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Turbulent Spirits

Aboriginal Patients in the British Columbia Psychiatric System, 1879–1950

ROBERT MENZIES AND TED PALYS

REMEMBERING CHARLEY WOLVERINE

In the late fall of 1941, sixty-two-year-old Charley Wolverine,[1] a member of the Dakelh (formerly Carrier) First Nation of west-central British Columbia, was becoming increasingly erratic and confused. He had been wandering aimlessly around his home reserve at night for several weeks when the village chief at last decided to summon the local British Columbia Provincial Police (BCPP) constable. The latter promptly jailed Charley and called in two white general physicians from a nearby town. Although Charley was deaf, non-English-speaking, disoriented, and nearly blind, the two medical men quickly determined that he was an insanity case who needed immediate institutionalization. They filed the necessary involuntary certification forms under the provincial *Mental Hospitals Act*,[2] to which they appended an application for admission completed by the BCPP constable and legal authorization from the presiding stipendiary magistrate for the district.

Following a train journey south, Charley was shepherded into the admission unit at Essondale, the province's flagship psychiatric facility in the Vancouver suburb of Coquitlam, eight hundred kilometres from his home, where he was bathed, photographed, and given a preliminary examination. The admitting physician noted, "He is very dull and seclusive in his manner ... He takes no interest in his surroundings. He is quite deaf and it is difficult to talk to him. He is markedly confused in his conversation, and his

memory is faulty for past events."[3] Thereupon the doctor ushered Charley Wolverine first onto the Centre Lawn wards and from there a few dozen metres westward to the Male Chronic (West Lawn) Building.

Through that winter and into the spring and summer months of 1942, Charley Wolverine's family members and friends mustered what few resources availed them in a fruitless campaign to bring Charley home. With assistance from village members who enjoyed some fluency in written English, his wife, Martha, directed letter after letter to institutional authorities, variously imploring and reasoning with them, appealing to their sense of humanity, and relentlessly insisting on his immediate release back to his home and community. Various other relatives (including his married daughter) also wrote, generating through the term of Charley's confinement a formidable body of correspondence that survives to the present day in his clinical dossier, stored at the British Columbia Archives in Victoria.

A prophetic note that Martha sent in February to Medical Superintendent E.J. Ryan consisted of "a few lines to say we want you to send Charley Wolverine back to [the village], we all want him to come back, if he will not get better, then we would like him to come home and die here at his own home … His [three teenaged] children want to talk to him before he has to die." Two months later Martha tried again, begging for the railway fare to come visit him in hospital:

> I have not seen him for a long time now, and Im[4] not too well. My husband he has never written me a letter … Lots of people get pass on the train, Indian Agent give one to them, so please you send me one … Ive not got any money or I would pay my own fare to Essondale … Two hospital here both for Indians we don't want Charley to stay such a long way, his [people] want him, seems there is no straight talk … I want to talk to him. I got your letter and everybody is sorry and cry. I walk all the time please send Charley back, I ask you please, or send me a pass to come down to him.

In a penultimate note, composed in mid-July, Martha tried in desperation to invoke the influence of the federal Indian Affairs Branch and the provincial police:

> The Indian Agent is at Vancouver just now so I cannot see him about Charley. May be you will see the Indian Agent and the Police man say Charley is alright and he can come back soon. I see the police on Sat night. Ruth [her daughter] is home from [residential] school and she is sorry her father is not in [the village] and she cry all the time … The house I have to live in has no window and its too cold I want my

husband to come back and fis it so I can live in my own hous. I am sorry every day … Soon I go to Vancouver. Ruth says good bye and I say good bye to Charley. Cheers to you all, thanks a lot.

But all was for naught. When he did respond to Martha and her relatives, Superintendent Ryan's communications recurrently underscored the superior medical treatment that Charley was enjoying, his supposed satisfaction with hospital life, and above all else, the manifest hopelessness of his case. In December 1941 Ryan wrote to Martha, "[Charley] is still rather dull and confused and takes no interest in his surroundings … He shows considerable mental failure, but is no active trouble on the ward … He is in no condition mentally to carry on outside the hospital." Early in the new year Ryan added, "It is impossible to discuss his past difficulties on account of his poor knowledge of English" and "[h]e … seems quite content and satisfied in his present surroundings, but spends most of his time in bed … He seems pleasant and happy in his surroundings but does not make any effort to talk at all, even with other Indians on the ward and has shown little improvement physically." On the subject of Charley's possible return to his village, Ryan's assertion of March 1942 was typical: "We do not feel that he is in any condition to be outside the hospital at the present time … Should his condition improve … your wishes will certainly be born in mind."

When the Indian agent for Charley's district sought out Ryan later that spring, the latter responded more favourably to this white voice of state authority than he had to Martha, while continuing to stress that strict conditions would necessarily adhere to any contemplated discharge from Essondale. "In reference to the above, he is in bed most of the time. He has an old tubercular condition of the chest which is not very active at the present time, but he is dull, simple and shows considerable mental deterioration … His wife and friends are agitating constantly for his release, and we would be agreeable to his returning if conditions are such that he could be properly supervised, and he would need an escort. It might be advisable to place him in the hospital for a time before returning home." As it turned out, such measures were not needed. The tuberculosis to which Ryan referred entered an acute phase just two months after that exchange. At around 10:30 on a late summer weekday morning, nine months after his admission, Charley Wolverine died, far from his family, on the wards of the Essondale West Lawn Building. The presiding physician called in the Roman Catholic priest and wired the Indian agent to contact the next of kin. Charley's parting psychiatric diagnosis (doubtless influenced by an

Indian Affairs Branch nurse's report that he had suffered "a slight stroke" a month prior to admission) was "arteriosclerotic dementia." Two days later Charley Wolverine at last began his journey home in the hold of the Vancouver–Prince Rupert steamer, encased in an institutional casket bound for burial near the village where he had spent all but nine months of a too-brief life. In one affectingly understated, encapsulating coda, Superintendent Ryan penned a final missive to Martha in mid-September of 1942: "In reply to your letter of the 6th inst., in reference to your late husband, I am enclosing herewith cheque for $6.65 which is in the amount of cash he had on admission to the Hospital, and also a small black purse. Kindly acknowledge receipt of these. I am obtaining a copy of his picture and will forward it to you."

INTERROGATING PUBLIC PSYCHIATRY AND ABORIGINALITY

Charley Wolverine's story is one of thousands of human dramas that populate the pages of the clinical records assembled, over the past 130 years, under the auspices of the British Columbia mental health system. What distinguishes his narrative is that Charley Wolverine was a man of First Nations heritage. His journey from the village of his ancestors to the wards of Essondale therefore extends beyond information about asylum patient life in the province during the World War II era to mine a previously untapped vein of information regarding Indigenous experience in British Columbia. Charley's commitment, hospitalization, and ultimate demise, and the roles of British Columbia's medical and policing communities, the federal Indian agent, and Charley's family in the creation of that experience, raise important questions about the recursive relations of race, ethnicity, Aboriginality, and psychiatry across the province and nation that have not yet been addressed in the literature.

Apart from a few sporadic references and singular "case studies" (such as that of the Canadian Métis leader Louis Riel),[5] the psychiatric historical record is peculiarly silent on the important subject of Aboriginality. We attempt to address that deficiency by exploring the attributes and experiences of a hundred Native patients who entered British Columbia's public mental hospital system under the provisions of the province's Mental Hospitals Act between 1879 and 1950. In doing so, we add to a wealth of patient-centred research that has emerged over the past two decades.[6] At its best, this body of work powerfully depicts the range of human experience that has left its imprint on psychiatric settings, historical and current;

the intrinsically contested and contradictory nature of ideas about, and policies and practices aimed at containing, madness; the complex interplay of power relations that shape encounters between psychiatrized people, medical professionals, community, and state; and above all else, the resolute capacity of human beings to challenge affliction, segregation, and stigma in the face of sometimes unfathomable odds.

Our sample was drawn from the 193 registered Aboriginal clinical files stored in the British Columbia Archives and Riverview East Lawn Records facilities. We selected every second case from a list of cases ordered chronologically (substituting randomly ahead or back for 12 files that were unavailable in the databases or accession groups) and then randomly added three cases to reach our final sample size of 100.[7] The records in each file include a diverse collection of legal documents, personal and family histories, clinical, social service, and psychological reports, ward notes, patient interviews, and correspondence. Together they afford an illuminating historical window into the administration, operations, organizational culture, and daily life of the provincial psychiatric machinery. Even more important, they open a revealing portal into the lived experiences of patients and their families through their own speech and writings, as preserved in the files, and through observations compiled by medical professionals and line staff.

While the files must be recognized as second-order artifacts that are far from mimetic renderings of the human record, and while the earlier files (through to about 1910) are sometimes threadbare, the collection constitutes a rich and compelling archive of hospital life during the late nineteenth and early twentieth centuries.[8] As in jurisdictions elsewhere, these hospital case files have come to offer an absorbing and potent resource for students of madness, psychiatry, and public health history. Read in the context of the sweeping systemic, ideological and human developments against which their lives played out, these patient biographies figure prominently in the exciting new psychiatric histories that have flourished in the wake of the 1980s pioneering work of Dale Peterson and the late Roy Porter[9] and, more recently, of various other writers from around the world.[10]

We base our analysis and discussion in this chapter on our detailed transcriptions of the 100 sample files (totalling 462 single-spaced pages of text), supplemented by other primary documents, including government reports, institutional correspondence, and media clippings. Our analysis layers in the institutional, cultural, and human environments that framed Indigenous patient biographies; considers how ideas about Aboriginality,

pathology, and reason figured into the medico-legal management of "insane" Native people; and illustrates some of the efforts that patients and their advocates made to resist and transcend official imputations of pathology, identity, and race.

INSTITUTIONALIZING NATIVE PEOPLE IN BRITISH COLUMBIA

Understanding the experiences of Charley Wolverine and his Indigenous compatriots in British Columbia's mental health complex requires an appreciation of who these people were and where they came from, as well as of the changing institutional context in which they were held and the broader social relations between Aboriginal and non-Aboriginal people of which their institutional confinement formed a part.

Table 6.1 shows demographic information available to us through the patient files. There were slightly more males than females, with an average age at admission (for those for whom we know it) of thirty-seven years (the range was from eight to eighty-five). The sample was about evenly divided between those categorized as married (38) and as single (37), with smaller numbers widowed, separated, or living common law. While most individuals were childless, the 37 patients who were known to be parents had a total of 119 children among them (or 3.2 per parent patient). Formal education levels were low: most (46) had experienced no formal education; 31 had received a primary level of instruction at most, with at least 13 of these having been sent to residential school.

The deep penetration of European religion and missionary work – as well as European definitions of what practices constituted "religion" – were plainly evident in the files, with most patients identified as Roman Catholic (53) or Church of England (19). Employment records revealed the diversity of Aboriginal labour experience in the province. Of the 96 women, men and children for whom information was available, the largest number (33) were considered to have no employment; job categories for the others included (in decreasing order of frequency) "housewives," fishers, general labourers, hunters and trappers, ranch workers, farmers, domestics, students, band chief, boat builder, cannery worker, and "prostitute."

Among those patients so identified, 82 were status Indians and thus under the jurisdiction of the federal Indian Act, with the consequence that the federal Indian Affairs Department and Branch paid their hospital maintenance fees as wards of the dominion.[11] Another 3 originated in the

Table 6.1 Attributes of selected Aboriginal patients in British Columbia, 1879–1950

	Number	*Percentage*[a]		*Number*	*Percentage*[a]
Gender			Religion		
Male	57	57	Roman Catholic	53	58
Female	43	43	Church of England	19	21
			United Church	8	9
			Methodist	4	4
Marital status			Salvation Army	4	4
Single	38	40	Presbyterian	1	1
Married	37	40	Protestant (unspec'd)	1	1
Widowed	15	16	None	1	1
Separated	3	4			
Common law	2	2			
			Occupation		
			None	33	34
Number of children			Housewife	28	19
None	55	60	Fisher	12	13
1	10	11	Hunter-trapper	7	7
2	6	7	Labourer	8	8
3	6	7	Ranch worker	5	5
4	5	5	Farmer	4	4
5	6	7	Domestic	3	3
6	2	2	Student	2	2
7	1	1	Band chief	1	1
10	1	1	Boat builder	1	1
			Cannery worker	1	1
			Prostitute	1	1
Years of education					
None	46	46			
Primary (1-7 yrs)	31	31	First Nations standing		
No mention[b]	23	23	BC status Indian	82	90
			Yukon transfer patient	3	3
			Enfranchised/ Non-status	6	7

[a] Cases with missing information were excluded from the percentage calculations.
[b] In most of these cases, there was probably no educational background.

Yukon Territory,[12] and 6 were enfranchised (through their acquisition of Canadian citizenship, mixed-blood heritage, or, in the case of some women, via marriage to non-Aboriginals). Map 6.1 shows that these women, men, and children originated from virtually every region of the province (and, in the case of the three Yukon patients, from beyond), spoke many different languages and dialects, and hailed from bands, tribes, localities and nations representing a diverse cultural and geopolitical heritage.[13] By the time period canvassed in this study, few traditional

territories were beyond the reach of medico-legal administration and intervention.

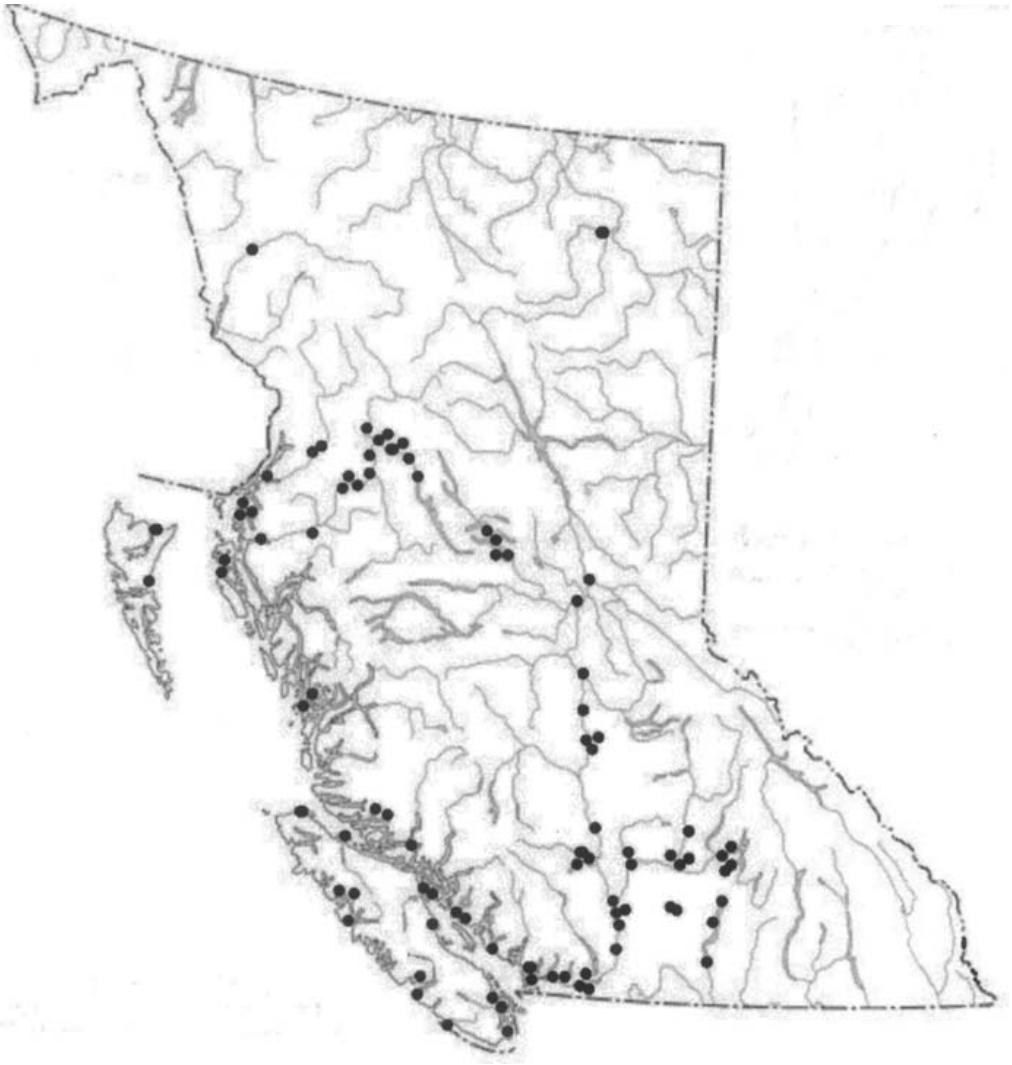
THE INSTITUTIONAL CONTEXT

Compared to its counterparts in central and eastern Canada, the British Columbia mental health system is of relatively recent origin. The province's public asylum operations officially began with the opening in 1872 of the Victoria Lunatic Asylum in traditional Songhees First Nations territory on the north shore of the city's inner harbour.[14] For the next eight decades, institutional psychiatry in British Columbia would parallel other Canadian and international jurisdictions in experiencing an explosion in physical facilities, organizational structures, professional and frontline personnel, and patient populations.

By 1950 the provincial mental health apparatus had become an expansive enterprise. Along with Essondale, it comprised the Provincial Mental Hospital, New Westminster (which opened in 1878 and specialized, from the mid-1930s, in the care of the cognitively disabled); the Colquitz Mental Home, on the fringes of Victoria (with its cohort of "criminally insane" or otherwise "difficult to manage" men); and branch facilities around the province. In their annual report for fiscal year 1949–50, hospital administrators enumerated 4,602 patients in residence, 53 medical staff on payroll, and gross operating costs of $4.8 million per annum.[15] From those first tentative overtures of the Victoria asylum through to mid-twentieth century, a total of 28,100 women, men, and children would pass through the doors of one or more of these psychiatric edifices.[16]

ABORIGINAL/NON-ABORIGINAL RELATIONS

As historians have recounted, the nineteenth century represented an era of profound devastation for the First Peoples of the province. Complex, sophisticated, and diverse societies that had occupied the entirety of the northern Cordillera for at least ten millennia soon faced the intrusive politics, economies, religions, and languages of successive waves of encroaching Europeans. Cultures that were flourishing at first contact and through the early years of the fur trade became increasingly vulnerable, as the century unfolded, to the combined impacts of disease, depopulation, assimilation, dispossession, and poverty. Missionaries covered the territory in an effort to "Christianize" its "heathen" inhabitants and later administered residential schools that allegedly would "modernize" their children.[17] Pan-



Map 6.1 Geographic origins of Aboriginal psychiatric patients in British Columbia

demics of measles, smallpox, tuberculosis, and other infectious diseases unleashed a decades-long reign of misery and death.[18]

As British Columbia's Aboriginal population fell, non-Aboriginals arrived en masse and multiplied: the Native proportion of the provincial population fell from 71 per cent at Confederation to 2.4 per cent in the 1951 census.[19] Colonial and Westernized political, legal, labour, health, education, family, and social institutions further reinforced Aboriginal marginalization and displacement.[20] A fragmented "Indian" reserve system that evolved through the later nineteenth century served, temporarily at least, to "legalize" the expropriation of Aboriginal land; by the early

1900s, First Peoples occupied just one-third of 1 per cent of the province's land mass.[21]

Aboriginal peoples' post-fur-trade experiences with the European colonizers ranged from over-attention and intrusiveness when it came to imposed efforts at assimilation and the criminalization of Aboriginal culture and practices (e.g., required attendance at residential schools; banning of the potlatch) to rejection and neglect (e.g., exclusion of Aboriginals from the commercial fishery; making it illegal for Aboriginal people to hire lawyers to assert land rights). The psychiatric establishment, at least during the years canvassed by our research, appears closer to the latter than the former. Our scouring of the hospital registries[22] located only 193 patients whom medical authorities identified as "Indian" or "Native" on hospital admission between 1879[23] and the end of calendar year 1950. While this figure is almost certainly an underestimate (at least with respect to non-status Indians), based as it is on frequently incomplete information, and on documents and impressions assembled by white male professionals who were often indifferent to Aboriginals' own concepts of identity, the relative dearth of First Peoples in these mental health settings (a scant 0.7 per cent of the total admissions) remains a graphic and consistent pattern throughout the time period.[24]

Of course, "out of sight, out of mind" would have been consistent with other policies of the day. Although the phenomenon of "over-representation" in contemporary times is well known[25] – the imprisonment rate for Aboriginal people far exceeds their representational proportion in the general population – Don McCaskill suggests that this phenomenon is relatively recent: "Perhaps the most serious consequence of the colonial experience in human terms has been the disproportionately large number of native people coming into conflict with the law and their subsequent incarceration in correctional institutions in this country. It is interesting to note that the high incidence of conflicts with the law have occurred only within the last twenty years since native people have begun to extend their participation beyond the boundaries of the reserve and compete within the structures of the dominant society."[26] It is thus important to note that our records date to a time when the reserve system and federal intervention were at their strongest and when, from the 1920s onward, an oppressive system of Indian agent–administered "location tickets" restricted movement, required full-time residential school attendance, and – combined with other exclusionary policies – kept Aboriginal populations in isolated surveillance. The police, medical authorities, and the provincial and federal governments all had mechanisms to remove those who were trouble for

themselves or others. When Aboriginal people did turn up on the hospital rolls, it was often as a regulatory response to social conflict or individual disturbance, more than as a therapeutic measure aimed at dispensing medical treatment to people in need.

THE INSTITUTIONAL EXPERIENCE

Even a surface scanning of the Aboriginal patient files succeeds in evoking the breadth of human endurance, affliction, conflict, and resolution that they collectively harbour. In what follows, we consider the social forces that propelled Aboriginal patients into hospital settings and effected their characterization as "insane," and we examine Native peoples' own recorded understandings of their racial and medical identities, their imputed pathologies, and their relationship to the state's therapeutic and legal order.

Table 6.2 outlines the main categories of patient deployment, official decision-making, and psychiatric labelling that structured the institutional careers of this "insane" Aboriginal cohort. At first glance, the synopsis suggests that the Indigenous patient experience was not entirely different from that of other inmates, as exhibited by Native pathways taken to the asylum, their lives on the hospital wards, and their depictions by legal and medical authorities.[27]

However, a closer examination of these patterns, combined with a qualitative probing of the clinical files, sharply exposes the pervasive and frequently determinative presence of racialized ideas about health and madness. Isaiah Coventry, for example, was a Shuswap Lake area band chief in 1921 who, while characterized as "an Indian of the very best type," had increasingly deteriorated over time and became "careless in his personal appearance." Another patient, Julia Friendly, originally from the upper Fraser Valley, had been widowed when her husband died violently while working for the Canadian Pacific Railway. This "small Indian woman of middle life and an imbecile" was living on relief during the Great Depression in a ramshackle hut on the Burnaby waterfront when municipal authorities, citing her "demented" behaviour and financial burden to the community, mobilized to have her certified.

The records also reveal that Aboriginal people made claims of their own upon medical authorities and were sometimes able to enlist the psychiatric apparatus to serve their purposes. For example, Philip,[28] the very first "Indian" to enter psychiatric facilities in the province, was admitted to the New Westminster Asylum from Yale (at the south end of the Fraser

Table 6.2 Institutional experiences of BC Aboriginal patients[a]

	Number	*Percentage*[a]		*Number*	*Percentage*[a]
Which hospital					
PHI[b]	19	19	Epilepsy	6	6
Essondale	64	64	Paranoia	4	4
PHI/Essondale	16	16	Melancholia/depression	3	3
Essondale / Colquitz	1	1	Chronic brain syndrome	2	2
			Toxic psychosis	1	1
Status on admission					
Certified from community	89	89	Treatment in hospital		
Certified from GIS/BIS[c]	4	4	None stated	68	68
Deported from USA	2	2	Medication for paresis	11	11
Oakalla Gaol transfer	2	2	Sedatives for epilepsy	6	6
NGRI[d]	2	2	ECT	3	3
Certified from Coqualeetza	1	1	ECT psychotropic drugs	2	2
			Malaria for paresis	2	2
Who initiated admission[e]			Psychotropic drugs	2	2
Indian agent/Supt	25	27	Mercury for paresis	1	1
Physician	23	25	Metrazol	1	1
Constable/police	13	14	Dilantin for epilepsy	1	1
Family members	10	11	Anti-Parkinsonism drugs	1	1
Jailer or warden	4	4	Sterilization	1	1
GIS or BIS supt	4	4	Vitamins/penicillin	1	1
Community members	3	3			
Local band nurse	2	2		Yes	No
Band reserve chief	2	2	Reasons for admission[f]		
Priest	1	1	General psychosis	58	42
Indian Dept teacher	1	1	Unmanageable/destructive	18	82
Immigration officials	1	1	Violent	13	87
Provincial Welfare Dept	1	1	Senile dementia	12	88
Division of VD Control	1	1	Wandered off	10	90
Criminal court (NGRI)	1	1	Suicidal/att'd suicide	10	90
			Threatening	8	92
Diagnosis			Mentally "defective"	6	94
Mental deficiency	21	26	Epileptic seizures	5	95
Dementia/schizophrenia	19	20	Killed someone	2	98
Senile/terminal dementia	17	18	Sexual assaults	2	98
Paresis/neurosyphilis	13	14	Escaped from GIS	1	99
Manic depressive	7	8			

[a] Cases with missing information were excluded from the percentage calculations.
[b] Public Hospital for the Insane (formerly the New Westminster Asylum).
[c] Girls' and Boys' Industrial Schools.
[d] Not guilty by reason of insanity.
[e] Who signed admission application (in practice, several people were often involved).
[f] Cases received multiple codings where more than one category applied.

canyon) in February 1879, on the urging of other Aboriginals in the area who, according to the medical certificate, reported that he was "insane and that they are afraid of him."

The social regulatory function of psychiatric commitment is by far the most resounding theme in the historical mental health literature,[29] and that function is evident here in official reactions to Aboriginal persons seen as troublesome, obdurate, wild, abusive, resistive, or otherwise indecipherable. A common thread linking these diverse cases of Aboriginal certification was the perceived unruliness and intractability of Native persons earmarked for psychiatric intervention. At least as pivotal as their mental disturbance – and often the apparent basis for concluding one existed – was the fact that such people were breaching social and racial conventions through their recalcitrant, transgressive, destructive, and generally incomprehensible conduct. For a constellation of reasons, their relations and communities, or the government agents who oversaw their lives, or the educational, health or correctional institutions into which they had gravitated, could no longer manage them in accustomed ways.[30]

The Aboriginal certification process was governed in large part by the ubiquitous presence of state and civil institutions in the lives of these 100 individuals and in the wider management of their villages, bands, tribes, and nations. Again and again, as the statistics in table 6.2 show, it was largely the individual and collective interventions of federal Indian agents, provincial police constables, and medical professionals that marked Native routes to the asylum. These interlocking networks of government and expert scrutiny operated in concert with the activities of missionaries, priests and pastors, nurses, teachers, and, increasingly by the 1930s, social workers practising in the field service of the provincial Welfare Branch.

Sometimes Indian agents would assume the primary responsibility for committal, as with agent W.E. Collison of Prince Rupert, who decided in 1929 that a delusional Winston Murphy had become an imminent risk to his wife and five children and accordingly secured the Tsimshian fisher's removal to Essondale, where he contracted tuberculosis and died two years later. On other occasions, medical practitioners took the lead. Three years prior to Winston Murphy's hospitalization and in a village located farther down the province's mainland coast, a physician on the regional hospital staff took it upon himself to contact Essondale medical superintendent H.C. Steeves about one of his patients, eighteen-year-old Johnson Longstreet, who reportedly "has struck his father a couple of times and has the family pretty well scared." Receiving the needed documents by return mail, the medical man coordinated Longstreet's certification to the Coquitlam hospital, where he would spend the next thirty-eight years until he finally died from pulmonary edema in the mid-1960s.

Tallulah Bill was a transfer patient from the Coqualeetza Indian Hospital who had been working with her husband and five children in the hops

harvest near Agassiz. It was the Coqualeetza medical staff who in the early fall of 1943 certified Tallulah. They first admitted her to the Sardis institution in the throes of an apparent acute psychotic episode, and then – describing her as "[m]uttering in her Indian language ... running around the ward in the nude [and] fighting to get out of her bed" while in hospital – arranged for her relocation down the Fraser valley to Essondale. Tallulah too died there, four years later, having contracted a particularly gruesome strain of tuberculosis of the bone.

Beyond the grim prospects of displacement, illness, and death, life on the wards of Essondale and, earlier, the New Westminster Public Hospital for the Insane (PHI), must have been a profoundly alienating cultural experience for these Aboriginal patients. Once committed, an individual often would discover that she or he was the only Native person on the floor or, at times, in the entire institution. Unilingual patients frequently had no one with whom to carry on a simple conversation, no translators who might mediate their encounters with hospital staff, and until the latter half of the twentieth century, no cultural resources available to connect them with the Aboriginal world beyond the asylum walls.

British Columbia is the province with the greatest diversity in its Aboriginal peoples: one-third of Canada's First Nations are in the province, and five of the country's eleven Aboriginal language systems are indigenous to British Columbia. Even if another Aboriginal patient was in the institution, the two might not speak the same language, particularly in the early years of the residential schools, before English became the common provincial language. This fact only highlights the racism and ignorance of Aboriginal diversity embodied in Superintendent Ryan's letter regarding Charley Wolverine, in which he noted that Charley "does not make any effort to talk at all, even with other Indians on the ward."

Opportunities for labour, especially among women, who were generally denied outdoor work, were limited and banal. As noted in table 6.2 above, the majority of Indigenous patients (68 of 100) received absolutely no form of psychiatric treatment during an era when mental hospitalization could be described at its best as a benevolent warehousing and at its worst as an alternative form of imprisonment. It was not insignificant that police and medical authorities played cooperative roles in the institutionalization of Charley Wolverine, with whose story we opened this chapter; nor was that a rare event. As Edward Staples's Dakelh father commented in a handwritten note in 1951: "Edward he has nothing going and Police send him out. You know your self, all u know he joke too much and when he work – he always doing good ... Let me know why you hold him so long. I think Police was mistake."

Isolated, impoverished, far distant, and frequently illiterate in English, relations could usually ill afford the train or steamer passage needed to visit the hospital and were forced to enlist others who could draft or transcribe correspondence to patients on their behalf. For the latter, failing a fortuitous recovery or some other timely intervention, hospital life soon devolved into a lonely, grinding, monotonic repetition of gloomy institutional routine – and for too many, a slow decline toward death.

Compounding the tribulations of Native patients were the racializing thoughts, words and deeds of some mental hospital staff. In 1924 the attending PHI physician described eighteen-year-old Sliammon youth Wilbert Roper as being of "very low mental gauge," declaring that it was "very difficult to elicit anything from him, except the occasional grunt, typical of his race." Similarly, upon administering an intelligence test in the early 1940s, the resident Essondale psychometrist observed of Pauline Boone that "she does not show much interest and makes no effort to respond, remarks in Indian fashion 'I don't know.'" Corresponding with a Department of Indian Affairs official during the winter of 1926, Essondale medical superintendent H.C. Steeves wrote of Lucy David, a "dementia praecox case" from the Yukon who would be dead four months later of nephritis, that "she takes no interest in her appearance whatever as is customary with the persuasion to which she belongs." Ten years later, Secwepemc patient Randall Winfree gained a rather more favourable appraisal from his ward physician, who allowed that "for an Indian" he had "not too bad a mentality."

According to some staff reports – for example, a psychometrist's 1950 evaluation of Peace River Slavey (Dene-thah) trapper Donald Napier – a "deficient" Native mind state might not prove to be as detrimental to rehabilitation as for whites, as perhaps "detailed knowledge of the patient's environmental situation would reveal that its demands are not great … [and] … his intellectual status would not render him inadequate to cope with simple requirements of everyday living."

In other instances, a demonstration of willingness to assimilate could become an indicator of recovery and a passport to liberty, as with Edna Paul, another Aboriginal woman from the Yukon, who won her release in the summer of 1955 after seven years spent on the Essondale East Lawn wards. On her discharge, the physician in charge reported authoritatively: "It is interesting to note that when the patient was severely ill she could not speak English and in spite of being in an English environment she did not learn even a few simple words, but during the last 3 or 4 months she started to show good progress and … at the same time developed a need to learn the language and in the last few weeks she could express herself

quite relevantly in short sentences. She was therefore discharged … to the care of [the] Indian Commissioner for BC."

That said, the medico-legal powers circulating through British Columbia's therapeutic confines were not unitary, totalizing, or unchallenged. As illustrated by Martha Wolverine's letters, which began this chapter, conflict over the inherent meanings of mental disorder and what to do about it infused these historical clinical files. Aboriginals and whites often harboured very disparate conceptions of what constituted insane and normal.[32] It is clear from the medical files we reviewed that, consistent with Loo's discussion of Indigenous invocations of legal discourse, doctrine, and subjecthood in late nineteenth- and early twentieth-century British Columbia, Aboriginal people often assertively challenged state medical apparatus inertia, as, for example, did the brothers of Catherine Jamieson and Andrew Napoleon. Both steadfastly rebuffed medical requests that they add their signatures to treatment permission forms, the latter brother asserting: "I'm sorry can't sign this paper you sent unless we find out what is wrong with Andrew. If you'd explain in an easier way that we can understand … I will sign the paper."

While the racial hierarchies of governing institutions remained firmly in place throughout the period, and while these recurring life tragedies showed that individual resistance was often futile, one need scarcely be a devout Foucauldian to acknowledge the formidable potential for Aboriginal identity to assert itself through power struggles with white medico-legal authority.

As was true of asylum inmates more generally,[32] Aboriginal patient resistance was everywhere in evidence. It took many forms. Some patients refused to eat, to work, to communicate with professionals and attendants, or to conform to the daily hospital routine. A few people lashed out at others,[33] and three women undertook nine suicide attempts (one successfully, as chronicled below). Others endeavoured to recruit allies from outside the hospital – for example, the earlier-mentioned Edward Staples, who during the early 1950s tried to solicit help in his release from Canadian Legion officials and from his Indian agent.[34]

Eleven of 100 patients effected a total of 41 escapes from Essondale and the PHI. Jack Calhoun, originating from the Skeena River district, ran off four times between his transfer to the PHI from Oakalla Prison in 1915 (where he was awaiting trial for breaking and entering) and his death in 1925 from tuberculosis. Wilbert Roper's death from the same disease was no doubt hastened by a broken back suffered when the Sliammon youth removed a pane of glass and leapt some thirty feet from a dormitory bath-

room window in a failed effort to take flight. His father had complained bitterly to his Indian agent that Wilbert was being abused in hospital and had endeavoured at one point personally to spirit his son via motor launch away from hospital. In another exploit prior to their TB-induced deaths in 1944, Lydia Tom and Pauline Boone bolted from a women patients' spring "walking party," rowed down the Fraser River, hitched a ride from Steveston to Vancouver, and "entertained several men" during a week of partying in a downtown hotel room before authorities caught up with them.

Especially affecting were the interventions of relations, community members, and other advocates who peppered Essondale and PHI physicians from all regions of the province with their inquiries, supplications, and importuning. The loss of their institutionalized parents, spouses, siblings, and children could have a devastating impact on Aboriginal families who were already grappling with a liminal existence at the margins of a growingly prevalent and imposing Eurocentric social order. For example, through the late 1920s and into the following decades, we encounter countless dispatches from the family of long-term patient Johnson Longstreet; his father wrote in early 1927 that Johnson's "mother cannot eat and some times when she thinking for Johnson because he is only one boy we get," and his mother added five months later, "I got a baby boy [in] march and he die on last week I am very sorry."

Notwithstanding vast distances, barriers of language, and the imperviousness of white authority, correspondents could show extraordinary eloquence and fortitude in their myriad efforts to secure information about their relatives' welfare in hospital and better the circumstances of their detention. As Olive Kirk's sister pleaded to doctors in a 1950 missive, "I don't think she needs to be there much longer. I need her very desperately here. I will also take good care of her … The children miss her very much … I will do anything if you'd let her come home."

And finally, the bonds of kinship survive even the institutional deaths of departed members: Timothy Fergus's family, although utterly destitute, expended borrowed funds on a box and coffin, which they freighted to Essondale from their Vancouver Island village in 1937, along with instructions (conveyed by the local Indian agent) that physicians "have the body shipped home with as little expense as possible," and Jennie Flinders's mother, on learning of the young Gitxsan woman's death from TB in the early fall of 1950, forwarded one last list of appeals: "We sure want her clothes all of them and her picture which we've told you to take and develop and we'll now be expecting it in a few days. We want her picture which they took on her burial day. We want to ask you whether there

something wrong in her brain or her head, some day we'll go down there and see her grave yards perhaps October. We'll be expect your welcome answers."[35]

CONCLUSIONS

As this initial, fleeting glance at the world of British Columbia's Aboriginal psychiatric patients draws to a close, we outline the manifold ways in which these assembled institutional and human narratives variously ended, and we offer a final reflection on the enduring meanings of these turbulent lives, both within the times and spaces they collectively inhabited, and for the present.

Table 6.3 summarizes details of the outcomes of these Native people's asylum encounters. First, and arguably the most lacerating finding of this entire study, was the discovery that, for the majority of Aboriginal people who entered the British Columbia mental health system, their committal was effectively a sentence of death. Of the 97 individuals whose fate we know, 62 died on the wards and infirmaries of Essondale and the PHI. Only 35 left hospital alive: 20 of these were released on "probation,"[36] 5 were discharged in full, 5 escaped, 3 received "special probation,"[37] and 2 gained transfer to a home for the aged. Physicians characterized only 9 of these discharged patients as "recovered" and another 16 as "improved."

Among those who died, nearly half (26 in all)[38] yielded to the ravages of tuberculosis. In all, 36 of the 100 Aboriginal inmates contracted this infectious and lethal bacillus either before or during their hospital confinement.[39] The average age of demise for the 65 patients whose death record appeared on file was forty-seven years (one child expired at age eight, and 16 people failed to reach age thirty). Their appallingly high mortality rate no doubt contributed to the Aboriginal patients' relatively brief average length of hospitalization (four years and seven months), although 9 people were institutionalized for more than ten consecutive years, and one man remained on the wards one year short of four decades. And for 6 of the 35 patients who survived the asylum, there would be further involvement with the state psychiatric enterprise.

In the final analysis, about a third of the Aboriginal patients succeeded, at least temporarily and to a partial degree, in breaking free of the gravitational forces that the British Columbia mental health apparatus exerted over them. These included Sarah Loveless, a married Nisga'a woman diagnosed with "melancholia" (following a suicide attempt by hanging), who won her probation in the fall of 1912 on the strength of interventions by

Table 6.3 Outcomes of Aboriginal psychiatric encounters[a]

	Number	*Percentage*[a]		*Number*	*Percentage*[a]
Status on discharge			Age of death[d]		
Deceased	62	64	LT 10	1	2
Probation	20	21	10–19	2	3
Discharge in full	5	5	20–29	13	20
Escape	5	5	30–39	5	8
Special probation[b]	3	3	40–49	16	25
Home for the aged	2	2	50–59	7	11
			60–69	13	20
			70–79	5	8
Condition on discharge			80–89	3	5
Deceased	62	65			
Improved	16	17			
Recovered	9	9	Length of hospitalization[e]		
Unimproved	8	8	LT 1 mth	6	6
			GE 1 mth, LT 6 mths	19	19
			GE 6 mths, LT 1 yr	11	11
Cause of death[c]			GE 1 yr, LT 2 yrs	17	17
Tuberculosis	26	43	GT 2 yrs, LT 5 yrs	23	23
Bronchopneumonia	9	15	GT 5 yrs, LT 10 yrs	13	13
Exhaustion: senile dementia	5	8	GT 10 yrs, LT 20 yrs	2	2
Chronic Heart failure	4	7	GT 30 yrs, LT 40 yrs	5	5
Cerebral hemorrhage	3	5			
Pulmonary edema	2	3			
Nephritis (kidneys)	2	3	Subsequent admissions		
Exhaustion: schizophrenia	1	2	None mentioned	94	94
Exhaustion: epilepsy	1	2	One	3	3
Bright's disease	1	2	Two	2	2
Suicide by hanging	1	2	Seventeen	1	1

[a] Cases with missing information were excluded from the percentage calculations.

[b] Under the BC Mental Hospitals Act, these cases received a six-month probationary leave from hospital into the care of a relative or other guardian, against the advice of physicians.

[c] Thirty-six patients did not die in hospital; in one case of death the cause was unspecified; and the institutional fate of two people is unknown.

[d] Mean age at death = 46.6 years (range = 8–86). Included are 8 patients with medical indications of "approximate" ages.

[e] Mean length of hospitalization = 4 years and 7 months (range = 3 days to 38 years, 11 months and 2 days).

the local Indian agent and Anglican archdeacon; Zelda Braithwaite, a sixty-five-year-old woman from the northern mainland coast suffering from "senile dementia," whose children secured her release in early 1923 after just two months in the Public Hospital for the Insane; the irrepressible Randall Winfree, who walked away from Essondale several times before an exasperated medical staff discharged him "on escape" in late 1944; and

Sam Ketchum, Kamloops-born and a long-time fixture on the Essondale and Riverview Hospital[40] chronic wards, whose thirty-nine–year institutional history of multiple diagnoses, somatic "treatments," and abortive escapes finally came full circle when he vanished for good one week prior to Christmas in 1979.

As these statistics show, however, far more emblematic were those women, men, and children who, once institutionalized, never left the hospital wards alive. Their numbers included Mabel, a blind, elderly Vancouver Island Kwakiutl (Kwakwaka'wakw) woman showing the terrible, advancing effects of chronic tertiary syphilis, who survived detention at the PHI for scarcely five months in 1900 before succumbing to a cerebral hemorrhage in early July. There was also eleven-year-old Len Moon, a "mentally deficient" boy from the Nicola valley, certified for recurrently wandering off his reserve, who died from tuberculosis in midsummer 1922 after barely a year of confinement, and who received an institutional burial despite his impoverished mother's pleas to have his body sent back home. Hugh Tugwell, of the Secwepemc nation, passed away at Essondale of chronic pulmonary edema in late spring of 1962 after a thirty-seven-year career in the provincial hospital system, a career initially prompted by his recurrent epileptic seizures and general unmanageability as a Boys' Industrial School inmate, and which featured a thirty-four-year consecutive stretch of incarceration in the prison-like milieu of the Colquitz Mental Home.

Vancouver-born Agnes Reid died at her own hand. Her twenty-one-year life in many ways epitomized the Aboriginal experience with Canadian and provincial state institutions, as she graduated successively from four years of residential school in the province's interior, to the Girls' Industrial School in the Lower Mainland, to the secure wards of Essondale a few kilometres distant. Described by one hospital physician as "the most dangerous patient we had in the hospital," Agnes was in her eighth year of psychiatric detention in the late fall of 1951 when, alone at night in the locked side-room of the "J" ward for recalcitrant patients in the East Lawn (Chronic Women's) Building, she managed to slip out of the straitjacket in which the staff had encased her. Slightly after 11:00 pm, nurses found Agnes Reid hanging lifeless from the window screening, with the five-foot-long straitjacket cord and a strip torn from her nightgown taut around her neck. Her final note, scrawled with a pencil on the cell wall in total darkness, read in part: "hope you all be happy now I've made up my mind … love to you … now that it is done … can't see but [h]ope you can read it."

In a subsequent coroner's inquest, the jurors determined that "no blame [is] to be attached to anyone on this Institution."

So absolved, the medical authorities closed the books on Agnes Reid's case and bundled her terminated file, the accumulated digest of a broken life, off to the Essondale clinical records stackroom. The documents languished there (almost certainly unread) for nearly half a century until their transfer across the Strait of Georgia to the provincial archives in Victoria. But after all these years, we now find ourselves in the unforeseen (and daunting) position of being able to ponder the relevancies of Agnes Reid's melancholy life journey – and that of the similarly fated pathways taken by Hugh Tugwell and little Len Moon and Mabel (whose Aboriginal name, and English surname, we will probably never know) and, of course, the ill-fated Charley Wolverine, with whose story this chapter began.

These accumulated human and institutional narratives, to be sure, register at myriad levels, and they invite alternative ethical readings and historical interpretations. Without question, the files chronicle with disconcerting frequency examples of lives ruined, power abused, professional arrogance, and racial intolerance inscribed into the very foundations of our public health institutions. Yet these 100 accounts of affliction, segregation, and death are also vivid reminders that madness is a complex and contested cultural phenomenon, and its impact is never preordained. In this sense, the documents speak volumes as much about the limitations as about the effects of state and psychiatric power. They show that historical actors are capable of resisting, and sometimes even transcending, the "insanity" and death that surround them on every side. If the remarkable stories of Charley Wolverine, Agnes Reid, and their many Aboriginal counterparts in the British Columbia asylum system can tell us anything, it is that the miracle of human identity can survive even the darkest of institutional spaces and the corrosive passage of time. With Indigenous people and all others, this is the key historical lesson – and the abiding moral implication – of "patient-centred" research on psychiatry, sanity, and madness.

NOTES

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1 We pseudonymize patient names throughout the chapter, and we alter or generalize locations and other potentially identifying details wherever needed to safeguard confidentiality.

2 The original BC Insane Asylums Act of 1873 (36 Vict., no. 28, amended 1893) was the principal mental health law in the province until the enactment of the 1897 Hospitals for the Insane Act (61 Vict., c.101). Retitled the Mental Hospitals Act in 1912, the legislation remained in place (with revisions in 1940, including the establishment of appeal boards) until the Mental Health Act came into force in 1964.

3 All direct quotations, if not otherwise referenced, derive from the patient clinical files.

4 We retain without comment all original spelling, grammatical, and other errors from the patient file documents.

5 Thomas Flanagan, *Louis Riel* (Ottawa: Canadian Historical Association, 1992); George R.D. Goulet, *The Trial of Louis Riel: Justice and Mercy Denied: A Critical, Legal and Political Analysis* (Calgary: Tellwell, 1999).

6 Thomas E. Brown, "'Living with God's Afflicted': A History of the Provincial Lunatic Asylum at Toronto, 1830–1911" (PhD thesis, Queen's University, 1980); Dorothy E. Chunn and Robert Menzies, "Out of Mind, Out of Law: The Regulation of 'Criminally Insane' Women inside British Columbia's Public Mental Hospitals, 1888–1973," *Canadian Journal of Women and the Law* 10 (1998): 1–32; Megan J. Davies, "The Patient's World: British Columbia's Mental Health Facilities, 1920–1935" (MA thesis, University of Waterloo 1987); Mary-Ellen Kelm, "Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905–1915," *Journal of Family History* 19 (1994): 177–93; James E. Moran, *Committed to the Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal and Kingston: McGill-Queen's University Press, 2000); Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto*

Hospital for the Insane, 1870–1940 (Toronto: Oxford University Press, 2000); Cheryl Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883–1923* (Montreal and Kingston: McGill-Queen's University Press, 1989).

7 Of these 100 files, 97 were available in the British Columbia Archives (44 in the GR 2880 collection, "British Columbia, Mental Health Services, Originals, 1872–1942," and 53 in the 93-5683 accessions group, "Riverview Hospital Client Clinical Files, 1946–1969"). The remaining 3 files, all closed during the 1970s, are under the auspices of the Riverview East Lawn Clinical Records Service and are held at the Iron Mountain storage facility.

8 The canonical source on historical case file research is Franca Iacovetta and Wendy Mitchinson, eds., *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998).

9 Dale Peterson, *A Mad People's History of Madness* (Pittsburgh: University of Pittsburgh Press, 1982); Roy Porter, *A Social History of Madness* (New York: E.P. Dutton, 1989).

10 See, among many others, Jonathan Andrews and Anne Digby, eds., *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the Historiography of British and Irish Psychiatry* (Amsterdam: Rodopi, 2002); Ellen Dwyer, *Homes for the Mad: Life inside Two Nineteenth-Century Asylums* (New Brunswick, NJ: Rutgers University Press, 1987); Jeffrey L. Geller and Maxine Harris, eds., *Women of the Asylum: Voices from Behind the Walls, 1840–1945* (New York: Anchor Doubleday, 1994); Bronwyn Labrum, "Looking beyond the Asylum: Gender and the Process of Committal in Auckland, 1870–1910," *New Zealand Journal of History* 26, 2 (1992): 125–45; and Yannick Ripa, *Women and Madness: The Incarceration of Women in Nineteenth-Century France* (Minneapolis: University of Minnesota Press, 1990).

11 The fees, amounting to $1.00 daily per patient, rose to $1.35 in the mid-1930s. See British Columbia Archives, GR 542, box 23, file 8, H.W. McGill, deputy superintendent general of Indian Affairs, Dominion of Canada, to H.M. Cassidy, director of social welfare, Province of British Columbia, 24 November 1936.

12 In 1899 the British Columbia and dominion governments struck an agreement for the transfer at federal expense of Yukon psychiatric patients (both Aboriginal and non-Aboriginal) to the Provincial Hospital for the Insane. See British Columbia Archives, GR 2880, box 7, file 953.

13 We use contemporary names and spellings of Aboriginal bands and nations and include original names where needed for purposes of comparison. A comprehensive listing of current First Nations in British Columbia is available from the Union of BC Indian Chiefs Web site at <http://www.ubcic.bc.ca>. See also Robert J. Muckle,

The First Nations of British Columbia (Vancouver: University of British Columbia Press, 1998).

14 Gerry Ferguson, "Control of the Insane in British Columbia, 1849–78,"in John McLaren, Robert Menzies, and Dorothy E. Chunn, eds., *Regulating Lives: Historical Essays on the State, Society, the Individual and the Law* (Vancouver: University of British Columbia Press, 2002), 63–96.

15 "Annual Report for Twelve Months Ended March 31st, 1950." Mental Health Services, Province of British Columbia. Department of Provincial Secretary, BC *Sessional Papers*, 1951 9: 10, 15, 72 (Victoria: Queen's Printer, 1951).

16 For general accounts of the British Columbia psychiatric hospital system and its patients, see Davies, "The Patients' World"; Kelm, "Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905–1915"; Robert Menzies, "'I Do Not Care for a Lunatic's Role': Modes of Regulation and Resistance inside the Colquitz Mental Home, British Columbia, 1919–33," *Canadian Bulletin of Medical History* 16 (1999): 181–213; Robert Menzies and Dorothy E. Chunn, "The Gender Politics of Criminal Insanity: 'Order-in-Council' Women in British Columbia, 1888–1950," *Histoire sociale/Social History* 31 (1999): 241–79.

17 Brett Christophers, *Positioning the Missionary: John Booth Good and the Confluence of Cultures in Nineteenth-Century British Columbia* (Vancouver: University of British Columbia Press, 1998); Elizabeth Furniss, *Victims of Benevolence: Discipline and Death at the Williams Lake Indian Residential School, 1891–1920* (Williams Lake: Cariboo Tribal Council, 1992); J.R. Miller, *Shingwauk's Vision: A History of Native Residential Schools* (Toronto: University of Toronto Press, 1996); John S. Milloy, *A National Crime: The Canadian Government and the Residential School System, 1879–1986* (Winnipeg: University of Manitoba Press, 1999); Peter Murray, *The Devil and Mr. Duncan* (Victoria: Sono Nis Press, 1985).

18 Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–50* (Vancouver: University of British Columbia Press, 1998). See also Robert Boyd, *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population Decline among Northwest Coast Indians, 1774–1874* (Vancouver: University of British Columbia Press 1999); Robert M. Galois, "Measles, 1847–1850: The First Modern Epidemic in British Columbia," *BC Studies* 109 (1996): 31–43.

19 See Jean Barman, *The West beyond the West: A History of British Columbia*, 2nd Ed. (Toronto: University of Toronto Press, 1996), 363.

20 Among other British Columbia sources, see Jean Barman, "Taming Aboriginal Sexuality: Gender, Power, and Race in British Columbia, 1850–1900," *BC Studies* 115/116 (1997–98): 237–66; Douglas Cole and Ira Chaikin, *An Iron Hand upon*

the People: The Law against the Potlatch on the Northwest Coast (Vancouver: Douglas & McIntyre, 1990); Robin Fisher, *Contact and Conflict: Indian-European Relations in British Columbia, 1774–1890* (Vancouver: University of British Columbia Press, 1977); Douglas Harris, *Fish, Law, and Colonialism: The Legal Capture of the Aboriginal Fishery in British Columbia* (Toronto: University of Toronto Press, 2001); Rolf Knight, *Indians at Work: An Informal History of Native Indian Labour in British Columbia, 1858–1930* (Vancouver: New Star Books, 1978); John Lutz, "After the Fur Trade: The Aboriginal Labouring Class of British Columbia, 1849–1890," *Journal of the Canadian Historical Association*, n.s. 2 (1992): 69–94; Paul Tennant, *Aboriginal Peoples and Politics: The Indian Land Question in British Columbia, 1849–1989* (Vancouver: University of British Columbia Press, 1990); *Tina Loo, Making Law, Order, and Authority in British Columbia, 1821–1871* (Toronto: University of Toronto Press, 1994).

21 Cole Harris, *Making Native Space: Colonialism, Resistance, and Reserves in British Columbia* (Vancouver: University of British Columbia Press, 2002).

22 British Columbia Archives, GR 1754, boxes 1–2, vols. 1–6, "Provincial Mental Hospital, Essondale, Originals. Admission Books 1872–1947"; and GR 3019, box 89-941-1, vol. 1, "Riverview Hospital, Originals, 1934–1971. Admission Book 1947–51."

23 Evidently, no Aboriginal person spent time at the Victoria Lunatic Asylum during its brief existence as the province's first psychiatric establishment between 1872 and 1878.

24 Overall hospital patient admissions, Aboriginal admissions, and study sample numbers by decade were as follows (the statistics in the first two columns derive from the Mental Health Services 1951 annual report (see note 15 above):

Years	*Total general admissions*	*Total aboriginal admissions*	*Study sample*
1872–79	144	1	1
1880–89	205	2	1
1890–99	659	3	2
1900–09	1,559	7	3
1910–19	3,774	25	13
1920–29	4,963	39	22
1930–39	6,264	46	24
1940–49	9,117	59	29
1950–	1,415	11	5

25 Ross Gordon Green, *Justice in Aboriginal Communities: Sentencing Alternatives* (Saskatoon: Purich, 1998); Kayleen M. Hazlehurst, ed., *Legal Pluralism and the Colonial Legacy: Indigenous Experiences of Justice in Canada, Australia, and*

New Zealand (Brookfield VT: Aldershot, 1995); Marianne O. Nielsen and Robert A. Silverman, eds., *Native Americans, Crime, and Justice* (Boulder: Westview Press, 1996); *Royal Commission on Aboriginal Peoples*, *Aboriginal Peoples and the Justice System: Report of the National Round Table on Aboriginal Justice Issues* (Ottawa: Royal Commission on Aboriginal Peoples, 1993).

26 Don McCaskill, "Native People and the Justice System," in Ian A.L. Getty and Antoine S. Lussier, eds., *As Long as the Sun Shines and Water Flows: A Reader in Canadian Native Studies* (Vancouver: University of British Columbia Press, 1983), 288–98.

27 Summaries of BC patient attributes are available in Davies, "The Patients' World"; Mary-Ellen Kelm, "Women and Families in the Asylum Practice of Charles Edward Doherty at the Provincial Hospital for the Insane, 1905–1915" (MA thesis, Department of History, Simon Fraser University); Robert Menzies, "Historical Profiles of Criminal Insanity," *International Journal of Law and Psychiatry* 25 (2002): 379–404; Menzies, "'I Do Not Care for a Lunatic's Role.'" See also the annual reports of the provincial asylums and mental hospitals, published from Confederation onward in the BC *Sessional Papers* (see note 15 above).

28 Philip, like many BC Aboriginal people of the era, had an English given name, but no known surname.

29 See notes 6, 9, 10, and 16 above.

30 Frantz Fanon observes how, for racialized peoples, the personal experience of madness is intertwined with the historical processes of colonialism. "A normal Negro child," Fanon writes in *Black Skins, White Masks* (New York: Grove, 1967 [1952], 147), "having grown up within a normal family, will become abnormal on the slightest contact with the white world." Our thanks to Renisa Mawani for bringing this quotation to our attention.

31 On general Aboriginal understandings of health and illness, see Kelm, *Colonizing Bodies*. For a recent account of ideas about insanity and violence among the Tununirmiut of North Baffin Island during the early twentieth century, see Shelagh D. Grant, *Arctic Justice: On Trial for Murder, Pond Inlet, 1923* (Montreal and Kingston: McGill-Queen's University Press, 2002).

32 Mark Finnane, "Asylums, Families and the State," *History Workshop Journal* 20 (1985): 134–48; Kelm, "Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905–1915"; Labrum, "Looking beyond the Asylum"; Patricia E. Prestwich, "Family Strategies and Medical Power: 'Voluntary' Committal in a Parisian Asylum, 1876–1914," *Journal of Social History* 27 (1994): 799–818; Reaume, *Remembrance of Patients Past*.

33 The ward progress notes and incident reports describe 9 of the 100 Aboriginal patients as having committed some act of violence while in hospital. Four people recorded one assault each. Two committed two assaults apiece, and 3 were

involved in "several" or "many" incidents (not all of which physicians deemed worthy of documenting).

34 The agent described Edward Staples's letter as being "quite intelligent for a patient of a Mental Hospital."

35 Medical Superintendent Ryan's reply, addressed not to Mrs Flinders but to her husband, read as follows: "In reference to your late daughter, she had no clothes except a coat which was forwarded to you at the time of her death. In reference to the picture there are no pictures as your letter arrived too late for pictures to be taken of the coffin. It was suggested that a picture of the grave be taken later as at the present time it would simply show a mound."

36 Most involuntarily certified people released from Essondale or the Public Hospital for the Insane were granted six-month periods of "probation" in the community under s. 21 of the provincial Mental Hospitals Act. On the successful completion of the probationary term, a patient would typically receive a discharge in full, and hospital administrators would close her or his file. Authorities could revoke probation and recommit the patient in the event of mental relapse or other apprehended problem.

37 Under the Mental Hospitals Act, ss. 33 and 36, hospital physicians were empowered to grant six-month terms of "special probation" to patients when the latter were discharged against medical advice (usually on the insistence of family members).

38 Of the others, 9 were victims of pneumonia, while 6 died from the effects of advanced syphilis (paresis), 5 died of "exhaustion of senile dementia," 4 of chronic cardiac failure, 3 of stroke or hemorrhage, 2 each of kidney failure and edema of the lung, and 1 each of exhaustion of schizophrenia, exhaustion of epilepsy, Bright's disease, and suicide by hanging.

39 See note 18 above.

40 With the passage of a revised BC *Mental Health Act* in 1964, the Provincial Mental Hospital, Essondale, became Riverview Hospital. See generally Ministry of Health and Ministry Responsible for Seniors, Province of British Columbia, "Guide to the Mental Health Act," 15 November 1999, <https://www.healthservices.gov.bc.ca/mhd/pdf/MentalHealthGuide.pdf>.