Health, 47.
30 Ibid., 22, 12.
31 Ibid.:4
33 Ibid.:6
34 Ibid.: 6
35 Ibid.:24-25
37 Ibid.: 9
38 Ibid.: 26
39 Ibid.: 23
40 Ibid.: 27
41 Ibid.: 17
42 Ibid.: 63
43 Ibid.: 64
44 Ibid.: 27
47 Teillet, "Children Lost through Welfare."
49 Mr Cuthand is referring to the Indian Act provision which required status Indian women to relinquish their status upon marriage to a non-status man, repeal(Declaration of Principles, Child and Family Services Act)ed in 1985 Bill C-31.
50 Teillet, "Children Lost through Welfare."
52 Hudson and McKenzie, "Child Welfare and Native People: The Extension of Colonialism."
Dr Brenda Wattie, former Director of the Department of Health’s Mental Health Division and recently-appointed Director of the newly-established ‘Mental Health Advisory Services Unit’ within Indian and Northern Health Services, coordinated this work.

Frank McNulty, Oral history, November 26 2008, Toronto. OH4, 20m


Ibid., 6.

A later section of the report discusses ‘historical context’. Ibid., 16.

Ibid. Executive Summary, 4.

Also in 1989 the 1st edition of the report on the ‘Health of Canada’s Children’ was produced by the Canadian Institute of Child Health

Frank McNulty, Oral history, November 26 2008, Toronto. OH4, 34m; 39m

Frank McNulty, Oral history, November 26 2008, Toronto. OH 4, 47m.

Sylvia Maracle, Oral history, Toronto, April 17th 2009. OH9.3, 4m.

Sylvia Maracle, Oral history, Toronto, April 17th 2009. OH9.3


Sylvia Maracle, Oral history, Toronto, April 17th 2009. OH9.3, 10m.

http://www.betterbeginningssudbury.ca/ accessed September 21 2010


Ibid., 118.

Ibid., 121.


Ibid., 111.

Ibid., 112.

Ibid., 113.


Ibid., 125, f.n.71.


Al Garman, Oral history, November 13 2008, Ottawa, OH4:


Al Garman, Oral history, November 13 2008, Ottawa. OH3: 52m

Al Garman, Oral history, November 13 2008, Ottawa. OH3: 22m

Al Garman, Oral history, November 13 2008, Ottawa. OH3: 34m
As discussed in Chapter Two, ONWA was founded in 1972 and represents a large network of local Aboriginal women’s organizations located both on and off-reserve. Ontario Native Women’s Association, *Breaking Free: A Proposal for Change to Aboriginal Family Violence*. 

Ibid., 7-9.

Ibid., 22-23.


Under Premier David Peterson, the Liberal government (1985-1990) established a “Policy framework for Native Affairs’ in 1985 which provided cautious endorsement of greater provincial government provision of Aboriginal-specific programs based on principles of self-determination and self-reliance, but with multiple caveats such as ‘each ministry is free to determine the degree of its involvement’, and “to the extent ministry budget allocations and program planning permit”. The 1987 Ministry of Community and Social Services ‘Strategic Plan of Services to the Native Community’ articulated principles of Aboriginal ‘self-direction’, recognition of ‘differences in Native communities’, and cultural ‘appropriateness and protection’, and hinted at equity: ‘equal treatment may necessitate special provisions’. Off-Reserve Native Services Policy Working Group 1988-90 #21, File B318921, Record group 29-153, Archives of Ontario. Perhaps the most significant example of provincial collaboration with Aboriginal organizations during Peterson’s government was the collaboration between Aboriginal organizations and the Ministry of Education on the development of a post-secondary education strategy in 1988.


Ibid.

Aboriginal organizations were the Association of Iroquois and Allied Indians, Grand Council Treaty #3, Nishnawbe Aski Nation, the Union of Ontario Indians, the Ontario Federation of Indian Friendship Centres, the Ontario Métis Aboriginal Association, and the Ontario Native Women’s Association. Ministries included the Attorney General, Citizenship, Community and Social Services, Education, Northern Development and Mines, Housing, Health, Solicitor General/Corrections and the Ontario Women’s Directorate and Ontario Native Affairs Secretariat.


Ibid., 166.

Ibid., 171-72.

Ibid., 186-87.

Ibid., 173-74.

Ibid., 175.


Eight Aboriginal organizations first met with the Ministry of Health’s newly-established Aboriginal Health Office in December 1991 to plan towards developing an Aboriginal Health Policy. This led to the formation of a Health Policy Working Group comprised of the provincial Aboriginal organizations and the Ministry of Health, and community consultations (which some Aboriginal organizations combined with the AFH consultations).


Government key informant quoted in Ibid., 203.

Ibid., 204-06.

Ibid., 202-09.


For example, policy principles include the statements ‘Aboriginal people are distinct and not part of a multicultural mosaic’, and ‘Nothing in this policy suggests either directly or by implication the consent of the First Nations or Aboriginal communities to any amendment in the meaning and intent of their original treaties or Aboriginal rights or to any measure that would constrain or prevent the full implementation of their treaties or Aboriginal rights.’ Ontario Ministry of Health, "New Directions. Aboriginal Health Policy for Ontario.," ed. Ontario Ministry of Health (Toronto1994), 15.

Chapter 4  Aboriginal Healing and the Canadian State: Trauma, Invocations of History, and Indigenous Victimhood, 1990-2010

The Aboriginal People in Ontario define family violence as consequent to colonization, forced assimilation, and cultural genocide, the learned negative, cumulative, multi-generational actions, values, beliefs, attitudes and behavioural patterns practiced by one or more people that weaken or destroy the harmony and well-being of an Aboriginal individual, family, extended family, community, or nationhood.

Aboriginal Family Healing Joint Steering Committee, Ontario, 1993¹

Canada's history as a non-colonizing power, champion of constructive multilateralism and effective international mediator, underpins an important and distinctive role among nations as they seek to build a new and better order.

Foreign Affairs and International Trade Canada, 1995²

Introduction

Tension between Canada’s self-promoted image as international peacekeeper and haven of multiculturalism on the one hand, and Indigenous experiences of historical and ongoing colonization on the other became increasingly untenable for the Canadian state during the 1990s. Developments in Indigenous-state relations in Canada, emergent international political discourses on reconciliation, a new provincial government heralding a significant shift in the ruling political ideology in Ontario, and the federal government’s efforts to contain the mounting legal challenge from former residential school students combined to facilitate the ascent of “Aboriginal healing” as a central concept in Canadian public policy. Beginning with Ontario’s Aboriginal Healing and Wellness Strategy in 1994, discussed in the last chapter, and culminating in Prime Minister Stephen Harper’s official apology for residential schools in 2008 the Canadian state initiated a series of measures and committed significant resources to addressing ‘Aboriginal healing’ as a new-found policy goal.

This marked shift in Canadian Aboriginal policy discourse needs to be understood in the context of several important developments in international political cultures and relations between Indigenous peoples and the Canadian state over the past two decades. This
chapter provides insight into the dynamics of Indigenous-state relations during this period, highlights the antecedents and implications of the ascent of historical trauma in the moral economy, and explores the contradictions inherent to state policy and discourse on Indigenous healing. Federal policy on reparations for residential schools has developed during a decade-long process spanning three governments and characterized by strong leadership by the Assembly of First Nations, a focus on legal and financial solutions to problems of Indigenous suffering, and a marginal role for Indigenous knowledge and other national Indigenous organizations. At the same time, Métis and Inuit have engaged strategically with dominant discourses to articulate their peoples’ distinct experiences of colonization and linked entitlement to resources in support of healing.

The next section provides important political and theoretical background, focusing on the heightened Indigenous-state conflict in Canada during the 1990s, the emergence of residential school abuses into public consciousness, and a critical analysis of the international rise of an ideology of state reparations and reconciliation. Section Two looks at how the work of the Royal Commission on Aboriginal Peoples and a growing number of Aboriginal mental health professionals contributed to the emergence of residential schools as a focal point and historical trauma as a central concept in Indigenous healing discourse. In Section Three I analyse the development of federal policy addressing Aboriginal healing from the late 1990s, and consider the disconnect between dominant and Indigenous understandings. Section Four resumes the critique of reconciliation and reparations ideology introduced in Section One, focusing on Canadian policy. Here I problematise assumptions about the inherently healing nature of testimony, explore divergent perspectives on the discursive effects of the national apology, and consider the evidence that the reparations model has been harmful rather than healing. Finally, Section Five considers how the discourse on trauma and residential schools has constrained Indigenous subject positions and facilitated the rise to prominence of Indigenous victimhood, and explores the implications of this development.
1. Background
The early 1980s saw several significant developments in relations between Aboriginal peoples and the federal government. Indigenous peoples gained an important political tool in 1982, after a prolonged campaign led to the Canada Act’s enshrinement of ‘existing Aboriginal and Treaty Rights’ in the Constitution. In 1983, the parliamentary committee commonly known as the “Penner Committee” advocated recognition of Aboriginal rights to self-government. The first part of the 1980s was characterized by an emerging cross-party consensus on Aboriginal issues in parliament, supported by increasingly positive and informed media coverage of Aboriginal issues. But good will and broader support for Aboriginal self-determination was gradually eroded during the latter part of the decade. MP Elijah Harper’s strategic opposition to the Meech Lake accord in the Manitoba legislature in 1990 powerfully illustrated the ‘hardening of relationships’ between national Aboriginal organizations and federal and provincial political leaders.

Indigenous protest and the international shaming of Canada
The stand-off between Mohawk protestors and the Canadian military at Kahnesatake in 1990 served both as inspiration to greater Indigenous solidarity across Canada, and a vivid illustration of the continuation of anti-Aboriginal racism in settler society. During the winter of 1990, women from Kahnesatake first occupied 'the Pines', traditional Kahnesatake land and site of an ancient cemetery, which was threatened by the planned expansion of a golf course. 'Their vigil was vocal but peaceful, a statement of heritage and heresy voiced without the guns that attract media attention'. The mayor of the adjacent settler town of Oka obtained a court injunction and police were directed to remove the women in June. In response, the women requested support from the Mohawk Warrior Society in erecting road blocks and occupying an addictions treatment centre. In solidarity with the Kahnesatake protest, Kahnawake Mohawks blocked Mercier bridge between Kahnawake and Montreal for twenty-seven days. Journalist Richard Wagamese wrote

Native groups across Canada have become enlightened and encouraged by the actions of the Mohawks. There is a deep-rooted sense of Aboriginal solidarity that has never existed in Canada before. Oka has become a symbol, both to the Indians and to mainstream Canadians, of the failures on the part of government to provide a fair and equitable place for the Indians in the Constitution and society at large.
The Kanehsatake resistance gave new impetus to the languishing issue of Aboriginal land claims, including relevant policy developments in British Columbia and the establishment of the ‘Indian Specific Claims Commission’ with Harry LaForme as its first commissioner.\textsuperscript{8} A collection of works analyzing and celebrating the Kahnesatake resistance published in 2010 is testimony to the enduring significance of this event in Indigenous consciousness.\textsuperscript{9}

The Kahnesatake stand-off attracted an unprecedented level of national and international media attention and an outpouring of anti-Aboriginal sentiment towards the protestors. The latter behaviour is in no way exceptional in Canada, although the extent of media coverage of this particular conflict was unprecedented. Canadian settler-descendants, police, and media have shown racism, hatred and violence towards protestors in multiple conflicts over Indigenous land entitlements, from Anicinawbe Park in 1974 to the ongoing dispute in Caledonia, Ontario.\textsuperscript{10} During the Kahnesatake protest, counter-protestors around both the Kahnesatake site and the occupied Mercier Bridge burned effigies of Mohawks and attacked the Aboriginal protestors with rocks and bottles.\textsuperscript{11} Although many Aboriginal protestors were charged, the police failed to charge any of the counter-protestors. For many Canadians, lacking both an understanding of and an interest in Indigenous perspectives on colonial history, Aboriginal protestors symbolize a dangerous threat to “law and order” and the sanctity of private property.\textsuperscript{12} Much of the media coverage of Kahnesatake fuelled such perceptions.

Critical international media coverage of Oka added further fuel to an increasingly powerful international discourse on Indigenous rights in which Canada was frequently singled out as a major violator. Damning reports from the United Nations and international non-governmental organizations through the 1990s (and into the present day) brought pressure to bear on the Canadian state to address longstanding Indigenous grievances.\textsuperscript{13} Both internationally and within nation-states, decades of Indigenous peoples’ activism resulted in the intensification of political gains from the mid-1980s onwards. The International Labour Organisation’s Convention on Indigenous and Tribal Peoples, 1989 (no. 169) entered into force on September 5, 1991. The United Nations declared 1993 as the International Year of the World’s Indigenous People, which was followed by the first
International Decade of the World’s Indigenous People (1995-2004). Individual settler states from New Zealand to Mexico granted increasing political recognition to Indigenous rights during the same period.\textsuperscript{14} Canadian federal and provincial governments’ failure to respond adequately to the Royal Commission on Aboriginal Peoples’ 1997 final report stoked international and domestic criticisms of the Canadian state’s inaction on Indigenous rights, as I will discuss in Section Three.\textsuperscript{15}

\textit{Healing and reconciliation as state-building projects}

Canadian policy on Aboriginal healing emerged in the context of an increasingly widespread international ideology of reparations and reconciliation from the 1980s.\textsuperscript{16} National and transnational state apologies, war crimes tribunals, and truth and reconciliation commissions proliferated, constituting national and international projects aimed variously at truth-telling, identifying perpetrators, making amends to victims, and unifying post-conflict societies. Between the early 1970s and the early 2000s approximately twenty truth and reconciliation commissions were established globally.\textsuperscript{17} Major political transformations including the collapse of the Soviet Union, and post-Cold War transitions from authoritarian to elected forms of governance in Latin America and Eastern Europe gave rise to new public discussions about the politics of memory and history, and the possibilities for justice for historical oppressions.\textsuperscript{18} Some scholars have identified national reconciliation projects as responses to a generalised international crisis of sovereignty amongst postcolonial states.\textsuperscript{19} In settler colonies including post-Apartheid South Africa and Australia, such discourses were mobilized in projects which were simultaneously about putting closure to collective pasts sullied by state violence, and constructing newly unified national identities. In Canada, federal government reparations made to the National Association of Japanese Canadians in 1988 for the internment of 22,000 Japanese Canadians during World War Two established a national precedent for the Canadian state’s response to collectivities seeking redress for historical injustices.\textsuperscript{20}

In policy addressing reparations for residential school experiences from 1998 onwards, Canada followed the lead of other settler colonies by linking “healing” and “reconciliation” in public policy discourse, making both implicit and explicit claims to the therapeutic effects of state-sponsored reconciliation processes. Australia”s second national “Sorry Day”
was subtitled a “Journey of Healing” in 1999, and in 2005 “Sorry Day” was renamed as the “National Day of Healing”. Annual Australian Sorry Days involve Indigenous and settler Australians marching together, intended as a gesture of solidarity and recognition of the violence of colonial history. The South African Truth and Reconciliation Commission (1996-1998) recognized “the healing potential of telling stories”. At a 1998 international psychotherapy conference hosted by the South African Medical Research Council in the wake of the South African Truth and Reconciliation Commission (TRC), mental health professionals from outside of South Africa consistently lauded the TRC for its presumed positive effects on mental health, whilst failing to invoke a single piece of empirical evidence of such effects.

Historians, anthropologists, and other scholars have offered varied interpretations of the ascent of this international discourse broadly concerned with redressing historical injustices. Some scholars have celebrated the globalization of human rights and emergence of new international moral standards, anticipating universally positive effects of reconciliation and reparations processes for individuals and nations alike. Others have responded more cautiously, arguing the need to question how this “new moral order” is being used to legitimate powerful states and contemporary and ongoing injustices. Anthropologist Nandini Sundar observes that “in the process of attributing culpability to others, including their past selves, through apologies and truth commissions, powerful states often conceal their own culpability in the present”. Sundar identifies multiple problematics and analytic entry points in international political discourse in support of her argument for a more rigorous “anthropology of culpability”. Questions need to be asked, she argues, about processes for determining “appropriate unit of reparation --whether entire countries, communities, or individuals”; about the competition between historical entitlements based on expropriation of resources, and current entitlements based on need; and about competing representations of history which provide the bases for determining victimhood and culpability. Further, Sundar questions how processes dominated by a legalistic paradigm of individual culpability can effectively consider societal processes. As we shall see, all of these questions are relevant in the Canadian context.
Residential schools & the Royal Commission on Aboriginal Peoples

In October 1990, shortly after the stand-off at Kahnesatake was resolved, Chief Phil Fontaine discussed his experiences of abuse at residential school in a televised interview. By this time former residential school students had already launched several law suits alleging sexual and physical abuse in the schools, and Indigenous and non-Indigenous authors had published books and articles on the history of the residential schools, bringing the issue to the attention of the Canadian public. During the late 1980s former students of St George’s Residential School and St Joseph’s Mission, both in British Columbia, lodged charges of sexual abuse against former staff of the schools. (This followed the emergence around 1980 of a trend for First Nations to pursue land claims through litigation, rather than through the federal claims process.30) The same period saw the publication of Ojibwe writer Basil Johnston’s autobiographical account of life at St Peter Claver’s School in Spanish, Ontario, and historical accounts of residential schools in British Columbia: St Joseph’s in Williams Lake and the Kamloops Residential School.31 Fontaine, at that time head of the Assembly of Manitoba Chiefs, met with Catholic Church authorities in Manitoba in October 1990 to discuss the historical abuse of Aboriginal children in residential schools and disclosed his own experiences of physical, sexual, and psychological abuse in the Fort Alexander Catholic residential school during a televised interview about the meeting.32 This public disclosure by a prominent Aboriginal leader added to the momentum of escalating litigation and media coverage relating to residential school abuse, both of which intensified over the course of the 1990s.33

The Royal Commission on Aboriginal Peoples was established by the Conservative federal government in 1992 as part of a conscious strategy to demonstrate willingness to engage with Aboriginal policy issues, in the context of international scrutiny following the Indigenous resistance at Kanehsatake, the failure of the Meech Lake Accord, and growing public, media and legal attention to reports of abuse in the Indian residential schools.34 But the conciliatory tone struck by the establishment of RCAP was undermined by the outcome of the subsequent federal election in 1993, which contributed to a shift in national Aboriginal policy discourse. Although a Liberal government was elected, the emergent right-wing Reform Party gained 52 seats and nearly 20% of the vote, and the formerly
ruling Progressive Conservative party was reduced to just two seats. Parliamentary
dialogue on Indigenous issues became polarized: the previous cross-party consensus on
Aboriginal policy was lost, clearly denounced by the Reform party, whose members freely
used racist language.\textsuperscript{35} This political climate fostered the spread of what anthropologist
Wayne Warry describes as “new assimilation arguments”.\textsuperscript{36} In 1995 Melvin Smith, a lawyer
and former provincial civil servant in British Columbia, published \textit{Our Home OR Native Land}, an attack on the federal and provincial governments’ recently demonstrated
willingness to recognize Aboriginal rights, particularly land claims and fishery
entitlements.\textsuperscript{37} Conservative journalist Diane Francis lauded Smith’s book in a review in the
national news magazine \textit{Maclean’s}, and took Smith’s opposition to land claim
settlements even further, noting that she would “insist that all settled claims be re-
examined and renegotiated”, after which she would “never entertain future negotiations
unless Aboriginal claimants first set aside all their existing privileges.”\textsuperscript{38} Francis and other
journalists arguing in favour of assimilation and against Indigenous rights gained a new
forum in which to espouse their view with the founding of the \textit{National Post} in 1998.\textsuperscript{39} It
was against this political backdrop that the Royal Commission on Aboriginal Peoples
produced reports through the mid-1990s, growing numbers of former residential schools
students launched legal cases, and Aboriginal mental health professionals and others
developed a powerful discourse on history, trauma and Indigenous suffering through
publications and through participation in the Royal Commission on Aboriginal Peoples
during the 1990s. These developments are discussed in the next section.

2. The ascent of trauma in Indigenous healing discourse

\textit{Being traumatized is a deeply wounding experience [but] it does not mean that a child who
attended residential school belongs to a distinct category of people. [...] Drawing a distinction
between those who attended residential school and those who did not trivializes the complexity
of the experience of living as a First Nations person and of the impact of residential school.}

Assembly of First Nations report, 1994\textsuperscript{40}

\textit{For the ones that went to the residential schools and had to reclaim their spiritual and cultural
teachings, and say for the ones that never went to the residential school, there’s quite a
difference there. We do the same teachings and everything else, but for the residential school
ones, they’re more like the mainstream, [...] rather than the cultural and Native. You know, it}
seems like we missed out on that young part, when we were in the residential school, we were not raised, kept on going, we missed that part. So we didn’t stay like Native because we went to a residential school. We were being changed, and brainwashed, so we don’t have that Nativeness. [...] It’s different, it’s just different. We can feel it, we can feel the difference. [...] There’s something missing, something missing with us that we, we... that was taken from us.

Elder Irene Lindsay, Residential school survivor, Ottawa, Oral history, 2009

Since the mid-1990s, the effects of Indian residential schools and the concept of trauma have become focal points in national and international discourses on Indigenous healing in the context of growing attention to colonial history and oppression as determinants of Indigenous suffering. Indigenous and non-Indigenous people involved in policy, clinical practice and research related to healing in Aboriginal communities have broadly agreed upon the value of attending to colonial history in the therapeutic context. This consensus builds on the healing practices initiated by many Indigenous communities during the two decades prior, discussed in Chapter Two. What remains contentious in the context of discussions of historical trauma, healing and reconciliation, is which colonial and Indigenous histories are presented, and how. Beyond debates about models of care for Indigenous healing, at stake are the range of legitimate subject positions for Indigenous people to occupy, and understandings of how healing relates to broader issues of Indigenous self-determination and relations with the Canadian state and settler society. As the quotations above suggest, there is a tension between arguments that recognize residential school attendance as a fundamentally and negatively transformative experience, and others that resist this framing as a simplification and flattening of Indigenous experiences.

My approach to the following analysis has been influenced by medical anthropologists Didier Fassin and Richard Rechtman’s recent work on trauma, which focuses on both the social agency, the ‘political competency’ of those who choose to label themselves as traumatized, and the broader socio-cultural shifts which have enabled this change to take place, that is ‘how the contemporary moral economy has been reshaped’. Since the 1980s, ‘a line of imputability and inevitability has gradually been established’ between the experiences and psychic consequences of suffering, particularly physical and sexual
abuse. In other words, there is now a prevalent presumption that experiences of suffering, and particularly physical and sexual abuse, cause psychic damage to the abused person. Previously, this relationship was rarely recognized outside of the expert fields of psychiatry and psychology, and even within those fields was considered a ‘suspect’ condition. As Fassin and Rechtman explain, psychiatrists and psychologists historically doubted the legitimacy of claims to psychic distress by soldiers or injured workers, who were suspected of ‘malingering, bad faith, and financial motives’ as a matter of course.

This significant shift is not attributable to developments in psychological diagnostic techniques. Rather, social movements addressing veterans’, women’s and children’s rights have formed alliances with psychiatrists, psychologists, and other medical professionals, leading to “a narrowing of the gap between the climate of public opinion and the preoccupations of mental health professionals, between the moral economy and medical theory”. Within the past twenty-five years, the concept of trauma has become so broadly recognized that it now designates a virtually irrefutable reality. Not only is the authenticity of the victim’s suffering no longer questioned but the traumatized victim has become “the very embodiment of our common humanity.”

Thus Fassin and Rechtman’s approach moves away from the focus on institutional processes and the deconstruction of scientific knowledge that has characterized many anthropological analyses of biomedical discourse for the past two decades, as exemplified by Alan Young’s widely-cited work on post-traumatic stress disorder. Whilst the latter approach continues to be important to medical anthropology in general, it is not sufficient for an understanding of Indigenous people’s use of trauma as a political and therapeutic tool. Fassin and Rechtman’s analysis is helpful in that it attends to the agency of those who would frame themselves as victims as a deliberate strategy for attracting resources and attention to their suffering.

In the current analysis, it is equally important to attend to Indigenous health professionals as social actors, and to the broader political context of relations between Indigenous peoples and the Canadian state and settler society. Anthropologists Michael Lambek and Paul Antze note that “any invocation of memory is part of an identity discourse and thus [...]

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conceptualizations of memory and of the ‘self’, or ‘subject’, mutually imply one another”. Thus invocations of memory in the context of therapy necessarily have implications for identity, and vice versa. Understanding this relationship helps us to appreciate the significant role of the Indigenous therapist (or one of any historically oppressed ethno-nationality) in elaborating discourses that link history with healing.

Fassin and Rechtman’s discussion of the central role played by Armenian psychiatrists in international agencies’ responses to the Armenian earthquake in 1988 -- identified as the genesis of humanitarian psychiatry -- provides a useful illustration of this dynamic. Importantly, at this time the concept of trauma was not yet central to the nascent discourse of humanitarian psychiatry, indicating the extent to which trauma is simply a contemporary tool in the service of a more long-standing practice of harnessing history to make meaning out of contemporary suffering. In the months following the Armenian earthquake, medical workers providing care to those affected identified a continuing demand for treatment, reflecting people’s needs to talk about what had happened and to be listened to. Armenian psychiatrists were the first to respond to requests for psychiatric support. According to Médecins sans Frontières’s director of mental health programs, "they offered their help spontaneously, more as Armenians than as psychiatrists", an observation validated by an Armenian psychiatrist who explained, "I was motivated more by my own history, what my people had lived through, than by my psychiatric training". The latter’s account shows how he framed the suffering of the earthquake survivors in terms of the Armenians’ history of resistance to persecution and foreign domination. Drawing on this framework in his treatment of one little boy, the psychiatrist recognised the possibility for the child to be identified as a hero as much as a victim. He reframed the child’s suffering as that of a powerful national hero fighting against adversity, and locates himself as his ally. The psychiatrist’s approach was credited with facilitating the boy’s recovery. This account illustrates how ethno-national solidarity and invocations of history may powerfully facilitate healing, in a therapeutic encounter occurring prior to the emergence of trauma as a dominant discourse.
I suggest that like the Armenian psychiatrist, some Indigenous clinicians may be motivated by empathy rooted in a common ethno-national identity, which drives their quest for historical reference points to explain current suffering. This is continuous with the way that earlier Indigenous healing initiatives focused on a shared past as the source of both current suffering and possibilities for healing, as discussed in Chapter Two. I elaborate on this idea below.

**Emergence of an Indigenous North American Liberation Psychology**

Indigenous people in North America have been voicing the damaging effects of colonialism on their nations and communities for generations. Those engaged in activism and community building in urban Ontario during the 1960s, 1970s and 1980s elaborated a discourse relating collective experiences of loss of culture, family and identity to contemporary suffering and problematic individual behavior such as alcohol and substance abuse. As shown in Chapter Two, these earlier discourses on healing frequently referenced history, but conveyed a generalized sense of loss and social disruption without specifically invoking colonialism, and rarely discussed specific aspects of colonial policy which might have had long-lasting effects on Indigenous peoples. This is not of course to say that Aboriginal people did not undertake such analyses, which are visible in political discourses many decades earlier, but they did not feature in *policy and programme discourses related to healing* during this period.

Work produced by Aboriginal mental health professionals during the 1990s may be broadly characterized as an Indigenous North American liberation psychology. As Shirley Yeung notes, the term ‘liberation psychology’ connotes multiple meanings and associations, ranging from the work of anti-colonial writers such as psychiatrist Frantz Fanon and philosopher Albert Memmi, to social movements such as Sikolohiyang Pilipino (Filipino Psychology) -- the subject of Yeung’s paper -- and Latin American liberation theology and critical pedagogy. In North America, growing numbers of Indigenous people qualified as psychologists and social workers during the 1980s (whilst the number of Aboriginal psychiatrists remained very few); some of these mental health professionals began to contribute to academic and policy discourses on Indigenous suffering and healing during
the 1990s. The discourse on Aboriginal mental health and healing emerging during the 1990s diverges from earlier work on Aboriginal mental health dominated by psychiatrists, discussed in the previous chapter. This emergent discourse considers conventional psychology and psychiatry to be of limited benefit and potentially harmful to Indigenous people; names colonialism, and labels historical factors as “oppressive” rather than the previously standard and more neutral descriptor of “social change”; advocates respect for Indigenous healing knowledge; assertively promotes the value of Indigenous therapists; uses the concept of oppression; references liberationist thinkers including Freire and Fanon; and discusses the individual psychological and intergenerational effects of colonial policies and practices.

Within this broad body of work, some Aboriginal mental health professionals began writing about the psychological effects of residential schools. Whilst the Indian residential school system (known as ‘boarding schools’ in the United States) and its intergenerational effects quickly emerged as a focal point within the emerging liberationist discourse on Aboriginal mental health, the schools were initially discussed within the context of a broader interest in how colonial oppression has contributed to contemporary health and social problems. Some writers started to invoke the concept of trauma to discuss Indigenous suffering around the same time, but the two were not initially put together. During the early 1990s, those writing about Aboriginal mental health discussed the effects of residential schools in terms of family disruption, intergenerational effects, and loss of Indigenous knowledge and livelihoods. For example, the 1991 book Making Meaning of Mental Health Challenges in First Nations. A Freirean Perspective by Sto:lo social work educator Bill Mussell (who succeeded psychiatrist Clare Brant as the Chairman of the Native Mental Health Association of Canada) begins with a brief discussion of colonial history focused on the effects of the residential schools, including loss of traditional knowledge and values, and the schools’ failure to equip young people to be productive in either traditional or colonial livelihoods. Mussell discusses trauma elsewhere in his book but does not link it with the experience of residential schools. In another analysis of historical factors influencing Aboriginal mental health published in 1990, Pueblo/ Apache Psychologist Eduardo Duran also discusses “the systematic destruction of the Indian family” through the boarding school system in the
United States. Elsewhere in the book Duran discusses post-traumatic stress disorder, but it is not a central focus of his analysis. Duran makes a case for the intergenerational transmission of the damaging effects of compulsory assimilative education, focusing on loss of family, without invoking the concept of trauma:

> Once the idea of family is eradicated from the thinking of an individual, then it is passed on to subsequent generations. [...] Many times the task in working with families involves the actual education of what the concept of family is, since the governmental policy was so effective in such instances. A therapist that approaches a family session with the notion that a family is pathological in a way which doesn’t account for the history of ethnocide, is him/herself co-conspirator to that history as s/he proceeds with a “blaming the victim” mentality.  

Neither Mussell nor Duran invoke the concept of trauma in their discussions of the psycho-social effects of residential schools, nor do they discuss physical and sexual abuse, although former residential school students had already begun to launch lawsuits by the time of these publications. This suggests the extent to which therapists’ interests at this time were firmly on collective experiences of suffering, rather than financially compensatable individual experiences of physical and sexual abuse, and that trauma was still conceived more narrowly.

Indigenous professionals working in the child welfare system also highlighted the intergenerational effects of the residential school system. In a 1992 submission to the Royal Commission on Aboriginal Peoples, Kenn Richard, Métis social worker and Executive Director of Native Child and Family Services of Toronto, highlighted continuities between residential schools and the child welfare system in undermining Aboriginal parenting and family stability:

> Most of our clients – probably 90 per cent of them – are, in fact, victims themselves of the child welfare system. Most of our clients are young, sole support mothers who very often were removed as children themselves. So we are dealing with perhaps the end product of the child welfare system that was apparent in the sixties scoop. Actually the sixties scoop lasted well into the ’70s and we are seeing the reality of that on our case loads.... [...] The other interesting note is that while the mother may have been in foster care the grandmother – I think we all know where she was. She was in residential school. So we are into a third generation.
Thus by the early 1990s, Indigenous mental health professionals were increasingly citing residential schools as a crucial dimension of Aboriginal experiences of colonialism, with direct implications for contemporary social suffering beyond that of the former students, through the intergenerational transmission of psycho-social effects. The First National Conference on Residential Schools was hosted by the Cariboo Tribal Council hosted in Vancouver in June 1991. As this discourse was taken up more widely by the residential schools survivors’ movement and the media, the concept of trauma was incorporated and a more pronounced emphasis on individual pathology began to emerge.

**The Royal Commission on Aboriginal Peoples, colonial history and residential schools**
The Royal Commission on Aboriginal Peoples (RCAP) provided an important and unprecedented forum in which Indigenous clinicians and academics could lead the elaboration of a discourse on colonialism, suffering and healing. Marlene Brant Castellano, Co-Director of Research for RCAP, recalled in an oral history interview,

*by 1992, 1993, there were a lot of very competent researchers who had been bridging those two worlds of academe and [Indigenous] community life and accepting the authority that comes from experience. So we had that, but the principal challenge that we worked on in the research and then subsequently in the policy analysis and the writing of the report was finding that balance between the experiential knowledge of First Nations, Inuit and Métis and urban Aboriginal people and women that was expressed in a narrative, sometimes metaphorical form, and the more intellectualized, the intellectually conceptualized analysis that comes from professionals and academe.*

The leadership of Indigenous intellectuals, political leaders and clinicians, in dialogue with thousands of participants in community fora, facilitated RCAP’s contribution to discourse on Indigenous healing during the 1990s.

The concept of an affliction known as “residential schools syndrome” began to circulate during the Royal Commission on Aboriginal Peoples’ hearings between 1992 and 1995, as both legal cases and public discourse around residential schools were gaining momentum. Some participants began to frame former students as victims, afflicted by a characteristic set of symptoms and experiences in the present which were directly attributable to their personal history of residential school attendance. By the time of the RCAP National
Roundtable on Health and Social Issues in Vancouver in March 1993, it was clear that residential schools were becoming a major policy issue which the RCAP Commissioners would need to engage with. The fact that none of the eleven papers commissioned for the roundtable focused on residential schools suggests that the Commissioners were not anticipating the level of interest in the issue.\(^{59}\) Roundtable participants prioritised “victims of residential schools” as one of five groups whose needs “require targeted attention and specific policy frameworks”, alongside “Aboriginal people with disabilities”, “victims of sexual abuse and domestic violence”, “Aboriginal people with AIDS”, and “children with fetal alcohol syndrome.” The appointed rapporteur for the roundtable, anthropologist John O’Neil, described the consensus among participants at the Round Table:

> although the impact of residential schools on Aboriginal society must be considered in broader terms than health consequences, many participants at the Round Table linked their own and others’ experiences in the residential schools to problems of alcohol abuse, suicide, and family violence in Aboriginal communities today. While significant efforts are under way within Aboriginal communities to heal the wounds inflicted by residential schools, broader policy for compensation must be developed and provided to individuals, families, and communities whose lives have been disrupted by this particular historical experience.\(^{60}\)

The 1993 Roundtable on Health and subsequent RCAP reports suggest that Indigenous and other participants were grappling with the political and analytical implications of framing colonialism as a determinant of Aboriginal suffering. (As discussed in the last chapter, participants in the development of policies on Aboriginal family violence and healing in Ontario were working on the same issue around this time.) The transcript of the Roundtable suggests some ambivalence and a lack of consensus amongst participants regarding the political implications of recognizing colonization as a determinant of health. Anthropologist John O’Neil, the rapporteur, shared an anecdote about an argument between Eric Shirt, the founder of Nechi Institute, and an anthropologist at an Australian conference on Aboriginal health. According to O’Neil’s account, Shirt took issue with the anthropologist’s socio-historical perspective on Aboriginal alcohol abuse, and argued that such a framing fuels government reluctance to fund programmes for individual treatment. O’Neil suggests that “ ‘Colonialism’ as a central explanation for current Aboriginal health conditions may have limited applicability.”\(^{61}\)
However the 1995 RCAP special report on suicide *Choosing Life* put colonization front and centre as a major underlying factor explaining disproportionate suicide rates in Aboriginal populations. Suicide is conceptualised as

the expression of a kind of collective anguish - part grief, part anger – tearing at the minds and hearts of many people. This anguish is the cumulative effect of 300 years of colonial history: lands occupied, resources seized, beliefs and cultures ridiculed, children taken away, power concentrated in distant capitals, hopes for honourable co-existence dashed over and over again.62

In this report, residential schools are discussed as one form of colonial violence, but the Commissioners are careful to stress that residential schools were not the only colonial policy to significantly disrupt Indigenous family life. They also discuss adoption by non-Aboriginal families and hospitalization far from home for tuberculosis treatment as experiences with damaging long-term effects which may increase individual risk of suicide, and which are compounded, even escalated, over generations.63 Similarly, in their final report, the Commissioners focused on residential schools as one of four areas of federal Aboriginal policy warranting in-depth analysis and particular recommendations, alongside the Indian Act, relocation of communities, and the treatment of Aboriginal veterans.64 The criteria for selection of these policies were the injustice of the policies as determined by Aboriginal participants in the Commission, and the continuing effects on Aboriginal people. With regards to residential schools policy in particular, the Commissioners noted that Aboriginal people had strongly opposed the residential school system, and observed that

of all the nineteenth-century policies formulated to respond to the Indian question, none was more obviously the creature of that era’s paternalistic attitudes and its stern assimilative determination than residential school education. [...] The damage to thousands of Aboriginal people, once children and now adults, continues to the present day. Bad policies always claim victims. But the effects of bad education policies seep through the decades, from child to parent to family to community, and from one generation to those that follow.65

Many commentators, including participants in oral histories as part of this research, have credited RCAP with galvanizing the federal government to respond to the residential schools issue. Despite the media and legal salience of the residential schools, it is noteworthy that the Commissioners insisted on contextualising this dimension of Indigenous experience within the long and complex history of Canadian colonialism. As we shall see, government policy during the subsequent decade took a far narrower approach.
The emergence of trauma in Indigenous healing discourse

In 1996, anthropologists Michael Lambek and Paul Antze observed that “increasingly, memory worth talking about – worth remembering – is memory of trauma”.\(^{66}\) Prior to the 1990s trauma had featured only occasionally in academic literature and discourse around Indigenous healing, as a psychiatric condition linked not to colonial history but to the effects of events occurring within an individual’s lifetime, largely devoid of political context, such as relocation to the city, sexual abuse, or participation in the Vietnam war.\(^{67}\) But signs of an affinity between Indigenous liberationist and Holocaust survivor discourses appeared much earlier. Stimulated by the translation into English of books by Holocaust survivors such as Primo Levi and (later) Jean Améry, and the 1978-1979 broadcast of the television mini-series Holocaust, North American society expressed a growing interest in the Holocaust from the 1960s onwards.\(^{68}\) At least a decade before trauma came into circulation as a new metaphor for colonial oppression, Indigenous and other critical analysts of North American colonial relations began to draw parallels between the Holocaust and Indigenous experiences of colonization in the Americas. Writers on North American history began to invoke the concept of genocide during the late 1970s.\(^{69}\) Invoking the Holocaust in an anti-colonial critique presented a powerful challenge to understandings of contemporary western European and North American societies as morally superior and the pinnacle of Enlightenment and civilization.\(^{70}\) But it was not until the 1990s that writers on Indigenous healing began link the concepts of genocide and trauma. Pueblo-Apache psychologist Eduardo Duran was one of the first writers on Indigenous healing to discuss the intergenerational transmission of post-traumatic stress disorder (PTSD), and to liken colonialism and its effects to genocide. In 1990, Duran wrote,\(^{71}\)

Indian people suffer from Post Traumatic Stress Disorder as a consequence of the devastating effects of genocide perpetrated by the U.S. government. Studies indicate that the trauma can be intergenerational as found out recently with the work being done on World War II holocaust survivors.

As Fassin and Rechtman note, the Holocaust provides a particularly appropriate ‘paradigm for trauma’, not only because it serves as a universal frame of reference for extremes of violence and suffering, but also because survivors’ memories of atrocities experienced emerged some time after the event.\(^{72}\) This well-documented phenomenon therefore legitimates the connection between prior suffering and symptoms experienced some time
later. Judith Herman’s work on complex PTSD is commonly cited by writers on Aboriginal experiences of trauma, who find Herman’s conceptualization of repeated exposure to multiple traumatizing experiences over time relevant to Indigenous experiences.\textsuperscript{73}

Maria Yellow Horse Brave Heart’s account of the historical trajectory by which she developed her theories of historical trauma, historical trauma response and historical unresolved grief illustrates the significance of both the salience of the Holocaust in North American society during the 1970s, and Brave Heart’s own Indigenous identity. A Lakota professor of social work and one of the most widely published proponents of trauma as a central concept in Indigenous healing, Brave Heart described the genesis of her analysis as the intersection between her individual consciousness of carrying the ‘ancestral grief’ of her people, postgraduate training in psychoanalysis, and learning about the experiences of Jewish Holocaust survivors and their descendants in the late 1970s, particularly through Helen Epstein’s 1978 book \textit{Children of the Holocaust}.\textsuperscript{74} Brave Heart’s clinical practice with urban and reservation communities from 1978 onwards, and particularly work with the \textit{Takini} (survivor) Network, a Native non-profit organization supporting healing from historical trauma, provided extensive material for the further development of her theoretical framework. Brave Heart presents her arguments for the analysis of Indigenous suffering as ‘the American Indian Holocaust’ in a series of papers published from 1998 onwards. She draws heavily on the literature on Holocaust survivors and their descendants, and invokes the 1890 massacre of the Lakota at Wounded Knee as evidence of the similarities between North American Indigenous and European Jewish experiences.

In 1994, the Assembly of First Nations produced one of the first significant reports on residential schools to invoke trauma as a relevant concept for understanding the effects of residential school experiences.\textsuperscript{75} The authors discuss the traumatizing effects of children’s experiences of physical and sexual abuse in residential school, typified in a disturbing account of a twelve year old girl who was raped and impregnated by male staff, and subsequently made to undergo an abortion. They also discuss physical punishment and the witnessing of other children’s punishment, the ubiquity of fear and shame, and the incomprehensibility and loss of social meaning experienced in the utterly alien
environment of the residential school, as potentially traumatizing. At the same time, the report discusses factors 'limiting' experiences of trauma, including the distinct responses of individual children to challenging situations (which contemporary psychoanalytic language describes as ‘resilience’), as well as situations which helped children to cope and had the effect of ‘limiting’ trauma: involvement with respected and non-abusive teachers, regular home visits, retaining one’s own language, participation in sports and arts, and reading.  

By the late 1990s trauma was firmly established as a central concept in Indigenous healing discourse, commonly invoked in relation to experiences of residential schools and other dimensions of Indigenous suffering under colonialism.


An analysis of Canadian policy on reparations for residential school attendance reveals a profound disconnect between how ‘healing’ has been invoked in public policy discourse, and Indigenous understandings of healing based on historical and political analysis. Canadian residential schools reparations policy has unfolded over more than a decade and under four successive governments, beginning with the belated federal response to the work of the Royal Commission on Aboriginal Peoples in the 1998 ‘Gathering Strength’ policy. The centerpiece is the Indian Residential Schools Settlement Agreement (IRSSA). Publicly announced by the federal government on September 19th 2007, it is the largest and most complex out-of-court settlement in Canadian history and includes provision for a Truth and Reconciliation Commission (TRC). The TRC’s mandate is to ‘contribute to truth, healing and reconciliation’ and ‘rebuilding and renewing Aboriginal relationships and the relationship between Aboriginal and non-Aboriginal Canadians’. At the time of this writing it has just hosted its first national event in Winnipeg on June 16-19, 2010. A timeline of the major events in the development and implementation of federal residential schools reparations policy is presented in Table 4.1 below.

In this section I analyse the social implications of federal policy on reparations for residential schools, reconciliation, and Aboriginal healing. First I consider the role of the Assembly of First Nations in influencing policy development in this area, and the
concurrent marginalization of the Métis who have been excluded from the residential schools settlement. I then provide an overview of some of the concerns raised by Indigenous and other commentators regarding the inconsistencies between policy rhetoric on healing and ongoing Aboriginal policy which disregards Aboriginal priorities. These two issues background my central concern with the fundamental inconsistency between the legalist model structuring government policy and the relational model underpinning Indigenous understandings of healing.

**National Indigenous organisations and Canadian reparations policy**

On May 30, 2005, Deputy Prime Minister Anne McLellan wrote to Phil Fontaine, National Chief of the Assembly of First Nations: ‘the work of the Assembly of First Nations (AFN), and your individual efforts as National Chief, have been instrumental in the development of the Government of Canada’s renewed strategy for the resolution of the [Indian residential schools] legacy.’ Whilst Chief Fontaine -- himself a survivor of residential schools and a longstanding champion for the cause of reparations -- and the AFN have significantly influenced federal residential schools policy, other Indigenous groups whose interests are not represented by the AFN have been more marginalized, reflecting the extent to which the Indian Act continues to shape identity and entitlement in contemporary Aboriginal policy. Other Indigenous collectivities -- the Inuit Tapiriit Kanatami, the Métis National Council, the Congress for Aboriginal Peoples and the Native Women’s Association of Canada -- all complained that they were not formally consulted during the development of ‘Gathering Strength’ in 1997.
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>Jan 1998</td>
<td>Minister Jane Stewart delivered ‘Statement of Reconciliation’ and announced ‘Gathering Strength – Canada’s Aboriginal Action Plan’ including $350 million healing fund</td>
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<tr>
<td>March 1998</td>
<td>‘Aboriginal Healing Fund’ established to manage funds allocated in ‘Gathering Strength’.</td>
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<tr>
<td>1998</td>
<td>Working group on ‘truth and reconciliation’ established</td>
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<tr>
<td>2001</td>
<td>Federal government established Department of Indian Residential Schools Resolution Canada</td>
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<tr>
<td>2002</td>
<td>Federal government announced ‘Alternative Dispute Resolution Framework’ for provision of compensation to victims of abuse in residential schools</td>
</tr>
<tr>
<td>2004</td>
<td>Assembly of First Nations released report proposing wide-ranging changes to the Government’s model for reparations for residential schools experiences.</td>
</tr>
<tr>
<td>2006</td>
<td>Federal government signed Indian Residential Schools Settlement Agreement with legal representatives for former residential schools students, the Assembly of First Nations, Inuit land claims organisations, and the churches</td>
</tr>
</tbody>
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| 2007      | Federal government announced Indian Residential Schools Settlement Agreement:  
|           | • Common Experience Payments for all former students of government-recognised residential schools  
|           | • Independent Assessment Process for cases of physical and sexual abuse  
|           | • additional $125 million to the Aboriginal Healing Foundation  
|           | • commitment to establish and fund the Truth and Reconciliation Commission |
| June 2008 | First Truth and Reconciliation Commission (TRC) launched  
|           | Prime Minister Stephen Harper issues Government apology for residential schools  
|           | Métis and Inuit leaders highlight exclusion of Métis and Nunatsiavut Inuit former students. |
| Oct 2008  | Harry LaForme resigns as Chair of TRC |
| June 2009 | New TRC Commissioners announced |
| Dec 2009  | Independent evaluation of Aboriginal Healing Foundation produces report recommending continued funding at least until the IRSSA implementation is completed. |
| March 2010| Federal government fails to renew the Aboriginal Healing Foundation’s mandate |
| June 2010 | TRC’s first national event held in Winnipeg. |

Table 4.1 Timeline of federal residential schools reparations policy
The AFN also shaped the terms of the Residential Schools Settlement announced in 2007. Following the launch of the government’s initial Indian residential schools dispute resolution plan in November 2003, the AFN quickly articulated its dissatisfaction with the government-proposed process and took action to influence changes. An AFN-convened expert group including eight law professors produced a highly critical report in November 2004 which stated,

It has become evident that the [dispute resolution] plan is not meeting its goals of just and fair compensation leading to reconciliation. Indeed, there is a real fear that the present system of compensation is causing additional harms to the survivors.  

The degree of the AFN’s influence in the 2007 Residential Schools Settlement is evidenced by the inclusion of many of the recommendations from the AFN’s 2004 report. In particular, the commitment of at least $1.9 billion to fund Common Experience Payments for all former residential school students represented an important moral and political victory for the AFN, symbolising the federal government’s acknowledgement that the residential schools inflicted harm on students beyond individual experiences of physical and sexual abuse.

As policy on residential schools reparations developed, Inuit and Métis leaders increasingly engaged in advocating for their people’s inclusion in these policies, whilst seizing the opportunity to advance government and public understandings of the distinct historical experiences of Inuit and Métis. Inuvialuit Regional Corporation, Nunavut Tunngavik Inc. and Makivik Corporation represented Inuit interests in the residential schools settlement negotiations, and argued successfully for the inclusion of some Inuit schools not originally recognized by the federal government, including hostels and camps. However Inuit who attended residential schools in Nunatsiavut (Labrador) were excluded from the agreement, on the basis that they were never within the jurisdiction of the Federal government, because Aboriginal people were entirely omitted from the 1949 Terms of Union transferring Newfoundland from British to Canadian territory.

Mary Simon, President of Inuit Tapiriit Kanatami, raised the exclusion of the Nunatsiavut Inuit in her speech at the reception following the Prime Minister’s apology on June 11,
2008 and again in a Senate address on June 12th. She has since advocated further for Inuit interests in the implementation of healing policy, publicly expressing her disappointment at the government’s failure to include an Inuk Commissioner when the Commissioners for the second round of the Truth & Reconciliation Commission were appointed in 2009, and using the opportunity to convey the Inuit Tapiriit Kanatami’s request that an Inuit Sub-Commission be established ‘to ensure that Inuit survivors of the Residential Schools experience are fully consulted as part of the truth telling reconciliation process’.87

Addressing the House of Commons following Prime Minister Harper’s apology, Mr. Clem Chartier, President of the Métis National Council, took the opportunity to express his disappointment at the exclusion of the Métis from the residential school settlement, and used this as a metaphor to make a point about the exclusion of the Métis from broader political processes in Canada:

although I am very sincere and happy, perhaps, that this is happening, I also feel deeply conflicted, because there is still misunderstanding about the situation of the Métis Nation, our history and our contemporary situation. [...] I really do feel conflicted, because I am one of the survivors of a Métis residential school, which was no different from Indian residential schools except for the question of who paid. As for who paid, it was those young people who went there, people like Don, people like me. We paid. I hope and I do believe sincerely in the words of the minister that we will address this. I said that the Métis Nation would be here to share this day with those people who have waited for so long. [...] Finally, Prime Minister, the Métis Nation of western Canada, which has been excluded from many things by the workings of this House and its policies, wants in.88

But the question of ‘who paid’ was of course paramount for the federal government, whose overriding concern was to minimize its vulnerability to litigation. The Métis National Council was excluded from the Residential Schools settlement negotiations at which First Nations peoples and Inuit were represented. Despite appeals to the Federal Interlocutor for Métis and non-Status Indians, many of the schools attended by Métis children, although run by the same administrations as the Indian residential schools, have not been recognized by the government in the settlement agreement, thereby excluding many Métis former students from receiving financial compensation.89 As discussed in Chapter One, researchers have recently produced evidence that Métis students at residential and church-
run day schools suffered abuse and losses of culture and language comparable to the experiences of other Indigenous residential school students.\textsuperscript{90} The Agreement includes a mechanism by which the exclusion of schools may be appealed; at the time of writing, approximately one thousand different institutions have been named in such appeals, and some Métis former students have launched independent cases against the federal and provincial governments.\textsuperscript{91}

**Healing rhetoric and federal Aboriginal policy: the disjuncture**

Successive governments claiming support for ‘Aboriginal healing’ and ‘reconciliation’ have enacted and continued other policies which disregard Aboriginal entitlements and perpetuate colonial relationships.\textsuperscript{92} Child welfare policy is perhaps the most glaring example given that, as Cindy Blackstock points out, in 2008 there were three times as many First Nations children in the care of child welfare agencies (approximately 27,000) as there were children in residential schools at the peak of enrollment in the 1940s.\textsuperscript{93} The 1998 ‘Statement of Reconciliation’ issued by the Liberal government raised some Indigenous people’s expectations of changes in relations with government, but unilateral policymaking continued as exemplified by the 2002 First Nations Governance Act, which was widely criticized by First Nations and eventually defeated.\textsuperscript{94} Liberal and Conservative governments alike have actively blocked progress towards resolution of land claims and treaty disputes; provincial governments have continued to authorize the extraction of resources from lands subject to Indigenous claims.\textsuperscript{95} Perhaps the most widely hailed irony of Canadian Aboriginal healing policy was the delivery of the (second and more substantial) federal government apology for residential schools by Conservative Prime Minister Stephen Harper in 2008, in the wake of the same government’s failures to implement the 2005 Kelowna Accord and to ratify the United Nations’ ‘Declaration on the Rights of Indigenous Peoples’.\textsuperscript{96,97} Australia’s subsequent ratification of the UN Declaration in 2009 and New Zealand’s qualified endorsement in April 2010 highlighted the Canadian government’s intransigence on this issue. The Harper government finally endorsed the declaration on November 12\textsuperscript{th} 2010, whilst describing it as an ‘aspirational document’ and indicating that the government’s long-standing concerns ‘are well-known and remain’.\textsuperscript{98}
\textbf{A clash of paradigms}

Canadian policy on residential schools reparations represents both a triumph of a legalistic-financial model of reparations and the concurrent denigration of social processes inherent to Indigenous understandings of healing. Most former residential schools survivors who have sought reparations through the Common Experience Payment concluded that ‘the decision to settle for individual monetary compensation was misguided and insufficient’.\textsuperscript{99} Meanwhile, the Aboriginal Healing Foundation (AHF), established in 1998 as part of ‘Gathering Strength’ to oversee funding of community-based healing projects for former residential school students and their families, has been constrained by its narrow, legally-derived remit and insufficient financial resources. In oral history shared as part of the current research, Executive Director Mike DeGagné described the AHF’s mandated focus on ‘physical and sexual abuse’ which led the AHF to reject three-quarters of the proposals they received from Aboriginal community groups:

\textit{We were limited to a very specific type of trauma and a very specific type of program to deal with that trauma. [...] By definition, a lot of health issues were left out. Even some basic things like language programs and the very important role of language and culture had to be left out, because that wasn’t an acceptable part of our mandate [...]. This was a way to limit it because the government was only prepared to address needs that were the ones that people were lined up out the door to take to court, to talk about in court, right. [...] Loss of language and culture is not a compensable issue in court, but physical and sexual abuse is. And it was very strictly limited in that way.}\textsuperscript{100}

Over the past decade, successive governments have failed to commit adequate resources to support the continuation of the AHF’s work, despite clear evidence of both the long-term nature of healing processes, and the Foundation’s interim successes.\textsuperscript{101,102} Following an independent evaluation commissioned by Indian and Northern Affairs Canada (INAC) in late 2009, senior INAC staff strongly recommended an extension of AHF’s term, but the federal government’s March 2010 budget included no additional funding for the AHF, effectively ensuring that programmes previously supported by the AHF will terminate in 2011.\textsuperscript{103} On the basis of the evaluation report INAC concluded that ‘the AHF has been very successful at both achieving its objectives and in governance and fiscal management’, and that ‘the evaluation results strongly support the case for continued need for these programs, due to the complex needs and long-term nature of the healing process’.\textsuperscript{104}
Further, the report highlighted the increasing demand for healing programmes as a result of the Common Experience Payment and Independent Assessment Process (and projected increased demand resulting from the forthcoming Truth and Reconciliation Commission); the particular needs of Inuit communities whose programmes started later that others; and the very limited chances of AHF-supported programmes securing funding from other sources due to the lack of funding agencies with overlapping mandates. Justice Murray Sinclair, Chair of the Truth and Reconciliation Commission, publicly expressed his view that the AHF should have continued to function for the duration of the TRC, at a minimum. But Indian Affairs Minister Chuk Strahl declared ‘the AHF has run its course’, a pronouncement characterized by Marlene Brant Castellano as resonating with ‘the clarity and the violence of the oppressor’. The federal government’s decision not to table the December 2009 AHF evaluation report in parliament until March 5th 2010, the day after presenting the budget, indicates a cynical refusal to even entertain open discussion of the evidenced need for continuing support for long-term healing processes.

But as an alternative to extending the AHF’s mandate, the government has allocated $65.9 million towards Health Canada programmes providing ‘mental health and emotional abuse support services for former residential school students and their families’. Given the extent to which the AHF has modeled Indigenous self-governance with a diverse base of support and the application of Indigenous knowledge to the alleviation of suffering, this shift can be interpreted as a ‘therapeutic strategy’ by which the Canadian state is (re)asserting its illegitimate authority over Indigenous health and healing. The work of the AHF is rendered temporary and transient, whilst the sovereignty of the Canadian state and the technological superiority of biomedical approaches to healing are reasserted.

4. Reconciliation, reparations, testimony & healing: troubling presumed relationships
Reconciliation discourse shares with trauma-focused therapeutic work a model of testimony as an inherently healing process. Many commentators in the Canadian context -- even some of those expressing doubts about the willingness of the state and settler society to participate in a meaningful way -- have optimistically cited the literature
espousing this model. But some scholars have problematised this presumed relationship.

Anthropologist Fiona Ross questions the implicit presumption that testimonies will be heard and understood as their speakers intend, noting the South African Truth and Reconciliation Commission’s inattention to the complexity of the power relations and social context within which testimonies are delivered. Ross’s work with women who testified at the South African TRC showed that participants did not anticipate the extent to which their testimonies would be circulated and re-worked through global mass media and academic publications, becoming commodities to be bought and sold. She observes that in the re-telling through media coverage and the Commission’s Report,

> the complexity of the testimonies and their often rich performative contexts and content were often reduced and reified as stories of suffering. Such crystallized forms quickly became formulaic losing the capacity to hold the attention and restricting the range of expressions through which to give voice to experience.

This observation raises questions regarding testifiers’ relationships to their testimonies and the implications for subjectivities, including the presumed individual and collective healing effects of participation in the TRC.

In the Canadian context, Roger Simon has raised related concerns about the implicit pedagogical assumptions where the testimonials of victims/survivors are central to processes of reconciliation. Simon challenges the notion that ‘such narratives elicit a form of natural empathy and critical historical judgement that can lead, not only to an understanding of the lives of Indigenous peoples, but a restorative project within which widely diverse people work together to fulfill the requirements for a more just future’. Simon identifies particular problems inherent to the process of settler Canadians listening to Indigenous stories with the aim of effecting social change, including the tendency for the listener to misrecognise the testifier as simply a victim of history, thereby both denying Indigenous subjectivity and failing to see herself as implicated in ongoing suffering. As Simon observes, these problems arise particularly where pathos is a central element to testimonies, diverting attention both from the social and political contexts of colonial policy
and practice, and from the continuation of colonial thinking in the present time. Although at the time of writing the TRC is just beginning its work, these social processes are already occurring, since media and broader public discussion of residential schools has been ongoing since the mid-1990s.

Government healing policy, including the narrow mandate and short lifespan of the Aboriginal Healing Foundation and the discourse around the apology for residential schools, suggests intentions to foreclose not only future legal action by former residential schools students, but also further critical reflection on Canada’s colonial history, continuing injustices experienced by Indigenous peoples, and the culpability of the state and settler society. Policy discourse focuses on “Aboriginal healing” rather than broader societal healing, indicating a reluctance to contemplate serious processes of political and social change necessary to shift established patterns of relationships between the state, settler society and Indigenous peoples. As Stan McKay notes, the very name of the Aboriginal Healing Foundation “perpetuates the paternalistic concept that only Aboriginal peoples are in need of healing”. Both state apologies failed to recognize the roles of state actors and name perpetrators. Whilst a surprising 83% of non-Aboriginal survey respondents were aware of the apology, with 71% of those supporting it, the meaning and effects cannot be assumed. Media critic Rick Salutin noted “a smug sense on the part of some apologizers that It’s all about us” and that Indian Affairs Minister Chuck Strahl’s public discussion of the apology had “an odd, cheerleading air”. In her analysis of “national shame” in the context of Indigenous-settler relations in Australia, Sara Ahmed argues that temporary feelings of shame associated with public discourse on colonial history and Indigenous suffering quickly give way to a renewed national (settler) identity, based on self-congratulatory experiences of witnessing past injustices. By locating injustice firmly in past events, this process both conceals ongoing culpabilities and absolves individuals in the present.

The significance of these critiques notwithstanding, it is also important to acknowledge the evidence that some Aboriginal people experienced the 2008 government apology as a meaningful event which contributed in some way to processes of healing and recovery. Over a quarter of participants in an Aboriginal Healing Foundation-sponsored survey of
former residential school students expressed the opinion that the apology was ‘sincere’, ‘necessary’, and/or an important first step towards making amends. In oral history shared as part of the current research, Ottawa-based Inuk Reepa Evic-Carleton recalled her experiences on the day of Prime Minister Harper’s apology. Reepa and other staff from Mamisarvik Healing Centre accompanied their clients to hear the apology on Parliament Hill; Reepa’s mother was invited to be Elder at an evening reception for residential schools hosted by Tungasungling Inuit, the Inuit friendship centre in Ottawa. As her mother shared her story at the reception, Reepa interpreted from Inuktitut into English. Reepa wept as she described to me how she heard for the first time her own mother’s story of losing her young first-born son:

\[\textit{for the first time, I heard the story of how it was for my mother to have a five-year-old boy taken away. [...] One day everybody’s happy and living life as they’ve always lived it, one day somebody showed up into their camp and removed children, no notice. My parents had no say. Not just my parents, but other parents too. And [the children] were taken away. [...] I still have tears to this day.}\]

Reepa’s account illustrates the significance of the apology as an historical event with the power to precipitate important social processes, including communication within families and communities and individual healing. At the same time, for 35% of respondents to the AHF survey the apology was “insincere”, “meaningless”, “not enough”, and/or “too late”.

**The Residential schools settlement and healing: seeking premature closure**

The task of critically assessing the implications of the residential school settlement for individuals and communities has been rendered more difficult by racist media coverage of the settlement, which has conveyed messages that compensation was excessive and undeserved, or that Aboriginal people are too backwards to manage substantial sums of money. In this climate, those questioning the morality or appropriateness of individual financial compensation have risked being accused of undermining ‘the right of former residential school attendees to receive and use their money free of judgement, paternalistic meddling, or external pressure.’

Nevertheless, recent research conducted on behalf of the Aboriginal Healing Foundation has confirmed multiple anecdotal reports that whilst a substantial number of participants
reporting positive experiences of the settlement process, many others -- apparently a substantial minority -- have suffered devastating losses and setbacks on their healing journeys as a direct result of the residential schools settlement.\textsuperscript{125} The inappropriateness of the reparations model, the harmfulness of the application process and the damage resulting from the receipt of payments are all evidenced by research and by empirical reports from service providers. Between autumn 2007 and May 2010, the federal government disbursed over 1.5 billion dollars in Common Experience Payments to 75,926 individuals, with individual payments averaging $20,535.\textsuperscript{126} The Aboriginal Healing Foundation-sponsored report concluded, 

\begin{quote}
the general message of Survivors’ accounts of negative impacts [of the Common Experience Payment] was that the decision to settle for individual monetary compensation was misguided and insufficient, compounded by a lack of planning on the part of those implementing the CEP to prepare for the triggers, self-destructive reactions, and predatory behaviours.\textsuperscript{127}
\end{quote}

For about a quarter of participants, the payment was a meaningful symbol of public recognition of their suffering, government’s admission of wrongdoing, and an important step towards reconciliation; nearly as many described their experiences of the application process and the payment as undermining progress on their healing journey.\textsuperscript{128} The application process itself was challenging for many, with only one-third reporting it was straightforward, and 40% finding it difficult – particularly those over age 60, not fluent in English or French, and lacking support from local services. The onus was on former students to produce evidence of their attendance which was often difficult due to lack of records – particularly for Métis who were often day students not funded by Indian Affairs. Nearly 25,000 people have initiated appeals processes after the distressing experience of their first application being rejected. More than a third of research participants experienced challenging reactions to the CEP application process, ranging from difficult memories to depression, panic, exacerbated addictive behaviour and suicide attempts, leading the report’s authors to conclude that in some communities the negative effects of the settlement “greatly outweighed any positive, material benefits of the payments”.\textsuperscript{129} In Ontario, addictions counsellors working in the provincial treatment system witnessed an increase in Aboriginal clients needing support with gambling and substance abuse
problems following the distribution of Common Experience Payments. Psychiatrist Gary Chaimowitz who has worked extensively with former students observed,

\[ \text{the argument is that once the compensation is paid out, you can move on -- but the} \]
\[ \text{trauma associated with the payments causes further problems. Experiences of being a} \]
\[ \text{victim are reinforced by systems that describe you as a victim. Once you have accepted} \]
\[ \text{compensation, the apology, etc, it becomes a difficult psychological space to be in. [...]} \]
\[ \text{there have been cases of people who've been back a second time, having blown the first} \]
\[ \text{payment on alcohol and drugs -- they then need treatment, not more money.} \]

A separate study evaluating the progress of Aboriginal Healing Fund-supported projects described similar perspectives of staff: 68% (from 51 projects) reported that the Common Experience Payment and Independent Assessment Process have created challenges for individual and community healing processes, 37% reported that the payments exacerbated addictions and family violence, and 17% (13 projects) describing the CEP and IAP processes as ‘harmful’.

No research is currently available to describe the experiences of over 16,000 former students participating in the Independent Assessment Process to receive compensation for physical and sexual abuse in residential schools. One might assume a comparable spectrum of experiences to those who participated in the CEP process, but there are two important differences complicating such a comparison. First, the IAP requires claimants to attend a hearing, and second, participants in this process are offered the services of Health Canada’s Indian Residential Schools Resolution Health Support Programme. The Indian Residential Schools Resolution Health Support Programme (IRSRHSP) was established in 2003, and expanded in 2006 following the signing of the Settlement Agreement. Its remit is to ‘provide funding to ensure mental health support and emotional support and cultural support for former students and their families’ as they participate in the Independent Assessment Process (IAP) and/or the Truth and Reconciliation Commission. Support is delivered by a network of approximately 200 paraprofessional workers, professional mental health therapists and counsellors, and Elder and traditional healers. The paraprofessionals, Elders and traditional healers are all recruited locally through agreements with Band Councils and health centres. Between September 2007 and May 2010 over 16,000 former students submitted IAP applications, and nearly 6,000 hearings have been held to-date. In a 2009 interview, IRSRHSP manager Kari Nisbet described a
steady increase in demand for the programme’s services, with the majority of former students -- particularly those in northern regions -- choosing to receive support from Elders and traditional healers or para-professionals over biomedically-trained professionals.\textsuperscript{135}

The misery experienced by many individuals and communities participating in the CEP process -- and one can assume the IAP -- reveals the gap between a neoliberal understanding of victimhood as an individual phenomenon for which a financial solution is both appropriate and adequate, and more multifaceted understandings of suffering and healing consistent with Indigenous worldviews. This argument is not to be confused with negative media messages that compensation was undeserved, or that Aboriginal people are too backwards to manage money. Rather, my point is that the government is willing to distribute individual financial compensation whilst simultaneously refusing, by its termination of the Aboriginal Healing Fund, to support long-term, Indigenous-directed and community-based healing. This is strong evidence that the government’s primary intention is \textit{not} to support integrated individual and collective processes of rebuilding identities and relationships, but to foreclose both future legal action on the residential schools, and further critical reflection on Canada’s colonial history and the culpability of the state and settler society in ongoing Indigenous experiences of suffering and injustice.

5. \textbf{Historical trauma, Indigenous subjectivities and the salience of victimhood}

\textit{I’m really tired of the stereotype of Native people. I’m thinking of ‘Conspiracy of Silence’, the Betty Osborne story, and ‘Where the Spirit Lives’, about the residential schools, and that sort of thing. Although the stories need to be told and they need to be seen, as a Native person I’m sick of being the victim and being looked at as this poor person who has been manipulated and abused and had all these terrible things done to them over the years. I think in one way it’s true, but let’s get on with our lives. It’s making an assertive move and no longer being there – moving beyond all that. Part of it is just ignoring social good taste.}

Shelley Niro, artist and Bay of Quinte Mohawk, interviewed by Carol Podedworny (1992), ‘Rethinking History’ Group Exhibition.\textsuperscript{136}

\textit{How did people talk about the world’s conflicts and injustices twenty years ago, when there was as yet no reference to trauma, and psychologists and psychiatrists were not being sent to help people facing crisis situations? [...] If we think of Palestine, the period of dictatorships in Latin America, or, longer ago,}
the period of decolonization in Africa, there were other words, other readings, other methods of resolution that were used. The focus was not so much on trauma as on violence. The talk was of the resistance of fighters rather than the resilience of patients. Those who were being defended were always oppressed, often heroes, never victims.

Fassin and Rechtman, *The Empire of Trauma*¹³⁷

The discourse on Indigenous suffering, residential schools and historical trauma which emerged in Canada during the 1990s established a consensus among many social actors -- particularly Indigenous and non-Indigenous professionals involved in policy, clinical practice and research related to healing in Aboriginal communities -- regarding the value of attending to colonial history in the therapeutic context. This consensus builds on the healing practices initiated by many Indigenous communities during the two decades prior. What remains contentious in the context of discussions of historical trauma, healing, and reconciliation, is which colonial and Indigenous histories are presented, and how.

In this section I consider how the different models of colonial power and Indigenous suffering implicit in psychologists’ and anthropologists’ accounts produce different Indigenous subjectivities. By ‘subjectivity’ I mean self-awareness and self-identity as constituted in a particular social and historical context: individual subjectivity and agency are both constituted by, and constitutive of, social forces, without either being reducible to the other.¹³⁸ So in other words, how do particular accounts of Indigenous histories foreground certain Indigenous identities whilst rendering others less legitimate? As the quotation from Shelley Niro at the beginning of this section suggests, victimhood has come to the fore as a dominant Indigenous identity in public discourse around residential schools. As Fassin and Rechtman note, trauma discourse similarly focuses on victimhood, and displaces other historical accounts, such as those of anti-colonial movements which foreground resistance. In a parallel discussion, historian Dominick LaCapra has argued that analyses of the Holocaust are commonly limited by reference to a “grid of subject positions” incorporating “the victim, perpetrators, bystanders, collaborators, resisters, those in [Primo Levi’s] grey zone”, “those born later”, and more recently “the rescuer”, as portrayed in Steven Spielberg’s 1993 film *Schindler’s List*.¹³⁹ In Indigenous healing discourse, the subject positions produced have implications for Indigenous healing
practice, subjectivities, and understandings of how healing relates to broader issues of Indigenous self-determination and relations with the Canadian state and settler society.

**Residential schools, trauma, and Indigenous resistance**

In some of the earlier accounts of residential school experiences and Indigenous suffering, Indigenous people were portrayed as resisting the violence and control of the schools. Anthropologist Celia Haig Brown’s 1988 study of the Kamloops Indian Residential School in British Columbia focuses on “the extent and complexity of the resistance movement which the students and their families developed against the invasive presence of the residential school”\(^{140}\). Camaraderie in stealing and sharing food, maintaining dignity in the face of punishment, humour at the expense of school authorities, devising mechanisms for boys and girls to interact, and running away from school, are some of the multiple forms of resistance which Haig Brown documents. The Assembly of First Nation’s 1994 report on residential schools also provides multiple examples of how children in residential schools thought creatively and acted boldly to break rules and avoid punishment.\(^{141}\) They savoured brief periods of freedom: in one school children were allowed to trap; most schools allowed some time for play each day. Some children worked hard to excel at academics or sports and took some satisfaction from their success. Some bravely reclaimed the basic entitlements that the school had denied them: sneaking out of school to enjoy brief “periods of freedom and solitude”, illicit conversations in their own language, or visits with siblings one had been forbidden to see. Solidarity amongst children emerges as a prominent theme: former students reported consistently refusing to identify other children who had “misbehaved”. As in Haig-Brown’s account, older children provided care for younger ones, for example by sharing food they raided during the night. In one compelling story, an older boy deliberately urinated in his bed so that he could share in his younger cousin’s punishment of being publicly stripped and paraded in front of the other boys. This compassionate gesture had a lasting positive impact on the younger child, who went on to support another child being punished for his poor reading by feigning inability himself, and then used the opportunity of their shared punishment to assist the boy who was struggling. Older children’s acts of defiance also inspired their younger peers: one former student described how he watched an older boy “crossing out the word ‘savages’ in
his textbook, and replacing it with a more positive word”.142 This experience inspired the younger boy to strive for academic excellence; he went on to become second in his class. Whilst processes and experiences of victimization are clearly discernible in these accounts, the children are portrayed not simply as victims but as rebels, co-conspirators, leaders, allies, even heroes.

In contrast, the discourse on historical trauma which became increasingly dominant in discussions of residential schools (and Indigenous healing more broadly) from the latter part of the 1990s often portrays Indigenous people simply as victims. Anthropologist James Waldram notes that invocations of history in historical trauma discourse are reductionist in describing “not only a uniform history of colonial experience but also a uniform reaction to that experience” (my emphasis).143 Some Aboriginal mental health professionals have problematised the uncritical application of concepts of trauma and historical trauma to Indigenous experiences of suffering. Métis psychologist Joe Couture recognized the concept of trauma as relevant to therapeutic work with Aboriginal people, particularly to incarcerated men with personal histories of “prolonged, repeated abuse”--but also cautioned that the concept might have the effect of denying Indigenous agency.144 In a 1994 report for Corrections Canada, Couture quotes Judith Herman’s argument regarding commonalities between survivors of multiple forms of trauma, noting that “there seems to be a close parallel, if not a direct analogy, between Aboriginal symptoms of personality disorder and pathology and those of victims of other situations”, and that dominant social forces of “acculturation” may induce such symptoms.145 However, Couture is careful to qualify the application of a model which focuses so strongly on the effects of colonial oppression that it negates individual agency, which is of great relevance to clinical work with Indigenous people. He acknowledges the importance of “decades of colonial, oppressive control and damaging manipulations, compounded by overt and covert systemic racism”, but makes the countervailing point that

*there are unequivocal traditional teachings regarding personal responsibility, for one’s actions and their consequences, as these guide the maintenance of essential life-giving and restoring connections.*146
Thus Couture refuses to propagate a simplistic image of Aboriginal people as victims by delegating all responsibility to trauma; rather he insists on retaining the Indigenous moral principle that individuals are responsible for their actions, and that acceptance of this responsibility is a prerequisite to healing.\textsuperscript{147}

In a stronger critique written in the mid-1990s, Haudenusaunee psychologist Roland Chrisjohn condemned both the focus on trauma in discourse on the residential schools, and what he describes as ‘a therapy-driven approach to residential schooling’.\textsuperscript{148} Chrisjohn was lead researcher with the Cariboo Tribal Council in Williams Lake, British Columbia and did some of the earliest work on residential schools, which he reported to the Royal Commission on Aboriginal Peoples in 1994. Chrisjohn argues that the prevalent focus on trauma and individual psychological problems obscures recognition of the broader political context and the fact that residential schooling “was an assault on First Nations ways of life as a whole”. In a prescient analysis he also noted the problems inherent to individualized legal redress for residential school experiences: “isolating the experience removes the First Nations complainant and his or her complaint from an ideologically meaningful context”. Written at a time when prominent Indigenous mental health professionals and other commentators were embracing trauma as relevant and valuable to the understanding of Indigenous suffering, Chrisjohn’s concerns about the broader effects of the concept are noteworthy. In his analysis, dominant framings of residential schools have invoked history in a narrow and selective way, focusing on individual suffering whilst failing to address the broader social, political and historical significance of residential schools.

**Historical trauma and the salience of Indigenous victimhood**

Waldrum interprets the ascent of Indigenous victimhood in trauma discourse as an “attempt to establish the history of oppression and the damage done, and to have this legitimated in the eyes of the larger society”.\textsuperscript{149} It is important to recognize that victimhood may indeed be a strategic choice -- whether in the context of an individual life, or a professional discourse -- strategic precisely because of the prevailing moral economy, or as Shelley Niro articulated in this chapter’s opening quote, “social good taste”. As an illustration of victimhood as an individual strategic choice, anthropologist Mats Utas’s analysis of young women’s experiences of the Liberian civil war recognizes a range of
complex survival strategies; he argues that young women deliberately represent themselves as victims of war, as one among many possible tactics.\textsuperscript{150} Assuming a simplistic victim identity facilitates young women’s recognition as deserving recipients of humanitarian aid. As Utas notes, in this analysis, “agency is no longer something you possess or do not. Rather, it is something you maintain in relation to a social field inhabited with other social actors.”\textsuperscript{151}

In an example from Indigenous healing discourse which appears to embrace a narrow representation of Indigenous people as victims of history, anthropologists Cynthia Wesley-Esquimaux and Magdalena Smolewski advocate a “purposeful universalization of Aboriginal people’s experiences”.\textsuperscript{152} In their account, which ranges widely across time and space, Indigenous experiences are represented as extreme and unremitting victimization:

\begin{quote}
After centuries of depersonalization, isolation from a sound culture and social milieu, with the group identity removed, people become extremely vulnerable and almost naked in the face of their powerful oppressors. Being treated with utmost contempt and derision and being brutally stripped of every reminder of their previous cultural identity and their predictable social environment, they lost their strength as a people and as individuals. The almost complete destruction of their social context and their social identity left them unbearably anxious, tremendously uncertain and miserably subject to a new and uncertain world. One must always remember that, in past centuries of moral terror, the Aboriginal people’s intra-social structure was shattered.\textsuperscript{153}
\end{quote}

As Wesley-Esquimaux and Smolewski explain, this approach is intended to ‘make [Indigenous experience] available and understandable to everyone’. They contrast their strategic universalization of Indigenous colonial experience with dominant actors’ particularization of Indigenous experience, in which ‘Indigenous people’s experiences and their memories have been turned into something unusual and exotic, something singled out among many “normal” lives, “normal” reactions and “normal” memories; something minute, specific only to “them” and not to others; and something encapsulated, something marginal.’\textsuperscript{154}

The universal Indigenous victim is also a ready candidate for therapeutic interventions, in contrast to the resistor, who demands a more profound restructuring of social and political relations. It is perhaps unsurprising that some Indigenous and other mental health professionals would perpetuate the former representation, as it brings Indigenous suffering into a realm where it may be managed by professional intervention. By this I do
not mean that health professionals are driven by narrow self-interest, but that in general they are invested in broader discourses of modernization and development which privilege the application of professional knowledge and technical solutions over social and political change. Simplified and standardized accounts of Indigenous histories support both the framing of contemporary Indigenous people as victims, and the idea that invoking history in healing is a straightforward process. The latter assumption appears to underlie recommendations such as that of Brave Heart and Weaver, who advise social workers to 'explore the relevance of historical trauma' during assessments of all Native clients:

*Information should be collected on multigenerational trauma experienced by a client’s family and nation. The assessment should explore the meaning of boarding schools, massacres, loss of land, and similar phenomena in relation to contemporary social and health problems. Once historical trauma is determined to be a relevant factor in the client's current situation, then taking steps toward recognizing, dealing with, and healing that trauma is critical.*

Such proposals are most practical if one assumes a singular set of uncontested meanings for Indigenous experience. The coexistence of unimaginable horrors, everyday forms of structural violence and inspiring acts of resistance and solidarity presented in the more nuanced accounts may be less amenable to therapeutic intervention.

To understand the prominence of the Indigenous victim in healing discourse one must consider this subject position’s currency in the dominant moral economy. Individual experiences of trauma and suffering are more salient than collective experiences; discrete historical events are more digestible than nuanced analyses of more diffuse experiences of violence; and victims attract more public sympathy than protestors. It is clear that former residential school students’ accusations of sexual abuse, for example, catalysed public discussion of the broader effects of residential schools. RCAP commissioners suggested that the Canadian public was rendered more receptive to the issue of abuse in residential schools by concurrent media reporting of the sexual abuse of (non-Aboriginal) children in other institutional settings: Mount Cashel orphanage in St John’s, Newfoundland and Saint Joseph Reform School run by the Christian Brothers in Alfred, Ontario. Non-Aboriginal Canadians found that Aboriginal revelations and their attack on the schools, and on the disastrous consequences of federal policy in general, fell within the parameters of their
own social concerns, and thus non-Aboriginal voices joined the chorus of condemnation.”\textsuperscript{157} But as Marlene Brant Castellano notes, most Canadians continue to 
\textit{disagree} that residential school attendance was “injurious in itself, and not just in instances of physical and sexual abuse”.\textsuperscript{158} Compared with physical and sexual abuse, there has been a relative lack of media attention devoted to other aspects of residential school experience, ranging from high rates of morbidity and mortality from malnutrition and infectious disease, to the more diffuse but no less serious forms of social disruption caused by the estrangement of intergenerational relationships. In advocating for the strategic universalization of Indigenous historical experience, Wesley-Esquimaux and Smolewski risk pandering to this sort of ahistorical populist sentiment. Is the complexity of collective effects, such as loss of language, knowledge systems and livelihoods, simply beyond the meaning-systems of most Canadians, and therefore incomprehensible? The concept of ‘collective trauma’ aims to encompass this complexity; used mainly by writers on Indigenous suffering outside of the field of mental health, it has received far less attention from the media and in the Aboriginal health literature than individual trauma resulting from sexual and physical abuse in residential schools.\textsuperscript{159} Collective trauma focuses on the effects of state and capitalist interventions affecting whole communities, such as forced relocation and industrial pollution of traditional Indigenous harvesting sites, where the community has little or no control over the intervention.\textsuperscript{160} Central to such analyses is the recognition of the complex social and cultural meanings of wild harvesting activities to Indigenous peoples: disruption goes beyond obvious economic and nutritional effects, encompassing implications for family relations, spirituality, individual self-esteem, and all aspects of health. Whilst this framework is clearly relevant to analyzing the societal impact of residential schools, it has rarely been taken up in health or media discourse on Indigenous experiences of trauma. This neglect may reflect the extent to which collective trauma implies a wide-ranging critique of Canadian capitalism and settler modernity, rather than simply indicting the behaviour of church and school officials.
Whilst the individual Indigenous trauma victim clearly holds currency in the contemporary moral economy and therapeutic discourse, the broader effects of this dominant subject position may run counter to the goals of healing for both individuals and collectivities. Such effects include disproportionate attention to media-worthy singular events, such as sexual abuse in residential schools, at the expense of more complex and ongoing forms of structural violence, and neglect of the complexity and diversity of Indigenous histories and societies. Invoking trauma to draw attention to past suffering may inadvertently minimize long-standing and continuing suffering in the context of more complex social and political relations: 'trauma is not only silent on these realities; it actually obscures them.' 161 As Fassin and Rechtman observe, groups of people using 'trauma' to claim victim status in relation to a particular historical event have commonly already experienced longstanding social and political oppression and violence, which both predated the traumatic event, and continued to exert effects long after the event. As psychiatrist Gary Chaimowitz (quoted above) noted, victimhood “becomes a difficult psychological space to be in”; because it typically does not offer any alternative subjectivities, trauma discourse may not offer an escape route.

Feminist theorists writing on racialised women's experiences of intimate partner violence have offered relevant analyses, emphasizing the extent to which physical and sexual abuse are part of a continuum of violent and oppressive experiences, rather than distinct and exceptional.162 For example, Patricia Connell writes that the range of experiences Black women experience as abusive -- including forced sex, but also verbal abuse and economic deprivation -- are broader than those conceptualized in either the traditional feminist literature (focusing on gender oppression) or anti-racist research (concentrating on racial oppression), 'both failing to address the ways in which the two forms of domination connect in Black women’s lives'.163 Whilst some writers on Indigenous historical trauma are trying to get the concept to do this work by using it in a very diffuse sense to incorporate a myriad of colonial oppressions (such as Wesley-Esquimaux’s work discussed above), such attempts inevitably come up against the inadequacies of the concept, which invokes only suffering resulting from past events, not ongoing social processes. Further, it is based on a simplified understanding of colonialism, incorporating a narrow
understanding of power as hegemonic and therefore offering a limited range of Indigenous subject positions. To adapt Connell’s framing, a model that locates contemporary Indigenous suffering solely as a result of historic trauma, and which fails to conceptualise any interconnection with other structural sites of domination, is arguably less effective in challenging such suffering than a model which attempts to address a range of variables.

Historic trauma discourse centred on Indigenous victims may obscure the complexities of both pre-colonial and colonial Indigenous histories. It invokes or implies an Arcadian stereotype of pre-contact life, a romanticised image of “people without history”.164 Psychologist Joseph Gone has described this trend within Aboriginal mental health discourse as ‘the imperialist nostalgia of others – all too frequently made our own – for the unspoiled splendor of the pristine, primal past’.165 This construct obscures the fact that Indigenous experiences of trauma did not originate with the arrival of European colonizers.166 Not only did Indigenous peoples experience violent conflict and other potentially traumatizing experiences prior to colonization, they had interventions to support healing from such experiences. Since the late 1990s, archaeological and ethno-historical researchers have amassed extensive evidence of extensive intergroup violence throughout the pre-colonial Americas.167 Indigenous peoples also developed therapeutic interventions aimed at supporting warriors in their recovery from traumatic experiences.168

Regarding representations of Indigenous experiences of colonization, again the Black feminist literature provides helpful comparative material, applicable to the ways in which literature on historic trauma depicts Indigenous experiences of colonization as universal victimization. Connell describes ‘the selective depiction of “negative” phenomena as definers of Black experience’ as ‘another strand in the tendency to define abuse women in terms of victimization’.169 As she argues, these depictions occlude the range of experiences within Black communities and ‘represent the entire experience by the instance of subordination, without contextualizing and writing the problem into the fuller experience of Black life (positive images and oppression alike)’.170 Similarly, the fuller Indigenous experiences of colonization are not well represented in the discourse on historic trauma,
constraining the possibilities for invocations of history to contribute to healing. These issues are explored further in the context of urban settings in Chapter Six.

6. Conclusion
Since the 1990s, Indigenous and other commentators have increasingly wielded international human rights discourse to attack the Canadian government’s treatment of Indigenous peoples. During the same period, former residential school students, empowered by the rise of strategic victimhood and the moral currency of trauma in public discourse, mounted an unprecedented legal challenge to the state and Canadian churches. Scrambling to defend its international image and contain financial liability, the Canadian government has embraced the role of the ‘therapeutic state’. The current analysis concurs with that of Michael Humphrey in concluding that the state’s ultimate political objective in this exercise has been the re-establishment of sovereignty: ‘the focus on health and healing helps make violence, and therefore the question of rights, disappear from the narrative of reconciliation by focusing on the effects of violence rather than on its causes’.171

This is not to deny the significant shifts in Indigenous-state relations represented by the emergence of ‘Aboriginal healing’ in Canadian public policy, nor the very real therapeutic effects which many former residential schools students and others have experienced as a result of state-supported programming. Ontario’s Aboriginal Healing and Wellness Strategy, discussed in Chapter Three, powerfully demonstrated the possibilities for transformative relationships and ways of working between Indigenous people and settlers within dominant institutions, given Aboriginal solidarity, political will, and openness to learning on the part of government representatives. The Prime Minister’s apology and the compensation payments provided impetus for healing for some former residential schools students. The Aboriginal Healing Fund has supported thousands of community-based projects, most of which have incorporated Indigenous knowledge.

But the profound disjuncture between Indigenous models of healing as a social and spiritual process informed by historical analysis, and State actors’ manipulation of healing discourse in order to salvage Canada’s international reputation and limit culpability, is increasingly stark. This disconnect is well-illustrated by the way the Aboriginal Healing
Fund’s work has been constrained and curtailed, disregarding the long-term nature of healing processes which are inherently social processes. Presumptions of the healing power of testimony pervading much international discourse on reparations and reconciliation similarly disregard social context; international evidence suggests limitations to the power of testimony to effect changes in social relations. Damage inflicted on some former residential school students, their families and entire communities by the Common Experience Payment is a bleak illustration of the inadequacies of the asocial, ahistorical neoliberal model of ‘healing’ espoused by the state. Further, the Canadian government’s failure to recognize reparations claims of less powerful Indigenous peoples including the Métis and the Nunatsiavut Inuit provides evidence of an unwillingness to accept that healing and Indigenous self-determination are interdependent processes. And whilst many Indigenous commentators welcomed the Prime Minister’s apology as a beginning of constructive engagement with settler society, many settler-descendants viewed it as an absolution and, therefore, an end.

The discourse on historical trauma both fosters recognition of colonialism as a primary determinant of Indigenous suffering, and limits the range of subject positions available to Aboriginal people, foregrounding the victim and marginalizing the resistor. Whilst victimhood may be a strategic choice designed to attract political capital, this particular subject position has the effect of occluding and de-legitimizing alternative Indigenous subjectivities. As Lambek and Antze argue,

*the political gains conferred by a victim identity (e.g. “trauma survivor”) are accessible only through expert discourses (in law, medicine, psychiatry) which have their own agendas and are themselves instruments of power. By their very nature such discourses deal in causes rather than meanings, events rather than persons, instances rather than entire lives. Thus [...] reinscribing personal stories into these public discourses often obscures their richness and moral complexity.*

The pre-eminence of strategic victimhood in the historical trauma discourse points to the challenge of navigating identity politics in the context of severe oppression, in order to move beyond a limiting, pre-defined range of subject positions, such as those defined by the grid of subject positions in Holocaust studies. Dominick LaCapra defines identity politics as
a form of thinking wherein research or thought simply validates your beginning subject position. Through identity politics, your initial subject position remains firm and, if anything, through research and inquiry is further strengthened time and again.\textsuperscript{173}

The challenge which LaCapra identifies for research on the Holocaust applies equally well to invocations of historic trauma in healing discourse, and the emerging discourse on reconciliation: how can analysis move beyond this narrow range to conceive of ‘relations between people that are not beholden to victimization and the consequences of victimization’?\textsuperscript{174}

Arguments in feminist and anthropological literatures which recommend going beyond a limited and limiting construction of agency and victimhood in opposition to one another are helpful here. Writing about Black women’s experiences of intimate partner violence in Britain, Patricia Connell argues for a wide definition of agency which recognizes the possibilities for resistance within the context of an abusive relationship.\textsuperscript{175} Such an approach requires an understanding of power relations which incorporate both experiences of suffering oppression, and resistance to oppression, avoiding the pitfall of some liberationist thought which confuses the recognition of resistance as somehow undermining the legitimacy of claims to oppression. In other words, it is a mistake to understand agency as 'an absence of oppression', rather it is 'acting for oneself under oppression'.\textsuperscript{176}

In the wake of the significant developments in Aboriginal healing policy and public discourse discussed in this chapter, it remains to the proponents of Indigenous healing to move beyond the increasingly dominant trope of Aboriginal victimhood. More rigorous, nuanced and locally-grounded historical accounts could broaden the range of Indigenous subjectivities suggested by healing discourse, as well as drawing attention to the myriad colonial modes of victimization and their continuities in the present.
End-notes to Chapter Four


3 The 1983 First Ministers Conference achieved some progress on Aboriginal issues. In 1985 the Federal Interlocutor for Métis and Non-Status Indians was established, the first formal federal liaison mechanism for Indigenous people — including those in urban centres - other than Status Indians and Inuit. Professor Brad Morse, Faculty of Law, University of Ottawa: conversation with author, July 29th 2008. (Professor Morse was Chief of Staff for Minister for Indian Affairs Ron Irwin under Prime Minister Jean Chretien between 1993 and 97.)

4 Professor Brad Morse, Faculty of Law, University of Ottawa: conversation with author, July 29th 2008.


8 Federal government made changes to land claim policy in Sept 1990 which paved the way for the belated consideration of claims in BC, as well as removing barriers to claims elsewhere. In October the BC government agreed to begin land claim negotiations with the Nisga’a Tribal Council; the parties signed the first modern-day treaty in BC in 1998, also historically significant for being the first treaty in Canada to address both land claim and self-governance. Harry LaForme, Indian Commissioner of Ontario (and later the first chair of the Truth and Reconciliation Commission) produced an influential report focusing on the land claim aspect of the Oka conflict in December 1990. LaForme’s report included a comprehensive proposal focusing on Aboriginal land claims not related to title, including the erosion of reserve lands, non-fulfillment of treaty obligations, and administrative fraud. The report quickly worked its way through Federal Government, and according to Professor Brad Morse was central to two major policy developments in the spring of 1991: a new approach to land claims, embodied in the ‘Indian Specific Claims Commission’ to which Harry LaForme was appointed as the first commissioner; and the appointment of Brian Dickson to lead a consultation on terms of reference for a Royal Commission on Aboriginal Peoples. Morse also suggested that the government hoped that Aboriginal organisations being preoccupied with the RCAP consultation and would be less engaged in steps towards a new constitutional proposal for which initial discussion papers were released Sept 1991. Professor Brad Morse, Faculty of Law, University of Ottawa: conversation with author, July 29th 2008.


12 In a recent sociological study of relations between Aboriginal and settler-descendant residents in Fort Frances, Ontario, participants from the latter group gave ‘Aboriginal protestors’ the lowest rating on a scale describing their feelings toward a particular group. On a 1 to 5 scale in which 1 means “strongly


15 In April 1999 the United Nations Human Rights Committee expressed concerns regarding the Canadian government’s failure to implement RCAP’s recommendations. The Canadian Human Rights

16 Historian Regula Ludi provides an extremely helpful history of postwar victim reparations which sheds light on both the international origins of reparations practices in the periods following the First and Second World Wars, and the significant cultural shifts during the 1960s and 1970s which influenced the emergence of contemporary reparations discourse. Earlier approaches to reparations after the First and Second World Wars struggled with the limitations of international law at the time, including its incapacity to recognize collective grievances not represented by a recognised nation-state, and a lack of procedures for distributing compensation to individual civilians. Early repair schemes Post-World War Two were shaped by western legal traditions’ emphasis on property rights ‘while they paid little heed to the issue of compensation or conceived it merely as a form of relief to be allocated to survivors in accordance with their needs’. Further, there was no framework by which ‘monetary reparations for the violation of human rights and human dignity’ might be assessed; indeed, at that time, ‘to many, the equation of mental and physical suffering with a sum of money also appeared morally abhorrent’. Ludi joins other commentators in identifying the 1978/1979 mini-series ‘Holocaust’ as ‘the turning point when popular representations of the Final Solution dramatically changed and what some deem the globalization and universalizing of Holocaust memory through the mass media began’, leading to the more recent phenomenon of focusing on the roles of victims, and changing concepts of victimhood associated with increasing moral authority and political legitimacy. Regula Ludi, "The Vectors of Postwar Victim Reparations: Relief, Redress and Memory Politics," Journal of Contemporary History 41, no. 3 (2006): 429-30; 35; 25.


18 Ibid.


27 Ibid.: 149.

28 Ibid.


31 A clip of Fontaine’s interview can be viewed at http://archives.cbc.ca/society/education/clips/11177/

32 The idea of a Royal Commission to address Aboriginal issues had been floated in federal political circles as early as 1986. According to Bradford Morse, the Canadian Bar Association’s Task Force on Aboriginal issues, a group of Aboriginal and non-Aboriginal lawyers including David Hawkes (later co-director of research for the RCAP), originally made this recommendation. At that time the media and the Liberal and NDP parties responded positively to the idea, but it was not taken up by PM Mulroney. By 1990, in the context of growing Aboriginal opposition to the Meech Lake Accord, the RC idea was formally included in Mulroney’s proposal to Manitoba MLA Elijah Harper. Morse recalls discussion with Deputy Minister of Indian Affairs Harry Swain, who was a key figure in these negotiations, regarding the CBA’s recommendation for the establishment of a Royal Commission. But Elijah Harper rejected Mulroney’s proposal based on advice of Phil Fontaine and Association of Manitoba Chiefs. (Professor Brad Morse, Faculty of Law, University of Ottawa: conversation with author, July 29th 2008)

35 Professor Brad Morse, Faculty of Law, University of Ottawa: conversation with author, July 29th 2008.


Assembly of First Nations, "Breaking the Silence: An Interpretive Study of Residential School Impact and Healing as Illustrated by the Stories of First Nations Individuals."

Elder Irene Lindsay, Oral History, Ottawa, June 15th 2009. OH14, 13m.

Fassin and Recthman, The Empire of Trauma. An Inquiry into the Condition of Victimhood, 6-7.

Ibid.

Ibid., 39.

Ibid., 22.

Ibid.(4-6; 23)


Fassin and Recthman, The Empire of Trauma. An Inquiry into the Condition of Victimhood, 163-70.

Ibid., 166-67.

Ibid., 167-68.

An important exception to this general inattention in both scholarly and grey literature was the paper I discussed in the Chapter Three by Hudson and McKenzie, "Child Welfare and Native People: The Extension of Colonialism."


Aboriginal people from Ontario who qualified as psychologists during this period include Dr Ed Connors (Mohawk), Dr Roland Chrisjohn (Onyota’a:ka of the Haudenausanee/ Mohawk), Dr Rod McCormick (Mohawk), and Dr Brenda Restoule (Ojibwe).


Marlene Brant Castellano, Oral History interview, March 22nd 2010, Tyendinega, OH26, 48m

60 Royal Commission on Aboriginal Peoples, "The Path to Healing: Report of the National Round Table on Aboriginal Health and Social Issues" (Ottawa: Ministry of Supply and Services Canada, 1993), 23.
61 Ibid., 28.
63 Ibid., 22-23.
65 Ibid., 251.
66 Lambek and Antze, "Introduction. Forecasting Memory," xii.
69 An early example of scholarly writing on North American Indigenous history invoking the concept of genocide (in this case argued to be an ongoing process), is Bruce Johansen and Roberto Maestas, Wasi’chu: The Continuing Indian Wars (New York: Monthly Review Press, 1979). Legters and other writers invoked the United Nations Convention on Genocide (1948), arguing that the effects of settler colonialism in North America were consistent with actions outlined in the UN definition, including ‘causing serious bodily or mental harm’, ‘inflicting... conditions of life calculated to bring about [the group’s] physical destruction in whole or in part’, and ‘forcibly transferring children of the group to another group’. At the same time Legters sounded a cautionary note regarding the limits of comparability: ‘It is plain enough that North America has never seen a calculated program of extermination of Native Americans in any way comparable to Hitler’s campaign to liquidate European Jewry’. Lyman H. Legters, "The American Genocide," Policy Studies Journal 16, no. 4 (1988)
70 Dominick LaCapra, Writing History, Writing Trauma (Baltimore and London: The Johns Hopkins University Press, 2001), 175-76.
71 Duran, Transforming the Soul Wound. A Theoretical / Clinical Approach to American Indian Psychology., 93.
72 Fassin and Recthman, The Empire of Trauma. An Inquiry into the Condition of Victimhood, 18.
74 Maria Yellow Horse Brave Heart, "Historical Trauma Theory and Research: Promise and Challenges," in National Network for Aboriginal Mental Health Research Annual Meeting (Montreal, 2008).
75 Assembly of First Nations, "Breaking the Silence: An Interpretive Study of Residential School Impact and Healing as Illustrated by the Stories of First Nations Individuals."
76 Ibid., 76-77.


78 For a more detailed chronological account of federal Aboriginal policy since the Royal Commission on Aboriginal Peoples see Courtney Jung, "Canada and the Legacy of the Residential Schools: Transitional Justice for Indigenous People in a Non-Transitional Society," (University of Toronto, 2009).

80 Mike DeGagné, Oral history, September 17th 2008, Toronto; Letter from Anne McLellan to National Chief Phil Fontaine, May 30, 2005 stating ‘the work of the Assembly of First Nations (AFN), and your individual efforts as National Chief, have been instrumental in the development of the Government of Canada’s renewed strategy for the resolution of the IRS legacy.’ Viewed at http://www.afn.ca/residentialschools/PDF/05-05-30_IRS_Accord.pdf, August 16th 2010.

81 Cf. Lawrence, "Real" Indians and Others: Mixed-Blood Urban Native Peoples and Indigenous Nationhood.


84 The report identifies twelve main problems with the process, including the resolution framework’s formula for calculating compensation: the emphasis on abusive acts over consequences of abuse, and the failure to recognise ‘emotional abuse, loss of family life, forced labour, and the loss of language and culture’ as experiences warranting compensation. Further, the AFN report compared the Canadian compensation process unfavourably to that of Ireland, noting that the Canadian government was spending ‘proportionately 25 times less’ than its Irish counterpart. Insufficient attention to ‘the healing needs of the survivors and their families’ was another important criticism. ———, "Report on Canada's Dispute Resolution Plan to Compensate for Abuses in Indian Residential Schools," 2-3.

85 The Department of Northern Affairs described the schools it administered in the Yukon and Northwest Territories northern Ontario, Quebec, Manitoba and Alberta, as ‘federal day schools’ rather than ‘residential schools’. Inuit and First Nations students attending these schools lived away from their families in hostels adjacent to the schools. King, "A Brief Report of the Government of Canada’s Residential School System for Inuit." Sixteen ‘federal hostels’ were included in ‘Schedule F’ of the Agreement as ‘Additional Residential Schools’. Residential Schools Settlement Official Court Notice http://www.residentialschoolsettlement.ca/Schedule_F-AdditionalResidentialSchools.PDF accessed August 18th 2010.


Métis children often attended day schools, or residential schools as day students, because Indian Affairs would not cover the costs of their transportation. Further, because the Métis did not fall under the remit of Indian Affairs and historically neither provincial nor federal governments assumed responsibility for providing services to them, record-keeping for Métis students was often less complete than for students who were status Indians. Provincially-funded schools were also excluded from the settlement. Chartrand, Logan, and Daniels, *Métis History and Experience and Residential Schools in Canada.*

Ibid; Logan, "A Métis Perspective on Truth and Reconciliation."


National Aboriginal leaders negotiated the ‘Kelowna Accord’ with Premiers and Liberal Prime Minister Paul Martin at the First Ministers’ Conference on Aboriginal Affairs in November 2005. The agreement, endorsed by all provincial premiers, had committed $5 billion over five years towards government spending on Aboriginal education, housing, water supplies, health services, and economic development. However the minority Liberal government was defeated just days after the First Ministers’ Conference, leading to a federal election in Jan 2006 which was won by Stephen Harper’s Conservative party. The new government allocated significantly reduced funds to expenditure on Aboriginal issues – for example, $150 million towards education in 2006, compared with $600 million under the Kelowna accord – in its first budget tabled May 2, 2006. CBC news, "Undoing the Kelowna Agreement," *CBC News*

97 See Younging, "Inherited History, International Law, and the Un Declaration." The ‘Declaration on the Rights of Indigenous Peoples’ was adopted by the UN General Assembly on September 13, 2007 with only Canada, the United States, New Zealand and Australia opposed. In April 2008 the Canadian House of Commons voted to support ratification of the Declaration, but the government chose to ignore this vote.


100 Mike DeGagné, Oral history, September 17th 2008, Toronto

101 From its inception, AHF leadership requested to function as a foundation subject to fewer restrictions (this was also an option proposed in the subsequent 2009 INAC Evaluation), and to be allocated a longer timeframe to allow for investment of funds. The then-Liberal government denied these requests. The AHF was not a party to the 2006 settlement negotiations, but presented a case to the parties involved for an additional allocation of 600 million dollars to support another 30 years of operation. (By this time AHF research had established that participating Aboriginal communities required approximately ten years to develop well-established processes of healing.) But the final agreement provided for just $125 million over 5 years. This allocation disregards the fact that the AHF had been operating on $40 million per year at end of first mandate, and had been specifically asked not to cut funding to ongoing projects. AHF leadership then took the decision to fund some projects until 2010 and to continue to support the eleven larger Healing Centres until 2012. Jonathan Dewar, Director of Research for the Aboriginal Healing Foundation, communication with author, July 22nd 2010.

102 An evaluation report commissioned by the AHF to assess progress in healing since the Settlement Agreement concluded in 2009 that ‘healing from trauma experienced at residential schools has just started. Communities require long-term funding, more training for staff in the communities, more service providers to deal with increased demand, and additional accessible facilities.’ Gwen Reimer, ""Mapping Progress" on Community Healing since Implementation of the Settlement Agreement: Effectiveness of Evaluation Tools Used by Projects Funded by the Aboriginal Healing Foundation," in Aboriginal Healing Foundation Research Series (Ottawa: Aboriginal Healing Foundation, 2010). Further evidence of the long-term nature of the healing work supported by the AHF, growing demand for healing services, and how the residential schools settlement has enhanced demand for healing services, is found in Reimer, "The Indian Residential Schools Settlement Agreement’s Common Experience Payment and Healing: A Qualitative Study Exploring Impacts on Recipients."; Indian and Northern Affairs Canada, "Evaluation of Community-Based Healing Initiatives Supported through the Aboriginal Healing Foundation," ed. Indian and Northern Affairs Canada, Performance Measurement Evaluation, and Review Branch; , and Audit and Evaluation Sector (Ottawa2009). and ; Kishk Anaquot Health Research, "Final Report of the Aboriginal Healing Foundation Volume 2. Measuring Progress: Programme Evaluation.," (Ottawa: Aboriginal Healing Foundation, 2006).

103 Indian and Northern Affairs Canada, “Evaluation of Community-Based Healing Initiatives Supported through the Aboriginal Healing Foundation," 5.

104 Ibid.

105 Ibid., 4; 5.


107 Ibid.; Marlene Brant Castellano, Oral history, Tyendinaga, March 22 2010, OH26, 50m.
The stated purpose of the evaluation report was to 'provide evidence that will support the Government’s decision-making regarding whether and to what extent funding should continue beyond the current end date of March 2010 for some projects and March 2012 for others'. Indian and Northern Affairs Canada, "Evaluation of Community-Based Healing Initiatives Supported through the Aboriginal Healing Foundation." Nevertheless, the report was tabled by the INAC Parliamentary Secretary on March 5th 2010. John Duncan, "Routine Proceedings: Aboriginal Affairs. House of Commons Debates, Official Report (Hansard), Friday March 5th, 2010," ed. House of Commons, House of Commons Debates, Official report (Hansard), Friday March 5th (Ottawa 2010).

CBC news, "Residential School Survivors Fear Network End."

cf. Humphrey, "Reconciliation and the Therapeutic State."


See many of the papers in the Aboriginal Healing Foundation’s edited collections, available online at http://www.ahf.ca/publications/research-series

Ross, "On Having Voice and Being Heard. Some after-Effects of Testifying before the South African Truth and Reconciliation Commission."


Reepa Evic-Carleton, Oral History, Ottawa, April 9th 2010. OH29,18m.


Between June 2008 and April 2009, researchers interviewed 281 individuals (First Nations, Inuit and Métis) who had applied for common experience payments. 22% of respondents lived in urban areas. Incarcerated and homeless individuals were under-represented among study respondents. Reimer, "The Indian Residential Schools Settlement Agreement's Common Experience Payment and Healing: A Qualitative Study Exploring Impacts on Recipients."


Ibid., 50; 93-94.

Ibid., 93; 95.

Legislative Assembly Of Ontario Select Committee On Mental Health And Addictions, "Committee Transcripts: Select Committee on Mental Health and Addictions - March 24, 2010 - Mental Health and Addictions Strategy ", ed. Second session Legislative Assembly of Ontario, 39th parliament (Toronto 2010).

Gary Chaimowitz, oral history, February 17th 2010, Hamilton. OH21, 50m.


The initial remit was support for former students only; families were included with the expansion of the programme from 2006.


Kari Nisbet, Oral History, June 16th 2009, Ottawa. OH16, 28m


Fassin and Recthman, The Empire of Trauma. An Inquiry into the Condition of Victimhood, 159-60.


LaCapra, Writing History, Writing Trauma, 175.


Ibid., 46.

Waldram, "The Traumatized Aboriginal," 228; 35.


Ibid., 5; 13.

Ibid., 5-6.

Ibid., 18.


Waldram, "The Traumatized Aboriginal," 228.


Ibid.: 407.

153 Ibid., 79.
154 Ibid., 10.
155 Weaver and Brave Heart, "Examining Two Facets of American Indian Identity: Exposure to Other Cultures and the Influence of Historical Trauma," 29.
161 Fassin and Rechtman, The Empire of Trauma. An Inquiry into the Condition of Victimhood, 281.
163 Connell, "Understanding Victimization and Agency: Considerations of Race, Class and Gender," 116.
164 The discipline of anthropology bears significant responsibility for this stereotype. Important early discussions of this are in Fabian, Time and the Other: How Anthropology Makes Its Object; Eric R. Wolf, Europe and the People without History (Berkeley CA: University of California Press, 1982).
166 Waldram, "The Traumatized Aboriginal."
169 Connell, "Understanding Victimization and Agency: Considerations of Race, Class and Gender," 116.
Ibid.: 117; See also Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Colour."

171 Humphrey, "Reconciliation and the Therapeutic State," 204.
172 Lambek and Antze, "Introduction. Forecasting Memory," xxiv.
173 LaCapra, Writing History, Writing Trauma, 174-75.
174 Ibid.
175 Connell, "Understanding Victimization and Agency: Considerations of Race, Class and Gender," 118-20.
Chapter 5  
Liberal Multiculturalism, Mental Health, and the (Mis) Recognition of Indigenous Suffering: Provincial Policy Reform and Urban Biomedical Institutions

Introduction

Raymond Chan, Executive Director of Hong Fook Mental Health Association in Toronto, wrote of Ontario’s mental health reform process in 1996,

_We see this as a great opportunity for immigrant and ethno-racial communities to express our needs and advocate for changes in order to establish a racially and culturally responsive mental health system._

During the 1990s Ontario’s New Democratic government began to operationalise longstanding rhetoric about involving community agencies and service users in mental health care planning. Immigrant and racialised community groups -- some of whom, such as Hong Fook, had been delivering community-based mental health programmes since the early 1980s -- became increasingly vocal participants in mental health policy-making. Thus mental health reform in Ontario provided a forum in which differently situated actors articulated competing discourses about social difference and health care. Such discourses drew on different political ideologies but shared a common focus on the perceived needs of immigrant and racialised groups. From the late 1980s, ‘multicultural health’ as a discursive framework provided valuable leverage for immigrant and racialised groups in southern Ontario cities intent on influencing provincial policymaking towards the delivery of more appropriate and accessible healthcare programmes for their communities.

In this chapter I argue that not only were Indigenous peoples marginalized from the 1990s mental health reform process, they have been further marginalized by liberal discourses on multiculturalism and mental health which remain dominant in the present. Canadian policy and discourse on multiculturalism have a long history of concealing the existence of Indigenous peoples, as Sunera Thobani has discussed. The 1963 Royal Commission on Bilingualism and Biculturalism, which led to the 1971 federal multiculturalism policy, occluded the existence of Indigenous peoples by its very mandate, which referred to 'the two founding races' of Canada. Joseph Garcea’s analysis has shown that most provincial multiculturalism policies focused explicitly on immigrant populations. In the popular imagination of settler-descendants and new immigrants alike, Canadian multiculturalism
both valorized Canada as morally superior to the United States, with its immigrant assimilation policies, and put closure to the colonial era, ushering in a new period of ethnically-diverse liberal democracy distinguished by distinctly Canadian willingness and ability to smooth over intra-ethnic differences. But as Robyn Bourgeois points out, multicultural policy has itself perpetuated the erasure of Indigenous peoples. By limiting its historical focus to the post-war period, multicultural perspectives neglect Indigenous peoples’ much longer histories both prior and subsequent to the arrival of settlers. From Indigenous perspectives, Canadian colonial policies have been characterized by assimilation, coercion and containment rather than celebration.7

Shifts in mental health policy and the organisation of services over the past forty years, in Ontario as elsewhere, must be contextualized in the broader retrenchment of the welfare state. Whilst changes internal to psychiatry, the rise of anti-psychiatric discourses and the community mental health movement generated some momentum towards deinstitutionalization, it was the political dominance of a neoliberal agenda of cost-cutting and the ‘restructuring’ of health care which ultimately drove the large-scale closure of psychiatric institutions in Ontario.8 Provincial policymakers had discussed the deinstitutionalization of mental health care since the 1960s, but as Mary Wiktorowicz has argued, the process did not gain significant momentum in the province until the 1990s, particularly under the Conservative government of Mike Harris (1995-2002). Commitments to developing alternative, community-based models of mental health care materialized very slowly during this period, but significant rhetoric was generated and provided fertile terrain for discussions of social difference and community mental health.9 Throughout most of the 1980s the Ontario government continued to define ‘community mental health’ in terms of psychiatric units in general hospitals, outpatient units, and the ‘Homes for Special Care’ programme.10 In contrast, proponents outside of government defined community mental health care as a spectrum of programmes and services encompassing housing, vocational rehabilitation, recreation facilities and case management.11 Clearly, closing large institutions to recover significant public expenditure aligns perfectly with neoliberal political rationality; the concurrent reinvestment of funds
required to develop community-based infrastructure to support people living with mental illness has been less attractive to governments.

Section One of this chapter draws on sources from the Ontario provincial archives to analyse the rise of a liberal multicultural health paradigm in Ontario from the late 1980s, and the efforts of policymakers to subsume Aboriginal interests within this framework. During the 1990s provincial mental health reform became the site for competing discourses on cultural and ethnic difference, ‘race’ and mental health: a liberal framing which focused on cultural sensitivity training, and an anti-racist analysis, which also incorporated professional education but went further in demands for more profound changes in health care institutions. Both discourses alternated between subsuming Indigenous peoples and occluding them entirely.

Section Two presents ethnographic research conducted with mental health professionals in a large, urban biomedical institution in southern Ontario. Here I show how the continuing dominance of ‘diversity’ and ‘cultural competence’ models in mental health, combined with discourses on professional excellence and best practice, have perpetuated the marginalization of Indigenous interests in the present.

A ‘multicultural health’ paradigm first emerged in Ontario public policy discourse during the late 1980s. The Liberal provincial government’s 1989 policy statement on multiculturalism espoused a celebratory model of social difference, linking ethnic diversity to prosperity and reinforcing neoliberal values of individual choice, opportunity and ‘responsible citizenship’. Social change towards greater inter-ethnic harmony was to be achieved, the policy posited, through processes of knowledge acquisition, education, understanding, and greater ‘sensitivity’ on the part of public services. The policy was silent on issues of racism, oppression, colonialism and Indigenous peoples.

Actors in the Ontario health policy sector quickly embraced the liberal multiculturalism model. In 1988 the Ministry of Health announced that ‘multicultural health’ was a policy
priority (alongside ‘Native health’, ‘francophone health’, ‘women’s health’ and ‘northern health’), established a Minister’s Advisory Committee on Multicultural Health, and instructed District Health Councils to ensure that both their members and district services ‘adequately recognised’ multiculturalism.\(^\text{13}\) In January 1990, Italian-Canadian physician Dr Ralph Masi, founding president of the Multicultural Health Coalition (later the Canadian Council on Multicultural Health), was appointed as the first Multicultural Health Coordinator in the Ministry of Health.\(^\text{14}\) The Ministry initiated a campaign to educate health professionals on ‘the needs of multicultural groups’, based on the unproven but popular assumption that training interventions produce a “sensitized workforce” able to deliver services which are ‘more relevant’ to ‘ethnic minorities’ needs’.\(^\text{15}\) This approach places the burden of responsibility for the delivery of culturally appropriate services solely on the shoulders of health care workers. The underlying assumption is that once professionals have been trained in the correct language and approach to working with ethnic ‘others’, the latter will face no further barriers to utilizing services. Clearly this framing occludes attention to institutional factors and broader policies which enshrine inequities and are beyond the influence of individual practitioners. Figure 5.1 (below) shows ‘the Identity Petal’, a training resource used in publicly-funded trainings in multiculturalism for service agency staff during the early 1990s, illustrating the aspects of social difference considered significant.

Purveyors of the multicultural health paradigm confidently subsumed Aboriginal issues within their mandate. Multicultural Health Coordinator Dr Masi issued standing invitations to the Ministry’s recently appointed Native Health Program Coordinator, D. Stuart, and the Francophone Health Program Coordinator, to join the Advisory Committee on Health and Culture in 1990.\(^\text{16}\) In 1987 the Ministry of Health conducted an extensive survey of 400 health providers across Ontario to ascertain the ‘information and services offered to ethnocultural community groups’, using a questionnaire which referred simply to ‘cultural groups’ and made no mention of Aboriginal peoples. Nevertheless the survey elicited detailed information about the Native Healer’s Programme at Lake of the Woods Hospital in Kenora (discussed in Chapter Two) which the survey report described as ‘targeted to a specific cultural group, namely, the Ojibway bands of Northwestern Ontario’.\(^\text{17}\) The Lake of
the Woods response highlighted the hospital’s struggles to provide adequate interpretation services for growing numbers of Cree patients. The survey report indicates that the liberal multicultural health model constructed Indigenous peoples as simply a ‘cultural group’ alongside new immigrant ‘cultural groups’.

The ethnocultural health survey results demonstrate the extent to which a multicultural health paradigm was becoming institutionalized in some urban health providers in southern Ontario even prior to Ministry of Health policy initiatives. The majority of the 127 survey respondents reported either no particular services for ‘cultural groups’, or described the availability of interpreters for some languages other than English or French. Apart from the Lake of the Woods programme, no Aboriginal programming or services were reported. However healthcare providers in southern Ontario cities, particularly Toronto, had clearly begun to develop programming for ‘cultural groups’ by 1987. Several hospitals had produced patient information publications in languages including Italian, Portuguese, Chinese, Spanish and Serbo-Croatian. Toronto hospitals reported extensive capacity for interpretation, ranging from 24 to 51 languages. Public health units in London and Ottawa also reported offering interpretation and patient information in several languages. Several institutions were providing in-house training in multiculturalism and health for staff, including the London Public Health Unit, Ottawa’s Children’s Hospital, and Doctor’s Hospital, Central Hospital and Mount Sinai Hospital in Toronto. And at least nine institutions were providing services ‘directed at specific cultural groups’, including primary health care, health promotion and outreach, sexual assault care, birth control counseling and abortion referral, social work, psychiatry, nutritional counseling, and obstetrical nursing. Historical analysis at the institutional level is needed to determine the forces driving these initiatives, which may have included a combination of advocacy by community groups and emerging professional discourses on ‘cultural competence’ (discussed below).

**Multicultural mental health**

Within the realm of policymaking, proponents of multicultural health quickly identified mental health as a priority issue. During the late 1980s and early 1990s, several
government and non-governmental agencies at all jurisdictional levels produced reports addressing the mental health needs of immigrant and other non-Indigenous racialised groups. In a November 1990 meeting with a senior civil servant responsible for the reform of long term care, members of the Advisory Committee asked ‘how cultural sensitivity issues and needs were being addressed’ and ‘how ethnocultural groups were being involved’ in mental health care reform. The first trainings on ‘multiculturalism and race relations’ for health professionals in psychiatric hospitals began in 1990. Evidence of the pressing need for such training was produced by a needs assessment with staff at London Psychiatric Hospital in southwestern Ontario. A Staff Development Officer reported that whilst all participants in the needs assessment ‘had some idea of the notion of multiculturalism’, ‘culturally sensitive health care’ was a new concept for many, and a majority ‘could not identify any reasons why an ethnic patient [sic] in particular might not be accessing services’. The needs assessment informed the development of a five day training of trainers on ‘multicultural, ethnic and race relations’, after which participants from the provincial psychiatric hospitals were expected to develop their own ‘implementation plan for Multiculturalism training’, to be reviewed by Ministry of Health staff, with the goal of training all hospital staff within two years.

Mental health reform gained significant impetus under the 1990-1995 New Democratic provincial government, and new opportunities emerged for established community agencies and emerging alliances to advocate for better recognition of their clients’ needs. The 1993 report Putting People First recognized ‘consumer/survivors’ of mental health services as central to the reform process, and advocated for sensitivity to ‘gender, culture and race, and to the special needs of vulnerable groups and ensuring equitable access to services’. Further, the New Democratic government established an ambitious target of reallocating funds from the hospital to the community sector, proposing to shift from a 80%:20% split to a 40%:60% split by 2003. Content of community programming was to focus on housing, case-management and crisis care. Settlement agencies in southern Ontario cities already providing such services (with inadequate funding support) recognised the opportunity to obtain greater public recognition of their work.
Figure 5.1  ‘The Identity Petal’, Organization Change Towards Multiculturalism (1990)
The emergence of anti-racist mental health in Ontario policy discourse, 1993-1995

During the early 1990s, activists from various immigrant and racialised communities increasingly employed the more assertive language of ‘anti-racism’ and ‘organizational change’ in the context of mental health reform, which began to overtake liberal discourse on multiculturalism and mental health during the NDP’s term in office. In 1993/4 the Ministry of Health produced an Anti-Racism Strategy, Strengthening Voices, which stated unequivocally that “racism is a serious health issue in Ontario” and that anti-racism values must be incorporated into services. Like the Liberal government’s Multicultural Policy before it, the Anti-Racism Strategy did not acknowledge Aboriginal peoples, focusing instead on ‘ethnoracial groups’. The Strategy appears to have had little impact initially, given that as late as March 1994, community agency representatives complained that it had not been effectively disseminated, and that members of the Provincial Advisory Committee on Mental Health Reform and the Metropolitan Toronto District Health Council were not even aware of its existence. The Ethnoracial Mental Health Reform Work Group, established in autumn 1993 to support the reform planning process led by the Mental Health Reform Steering Committee, contributed to the development of Guidelines to meet the mental health needs of ethnoracial communities drafted in April 1995.

Outside of government, anti-racism and the ‘ethno-racial’ identification became increasingly important foundations for inter-agency alliances and advocacy. The Ontario Division of the Canadian Mental Health Association (the most influential community-based player in provincial mental health reform by the late 1990s) hosted a seminar in 1994 entitled “Making a shift to Anti-racism in the Mental Health Reform”. In 1992, community agencies including Hong Fook, Women's Health in Women's Hands, as well as some individual consumer/survivors and family members, formed the Ethnoracial Mental Health Committee. Members of this Committee were active on various Ministry of Health mental health reform committees, engaged in advocacy and educational activities, and in 1995 established Across Boundaries Ethnoracial Mental Health Centre, with provincial funding dispersed through the District Health Council. Ministry of Health consultants were initially unsupportive given a cost-cutting fiscal climate which discouraged the creation of new institutions, but the proposal received extensive backing from multiple agencies.
including the Ontario Public Health Association and was eventually supported by the Ministry of Health.  

Both the liberal multicultural and the anti-racism frameworks present the education and training of health professionals as a central mechanism for effecting social change. As we shall see in the next section, this has had significant implications for how diversity policies are operationalised within dominant biomedical institutions. Another commonality is a (usually implicit) modernizing discourse which identifies ethnic ‘others’ as backwards and primitive, and professional biomedical knowledge and Canadian institutions as modern and progressive. This sometimes manifests as discussion about ‘stigma’ in which racialised groups’ apparent reluctance to use mental health services is attributed to ‘traditional beliefs’ which contradict modern medical paradigms. The presence of an implicit but powerful modernizing discourse in multicultural and anti-racism frameworks is not surprising if we note that many of the leaders of these social movements are themselves trained in western biomedicine, nursing, and psychiatry.

What distinguishes the anti-racism organizational change model from the liberal multicultural model is an emphasis on changing not only ‘practices’ but also ‘structures’. Anti-racism service delivery incorporates service providers’ knowledge -- broadened to include ‘issues of race, gender, power and privilege’ -- but also prescribes that ‘service delivery models are developed in collaboration with ethnoracial communities and incorporate their values’ (my emphasis). The idea that health services should adapt their underlying values to incorporate those of ‘ethnoracial’ communities suggests more fundamental systemic change that what is espoused by the multicultural model.

‘Not part of the multicultural mosaic’: multicultural/ anti-racist mental health & Indigenous marginalization

Both discourses have an inconsistent relationship with Indigenous issues. The former may explicitly subsume the latter, but most commonly the existence and rights of Indigenous peoples in Canada are simply ignored. In the 1995 Guidelines to meet the mental health
needs of ethnoracial communities, ‘ethnoracial’ is defined in terms which would include Indigenous peoples by default:

The term “ethnoracial” acknowledges that all Ontarians have a racial, cultural and/or linguistic identity. The use of the designation “ethnoracial” refers to members of those communities who do not identify themselves with the dominant community group. And yet nowhere does the document articulate that Indigenous peoples simultaneously constitute a racialised group, and have distinct experiences of historical and contemporary oppression and entitlements to land and self-determination, as the original inhabitants of what we call North America and by virtue of the treaties signed with European colonizers. Elsewhere in the document, the phrase ‘immigrants, refugees and people of colour’ clearly excludes Indigenous peoples. For these discourses to recognize the distinct status of Indigenous peoples would be to acknowledge that even the most marginalized refugee seeking asylum in Canada has in some sense benefitted from the wealth and privileges accrued by the Canadian state and settler society through the exploitation of Indigenous peoples and lands. Or as Bonita Lawrence and Enakshi Dua articulate,

To acknowledge that we all share the same land base and yet to question the differential terms on which it is occupied is to become aware of the colonial project that is taking place around us.

Instead, discourses on multicultural, ethno-racial and anti-racist mental health which gained prominence during Ontario's 1990s mental health reforms generally occluded the existence of Indigenous suffering.

It is also important to recognize that Aboriginal groups articulated their resistance to being subsumed within multicultural health policy. In 1993 members of the Aboriginal Health Policy working group wrote to senior mental health staff in the Ministry of Health to express their concerns regarding the provincial mental health strategy document Putting People First. They protested against the submersion of Aboriginal health within the ‘Ethnocultural Groups’ category, and the apparent lack of ‘Aboriginal advice and direction’ in the preparation of the strategy. Further, working group members admonished that mental health policy ‘must acknowledge and not undermine the Aboriginal Health Policy principles, issues and strategies in mental health restructuring’ and that a separate Aboriginal Mental Health Strategy must be planned for, in keeping with the expectations of
the Aboriginal Health Policy (discussed in Chapter Three). Aboriginal people later articulated their concerns about submersion within the multicultural health paradigm through the text of the 1994 Aboriginal Healing and Wellness strategy, which asserted that ‘new relationships’ between Aboriginal peoples and the provincial government would ‘respect the Statement of Political Relationship’ and importantly, that Aboriginal peoples are ‘not part of the multi-cultural mosaic’.34

The emergence of ‘cultural competence’ and ‘cultural safety’ in mental health, 1978-2002

Outside of policy-making circles, from the 1980s onwards mental health and other clinicians were engaged in their own process of constructing a body of knowledge and style of practice intended to facilitate their professional engagement with clients of ethnicities different to their own.35 The cultural competence paradigm has developed in North America (and to a lesser extent in Western Europe) against a backdrop of increasing ethnic diversity in mostly urban settings. Health care practitioners from a range of disciplines, including social work, nursing, psychology, psychiatry and medicine, have participated in developing versions of multicultural and transcultural frameworks for use in health care settings. Whilst the cultural competence framework has most commonly been used in the context of addressing health inequalities of ethnic and racialized minorities (typically immigrants), it has also been applied to other forms of social difference, including gender, age, sexual and gender orientation, and people living with disabilities.36

Psychologists have led the development of ‘cross-cultural’ treatment models for Aboriginal clients during the same period. James Waldram describes this body of work as characterized by ‘a tension between the need to emphasize cultural heterogeneity and denounce stereotypes, and the need to present meaningful generalizations to the practitioner’.37 The latter need has prevailed, leading to a proliferation of publications aimed at clinicians which present lists of essentialised behavioural traits such as ‘passivity’, ‘lack of eye contact’ and ‘harmony with nature’, which are generalized to all North American Indigenous peoples. Waldram’s analysis shows that very few of such publications are based on actual empirical research, with the majority relying on citations
of other scholars’ work, including anthropological research dating back to the early 1950s.\textsuperscript{38}

Whether applied to therapeutic work with Indigenous peoples or, as is more often the case, racialised immigrant groups, the cultural competence model rests on many untested assumptions.\textsuperscript{39} Perhaps most prominent among these is the idea that after a short period of training a practitioner will have acquired the knowledge, skills and attitudes necessary to bracket the meaning-systems and thought-styles shaped by her own social, professional and cultural locations. Despite scholarly recognition of the ubiquity of western biomedical culture, the impact of this and other professional cultures, such as those of social work and nursing, is barely acknowledged in the literature on cultural competence.\textsuperscript{40} Further, there is evidence to suggest that health professionals typically don’t recognize their professional worlds as constituting distinct cultures: such identities are taken to be constituted by a shared understanding of universal truths (biomedical knowledge) which is \textit{beyond} culture.\textsuperscript{41} Proponents have similarly failed to investigate the extent to which health professionals reproduce dominant frameworks for making sense of difference whether sub-consciously or through the use of particular theoretical frameworks which reproduce dominant values. Indeed, there is little empirical evidence to support the use of cultural competence models in health care practice.\textsuperscript{42}

Māori nurses in New Zealand, led by nurse, academic and activist Irihapeti Ramsden, developed the concept of “cultural safety” in 1992, and it has since featured in New Zealand nursing and midwifery curricula.\textsuperscript{43} Cultural safety has been succinctly defined as “an educational framework for the analysis of power relationships between health professionals and those they serve”.\textsuperscript{44} Cultural safety focuses specifically on power relations and the social distribution of resources, and the implications for nurse-patient interactions. A nurse is conceptualized as “a bearer of his or her own culture and attitudes, and consciously or unconsciously exercised power”.\textsuperscript{45} As such, cultural safety prescribes practice informed by the nurse’s conscious self-reflection and awareness of her own social location. Ramsden frames cultural safety as a reaction against earlier work in the field of transcultural nursing. She argues for the inclusion of post-colonial analysis and against the
inclusion of encapsulated knowledge of particular cultures in capacity-building for service providers in inter-cultural settings. Ramsden makes the point that focusing on the culture of patients distracts attention from the impact of historical, social, political and economic factors on the health of racialized groups. Further, given the heterogeneity of the Māori population, and in particular the impact of urbanization and acculturation, knowledge of traditional Māori culture and language may be irrelevant to the provision of healthcare for many Māori. Finally, teaching aspects of Māori culture to nurses constitutes cultural appropriation and may contribute to the disempowerment of Māori, many of whom are currently lacking knowledge of their own culture.

In Canada, Smye and Browne have argued that the concept of cultural safety is valuable as “a moral discourse” to inform health policy analysis in relation to the needs of Aboriginals in Canada. More recently the First Nations Inuit and Métis Advisory Group to the Mental Health Commission of Canada have advocated for the application of the cultural safety framework to Aboriginal mental health care in Canada. The most obvious difference to consider in applying the cultural safety model in Canada is that it is based on New Zealand’s biculturalism model and assumes that most non-Māori nurses are white, and therefore is silent on the situation in Canada where significant and increasing numbers of nurses are themselves members of racialised and historically colonized groups.

The International Initiative for Mental health Leadership, 2007

Recent scholarship suggests that the antiracist movement in Canada continues to neglect Indigenous issues. Bonita Lawrence and Enakshi Dua wrote in 2005, “Canadian antiracism is furthering contemporary colonial agendas”. They discuss how antiracist frameworks in Canada and beyond have both failed to “integrate an understanding of Canada as a colonialist state” and disregarded the ongoing colonization of Indigenous peoples, which should be foundational to antiracist work. The account below illustrates how such tensions are appearing in the context of a nascent international alliance on racism and mental health.
In August 2008, Akwatu Khenti, Director of the International Health Program at the Centre for Addiction and Mental Health (CAMH) and a respected leader in Toronto’s African-Canadian community, addressed a meeting of international delegates at the International Initiative for Mental Health Leadership’s “Race and Culture Roundtable” in a Toronto community centre. CAMH is the largest mental health and addictions hospital in Canada. Akwatu spoke articulately and confidently about CAMH’s “international partnerships” and “collaborative capacity building” in Mexico, Brazil and anglophone Caribbean countries, describing the high level of demand in these countries for “evidence-based interventions” including treatment approaches such as “motivational interviewing” and “brief treatment for young people” which he described as “readily adaptable across cultures”. Immediately afterwards Peter Menzies, an Anishnaabe man and Director of Aboriginal Services at CAMH, spoke briefly about the continuing isolation and poverty of First Nations reserves in Canada and Aboriginal communities’ rejection of “mainstream” health care services.

Later that afternoon the meeting broke into smaller groups to prepare presentations. In the Indigenous group (which I joined with permission), Māori delegates immediately began to discuss their concerns about Akwatu’s presentation. They wondered at the arrogance of a dominant Canadian biomedical institution presuming to share its mental health expertise internationally, whilst Indigenous peoples continue to suffer at the hands of the Canadian state and settler society.

The Māori delegates’ concerns were consistent with Canadian-based Indigenous mental health professionals’ criticisms of the perceived ‘arrogance’ of the Centre for Addictions and Mental Health in the context of the International Initiative for Mental Health Leadership’s conference in Ottawa, held immediately prior to the Toronto Roundtable. Ojibwe psychologist Brenda M. Restoule, one of two Indigenous members of the Committee organizing the conference, described conflict with CAMH (which had two representatives on the eleven-member Committee) over the institution’s presumed leadership role, failure to value Indigenous knowledge and expertise and marginalisation of Indigenous interests, as illustrated by the absence of any Canadian Indigenous speakers on the panel.
Aboriginal groups and their concerns were largely excluded from Ontario’s mental health reforms during the 1990s and continue to be excluded from international fora on racism and mental health. Proponents of multicultural, ethnocultural and antiracist mental health have also argued that their interests have not been well served in Ontario’s mental health reforms, and mental health services continue to fail to meet the needs of racialised settler communities. Nevertheless, a paradigm of liberal multicultural difference is now well-established in Canadian biomedical institutions and international professional networks, and contributes to rendering Indigenous peoples invisible in the context of an urban biomedical setting in southern Ontario, as we shall see in the next section.

2. Mental health practitioners and the (mis-)recognition of Indigenous suffering

We all have differences!
Mental health practitioner, key informant interview 2

This section provides an ethnographic illustration of how institutional discourses on social difference, emerging from the interface of anti-racist activism and professional cultural competence, blind mental health professionals in southern Ontario to the particularities of Indigenous suffering in contemporary Canada. As it draws on a discrete piece of fieldwork based in a single biomedical institution, I begin by discussing how I gained access to this site and the particular challenges I experienced there.

Fieldwork context
This component of the research grew out of my commitment to making dominant policies and institutions, rather than Aboriginal communities, the objects of my analysis. One of the two questions with which I began this project was “how does a large biomedical mental health institution participate in the production of (urban) Aboriginal subjects?”. This question, and my intention to conduct long-term ethnographic fieldwork in an urban biomedical-mental health institution, were based on the understanding that credentialled mental health professionals -- who, in Canada, are predominantly settlers of diverse ethnicities -- wield significant authority and an increasing range of influence over discourse and practice in urban social service settings, in contrast with Aboriginal service providers who often lack such credentials.
A central feature of the contemporary mental health paradigm is a growing role for psychiatrists and other specialists in the supervision and training of other health and social service workers. Mental health experts are increasingly involved in sharing knowledge with providers of primary health care and social services, including Aboriginal service agencies. Yet relations between large urban mental health institutions and Aboriginal service agencies in southern Ontario are ambivalent at best. Recognizing that their own agencies lack capacity to treat mental illness, Aboriginal agencies refer many of their clients to non-Aboriginal biomedical mental health services, whilst continuing to express dissatisfaction with the services their clients receive. Their criticisms echo those expressed in the Royal Commission on Aboriginal Peoples’ report on urban Aboriginal issues, including inaccurate diagnoses, a lack of basic understanding of Aboriginal clients’ needs, racism, stereotyping, cultural insensitivity, intimidating environments and long waiting periods. These issues are discussed in more detail in Chapter Six.

I conducted fieldwork with one inpatient and one outpatient programme, both treating patients with mood disorders in a large hospital located in a southern Ontario city. These are described collectively here as the ‘Mood Disorders Programme’; where relevant I distinguish inpatient or outpatient services. An Aboriginal service organization, ‘Native Addictions Services’ was instrumental in facilitating access to the hospital-based programmes. Native Addictions Services had been working closely with the hospital programmes for over a year prior to the start of the research, in a collaboration which included mutual training and (in theory) cross-referrals. The current research was thus partially intended to provide some insight into the workings of this evolving partnership.

As I gained a clearer understanding of the research setting, I was obliged to significantly revise both my original question and my fieldwork goals. Active resistance from several practitioners and passive resistance from others prevented me from attending clinical rounds and team meetings as planned. Further, I had not anticipated the extent to which Aboriginal clients and issues were utterly marginalized within the institutional setting and professional discourse. It is possible that longer-term and more in-depth research might
have afforded some opportunities to observe how practitioners engaged in producing knowledge about Aboriginal clients. But as we shall see, the pervasive practice was to locate Aboriginal clients within a multicultural discourse in which indigeneity is a relatively empty discursive category. Thus my focus shifted from how the practitioners participated in producing knowledge of Aboriginal subjects, to how they participated in rendering Aboriginal people invisible and irrelevant.

As far as I could discern, practitioners’ resistance to the research centred on the linked concerns that their individual identities and/or that of their programme might be recognisable in any publications or presentations resulting from the research, and that they would inevitably be cast in an unflattering light. We discussed these issues at length during two meetings, eventually arriving at two points of agreement: firstly, that I would not identify individuals by particular discipline (i.e. ‘social worker’) but would use a generic term such as ‘mental health practitioner’; secondly, that I would circulate all typed field notes from meetings and rounds and invite individuals to correct errors or add missed context. I initially had the impression that with these changes to the terms of engagement agreed, the work could proceed. However, after I had spent several weeks seeking informed consent from clients whose cases were to be discussed in my presence during rounds (almost all of whom gave consent), several practitioners in one team began to express vehement opposition to my presence in clinical rounds and team meetings. Their stance threatened to divide the team, leading their colleagues to withdraw the consent they had previously given, invoking ‘the best interest of client care and group cohesion’. In the second team, no practitioners expressed opposition directly, but only a small minority of practitioners gave consent, making the planned participant observation unworkable.

Given these constraints, the following analysis relies heavily on key informant interviews with twelve mental health professionals from the two teams, including nurses, psychologists, social workers and administrators (all but one in the latter category were themselves trained in one of the practitioner categories), supplemented by fieldnotes from informal conversations with these and other staff, and the few team meetings and clinical rounds to which I was able to gain access at the beginning of the study. The tables below
provide descriptive data about participants in the key informant interviews. In negotiating the conditions of participation I made a commitment to conceal the identity of both the institution and individual staff as far as I am able, which necessarily limits the amount of contextual detail I am able to share. Both males and females participated but female pronouns are used throughout to protect anonymity. For the same reason I do not describe participants’ individual professional identities, although they were variously qualified as nurses (RNs), social workers (Masters of Social Work), psychologists and non-clinical administrators. Other team members are psychiatrists and occupational therapists, all of whom declined to participate. Full details of methodology and methods are provided in the thesis Introduction.

<table>
<thead>
<tr>
<th>Clinician (inpatient &amp; outpatient programmes)</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager/ Director/ Advanced Practice Clinician/Administrator</td>
<td>5</td>
</tr>
</tbody>
</table>

**Table 5.1**  Research participants’ current professional role

<table>
<thead>
<tr>
<th>Number of years research participants have worked at current hospital</th>
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</thead>
<tbody>
<tr>
<td>Less than 5</td>
</tr>
<tr>
<td>5-10</td>
</tr>
<tr>
<td>10+</td>
</tr>
</tbody>
</table>

**Table 5.2**  Number of years research participants have worked at current hospital

<table>
<thead>
<tr>
<th>Proportion of life lived in Canada</th>
<th>63</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born and/or raised in Canada</td>
<td>10</td>
</tr>
<tr>
<td>Immigrated to Canada as an adult</td>
<td>2</td>
</tr>
</tbody>
</table>

**Table 5.3**  Proportion of life lived in Canada

**Institutional context & Indigenous invisibility**

The research site is one of several hospitals in southern Ontario which has officially prioritized diversity and cultural competence for over a decade, in response to pressure from community agencies and activists, developments in professional discourses, and provincial policy developments, as discussed in Section One of this chapter. An external
In contrast to the dominant discourse on diversity, Aboriginal people and issues are relatively invisible in this institution. Hospital statistics indicate that 1% - 3% of clients in the Mood Disorders Programme are Aboriginal, but there are many reasons to suspect these figures may be underestimates. Standardised intake procedures are clearly insufficiently sensitive to identify most Indigenous clients. The hospital's admission form includes 'First Nations' but no other Indigenous identity in the list of options under the heading of 'Citizenship/Status'. The ‘interRAI Community Mental Health’ form includes ‘Federal government – First Nations and Inuit Health Branch (FNIHB)’ in the list of options under the heading ‘Current Payment Sources for Community Care’.
The Diversity Flower has been adopted from the Power Flower (Source: Arnold, R., Burke, B., James, C. & Martin, D. (1991) Educating for a Change, Toronto, ON: Between The Lines).

Figure 5.2  ‘The Diversity Flower’, a training resource commonly used in diversity trainings in hospitals and other health and social services settings in southern Ontario

The Mood Disorders Programme’s referral form, typically completed by GPs, psychiatrists and staff at other hospitals (usually Emergency services), does not include space for specifying ethno-national identity, nor does the outpatient programme’s three page intake assessment form. Although the majority of inpatients in the mood disorders programme are referred through emergency services (both within this hospital, and from other hospitals in the city), and Aboriginal patients are known to be heavy users of emergency services, staff report receiving few Aboriginal clients. This puzzle suggests that Aboriginal patients’ experiences of emergency rooms and patterns of ER referrals of Aboriginal patients are important topics for further research.
In addition to the invisibility of Aboriginal clients, there are few Aboriginal staff in the hospital, and the institution as a whole has clearly attached little priority to practitioners acquiring knowledge of Aboriginal issues. The hospital recently conducted an employment equity survey and determined that of the four groups considered, only Aboriginal people were significantly under-represented among the institution’s employees. In a 2006 external review of the hospital’s diversity initiative, participants (both internal and external to the institution) identified ‘Aboriginal issues’ as a concern: ‘Diversity agenda’s approach to Aboriginal issues is somewhat ambiguous’. The authors of the review report note that Aboriginal issues are ‘listed as separate’, but ‘included in discussions of diversity’, whilst there is minimal content on Aboriginal issues in the diversity and cultural competence training curricula. One-day trainings on Aboriginal mental health, delivered by management and therapists from Native Addictions Services, have been initiated within the past two years; in contrast to the one-day diversity training, these are not mandatory.

Most participants in the current research reported little or no professional training in Aboriginal health, mental health or addictions issues, either during their professional training or whilst in their current position. However, the Mood Disorders practitioners have all participated in a one-day diversity training -- some many years ago -- and some have also taken part in clinical cultural competence training. Mood Disorders managers encouraged their teams to attend one-day trainings on Aboriginal mental health; more than half of the research participants had attended either before or during the period when this research was conducted. For most interview participants this was the only specialized training in Aboriginal health, mental health or addictions which they had ever received. The exceptions were two newly-qualified practitioners with some experience of Aboriginal issues from recent professional training in large Canadian universities.

**Equality, difference, and the misrecognition of Aboriginal clients**

As Laurence Kirmayer has noted, for mental health practitioners to recognize the ‘socially embedded particularity’ of individual suffering in the context of the clinical encounter is crucial to appropriate and effective care:
Because health care is a vitally important service that people resort to for serious problems and in times of crisis, recognition in this domain may have great weight and lasting impact, working to restore fundamental trust, self-respect and self-esteem and so strengthening both individual mental health and collective identity.73

In contrast, failure to recognise and respond appropriately to socio-cultural difference exacerbates existing inequities and even causes ‘direct harm’, for example through misdiagnosis, inappropriate treatment, and patient experiences of racism and discrimination in the healthcare system.74

Given the dominance of the liberal multicultural framework which prioritises the visible and audible recognition of difference, it is perhaps unsurprising that clinicians might commonly fail to recognize an Aboriginal client who does not self-identify. Only a couple of participants showed any awareness that an Aboriginal person may not necessarily be recognizable by appearance or name. Further, clinicians are apparently unaware that there are many reasons why people might be ambivalent about identifying themselves as Aboriginal to a mental health professional, not least of which is the continuing over-representation of Aboriginal children in the care of child welfare agencies.75 Practitioners’ apparent lack of insight into these issues supports an assertion made by members of the Native Addiction Services team, namely that Aboriginal clients are using the Mood Disorders programme, but clinicians are failing to recognize them. In contrast, the Mood Disorders practitioners told me confidently that they see few Aboriginal clients in their programmes, with the implication that such clients would, of course, be readily identified were they to use the service. This pervasive misperception created challenges during interviewing, as it meant that most practitioners perceived that they had no prior experience to draw on in responding to questions.

Some practitioners invoked the apparent lack of Aboriginal clients as evidence to suggest that Aboriginal people are not interested in accessing biomedical mental health care, suggesting that any obstacles originated with the former, rather than the institution.

I: Overall, how well do you think your programme addresses the needs of Aboriginal people with mood disorders in Toronto?
R: I don’t think we put up barriers. The lack of Aboriginal clients is not our issue.\textsuperscript{76}

Later in the discussion the same practitioner speculated further:

*Which way does the stigma lie? Are we being stigmatized and that’s why they’re not coming to us? We are doing our best [...] Is it an issue of distance and the support needed to travel? Or is it the stigma they would endure – sometimes it isn’t worth it to them.*

She went on to discuss the degree of stigma historically attached to mental health services: ‘until recently, families would take care of people themselves for over 30 years rather than send someone here’. In this contemporary discourse on the stigmatization of mental illness, utilization of biomedically-based mental health services is heralded as a hallmark of modernity and progressive Canadian social values, whilst ‘traditional’ (non-western) cultures are presumed to embrace outdated and superstitious notions which prevent them from accessing services appropriately. As discussed in the thesis Introduction, such ‘culturalist’ explanations for non-utilisation of services are commonly invoked in public health analyses of urban Aboriginal health. This discourse obscures three important issues regarding mental health care: the continuation of very real systemic barriers to service use (such as inadequate primary health care and lack of interpretation services in mental health facilities), the validity of critiques of contemporary mental health services, and the viability of approaches to treatment based on non-biomedical epistemologies.

A minority of practitioners were aware that recognising a client as Aboriginal may not be a straightforward process, but lacked the framework to discuss this without resorting to stereotypes:

*If somebody that’s a university kid and they’re practicing law and they’re not living on the reservation, they’re basically Canadian. That’s where sometimes you lose identity, they lose identity, they lose their cultural markings, I don’t know what the word is, it’s not someone like a Chinese person comes in, they have a language, they have a look, maybe they have the food, the diet, that kind of stuff, so you differentiate in that kind of way. Unless somebody, you know, one of the guys that usually lives on the street and they come in drunk, you know, having a problem that way, you probably wouldn’t recognize them as Aboriginal.*\textsuperscript{77}

This comment suggests a lack of understanding that someone may simultaneously identify as Aboriginal, value Indigenous therapeutic knowledge and practices, and be educated, middle-class and urban. Rather the speaker invokes binarily opposed caricatures: the
visibly recognizable ‘drunken Indian’, and the fully assimilated urban lawyer. This practitioner’s resort to stereotypes is not exceptional among health professionals. Research with general practitioner physicians in Montreal similarly found that a large majority made use of stereotypes based on a patient’s ethno-cultural origin to inform diagnosis and treatment.\textsuperscript{78}

Practitioners’ lack of understanding of the significance of Indigenous identity for diagnosis and treatment was also apparent. Some expressed uncertainty about whether it would be appropriate to discuss a hypothetical client’s Aboriginal identity with colleagues. One practitioner drew an explicit parallel with the involuntary outing of a queer client. During an interview with another practitioner, I asked:

I: So if you had a client who had ticked that they identified as Aboriginal [on the intake form] is that something that would be flagged within the [clinical] team? Or not necessarily?

R: Well, if we had anybody, well we would mention it, just like everyone else, we’d mention it, but I don’t know, I’m just thinking [...] it’s like, in my opinion, it’s more discriminatory I think, why would we flag Native Indian. I mean, you know...

I: Yeah, it’s a valid question.

R: You know, like don’t flag anybody and then flag them.\textsuperscript{79}

This practitioner is articulating the liberal assumption commonly described as ‘colour blind’, that is, that if everyone is treated equally outcomes will be equalized, and that to call attention to social difference is to exacerbate inequalities.\textsuperscript{80}

Whilst most participants expressed confidence that ‘Aboriginal cultural needs’ would be met in their programme, further discussion indicated that they had a limited understanding of what such needs might be. One person contrasted Aboriginal clients, whose needs are somewhat mysterious to her, with Muslim clients, whose dietary requirements and demand for access to space for prayer she considers straightforward. Practitioners’ perceptions that Aboriginal clients have not articulated specific ‘cultural needs’ has even led some to conclude that such clients must be ‘assimilated’.

Practitioners commonly drew on liberal multicultural values in making sense of Aboriginal clients’ mental health care needs. For example, in discussing the implications of Canadian public policy for Aboriginal mental health issues, one participant commented,
Aboriginal people have equal rights and they should be able, entitled to do, you know, other things that everyone else is able to do and respect their culture and, I mean, when you look at other people that come from different countries, I mean, we’re pretty okay to accept that people, you know, from Pakistan wear turbans or whatever.\textsuperscript{81} This speaker is signaling her positive intentions towards Aboriginal peoples, drawing on the widely-publicised national debate around the rights of Sikhs to wear turbans in Canada, and asserting Aboriginal peoples’ ‘equal rights’ to public recognition of their culture. Her comment is consistent with the practitioners’ often-repeated assertion that ‘we treat everyone the same’, by which they meant that they strive to meet the particular ‘cultural needs’ of all clients, including those identifying as Aboriginal. In responding to how well her programme might meet the needs of Aboriginal clients, one clinician speculated:

\begin{quote}
I think they would do really well, because our clinical team are very open to diverse, you know, diversity. But some how we’ve never gotten anyone, not that I know of. But I’m sure if they come, we usually are quite, very good at finding resources, especially the clinical team, like we find resources for, we’ve had a lot of gay, lesbian, right. […] So I don’t think, if the Aboriginal, if they come, they won’t be treated any differently. They’ll just be treated like everybody else.\textsuperscript{82}
\end{quote}

This clinician is drawing on a cultural competence framework which posits that with good intentions and the right resources, a programme based on the dominant biomedical paradigm of mental health can be rendered accessible and appropriate for any marginalized group, be they racialised, queer or Indigenous. But this model, like the Sikh turban analogy, is problematic. Assigning indigeneity a category akin to a marginalized immigrant, settler-descendant or other non-Aboriginal group obscures the significance Indigenous status as original inhabitants of North America, Canada’s history as a settler colony, and continuing colonialism. As we have seen, in Indigenous frameworks, as well as much recent health and social science research, the resulting historical and ongoing loss and conflict resulting from colonization is understood to be the very \textit{basis} for much of contemporary Aboriginal suffering, including the social problems of addictions, suicide and interpersonal violence.

\textit{Cultural competence and practitioner anxiety}

As my work with the Mood Disorders Programme got underway, I quickly observed that the very topic of ‘Aboriginal Mental health’ seemed to induce anxiety in some practitioners.
It became clear that some clinicians’ strong reluctance to participate in the research, and in particular, their opposition to my presence in clinical rounds and team meetings, was based on feeling threatened by the possibility that the research might “out” them as “under-knowledged” (their words). A couple of practitioners hinted that they feared repercussions for their employment should the research findings become known within the institution and were traced back to them. Key informants from elsewhere in the hospital suggested that this phenomenon was linked to an institutional-level issue: that staff in some clinical teams are under such pressure to perform to standards of “excellence”, that the concept of “diversity”, alongside that of “best practices” in clinical care, has come to cause them intense anxiety. This is unsurprising given that both concepts foreground individual practitioners’ competence as the measurable, primary determinant of the quality of service delivered to clients. Given the institutional prominence of these discourses, many clinicians are reportedly without a “safe” space in the workplace in which to admit to their lack of expertise on issues relating to diversity and best practices.

Participants’ responses to the one-day trainings on Aboriginal mental health delivered by Native Addictions Services provided further evidence of high levels of anxiety regarding individual professional knowledge. Although all interview participants told me that they had little or no prior training on Aboriginal issues, either during professional education or in-service training, after the trainings some clinicians claimed prior familiarity with the content:

*a lot of people said well, you know, they really were pretty familiar with all these issues already, so I don’t think it really made that much change.*

Another person claimed, “I knew a lot of the history already” but admitted that “it’s good to hear it again”. One clinician praised the Aboriginal Services Trainers for creating an atmosphere in which

*I felt like I could ask important questions and not feel judged, or like a bad person for not knowing that.*

This last comment suggests that in other settings, asking such questions might lead one to be blamed as professionally inadequate. Defensiveness regarding professional knowledge
surfaced again in a discussion with another clinician about agencies serving Aboriginal people. She had a hazy recollection of previously working with a particular Aboriginal agency years before, and after struggling to remember the name and location, admitted,

*I don’t know exactly what they do for the Natives, so that’s where I’m weak.*

She then quickly added,

*And saying that I don’t think I’m any worse than anybody else on the floor. I think if I don’t know, I would think there’s probably a few people on the floor who don’t know anything about that either, yeah.*

**Institutional constraints, defensiveness and commitment to change**

The analysis thus far suggests that discourse on liberal multicultural health, and its institutional manifestations in policy and practice around diversity, cultural competence and ‘best practice’, combine to emphasise individual professional knowledge as the central vehicle by which services are made equitable to marginalized groups. At the same time, practitioners de-emphasise broader structural and institutional factors. The disparate analyses used by different categories of staff in response to a question about how well their team is meeting the needs of Aboriginal clients provides a final illustration of how this discourse is taken up. Frontline clinicians were most likely to speak positively about the capacity of their teams, and to assert their openness to working with Aboriginal clients, whilst rarely mentioning institutional barriers:

*I mean, I think that our service would do very well if we had more Aboriginal people come. I think that we’re aware of a lot of issues that they might have, but then I think we’re very open to you know to listen to what issues they might have and, just like we are with everyone else. So, I mean, you know, so we would definitely welcome them.*

Managers were more doubtful about their team’s capacity to serve Aboriginal clients given the perceived limitations to change presented by the institutional setting. Managers argued that Aboriginal clients’ needs are so inherently different to those of other populations that the hospital setting is simply incompatible with their needs, citing conversations with Native Addictions Services regarding how they might adapt their programming to better meet the needs of prospective Aboriginal clients. They suggested that Native Addictions therapists’ expectations that the hospital’s programmes would change in order to better meet their Aboriginal clients’ needs were unrealistic. One manager explained,
There are always going to be parameters to treatment protocols or services... certainly with flexibility built in... but you can’t change up a service to only serve one group without potentially excluding others....

Another was more defensive:

*I don’t think we put up barriers. The lack of Aboriginal clients is not our issue. Would they not want to come because we don’t have a smudge room? Maybe. Due to lack of space, we won’t.*

In contrast, two more senior managers -- both of whom had actively allied themselves with the Native Addictions Services team -- shared analyses which emphasized systemic and structural barriers, but without foreclosing the possibility for change:

*I think at some point, we need to step back and look at our care and treatment to say “so is this a fit for everyone like we think it is?” And that involves a much deeper analysis of things. I mean, structures that are very entrenched in psychiatry as to what care and treatment look like, family treatment, group treatment, individual treatment. Are there ways of being, that we have established for all these years of ‘this is the process for a [treatment] group’ that might get in the way of different cultural groups feeling comfortable and getting what they can from that environment.*

*I don’t think we’re doing well at all [in meeting the needs of Aboriginal people with mood disorders]. [...] Not because of ill will, but because of certain barriers we have that I think don’t really allow people to come here. Not in a, it’s more a systemic issue. Not that people would say if somebody wanted to come, ‘Oh we can’t serve you.’ It’s much more subtle than that.*

Frontline clinicians are most constrained by institutional pressures to appear knowledgeable and struggle to apply the liberal multicultural and cultural competence paradigms to make sense of the clinical implications of Aboriginal mental health, whilst defending themselves and their colleagues against perceived criticisms of professional inadequacy which may have very real consequences if proven. This reflects the particular pressure they are under to meet clinical performance standards according to diversity and best practice policies, as evaluated by managers. Middle managers, having had slightly more communication with the Native Addictions Services team, have some appreciation of the structural changes being demanded, which they posit as beyond their control and therefore resist. They seem to recognize that what is expected is more than just building staff competency, but appear unwilling or unable to support the necessary institutional
change. The two more senior participants have had the closest working relationships with the Native Addictions Services team – which may itself reflect a prior commitment and sensitivity to Indigenous issues. They may perceive themselves as ‘champions’ for Aboriginal issues and appear willing to advocate for internal reform, whilst recognizing the extent to which barriers are systemic and therefore not entirely within the control of the institution.

*Old and new Canadians: defensiveness and empathic curiosity*

Beyond the institutional pressures to appear knowledgeable about all aspects of social difference, is the investment in being seen to be familiar with Aboriginal issues also connected with aspects of Canadian identity more broadly? Two participating clinicians who are first-generation immigrants, both with adult experience of living in other countries with colonial histories, appeared more willing than their Canadian-born colleagues to admit to their *lack* of knowledge of Indigenous issues. In discussing the recent training on Aboriginal mental health, for instance, one woman’s enthusiasm contrasted markedly with her colleagues’ indifference. She described the training as ‘an amazing orientation’, and said that it had brought her understanding to a level where she would now feel confident enough to participate in discussion on Aboriginal issues. Ironically, she was atypical of the participants in having some prior training on Aboriginal mental health in the context of recent professional education, brief (a few classes) but more than most of her colleagues had experienced. However she had enough basic knowledge to realize the extent of her ignorance and was therefore more humble than some of her colleagues.

Another clinician who has worked in urban Canada for over twenty years expressed her confusion about the reserve system with an honesty which contrasted refreshingly with her Canadian-born colleagues’ scrambles to defend their ‘cultural competence’:

*I always wondered, but I guess, I don’t know, why they keep them separately, but then at the same time I think that is the safe place. I think it must be true. Why do they keep them separately?*  

It is difficult to imagine a Canadian-born mental health professional being so willing to signal their ignorance and so open to asking basic questions about Indigenous lives, and yet it is well established that most Canadians, particularly in urban settings, have a very poor
understanding of Indigenous peoples’ histories and contemporary realities. Given the lack of relevant curriculum in most professional training programmes and higher education institutions, there is no reason to expect any different from mental health professionals. But this level of humility and openness to learning is what is necessary for dominant biomedical and mental health institutions to begin to build trusting relationships with Aboriginal practitioners and clients alike.

3. Conclusion
In this chapter I have shown the discursive continuities between policy and activist initiatives on multiculturalism, anti-racism and mental health in the early 1990s, and cultural competence and diversity frameworks in a contemporary mental health care setting. All share an ahistorical analysis which fails to recognize either the significance of Canadian colonialism for Indigenous suffering, or the continuation of this colonialism in the present. This failure makes it impossible for mental health professionals steeped in these discourses to truly recognize Indigenous clients, let alone begin to formulate an appropriate clinical response to their needs. Instead, Indigenous identity is rendered irrelevant -- it’s been ‘lost’, so Indigenous people are ‘basically Canadian’ -- or invisible, since even when it is communicated, practitioners are uncertain as to the implications of Indigenous identity for patient care. This dynamic has arguably been exacerbated with the advent of the wide-ranging diversity paradigm: by its very claim of providing an all-inclusive framework for the analysis of social difference in the context of health services, its pointed exclusion of indigeneity is rendered even more stark. Given the dominance of this framework, Indigenous people are left with impossible options: be reduced to a petal on the diversity flower -- whose ultimate message is, as expressed by one participant, "We all have differences!" -- or having refused the status of ‘cultural group’, be utterly unseen.

Anthropologist Linda Hunt has written,

*the most serious barrier to culturally appropriate care is not a lack of knowledge of the details of any given cultural orientation, but the providers’ failure to develop self-awareness and a respectful attitude toward diverse points of view.*

Paradigms whose aim is to make services more appropriate and accessible but which focus narrowly on individual staff performance are self-defeating in this context. What is
required as a starting point for settler health professionals to develop their capacity to work with Aboriginal clients is greater humility. What we have is an apparently overwhelming institutional pressure to appear competent, leading to defensiveness.

In the context of the ongoing Mental Health Commission of Canada, Indigenous mental health advocates are currently promoting the ‘Cultural Safety’ paradigm as an alternative approach to rendering mental health care more appropriate for Indigenous people. In adapting this framework for Canadian healthcare settings, there is an urgent need to address the decolonization of dominant anti-racist discourse, and to explore how greater attention to histories of colonization might reveal common ground for Indigenous peoples and racialised settler communities, which might serve as a basis for future collaborations and solidarity.
End-Notes to Chapter Five

1 Hong Fook Mental Health Association in Toronto was the first community based mental health programme in Ontario – and one of the first in Canada -- to focus on the needs of a particular marginalised immigrant group. (Also during the early 1980s the Strathcona Mental Health Team was providing out-patient psychiatric services to Chinese-Canadian and other marginalized groups in poor neighbourhoods of downtown Vancouver, British Columbia on Canada’s west coast.) Psychiatrist Hung-Tat Lo founded Hong Fook in 1982 with support from Mount Sinai Hospital’s Department of Psychiatry, with a mission to ameliorate Chinese mental health patients’ challenges in accessing care. As well as direct service provision, Hong Fook soon developed a strong advocacy focus, ‘striving for an equitable mental health system for our diverse community. […] The system includes not only services, but structures of resource distribution, decision-making and governance. For this reason, Hong Fook has been actively participating in the provincial mental health reform since its beginning in 1993.’ By the mid-1990s Hong Fook was providing services to the Vietnamese and Cambodian communities in Toronto as well as the Chinese community. Chan, Raymond “Hong Fook – Serving Ethno-Racial Communities”, Ontario Council of Agencies Servicing Immigrants (OCASI) Newsletter, Winter 1996, 2. Ontario Provincial Archives, Record Group 10-76, Community Mental Health Services Program Files, Box B727036, file ‘Multicultural Mental Health Services’. Hung-Tat (Ted) Lo and Raymond C.Y. Chung, "The Hong Fook Experience: Working with Ethnocultural Communities in Toronto 1982-2002," Transcultural Psychiatry 42, no. 3 (2005).

2 Dr Gil Heseltine’s 1983 report ‘Towards a Blueprint for Change: A Mental Health Program and Policy Perspective’ Toronto emphasised the need for consumer involvement in program development. The Conservative government appointed an Assistant Deputy Minister for mental health in 1984 but took little other action. David Peterson’s Liberal government (1985-1990) established the Provincial Community Mental Health Committee in 1987 and published the 1988 report, Building Community Support for People: A Plan for Mental Health Reform in Ontario (the ‘Graham report’). The New Democratic government of 1990-1995 was the first provincial government to develop a longer term strategy for the restructuring of mental health services.

3 In addition to Hong Fook Mental Health Association in Toronto, founded in 1982, another early agency was the Multicultural Mental Health Services Program, established in 1984 by Immigrant Settlement & Counseling Services of Brant, also in southern Ontario. Petrella, Lill ‘The Multicultural Mental Health Services in Brant’. Ontario Council of Agencies Servicing Immigrants (OCASI) Newsletter, Winter 1996, 6. Ontario Provincial Archives, Record Group 10-76, Community mental Health Services Program Files, Box B727036, file ‘Multicultural Mental Health Services’.


5 Ibid., 144.


9 Ibid.

10 Harvey Simmons, Unbalanced: Mental Health Policy in Ontario, 1930-1989 (Toronto: Wall & Thompson, 1990). The Homes for Special Care Programme was created in the early 1960s, which
transferred newly-discharged former psychiatric patients to existing nursing homes, where their costs were indirectly subsidized by the federal government.


13 During the same year the Ministry provided a grant of $57,400 to the ‘Multicultural Health Coalition’ in support of a health information service (MoH Annual Report, 1988-89). In mid-1990 the Advisory Committee expanded its membership and mandate, and was renamed the ‘Advisory Committee on Health and Culture’.

14 Dr Masi established The Canadian Council on Multicultural Health with Professors Lynette Mensah and Keith McLeod in the late 1980s. The Council hosted the ‘First National Conference on Multiculturalism and Health’ in March 1989. Canadian Council on Multicultural Health (1989) ‘Multicultural Health – Call for Papers’. Ontario Provincial Archives, Record Group 10-256 records of the Health Programs Unit, Box B322647, file ‘Multicultural health – initiatives’. Dr Masi was initially appointed to the position of Multicultural Coordinator in the Ministry of Health for just one day a week but after the first year this was increased to two days.


16 Advisory Committee on Health and Culture, Minutes July 27 1990. Ontario Provincial Archives, Record Group 10-256 Records of the Health Programs Unit, Box B322647, file ‘Multicultural health – Advisory Committee’.


19 The Ontario Ministry of Health’s ‘Advisory Committee on Health and Culture’ identified mental health as one of three priority areas for multicultural health in Ontario. Report of the Multicultural Health Coordinator for Sept, Oct, Nov, Dec 1990


21 Advisory Committee on Health and Culture, Minutes November 30 1990.


Some consumer groups criticized the report for inadequately addressing the issue of employment for clients of mental health services. Wiktorowicz, "Restructuring Mental Health Policy in Ontario: Deconstructing the Evolving Welfare State."


March 16, 1994 letter to Gail Forsyth, Mental Health Programs & Services Group, from Amoy Ong, Chair, Proposal Writing Work Group, Ethnoracial Mental Health Committee. Ontario Provincial Archives, Record Group 10-76 Community Mental Health Services Programme, Files, File B714459 [1994], ‘Across Boundaries’.


Gail Forsyth, Community Program Consultant with the Mental Health Programs & Services Group in the Ministry of Health, noted in an internal memo ‘Creating new administrations is costly, and something we have discouraged’, but observed that members of the Ethno-racial Mental Health Committee ‘are not receptive to the idea that there are many Boards which are sensitive to ethno-racial issues, and could become more so, by changing their Board and staff composition, over time, to be representative of the community’. Typed note February 1st 1994, no heading, to Dennis from Gail. Ontario Provincial Archives, Record Group 10-76 Community Mental Health Services Programme, Files, File B714459 [1994], ‘Across Boundaries’.

Frantz Fanon wrote in 1961 about the internalization of French colonialist discourse by Algerian medical students. He quotes one such student who, having been taught about the biological basis for his people’s alleged criminality, commented ‘It’s hard to swallow, but it’s been scientifically proved’. Fanon, "Colonial War and Mental Disorders," 223.

Guidelines to meet the mental health needs of ethnoracial communities: 5

Lawrence and Dua, "Decolonizing Anti-Racism," 126.

Memorandum August 25th, 1993 to Celia Denov, Executive Director, Community Health Division; Jessica Hill, Director, Mental Health Branch; Lynne Livingstone, Priority Lead, Mental Health Reform. From Aboriginal Health Policy Working Group. Re. Comments — Mental health reform strategy and the document “Putting People First”. Ontario Provincial Archives, Record Group 10-76 Community Mental Health Services Program Files, File B409690 ‘Native Issues [1996]’. The Aboriginal Health Policy Working Group included representatives of the Association of Iroquois and Allied Indians, the Chiefs of Ontario, Grand Council Treaty #3, Nishnawbe-Aski Nation, the Ontario Federation of Indian Friendship Centres, the Ontario Métis Aboriginal Association, the Ontario Native Women’s Association, the Union of Ontario Indians, and the Ojibways of Walpole Island First Nation.

As discussed in Chapter Three, the Statement of Political Relationship, signed August 6th 1991 by the Ontario government and fourteen Chiefs representing the Ontario First Nations, was the first formal recognition by any Canadian government of Aboriginal peoples’ inherent right to self-

33 Chinese-American psychologist Derald Wing Sue is one the leading thinkers on cultural competence in North America, and has published widely on this topic since the late 1970s. The work of elaborating a professional discourses on cultural difference within nursing was initiated by white American nurse Madeleine Leininger. M. Leininger, Transcultural Nursing (Thorofare, NJ: Slack, 1978).


38 Ibid., 253-54.


40 A rare proposal for a cultural competence curriculum focused on the professional culture of medicine is presented in Carla Boutin-Foster, Jordan C. Foster, and Lyuba Konopasek, "Viewpoint: Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence," Academic Medicine 83, no. 1 (2008).

41 Janelle S. Taylor, "Confronting "Culture" in Medicine's "Culture of No Culture"," Academic Medicine 78, no. 6 (2003).


45 Irihapeti Merenia Ramsden, "Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu" (Victoria University of Wellington 2002), 109.

46 Ibid.


48 Dr Brenda Restoule, oral history, March 6th 2009, Toronto. OH8.

49 Gupta, Real Nurses and Others: Racism in Nursing; Stasiulis and Bakan, "Marginalized and Dissident Citizens: Nurses of Colour."

50 Lawrence and Dua, "Decolonizing Antiracism."; Bourgeois, "Deceptive Inclusion. The 2010 Vancouver Olympics and Violence against First Nations People."

51 Lawrence and Dua, "Decolonizing Antiracism," 123.

52 Ibid.: 123;32.

53 Fieldnotes, August 28th 2007, 519 Community Centre, Toronto.


55 Dr Brenda Restoule, oral history, March 6th 2009, Toronto. OH8.
For a recent discussion of issues relating to ethnic diversity, immigration, racism and mental health in Canada, see Mental Health Commission of Canada Diversity Task Group, "Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized Groups. Issues and Options for Service Improvement," (Ottawa: Mental Health Commission of Canada & Centre for Addiction and Mental Health, 2009).


Such concerns are well articulated in the report produced by several Aboriginal agencies in Toronto, Native Management Services, "Needs Assessment and Delivery Models to Address Mental Health Needs of the Aboriginal Community of Toronto."

Royal Commission on Aboriginal Peoples, Aboriginal Peoples in Urban Centres: Report of the National Round Table on Aboriginal Urban Issues.

This is a pseudonym to protect the identities of the research participants.

February 2nd 2009 email from research participant.

I did not ask participants these questions directly, but two participants who immigrated as adults made important references to their countries of origin. From discussions about experiences of education and professional training I deducted that all other participants were either born in Canada or immigrated as children.

2006 external review of institution’s diversity policy. Report cannot be named in order to protect the identity of participating programmes.

Ibid.

Ibid.

Admission form, November 2007 version.


The Urban Aboriginal Task Force survey report indicates that 22% of survey respondents reported using emergency rooms as their first point of access for health services. Urban Aboriginal Task Force, "Final Report," (Toronto: Ontario Federation of Indian Friendship Centres, Ontario Metis Aboriginal Association, Ontario Native Women's Association, 2007), 119.

There is minimal North American research investigating differential referral patterns to mental health services for racialised groups. For a summary of the (mostly British) existing literature, and presentation of research evidence that African-Canadians are more likely to be referred to emergency psychiatric services by police and ambulance, see G.E. Jarvis et al., "The Role of Afro-Canadian Status in Police or Ambulance Referral to Emergency Psychiatric Services," Psychiatric Services 56, no. 6 (2005).

The four categories assessed were derived from federal employment equity legislation and are Aboriginal people, women, ‘visible minorities’, and ‘people with disabilities’. Senior human resources staff (name withheld in order to protect the identity of participating programmes), communication with researcher, May 2010.

2006 external review of institution’s diversity policy. Report cannot be named in order to protect the identity of participating programmes.

Ibid. (pre-publication) 10.
Blackstock, "Reconciliation Means Not Saying Sorry Twice: Lessons from Child Welfare in Canada.;
Richardson and Nelson, "A Change of Residence: Government Schools and Foster Homes as Sites of
Forced Aboriginal Assimilation - a Paper Designed to Provoke Thought and Systemic Change."
Interview KI8, from notes.
Interview KI12
Rosenberg et al., "G.P.S' Strategies in Intercultural Clinical Encounters."
Interview KI3:22m
BBC Radio transcript.
Interview KI4, 61m.
Interview KI3, 47m.
Fieldnotes, January 9th 2009.
Interview KI4.
Interview KI6.
Interview KI7; from notes.
Interview KI12: 38m
Interview KI4.
Interview KI5.2
Interview KI8.
Interview KI9.
Interview KI1.
Interview KI3
Susan Dion, "Braiding Histories. Responding to the Problematics of Canadians Hearing First Nations
Post-Contact Experiences" (Ontario Institute for Studies in Education of the University of Toronto, 2002);
Warry, Ending Denial. Understanding Aboriginal Issues.
Linda M. Hunt, "Beyond Cultural Competence: Applying Humility to Clinical Settings.," Park Ridge
Introduction
In 1973 Vern Harper developed a proposal for mental health services for the Aboriginal community in Toronto. At that time Vern was Native court worker at the Native Canadian Centre. Although “leery of psychiatry – most Native people are”, he approached senior psychiatrists at the Clarke Institute of Psychiatry, one of Canada’s largest psychiatric research and treatment facilities, to propose that that institution hire Native counsellors to meet the particular needs of the city’s growing Aboriginal population. The psychiatrists expressed interest initially, but discussion foundered when Vern was asked about professional credentials, which he lacked. Vern was eventually told that it was ‘not the right time’ for their institution to embark on such a programme.

The right time arrived about 30 years later. In July 2002, Vern Harper -- by then recognised by Indigenous communities across Canada as an ‘urban Elder’-- was employed by Toronto’s Centre for Addiction and Mental Health (CAMH), a large biomedical institution in Toronto, ‘the first [A]boriginal Elder ever to be employed full-time by a Canadian health care institution’. Ironically enough, CAMH was formed in 1998 by the merger of several psychiatric and addictions facilities including the Clarke Institute of Psychiatry, where Vern’s overtures were rejected in the 1970s. At CAMH Vern works alongside Indigenous and non-Indigenous psychologists and credentialed addictions therapists, treating Aboriginal clients with addiction and mental health issues.

Vern’s employment by Canada’s largest mental health institution signals a significant shift in the terrain of urban Aboriginal healing which has been unfolding since the 1990s. Government and non-governmental reports from this period indicate the emergence of ‘Aboriginal mental health’ as a salient framework for explaining and responding to Indigenous distress in public policy discourse. During the same period policymakers at provincial and federal levels have begun to engage with the concept of ‘Aboriginal healing’, as discussed in Chapters Three and Four, contributing to the emergence of dominant, often universalizing discourses on Indigenous suffering. In particular, federal policy has
promoted residential schools as a ubiquitous metaphor for Indigenous experiences of colonization; this representation has been widely taken up by urban healing programmes, arguably foreclosing explorations of a far broader range of experiences and effects of colonization. At the same time the emergence of Aboriginal healing in Ontario and federal policy has created opportunities for urban and other Indigenous groups to access resources for healing programmes.

This chapter considers how Indigenous communities in urban Ontario have engaged with state policies and dominant discourses on Aboriginal suffering and healing from the mid-1990s to the present, with a particular focus on the uptake of Aboriginal mental health and residential schools discourses. I argue that because the (re)construction of identity is central to Indigenous healing, the incursion of public policy and dominant institutions into the terrain of urban Indigenous healing harbours both important implications for Indigenous subjectivities, and a potential threat to Indigenous autonomy. In Section One I provide background on the changing landscape of Aboriginal healing since the mid-1990s and discuss the continuing challenges to self-determination presented by the institutional and policy contexts in urban settings. I draw on oral histories from directors of two Aboriginal women’s centres to illustrate both the need for autonomous Indigenous institutions and the myriad obstacles they encounter. Section Two considers how urban Indigenous groups in southern Ontario are increasingly taking up mental health as a relevant framework, and asks what is at stake discursively and materially in utilizing Aboriginal mental health as a framework for explaining and managing urban Indigenous suffering. I draw on oral history and key informant interviews to analyse how the recent ascent of Aboriginal mental health relates to longer-standing discourses and practices on urban Indigenous healing, and explore the implications for the future of urban Indigenous healing and self-determination.

Public policy discourse on Indigenous healing has become an important site for the assertion of Inuit and Métis ethno-national claims within the past decade, as Chapter Four’s discussion of federal residential schools policy illustrated. Section Three of this chapter draws on oral histories and policy documents to address the emergence of Métis and Inuit
healing programmes in Ontario, and explores the significance of specific ethno-national histories in the healing process through an analysis of the work of Mamisarvik Inuit healing centre in Ottawa.

Whilst Métis and Inuit have begun in the past decade to establish healing programmes which draw on their respective histories and traditions, universalizing and ‘pan-Aboriginal’ discourses and practices also appear to be proliferating in southern Ontario cities. Public policy on Aboriginal healing has shaped emerging discourse on colonization as a determinant of health to focus narrowly on abuse in residential schools as the *sine qua non* representation of Indigenous colonial experience and contemporary social suffering. Further, the ubiquity of First Nations as a generalized Indigenous identity in policy and programming obscures the distinct geographical, historical, linguistic and cultural experiences of *particular* Indigenous nations and collectivities. These concurrent phenomena provoke questions about balancing emerging cosmopolitan indigeneities and broadly inclusive services with adequate support for local and marginalized healing traditions in urban settings, issues I discuss in Section Four.

1. **The changing landscape of urban Aboriginal Healing: public policy & Indigenous self-determination in urban Ontario**

There are many more publicly-funded Indigenous healing programmes in Ontario cities now than twenty years ago. This is partially a reflection of the rapid growth in the number of Aboriginal organizations in Canadian cities, which have become increasingly significant providers of services since the 1990s. Also, state funders have shown themselves more willing to recognize the value of Indigenous knowledge in therapeutic settings, as evidenced by the provincial Aboriginal Healing and Wellness Strategy’s funding for ten Aboriginal Health Access Centres, eight of which are in urban centres, each employing traditional healers and Elders alongside biomedical practitioners (see Table 6.1 below).
<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kanonhkwa'tsheio:io and Social Facilities</td>
<td>Cornwall (Akwesasne First Nation)</td>
<td>1996</td>
</tr>
<tr>
<td>(Mohawk, meaning ‘medicine for healing)</td>
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</tr>
<tr>
<td>Shkagamik-kwe Health Centre</td>
<td>Sudbury</td>
<td>1997</td>
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<tr>
<td>(Ojibwe, meaning ‘mother earth’)</td>
<td></td>
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<tr>
<td>De Dwa Da Dehs Nyes</td>
<td>Hamilton</td>
<td>1998</td>
</tr>
<tr>
<td>(Cayuga, meaning ‘place where we come together and help each other)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wabano Health Access for Aboriginal People</td>
<td>Ottawa</td>
<td>1998</td>
</tr>
<tr>
<td>(Algonquin, meaning ‘place in the east’ and ‘a place of new beginnings’)</td>
<td></td>
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<tr>
<td>Southwest Ontario Aboriginal Health Access Centre</td>
<td>London</td>
<td>1998</td>
</tr>
<tr>
<td>Gizhewaadiziwin Access Centre</td>
<td>Fort Frances</td>
<td>1998</td>
</tr>
<tr>
<td>(Ojibwe, meaning ‘to love and care for one another’)</td>
<td></td>
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<tr>
<td>Anishnawbe Mushkiki</td>
<td>Thunder Bay</td>
<td>2000</td>
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<tr>
<td>(Ojibwe, meaning ‘Aboriginal medicine’)</td>
<td></td>
<td></td>
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<tr>
<td>Wassay-Gezhig Na-Nahn-Dah-We-Igamig</td>
<td>Kenora</td>
<td>2006</td>
</tr>
<tr>
<td>(Ojibwe, meaning ‘rising sun or big expanse of sky in the morning’ and ‘place of healing’)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6.1: Timeline for establishment of Aboriginal Health Access Centres in Ontario cities

n.b. Anishnawbe Health Toronto, founded in 1989 as discussed in Chapter Two, is not included in this table as it is funded separately to the Aboriginal Health Access Centres.

The presence of urban Aboriginal health centres in some Ontario cities has contributed to the creation of a critical mass of Aboriginal-directed agencies, thereby bolstering collective political power, according to participants in a 2009 evaluation of the Aboriginal Healing and Wellness Strategy:

Because of an entity like [Aboriginal health access centre], it has strengthened other organizations like our sister agencies like the friendship centre, and the women's shelter... because with strong structures, we come together and we become stronger, therefore we are able to come together and work with the city [...] to develop relationships and protocol for the police service. You know, with the city [...] we now have an Aboriginal organization where the city then comes to us for any issues. So our voice is now being heard where it wasn’t ten years ago.⁵
Whilst the significant growth in Indigenous healing programmes and urban service agencies more generally suggests a concurrent increase in Indigenous power to negotiate self-determination in urban settings, a closer look reveals multiple challenges and conflicts deriving from both continuing inequities in public funding, and a broader lack of clarity and consensus regarding urban Indigenous governance in Canada. Certainly Aboriginal service providers have led the development of institutions of urban governance; the first in Canada was the Aboriginal Council of Winnipeg, established in 1990. In Ontario, the Peoples’ Aboriginal Council of Toronto formed in 1996, the Hamilton Executive Directors Aboriginal Coalition in 1995, and the Ottawa Aboriginal Coalition in 2001. Despite these developments and the influx of resources associated with the Ontario Aboriginal Healing and Wellness Strategy and the Aboriginal Healing Fund, agency directors and other participants in the current research (representing sixteen different agencies in three Ontario cities) spoke of multiple challenges: juggling inadequate and short-term funding from three levels of government and non-governmental sources; enduring continuing lack of pay equity with the ‘mainstream’ health sector; managing recruitment in the context of a continuing shortage of Aboriginal health professionals; and coordinating the activities of multiple agencies with diverse clientele in an atmosphere of intense competition for resources which tends to undermine solidarity. Research conducted for the Urban Aboriginal Task Force in 2007 describes similar experiences of Executive Directors of urban Aboriginal agencies in seven Ontario cities, who reported less long-term core funding and lower rates of funding overall compared with non-Aboriginal agencies. The challenges experienced by Aboriginal women’s centres, important providers of healing programmes for women and children (and occasionally men) in Ontario cities, illustrate how some of the issues in urban self-determination have shaped and constrained therapeutic work.

**Urban Indigenous healing & self-determination: the case of Native women’s centres**

As discussed in earlier chapters, Aboriginal women have performed leadership roles in urban Indigenous communities for many decades, often in informal and under-recognised capacities. For women fleeing violence and suffering in reserve and rural communities, urban Indigenous communities and organisations can provide ‘a place to heal and to build
Women have led a growing Aboriginal-specific movement against family and sexual violence in Ontario since the late 1960s, when they established the first urban Aboriginal shelters (see Table 2.2 in Chapter Two above). Family healing has become an integral part of the broader healing infrastructure and practices in many urban Indigenous communities in Ontario. Further, discourse on family healing has contributed to reinvigorating historical analysis as a central component of the Indigenous healing paradigm. As discussed in Chapter Three, colonialism as a determinant of Aboriginal suffering first entered into provincial policy discourse as a result of the Ontario Native Women’s Association’s work on family violence from 1989.

Aboriginal women’s shelters in large cities such as Ottawa, Hamilton and Toronto are funded by the Ontario Ministry of Community and Social Services, which currently funds about fifteen Aboriginal women shelters from within its ‘mainstream’ shelters budget. None of the nine shelters funded by the Aboriginal Healing and Wellness Strategy are in large urban centres; some are based on First Nations reserves, others are in towns adjacent to reserves and/or outside of large urban centres. Whilst the fact that this sector is predominantly funded by the Ministry of Community and Social Services rather than the Ministry of Health might be taken as an indication of the limited extent to which the Aboriginal Healing and Wellness Strategy has challenged traditional sectoral boundaries within the state, it is also advantageous that not all Aboriginal healing initiatives are funded by one sector. As Sylvia Maracle points out, this arrangement makes it harder for the state to dismantle all programmes at once, and prevents particular sectors from abrogating responsibility for Aboriginal programming.

Social workers Colleen Whiteduck (Algonquin) and Irene Compton (Saulteaux) founded Minwaashin Lodge in 1993 with the intention of providing social and healing services relevant to the needs of Aboriginal women in Ottawa. At that time there were a small number of Aboriginal agencies in Ottawa, mostly focused on housing needs, with Odawa Friendship Centre providing some basic counselling services, but no specific programming for Aboriginal women or Aboriginal people recovering from addictions. Many Aboriginal women were not accessing health and social services in Ottawa, because of experiences of
racism, and the irrelevance of the dominant bio-medical model to their life experiences. Professional Aboriginal women working as nurses and counsellors also experienced racism and marginalisation within dominant agencies in urban centres. In an oral history interview, Linda Ense, Executive Director of Hamilton Native Women’s Centre, described to me how she has felt socially isolated and unheard in her work with non-Aboriginal agencies in Hamilton; to sustain such collaborations requires significant inner strength and perseverance. Despite the obvious gaps in services for Aboriginal women in Ottawa, during their initial needs assessment Colleen and Irene encountered resistance from other agencies, including Aboriginal organizations threatened by the prospect of competition for limited funding resources.

The racism and ignorance of health and social service professionals continue to constitute barriers to Aboriginal women using ‘mainstream’ health and social services. Research in an urban Aboriginal health care setting in Vancouver has described the extent to which Aboriginal women value compassionate, Aboriginal-identified staff with life experiences akin to those of the clients they are serving. Minwaashin Lodge’s Executive Director Castille Troy explained:

I know that a lot of Aboriginal women do not want to go to mainstream agencies, whether it’s for counselling or medical services. There are systemic barriers, and although they may not articulate it in that way, they all say they “don’t feel comfortable”, “don’t feel welcome”, “don’t feel like they’re understood”. Sometimes they’ll come right out and say, “it’s racism”. They felt like they were treated differently, not with respect. Sometimes it’s more subtle and other times it seems to be quite blatant.

Minwaashin’s approach to providing relevant services is to recognize that community is central to ‘culture’, and shared experiences of suffering are often central to a sense of urban Indigenous community. Thus it is important that Aboriginal women using the services experience a sense of shared history with other users and with staff, including ‘the legacy of the residential school system or the sixties scoop’. This translates into a policy of only hiring Aboriginal staff, which has been challenging to implement due to shortages of Aboriginal women with appropriate training and education. If Castille cannot hire an
Aboriginal woman to fill a particular position – as recently happened with a Case Manager position – she will contract out the work rather than hire someone non-Aboriginal.

*We dig in our heels and will not hire, and just try to work around it rather than starting to bring in non-Aboriginal staff, because we know that will change the agency considerably and the way in which we can [...] provide service. And it’s a struggle. That’s culture. A lot of the women who work here have lived in a reserve, so they know the experience of clients who have come from a reserve... I guess that’s what I mean when I talk about grass roots.*

Whilst Aboriginal healing policy has provided some additional resources for Minwaashin and Hamilton’s Native Women’s Centre, like other urban Aboriginal agencies, both continue to rely on funding from a wide range of sources to deliver an extraordinarily broad range of programming, far beyond emergency shelter, designed to meet the extensive needs of their clients. All of Minwaashin’s programming addresses healing, but because they have eschewed a biomedical model, they receive almost no health sector funding. Since 2000, the Aboriginal Healing Foundation has funded four positions at Minwaashin, including counsellors and a traditional healer/Elder; this support will soon terminate with the imminent expiry of AHF’s federal funding. Because their official mandate is violence against women, both agencies receive most of their public funding through the Ontario Ministry of Community and Social Services. But as this is nowhere near sufficient to meet the needs of their clients, they must continually seek funding from a wide range of sources, including all three levels of governments, as well as non-governmental sources including the United Way and the Trillium Foundation; nearly 40% of Minwaashin’s funds are short-term programme grants. Minwaashin Lodge struggled for fourteen years to obtain core funding for an Aboriginal women’s shelter, finally succeeding in 2007 through extreme persistence and determination and a willingness to adapt to funders’ changing agendas. Funding for addictions treatment was another struggle. The Executive Director recalled extreme difficulties funding an addictions counsellor, particularly during the years of Premier Mike Harris’s Progressive Conservative government (1995-2002) when funding for addictions programming was universally cut.

Julie Tomiak has noted that despite the emergence of a ‘collaborative paradigm’ with respect to urban Aboriginal governance, ‘transformations converge more with larger
processes around urban governance and neoliberal restructuring than with Indigenous struggles for self-determination’. In other words, the dominant ideology underlying state support for urban Indigenous agencies is about downloading responsibilities from higher levels of government to urban service providers, rather than recognising urban Indigenous peoples’ entitlements to access sufficient public resources for the administration of their own programmes and services. Urban Aboriginal agencies continue to struggle to obtain adequate long-term funding to support their healing work. Over-reliance on short-term programme funding drains human resources because of the onerous administrative and reporting requirements. Further, intense competition for limited resources undermines solidarity between agencies, an essential requirement for the development of more effective urban Indigenous governance. Until the provincial and federal governments clarify their respective responsibilities to urban Aboriginal peoples, and all levels of government allocate sufficient resources to Aboriginal healing policy, Aboriginal women’s centres and other urban agencies will be unable to meet the demand for healing services.

2. Aboriginal mental health & urban Indigenous healing
Indigenous agencies are increasingly using the discourse of ‘mental health’ to call attention to a reported intensification of suffering in urban Aboriginal communities in southern Ontario, as signaled by a series of reports, surveys and events from 2004 onwards. In that year a consortium of Aboriginal service agencies in Toronto commissioned a ‘mental health needs assessment’ for Aboriginal people. Staff of three agencies -- Native Child and Family Services, Council Fire Cultural Centre, and Two Spirit People of First Nations -- reported that a majority of their clients had unmet ‘mental health needs’, whilst Anishnawbe Health Toronto emphasized the mental health needs of their homeless clients, numbering approximately 300.

The needs assessment report illustrates the extent to which the (mostly Aboriginal) agency staff employ terminology from the field of mental health. Whilst they are careful to articulate that they aren’t qualified to diagnose clients, in interviews and focus groups staff shared descriptors of the ‘mental health issues’ they have identified amongst their clients. The list is dominated by DSMIV diagnostic categories -- post-traumatic stress disorder,
depression, anxiety, schizophrenia, bipolar disorder, dementia, foetal alcohol disorder -- with two descriptors of behaviour, ‘suicidal tendencies’ and ‘self-harming’. The Aboriginal agency staff’s apparently confident (albeit qualified) use of biomedical categories is not simply a reflection of the wider circulation of these terms in North American society, although this is certainly a trend recognised by the scholarly literature. Since 2003, staff at two of the participating agencies had received introductory-level training from mental health professionals at the Centre for Addiction and Mental Health in Toronto in the symptoms and treatment of several major psychiatric disorders.

Clients of urban Aboriginal agencies have also identified ‘mental health’ as a priority concern, according to two surveys conducted in 2004 and 2007: the 2003-2004 Aboriginal Healing and Wellness Strategy (AHWS) consultations in anticipation of its third term, and the 2007 Urban Aboriginal Task Force survey conducted in seven Ontario cities. In response to this apparent demand, the third phase of the AHWS included the allocation of $1.41 million to three ‘mental health demonstration projects’ based in Aboriginal Health Access Centres, including Ottawa and Hamilton. In 2005 Anishnawbe Health Toronto produced its ‘Aboriginal Mental Health Strategy’, and in 2006 the Ontario Federation of Indian Friendship Centres (OFIFC) followed suit with its mental health strategy, “Good Mind”, which described ‘increasing numbers of clients who suffer from concurrent mental health disorders and/or multiple mental health problems’. And in 2007, the OFIFC hosted the ‘Leaders for Change’ Aboriginal Mental Health and Wellness Conference.

How are we to understand the intensifying interest of urban Indigenous groups (alongside governmental agencies, professional associations and mental illness-focused NGOs) in locating Aboriginal suffering in the realm of mental health? In approaching this question, it is crucial to understand how the contemporary field of mental health has been historically constituted. To speak of the historical constructedness of the field of mental health is not to deny the reality of mental illness. Rather it means appreciating the extent to which forces beyond the realm of individual suffering structure the dominant framework within which mental disorders are recognised, defined and managed. As discussed in the Introduction to this thesis, such forces range from the financial interests of international
pharmaceutical companies to urban housing policy. Further, historicizing dominant understandings of mental health draws attention to how the very processes by which mental health and mental illness are categorized and responded to themselves have implications for the exacerbation or amelioration of individual and collective suffering.

Since Clare Brant qualified as the first Aboriginal psychiatrist in Canada and Vern Harper first approached the Clarke Institute of Psychiatry during the 1970s, the field of mental health in Ontario and beyond has changed profoundly. Mental health discourse has simultaneously become increasingly poly-vocal, extended its reach far beyond the confines of biomedical institutions into everyday social interactions, and medicalized a vast range of human behaviours and experiences through the creation of hundreds of subcategories of ‘mental disorders’. The range of professional, institutional and individual actors engaged in (re)shaping the field of mental health has broadened markedly over the past three decades. The expansion of the sub-field of community mental health and discourses on ‘recovery’ and ‘rehabilitation’ have constructed active roles for consumer-survivors, patients and families in the planning and delivery of mental health care. Non-medical professionals such as social workers and psychologists have challenged medical and psychiatric dominance to the extent that some commentators argue that mental health may no longer be accurately described as an exclusively medical field, but rather the terrain of a range of professional groups, each staking distinct claims to expert knowledge. And community-based organisations are increasingly involved in providing mental health services and, to some extent, influencing mental health policy.

Whilst mental health has become increasingly prominent in policy and popular discourse in Canada and internationally, Aboriginal groups have been marginalised from Ontario’s mental health reform process, as discussed in Chapter Five. Recent urban Indigenous engagement with mental health may be interpreted as a strategy for attracting greater recognition and resources for existing, underfunded Aboriginal healing institutions and practices. As the OFIFC’s Good Minds report notes,
Aboriginal Healing Lodge and Treatment centres are not given proper recognition as the effective mental health institutions that they are and continue to be under funded, prohibiting their necessary expansion and professional development of their staff. This assertion is reminiscent of Madeline Skead’s framing of the Lake of the Woods Native Healers programme in 1996 as ‘providing the bulk of primary mental health services’ to Indigenous people in the Kenora area, discussed in Chapter Two, and also the arguments put forward by urban agencies serving immigrant and racialised groups during provincial mental health reform in the 1990s, discussed in Chapter Five.

Further, the Ontario Federation of Indian Friendship Centres notes that the mental health sector has lagged behind others in the Ontario healthcare system -- such as the Ontario Diabetes Strategy and Cancer Care Ontario -- in respecting Aboriginal rights to self-determination in health, and articulates its frustration at continuing hospital dominance of the mental health sector. The latter concern is of course shared by many community agencies, consumer-survivor groups, and other stakeholders in the mental health sector, but urban Aboriginal groups are distinctly concerned with issues of governance and how urban biomedical institutions undermine Indigenous self-determination:

An accountability process should be implemented to identify ways in which mental health programs and services controlled by non-Native interests, like that of the Centre for Addictions and Mental Health, can be held accountable to urban Aboriginal communities and their respective health managers.

Thus urban Indigenous engagement with mental health also incorporates a critique of how the dominant order channels disproportionate public resources to biomedical secondary and tertiary care providers who lack accountability to urban Indigenous peoples.

Such concerns came to a head during 2006 and 2007 when the Ontario Ministry of Health allocated $6 million in new and ongoing funding towards Aboriginal health programmes, $5 million of which was earmarked for mental health. Amounts ranging from $85,000 to $500,000 were disbursed to support twenty-five programmes, most operated by urban Aboriginal agencies including Aboriginal Health Access Centres, friendship centres and Aboriginal-run healing lodges and residential treatment centres. However $200,000 was allocated to the Centre for Addictions and Mental Health in Toronto to provide ‘provincial
training and capacity building services’. Urban agencies led by the Ontario Federation of Indian Friendship Centres were indignant that Aboriginal-specific funding should be allocated to such a well-funded institution, which ought to be financing such interventions from within its existing resources.43 Such concerns highlight a pervasive lack of clarity regarding the role and responsibilities of urban biomedical institutions in both honouring Indigenous rights to self-determination and meeting Aboriginal people’s needs for health and social services.

**Biomedical institutions and Aboriginal mental health in southern Ontario cities**

Two linked concepts structure urban Aboriginal agencies’ relationships with biomedical institutions in the present period: ‘partnership’ and ‘integration’. Partnership features prominently in neoliberal policy discourse around ‘synergies’, ‘avoiding duplication’ and ‘cost-saving’. Aboriginal service agencies describe a ‘pressure to partner’ from government and other funders, but identify multiple challenges to working with ‘mainstream’ agencies, including inequality in resources, a pervasive lack of understanding and respect for Aboriginal people and approaches from the ‘mainstream’, and ‘credentialism’ which values professional qualifications above individual life histories and accumulated knowledge of many staff of Aboriginal agencies.44 Kenn Richard, Executive Director of Native Child and Family Services in Toronto, spoke about the opportunities and challenges for urban Aboriginal agencies in working with large biomedical institutions:

> Where we can cooperate on a practical basis in the delivery of services by, you know, leveraging one another’s pool of staff or mandates or money, we do that. [...] But it has to be done, I think, with a clear sense that the institutions aren’t in charge and they aren’t the big experts either. Because they typically are not, at any level. [...] I’m one that is very strong on the development of an Aboriginal-controlled infrastructure, of services that would mirror what’s out there. I don’t believe in ‘Native units’. I don’t believe in large institutions arbitrarily establishing their responses without getting permission to do so.45

Thus urban Indigenous agencies harbor hopes for ‘service agreements’ as a viable model for collaboration with dominant institutions, alongside serious concerns about the tendency of biomedical institutions to dominate Indigenous agencies and undermine self-determination.46
The ‘integration’ of Indigenous healing and western biomedicine has been a widely celebrated concept in Aboriginal health discourse in Canada over the past twenty years, and in the broader international health literature, inspired by World Health Organisation policies since 1978. The Royal Commission on Aboriginal Peoples’ National Roundtable on Aboriginal Health and Social Issues promoted a ‘new integration paradigm’ for western biomedicine and Indigenous healing knowledge and practice. Combining biomedical and Indigenous approaches to healing is central to the discourse of the Ontario Aboriginal Healing and Wellness Strategy discourse. Given the very different epistemological and ontological bases to western biomedicine and Indigenous healing, it is noteworthy that so few commentators have acknowledged the complexity and challenges inherent to ‘combining’ divergent healing practices. In the field of mental health in particular, the current dominance of neurobiological models and the proliferation of medication-based treatment suggests shrinking common ground between biomedically trained and traditional Indigenous practitioners.

In a rare critique of the dominant discourse on integration, Gros Ventre psychologist Joseph Gone notes that the scholarly literatures show little regard for the complexity of the process of integrating traditional Indigenous healing and dominant/ biomedical approaches to psychotherapy, which, he suggests, is unsurprising given the scarcity of detailed published accounts of locally-specific traditional healing practices in the psychological literature. Gone concludes that

\textit{in light of the rudimentary disciplinary status of such integrative efforts, it is perhaps time to move beyond breezy commendations of incorporating traditional healing when counseling the culturally different.}

Proponents of ‘integration’ often act as though Indigenous and western biomedical knowledge interact on a level playing field, failing to acknowledge the extent to which western biomedicine draws on enormous social, political and economic resources. For example, the Toronto mental health needs assessment report advocates a ‘synergy of traditional medicine and practices and western medicine through a continuum of care from traditional to western-based’. The thesis introduction provided an overview of the extent to which the field of mental health at this historical juncture is dominated by DSM
diagnoses, individualistic neurological and genetic models, and pharmaceutical treatment. These frameworks and approaches appear inconsistent with the historical analysis, holistic and relational approach, centrality of cultural revitalization, and respect for individual autonomy which characterize most Indigenous healing knowledges. Surprisingly, this apparent conflict is rarely articulated in emerging discourse on Aboriginal mental health produced by urban Indigenous agencies, such as the mental health needs assessment report. Demands for training of Aboriginal agency staff, for instance, suggest an assumption that the imposition of biomedical knowledge is a value-neutral process. Of course, Indigenous actors are not empty vessels and will make their own assessments as to what is of value and relevance to their work. But it remains troubling how little discussion there is in programmatic and published literature regarding how dominant biomedical knowledge of ‘Aboriginal mental health’ may reproduce colonial relationships and undermines Indigenous epistemologies. Perhaps this silence is itself a reflection of the hegemony of biomedical understandings of ‘mental health problems’.

Beyond epistemological divergence and the shortage of useful empirical accounts of ‘integration’, where practitioners are also divided along colonizer: Indigenous lines the challenges of combining Indigenous and biomedical approaches will likely be exacerbated. Given the continuing shortage of credentialed Aboriginal health professionals in Canada, most of the physicians, nurses and other biomedically trained staff employed by the Aboriginal Health Access Centres in Ontario, for example, are non-Indigenous. Nonetheless, healing centres purport to be putting the integration rhetoric into action. Anishnawbe Health Toronto is widely cited as a pioneer in this area although there is little published documentation of their work. Verbal reports from southern Ontario Aboriginal Health Access Centres suggest less progress in combining Indigenous and biomedical approaches to mental health care. A physician from one urban Aboriginal health centre reported that community development and health promotion programmes (staffed mainly by Indigenous workers) are very weakly linked to the primary health care and mental health care teams (staffed almost entirely by non-Indigenous workers). The traditional healing coordinator in De Dwa Da Dehs Nyes in Hamilton reported a similar lack of coordination between the traditional healing and primary health care programmes.
there. A rare published account describes the integration of ‘community mental health’ and traditional Anishinaabe healing at the Noojmowin Teg Aboriginal health centre on Manitoulin Island. The extent to which this model is applicable to urban settings is questionable, given the rural setting, culturally homogenous (Anishnaabe) clients, and the area’s long history of involvement with biomedical approaches to mental health (Manitoulin Island hosted some of the earliest psychiatric interventions in response to youth suicide in the 1970s).

The continuing dominance of the liberal multicultural model presents another obstacle to collaboration between urban Indigenous agencies and biomedical mental health institutions. As Chapter Five illustrated, mental health practitioners draw on discourses of multiculturalism and cultural competence whose ahistoricism renders Indigenous peoples another marginalized ethnic group. Some Indigenous perspectives are directly critical of biomedical institutions’ attempts to apply cultural competence-type models in serving Indigenous people. The OFIFC Good Mind strategy states that Services must be reflective of Aboriginal cultural rights, views, values and expectations. This includes putting a stop to “culture based” services run by non-Aboriginal medical personnel and honouring self-determination of Aboriginal people to address mental health.

Castille Troy, Executive Director of Minwaashin Lodge in Ottawa, expressed skepticism regarding ‘mainstream’ institutions’ efforts to train their clinical staff in cultural competence or cultural safety, since culture is co-terminous with community. In an oral history interview she explained,

Our position is that you cannot be culturally competent... I wouldn’t presume to try to provide services for new Canadians moving from Somalia. How is it possible for us to be culturally competent for women from another country? Aboriginal women have their own culture.

But other urban Indigenous voices are invoking liberal multicultural discourse in discussions about working with biomedical institutions. The Toronto needs assessment report describes ‘cross-cultural sensitivity training’ as a component of ‘improved service by mainstream service providers’, and invokes the example of Toronto Western Hospital’s longstanding partnership with Spanish, Portuguese and Chinese communities. In problematising this discourse I do not mean to deny the possibility that Aboriginal agencies
may draw relevant lessons from analyzing marginalized immigrant groups’ experiences of working with biomedical institutions. Rather I am suggesting that to assume or imply a straightforward parallel between Chinese and Indigenous groups is to obscure the central challenge to a collaborative and reciprocal relationship between dominant biomedical institutions and professions and Indigenous peoples: namely the latter’s inherent right to self determination, and the former’s pervasive ignorance, denial and violation of that inherent right.62

It is clear that frontline workers in southern Ontario’s urban Aboriginal agencies have witnessed increasing levels of distress among clients in recent years.63 It is important to recognize that there are different ways to make sense of and address this suffering. Notwithstanding the standard assertions that Aboriginal understandings of mental health are holistic, involve mind body and spirit, and so on, the fact remains that the concept of mental health originated with biomedicine and is at core individualistic and ahistorical. No amount of rhetoric can change the fact that ‘mental health needs’, ‘mental disorders’ and ‘mental illness’ describe the deficiencies of an individual, devoid of social and historical context. The Aboriginal mental health paradigm is limited by a lack of clarity regarding how colonial power relations continue to shape Indigenous suffering in the present.

3. ‘It’s a hard history but we have to know’: Métis & Inuit histories and healing in urban Ontario
Over the past decade health and healing discourse, policy and programming have increasingly served as terrain on which Inuit and Métis peoples have expressed distinct ethno-national identities, as was discussed in Chapter Four. To some extent this has been facilitated by national policy: for example the National Aboriginal Health Organization, established in 2000, is subdivided into a Métis Centre, Inuit Tuttarvingat, and First Nations Centre, each of which have issued publications espousing distinct approaches to healing based on these respective identities. This policy climate may have contributed to urban Inuit and Métis in Ontario beginning to articulate their entitlements to develop and administer their own healing progammes.
These developments challenge longstanding values espoused by urban Indigenous agencies in Ontario, particularly friendship centres and women’s centres, which eschew such distinctions. As the Ontario Federation of Indian Friendship Centres states,

_The Friendship Centre movement continues to advocate for and deliver services to Aboriginal people who are Indian, Métis, Inuit, or Non-Status, believing that Status-based parameters for inclusion or exclusion reflect colonial definitions._

Further, the OFIFC is directly critical of recent public policy initiatives employing the “three streams approach” of dividing Aboriginal people into First Nations, Inuit and Métis:

_This has no relation to the manner in which we, as Aboriginal people, define ourselves, and further, disempowers us by taking away our right to self-definition. It is a strategy aimed at further dividing Aboriginal peoples from each other in order to perpetuate their marginalization and isolation and diminish the resources available to them as a whole. “Three streams” is the latest tactic in a long history of colonial practices, which includes residential schools, the sixties scoop, and the reserve system._

The Inuit and Métis populations in Ontario cities have increased since the early days of the friendship centre movement, and there is some evidence indicating that these groups have not always felt adequately welcomed or recognised in existing urban Indigenous agencies. During the 1970s there were very few Inuit in southern cities, but numbers have gradually increased, mainly due to migration for education and employment. Inuit in Ottawa established the community centre Tungasuvingat Inuit in 1987, many years later than most of the Aboriginal friendship centres in large Canadian cities. The Ontario Métis population is both much larger and more dispersed, with ten cities each hosting over 1,000 Métis residents, and the growth of the urban Métis population is a more complex issue as I discuss below.

Research conducted by the Métis Nation of Ontario (MNO) suggests that some Métis have felt unwelcome attending some of the Aboriginal Health Access Centres, but the findings are not consistent. For example Ottawa-based participants in the MNO research described their comfort in accessing the Wabano Centre for Aboriginal Health, and approved of Wabano’s display of Métis cultural symbols, such as a fiddle and a cart, alongside First Nations and Inuit cultural symbols. Research participants described contrasting experiences of attending Aboriginal health centres on reserves, or where the local Indigenous population is numerically dominated by a particular First Nation. In these
cases health centre staff tend to expect clients of the dominant First Nation identity and Métis clients may feel excluded, for example when asked to produce a status card.

**Métis healing in urban Ontario**
The astronomical growth of the Métis population in Ontario and elsewhere in Canada within the past fifteen years is controversial. Because of the historical role of the Métis in the Red River Rebellion, their experiences of stigmatization and persecution by the Canadian state may be distinguished from other Indigenous peoples' experiences of racialisation and colonial oppression. Many Métis have historically concealed their identities, and the Canadian state did not officially recognize Métis identity until 1982, under section 35 of the Constitution Act. The subsequent availability of demographic data has fuelled Métis ethno-national claims. Statisticians commented on a marked increase in the Métis population from the 1996 Census, which introduced a new format for the question regarding ethnic origins, from tick boxes to a blank space for a written response. Data from the 2006 census shows the Métis population growing at a faster rate than both the non-Aboriginal population and other Aboriginal groups, and constituting 34% of the total Aboriginal population: a 26% increase since 1996. This is of particular significance in urban settings given that Métis now make up 46% of the urban Indigenous population in Canada.

To understand the significant increase in the number of people self-identifying as Métis, one must appreciate that the term currently connotes two distinct meanings: first, ‘mixed’ heritage, and second, descent from the distinct Indigenous nation of the Métis with a homeland in western Canada. As Chris Andersen points out,

> “mixed ancestry” as a primary signifier for a Métis identity is problematic, given that ‘biological, cultural and linguistic “mixedness” constitutes a social fact for all Aboriginal people, First Nations included, who reside in the Canadian nation-state (especially those involved in the fur trade).”

The Census is incapable of distinguishing such complexity, and policy discourse contributes to the conflation of these divergent meanings. Anderson argues that the construction of a Métis identity based solely on census data 'requires a certain level of discursive violence which shears "Métis" of any national or even historical political roots and supplements
these with a simple emphasis on mixed ancestry’. Further, such changes to ethno-national categories have profound implications for public health research and practice. As social epidemiologist Nancy Krieger and other contributors discussed in a special issue of the American Journal of Public Health devoted to changing ethnic classifications in the United States Census, changing categories has a domino effect on ‘denominators for rates of birth, disease, disability and death’, ‘assessments of need, understandings of social inequalities in health, and claims for resources’ as well as ‘our view of ourselves in relation to [...] the social-political construct of race/ethnicity’. Interestingly, whilst the National Aboriginal Health Organisation employs a definition of Métis which gives equal weight to both meanings, the Métis Centre’s recent publication In the Words of Our Ancestors: Métis Health and Healing draws more narrowly on the second meaning. This illustrates both the strategic broadening of an ethno-national category as leverage for resources, and the concurrent recognition of the significance of geographically, historically and politically specific Indigenous experience to healing knowledge and practice.

Métis collectivities in Ontario have established healing programmes over the past decade with financial support from the provincial Aboriginal Healing and Wellness Strategy and the Aboriginal Healing Foundation, and in the context of the provincial government’s belated recognition of Métis rights. The Métis Nation of Ontario (MNO) began to engage with health and healing issues during the late 1990s. A Métis community survey on housing, and the MNO’s Training Initiatives Branch, identified several health issues, including addictions and mental health, as priorities for the Métis community. The Métis Nation of Ontario then launched its Health Branch in 1999, and from 2000, the Métis Nation of Ontario and the Ontario Métis Aboriginal Association joined the Aboriginal Healing and Wellness Strategy Management Committee, and received funding through the Aboriginal Healing and Wellness Strategy to develop healing programmes in the mid-northern and northern cities of North Bay, Midland, Sault Ste. Marie and Fort Frances. The Métis Family Resource Centre in Sault Ste Marie hosts a healing programme which incorporates individual and group counseling, youth mentoring, socials and gatherings, with funding from the AHF. Since this chapter focuses on southern Ontario these programmes are not discussed in any detail here.
Although several Métis healing programmes have been initiated in the province, Donna Lyons, the MNO’s Health Director, argues that Métis remain marginalized by the AHWS. At 3%, the proportion of AHWS funds distributed to Métis-specific programmes is woefully disproportionate to the size of the Métis population, which constitutes about 30% of the total Aboriginal population in Ontario. At the same time the MNO’s own research suggests that at least some sectors of the urban Métis population are satisfied with services provided through more generic Indigenous agencies such as the Aboriginal Health Access Centres.

**Inuit history, Inuit healing**

The Inuit population in Ottawa -- currently estimated by community members to be approximately 1300 -- is one of the largest in the country, with more inhabitants than 90% of the settlements in Nunavut. This relatively significant concentration of Inuit, plus the proximity to resources in Canada’s federal capital which hosts the headquarters of national Indigenous organizations, help to explain why the Ottawa-based community centre Tungasuuvingat Inuit has led the way in developing Inuit-specific approaches to healing in Canada. However, Inuit programmes were relatively slow to access the Aboriginal Healing Fund, partially because a small number of Inuit had relevant prior experience in writing grant proposals compared with many First Nations applicants from more established organisations. Tungasuuvingat Inuit established Mamisarvik, the first Inuit-specific residential treatment centre in Canada, in September 2003, one of twenty Inuit projects supported by the Aboriginal Healing Foundation.

Whilst the overall structure of Mamisarvik’s programme broadly resembles that of Toronto’s Pedahbun Lodge (discussed in Chapter Two) and other urban-based Indigenous residential treatment programmes, much of the content is distinctly Inuit. Parallels include work with Elders (resident Elder Ruby Arngna’naaq, a long-time Ottawa resident, and visiting Elder Meeka Arnakaq, based in Nunavut and unilingual in Inuktitut), wilderness camping trips, and art therapy. Programming at Mamisarvik is delivered in both Inuktitut and English and serves clients from Nunavut, Nunavik and Nunatsiavut (Labrador) as well as Inuit resident in Ottawa. Whilst Mamisarvik’s official description of their treatment
model is “bio-psycho-social-spiritual”, Inuit history, spirituality and cultural practices are prominent elements of the treatment. Residential clients are served “country food” such as caribou, Arctic char and seal. Activities include Inuit drumming and throat singing. Elders lead sessions on Inuit spirituality which include discussions of the role of shamans and “modern-day” religions, during which clients are invited to take turns to light the qulliq, a traditional seal oil lamp which burns in a long chain of small flames, a “powerful symbol of traditional wisdom”, and a beautiful and ingenious source of light and comfort.

And Inuit history features prominently in the group sessions, as discussed below.

The prominence of trauma as a concept in assessment and treatment at Mamisarvik is also a significant departure from earlier urban Indigenous healing programs. Reepa Evic-Carleton, Mamisarvik's Coordinator, is at once enthusiastic about the training she has received to facilitate trauma recovery, and skeptical about some aspects of the knowledge imparted. On the one hand, she considers the recognition afforded to the lasting effects of historical experiences to be very important. She values the normalizing effects of trauma discourse: from early in her training, she recognized the significance of framing trauma symptoms as “normal reactions to a very abnormal event”, and the relevance to Inuit’s experiences. On the other hand, Reepa rejects the notion that someone who has experienced trauma is permanently damaged due to irrevocable changes in their brain chemistry, and is generally skeptical about the use of “labels”. The concept of trauma did not exist in the Inuktitut language, so Inuit in Ottawa coined a term to use in their healing work, ‘qassaq’, meaning ‘an event that causes you to start or get scared’. As we saw in Chapter Four, trauma was a marginal concept in Indigenous healing discourse in Ontario cities during the 1970s and 1980s, appearing for example in a peripheral remark in a rare psychiatric commentary. Illustrating trauma’s current salience, all staff at Mamisarvik have participated in training on trauma at Algonquin College. Clients are assessed for symptoms of post-traumatic stress disorder before and after participation in the treatment programme; most are assessed as “moderate” or “severe” prior to treatment, and show a significant decrease in their score – sometime to zero – after treatment. Mamisarvik's intake assessment form is extremely lengthy and detailed, incorporating at least nine different standardized assessment instruments and constituting approximately four hours
of paperwork per client. Mamisarvik management have prefixed this rather overwhelming battery of psychological assessment instruments with questions of particular relevance to Inuit suffering and healing processes: did the client, client’s partner, parent or sibling attend residential school? Was the client, client’s immediate family, or family of origin relocated?

Reepa considers Inuit’s ignorance of their history -- particularly historical experiences of colonization -- to be a primary factor contributing to present-day suffering, preventing the resolution of grief and trauma and driving many people to alcohol and drug abuse “to numb the pain”. Thus the collective reconstruction of shared histories is inherently healing:

_“As hard as the realities are, when you begin to put the pieces together, there’s always a healing element there. [...] It’s a hard history, it’s a hard reality, but we have to know. Not knowing and not sharing the stories, it’s eating us away and so, that’s what I teach here, is the Inuit history. Because when people understand what’s happened to them, with that knowledge, because they’re here to get the help, to learn more about themselves, when they get that information, it moves them and it empowers them and it makes them say “No wonder! No wonder we are the way we are today”. There’s very, I’m not excusing this from some actions, but there’s a very deep-rooted issue of all the loss, the grief, the traumas that have happened to my people. And the need to move on from these things. And so ... I’m quite passionate about this.”_  

It is not simply the telling and hearing of stories which is therapeutic, but the active participation in piecing together a shared history in the context of current shared suffering. The social context provided by the Mamisarvik programme enables participants to experience and appreciate the extent to which Inuit have retained their knowledge, and its continuing relevance and value to the lives of contemporary Inuit. Inuit history has featured in Mamisarvik’s programming since the centre first opened. The Inuit history curriculum at Mamisarvik focuses on the particular ways that colonialism impacted Inuit families and communities, including coerced relocation from traditional camps to permanent settlements, the RCMP slaughtering sled dogs in Nunavut and Nunavik, removal of children to attend residential schools, and the rapid loss of fluency in Inuktitut. Residents view films such as ‘Broken Promises. The High Arctic Relocation’, which tells the story of the federal government’s coerced relocation of Inuit from northern Quebec to the High Arctic, and the National Film Board’s ‘Life in the Settlements’ series.
In oral history shared as part of the current research, Reepa used examples from her own family and community to convey both the devastating impact of colonial policies on her parents’ generation, and the lack of understanding of her own generation which contributes to ongoing suffering. Reepa’s family ‘lived off the land totally’ until her family was relocated when she was 6 years old. She shared her positive memories of that time:

\[I\ was\ surrounded\ by\ adults that\ really\ cared\ for\ me\ and\ I\ felt\ the\ security,\ the\ safety,\ the\ harmony\ because\ the\ groups\ were\ small.\ When\ we\ lived\ as,\ on\ the\ land,\ it\ wasn’t\ like\ the\ larger\ communities\ we\ have\ now.\ So\ everybody\ looked\ out\ for\ each\ other.\ The\ other\ thing\ that\ amazes\ me\ is\ that\ even\ though\ we\ had\ very\ little\ possessions,\ we\ did\ not\ feel\ like\ we\ were\ poor,\ like\ that\ was\ the\ way\ of\ life.\ I\ don’t\ remember\ ever\ having\ like\ store-bought\ toys.\ Everything\ that\ I\ played\ with\ was\ made\ by\ my\ mom\ or\ my\ father\ or\ anything\ we\ could\ collect\ from\ within\ the\ camp\ like\ tins\ or\ even\ we\ used\ like\ the\ flippers\ of\ a\ seal,\ of\ the\ seal,\ the\ bones\ we\ used\ them\ to\ play\ with.\ So,\ I\ have\ wonderful\ memories\ of\ how\ life\ was\ then.\]^{91}

Growing up in Pangnirtung, where she learned English and a new urban culture, Reepa felt increasingly estranged from her parents. She struggled to understand why they had moved when it was clearly such a difficult adjustment:

\[When\ my\ parents\ were\ relocated\ to\ move\ to\ a\ settlement,\ they\ were,\ like\ they\ were\ forced.\ I\ didn’t\ know\ [that]\ at\ the\ time.\ I\ remember\ going\ through\ an\ identity\ crisis\ where\ I\ wasn’t\ really\ an\ Inuk\ because\ I\ was\ learning\ another\ way\ now\ and\ the\ gap\ between\ my\ parents\ and\ I\ grew\ and\ grew.\ And\ I\ can\ honestly\ tell\ you\ that,\ my\ mother\ in\ particular[...\]\ was\ longing\ to\ go\ back\ and\ I\ would\ wonder,\ because\ I\ was\ too\ young\ to\ know\ the\ details\ at\ the\ time,\ I\ would\ wonder\ why\ did\ they\ ever\ move\ when\ she...?\ Why\ is\ she\ always\ wanting\ to\ go\ back?\ Why?\ I\ had\ a\ lot\ of\ “whys”.\ And\ now\ I\ know.\]^{92}

Reepa’s family continued to visit the site of their former home every year during the summer months through her teenage years, and as an adult she made regular visits with her parents and her own children. She described how, on one of these trips during the 1970s, she had an encounter with an elder which gave her insight into the extent to which her people were continuing to suffer as a result of federal policy of relocating Inuit, part of a broader strategy for asserting Canadian sovereignty in the Arctic:

\[I\ would\ look\ through\ the\ old\ campsites,\ just\ digging.\ At\ the\ time\ I\ didn’t\ know\ what\ I\ was\ really\ doing,\ other\ than...\ I\ wanted\ to\ find\ things.\ I\ now\ know\ I\ was\ looking\ for\ my,\ maybe,\ part\ of\ my\ identity.\ So\ one\ day,\ I\ have\ my\ amautik\ on,\ carrying\ my\ little\ baby\ in\ the\ back\ and\ I’m\ digging\ through\ the\ soil,\ looking\ for\ beads,\ or\ buttons,\ whatever\ glass,\ whatever\ I\ could\ find.\ And\ one\ of\ the\ elders\ that\ were\ camping\ with\ us\ came\ over,\ and\ I\ knew\ she\ had\ her\ home\ [there],\ like\ my\ mum,\ years\ ago.\ And\ I\ don’t\ know\ why,\ I’d\ never\ asked\ my\ mom\ how\ it\ was.\ But\ that\ particular\ day,\ I\ asked\ this\ lady.\ [...]\]
And I said ‘How was it then, to have ...experienced that...? Being removed from this, to....’. I didn’t expect the reaction, because she started to cry. I realized [...] back then, that... there’s a lot of pain associated with these drastic decisions that were made upon my people [Reepa’s voice becomes angry] without their input whatsoever! None! And so, I’ve had moments where I’ve been given the opportunity to kind of see, and then it kind of made me who I am, in the work that I do. How important this work is. How important it is for people to tell their stories.93

Reepa’s account vividly illustrates how silences within families and between generations in Indigenous communities prevent individuals from accessing and discussing memories which are important for making meaning of suffering in the present. Thus therapeutic work at Mamisarvik is never about an individual in isolation; it constitutes a social process of re-building a shared identity through reconstructing shared pasts. Recognition of colonial violence, oppression and processes of victimization leading to individual and collective experiences of suffering and loss is a crucial dimension of this process.

4. Identities, histories & universalization in urban Indigenous healing discourse
In 2006 the Ontario Federation of Indian Friendship Centres issued a statement condemning ’the “Pan-Aboriginal Approach”’, asserting that it

fails to recognize the differences between diverse and distinct Aboriginal cultures, and amalgamates all Aboriginal cultures into a single melting pot, thereby erasing crucial aspects of identity specific to different Aboriginal peoples [...] whereas the Friendship Centre movement believes that preservation of all distinct Aboriginal cultures is urgent and imperative.94

The emergence of a ‘hegemonic’ pan-Aboriginalism in Canada has also been critiqued by Indigenous scholars.95 In a recent collection, editor Leanne Simpson asserts the contributing authors’ collective commitment to the protection of Indigenous lands and knowledge systems, and explains

this commitment leads us to reject pan-Aboriginalism, because we believe that the uniqueness and diversity of our cultural teachings and ways of knowing, rather than some manufactured hegemonic ”Aboriginal” culture, holds the answers to the questions facing Indigenous Nations in contemporary times. We cherish the diversity of Indigenous cultures and believe that it is necessary to protect and promote that diversity.96

In this section I argue that these issues play out in complex ways in urban settings, such that pan-Aboriginalism and the protection and promotion of distinct Indigenous national cultures may co-exist as social phenomena not necessarily in diametrical opposition.
Contemporary discourse on Indigenous healing includes both elements which promote a universalization of Indigenous experience and knowledge, and others which emphasise ethno-national specificities. The latter was illustrated by the previous section’s discussion of Métis and Inuit communities’ mobilization of healing discourse to assert distinct histories and knowledge. Here I suggest the need to distinguish between two dynamics: first, syncretic and simplified forms of teachings and healings which reflect both the pragmatics of service delivery in urban settings and efforts to meet the needs of the socio-culturally disenfranchised; and second, the ways in which dominant policy discourse has fostered the universalization of Indigenous experience. Further, I argue that a complex interplay of historical, social, geographic, economic and political factors shapes the extent to which members of any particular Indigenous group have the desire and ability to (re)construct ethno-national healing knowledge in a given urban setting.

A critical perspective on healing traditions and pan-Aboriginalism in urban settings

In critically analyzing the homogenizing force of contemporary Aboriginal healing discourse, there is a danger of romanticizing and reifying Indigenous knowledge in a manner which disregards the fluidity of all healing cultures, and denies the capacity of Indigenous people to adapt to changing conditions and adopt useful components of other healing practices. As Indigenous psychologist Joe Gone has commented, ‘in the context of substantial colonial disruptions, it should not be surprising that many healing traditions have evolved remarkably during the past century.’ Even beyond the effects of colonialism, it is clear that diverse Indigenous societies living in proximity to one another commonly share elements of healing knowledge and practice, and that to regard localized Indigenous healing knowledge as a bounded entity is problematic. Indigenous healing roles and practices have their own histories, and are subject to influence by a range of factors including changing economic circumstances and the availability of alternate forms of healing.

Mohawk scholar Marlene Brant Castellano spoke to the challenges of reconstructing Indigenous healing knowledge in contemporary social contexts during an oral history interview contributed as part of the current research:
In a contemporary Aboriginal community, there is competitiveness, there is the individualism, there is the isolation, there are the intolerances and you can’t just go back to saying we’re going to treat ill health and mental ill health, mental disorders in a traditional way because there isn’t that supporting network of relationships and cultural ways. They have been fragmented. [...] it’s like trying to talk Greek philosophy if you only have a high school student’s knowledge of Greek language. You can begin to intuit, you can intuit the philosophies that are there and you can embroider using your current knowledge and situation, but you can’t go back, you can’t go back. And so what we’re engaged in now is trying to, using those precious parts of the vessel that has been broken. The shards are still there and you can still see, you know, the quality of the vessel that was, and you can be selective about bringing in other knowledge, other insights to create something new.100

Extending this metaphor, healing knowledge has not been fragmented to the same extent for all Indigenous peoples, who face both common and distinct challenges in reconstructing the ‘vessels’ particular to their nation or socio-cultural group. A too-narrowly relativist perspective may obscure attention to how both historical and ongoing state policy and public discourse sustains or undermines ethno-nationally specific or localized histories, healing knowledge and practices. A central argument of this thesis is the need for more critical analysis of how contemporary socio-political forces articulate with colonial continuities in ways which constrain or enable Indigenous self-determination, as an integral part of a more rigorous framework for analyzing Canadian colonialism. Shaped by public policy and other broader factors, contemporary Aboriginal healing discourse highlights particular colonial policies and neglects others, attracting resources and attention to the experiences of some Indigenous groups whilst exacerbating the marginalization -- and by extension the suffering -- of other groups.101 The most salient illustration of this dynamic is contemporary residential schools policy discourse.

**Residential schools policy and urban Indigenous healing: discursive & material effects**

Federal residential schools policy has narrowed the focus and thereby blunted the impact of a potentially powerful emerging discourse on colonization as a determinant of contemporary Indigenous health. It has also constructed a template for individual healing, which may or may not be taken up in local settings. Of course, the ubiquity of residential schools discourse in urban Indigenous healing practices is attributable to complex social and political factors beyond the scope of Aboriginal healing policy: the Indigenous and
‘mainstream’ media, the residential school survivors movement, and individuals’ decisions to discuss their experiences and their families’ experiences of residential schools in therapeutic contexts. (These issues were discussed in Chapter Four.) Nevertheless, the implications of residential schools policy are significant in urban settings: for example, 32.1% of the Aboriginal Healing Foundation's funding has been allocated to urban healing projects.

Minwaashin Lodge was one of the first agencies in Ottawa to develop programming specifically aimed at residential school survivors, in response to the founders’ initial assessments of women’s needs. Minwaashin has received support from the AHF since 2000. The first programme developed at Minwaashin was ‘Wisdom Keepers’, a healing circle for women aged over fifty who were former residential school students, which later became known as the ‘Grandmothers’ Group’. The group was initially led by Elder Lillian Pitawanakwat, the daughter of an Ojibwe mother and Potawotami father and granddaughter of a midwife, from Whitefish River, Manitoulin Island (also Elder Lillian McGregor’s home reserve). Members of the original Grandmothers’ Group visited Manitoulin Island and each participated in vision quests, four-day fasts, sweat lodges and other ceremonies. They also constructed their own sweat lodge outside of the city on land provided by Jim Albert, Lillian’s helper at the time. The sweat lodge continues to be used by women from Minwaashin Lodge. Through Elder Lillian’s teachings and participating in the circle, the women learned about their roles and responsibilities as grandmothers to address the many problems their families and communities were facing. Since 2003 some members of the Grandmothers’ Group have participate in the annual Women’s Water Walk by Anishinaabekwe (Ojibwe women) and their supporters, walking the perimeter of a different Great Lake each year to draw attention to water pollution. Many of the women who participated in the Grandmother’s Group have since become Elders and community leaders themselves, some in Ottawa, some on their home reserves.

One of these is Grandmother Irene Lindsay. Minwaashin Lodge invited Irene to take on the role of resident Elder at the Lodge in 2003. Irene describes herself as a residential schools survivor, having attended St. Michael’s Residential School in Duck Lake Saskatchewan.
Her own work as a healer is focused on helping others recover from the effects of residential schools, including the intergenerational effects experienced by the descendants of former students. Reflecting on her work in the Grandmothers’ Group with Elder Lillian, she observed,

*We had lost our culture. We had lost our spirituality, and most of us had lost our language when we went to the residential school. So we were kind of reclaiming this back, which was, which is what I’d like to see most of the residential school survivors do, you know, I would like to see them do that.*

Irene was born into the Cree nation, but doesn’t follow Cree spiritual traditions in particular, describing her national alignment as ‘neutral’. She feels at home in the Aboriginal community in Ottawa and has developed her own healing practices based on the medicines and teachings that have come to her through her journeys in the spiritual realm. She has her own spirit animal and powerful spirit helpers who came to her on her vision quest. She is a pipe carrier and a lodge-keeper. In short, in her words, ‘I think I have all the things I need to do what I need to do, to help people do their healing’.

In addition to her work at Minwaashin, Irene works part-time at Wabano Health Centre in Ottawa, where she has worked closely with an art therapist, and also serves as an Elder on the Board of Directors of the Aboriginal Healing Foundation.

Irene’s work as Elder and healer at Minwaashin Lodge focuses on reconstructing intergenerational relationships between Aboriginal women, and in particular, supporting other grandmothers to assume their traditional roles as teachers and advisors to younger women – ‘extended grandmothers in the community’. Irene described her experiences of working with the adult children of survivors, noting that they are often angry:

*the ones that are angry, and the thing is they don’t know what’s happened, what’s going on with them until you explain to them why they’re so angry and why they’re in that state of mind, and once they understand it, ‘Oh my gosh, okay, I’m gonna get rid of that.’ You know what I mean, they want to get rid of it.*

This work can be especially challenging in working with those whose parents have died without discussing their experiences of residential school, ‘especially when their parents are passed on already and they’re just finding out how they were treated’. In Irene’s experience, identifying their parents’ experiences of residential schools as the root cause of their current distress is therapeutic for these women. This healing work involves building
relationships over the long-term: Irene has worked with many different women over periods of several years. Irene uses the Ojibwe version of the medicine wheel as a tool to help women understand their roles in the community based on the position in the lifecycle. Women participating in healing circles discuss experiences of addictions and abuse, whilst relationship-building between older and younger women often happens spontaneously during shared activities, such as crafting powwow regalia and jewelry. In addition to group work, many women at Minwaashin benefit from individual counseling with Irene or another Elder who can facilitate their individual connection with spiritual teachings. Irene works with Indigenous knowledge such as the Seven Grandfather teachings, as well as contemporary psychotherapy concepts such as ‘the inner child’. If she senses her work with a client is not progressing she may discuss with her supervisor and refer to another counsellor within Minwaashin who works with a cognitive behavioural therapy model, or to a GP at Wabano Aboriginal Health Centre.

Discourse on residential schools may profoundly shape individual healing trajectories and, by extension, subjectivities. There are clearly important distinctions between the way such discourse may be used within land-based communities where a significant proportion of the population has intimate personal or familial experience of the same institution, and an urban setting in which participants in healing bring diverse personal, familial, and community histories of residential schools. Discussion of the intergenerational effects of residential schools has provided an important tool for exploring the historical context of violence and neglect in contemporary Indigenous families.

It is equally apparent that the emerging discourse provides a ready-make framework which both presumes and explains the suffering of former residential school students and their descendants, with the risk of universalizing experiences of abuse and trauma. Questions emerge regarding the effects of a standardized account of residential school experience, in particular the implications of an imposed victim status and the possibility of obscuring or neglecting other important elements of family and community history. In other words, Aboriginal women have plenty to be angry about in addition to and beyond residential schools, and healing programmes may profoundly shape how such anger is directed.
The dominance of residential schools in healing discourse has foreclosed discussion of broader experiences of colonization at the levels of therapeutic interventions and broader policy and programming. There is a relative lack of attention to other colonial policies with ongoing effects, such as the federal government’s mistreatment of veterans and the relocation of communities, two colonial policies which participants in Royal Commission on Aboriginal Peoples’ consultations identified as significantly damaging. Mamisarvik Healing Centre’s programmatic focus on Inuit communities’ history of relocation is exceptional. Many other Indigenous communities were forcefully relocated, including some whose members are well-represented in southern Ontario cities, such as the Mi’kmaq of Nova Scotia and several Anishnaabe (Ojibwe) communities in northwestern Ontario. But as colonial relocation is not a well-developed theme in healing discourse, these people are unlikely to encounter recognition of their particular communal histories in an urban healing programme.

Language retention and acquisition is another important dimension of Indigenous healing which has been marginalized in dominant healing discourse. Knowledge of an Indigenous language powerfully supports Indigenous well-being in the present, as evidenced by research on youth suicide amongst First Nations in British Columbia. Urban Indigenous people recognize language as the basis of Indigenous cultures, but overall levels of fluency in Indigenous languages are low in urban centres, and there is insufficient public funding for urban Indigenous language programmes. Although residential schools contributed to the decline of Indigenous languages, the legal paradigm dominating the settlement rendered loss of language irrelevant compared with ‘commensurable effects’ such as physical and sexual abuse. Thus multiple proposals for language programmes submitted to the Aboriginal Healing Fund were automatically rejected as ineligible. Despite the marginalization of Indigenous languages in healing policy, some local programmes have incorporated language training and provided evidence of the healing effects for former residential school students. Mamisavik Healing Centre has enabled Nunavut-based Elder Meeka Arnakaq to play a lead role in healing work with this community. Although rapid loss of fluency in the Inuktitut language has been a destructive force in Inuit communities, because the Inuit experienced residential schools and forced settlement relatively recently,
76% of Inuit are still fluent in Inuktitut and therefore able to benefit from the unmediated teachings of Elder Meeka, who is unilingual in Inuktitut.\textsuperscript{119} Until recently Inuit in Ottawa, over 2,500 km away from Nunavut, lacked access to any such support for the retention of Inuktitut.

The Meeting Place drop-in centre in Toronto has established a ‘hub’ of services for residential schools survivors in response to strong demand from Aboriginal clients. Meeting Place staff are therefore well situated to observe how receipt of payments from the residential schools settlement has affected the lives of some former residential schools students, well-represented among their clients, who are usually marginally housed or homeless, and often struggle with addictions. Meeting Place Coordinator Leslie Saunders shared her mixed reactions to the Common Experience Payment (CEP) based on her observations of how clients have been affected:

\begin{quote}
I think the Aboriginal school money is a positive thing, generally speaking, because it does give some money to people that previously didn’t have any money at all. However, having said that, it has also spiked, I think, the addictions and the suicides because people are drinking themselves to death with this money. Some of them are so re-traumatized by the process that’s required to get that money, that it’s putting them in a terrible state, a terrible mental state, because they’re forced to dredge up all these horrible memories that they’ve worked so hard to try to numb out. And then after they’ve been re-traumatized, they’re handed this cheque and so of course they do the only thing many of them know how to do and that’s numb out the pain with more drugs and alcohol. So, I really wished that they could have come up with a different process.\textsuperscript{120}
\end{quote}

\textit{Ethno-national diversity, healing \& equity in urban Indigenous communities}

A majority of people using urban Aboriginal health centres are drawn by the availability of ‘traditional services’.\textsuperscript{121} However, the current research joins existing work in suggesting that what is offered as ‘traditional’ healing in urban settings varies widely in the extent to which it continues distinct Indigenous healing traditions.\textsuperscript{122} It appears that healing programmes in southern Ontario cities often draw from a universalized version of Aboriginal healing knowledge based particularly on dominant Ojibwe and Cree symbols and practices such as the medicine wheel and the sweat lodge, as well as incorporating
various alternative and complementary therapies. Such accessible forms of healing knowledge and practice may be of particular value to the significant numbers of ‘culturally disenfranchised’ Aboriginal people in urban centres: people of diverse origins who have been alienated from their nation, family and self through experiences of residential schools, the child welfare system, and incarceration.\textsuperscript{123} As discussed in Chapter Two, many of those seeking healing in cities during the 1970s and 1980s had such a personal history, and responded well to a generic Aboriginal approach incorporating different healing traditions and a generalized historical-political analysis.

More recent evidence from Corene Cheeseman, addictions counsellor at Hamilton Regional Indian Centre, indicates that this is still the case. In an interview Corene described most of the people accessing services at the friendship centre as lacking knowledge about their Indigenous culture and ‘still seeking their past’. Many of these clients were raised by non-Native families; she continues to see people as young as 25 with this background. In oral history Corene distinguished the ‘universal teachings’ generally available to such clients in the urban setting, and healing traditions specific to particular First Nations:

\textit{So there’s a lot of people out there who are coming in [to the friendship centre] who are willing to learn more about their culture. When I talk about the culture, what is shared is sort of like the umm…. mainstream teachings. So when you talk about having teachings, the teachings from everyone in the community is sort of like universal teachings, like on a medicine wheel. The four medicines, smudging, they may have just….like universal teachings on all of that. However, it still helps an individual to come back, back to their Native background.}\textsuperscript{124}

Such ‘universal’ healing coexists with the practice of ethno-specific healing traditions, but the latter are not always available through urban healing programmes. The Ontario Federation of Indian Friendship Centres asserts that ‘when individuals walking into a Friendship Centre are assisted in finding an elder or teacher of their own nation we are closer to the assurance that our cultures are kept alive and relevant for Aboriginal peoples of all origins living in urban centres’.\textsuperscript{125} This is an admirable ideal, but the extent to which this is actually happening is unclear from the current research. Corene describes how particular national healing traditions may not be widely shared in urban settings:

\textit{My background, where I’m from... I could not just take anybody to the ceremonies of where I’m from, because of how it’s done. I’ll use Ojibwes for an example. Midewiwins}
have stages they go through, and I cannot be a Midewiwin because I’m not Midewiwin. So I could probably go to their ceremonies, however I would not become part of their ceremonies, because that’s not my past, it’s not my background. And a Midewiwin may not be able to go to my ceremonies, where I go, because they’re not from my past. She suggested that Aboriginal people in Hamilton who are socially connected to their home community and familiar with teachings traditional to their particular heritage may not be accessing traditional healing through urban health centres or friendship centres, but are more likely to seek out a healer practicing within their own particular tradition: if they’re living the teachings, they may not seek help. They’ll seek help from their own people. [...] So with those ones there, they may not be coming here.

Corene’s account is consistent with other research in Ontario which indicates that some urban-based Aboriginal people regularly travel to their home (usually reserve) community in order to participate in ceremonies and other healing activities. However the same research identifies distance and lack of financial resources as obstacles preventing some urban-based Aboriginal people from regularly pursuing this strategy. Urban Aboriginal Task Force research in Ottawa suggests the emergence of a distinct class-based pattern: those with higher incomes can afford regular access to traditional healers outside of the city, in contrast to those with lower incomes who cannot.

Kathi Wilson and Evelyn Peters noted different experiences for Anishnaabeg in northern Ontario cities, for whom both their home reserve and wilderness settings were more accessible, compared with those in southern Ontario cities, far from home reserves and also less accessible to undeveloped natural areas. The Ontario Urban Aboriginal Task Force research suggests that an individual’s experiences of family conflict, violence and abuse in their home community may also constitute social barriers to regular visits. Wilson and Peters also note that the same individuals employ both the strategy of regular home visits and participation in ‘pan-Aboriginal’ ceremonies in urban settings, thereby troubling the idea that urban healing services are particularly for the culturally disenfranchised. At the same time, Urban Aboriginal Task Force research suggests that there is significant unmet demand from the urban Aboriginal middle class for more ‘cultural programming’, although the content of such programming is not articulated.
Further research is needed to consider urban Indigenous people’s varied healing requirements in relation to socio-economic resources and ethno-national identity.

Thus multiple factors including public policy structure urban Indigenous peoples’ opportunities to sustain or resurrect distinct healing traditions. Patterns of ethno-national diversity within the urban Indigenous population, the proximity of reserves or homelands and the extent to which these are repositories of healing knowledge, and the prevalence of language-speakers are all important factors -- and are all, themselves, shaped by colonial histories. The specific Haudenosaunee (Iroquois) resources available to residents of Hamilton illustrate the potential advantages of those living in a city on and/or close to their traditional land-base. De Dwa Da Dehs Nyes Aboriginal Healing Centre in Hamilton employs two Mohawk healers (as well as an Indigenous healer from South America and Ojibway-Cree Elder Walter Cook), and Hamilton Regional Indian Centre hosts Mohawk language classes. In addition, Haudenosaunee in Hamilton with the means to travel have ready access to healing resources based at nearby Six Nations of the Grand River Mohawk territory. The Coordinator of traditional healing at De Dwa Da Dehs Nyes regularly refers clients to programmes at Six Nations, such as I da wad a di, a traditionally-based program to help Native women heal from the legacy of physical and sexual abuse coordinated by Mohawk Elder Jan Longboat, and ‘The Lost Generation’ support group for residential school survivors.133

James Bay Cree in Toronto have a very different experience. Cree people from the Atawapiskat and Fort Albany area on the west coast of James Bay in northeastern Ontario are disproportionately represented amongst the many Aboriginal clients using the Meeting Place drop-in centre in downtown Toronto.134 Their home region was heavily dominated by Christian proselytization from the arrival of Catholic missionaries at Fort Albany in 1896, followed by the first intake of students at St Anne’s residential school which operated from 1904 until 1973. There is strong evidence that students at St Anne’s residential school experienced exceptionally high rates of sexual and physical abuse.135 Psychiatrist Gary Chaimowitz has done outreach work in this region since 1990. In an oral history interview he described to me how people continue to be heavily influenced by Christianity,
and despite the gradual re-emergence of some traditional healing practices, many residents maintain abiding attitudes of fear and skepticism towards Indigenous healing knowledge and practices. Chaimowitz has witnessed unsatisfactory consultations resulting from an Indigenous physician’s insistence on advancing a ‘First Nations perspective’ with resistant elderly Christians in the region. This account challenges the uncritical celebration of the traditional as an essential element of healing for all Indigenous people, and underscores the importance of an historically and locally contextualized analysis of Indigenous social suffering.

The Meeting Place’s programming for former residential schools students is so popular amongst the west-coast James Bay Cree that it regularly attracts people from as far away as the James Bay coast and Sarnia. Since 2009 a bi-monthly ‘residential schools survivors’ dinner’ has focused on offering support to individuals who are going through the Independent Assessment Process of the Residential Schools Settlement, which requires individuals to testify about experiences of serious abuse, with the possibility of receiving individual financial compensation (discussed in Chapter Four). The Meeting Place also refers clients to a lawyer with expertise in residential schools, and coordinates a weekly therapy group conducted by a psychologist with extensive experience of working with residential schools survivors, which at the time of interview was attended by about sixteen people each week. Coordinator Leslie Saunders notes that the psychologist-led group attracted more participants than another weekly group based on a traditional healing circle. She attributes this higher attendance to the psychologist’s expertise in facilitating discussions about residential school experiences and ‘supporting the participants as they unpacked the feelings attached to their personal histories of abuse’. Psychiatrist Gary Chaimowitz also described an increasing preference for biomedically trained mental health professionals amongst James Bay Cree communities he works with. This pattern contradicts the trend towards preferences for traditional and para-professional healers amongst participants in Health Canada’s Indian Residential Schools Resolution Health Support Programme, described in Chapter Four. Whilst Gary and Leslie both attributed the apparently increasing interest to a generational shift and increasingly informed ‘consumers’, the distinct regional history of the west coast James Bay Cree, and in
particular their experience of intensive Christian proselytization, is likely an important factor shaping the prevailing preference for biomedical and psychological over Indigenous approaches. Whilst all Indigenous peoples in North America (and elsewhere) have suffered profound loss under colonization, some communities, regions and nations face particular obstacles in recovering local traditional knowledge in support of contemporary healing. This realization illustrates how local socio-historical analysis can inform the development and delivery of appropriate healing practice.

5. Conclusion
This chapter has explored the complex relationship between dominant discourse, ethn-national identities and healing practice in the context of urban Indigenous communities. Discourses on Aboriginal mental health and residential schools are increasingly dominant in discussions of urban Indigenous healing. The emergence of provincial and federal policy on Aboriginal healing, discussed in Chapters Three and Four, has facilitated an influx of resources designated for Aboriginal healing programmes, but in the context of a pervasive lack of clarity regarding urban Indigenous self-determination and continuing inequities in funding. Further, the resources flowing from policy developments within the past fifteen years are widely perceived to be inadequate and too time-limited to meet the pervasive need for healing in urban Aboriginal communities. In this context, urban agencies’ increasing engagement with mental health and residential schools discourses may be interpreted as a strategy for attracting recognition and resources to Indigenous social suffering.

In appealing to the mental health paradigm, urban Indigenous agencies and other actors may be subscribing to what Max Weber described as *zweckrational* action: ‘technical’ or ‘instrumental’ rationality. Instrumental rationality guides action taken in a calculated manner towards a predictable end. It may be contrasted with the competing rationality of *wertrational* or value-based action, which is undertaken because the actor believes it is the right thing to do. Weber argued that instrumental rationality became the dominant mode of action in modern society and particularly in administrative bureaucracies (such as western health care systems) because it is ‘calculable and predictive’, and assessable by
external observers as well as individual actors.\textsuperscript{141} In other words, instrumental rationality favours interventions which are empirically measurable, invoking processes such as ‘the codification of life events and chronic difficulties’ in the analysis of depression.\textsuperscript{142} The diagnostic and statistical manual of mental disorders is a typical example of instrumental rationality. In a political climate where fiscal restraint dominates and ‘efficiency’ and ‘effectiveness’ are the bases for the allocation of resources, instrumental rationality has come to predominate in health care and social services.

The danger noted by Weber is that in a system dominated by technical rationality, problems which are inherently about values may become redefined as technical questions. Cathy Richardson and Bill Nelson offer a similar analysis in their account of the Canadian child welfare system as a site of forced assimilation of Aboriginal children and families:

\textit{When we look deeply, we see that we are at a crisis point in the way we are living on the Earth. Most critically, we need to move from a culture of problem solving to one of visioning and creating the world we want.}\textsuperscript{143}

This suggests that understanding and beginning to alleviate contemporary Indigenous suffering requires a moral rather than a technical framework, which is consistent with Indigenous healing paradigms but not with the contemporary field of mental health. Rather, the latter is dominated by the discourses of biological psychiatry, the DSM-IV and cultural competence training which, as Jonathan Metzl has noted, ‘encourage collective forgetting’ and ‘interrogate the present at the expense of the past’.\textsuperscript{144} Appealing to this field as a source of succor for Aboriginal suffering may jeopardize the centrality of historical analysis which has characterized urban Indigenous discourse on healing for the past four decades.

Inuit working at Mamisarvik Healing Centre in Ottawa have effectively challenged universalizing discourse on Indigenous colonial experience by incorporating Inuit-specific histories well beyond residential schools into their healing programming. The development of Inuit and Métis healing programmes in Ontario cities raises questions about the effects of universalizing or ‘pan-Aboriginal’ approaches to urban Indigenous healing in the context of complex and diverse communities: what are the implications for
the continuation of distinct ethno-national healing knowledge, and for the recovery and dissemination of localized Indigenous histories of colonization? At the same time, programmes for residential school survivors such as that at Minwaashin Lodge are clearly focused on building Indigenous community in the city, prioritizing present and future inter-generational relationships for which a generalized shared history of surviving colonization is a sufficient basis.

The interpretation of individual healing choices and experiences needs to be informed by nuanced, localized colonial histories. An Indigenous individual may or may not find an Elder or healer working with their language and knowledge system in any given urban health centre in southern Ontario. Those with a home reserve to go to and the resources to get there --neither of which is a given for urban Indigenous people -- may choose to seek out healing in a reserve setting, clearly the practice of some. Other urban Indigenous people may learn from healing traditions other than their own without jeopardizing their own ethno-national identity. For example Toronto-based Ojibwe Elder Lillian McGregor identifies the late Mohawk Elder Ann Jock as one of her most significant teachers, alongside the late Ojibwe Elder Art Solomon.145 And for some, a healing practice drawing on an eclectic or generalized blend of Indigenous knowledge, incorporating historical analysis, spiritual awareness, and building relationships, may be more than adequate to meet their needs. Finally, it cannot be assumed that all Indigenous people will choose to work with traditional Indigenous healing practices: some, such as the west-coast James Bay Cree attending the Meeting Place in Toronto, express a distinct preference for working with biomedically trained health professionals with experience and knowledge of Indigenous peoples.

The next and final chapter explores possible directions for the reinvigoration of Indigenous healing discourse and the maintenance of colonial history as a central analytic focus.
End-notes to Chapter Six

1 Vern Harper, oral history interview, May 5th 2009, Toronto.
2 Pugh, "Urban Elder Brings Traditional Healing to the Twenty-First Century," 3. Whilst Vern favours the term 'urban Elder', not all Elders working in cities employ this term. In particular it may be seen as irrelevant for those whose role transcends an urban: reserve/ rural divide.
3 The 1991 Medical Services Branch report Agenda for First Nations and Inuit Mental Health (known as ‘the Agenda document’) was the first federal initiative of national scope to focus on Aboriginal mental health, as discussed in Chapter Three. However the report excluded off-reserve and non-status First Nations, Métis and Inuit outside of Labrador. Medical Services Branch, "Agenda for First Nations and Inuit Mental Health. Report of the Standing Committee." The Royal Commission on Aboriginal Peoples’ final report in 1996 referred approvingly to the Agenda document, noting its focus on ‘healing’ and ‘comprehensive Aboriginal-designed services’, but observed that five years after its publication, ‘the decisive action proposed in the agenda has still not been taken’. However the RCAP reports themselves make minimal use of the language of ‘mental health’, rather describing problems of ‘social disorganization in Aboriginal lives and spiritual emptiness in Aboriginal souls’, and a goal of ‘social and emotional health’ to be addressed by processes of ‘healing’.
4 Vanessa Gamble makes a parallel argument about how the Tuskegee Syphilis Study -- the subject of an apology from President Bill Clinton to African-Americans in 1997 -- has become a ‘powerful metaphor’ for ‘racism in medicine, misconduct in human research, the arrogance of physicians, and government abuse of Black people’, with the effect of obscuring attention to the myriad social and historical factors which have shaped, and continue to shape, relations between African Americans and the American health care system. Vanessa Gamble, "Under the Shadow of Tuskegee: African Americans and Health Care," American Journal of Public Health 87, no. 11 (1997).
7 Urban Aboriginal Task Force, "Final Report."
11 Ontario Native Women's Association, Breaking Free: A Proposal for Change to Aboriginal Family Violence.
12 http://www.ahwsontario.ca/programs/shelter.html accessed August 29th 2010
13 Sylvia Maracle, oral history, July 9th 2010, Toronto.
14 Canadian Research Institute for the Advancement of Women (CRIAW), "Aboriginal Women Healing Themselves, Their Families and Their Communities. The Case of Minwaashin Lodge," in Inspiring Case Studies of Women-Centred Alternatives to Resisting Poverty and Exclusion (Ottawa: CRIAW, 2008).

15 Castille Troy, oral history, February 19th 2009, Ottawa. OH6

16 Linda Ense, oral history, March 25th 2010, Hamilton. OH28, 12m

17 Canadian Research Institute for the Advancement of Women (CRIAW), "Aboriginal Women Healing Themselves, Their Families and Their Communities. The Case of Minwaashin Lodge."

18 Benoit, Carroll, and Chaudhry, "In Search of a Healing Place: Aboriginal Women in Vancouver's Downtown Eastside."

19 Castille began working at Minwaashin as a volunteer in 1995, and eventually left an established career in education and social services to accept a paid position there. Castille Troy, Oral history, February 19th 2009, Ottawa. OH6, 22m.

20 Castille Troy, oral history, February 19th 2009, Ottawa. OH6, 28m

21 Castille Troy, oral history, February 19th 2009, Ottawa. OH6, 32m

22 Minwaashin Lodge's services include a 21-bed emergency shelter for women and children, Oshki Kizis; cultural programming including healing circles, drumming and singing groups, ceremonies, individual counseling with an Elder; extensive programming for youth and children including violence prevention; counseling services for women, youth and children; outreach to homeless women and sex trade workers; family support including home visiting; and Two-Spirit programming.


24 Canadian Research Institute for the Advancement of Women (CRIAW), "Aboriginal Women Healing Themselves, Their Families and Their Communities. The Case of Minwaashin Lodge."

25 Castille Troy, oral history, February 19th 2009, Ottawa. OH6


27 Urban Aboriginal Task Force, "Final Report."

28 Ibid.

29 Native Management Services, "Needs Assessment and Delivery Models to Address Mental Health Needs of the Aboriginal Community of Toronto."

30 See for example Martin, Bipolar Expeditions. Mania and Depression in American Culture.

31 Native Management Services, "Needs Assessment and Delivery Models to Address Mental Health Needs of the Aboriginal Community of Toronto."


35 In 2006 the Senate Committee report on mental health care in Canada referred to ‘an epidemic of mental health problems [...] in Aboriginal communities’ and noted that ‘the overall mental health of Aboriginal peoples continues to be at serious risk. Taking the rates of suicide and of addiction as measures, their mental health is located at the extreme negative end of the continuum’. Also in 2006, a chapter on ‘Aboriginal people’s mental health and well-being’ featured in the report The Human...
Face of Mental Health and Mental Illness in Canada, produced by government health agencies and the Mood Disorder Society of Canada (who did not include a particular focus on Aboriginal peoples in the preceding version in 2002, A Report on Mental Illnesses in Canada). The Mental Health Commission of Canada (MHCC), established in March 2007, subsequently acted on the Senate Committee’s recommended to establish an Aboriginal Advisory Committee. The First Nations, Métis and Inuit Advisory Committee is one of eight such committees with a remit to advise the MHCC and support its engagement ‘with the broader stakeholder community’. Standing Senate Committee on Social Affairs Science and Technology and "'Out of the Shadows at Last'. Highlights and Recommendations of the Final Report on Mental Health, Mental Illness and Addiction," (Ottawa2006), 64. The Standing Senate Committee on Social Affairs Science and Technology, "Out of the Shadows at Last. Transforming Mental Health, Mental Illness and Addiction Services in Canada.," (Ottawa2006), 361; Government of Canada, The Human Face of Mental Health and Mental Illness in Canada, ed. Public Health Agency of Canada, et al. (Ottawa: Minister of Public Works and Government Services Canada, 2006).

http://www.mentalhealthcommission.ca/English/Pages/about_committees.aspx accessed September 26th 2010.

36 For a detailed account of the emergence of community mental health focused on the United States see Mechanic, Mental Health and Social Policy. The Emergence of Managed Care; For Ontario histories see Simmons, Unbalanced: Mental Health Policy in Ontario, 1930-1989; and Wiktorowicz, "Restructuring Mental Health Policy in Ontario: Deconstructing the Evolving Welfare State."


38 For an account of the social dynamics of an interdisciplinary mental health team see Seth D. Messinger, "'That's Not Only His Problem..." Clinical Teamwork in a Psychiatric Emergency Room," Culture, Medicine & Psychiatry 30, no. 3 (2006).


40 Ibid., 12.

41 Ibid., 10.

42 Letters to David Martin, President, Ontario Federation of Indian Friendship Centres from Minister George Smitherman, March 31 2006 and to Sylvia Maracle, Executive Director, Ontario Federation of Indian Friendship Centres from Assistant Deputy Minister Adalsteinn Brown, March 5th 2007. Copies in author’s possession.

43 Sylvia Maracle, oral history interview, July 9th 2010, Toronto. OH9.5.

44 For some discussion of how these issues manifest in relation to mental health programming in particular see Native Management Services, "Needs Assessment and Delivery Models to Address Mental Health Needs of the Aboriginal Community of Toronto."

45 Kenn Richard, Oral history, March 18th 2009, Toronto. OH10, 39m

46 Native Management Services, "Needs Assessment and Delivery Models to Address Mental Health Needs of the Aboriginal Community of Toronto."


Royal Commission on Aboriginal Peoples, "The Path to Healing: Report of the National Round Table on Aboriginal Health and Social Issues ."


Mohawk psychologist Rod McCormick notes that ‘Integration is often not the easiest or best solution [...] as there exists a power differential between Western medicine and traditional healing. [...] A more balanced and appropriate form of partnership may be a complementary one in which both systems collaborate, working side by side’. Rod McCormick, "Aboriginal Approaches to Counselling," in *Healing Traditions. The Mental Health of Aboriginal Peoples in Canada*, ed. Laurence J. Kirmayer and Gail Guthrie Valaskakis (Vancouver & Toronto: UBC Press, 2009).

Native Management Services, "Needs Assessment and Delivery Models to Address Mental Health Needs of the Aboriginal Community of Toronto," 27.

Romanow, "Building on Values. The Future of Health Care in Canada.."

See for example Royal Commission on Aboriginal Peoples, "The Path to Healing: Report of the National Round Table on Aboriginal Health and Social Issues ", 17.

In communication with author, June 13th 2008.

Janet Hill, oral history interview, March 3rd 2010, Hamilton. OH23, from notes.

Marion A. Maar and Marjory Shawande, "Traditional Anishinabe Healing in a Clinical Setting: The Development of an Aboriginal Interdisciplinary Approach to Community-Based Aboriginal Mental Health Care," *Journal of Aboriginal Health* (2010).


Castille Troy, Oral history, February 19 2009, Ottawa, OH6:34m.

Native Management Services, ""Needs Assessment and Delivery Models to Address Mental Health Needs of the Aboriginal Community of Toronto," 28; 25.

Ontario Federation of Indian Friendship Centres, ""Good Mind”. Ontario Federation of Indian Friendship Centres Mental Health Strategy 2006."


Ibid.


Donna Lyons, oral history, June 16th 2009, Ottawa OH17, 15-19m.


Ibid.
357


72 Ibid.: 359.


76 Lisa Pigeau, Oral history, June 16th 2009, Ottawa. OH17, 3-5m.


79 Donna Lyons, oral history, June 16th 2009, Ottawa. OH17, 20m.


81 Reepa Evic-Carleton, Oral History, Ottawa, April 9th 2010. OH29, 69m.

82 A second Inuit treatment centre, Saputjivik Treatment Centre in North West River, Labrador is based on the Mamisarvik model. There is still no residential treatment centre in Nunavut.


84 Reepa and Elder Ruby Arngna’naaq introduced me to the qulliq during my visit to Mamisarvik. The woman in an Inuit house was responsible for maintaining the qulliq. Hunters would carry a smaller version with them on hunting trips. Traditionally seal oil was burned, but it is now too expensive. Two different plants are used for the wick, cotton willow and moss. Reepa recalled how as a child when she woke up at night in fear after having bad dreams, she would feel comforted by the sight of the qulliq. During the day, she so enjoyed playing with it that her mother would hide the tool used to control the flame (by tamping the wick), so that the multiple flames burn evenly.

85 Reepa Evic-Carleton, Oral History, Ottawa, April 9th 2010. OH29, 45-54m.

86 Reepa Evic-Carleton, Oral History, Ottawa, April 9th 2010. OH29,54m.


88 Mamisarvik’s intake assessment form includes: the DSM-IV Post Traumatic Stress Disorder Checklist (civilian version), the Addictions Research Foundation’s Treatment Entry assessment (1997), the Drug
Abuse Screening Test (DAST) and Michigan Alcohol Screening Test (MAST), the Behaviour and Symptom Identification Scale (BASIS-32), the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) 8A and 8D (personal drug), the Centre for Addiction and Mental Health’s Drug Taking Confidence Questionnaires (DTCQ-8) for drugs and alcohol, and the Multidimensional Scale of Perceived Social Support (PSSS), 2001 version. Estimate of completion time based on author’s communication with addictions therapist Janine Robinson, Problem Gambling Programme, Centre for Addictions and Mental Health, Toronto.

90 Director: Tassinar, Broken Promises. The High Arctic Relocation.
91 Reepa Evic-Carleton, Oral History, Ottawa, April 9th 2010. OH29, 9m
92 Reepa Evic-Carleton, Oral History, Ottawa, April 9th 2010. OH29, 13-15m
93 Reepa Evic-Carleton, Oral History, Ottawa, April 9th 2010. OH29, 23m
94 Ontario Federation of Indian Friendship Centres, Statement on the "Pan-Aboriginal" Approach.
96 Ibid.
97 Gone, "Psychotherapy and Traditional Healing for American Indians: Exploring the Prospects for Therapeutic Integration," 175.
100 Marlene Brant Castellano, oral history, March 22 2010, Tyendinaga. OH 26, 68m
101 As the case of the Common Experience Payment for Residential Schools shows, policy attention based on an irrelevant paradigm may ironically exacerbate rather than alleviate suffering.
102 Elder Irene Lindsay, Oral history, June 15th 2009, Ottawa. OH14, 50m
103 Canadian Research Institute for the Advancement of Women (CRIAW), "Aboriginal Women Healing Themselves, Their Families and Their Communities. The Case of Minwaashin Lodge," 8.
105 Elder Irene Lindsay, Oral history, June 15th 2009, Ottawa. OH14, 12m.
107 Elder Irene Lindsay, Oral history, June 15th 2009, Ottawa. OH14, 4m.
108 Elder Irene Lindsay, Oral history, June 15th 2009, Ottawa. OH14, 7m
110 Elder Irene Lindsay, Oral history, June 15th 2009, Ottawa. OH14, 28m
111 Elder Irene Lindsay, Oral history, June 15th 2009, Ottawa. OH14, 15m
112 Ibid.
113 Reepa Evic-Carleton, Oral History, Ottawa, April 9th 2010. OH29
114 The policy of ‘centralization’ of the Mi’kmaq in Nova Scotia between 1942-49 led to their forced relocation from 20 small reserves to two large reserves at Eskasoni and Shubenacadie. The policy of ‘centralization’ of the Mi’kmaq in Nova Scotia between 1942-49 led to their forced relocation from 20 small reserves to two large reserves at Eskasoni and Shubenacadie. Royal Commission on Aboriginal Peoples, Report of the Royal Commission on Aboriginal Peoples Volume 1: Looking Forward, Looking Back. An account of the 1963 relocation of the Anishnabek community of Grassy Narrows in
northwestern Ontario, and the devastating effects on the community, is provided by Shkilnyk, *A Poison Stronger Than Love: The Destruction of an Ojibwa Community*.

115 Hallett, Chandler and Lalonde demonstrated that language retention is the most significant among a range of factors determining suicide rates in BC First Nations: bands in which more than 50% of members reported working knowledge of an Aboriginal language experienced low to non-existent rates of youth suicides, compared with suicide rates six times higher on average amongst bands in which less than half the population speaks an Aboriginal language. Darcy Hallett, Michael J. Chandler, and Christopher E. Lalonde, "Aboriginal Language Knowledge and Youth Suicide," *Cognitive Development* 22 (2007).


120 Leslie Saunders, Oral history, Oral history, March 18th 2010, Toronto. OH24.2, 4 m.

121 58.5% of clients surveyed indicated that this was a factor in making the decision to use the AHWS funded program/service. Clients surveyed were users of multiple AHWS-funded programmes including Aboriginal Health Access Centres. Aboriginal Healing and Wellness Strategy, "Aboriginal Healing and Wellness Strategy Phase 3 Longitudinal Study. Final Report.,” 47.

122 See for example papers in the collection Waldram, ed. *Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice*. Skye, "An Orchid in the Swamp: Traditional Medicine, Healing and Identity at an Urban Aboriginal Community Health Center”.


124 Corene Cheeseman, Oral history, March 24 2010, Hamilton. OH27, 42m

125 Ontario Federation of Indian Friendship Centres, *Statement on the "Pan-Aboriginal" Approach*

126 [ibid.]


129 Wilson and Peters, ""You Can Make a Place for It": Remapping Urban First Nations Spaces of Identity."


131 Wilson and Peters, ""You Can Make a Place for It": Remapping Urban First Nations Spaces of Identity."

132 Urban Aboriginal Task Force, "Final Report."
Janet Hill, Oral history, Hamilton, March 3 2010, OH23.  *I da wad a di* is coordinated by Jan Longboat, a Mohawk, Turtle Clan and a traditional herbalist, healer and Elder. ‘The Lost Generation’ support group for residential school survivors at Six Nations was founded in 1997 by Geronimo Henry.  


Gary Chaimowitz, Oral history, February 17th 2010, Hamilton.  OH 21, 17m,  

Leslie Saunders, Oral history, March 18th 2010, Toronto.  OH24, 23m.  

This was a six-month pilot project, funded through the federal Urban Aboriginal Strategy, and ended March 31st 2010.  

Leslie Saunders, Oral history, March 18th 2010, Toronto.  OH24, 55m.  


Ibid., 198.  


Elder Lillian McGregor, oral history, July 17th 2009, Toronto.  OH13.3.
Chapter 7 Conclusion: Colonial Histories, Healing and Self-determination in Urban Indigenous Communities

Indigenous peoples in Ontario cities and elsewhere have developed an analysis of contemporary Indigenous suffering as rooted in Canadian colonial history which has been central to a paradigm of healing since at least the late 1960s. This understanding has been valuable both for reorienting a focus on individual behaviour towards structural causes of distress, and contributing to a foundation for urban Indigenous community identity based on a collective consciousness of shared pasts and common social suffering in the present. As my thesis has shown, this analytic perspective can also be productively applied to broader issues.

I began the Introduction with two assertions: first, that the history of Indigenous healing as a socio-political movement in Canada is closely linked with the broader struggle for self-determination; and second, that in contemporary Aboriginal health literature, colonialism is widely invoked but narrowly employed, and typically under-utilised as an analytic concept. I have demonstrated an approach towards a more nuanced analysis of the interrelationships between histories of colonialism, social suffering and healing, by locating Canadian settler-colonialism in time and space and attending to how policies and discourses manifest at local levels and in institutional settings. The thesis has offered geographically-located social histories and an ethno-historical account of urban healing movements as a response to both of these problematics, illuminating both the micro-workings of colonial violence and Indigenous resistance to it. I have argued that in urban settings, the issue of self-determination is particularly salient in contestations over knowledge, authority and accountability in providing services to Aboriginal communities. In the Kenora example, self-determination and healing overlapped and intersected at multiple points. The Ojibway Warriors Society's 1974 occupation of Anicinabe Park provided a social forum and political impetus towards the development of a significant Native healing movement in the city. Ojibwe workers at the Addiction Research Foundation's Kenora Waystation linked recovery from alcohol abuse to the struggle for Native rights and the resurrection of Anishnaabe knowledge. Madeline Skead asserted the
value of Native healers in promoting and addressing Indigenous mental health in the face of skepticism from the Ontario Ministry of Health.

**History and healing: uses, abuses and political implications**

In the Introduction I indicated my interest in locating urban Indigenous healing within a broader socio-political context. The thesis has explored both the migration of history and healing into the realm of Canadian public policy, and how urban Indigenous healing discourses and framings of history have themselves been influenced by broader developments in Indigenous-state relations, health policy and biomedical discourse, and emerging international socio-political discourses including reparations, reconciliation and trauma.

Dominant policy discourse locates Canadian injustices against Indigenous peoples in a past which is represented as discontinuous with the present. My analysis of the Canadian state's invocations of history and forays into policy-making for Indigenous healing has shown how the Canadian state has co-opted Indigenous framings toward its own ends. I have discussed the framing of the apology for residential schools as an endpoint rather than a beginning; the conversion of collective suffering and injustice into individual, financially compensatable victimhood; and the reassignment of the work of the Aboriginal Healing Foundation to Health Canada’s mental health professionals. These developments all point to the deliberate foreclosure of what might have been a prolonged process, involving the reconceptualisation of Canadian colonial histories and continuities, Indigenous suffering, and the need for societal-level healing based on profound social and political change.

Indigenous healing discourse also has its own history. Trauma and its variants became central to Indigenous healing discourse from the mid-1990s, through the combined effects of Aboriginal psychologists and social workers, and legal, media and policy attention to the psycho-social effects of Indian residential schools. The significance of Indigenous mental health professionals as social and political actors became apparent as the work of Eduardo Duran, Maria Yellow Horse Brave Heart, and others was widely taken up in arguments for
recognition of Indigenous people’s distinct experiences of trauma. These contributions have been central in drawing attention to how collective experiences of violence and injustice over time shapes social suffering in the present, and in highlighting ethno-national solidarity as a component of care for oppressed peoples. At the same time, I have suggested that universalizing discourses on Indigenous trauma may be problematic in obscuring local social histories, reinscribing victimhood whilst denying alternative subjectivities, and failing to attend to the particularities of distinct Indigenous healing traditions.

Whilst dominant discourse on Indigenous trauma threatens to submerge varied experiences of colonialism, the development of public policy on Indigenous history and healing has provided a forum for the assertion of some distinct ethno-national identities, hinting at the range of social and political interests contained within the category ‘Indigenous’. The Assembly of First Nations’ (AFN) leadership in developing the 1998 policy Gathering Strength and subsequent residential schools policy was insufficient to ensure that all Indigenous peoples’ needs were addressed in subsequent initiatives, as evidenced by the exclusion of the Métis and the Labrador Inuit from the residential schools settlement. But the very fact of Indigenous histories becoming a focal point in Canadian policy-making, provided an important platform from which Inuit and Métis leaders were able to assert the distinct histories of their peoples.

Thus whilst residential schools have dominated public discourse on colonial history and Indigenous healing, and the AFN has dominated the development of residential schools policy, Inuit in particular have responded to the opportunity to develop their own formulations of history-suffering-healing. They have articulated their distinct colonial histories in various national fora, ranging from the Royal Commission on Aboriginal People’s special hearings on the high Arctic relocations, to participation in the residential school settlement and negotiation of the inclusion of Inuit schools, to Inuit Tapirisat Kanatami President Mary Simon’s appointment as Commissioner on the Mental Health Commission of Canada, to the Qikiqtani Truth Commission’s recently published report. Inuit in Ottawa have used funding from the Aboriginal Healing Foundation (mandated to
address recovery from residential schools abuses) to develop the first Inuit residential treatment programme in Canada. Here history plays a central therapeutic role: the collective piecing-together of ethno-nationally and regionally specific histories, in order to make sense of, and recover from, shared suffering in the present. At Mamisarvik and in broader fora, Inuit have employed discourses of history and healing to foreground Inuit suffering under Canadian colonialism, including but going well beyond the effects of the residential schools. Particular emphasis is being given to the coerced relocation from seasonal hunting and wild harvesting grounds, the slaughter of qimmiit (sled-dogs), and the long-term (sometimes permanent) separation of families for forced medical treatment in the south.²

Whilst Inuit and Métis assertions of distinct histories and approaches to healing have emerged in urban Ontario programmes as well as in national policy discussion over the past decade, this approach does not appear to be a priority for other Indigenous ethno-national collectivities in urban Ontario. Some Indigenous scholars have expressed concerns regarding ‘pan–Aboriginal’ approaches to healing, but many urban Aboriginal people are quick to point to commonalities across Indigenous cultures, and long histories of borrowing, sharing and adapting healing knowledge and practices. Further, whilst historical references continue to be integral to Indigenous healing paradigms, some urban groups, such as Minwaashin Lodge in Ottawa, are more focused on building urban Indigenous community in the present than on reconstructing shared histories. My analysis suggests that to consider pan-Aboriginal and distinct ethno-national approaches as binary opposites may be misguided. Rather, future research on Indigenous healing and ethno-national diversity might consider how urban institutions support or constrain the practice of a range of healing traditions reflective of urban Indigenous heterogeneity (including growing numbers of Indigenous peoples from beyond North America) in settings such as southern Ontario, and connections between healing knowledge and the maintenance and revitalization of Indigenous languages in Canadian cities.

The four decades covered by this thesis have seen a marked shift in how urban Aboriginal agencies frame the challenges facing Aboriginal people in urban centres. Whilst individual
struggles with alcohol were a central concern of interventions from the 1960s onwards, earlier analyses also focused on external structural factors shaped by the Canadian state and settler society: racism, poor housing, unemployment, lack of urban cultural resources and appropriate health care. ‘Mental health’ barely featured in documentation produced by southern Ontario Aboriginal agencies engaged in healing and social programmes from the 1970s to the early 1990s. In contrast, contemporary analyses are increasingly concerned with problems internal to individuals. Client surveys conducted by urban agencies in Ontario within the past decade have found mental health to be a major concern. Recent analyses continue to acknowledge structural factors including poverty, homelessness, incarceration and unemployment as determinants of Aboriginal mental health, but these are generally treated as background. A major conceptual shift is indicated in that the point of intervention becomes quite different when the primary problem is located within the individual Indigenous person, rather than within social structures and processes. Whilst earlier models located individual healing within community-building processes and trans-local Indigenous solidarity, the emerging paradigm seems to focus more narrowly on individual treatment, often invoking biomedical rather than Indigenous knowledge.

I have linked the ascent of mental health to urban Aboriginal service providers’ struggles to obtain adequate recognition and resources for healing programmes, and raised questions about the implications of this strategy. Of particular concern are the biomedical dominance of the mental health field and the proximity of biomedical institutions to urban Indigenous agencies and communities, and how these factors may combine to undermine Indigenous knowledge and self-determination in urban settings. The potential for biomedical dominance to exacerbate the marginalization of Indigenous knowledge is increased in urban settings, due to the relative lack of Elders, traditional people and those fluent in Indigenous languages compared with most reserve and land-based communities. ‘Mental health needs’, ‘mental disorders’ and ‘mental illness’ describe the deficiencies of an individual devoid of social and historical context, a framing at odds with the analyses informing Indigenous healing as a social and political movement. The field of mental health is currently dominated by psychiatric DSM diagnoses, individualistic neurological and genetic models, the ahistorical cultural competence paradigm as a framework for
conceptualising and responding to social difference, and pharmacological treatment. These approaches are all apparently inconsistent with the political-historical analysis, holistic and relational approach to treatment, cultural revitalization, and respect for individual autonomy which characterize most Indigenous healing practice. Surprisingly, this apparent conflict is rarely articulated in emerging discourse on Aboriginal mental health produced by urban Indigenous agencies, which often reflects an assumption that the imposition of biomedical knowledge is a politically-neutral process.

**Colonial continuities**

I noted in the Introduction that contemporary Aboriginal health literature tends to neglect how biomedical institutions and professional knowledge perpetuate colonial discourses and paternalistic relationships. Analysing how colonialism manifests at local and regional levels calls our attention to how colonial power has worked in and through institutions, health professions and reformist social movements. Canadian colonialism is not just about federal government policy and Indian agents. It is also about nurses and hospitals, social workers and child rescuers, provincial resource management strategies and public health policies. It is about overlapping and sometimes contradictory discourses, some of which render Indigenous peoples invisible and irrelevant, others which make them the objects of modernizing and development projects; still others portray Aboriginal people as dangerous -- to settlers, to themselves or to one another -- thereby legitimating coercive and violent interventions, such as the compulsory removal and confinement of tuberculosis patients, alcohol-consumers, or children.

Once we cast our analytic gaze more widely, as socio-historical and cultural analyses of settler colonialisms exhort us to do, we can begin to take in the extent to which colonialism is embedded in the Canadian social fabric. This recognition fosters analysis of how colonial discourses and practices continue in contemporary professional knowledge and the workings of dominant institutions, serving to perpetuate the dominance of biomedical models and marginalize Indigenous knowledge and approaches to healing. Such
understandings are a central concern for those committed to Indigenous self-
determination in urban settings.

Analyzing colonial continuities in the contemporary health care system requires attending
to how colonial discourses and practices articulate with other temporally-located political-
cultural formations. This thesis has argued that liberal discourses on multiculturalism and
diversity have contributed to the marginalization of Indigenous interests in the field of
mental health in urban Ontario over the past two decades. In provincial policy discourse
and the health care setting studied, dominant paradigms for understanding social
difference focus on racialised settler communities and visible and audible aspects of
difference, without acknowledging the distinct entitlements and perspectives of Indigenous
peoples. The relative invisibility of Indigenous peoples in large, ethnically-diverse
southern Ontario cities is compounded by the continuation of assimilationist arguments
from 1960s policy discourse which conflate recognition with discrimination. Denying
Indigenous people’s right to self-determination, such liberal perspectives imply that
ignoring Indigeneity as a form of difference will lead to equality of outcomes. Because
history is excluded from cultural competence and diversity frameworks, an important
opportunity to examine the interrelationship between colonialism and mental health --
both within Canada and internationally -- has been missed. I have suggested that future
analyses might attempt to stake out the common ground between Indigenous and
racialised settler communities’ analyses of colonial pasts and contemporary suffering,
facilitating the recognition of possibilities for intellectual and political alliances in the
present.³

Identifying dominant institutions and professional knowledge as important sites of colonial
continuities troubles assumptions about the ‘integration’ of Indigenous healing and
western biomedicine, or about the training of more Aboriginal health professionals as a
panacea to the problem of inappropriate health care for Indigenous peoples. In a recent
discussion of Indigenous public health research, Lil Tonmyr and Cindy Blackstock
foreground ‘ontological differences’ as the central concern in combining Indigenous and
public health approaches to researching Aboriginal health.⁴ In my view, their critique is
weakened by an inadequately historicized perspective. The argument which I have made
in this thesis is that we need to recognize public health, psychiatry and western biomedicine in general as historically constituted fields whose epistemologies are derived from and intimately connected with colonial and imperial contexts, and continue to be intertwined with dominant state, institutional and professional interests.

An awareness of these relationships does not, of course, prevent those committed to Indigenous healing projects from engaging strategically with dominant institutions and health professions. Many have done so successfully in urban settings, as evidenced by the multiple examples discussed in this thesis: I do not intend to foreclose the possibilities of future collaborations. There are a number of Indigenous scholars and practitioners, including psychologists such as the late Joseph Couture, Joseph Gone, Rod McCormick, Ed Connors, Brenda Restoule, and Roland Chrisjohn, whose scholarly and clinical work challenges dominant professional framings of Indigenous social suffering, as this thesis has discussed. Further, Indigenous health professionals are increasingly setting the research agenda for Aboriginal health research in Canada. But a contribution of this thesis is to call attention to how biomedical epistemologies, institutions and professions continue to dominate policymaking and programming on Aboriginal health and healing, whilst inadequate attention is devoted to analyzing the reproduction of colonial power relations in contemporary health policy, biomedical institutions, professional discourses and programme delivery. The pressing need for scholars to critically examine the roles of dominant institutions and professions is particularly clear at the interface between Indigenous healing and Aboriginal mental health in urban settings: a programme such as Mamisarvik, centred on Inuit history and spirituality, is obligated to validate its work by recourse to a battery of psychiatric assessments; frontline workers in Toronto Aboriginal agencies are invoking DSM-IV categories in advocating for their clients’ healthcare needs.

The emerging paradigm in which ‘mental health’ and ‘healing’ are increasingly interchangeable suffers from a lack of clarity regarding how colonial power relations continue to shape Indigenous experiences in the present. Colonial continuities in biomedical knowledge and practice and global pharmaceutical interests, and the implications of eroding investment in primary health care, public housing and social services, are all crucial context for urban Indigenous peoples to consider in assessing the
relevance of mental health frameworks to their needs. A broader lens might identify more salient points of intervention with greater potential to alleviate suffering, whilst simultaneously maintaining and advancing Indigenous epistemologies and autonomy in urban settings.

As this thesis has shown, the huge inequities in resource allocations for healing and social services in urban centres perpetuate biomedical dominance, whilst Indigenous knowledge continues to be marginalized. Large biomedical institutions continue to receive the lion’s share of financial resources because they are able to provide the kind of evidence and exert the type of advocacy required to sustain public and private funding. Urban Indigenous institutions are constrained by a lack of long-term funding and a continuing shortage of Aboriginal professionals, and often lack the resources to demonstrate the impact of their programmes in the manner required by funders. Indeed, many programmes are so overworked and under-resourced that they cannot always track their clients. But as we saw in the case of the Aboriginal Healing Foundation, the federal government refused to sustain a programme based on Indigenous healing knowledge, even in the face of an exemplary evaluation commissioned by one of its own departments. This is the continuation of Canadian colonialism.

**Decolonizing scholarship and urban Indigenous healing: towards a relationship**

The dearth of critiques of colonial continuities in Aboriginal health can be related to the under-representation of Indigenous scholars in the Canadian academy. I have become acutely aware of the seriousness of this issue in the course of conducting my research and of interacting with Indigenous and non-Indigenous graduate students over the past six years. There is an emerging generation of junior Indigenous scholars interested in Aboriginal health and healing, many of whom want to work with Indigenous knowledge in their research, but are undermined in their efforts by inadequate and inappropriate support and supervision within their universities. There are also settler-descendants like me who are simultaneously eager to learn from the distinct perspectives of experienced Indigenous scholars, and cognizant that they are a precious resource whose priorities should arguably be directed towards the mentoring of Indigenous students.
The current emphasis on training more Aboriginal health professionals is an inadequate response given the complex and tenacious inter-relationships among colonialism, western biomedicine and the health and helping professions. What is required is a dramatic increase in the number of Indigenous scholars in Canada across *all* disciplines, particularly the critical social sciences and humanities (including Indigenous studies), to lead the development of rigorous analyses of colonial continuities in contemporary health care, and research into the application of Indigenous knowledge to address social suffering. Further, universities and other research institutions need to go much farther in forging accountable and mutually respectful relationships with Indigenous peoples, including urban Indigenous communities.

These developments would provide a foundation for reinvigorating a critical and transformative Indigenous paradigm for understanding suffering and healing, and greater collaboration between scholars and urban Indigenous institutions. By linking contemporary Indigenous experiences and expressions of suffering to both present-day and historical structural factors, such a paradigm could extend analyses of historical colonialism into the present, to show how elements of colonial thinking and practices continue to cause harm to Indigenous nations, communities, families and individuals. As I have shown, this also involves attending to how (neo-)colonial relations articulate with other dominant social and political forces, including liberal multiculturalism, neoliberal health care restructuring, the loss of affordable housing in urban centres, the ‘therapeutic state’, biological psychiatry and the global psychopharmacology industry. Such analyses can focus on *processes of victimization*, rather than establishing victim status for Indigenous people. This research agenda could usefully inform both advocacy on behalf of urban Indigenous healing programmes and the development of greater autonomy for urban Indigenous institutions. Further, if evidence of substantial progress towards decolonizing and indigenizing the academy materializes, there is great potential for academic resources to do more to support urban Indigenous projects, particularly those linking history, healing and self-determination.

This thesis has suggested that the relationship between history and healing is far from straightforward. Invocations of Indigenous colonial histories are powerfully therapeutic in
particular social contexts. At the same time, such invocations are always deeply political and may be mobilized in pursuit of very different agendas, including the active obfuscation of Canadian culpability in Indigenous suffering and colonial continuities. The most urgent outstanding question is how urban Indigenous peoples can harness the current political prominence of mental health in the pursuit of much-needed healing resources, without compromising existing commitments to maintain a political-historical analysis, honour Indigenous knowledge and strengthen self-determination. The perspective offered by this thesis is that the recognition of colonial continuities in dominant discourses, institutions, professions and policies, and how these articulate with other forms of governance and broader cultural and political shifts, is crucial to ensuring that urban Indigenous healing continues to be a path towards decolonization.
End-notes to Chapter Seven

2 Ibid.
3 cf. Lawrence and Dua, "Decolonizing Anti-Racism."
5 More has been published on this issue in the United States. See for example Devon Abbott Mihesuah and Angela Cavender Wilson, *Indigenizing the Academy. Transforming Scholarship and Empowering Communities* (Lincoln & London: University of Nebraska Press, 2004).
6 I have explored these issues in a separate project with Katherine Minich. Katherine Minich and Krista Maxwell, "Graduate Researchers in Aboriginal Health and Indigenous Methodologies," in *American Public Health Association Annual Meeting* (Philadelphia2009).
7 Simon, "Towards a Hopeful Practice of Worrying: The Problematics of Listening and the Educative Responsibilities of Canada's Truth and Reconciliation Commission."
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## Appendix One: Participants in Oral History Interviews

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<thead>
<tr>
<th>Participant</th>
<th>Institutional affiliation (if relevant)</th>
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<tr>
<td>Al Garman</td>
<td>First Nations &amp; Inuit Health Branch</td>
<td>November 13(^{th}) 2008 Ottawa</td>
</tr>
<tr>
<td>Beverly Jacobs</td>
<td>Native Women’s Association of Canada</td>
<td>June 17(^{th}) 2009 Ottawa</td>
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<tr>
<td>Brenda M. Restoule</td>
<td>Native Mental Health Association of Canada</td>
<td>March 6(^{th}) 2009 Toronto</td>
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<tr>
<td>Castille Troy</td>
<td>Minwaashin Lodge Aboriginal Women’s Support Centre</td>
<td>February 19(^{th}) 2009 Ottawa</td>
</tr>
<tr>
<td>Chantal Whelan</td>
<td>Assertive Community Treatment (ACT) team, consultant to Wabano Health Centre</td>
<td>November 10(^{th}) 2008 Ottawa</td>
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<tr>
<td>Corene Cheeseman</td>
<td>Hamilton Regional Indian Centre</td>
<td>March 24(^{th}) 2010 Hamilton</td>
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<tr>
<td>Donna Lyons &amp; Lisa Pigeau</td>
<td>Métis Nation of Ontario</td>
<td>June 16(^{th}) 2009 Ottawa</td>
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<tr>
<td>Ed Connors</td>
<td>Psychologist/ independent consultant</td>
<td>June 1(^{st}) 2009 Orillia</td>
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<tr>
<td>Frank McNulty</td>
<td>First Nations &amp; Inuit Health Branch Ontario Region</td>
<td>November 26(^{th}) 2008 Toronto</td>
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<tr>
<td>Gary Chaimowitz</td>
<td>Department of Psychiatry, McMaster University/ Forensic Program, St Joseph’s Healthcare</td>
<td>February 17(^{th}) 2010 Hamilton</td>
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<tr>
<td>Elder Irene Lindsay</td>
<td>Minwaashin Lodge Aboriginal Women’s Support Centre</td>
<td>June 15(^{th}) 2010 Ottawa</td>
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<tr>
<td>Janet Hill</td>
<td>De Dwa Da Dehs Nyes Aboriginal Health Centre</td>
<td>March 3(^{rd}) 2010 Hamilton</td>
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<td>Jennifer Brasch</td>
<td>Psychiatric Emergency Service, St Joseph’s Healthcare</td>
<td>February 24(^{th}) 2010 Hamilton</td>
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<td>Joe Hester</td>
<td>Anishnawbe Health Toronto</td>
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<tr>
<td>Elder Joseph Morrison</td>
<td>Ne’Chee Friendship Centre, Kenora</td>
<td>November 28(^{th}) 2009</td>
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<td>Kari Nisbet</td>
<td>First Nations &amp; Inuit Health Branch</td>
<td>June 16(^{th}) 2009 Ottawa</td>
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<td>Kenn Richard</td>
<td>Native Child and Family Services</td>
<td>March 18(^{th}) 2009 Toronto</td>
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<td>Leslie Saunders</td>
<td>Meeting Place Drop-In (St Christopher’s House)</td>
<td>March 18(^{th}) 2010 Toronto</td>
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<td>Elder Lillian McGregor</td>
<td>Retired from First Nations House, University of Toronto</td>
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<td>Linda Ense</td>
<td>Hamilton Native Women’s Centre</td>
<td>March 25th 2010</td>
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<td>Looee Okalik</td>
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<td>Marge Lanigan</td>
<td>Odawa Friendship Centre</td>
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<td>Peter Boyles</td>
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