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Deviant Constructions: How Governments Preserve Colonial Narratives of Addictions and Poor Mental Health to Intervene into the Lives of Indigenous Children and Families in Canada

Sarah de Leeuw · Margo Greenwood · Emilie Cameron

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Abstract Colonial projects in Canada have a long history of violently intervening into the personal lives and social structures of Indigenous peoples. These interventions are associated with elevated rates of addictions and mental health issues among Indigenous peoples. In this paper we employ an indigenized social determinants approach to mental health and addictions that accounts for the multiple, intersecting effects of colonial discourse upon the health of Indigenous peoples, and particularly the health effects of colonial interventions into the lives of First Nations Indigenous children in Canada. We focus on both historic and contemporary discourses about Indigenous peoples as deviant, discourses that include particular ideas and assumptions held by government officials about Indigenous peoples, the series of policies, practices, and institutional structures developed to 'address' Indigenous deviance over time (including contemporary child protections systems), and their direct impact upon healthy child development and overall Indigenous health. From a discursive perspective, addictions and mental health issues among Indigenous peoples can be accounted for in relation to the ideas, policies, and practices that identify and aim to address these issues, something that the social determinants literature has yet to incorporate into its model.

Keywords Indigenous peoples · Discourse · Colonialism · Child intervention and protection · Social determinants of health

S. de Leeuw (✉)
Northern Medical Program, University of Northern British Columbia, Prince George, BC, Canada
e-mail: deleeuws@unbc.ca

M. Greenwood
National Collaborating Centre for Aboriginal Health, University of Northern British Columbia, Prince George, BC, Canada

E. Cameron
Department of Geography, Queen's University, Kingston, ON K7L 3N6, Canada

In 2002, 19-month old Sherry Charlie, a member of the Nuu-chah-nulth Port Alberni First Nation, was beaten to death by her uncle, in whose care she was placed by British Columbia's Ministry of Children and Family Development (MCFD). Sherry's uncle had a record of violence and his own history with MCFD, perhaps a reflection of mental health and addiction challenges, some of which may have stemmed from a history of his own family breakdown (see Government of British Columbia 2005). This paper is motivated by a belief that Sherry's death deserves attention. It deserves, we argue, to be understood in a complex, nuanced, and big picture way: not as an occurrence that 'just happened' or as a tragedy contained within a specific space or time. Sherry's tragic death, and the ongoing impacts it most definitely had and will always have on her family, her community, and the broader social structures within which all co-exist, must be understood as historically informed, as socially produced, and as linked to broad conditions of health and wellness, including mental health and addictions realities, in Indigenous communities, particularly First Nations, in Canada. Indeed, as Indigenous peoples around the world have always argued, the treatment and rearing of children, and the way all aspects of childhood are understood and constructed, impact generations to come.

This paper unfolds within three broad sections. We begin with an overview of the health disparities lived by Indigenous peoples in Canada. These health disparities and inequities, we argue, must be understood as socially determined, and we review the ways in which Indigenous health issues have been addressed by the burgeoning literature on the social determinants of health. What the social determinants literature tends not to account for, however, is the ways that colonial institutions, ideas, and practices combine to undermine Indigenous peoples' access to and control over a range of social determinants such as culture, physical environment, and healthy child development. The intersection of colonial institutions, ideas, laws, and policies and their impact on Indigenous peoples' addictions and mental health concerns, we argue, can be conceptualized through the concept of discourse. Discourse, we argue, is an effective lens for understanding how diverse ideas, practices, and beliefs shape the everyday materialities of Indigenous peoples' lives, and also for uncovering continuities between the colonial "past" and present (neo)colonial relations. Accordingly, in the second part of the paper we explore the historical development of a particular colonial discourse, that of Indigenous deviance, and its relation to Indigenous addictions and mental health issues. We argue that the embodied realities of Indigenous peoples were and are produced and perpetuated through texts, legislations, government policies and acts of state that (re)produce, rely on, and perpetuate understandings of deviance, particularly mental health and addiction deviance, in Indigenous peoples. These discourses simultaneously produce non-Indigenous peoples as legitimate and necessary agents of care, protection, and improvement. Third, we discuss contemporary child protection legislations in Canada. We argue these legislations perpetuate their historic antecedents and continue to rely on a "for their own good" logic that legitimates the state's juridical and punitive right to violently intervene into the lives of Indigenous and First Nations children, the latter being a particular focus of this paper. Throughout the paper, then, we are guided by the words of the commissioner who was tasked with investigating Sherry Charlie's death:

> Aboriginal children are being taken into care in British Columbia at a steadily rising rate. An Aboriginal child today is 9.5 times more likely to be in care than a non-Aboriginal child, and half the children in care in the province today are Aboriginal…. The challenge facing us all is to reduce the number of Aboriginal children who are at risk of harm by finding ways to make sure their families and communities are in a position to keep their children safe and well. (Hughes 2006, p. 50–52)

Not so Good: Looking at Indigenous Peoples' Health and the Status of Families and Communities as Socially and Discursively Determined

Indigenous peoples across Canada live what some call 'third world conditions of health' and what others refer to as the "embodiment of inequality" (Adelson 2005). Indeed, although Canada is ranked among the best places to live in the world, if the United Nations Human Development Index was applied to Indigenous peoples living on-reserve, Canada would rank between 68th and 80th in the world (Bennett et al. 2005; Silversides 2007; Webster 2006). The health profiles of Indigenous peoples around the globe, including and notably in developed nations like Aotearoa/New Zealand, Australia, and the United States, mirror those in Canada and thus, in the same way research from those countries has some bearing on Canada, discussions about the Canadian context may have relevance for those nations (Wallace and Roxbee 2003). Aboriginal peoples in Canada have higher rates of disease and die younger and at higher rates than their non-Aboriginal counterparts (Allard et al. 2004). Their life expectancy, although increasing, still falls "well below" that of non-Indigenous peoples (Adelson 2005). The Potential Years of Life Lost (PYLL) in areas with large Indigenous populations was 84, as opposed to 56 in regions with lower levels of Indigenous peoples. Injuries, including suicide and accidents involving a motor vehicle, account for a significant number of PYLL in regions with high Indigenous populations (32 per 1,000 persons at risk as opposed to 12 in areas with few Indigenous peoples) (see also Statistics Canada 2008).

Indigenous peoples have higher rates of infectious disease, but chronic diseases such as Type II Diabetes and various cancers are also increasing within Indigenous communities. Rates of tuberculosis were 8 to 10 times higher in First Nations communities in comparison to non-Indigenous communities and other infectious diseases such as hepatitis, chlamydia, and HIV/AIDS are all either more prevalent or increasing at higher rates in First Nations communities as compared with non-Indigenous populations (Adelson 2005). In 2006, nearly one-fourth of all Indigenous people in Canada lived in homes in need of major repairs and, when compared with their non-Indigenous counterparts, Indigenous peoples were almost four times more likely to live in a crowded dwelling (Statistics Canada 2008). Finally, results of the 2002/2003 First Nations Regional Longitudinal Health Survey (RHS), a unique survey because First Nations' communities implemented the research and the data remains the property of the National Aboriginal Health Organization (NAHO), corroborates non-Indigenous driven demographic profiles about the poor state of Indigenous people's health. According to the RHS, adult First Nations in communities (on reserve) have less education, higher unemployment rates and lower incomes that First Nations living out of community (off reserve). Both groups experience lower earnings than non-First Nations Canadians (NAHO 2002/2003). Evidences from a wide variety of sources leave little doubt that Indigenous people do not have access to the same levels of healthy living that their non-Indigenous counterparts experience. Given the linkages between poor mental health and community (particularly Indigenous people's) experience of health disparities and experience of health inequities, it is perhaps not surprising that Indigenous peoples in both Canada and other nations experience disproportionately high rates of mental health related illnesses (Kirmayer et al. 2000, 2003; Ypinazar et al. 2007).

In addition to living with increased rates of health inequities, Indigenous peoples in Canada face specific and significant mental illnesses in greater abundance than their non-Indigenous counterparts (Kirmayer et al. 2000). High rates of suicide (particularly in youth), alcoholism, violence, and feelings of demoralization appear to be the most commonly experienced mental illnesses in Indigenous communities (NAHO 2002/2003;

Kirmayer et al. 2000; Loppie and Wien 2008). According to the Regional Health Survey, Indigenous people aged 15 and over and living off-reserve are almost twice as likely as their non-Indigenous counterparts to have suffered a major depressive episode in the past 12 months and a high percentage of youth report feeling sad, blue, or depressed during two or more weeks in the previous year (Females, 37.1% and Males, 18.1%) (NAHO 2002/2003). Compared with their non-Indigenous counterparts, Indigenous women and girls in Canada, as in other nations, continue to face disproportionally high rates of family violence in the home and sexual violence both inside and outside the home (LaRocque 2009; Browne and Fiske 2001). Although it is not an empirically broad area of research, small psychiatrically intensive studies document that the vast majority of former residential school students suffer from a host of mental illnesses related directly to their time in the institutions (Corrado and Cohen 2003). These illnesses included post-traumatic stress disorder, substance abuse disorders and major depression. These illnesses, particularly substance abuse and depressions, which can lead to neglectful despondency, are precisely of the ilk that, according to much child protection legislation, would lead to a parent or family being an unfit environment for a child.

Health disparities experienced by Indigenous peoples, particularly in the areas of mental health and addictions, can be understood more holistically and comprehensively from a social determinants perspective. Social determinants of heath are garnering increased attention across multiple disciplines and "there is robust evidence demonstrating that social determinants have far greater influence upon health and the incidence of illness than conventional biomedical and behavioural risk factors" (Gleeson and Alperstein 2006, p. 266. See also Baum and Harris 2006; Raphael 2002; Lantz et al. 1998). Understanding people's health through a social determinants lens means thinking about the systems and structures in which people live as opposed to privileging inquiries about individuals as separate from their social contexts (Marmot et al. 2008). It has been described as research that moves thinking from 'the cell to the social' and as a practice of investigating 'the causes of the causes.' Social determinants foci move away from genetic or biomedical inquiries and instead examine why some people and communities are more prone to health deficits, or suffer more severely from their outcomes, as a function of their social contexts. The health and wellness of people is thus increasingly being conceptualized in relation to the social contexts in which people work, play, love, and experience life and to the social factors which impact that person, including (amongst other things) economics, education, development, housing and, importantly from our perspective, early childhood (Anderson et al. 2002; Marmot 2005).

A social determinants perspective on health has been widely and well received by Indigenous peoples and organizations. They argue that the model is more reflective of Indigenous ways of conceptualizing health while also providing some way of accounting for colonization as a crucial contributor to Indigenous people's present health statuses (Loppie and Wien 2008; Reading et al. 2007; Smylie 2009; Richmond and Ross 2009). Indeed, research has increasingly established that poor health outcomes in Indigenous peoples, and the health disparities realized by Indigenous peoples in almost all sectors of life as compared with their non-Indigenous counterparts, stem from or are related to colonial disruptions and ongoing erosion of human rights (Adelson 2005; D'Souza 1994; Tarantola 2007). Loss of language and cultural fluency, the outcome of assimilative policies resulting in practices such as residential schooling, are expressed as broad scale cultural trauma and lack of social cohesion that translate into diminished resiliency, lessened fortitude to overcome addictions, and higher rates of family violence (Adelson 2005; Cutcliffe 2005). Health disparities, including higher rates of non-infectious diseases such as Type-II diabetes, increased levels of mercury in diets and even elevated rates of

youth suicide, are associated with land and territorial dispossessions that result in Indigenous peoples' separation from healthy activities and food sources (Richmond et al. 2005; Young et al. 2000). In other cases, de/re/territorialization is linked to problematic housing conditions, particularly on-reserve, the outcome of which is increased exposure to mould, higher transmission rates of infectious illnesses, and, in some cases, higher risks for house fires (Richmond and Ross 2009).

From an Indigenized social determinants perspective, then, the multifaceted, intersecting pressures on Indigenous peoples' health that lead to addictions and mental health issues can be accounted for. In order to effectively address the complex origins of Indigenous health issues, however, (in effect, to 'cure' the causes of causes), one must grapple with and firmly understand the workings of colonialism, both historically and into the present. In particular, we argue that in order for the social determinants literature to effectively address the health of racialized and colonized groups, it must incorporate an understanding of colonial discourse as an imaginative and material practice within which particular ideas, people, institutions, and actions intersect and (re)produce inequalities (Said 1978, 1994; Spivak 1999). We work with an understanding of discourse as "a specific series of representations, practices, and performances through which meanings are produced, connected into networks, and legitimized" (Gregory 2000, p. 180). Discourses determine the horizons of what can be said, thought, and done in a given social context, and they "structure both our sense of reality and our notion of our own identity" (Mills 1997, p. 15). Discourses are firmly connected to ideological struggles and to the exercise of power. They regulate, constrain, and produce particular forms of relation. From a discursive perspective, both the health conditions experienced by Indigenous peoples *and* the ideas and interpretations of those health conditions can be thought of together, and their production within colonial power systems can be accounted for. Discourse is thus an invaluable tool for articulating the complex factors shaping Indigenous peoples' health within an Indigenized social determinants framework.

For Their Own Good: Imagining the Person, Writing the Policy, and Historical Constructions of Deviant Indians in Canada

From a discursive perspective Indigenous health conditions are understood to be real but also *produced*, both in a physical, material sense, and in the sense of being made to mean certain things for certain people. In this section, we trace the historical emergence of discourses of Indigenous deviance. We demonstrate that discourses of Indigenous deviance have been shaped by a range of institutional practices, beliefs, policies, and laws in Canada over the past 150 years and that they have particularly targeted Indigenous children. We argue that discourses of Indigenous deviance have directly shaped Indigenous peoples' health by regulating relations between the state, Indigenous children, and Indigenous communities more broadly.

One of the first documents to comprehensively address Indigenous peoples in Canada was the *Report on the Affairs of Indians in Canada* (known as The Bagot Report), presented to the Legislative Assembly of the then Province of Canada in 1845. The Report summarized existing British imperial thought and practices about Indians in the Province of Canada and outlined federal interest in the 'welfare' of Indigenous peoples:

> [We are] interested in the welfare of this race…[of] mass[ing] valuable information upon their present state, and suggestions for improving it…to form a judgment upon any scheme proposed for their future management (Rawson et al. 1845, p.3).

As this report makes clear, interest in Indigenous peoples' welfare involved the surveillance and documentation of their actions, characters, and bodies and the development of schemes to improve and manage them. Indigeneity, here, is framed in terms of deficiencies and deviance that can be improved and managed. As one of the foundational documents articulating relations between the state and Indigenous peoples in Canada, the importance of this discursive framing cannot be overstated. The report is an important archive of the discursivities upon which subsequent constructions of Indigenous peoples have been built. Its frequent reference to the childlike nature of Indians (see de Leeuw 2009) and to their mental inferiority, violence, unpredictability, and untrustworthiness would recur in subsequent documents. Notably, the presence of these deficits meant it was incumbent upon the state to "ameliorat[e] the condition of the Indians" (7) by providing them with education, coaching them in life skills, settling them onto appropriate lands, and intervening into their lives and families. Even as the Canadian state was in its early stages of formation, then, the relations between Indigenous peoples and the non-Indigenous government were already framed in terms of Indigenous deviance and state intervention 'for their own good'.

The pattern would continue in subsequent legislation and policy development. The 1869 *Act for the Gradual Enfranchisement of Indians* (The Enfranchisement Act), an Act designed to delineate the conditions for Indigenous citizenship, emphasized Indigenous peoples' poor mental health and their predilections toward addiction. Two of the Act's first decrees were to make illegal both the opening of taverns on Indian reserves and the selling of liquors or intoxicants to Indians, linking the consumption of alcohol in any quantity to addiction and presupposing an inability of Indigenous people to manage themselves in relation to intoxicants. The Act went on to decree that when tribes or families were not caring properly for their members, particularly the "sick, disabled or destitute," the federal government would intervene by force and "furnish sufficient aid from the funds of each tribe," reinforcing the expectation that Indigenous peoples did not appropriately care for or manage themselves. Finally, and perhaps most egregiously from the perspective of most Indigenous peoples, the Act ruled on family genealogy, decreeing that any woman who married a non-Indigenous man lost her status as an Indian as did any children resultant from that union. Fundamentally, the Act was premised on a logic that colonial subjects and the colonial state knew best how to manage Indians, understood best what constituted and comprised Indians and that, in both cases, was motivated by the best intentions towards Indians.

The Indian Act of 1876 followed in The Enfranchisement Act's discursive footsteps, maintaining and solidifying a logic justifying state intervention into the lives of Indigenous peoples and expanding the scope and reach of government into Indigenous affairs. The Act, tabled because it was "expedient to amend and consolidate the laws respective to Indians", made provisions to control and manage the "reserves, lands, money, and property of Indians in Canada." Leading off from the Enfranchisement Act, it began by defining what constituted an Indian in Canada, thereby legislatively producing a group of people cordoned off from non-Indigenous subjects (and, indeed, a group cordoned off from Indigenous subjecthood, to the extent that particular Indigenous peoples did not 'qualify' as Indian under the Act) and upon whom could be imposed specific policies. Despite a slight incongruence with the stated areas of purview, The Act dedicated seven clauses to "intoxicants," more clauses than addressed "monies," "councils and chiefs," or even "privileges of Indians".

Intoxicants and a fixation on addictions, then, figured prominently in the fledgling Canadian government's worries about the management of Indians. Of such concern were intoxicants that a micro-scale plan of managing them appears in the 1876 Indian Act.

Provisions address "vessels used in conveying intoxicants," including canoes in "any river, lake or stream" and the government decreed it lawful for

> any constable, without process of law, to arrest any Indian or non-treaty Indian whom he may find in a state of intoxication, and to convey him to any common gaol, house of correction, lock-up or other place of confinement, there to be kept until he shall have become sober. (Government of Canada 1876)

Within the Indian Act and like the Enfranchisement Act, citizenship itself was tied to the "degree of civilization to which he or she has attained, and the character for integrity, morality, and sobriety which he or she bears" (Government of Canada 1876). So seriously did the federal government take its role in monitoring and ensuring the sobriety of Indians that it was willing to suspend the "process of law" in order to ensure it. This concern with alcohol did not subside: over the next almost 100 years, all iterations of the Indian Act contained substantial reference to the intoxication of Indians, including the illegality of Indians to enter bars, to purchase alcohol, to organize functions with any availability of alcohol, or to make or sell alcohol either off or on reserve (Daugherty and Madill 1980). Policies concerning intoxication of Indians were intertwined with narratives about the moral character of Indians, narratives which intersected with broader social narratives of the times concerning the need for state and church driven efforts to transform Indians, often through corrective educational practices.

The federal government agenda of transforming Indigenous people into 'civilized' subjects and punishing those who did not comply rested on discourses of Indigenous deviance and non-Indigenous trusteeship, discourses that validated, buttressed, and naturalized a range of violent interventions into nearly every aspect of Indigenous peoples' lives, including their families and communities, their cultures and their lands. These discourses also produced and reinforced the very problems and pathologies they targeted. As interventions aimed at 'improving' Indigenous peoples expanded and intensified, so too did the range and scope of suffering in Indigenous communities intensify. Perhaps nowhere is this link between government improvement schemes and Indigenous peoples' suffering more clear than in the residential schooling project and its effects.

Referred to by some as Canada's "national crime" (Milloy 1999) and recognized by many others as perhaps one of the nation's most egregious interventions into Indigenous peoples' lives and social structures, residential schooling is now understood as an important contributor to the health disparities lived by Indigenous people across the country (Adelson 2005; Kirmayer et al. 2000; Loppie and Wien 2008; Richmond and Ross 2009). Residential schooling, although it shifted depending on the times and places in which it was delivered, was program instituted by the federal government, in conjunction with ecumenical organizations, which sought to reform Indigenous societies and cultures by transforming their children. It was an effort, as outlined in federal government policy documents and program documents, to "produce Indians…adjusted to modern life [and] capable of meeting the exacting demands of modern society with all its complexities" (Indian School Bulletin 1947, n.p.). The pedagogic imperatives behind residential schooling were Christianizing, moralizing, civilizing, and modernizing Indigenous children, all goals consistent with discourses of Indigenous deviance and a need for non-Indigenous trusteeship.

From its onset, residential schooling was framed as a means of 'saving' Indigenous children from the inherent deviance of their families and communities. For Father André Renaud, who by 1962 was the Director General of the Indian Eskimo Commission of the Oblate Fathers, the Vice-President of the Indian Eskimo Association, and a member of the Board of Directors of the Canadian Citizenship Council, the ultimate question with regard

to Indian education in the mid-twentieth century was: "Will they [Indians] keep rearing their children in a truncated cultural tradition or will they eventually give their children basically the same kind of home-background as non-Indians? There is only one way to prevent the former and insure the latter:…education" (Renaud 1958, p. 45). It was not only 'cultural traditions' that residential schooling aimed to protect Indigenous children from. The schools were also designed to provide for children whose parents were deemed unable to care for them, in some cases because of parental addiction issues (Milloy 1999; Miller 1997, 2001). More broadly, however, residential schooling was premised on the assumption that Indigenous children, by virtue of coming from Indigenous families, would inherently be predisposed toward social misfortune, thus justifying the need to provide them with "White" education:

> The day to day experiences of White children unconsciously impress them with the importance of reading…….[T]oday, thousands of our Indian children are being raised in homes in which the written word is almost as unknown as before the coming of the White. This is particularly true in the North West Territories but presents a real problem throughout the whole of Canada. (Indian School Bulletin 1947, p. 10–11)

These improvements were not optional. There were serious consequences to being labeled deviant, unfit, or non-compliant with government ideals and laws, and particularly for resisting the targeting of Indigenous children. By 1927, the *Indian Act* included precise provisions for punishing parents who did not send their children to residential schools, ranging from fines to imprisonment to the removal of lands held by parents or guardians, and the arrest without warrant of students found truant (Government of Canada 1927, Chapter 98). Viewed in hindsight, the system is now understood to have been, on the main, a colossal failure. There are resultant and ongoing repercussions, many of which involve social suffering associated directly with, somewhat ironically, a colonial system that understood itself as predicated on instilling well-being in Indigenous communities by intervening into the lives of children. The last residential school in Canada closed in 1986. Today, where we now turn our attention to, there are many parts of Canada with more children in the care child welfare systems, including government ministries like British Columbia's Ministry of Children and Family Development, than there were children in residential schools at the apex of those schooling practices (Blackstock et al. 2004; Bennett et al. 2005; Trome et al. 2004). The question thus arises: to what extent do contemporary child welfare programs emerge from and reproduce colonial discourses of Indigenous deviance and governmental trusteeship?

Still for Their Own Good: Contemporary Child Welfare Policies that Justify State Intervention into the Lives of Indigenous Peoples

If residential schooling represents one of the most obvious and egregious examples of colonial intervention into the lives of Indigenous children, a project that has manifested in a range of physical, emotional, spiritual, cultural, and mental health concerns for Indigenous individuals, families, and communities, it is important to observe that non-Indigenous Canadians have come to see residential schooling as deleterious only in the past several decades. The impulse to improve and help Indigenous peoples is remarkably immune to critique at the time of its unfolding. Indeed, Tania Murray Li (2007) argues that the construction of non-Indigenous governments and other agencies as helping, protecting, and benevolent forces aiming to 'improve' and transform Indigenous peoples 'for their own

good' is not only a crucial colonial strategy with remarkable tenacity, it also offers a means for colonizers to distance themselves from more 'obviously' coercive, violent, or colonial ideas, actions, and policies (see also Thomas 1994). We argue, on the contrary, that such benevolence is not a response to a politically neutral assessment of 'need' among Indigenous peoples. Rather, it is a longstanding contributor to a cycle of identifying deficiencies and needs that can then be fixed, making control more palatable to those involved. This cycle involves an endless deferral of the time at which Indigenous peoples can be deemed 'ready' to 'manage' themselves and produces some aspects of the very social dysfunction it claims to be interested in alleviating.

In this section, we seek to decipher some of the continuities between the aims and ideas underpinning residential schooling and contemporary programs and policies aimed at Indigenous children through child welfare systems. We argue that the foundational assumptions and framings of Indigenous peoples described in the previous section, as exemplified in historic policies, laws, and practices, continue to inform present policies and reports underpinning child welfare systems in Canada. We argue that federal governmental understandings of Indigenous peoples remain mired in the basic premise that Indigenous people are fundamentally different than Euro–Canadian settlers and that this 'difference' is invariably understood hierarchically: Indigenous peoples are understood in terms of their apparent deficits and inferiorities in comparison to the capacities and strengths of the governing culture. Contemporary child welfare documents are usually devoid of explicit reference to the specific 'qualities' and 'needs' of Indigenous peoples. However, given that between 30 and 40% of children in care are Indigenous (Farris-Manning and Zandstra 2003) when Indigenous peoples comprise only 3% of the overall population (Statistics Canada 2001), and that more Indigenous children encounter the state through child welfare programs than ever did through residential schooling, we submit that even child welfare documents that avoid explicit reference to Indigeneity are invariably implicitly aimed at Indigenous peoples. We are also attuned to the ways in which the identification of some peoples as deviant, helpless, vulnerable, and incompetent shores up the construction of other peoples as helpful, charitable, capable, and necessary. The preponderance of expressions of help, need, and protection in child welfare discourse are thus as revealing as those that identify deviance and deficits.

The 2009 wording of *The Child, Families, Services and Communities Act*, the legislation governing child welfare practices in the British Columbia, the word "care" is defined as the "physical care and control of the child" (Government of British Columbia 2009). To care for a child, in the wording of the government, is thus to control the child, an association that also informed the residential schooling project. Similarly, just as government agents were authorized to suspend the law in order to address alcohol use, truancy, or other perceived failures on the part of Indigenous peoples, under contemporary child protection laws a director with the Ministry of Children and Family Development can "without a court order, remove a child" from his or her dwelling (Section 30 of the Act) if there are "reasonable grounds" to believe a child is in need of protection (e.g. put in the "care" of the state). Under the Act a child is in need of protection "if the child is emotionally harmed by the parent's conduct," a provision which some Indingeous groups are increasingly arguing is applied to a parent's alleged use of intoxicants or substances that Indingeous peoples are, within colonial discourses, understood as not being able to use responsibly (see for instance Bennett et al. 2005; Blackstock et al. 2004; Trome et al. 2004). This surveillance of Indigenous families extends beyond institutional confines: in British Columbia, the public is encouraged to partake in monitoring the well being of children and to report any suspicion that a child requires protection. Under the rubric of "protecting children," the

province produced a handbook outlining the public's role in responding to child welfare concerns that begins: "Most children grow up in families where they are safe and secure. Others may be abused or neglected—and those children need our help" (Government of British Columbia 2007, p. 2). Premised by this overarching sentiment of doing right for those in need, and reminding readers that the "law gives child welfare workers the authority to help when a child is at risk," the document continues by defining what constitutes abuse or neglect: it "happens when a parent or guardian ignores or overlooks a child's basic needs…include[ing] failing to provide a child with good, shelter, basic health care, supervision, nurturing or protection from risk" (5). Bearing in mind that a child is anyone under the age of 19, the publication goes on to list warning signs of neglect, including "the child not seeing a doctor or dentist when needed, clothing that does not protect a child from the weather, and poor personal hygiene" (5–6).

The sentiments guiding policy in British Columbia are not unique. In Alberta, child protection is the domain of The Ministry of Child and Youth Services and is governed under *The Child, Youth, and Family Enhancement Act*. In explaining the Act, Alberta Child and Youth Services states that "[t]the term 'child welfare' may be more familiar…than 'child intervention services,' however child intervention services makes the child's well being a priority. The focus is on supporting families to be healthy and [to] make sure that children grow up in safe and nurturing homes" (Government of Alberta 2009). The Act itself is comprised of benevolent languages, stating in reference to removing or apprehending children that "any decision under this Act relating to the child must do so in the best interests of the child and must consider [that]…the family is the basic unit of society and its well-being should be supported and preserved" (Government of Alberta 2009). The Act in Alberta is even more explicit concerning drug and alcohol use by parents, stating that a child is "emotionally injured" and thus potentially in need of state protection, when there is "chronic alcohol or drug abuse by the guardian or by anyone living in the same residence as the child". As in British Columbia, the public is encouraged to report suspected cases of child neglect or abuse, informed both that "[p]eople can actually be fined under the *Child, Youth and Family Enhancement Act* for not reporting when a child is in need of intervention services" and that, if a child discloses neglect or abuse, one should say "I will try to help" (Government of Alberta 2009). Legislations governing child welfare are not dissimilar in Ontario. In that province, child protection services are delivered by non-governmental organizations operating at arms length from Ministry of Children and Youth Services in order to implement provincial legislation detailed in the Child and Family Services Act. Despite a slightly less centralized structuring of policy, the discursive structures of the policies remain strikingly similar, relying on a public monitoring, couched in protective and caring language, and governed sternly by the provincial government (see Government of Ontario 2009).

Our purpose in reviewing the language and laws informing child welfare practices is not to argue that children should not be protected from emotional, physical, sexual, and psychological abuse. Rather, it is to call attention to the discursive context within which such abuses are identified (a context in which Indigenous parents and guardians are always, already assumed to be deviant). We insist on understanding unhealthy families and communities as socially and historically determined and demonstrate that the very same ideas and impulses that informed the residential schooling project, a project that is now understood to have caused widespread cultural trauma and to have exacerbated the 'problems' it aimed to remediate, continue to inform child welfare practices in Canada. Without accounting for these continuities and for the larger context within which addictions and mental health issues arise, government efforts to 'help'

Indigenous peoples today will not only fail, they will worsen the health and well-being of Indigenous children, families, and communities. One of the ways in which such an 'accounting' can be undertaken is by addressing, and adding to, discussions about the social determinants of health.

What Good we Might Hope for: Thinking About Decolonization and Social Determinants of Health as Solutions to Addictions and Mental Health Challenges

The state of Indigenous people's health, including addictions and mental health, cannot in Canada be extricated from colonial projects. By discursively and directly intervening into the lives of Indigenous peoples, colonial policies and practices have colluded to produce states of poor health in many Indigenous communities. Many of the discursive apparatuses, and their concurrent material interventions, turned on paternalistic logics that colonial states and subjects had at heart the best interest of Indigenous peoples who were by nature abject and deficient beings often suffering from addictions. Best interests often focused on Indigenous children. When charted into the present day, many of the same interventionist logics appear alive and well in the form of state child "welfare" and child protection legislations. Given that the health and well being of Indigenous peoples has not markedly improved over time, and that Indigenous peoples continue to live some of the worst health profiles of any group in Canada, and given that the state continues to aggressively intervene into Indigenous communities through child protection services, we wonder if part of a healthy future for Indigenous peoples might reside in significant reconfigurations of state logics concerning what constitutes a child's well-being. This reconfiguration, we suggest, is emergent in efforts to Indigenize and decolonize the literature on the social determinants of health.

What does a discussion of discourse offer to the social determinants literature and to understandings of Indigenous addictions and mental health? We argue in this paper that when applying a social determinants approach to the study of the health of racialized and colonized groups, and particularly to the health of Indigenous peoples, it is imperative to account for the discursive context within which social factors such as education, income, social support networks, healthy child development, and physical environments emerge. We argue that discourses determine health, and in particular that the heterogeneous and yet intersecting practices, institutions, laws, texts, and ideas that constitute discourses of Indigenous deviance and non-Indigenous care and protection have material effects upon and the health and well-being of Indigenous peoples in Canada. These discourses have not only produced and naturalized the conditions that compromise Indigenous peoples' health (such as the dispossession of land, the removal and targeting of children, and a host of other assimilative and coercive practices), the poor health that results from colonial discursivities is used today to justify the continued attack upon Indigenous children through the child welfare system and results in further erosion of the health of families and communities. We argue, in other words, that colonial discourse is a 'cause of causes' of health disparities, but one with a unique ability to account for the interplay of imaginative and material factors, and to tease out the multiple processes and practices that contribute to health. The integrative, multi-layered framework enabled by a discursive approach is particularly well-suited to understanding addictions and mental health concerns, moreover, because these health issues are themselves so complex and multifaceted.

Discursive analysis does not necessarily offer clear policy or program directions for ameliorating Indigenous peoples' health. Its strength is in its analytical breadth and its ability to think holistically about the multiple forces shaping health. To the extent that

discursive analysis attends to the role of non-Indigenous peoples in producing Indigenous ill-health, however, it does demand a widening and shift in focus from the bodies and minds of Indigenous peoples towards the broader political, economic, social, and cultural contexts within which health issues arise. It demands that we think of Sherry Charlie's death as much more than a tragedy befalling an Indigenous community, and instead as an event shaped by long histories of undermining the ability for Indigenous families and communities to "keep their children safe and well" (Hughes 2006, p. 52). Indeed, discursive analysis, as part of an Indigenized social determinants of health framework, calls into question the capacity for isolated programs and policies targeting Indigenous peoples to address their addictions and mental health concerns. Comprehensive and meaningful decolonization of both Indigenous and settler communities is required in order to heal the deeper 'causes of causes' of health disparities in Canada.

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