Exhibit P-68

MAKING HISTORY HEAL:

SETTLER-COLONIALISM AND URBAN INDIGENOUS HEALING IN ONTARIO, 1970s-2010

by

Krista Maxwell

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Dalla Lana School of Public Health
University of Toronto

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'.[1] 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.[2] 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.[3]

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.[4] 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'".[5] 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.[6] As McElhinny points out, such interventions "required scientific child-raising practices that increasingly drew on the opinions of male experts rather than mothers".[7]

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.[8] 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'.[9] 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*.[10]

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.[11] 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'.[12] 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'.[13] In northern Ontario the only psychiatric hospital, Lakehead in Thunder Bay, was far from accessible to most northern Aboriginal communities.[14] 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.[15]

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.[16] 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.[17] 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.[18] 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.[19]

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*.[24]

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.[25] 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*.[26]

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".[27]

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.[28] 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*.[29]

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.* [30]

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.*[36]

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'.[37] 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.[38] 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*

> *not specific to Native people. There are organic mental health problems, that do require things. There are medical problems that do require white medicine.* [39]

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.'[40] 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.*[41]

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'.[42] 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.[45] 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.[46] 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.[47,48] 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.*[49] *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?* [50]

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. [51]

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

Native People: The Extension of Colonialism.'[52] 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.[53] 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".[54] 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.[55] 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.[56]

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'.[57] 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.*[58]

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.[59] 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].[60] 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.[61] Mulroney's government had a strong rhetorical focus on 'child poverty':