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Colonialism as a Broader Social Determinant of Health

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Abstract

A proposed broader or Indigenized social determinants of health framework includes "colonialism" along with other global processes. What does it mean to understand Canadian colonialism as a distal determinant of Indigenous health? This paper reviews pertinent discourses surrounding Indigenous mental health in Canada. With an emphasis on the notion of intergenerational trauma, there are real health effects of social, political, and economic marginalization embodied within individuals, which can collectively affect entire communities. Colonialism can also be enacted and reinforced within Indigenous mental health discourse, thus influencing scholarly and popular perceptions. Addressing this distal determinant through policy work necessitates that improving Indigenous health is inherently related to improving these relationships, i.e. eliminating colonial relations, and increasing self-determination.

Introduction

The social determinants of health are the environmental causes of ill health that affect populations. They point to evidence that highlights higher susceptibility to illness and disease as a product of particular socio-economic and physical environments. Considering these environments are socially constructed, it seems reasonable to conceptualize addressing these determinants through the generation of social welfare policy and infrastructural adjustments. However, the causes of ill health can stem from deeper social structures and processes that operate at the national and global levels, as identified in the Commission on the Social Determinants of Health (SDoH) most recent report (2008). "The inequity [in daily living conditions] is systematic, produced by social norms, policies and practices that tolerate or actually promote unfair distribution of and access to power, wealth and other necessary social resources" (Ibid). This statement acknowledges that there are larger *causes of causes*, or distal determinants, of unhealthy life conditions.

The Commission's report (2008) provides a greater breadth for appreciating how some groups are more likely to suffer from poor health, but it is limited in failing to accurately define the structures and processes that produce vulnerabilities. This omission highlights one of the mechanisms by which this unfair distribution of power, wealth and resources goes unabated: by refusing to expose the guiding ideologies that result in the disproportionate social burden for some. Labelling these mechanisms underlines a component missing from the mainstream SDoH analysis that would involve tracing the birth and pervasiveness of these mechanisms: stressing the effects of history and the notion that history is still in the making. When the health gap between Indigenous populations and settler populations persists globally, their shared history becomes all the more significant with regards to the aforementioned "unfair distribution".

At the International Symposium on the Social Determinants of Indigenous Health (2007), it was demonstrated that the determinants of Indigenous health differ from those of the mainstream population. This is in part due to how health is conceptualized amongst Indigenous populations compared to Western, biomedical definitions, but also that some of these previously cited mechanisms are actually identified as distal determinants. That an Indigenous SDoH framework would be different from the conventional framework stresses that the latter's indicators are limited and not reliable for all (Intl Symp., 2007). "Research and dialogue at the international level has demonstrated a common element that exists for all Indigenous peoples and affects every issue confronting them as a collective: the history of colonization and the associated subjugation of Indigenous peoples" (Ibid, p. 24). Since the SDoH themselves point to the very fact that the mechanisms that "influence health are humanly factored, socially influenced and unequal" (Lang, 2001, p. 162) and that the Commission (2008) acknowledges the unique "social exclusion" circumstances of Indigenous peoples, colonialism should really be allowed into the debate (Loppie-Reading & Wien, 2009; NAHO, 2006; Lang, 2001). With an emphasis on discourse analysis and Indigenous mental health research in Canada, this piece explores what it means to understand colonialism as a distal determinant of Indigenous health.

Colonialism: A Finished Project?

Why the use of the term *colonialism* instead of *post-colonialism*? Colonialism is defined as: i) the control or governing influence of a nation over a dependent country, territory, or people; ii) the system or policy by which a nation maintains or advocates such control or influence (Random House, 2010). Several authors and organizations speak to the notion that colonialism has never ceased; that our history of colonialism is interconnected with continuing colonial policies and historical events "spilling

over into the present" (Warry, 1998, p. 84). Whole communities are still trying to recover from the impacts of colonial legislation, the structural influences, such as the residential school system and "continuing, although more general, assimilationist tactics perpetuated by the Canadian government" (Wesley-Esquimaux 2007, p. 69). Spatially or symbolically, one such tactic is the urban daily practice that reifies essentialist notions of the Indigenous person as antithetical to urban space, such as the policing responses toward disadvantaged urban Aboriginals. Sherene Razack describes such responses as "cleansing rituals that enable settlers to know city space as theirs, and individual settlers to know themselves as the managers and rightful inhabitants of public" (2008) or "civilized" space.

On a symbolic level, and in contrast to material tactics or legislation, this last example speaks to the politics of erasure of the history of relations between Indigenous peoples and the colonial state. This erasure reflects a public consciousness that is ignorant of the goings-on in residential schools and the laws that were put in place to prohibit most forms of possible recourse for Indigenous families. This erasure also appears in the refusal to understand and accept Aboriginal title and respect Indigenous rights (as seen with the current government's shelving of the 2005 Kelowna Agreement[1]) or that up until very recently, Canada had not even signed the United Nations Declaration on the Rights of Indigenous Peoples[2]. This erasure also appears as the ignorance in everyday interactions such as in "banal liturgies" (Thobani, 2007, p. 79), or in racially discriminatory comments, such as the ethnocentrism and paternalism inherent in the referral to Indigenous peoples as "our" Aboriginals.

On a similar note, the National Aboriginal Health Organization (2001) draws a critical link between racism and colonialism: "Racism is one of the characteristics of colonization and as such it has a negative influence on how Indigenous peoples are positioned in Canadian society. Because they have endured rather invisible and long-term oppression and discrimination, they have fared worse in economic, political, cultural and social terms," (p. 13). Racism fuelled the disenfranchising, assimilationist and genocidal tactics; as well as the amnesia of this detailed history and how it has produced intergenerational impacts, compels us to question if racism as a motivator has ever dissipated. Thus, it is through the mentalities that perpetuate and reproduce these incidents and the continuation of certain policies that we see how settlers have gained illusionary freedom assuming colonialism is a *finished project*.

Indeed, borrowing from Anne McClintock's *The Angel of Progress* (1990), this "premature celebration of the pastness of colonialism, runs the risk of obscuring the continuities and discontinuities of colonial and imperial power" (p. 88). The term "post-colonial" also encourages a settler description of time and interpretation of history. This perception prioritizes European historiography and a perhaps hasty desire to put uncomfortable stories behind us (Sch."N"; St. Denis, 2009). This dichotomy of "colonial" and "post-colonial" "[then] may be in danger of neutralizing historical inequalities" (Miyawaki, 2004) and emphasizes a sometimes inappropriate vocalization of relations that does not necessarily reflect the lived realities of contemporary Indigenous peoples and the state.

From Historical Inequalities to Observable Disparities

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[1]First Ministers met with the federal government to discuss Aboriginal issues and to develop culturally appropriate First Nations governments over the long term (Warry 2008, p. 179).

[2] Adopted internationally in 2007 except for the US, Canada, Australia and New Zealand. Canada signed the Declaration on November 12, 2010.

Many of the reviewed statistics reiterate the aforementioned point of First Nations peoples faring worse overall when compared to the life situations of many non-Indigenous peoples[3]. When looking at *A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003* (HC, 2010), one observes that 48.6% of those aged 25-64 years have less than a high school graduation certificate, compared to 22.5% of non-Indigenous; 27.7% of on-reserve households have at least one standard below core housing standards, compared to 13.5% of the general population; and 27.7% of the on-reserve population is unemployed, compared to 7.3% of the general population. Furthermore, there are numerous communities with inadequate infrastructure for proper sanitation or access to potable water (Ibid). These and other disparities reflect a certain level of consent to inaction from the Canadian government and also contribute to the health disparities that exist between the Indigenous and the non-Indigenous populations. For instance, Indigenous peoples in Canada represent only 3.8% of the population, but they are disproportionately afflicted with AIDS (7.2% of cases) (Ibid). Twenty percent of the Indigenous population has *diabetes mellitus*, which indicates rates three to five times greater than the overall Canadian rate (CDA, 2010). The Potential Years of Life Loss to suicide is about three times greater amongst First Nations on-reserve (HC, 2010). Life expectancy can be contrasted as well to that of non-Indigenous, the latter enjoying a 5 to 8 year longer life expectancy than Indigenous peoples (Ibid). This list of health statistics is not exhaustive, and several more significant health statistics are also pertinent, but for the purpose of this discussion, we will now focus on how these disparities relate to the socially-manufactured environment.

"Colonialism" as a Broader Social Determinant of Health

There are and have been direct effects of colonialism or colonial policies on Indigenous health, for example, the introduction of contagious diseases like smallpox; the extinction of the Beothuk[4]; or the gamut of negative experiences within the residential schooling system, to name a few. However, the above disparities also reflect the protracted effects of land dispossession and sedentarization on cultural continuity, access to traditional economies, as well as physical separation from mainstream monetary economies, to name a few. In other words, these health gaps hint at the distal effects of colonial legislation.

The World Health Organization[5] refers to the *social determinants of health* as the "remarkable sensitivity of health to the social environment[;…]the common causes of the ill health that affects populations are environmental" (WHO 2003, p. 7). The WHO lists proximal determinants of health or

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[3] The surveys reviewed mainly speak only of the experiences of on-reserve First Nations peoples as compared to non-Aboriginals. *Non-Aboriginal* then includes the first waves of White Euro-Canadian settlers and extends to the subsequent and current newcomers to Canada (Thobani, 2007, p.16). It is certainly problematic to imply relative homogeneity within these groupings and it somewhat disregards the discrepancies between the experiences of White settlers and racialized settlers, or between the affluent and the poor. The statistics generated by Health Canada, Statistics Canada and others, despite this often generalizing methodology, still point to noteworthy disparities in many regards. Therefore, I will use them on these dualistic terms to help explain my point on colonialism as a distal determinant of health.

[4] Indigenous peoples from Newfoundland. The population decreased due to infectious disease, tuberculosis, loss of access to important food sources, and violent encounters with settlers and other Indigenous peoples because of colonial pressures. The last known member died in the 1820s.

[5] WHO.

what we see on the surface as follows: health behaviours, the physical and social environments; what diminishes capacity, limits control of material resources and exacerbates health problems. Intermediate or core determinants are what create these proximal ones. The former include such things as community infrastructure, resources, systems (labour and education) and capacities (Public Health Agency of Canada, 2003; Reading).

The National Collaborating Centre for Aboriginal Health (NCCAH) defines distal determinants of health as "the political, economic, and social contexts within which all other determinants[–proximal and intermediate–]are constructed" (2009, p. 20). Colonialism is the guiding force that manipulated the historic, political, social, and economic contexts shaping Indigenous/state/non-Indigenous relations and account for the public erasure of political and economic marginalization, and racism today. These combined components shape the health of Indigenous peoples. At the intermediate level, this occurs via the funding and organization of the health care, education and labour systems; as well as the extent to which Indigenous peoples can operate their environmental stewardship and maintain cultural continuity. Along with these *intermediate* determinants, *proximal* determinants are also subsumed under this larger structural reality: that at the *root* of these determinants is colonial relations; relations that have produced and reproduce unfavourable conditions and environments. These conditions and environments determine healthy behaviours, or lack thereof, physical environments, employment and income, education, and food security (Loppie-Reading & Wien, 2009). These are not coincidentally some of the areas mentioned earlier where disparities can be seen between Indigenous and non-Indigenous populations.

The structural and systemic contexts make for colonialism to be *distal*. Distal determinants are generally beyond the individual or community's control and are the *causes of causes* for unjust life situations for certain groups or people over others. Exploring colonialism as a distal determinant of health is linked to examining how current ideologies and historic events influence the health of contemporary Indigenous peoples.

A Focus on Mental Health

Although there is certainly a huge variance of mental health factors from one community to the next, overall, suicide rates are five to six times greater among First Nations on-reserve youth than the general Canadian population (Trumper 2004). And "the 1997 First Nations and Inuit Regional Health Surveys, conducted across Canada, found elevated rates of depression (18%) and problems with alcohol (27%)" (Kirmayer et al., 2009, p. 17). Can the production of these mental health disparities be attributable to how mental health is conceptualized? Albeit the presence of specific Indigenous vocabularies (see Kirmayer, Fletcher & Watt, 2009) that describe afflictions of the mind that are comparable to biomedical mental ill-health categories, for many, Indigenous health is still often spoken about and represented more broadly than the physical being. For instance, the medicine wheel reflects good health as a balance between four realms: the mental, the spiritual, the emotional, and the physical. This conceptualization of health speaks to the interconnectedness of these spheres of being and emphasizes the notion of holism when attempting to understand what it means to be well. These dimensions, which also represent the four directions, can provide a way to conceptualize our belonging in the world and they also relate our health to the social environment around us.

Although there are points of convergence and divergence in comparing a biomedical definition of mental health to that of Indigenous conceptualizations of mental health, a most important element of variance is the complexity of factors that determine health as seen through the different relationships implicated. In *Healing Traditions* (2009) Joseph Gone speaks of his community of the Gros Ventre tribe in Montana as one that configures "wellness much differently than the 'mental health' of professional

psychology, emphasizing respectful relationships instead of egoistic individualism and the ritual circulation of sacred power instead of the liberating enlightenment of secular humanism" (p. 427). Naomi Adelson's work with the James Bay Cree also provides us with an understanding of health that connects land and identity to social and political well-being (2000). The Cree concept of "being alive well" or *miyupimaatisiun* is informed by historical, contemporary events and cultural practices (Ibid). This definition extends beyond the usual biomedical parameters of physiological well-being and highlights the importance that various relationships have on health. These relationships, in particular those to the land, are explored in Kirmayer et al. (2009, p. 22) and are articulated through the concept of the "ecocentric self", which envisions the ego as one piece in a web of relationships that includes extended family, kin, clan, ancestors, for some also animals, elements of the natural world and spirits. The idea of these relationships is key to a healthy social environment, and is a concept we will return to.

Deconstructing Indigenous Mental Illness

Colonial policies have produced their own collective mental dis-ease[6] that affects Indigenous peoples today; however, the impacts of these policies are compounded by *colonial mentalities* that produce and reproduce detrimental discursive environments. The examples to follow allude to how Indigenous mental health discourse can be both demonstrative and influential. The discourse is demonstrative in that *how* mental health is conceptualized by various authors, *how* the very act of explaining, i.e., producing discourse on Indigenous mental health, reflects how mainstream authors construct the "other" (in this case the "Aboriginal"); as well, the discourse elicits the power differentials involved in generating these constructions. The discourse is then *influential* in that there are potential outcomes of the unquestioned acceptance of these constructions.

Why the focus on mental health? In *Revenge of the Windigo* (2004), a comprehensive review of mental health literature on Indigenous peoples in North America, medical anthropologist James B. Waldram states that mental health is the most written about sector of Indigenous health. From his research, it becomes apparent that the concept of the "disordered Aboriginal" stems from anthropologists', psychologists' and psychiatrists' interpretations and projections of a contemporary inability of Indigenous peoples to "deal with their problems". Waldram highlights that there is a lack of an anthropologically sophisticated view of culture in mental health research; researchers often reduce the concept to a set of arbitrary characteristics, or worse, blame culture for health outcomes. He also points to the utilization of problematic methodologies and, to a lesser extent, the underlying assumptions of race and biology–such as attributing substance abuse to a genetic predisposition–in much of the existent Indigenous mental health work. He criticizes the fact that much of this work often points to what makes people sick instead of what makes people healthy; hence, although he critiques the inconclusive indicators of cultural continuity described by Chandler and Lalonde (1998), he applauds their seminal piece as significant in addressing what makes suicide a non-issue in some First Nations communities.

On a similar vein, Waldram cautions that the notion of the "depressed Aboriginal" is informed by a "tendency to embrace panoptic explanations which uncritically attribute psychopathology to broad historical and cultural phenomena while ignoring local cultural heterogeneity, continuity, and adaptation" (2004, p. 198). Another category, "the traumatized Aboriginal", is a concept we will unpack more thoroughly–and is also spoken about reflexively in consideration of the aforementioned concern. With the latter in mind, utilizing the statistics cited earlier additionally run the risk of essentializing Indigenous peoples as "victims" or inherently "sick". On the other hand, acknowledging a degree of

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[6]Deliberate spelling based on Adelson's (2000) and other scholars' work.

trauma can create "assets that could be used to leverage the state for compensation" (Petryna 2002, p. 31). Either way, it is a category that should not be entirely discarded because although Indigenous peoples may not embrace trauma as the pathological condition that some scholars have proposed, trauma can still be seen as a particular disposition that attests to the seriousness of history as memory and "as a metaphor for [Indigenous peoples'] historical relationship with the European settler society" (Waldram 2004, p. 236). This last point reinforces the aforementioned centrality of relationships in conceptualizations of health and healthy outcomes.

From his extensive analysis of relevant research, Waldram (2004) concludes that the assumptions underlying these "disordered" categories are often a product of racial stereotypes, racial "othering", essentialism (Ibid), and continued colonial mentality. Therefore, the uncritical placement of individuals into these categories and related discourses affect how we understand mental health, how Indigenous mental health is constructed, but also how mental ill health is managed; thus, these discourses affect mental health outcomes. This last point is articulated well in de Leeuw, Greenwood and Cameron's work (2009):

> [I]n 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.[…]Discourses are firmly connected to ideological struggles and to the exercise of power. (p. 5).

The authors emphasize the necessity to understand unhealthy Indigenous families and communities as socially and historically constructed and argue that the ideas and impulses that informed the residential school project continue to find saliency today within Canadian child welfare practices (Ibid, p. 10). These works highlight the significance of "colonial discourse" as a *circumstance* that determines Indigenous mental health, in addition to the importance of contextualizing the health status of Indigenous peoples in Canada–grounding collective health status in historical and structural processes.

"Survivors of Survivors"

At his University of Toronto lecture in December 2009, Justice Murray Sinclair, chair for the Truth and Reconciliation Commission of Canada, stated that every Indigenous person has been affected directly or indirectly by the residential schools. In other words, this poignant fact points to the injuries inflicted within the residential schooling system that have produced "survivors"[7]; it also recognizes the biopolitical[8] production of intergenerational impacts on a population as culpable for the production of "survivors of survivors".

Many former students, as Patricia Monture-Angus put it, learned to "look the other way" (1999, p. 25) and retained the negative behaviours acquired during their time at the residential school, and the lack of positive, healthy relationships influenced their own interactions with others. These behaviours and the lack of exposure to healthy parenting skills (Bombay et al., 2009, p. 17) were passed down from

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[7] There has been some discussion on this term being problematic in terms of subjectivity; however, it is a term that past residential school students coined and use themselves. Thus, this term is used knowing that it can imply certain restrictions.

[8] Often associated with Michel Foucault's work (1997).

one family to the next creating a series of transmitted impacts of the residential schools in First Nations communities. These impacts–in collaboration with the effects of other colonial legislation and attempted cultural engineering (Niezen 2009, p. 187) such as displacement, the prohibition of cultural practices, the "60's scoop" (or the disproportionate amount of Indigenous children placed in White settler homes), birthing relocation, etc., within a continued oppressive social, political, and economic environment–are often encapsulated under the umbrella term of "intergenerational trauma". Anthropologist and Indigenous scholar Wesley-Esquimaux (2007) defines intergenerational trauma as:

> the historical experiences of First Nation people(s), which disrupted the process of indigenous cultural identity formation, [that] continue to loudly resonate in the present, and ...the harm done in the past [that]continue[s] to manifest inter-generationally into the present.[…T]he psychological "affect" generated by centuries of cultural dislocation, forced assimilation and the Indian Residential Schools (p. 7, 62).

The following paragraphs outline one such impact of the aforementioned psychological "affect" by choosing to highlight the discourse on Indigenous "trauma".

Bombay, Matheson and Anisman (2009) demonstrate evidence of a high incidence of Post-traumatic Stress Disorder: 64% amongst residential school survivors, with 50% of those showing co-morbid mental illnesses (p. 9-10). Moreover, protracted and severe stressors, including on-going discrimination, contribute to disease and may precipitate mental illness. The authors (Ibid) emphasize a particularly strong relationship between such stressors and substance abuse, in addition to depression and other anxiety disorders that "often occur in conjunction with...traumatic experiences, and are frequently co-morbid with PTSD" (Ibid, p. 26). They also found "that cumulative trauma was a significant predictor of parental abuse potential" (Ibid, p. 21). Their work suggests that groups vary in terms of culturally-based responses to stressors, as well as with their specific "histories, cultural norms and relationship to the mainstream culture, which in turn leads to variations in the nature, exposure, assessment and reactions," including resilience, "to stressful and traumatic events" (Ibid, p. 13). In addition to the concept of "cultural continuity", these items, along with the cultural diversity between First Nations, may help explain the variety in community experiences to stressors, not to mention individual-specific responses and the variance of the individual performance of cultural norms. Even measures and medical definitions of mental health are based on Western conceptualizations and "normalized against white middle class samples" (Ibid, p. 27) facilitating cultural inappropriateness and class-related misdiagnoses. In this regard, there is still a significant need for the employment of culturally-specific and -appropriate indicators of health and wellness for studies on Indigenous health (Ibid, p. 28).

As outlined above, researchers are attempting to demonstrate the links between the traumatic events experienced in the residential schools or the impacts of the placement of children in White settler homes, and place them under the umbrella term of historical trauma. It is a cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences (Wesley-Esquimaux & Smolewski, 2004); the collective "consequences of multiple stressors experienced by whole communities over generations (Castellano, 2008, p. 390). It has been proposed that the cumulative effect and sometimes violent nature of these colonial policies on Indigenous peoples can be appropriately termed an ethnic or cultural genocide (Smith, 2005). Another concept, that of "social suffering"–put forth by anthropologists Kleinman, Das and Locke (1997) as the pain and marginalization of a group–has also been used. Indeed, it has been proposed that the normalization of such pain contributes to its persistence (Niezen, 2009, p. 190).

There is an urgent need for empirical evaluations of Indigenous trauma and stressors, although the work of Ing shows the transmission of up to 46 impacts over 3 generations[9] (2006, p. 161). Spittal et al. (2002) draw links between injection drug use, HIV+ status and residential school lived experiences; and Menzies (2008) draws a link between residential school experiences and Indigenous homelessness. By stressing the connection between lived experiences and its impacts on daily living conditions, Kirmayer et al. (2009, p. 455) state that a focus on historical trauma deflects individual blame as outcomes may be out of the person's control; this focus valorizes suffering and directs people to righting the structural violence present in our society. The authors go on to say that the family and community are the locus for this kind of trauma and must be understood as the source of restoration and renewal in health promotion endeavours (2009, p. 463).

Whatever term is used to label these stressors and their subsequent induced distress, speaking of trauma provides a language that enables people to express the relationship between the past and its structurally oppressive forces, and the link to contemporary realities. It is important to keep in mind that speaking of trauma in such a broad way can obscure the multitude of individual experiences that exist and the specific contexts in which they were created. Moreover, people are not passive recipients of the epithet "traumatized"; neither does the dominant society divvy out equal value to "traumatized" subjects (Fassin & Rechtman 2007, p. 10). It can however be used as a "resource to support a right" or "to testify to the reality of persecution", thereby giving this mental health category social and political power (Ibid). However we approach collective memory and trauma, Bombay et al., through the limited studies available on First Nations peoples (and other studies that focus on childhood traumas) do indicate that adverse childhood experiences (if we restrict our analysis to say, the residential school system) affect appraisals, lead to altered coping strategies that can perpetuate into adulthood, and encourage poor mental health outcomes (2009, p. 18). This discussion on intergenerational and historical trauma presents certain effects of colonial policies on individuals and possibly whole communities.

This work suggests that the trauma embodied in parents or previous generations negatively impacts people's lives and mental health today, indicative of colonialism's interpretation as a generator of certain types of disadvantages and unjust environments, thus capable of determining health. It is for these reasons that it is important to contextualize and speak of colonial policies and the legacies they left behind when speaking about Indigenous mental health, and the health disparities we see when compared to the mainstream population. In regards to these items, Leeuw et al. (2009) summarize the work of other scholars and state that:

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) (p. 4).

Policy Implications of Colonialism as a Health Determinant

If we are to conceive colonialism as a force or set of practices that determines health as outlined above and we wanted to address this determinant, one could suggest policy implications like those described in the WHO Social Determinants of Health (2003) document. This could look something like:

▪ All citizens should be protected by minimum income guarantees, minimum wages legislation and access to services.

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[9]Impacts include: denial of FN identity, belief in myths about FN people, poor self esteem, etc. (Ing, 2006, p. 162).

▪   Legislative interventions to discrimination and social exclusion are needed at both the individual, the scholastic, and neighbourhood levels.

▪   Public health policies should remove barriers to health care, social services and affordable housing.

▪   Labour market, education and family welfare policies should aim to eliminate inequitable funding or lack of services.

▪   Measures should be taken provincially and federally to educate more mental health professionals and offer funds for mental well-being services.

These are loosely based on the policies suggested in the WHO document (Ibid) and are certainly all important, especially considering the lack of mental well-being services to meet community needs (Kirmayer et al., 2009). However, a SDoH approach to healing that strictly looks at the population as a whole could contribute to an "incorporation" (Intl Symp., 2007) agenda or to the normalized invisibility of the experiences of marginalized groups compared to the advantages enjoyed by the mainstream population. *Integration* is a common theme in colonial discourse and action, where the distinct history of Indigenous-settler relations and unique status with the state often go unacknowledged. Furthermore, the imposition of the conventional SDoH framework and what is recommended as necessary actions elicits questions about if these documents are truly addressing the determinants or perpetuating inequality (Krieger & Birn, 1998) by not allowing Indigenous peoples, for instance, to dictate what determines their health and what actions are needed to address health disparities.

Certainly the Commission (2008) breaches from the "conceptual conservatism" that facilitates inaction in settler societies with regards to the unethical and ineffective distribution of power (Venkatapuram, 2010); this break is exemplified by item 14.2: "National governments need to acknowledge, legitimize and support" Indigenous Peoples (2008), which would in turn allow for the improvement of socio-economic conditions. Nevertheless, without truly acknowledging the legacy of colonialism, including its concurrent forms (policies and discourse) and its intergenerational impacts (trauma), these documents do not question the basis and functioning of the state, and thus perhaps contribute to the unspoken agreement that we have reached the end of history "with the triumph of the West" (Lang, 2001). It is the danger in this belief that makes taking seriously colonialism as a distal determinant, whether or not the SDoH framework is embraced, absolutely pivotal.

If the "problems of social health are ultimately linked to colonial oppression" (Warry, 1998, p. 84), then we are not simply discussing issues of individual social exclusion, as outlined in the WHO document, but more so the marginalization of cultural groups, which is at least acknowledged in the Commission's report (2008). Therefore, if we return to the definition of colonialism that was provided earlier—"the control or governing influence of a nation over a dependent country, territory, or people; the system or policy by which a nation maintains or advocates such control or influence"—then ideally addressing this distal determinant of health is inherently connected to restoring respectful relationships, nation-to-nation relations (Turner, 2010), the return of lands and allowing for self-determination. .

In terms of decision-making over health services, many communities have embarked on or have completed health services transfers, but even these policies are problematic because services are not funded equitably compared to provincial services; the funding often does not account for a growing population; and there is cost shifting and administrative fragmentation by federal and provincial bodies, which provides for an overall limiting structure from which to offer the necessary holistic, responsive services that communities need and want (Lavoie, 2003, p. 345). Indigenous scholars like Monture-Angus insist that Indigenous peoples' health is essential to self-determination, and vice versa, which involves personal and community power and control over decision-making (as cited in NAHO, 2001, p. 18). This is especially important where Indigenous peoples and communities "have historically lacked control over their social health" (Warry, 1998, p. 65). Redressing the impacts of colonialism on a

population and ending paternal relations will take commitment, however, from all parties, and in addition to Indigenous solutions at the community-level, commitment is also needed from the government to contribute to developing economic sustainability and greater political inclusion. Ultimately, if an Indigenous SDoH framework demonstrates that settler ideologies, interactions and imposed systems are a significant cause of the causes of Indigenous ill-health, then settlers need to confront the persistence of racist attitudes and with this, society's role, along with the state and its institutions, at contributing to poor health outcomes.

It is difficult to estimate how changes in "empowerment" and a more prevalent allowance of "decision-making" (Commission, 2008) will happen under the nation-state that had refused to sign the UN Declaration on the Rights of Indigenous Peoples and who sanctions colonial tactics of ongoing land degradation and expansionism. With these items in mind, the aspirations of self-determination and land rights (Intl Symp., 2007) become more obvious as generators of "social, cultural and economic conditions" that improve health (Ibid), as well as issues of social justice and human rights (Larsen, 2006). These aspirations are especially significant considering they point to what Indigenous peoples identify would improve their well-being, when the conventional SDoH have been criticized for focusing on what keeps people healthy instead of what measures would help the ill (Intl Symp., 2007). The societal and structural reform (Ibid) at the state and institutional levels necessary for the paradigm shift that would allow these measures needs to be grounded in public interest and support, as well as through monitoring at the international level.

Concluding Thoughts

Recognizing colonialism as a determinant of health involves questioning if colonialism is a finished project, one of ongoing unequal relationships, but equally, that these relationships have real negative effects on health. As a result, interpreting colonialism as a determinant of health is related to recognizing its influence on Indigenous lives as multi-faceted. From a mental health perspective, colonialism can be produced and reinforced within Indigenous mental health discourses, but its effects can also be embodied as a reaction to contemporary political, social, economic situations and historically through trauma. Addressing the ongoing effects of colonialism, decolonizing Indigenous mental health discourse and allowing for just and adequate control over key dimensions, such as health services, is inherently related to self-determination and thus improving health. Therefore, reducing and possibly eliminating health disparities would require policy that addresses the structural *causes of causes* perpetuated by the general population and the government via transfers of power, and a sustained commitment to change from settlers, the various levels of government, and the Indigenous community.

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