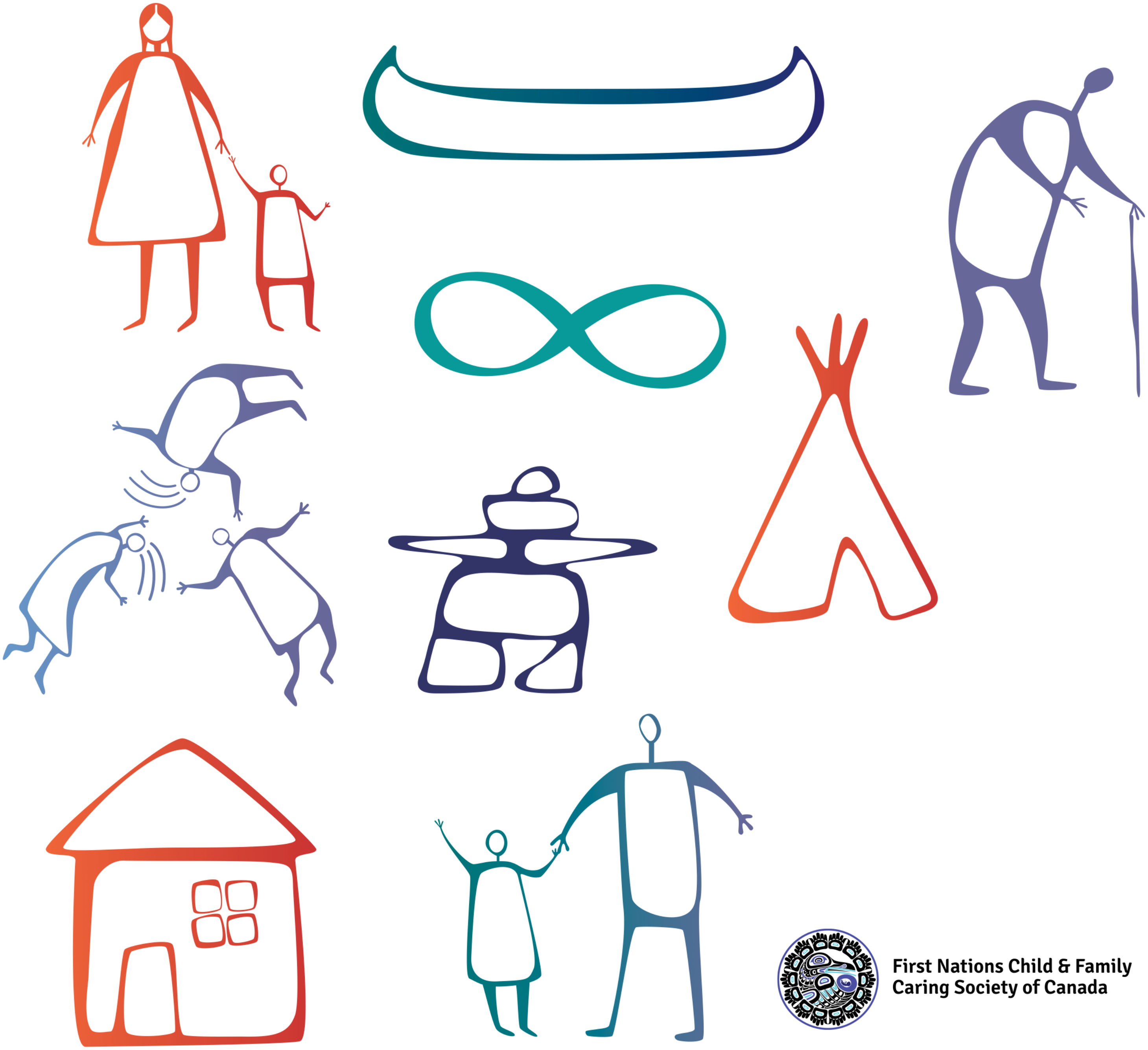
First Peoples Child & Family Review

An Interdisciplinary Journal

Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

2018
volume 13
number 1



First Nations Child & Family Caring Society of Canada

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal *Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*

Contents

First Nations Child & Family Caring Society of Canada

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal

Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Foreword

Marc St. Dennis[1]

[1] Coordinating Editor of *First Peoples Child & Family Review*, First Nations Child & Family Caring Society of Canada, Ottawa, Ontario, Canada

Contact: mstdennis@fncaringsociety.com

Dear readers,

It is my great pleasure to present volume 13(1) of the *First Peoples Child & Family Review*, which includes 7 brilliant published submissions from researchers and community experts. Thank you to all of the authors for sharing their knowledge, experiences, and stories, and to the peer referees for their thoughtful feedback. For those that were not selected for publication in this issue, we honour your hard work and look forward to your ongoing participation in the *First Peoples Child & Family Review* community.

Knowledge is shared throughout all of the life stages; therefore the editorial team and I are thrilled that the authors in this issue represent a balance of youth and adults voices. The *First Peoples Child & Family Review* is honoured to provide a platform for these diverse voices to be heard, all contributing to a respectful dialogue of social justice and cooperation to ensure a better world for Indigenous and non-Indigenous children, youth, and their families.

Readers will be delighted to see three poems showcasing dreams for a better future for Indigenous and non-Indigenous people. This issue also includes a speech calling on Canadians to stop ignoring the real problems that many Indigenous families encounter on a day-to-day basis and to start acting for meaningful change. In addition, we are pleased to publish an essay on bridging the digital divide, a literature review on Indigenous adults with Fetal Alcohol Spectrum Disorder, and a summary of an evaluation conducted about an innovative program entitled Live in Family Enhancement.

Hayley Harder's slam poem, *Life as a clock,* is a haunting reflection on 150-plus years of missing and murdered Indigenous women and girls in Canada. Harder questions the status quo and challenges readers to stand up for meaningful change. Time pushes us forward but it is up to us to choose a better path.

Melanie Samaroden's literature review entitled *Challenges and resiliency in Aboriginal adults with Fetal Alcohol Spectrum Disorder* starts with the observation that Fetal Alcohol Spectrum Disorder (FASD) is a lifelong ailment. However, there is very little research that is specific to supporting Indigenous *adults* with FASD (whereas there is abundant research and interventions for Indigenous *children* with FASD). Samaroden reviews the available literature and highlights opportunities for respectful and inclusive research that could empower Indigenous adults with FASD.

Fair, by Hamza Hussain and Yuktha Kowlessur, and *Give children all rights*, by Aliya Garasia, are two short poems that highlight the inequitable nature of Canada's two-tiered education system, where Indigenous children often receive far less than non-Indigenous children. Inspired by Shannen Koostachin, the authors of these two poems want nothing less than safe and comfy schools and culturally appropriate education for all children in Canada.

For those of us who live in urban centres, it may seem like computer technology and telecommunication options are abundant and easily accessible. Katalina Toth, Daisy Smith, and Daphne Giroux – authors of *Indigenous peoples and empowerment via technology* – remind us that the technology many take for granted is often neither available nor accessible to Indigenous communities. This is irrespective of whether the community is located in remote regions or urban centres. Toth et al. suggest that bridging the digital divide, if done respectfully and in partnership with Indigenous communities, has the potential to alleviate some of the difficulties Indigenous communities encounter.

Lawrence Deane, Jenna Glass, Inez Vystrcil-Spence, and Javier Mignone were commissioned by Metis Child, Family, and Community Services to conduct an evaluation of the child welfare agency's innovative program entitled Live-In Family Enhancement (LIFE). *Live-In Family Enhancement (LIFE): A comprehensive program for healing and family reunification* summarizes some of the important findings from the evaluation conducted by Deane et al. The authors note that the LIFE model, by leveraging existing funds, has great potential to be utilized and adapted by other agencies to provide families with the services they need, to increase reunification rates, and even as a means of prevention.

It is shocking that a country as rich as Canada actively created the conditions of poverty in many Indigenous communities and continues to perpetuate this legacy by refusing to equitably fund basic services that all humans have a right to, such as clean drinking water and healthcare. In *Une honte nationale*, author Katalina Toth brings the reader's attention to some of these injustices and challenges us to act so that every family in Canada has equitable access to the services they need, when they need them.

Thank you to our readers and community members who make the *First Peoples Child & Family Review* a great learning resource to respectfully share and engage with knowledge generated by and in allyship with Indigenous children, youth, and families. I hope you will enjoy reading this issue and find inspiration in the wonderful contributions contained within.

In good spirit,

Marc St. Dennis

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal

Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Life as a clock

Hayley Harder

Abstract

This slam poem is a reflection on 150-plus years of missing and murdered Indigenous women and girls in Canada and how this has affected Indigenous and non-Indigenous children, youth, and families.

Tick-tock, tick-tock, I'm a constant, cruising, clicking clock.
Hands are forever moving, never stopping;
moving even as a twelve-year-old girl is abducted from the sidewalk beside her school.
Taken for her skin colour and her ethnicity;
taken for being Aboriginal.
Her smile was a package or pure joy tied with a bright ribbon.
At school she was good at math, praised for her ability to subtract.
No one ever thought that her life would be subtracted from theirs.
Tick-tock, tick-tock, still a moving clock.

I keep going forever and ever,
even when a thirty-three-year-old Aboriginal woman is found dead on the side of the road.
She'd been missing for two weeks, my hands kept moving.
Her family wept every night, my hands kept moving.
Her child didn't understand where Mommy went, my hands kept moving.
And now she is proven gone, and my hands still keep moving.
Time heals they say,
but I can see they are wrong.

Tick-tock, tick-tock, I am a relentless clock.
Twenty-seven when she was last seen, forty-three she should have been.
My baby girl, her mother still wails,
was born into a wretched world.
If only my ancestors had the plain-paper complexion of those who took our home,
then my baby girl would be here with me.
Time heals nothing.
Time can’t bring anybody back to life,
Time can’t find a little girl who disappeared walking back from school.
Time heals nothing, it keeps moving forward like a disease.
Tick-tock, tick-tock, why can’t I just stop?

I’ve seen too many go,
for all the wrong reasons.
Humankind is a beast, that sneers, that leers, that wipes the blood off its hand in a smear.
Be different is a motto they are told,
but as soon as you aren’t different in the same way as everyone else,
you are slaughtered.
Simply for the beliefs you hold, and the ancestors that created you,
you are slaughtered.
Humankind is a beast.
Tick-tock, tick-tock, I keep ticking on.

Forever moving, never stopping, I keep ticking on.
No matter how many women go missing,
no matter how many meet their death too soon based off of their identity,
I keep moving.
Aboriginal women,
missing and murdered;
gone forever, no matter the efforts any government makes.
They are gone.
Tick-tock, tick-tock, my circular body never tires.

Time keeps moving, shown on my dull face,
and still there is no change.
Make it stop, just make it stop.
Missing and murdered Aboriginal girls
is still a problem, and yet humankind is a beast
and the problem just won't stop.
It keeps growing, like a flower in direct sunlight,
But it is ugly and gnarled with thorns sticking out of every surface.
Tick-tock, tick-tock, I am a forever moving clock.

Time is moving always,
And yet for these women,
Time stands still, time has stopped,
Tick-tock, tick-tock.

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal

Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Challenges and resiliency in Aboriginal adults with Fetal Alcohol Spectrum Disorder

Melanie Samaroden[1]

[1] Masters of Counselling candidate, Athabasca University, Athabasca, Alberta, Canada

Corresponding author: Melanie Samaroden, msamaroden@gmail.com

Abstract

Aboriginal adults with Fetal Alcohol Spectrum Disorder (FASD) face multiple barriers to services that did not exist in their childhood, yet they still cope with the same FASD-related cognitive issues that they experienced in childhood. Considerable effort is directed to research on children with FASD, but little research on adults with FASD. Furthermore, research on the population of Canada that is generalized to Aboriginal people is neither effective nor ethical. This literature review focuses on Aboriginal adults with FASD, specifically looking at criminal recidivism rates, the stigma attached to an FASD diagnosis, lack of support services, and the ongoing effects of intergenerational trauma. Future qualitative research is suggested to focus on adulthood and aging with FASD, and on helpful interventions.

Keywords: *fetal alcohol spectrum disorder (FASD), Aboriginal adults, resiliency*

Introduction

Fetal Alcohol Spectrum Disorder (FASD) is known in Canada as an affliction that affects significantly more Aboriginal people than non-Aboriginal people (Burnside & Fuchs, 2013; Eni & Senecal, 2009; Milward, 2014; Shankar, 2015; Tait, 2009). Children with FASD and their caregivers who try accessing services for FASD encounter misinformation from police, therapists, and social workers; this creates a barrier to services (Tremblay et al., 2017; Wilson, 2013). Tait (2009) argues that Aboriginal people with mental health afflictions, including FASD, are a manifestation of the "intergenerational effects of colonization" (p. 208). As these children transition to adulthood, these impacts often manifest as criminal recidivism (Burnside & Fuchs, 2013; Milward, 2014; Wheeler, Kenney, & Temple, 2013), victims and perpetrators of physical and sexual abuse (Burnside & Fuchs, 2013; Totten & The Native Women's Association of Canada, 2010; Wheeler et al., 2013), becoming a young parent (Burnside & Fuchs, 2013), and substance abuse (Burnside & Fuchs, 2013; Wheeler et al., 2013). Despite the cognitive setbacks and secondary characteristics (disabilities that develop because of a lack in supportive services that have not been acquired at appropriate times [Wheeler et al., 2013]), Aboriginal adults with FASD are resilient and find ways to cope with these setbacks. Resiliency is a factor in how well Aboriginal adults with FASD cope with cognitive and behavioural challenges in their lives. This literature review covers topics related to Aboriginal adults with FASD and points out the gaps in existing research.

Purpose

In Alberta, approximately 360 people are born with FASD every year (Shankar, 2015). FASD is the most common cause of mental health problems in Canada (Totten & The Native Women's Association of Canada, 2010). Approximately 10% of women consume alcohol during pregnancy in Canada, but about four times more Aboriginal women drink during pregnancy (Popova, Lange, Probst, Parunashvili, & Rehm, 2017). Specifically researching Aboriginal populations is important because when research done on a broader population is generalized to Aboriginal populations, it is more harmful than helpful (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, 2014; Wilson, 2013). The Tri-Council Policy Statement (Canadian Institutes of Health Research et al., 2014) notes that previous research conducted by non-Aboriginal researchers has been harmful and has not reflected the worldviews of Aboriginal people. This literature review looks at research about the challenges that Aboriginal adults with FASD encounter and what may contribute to their resiliency in the face of these challenges.

Method

Due to variations in policy and governance between countries regarding FASD, this literature review is focused on Canadian-based publications, with a few exceptions. These exceptions were considered because they added support to the existing Canadian literature.

Definitions

Fetal Alcohol Spectrum Disorder (FASD): An umbrella term that describes "…a lifelong disability that results from prenatal alcohol exposure (PAE)…" (Pei, Leung, Jampolsky, & Alsbury, 2016, p. 57) and includes "1) Fetal Alcohol Syndrome (FAS); 2) partial FAS (pFAS); 3) Alcohol-related Neuro-developmental Disorder (ARND); and 4) Alcohol-Related Birth Defects (ARBD)" (Pei et al., 2016, p. 61).

Primary characteristics of FASD: "refers to the direct impact of damage incurred to the brain as a result of prenatal exposure to substances and include difficulty with executive functioning tasks, memory problems, impaired judgement and decision making, difficulty with change and transitions, and impulsivity" (Burnside & Fuchs, 2013, p. 43).

Secondary characteristics of FASD: "behaviours that develop in reaction to, and as a way of coping with, the primary disability, including fear and anxiety, poor self-concept, pseudo-sophistication, school behaviour problems, depression, frustration, aggression, and trouble with the law" (Burnside & Fuchs, 2013, p. 43).

Misinformation about FASD

Misinformation about FASD prevents Aboriginal adults with FASD from getting the support they need from professionals such as therapists, police officers, and social workers. FASD is considered an invisible disorder because it is not usually obvious by looking at someone, so their behaviours can be misinterpreted (Brown, Mitchell, Wartnick, & Russell, 2015). It is difficult for adults with FASD to receive an appropriate diagnosis due to the lack of appropriate training for medical professionals (Wheeler et al., 2013). Without a proper diagnosis, Aboriginal adults with FASD will likely continue to turn to crime, inappropriate sexual behaviours, and substance abuse because the proper supports are not available (Wheeler et al., 2013). Professionals should educate themselves on FASD so that they can better serve this population (Knorr & McIntyre, 2016; Masotti, Longstaffe, Gammon, Isbister, Maxwell, & Hanlon-Dearman, 2015; Nash & Davies, 2017). It is important for support and information to continue for the lifespan of someone with FASD because it empowers their success (Wheeler et al., 2013).

Masotti et al. (2015) interviewed multiple interest groups related to the health and wellness of people with FASD and found a lack of training, education, and awareness for medical and non-medical providers. Education for professionals is effective; Knorr and McIntyre (2016) found that the school experience of an FASD child improved when their teachers attended a conference on FASD. An evaluation of existing interventions by Pei, Baugh, Andrew, and Rasmussen (2017) found that school interventions for children with FASD were the most common intervention to be recommended and that adherence to that recommendation was quite high, thus, teachers should be properly educated on FASD. Pei et al. (2017) posit that adherence to the recommendation of school interventions could be because it is easy to access or because it is perceived to be the most effective, meaning that there is potential for early intervention for people with FASD.

Although all of the provinces and territories have FASD awareness and prevention programs, gaps exist for pre-screening at-risk young women, pregnant women, and for postpartum care (Poole, Schmidt, Green, & Hemsing, 2016). These gaps are unfortunate given that Poole et al. (2016) found that when these programs are available at all levels they are successful at reducing the rate of FASD and improving the education and communication between healthcare providers. Masotti et al. (2015) also suggested that integrating care would improve communication and treatment for people with FASD. Medical and non-medical providers want to see more research on the impact of FASD on an individual, specifically periods when intervention would be most useful (Masotti et al., 2015). This lack of consistency of care grows as Aboriginal children with FASD move into adulthood. It is also important that information is available for parents and children with FASD so that strategies and coping skills can be developed (Nash & Davies, 2017). Tremblay et al. (2017) conducted community-based research so they could make informed suggestions to improve psychologists' understanding of FASD. They suggest that continuous collaboration between psychologists and staff, in the case that people with FASD live at an agency, would allow for a better understanding of FASD in general and help individuals with FASD in particular. A multilevel approach to understanding individuals with FASD would include improved communication "1) among clinicians; 2) between clinicians and other service providers; and 3) between clinicians, supervisory staff, and an FASD consultant" (Tremblay et al., 2017, p. 95). These steps exclude the person with FASD as part of the information process. Although information flow is improved, in this study, people with FASD do not receive information about themselves or participate in the process. Adding this component would allow for a model that includes people with FASD in the process, improving treatment for that particular individual.

Consistent evaluation methods do not currently exist in Canada or even across programs, making it difficult to know which programs and methods make positive contributions for people with FASD (Rutman, Hubberstey, Poole, Hume, & Van Bibber, 2016). Rutman et al. (2016) designed three circular maps to depict the levels of support necessary for Aboriginal people with FASD. The circular structure of the maps aligns with Aboriginal worldviews of community focus and interconnectedness in nature. The evaluation map for support programs puts the person with FASD in the centre, with family and community support as the first circle to surround it, speaking to the importance and centrality of family and community support to someone with FASD (Rutman et al., 2016). Not only is it important for family supports to have proper information about FASD, but family is the first source of learning resiliency for the person with FASD. The Participant Outcomes ring is modeled after the medicine wheel, a symbol of great importance to some Aboriginal people (Rutman et al., 2016). These maps provide a useful guide for professionals, staff, and families working with Aboriginal people with FASD. With the right tools and information, early diagnosis of FASD can occur, contributing to a more resilient adult (Burnside & Fuchs, 2013).

The effects of stigma on people with FASD

Due to maternal consumption of alcohol, a baby born with FASD must often contend with significant cognitive developmental deficits, often leading to mental health issues, and possible physical deformity that lasts throughout their life (Bell et al., 2016). Although diagnosis of FASD is important so that appropriate programming can be put into place, the diagnosis additionally creates a negative stigma against the person with FASD and their mother (Totten & The Native Women's Association of Canada, 2010).

Stigmatization of mothers

Aboriginal mothers with alcohol addictions are often blamed for their babies' cognitive impairment, so they fear seeking help for their addiction. This challenge adds to the cycle of FASD, rather than preventing it. When mothers find out that their drinking directly caused the cognitive impairments and possible physical deformities to their child, they may feel guilt (Nash & Davies, 2017), which leads to a reluctance to ask for help (Tait, 2009). Yet, Aboriginal mothers with substance abuse issues do need help to deal with the past personal trauma they have experienced and the intergenerational trauma that their community has experienced, and continues to experience.

FASD prevention programs stigmatize mothers who have been drinking during pregnancy, instead of recognizing it as a possible symptom of a larger problem. Prevention programs based on public marketing information has led some women to develop anxiety and shame from the blame they receive when they have been drinking while pregnant. This leads them to fear seeking professional help for their pregnancy or for their drinking problem (Bell et al., 2016). Bell et al. (2016) point out that there is a lack of information on how these awareness campaigns contribute to this stigma and how this stigma prevents mothers from seeking medical care. Prevention strategies that disseminate information to the public are prevalent in all Canadian provinces (Poole et al., 2016), yet women still make the decision to drink during their pregnancy (Nash & Davies, 2017). The decision-making capability is diminished when an Aboriginal woman is dealing with trauma or has FASD herself, increasing the likelihood that she will drink during pregnancy and have a child with FASD (Totten & The Native Women's Association of Canada, 2010).

There are environmental risk factors that make it more likely for a woman to partake in alcohol consumption during pregnancy, including "child custody, lower socioeconomic status, paternal drinking, binge drinking during pregnancy, reduced access to perinatal care . . ., inadequate nutrition, and a poor developmental environment" (Eni & Senecal, 2009, pp. 88-89). Many Aboriginal women are afraid of seeking help because they fear that their children will be removed and placed in foster care. This is a rational fear, considering the high rates of Aboriginal children in the child welfare system, including children whose mothers have FASD (Eni & Senecal, 2009; Totten & The Native Women's Association of Canada, 2010).

There are government programs to help mothers with alcohol related problems and children with FASD, such as Maternal Child Health and Aboriginal Head Start (Eni & Senecal, 2009), but the programs and the funding available in small communities is negligible. This lack of support for mothers with alcohol related problems directly correlates to children with FASD being at higher risk of suicide and who are significantly more likely to die from homicide than people without FASD (Totten & The Native Women's Association of Canada, 2010). People with FASD experience high rates of physical and sexual abuse in childhood, which is related to having the highest rates of involvement with the sex trade and sex trafficking (Totten & The Native Women's Association of Canada, 2010).

Stigmatization of people with FASD

Children with FASD are often labelled as behaviourally difficult, which continues into adulthood. Aboriginal adults with FASD continue to be stigmatized by professionals and society, making it difficult to obtain work, housing, or to even seek initial help. Children with FASD are considered the product of a breakdown in society, so are sometimes referred to as "society's children" (Tait, 2009, p. 198), yet this does not translate to interventions or assistance as 'society's adults' as they grow older (Bell et al., 2016; Burnside & Fuchs, 2013; Lynch, Kable, & Coles, 2015). The support that is available to children with FASD is no longer available once they reach adulthood (Lynch et al., 2015). The cognitive impairments seen in childhood translate to "academic failure, substance abuse, mental health problems, contact with law enforcement, and an inability to live independently and obtain/maintain employment" (Popova et al., 2017, p. 33). These issues, including becoming a young parent, are compounded if a child with FASD has been in the child welfare system (Burnside & Fuchs, 2013). Aboriginal children are far more likely than the general Canadian population to be in the child welfare system (Burnside & Fuchs, 2013). Burnside and Fuchs (2013) point out the nonsensical notion that children with FASD in the child welfare system are suddenly expected to make life decisions well once emancipated at adulthood. As Bell et al. (2016) point out, it is important that we research the long-term effects of negative public attitudes toward people with FASD and their mothers. Gaps in research exist, specific to how the long-term negative public attitude affects Aboriginal people with FASD.

Colonization and intergenerational trauma

Colonization and intergenerational trauma is the root of the challenges that Aboriginal adults with FASD must contend; to understand FASD in Aboriginal people, we must understand the effects of colonialism. It has not been adequately recognized that colonization has contributed to intergenerational trauma, which is the negative impact of systemic oppression over many generations (Eni & Senecal, 2009; Totten & The Native Women's Association of Canada, 2010). Although there is research that looks at the medical phenomenon of FASD, there is little research that looks at the social impact of colonization and intergenerational trauma (Wilson, 2013). Aboriginal youth experience higher rates of care in the child welfare system (Burnside & Fuchs, 2013; Eni & Senecal, 2009) which can cause intergenerational trauma and disconnect them from their community and families, contributing to the inability to form and integrate their identity as Aboriginal (Burnside & Fuchs, 2013). Colonization was, and still is, a harmful process:

> *. . . which included military conquest, the acquisition of Aboriginal land bases through treaties, and policies of assimilation that attempted to force Aboriginal peoples to abandon their own cultures in favour of Euro-Canadian lifestyles by criminalizing cultural activities. An especially harmful part of the history of colonization was forcing Aboriginal children to attend residential schools. Many were physically and sexually abused, and thus would themselves pass intergenerational trauma on to their descendants. Many were forced to abandon their languages and culture . . .* (Milward, 2014, p. 1029).

Interestingly, the secondary effects of FASD are similar to the secondary effects of intergenerational trauma; Eni and Senecal (2009) further posit that the trauma caused by the residential school system, including physical and sexual abuse, perpetuated a culture that consumed alcohol, leading to an increase in Aboriginal children born with FASD. Removing Aboriginal children from their homes to place elsewhere, either in residential schools or in adoptive homes, to be raised in a non-Aboriginal environment continues to this day in the form of the child welfare system (Eni & Senecal, 2009; Tait, 2009).

It is difficult to treat the root causes of FASD in Aboriginal people because it is so intrinsically linked to the practices of colonization (Totten & The Native Women's Association of Canada, 2010). Aboriginal children are disproportionately represented in care homes and programs for FASD (Eni & Senecal, 2009; Shankar, 2015); one possible reason is the over-surveillance of FASD in Aboriginal communities by government agencies (Shankar, 2015; Tait, 2009). According to Eni and Senecal (2009), past colonial practices of the Canadian government have a direct impact on the "physical and psychological illnesses among Aboriginal people" (p. 89) and suggest that support and programming for people with FASD should be developed with these factors in mind. These programs need to be specific to Aboriginal people in order to address the past and current trauma that is specific to their experiences.

The Truth and Reconciliation Commission of Canada (2015) supports Tait's (2009) claim that the effects of colonization have deeply affected Aboriginal communities in negative ways that contribute to poor mental health. Due to the ongoing intergenerational trauma to Aboriginal communities, we need to continue to research meaningful solutions for the communities that do not contribute to reinforcing colonial practices.

Criminal recidivism

Aboriginal adults with FASD have high criminal recidivism rates because deterrence does not often work with people who have memory and cognitive impairments, a common effect of FASD. To reduce these rates, the court system is slowly introducing educational programs specific to adults with FASD. Misinformation about FASD permeates the criminal justice system, making criminal recidivism a common theme among Aboriginal adults with FASD (Bracken, 2008; Brown et al., 2015; Milward, 2014). Training for professional staff in the criminal justice system should include education about FASD so that adults with FASD are not misunderstood or misrepresented (Brown et al., 2015). Informed sentencing that makes sense for an individual with FASD is essential.

Despite being only 3% of the population in Canada, "Aboriginal persons have consistently comprised 17-19% of all adult admissions to Canadian federal penitentiaries" (Milward, 2014, p. 1028). The percentage of the convicted that have FASD are underestimated due to under diagnosis (Pei et al., 2016). Awareness and change are slowly coming to the courts; some judges will make decisions regarding an Aboriginal adult's behaviour by acknowledging the cognitive deficits associated with FASD and intergenerational trauma (Bracken, 2008; Milward, 2014). Milward (2014) suggests that FASD reflects the social damage caused by colonialism, and is also a contributor to over-incarceration of Aboriginal adults. Lack of funding, required for alternatives to incarceration, from the Canadian government is slowing down the positive change of a justice system that recognizes that Aboriginal adults with FASD must be treated with awareness of their cognitive issues (Milward, 2014; Pei et al., 2016).

Milward (2014) looks closely at three objectives of sentencing: "deterrence, retribution, and rehabilitation" (p. 1034) as it pertains to Aboriginal adults with FASD and whether these objectives meet their goals. These objectives are formed with the idea that normally, a person willingly and knowingly commits a crime and is able to learn from their behaviour through a punitive system (Pei et al., 2016).

Deterrence is ineffective because it works on the assumption that people can understand the consequences of their actions. Someone with cognitive impairments due to FASD may not understand the consequences of their actions (Milward, 2014). Also, if incarcerated, an individual with FASD is exposed to more criminals and criminal behaviour; this makes their situation worse because their condition makes them more susceptible to negative influences. Alternatively, if they are asked to complete community service, there is little subsequent support for the individual, thus increasing the likelihood that they would repeat the same criminal behaviour (Bracken, 2008). However, Milward (2014) points out that deterrence can be used for those who have not yet committed a crime, which is why some judges choose to sentence an Aboriginal adult with FASD when they know that deterrence does not work for the individual.

The objective of retribution is to punish the offender equal to the amount of harm they caused by their crime; this does not consider the offender's background, moral agency, or whether the sentence is effective (Milward, 2014). Milward (2014) rightly points out that when deterrence and retribution are the primary objectives for sentencing, more harm than good is caused to Aboriginal adults with FASD and their community. However, Milward also notes that rehabilitation moves in the right direction to help Aboriginal people with FASD because it considers the cognitive damage and the intergenerational trauma experienced from colonization. A successful program in Lethbridge, Alberta, helps teens with FASD by having a constable advocate for the adolescents in court; they inform the lawyers and judges about FASD and the sentences are focused on rehabilitation rather than deterrence (Canadian Broadcasting Corporation, 2009). A program like this can be modified for Aboriginal adults with FASD. Ideally, the results of the Lethbridge program for teens would translate to adults, reducing criminal recidivism and incarceration rates overall.

Despite Milward's (2014) positive outlook, change in the criminal justice system is slow. Aboriginal offenders are sentenced more often now than ten years ago, with twice as many men incarcerated and triple the number of women (Macdonald & Campbell, 2017). Therefore, it is imperative that research continues regarding Aboriginal adults with FASD in the criminal system. This research will show the importance of recognizing the long-term effects of colonization, intergenerational trauma, and the cognitive deficits that must be taken into consideration when sentencing.

Brown et al. (2015) note that going through the judicial system can escalate conditions for adults with FASD because they often find it difficult to understand abstract concepts and the severity of their situation. The Canadian Bar Association is attempting to address the issue of adults with FASD in the criminal justice system by proposing some changes (Pei et al., 2016), including:

> *1) establishing a legal definition of FASD; 2) allowing judges to order assessments for individuals who are suspected of having FASD; 3) identifying FASD as a mitigating factor in sentencing; 4) setting up an external support plan, and 5) providing accommodations within correctional services for inmates with an FASD* (Pei et al., 2016, p. 59-60).

Bracken (2008) suggests that a screening process for identifying people with FASD, rather than relying on previous identification, will help increase the likelihood that the criminal justice system will use the FASD diagnosis to inform judgement. Popova, Lange, Burd, and Rehm (2015) agree that individuals in the criminal justice system should be screened for FASD, since FASD is so prevalent in correctional facilities. Research supports that the justice system would be assisted in making better decisions if a person is diagnosed with FASD; for Aboriginal people with FASD the justice system would also benefit from knowing about the specific intergenerational trauma the individual may have suffered (Brown et al., 2015; Milward, 2014; Pei et al., 2016).

Resiliency

Resiliency, which is the ability to endure adversity and have a better chance of successfully overcoming adversity (Burnside & Fuchs, 2013), is a factor that contributes to Aboriginal adults with FASD overcoming their cognitive and behaviour challenges. But more research is needed to understand how Aboriginal adults with FASD can learn or improve their resiliency. Young adults with FASD are a vulnerable population because they are transitioning from having many available supports to few available supports. This often directs them to participation in negative actions, such as crime, substance use, and inappropriate sexual behaviour (Lynch et al., 2015). Lynch et al. (2015) show that “60% [of young adults with FASD] had disrupted school experiences . . . and 79% . . . had problems with employment” (p. 53). The secondary characteristics of FASD continue into adulthood, affecting an adult’s ability to obtain and keep employment, obtain housing, stay in school, avoid criminal behaviour, and avoid substance abuse (Popova et al., 2017). Aboriginal adults with FASD have at best been able to overcome all of these challenges, and at the worst, survive despite them (Lynch et al., 2015). Resiliency has both internal and external components; external components are the supports that a person receives to help them persevere. These external components include interventions at appropriate points in an Aboriginal person with FASD’s life that are shown to have positive outcomes (Burnside & Fuchs, 2013; Wheeler et al., 2013). Some of these external factors include “early diagnosis of FASD . . ., a steady caregiver who understands the disability, a stable and nurturing home environment, and adjustments to the environment that meet the needs of the child” (Burnside & Fuchs, 2013, p. 44). An example of the outcome of external factors is a large percentage of adults with FASD were able to find and keep employment (Lynch et al., 2015), but this is not necessarily generalizable to Aboriginal adults with FASD because this subgroup encounters additional challenges, such as intergenerational trauma. Knorr and McIntyre (2016) interviewed four adults with FASD about their home and school experiences. Themes emerged of extra help at school, teachers with knowledge of FASD, and how supportive parents contributed to the resiliency of the students. Although these students did not have a stable home environment, Knorr and McIntyre (2016) pointed out that this is another contributing factor for children with FASD to persevere into adulthood. Milward (2014) points out that we have two opportunities for intervention: before an Aboriginal child is born by reducing "maternal alcohol consumption" (p. 1027), and the second is before an Aboriginal child born with FASD becomes involved in criminal behaviour.

The Bissell Centre in Edmonton, Alberta has a program that has incorporated elements of Aboriginal cultural practices (Miller, 2013). This program refers Aboriginal adults with FASD to cultural activities to receive additional help from members of their culture (Miller, 2013). Consideration of Aboriginal cultures is an important part of helping Aboriginal adults with FASD in a holistic way and to build internal resilience that acknowledges the trauma they have experienced and continue to experience.

Many Aboriginal youth and adults are able to build their resiliency in negative ways that serve a positive outcome. One example of this is joining a gang to replace a family that is not providing a stable home environment. Youth find supportive relationships within the gang, but are still mired in substance abuse, crime, and inappropriate sexual behaviours (Totten & The Native Women's Association of Canada, 2010). Resiliency that is built from these negative choices could be termed 'dysfunctional resiliency.' Dysfunctional resiliency occurs when a person adopts a coping mechanism that gives the support they are lacking, but is not a positive change and can lead to more negative actions.

Totten and The Native Women's Association of Canada (2010) suggest that the diagnosis of FASD can create a focus on the negative behaviours and effects of the alcohol, yet focusing on a person with FASD's strengths and building resiliency is more helpful throughout the course of their lives. Wheeler et al. (2013) reviewed research on interventions for adults with FASD, finding that there is a need for more research and evaluation on current interventions for adults with FASD so that necessary modifications and development can occur. Wheeler et al. (2013) argue that well-developed interventions for adults with FASD that target effects like criminal activity and substance abuse support positive actions and successful life experiences.

Discussion and conclusion

Aboriginal adults with FASD encounter many challenges throughout their lives, yet many develop resiliency to cope with those challenges. The effects of colonization on Aboriginal people are traumatic, causing intergenerational trauma. This trauma is compounded by the stigma toward mothers who drink during their pregnancy and the stigma toward the person with FASD, discouraging them from seeking help. Rates of FASD are high in the incarcerated Aboriginal adult population, prompting a review of the criminal justice system and its response to Aboriginal adults with FASD. The misinformation that permeates the criminal justice system is also a problem within the education system, the medical system, and with psychologists. This lack of information means that professionals are unsure how to help someone with FASD properly. Despite all of these setbacks, Aboriginal people with FASD develop resiliency through the various support networks in their life, allowing them to cope, even in a dysfunctional way. More research is needed to understand how Aboriginal adults with FASD develop resiliency to cope with the challenges in their lives. Understanding resiliency will improve existing programs that help people with FASD and create policy that considers their strengths rather than the detriments that the disorder can cause.

Most research about Aboriginal people with FASD focuses on prevention and the effects on children diagnosed with FASD, but few studies exist on Aboriginal adults with FASD (Lynch et al., 2015). However, FASD is a lifelong disorder (Poole et al., 2016). It is imperative that research is conducted on the impact of FASD on adulthood and aging, and helpful and detrimental interventions.

For future research about Aboriginal adults with FASD, a qualitative approach would align with the predominance of storytelling in Aboriginal cultures (Blue, Darou, & Ruano, 2010; Wilson, 2013). Wilson (2013) suggests using narrative inquiry or participatory action research when researching in Aboriginal communities because these methods would align with Aboriginal worldviews.

References

Bell, E., Andrew, G., Di Pietro, N., Chudley, A. E., Reynolds, J. N., & Racine, E. (2016). It's a shame! Stigma against fetal alcohol spectrum disorder: Examining the ethical implications for public health practices and policies. *Public Health Ethics, 9*(1), 65-77. http://dx.doi.org/10.1093/phe/phv012

Blue, A., Darou, W., Ruano, C. (2010). Engaging the elder within: Bridging and honouring the cultural spaces in counselling with First Nations. In N. Arthur & S. Collins (Eds.), *Culture-Infused Counselling* (2nd *Ed.*). (pp. 259-284). Calgary, AB: Counselling Concepts.

Bracken, D. C. (2008). Canada's Aboriginal people, fetal alcohol syndrome and the criminal justice system. *British Journal of Community Justice, 6*(3), 21-33. Retrieved from http://www.cjp.org.uk

Brown, J., Mitchell, M., Wartnik, A., & Russell, A. (2015). FASD and the courts: A reference for legal professionals. *Bench & Bar of Minnesota*, 24-28. Retrieved from http://mnbenchbar.com/

Burnside, L. & Fuchs, D. (2013). Bound by the clock: The experiences of youth with FASD transitioning to adulthood from child welfare care. *First Peoples Child & Family Review, 8*(1), 41-62. Retrieved from http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/view/200

Canadian Broadcasting Corporation. (2009). *Unique project helps keep FASD teens out of jail*. Retrieved from www.cbc.ca/news/canada/edmonton/unique-project-helps-keep-fasd-teens-out-of-jail-1.827083

Canadian Institutes of Health Research., Natural Sciences and Engineering Research Council of Canada., Social Sciences and Humanities Research Council of Canada. (2014). *Tri-council policy statement: Ethical conduct for research involving humans*. Ottawa: Secretariat on Responsible Conduct of Research.

Eni, R. & Senecal, S. (2009). Pathways to fetal alcohol spectrum disorder in Aboriginal communities. *Canadian Diversity, 7*(3), 85-92. Retrieved from http://www.acs-aec.ca/

Knorr, L. & McIntyre, L. J. (2016). Resilience in the face of adversity: Stories from adults with fetal alcohol spectrum disorders. *Exceptionality Education International, 26*(1), 53-75. Retrieved from http://ir.lib.uwo.ca/eei/vol26/iss1/4

Lynch, M. E., Kable, J. A., & Coles, C. D. (2015). Prenatal alcohol exposure, adaptive function, and entry into adult roles in a prospective study of young adults. *Neurotoxicology and Teratology, 51*, 52-60. http://dx.doi.org/10.1016/j.ntt.2015.07.008

Macdonald, N. & Campbell, M. (2017). Lost and broken. *MacLean's, 130*(9), 24-29.

Masotti, P., Longstaffe, S., Gammon, H., Isbister, J., Maxwell, B., & Hanlon-Dearman, A. (2015). Integrating care for individuals with FASD: Results from a multi-stakeholder symposium. *BMC Health Services Research, 15,* 457-469. http://dx.doi.org/10.1186/s12913-015-1113-8

Miller, H. A. (2013). Two-way impact with FASD treatment. *Alberta Sweetgrass, 20*(5), 12. Retrieved from http://www.ammsa.com/sweetgrass/index.asp

Milward, D. (2014). The sentencing of Aboriginal accused with FASD: A search for different pathways. *UBC Law Review, 47*(3), 1025-1056. Retrieved from http://ubclawreview.ca/issues/volume-473/

Nash, A., & Davies, L. (2017). Fetal alcohol spectrum disorders: What pediatric providers need to know. *Journal of Pediatric Health Care, 31*(5), 594-606. http://dx.doi.org/10.1016/j.pedhc.2017.04.002

Pei, J., Baugh, L., Andrew, G., & Rasmussen, C. (2017). Intervention recommendations and subsequent access to services following clinical assessment for fetal alcohol spectrum disorders. *Research in Developmental Disabilities, 60*, 176-186. http://dx.doi.org/10.1016/j.ridd.2016.11.007

Pei, J., Leung, W. S. W., Jampolsky, F., & Alsbury, B. (2016). Experiences in the Canadian criminal justice system for individuals with fetal alcohol spectrum disorders: Double jeopardy? *Canadian Journal of Criminology & Criminal Justice, 58*(1), 56-86. http://dx.doi.org/10.3138/cjccj.2014.E25

Poole, N., Schmidt, R. A., Green, C., & Hemsing, N. (2016). Prevention of fetal alcohol spectrum disorder: Current Canadian efforts and analysis of gaps. *Substance Abuse: Research and Treatment, 10*(S1), 1-11. http://dx.doi.org/10.4137/SART.S34545

Popova, S., Lange, S., Burd, L., & Rehm, J. (2015). Cost attributable to fetal alcohol spectrum disorder in the Canadian correctional system. *International Journal of Law and Psychiatry, 41*, 76-81. http://dx.doi.org/10.1016/j.ijlp.2015.03.010

Popova, S., Lange, S., Probst, C., Parunashvili, N., & Rehm, J. (2017). Prevalence of alcohol consumption during pregnancy and fetal alcohol spectrum disorders among the general and Aboriginal populations in Canada and the United States. *European Journal of Medical Genetics, 60*, 32-48. http://dx.doi.org/10.1016/j.ejmg.2016.09.010

Rutman, D., Hubberstey, C., Poole, N., Hume, S., & Van Bibber, M. (2016). Developing and using a common framework to evaluate FASD programs: Results of a three-year Canadian project. *International Journal of Mental Health Addiction, 14*, 472-482. http://dx.doi.org/10.1007/s11469-015-9597-3

Shankar, I. (2015). The making of a medical disorder: Tracing the emergence of fetal alcohol spectrum disorder in Alberta. *Social Work in Public Health, 30*, 38-50. http://dx.doi.org/10.1080/19371918.2014.938930

Tait, C. (2009). Disruptions in nature, disruptions in society: Aboriginal Peoples of Canada and the "making" of fetal alcohol syndrome. In L. J. Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal People in Canada* (pp. 196-220). Vancouver, Canada: UBC Press.

Totten, M. & The Native Women's Association of Canada. (2010). Investigating the linkages between FASD, gangs, sexual exploitation and woman abuse in the Canadian Aboriginal population: A preliminary study. *First Peoples Child & Family Review, 5*(2), 9-22. Retrieved from http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/view/89

Tremblay, M., Pei, J., Plesuk, D., Muchortow, A., Mihai, P., & Jordao, R. (2017). Development of a clinical practice model for serving clients with fetal alcohol spectrum disorder. *International Journal of Advanced Counselling, 39*, 82-97. http://dx.doi.org/10.1007/s10447-017-9284-0

Truth and Reconciliation Commission of Canada. (2015). Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada. Winnipeg, MB: Truth and Reconciliation Commission of Canada.

Wheeler, J. A., Kenney, K. A., & Temple, V. (2013). Fetal alcohol spectrum disorder: Exploratory investigation of services and interventions for adults. *Journal on Developmental Disabilities, 19*(3), 62-75. Retrieved from http://www.oadd.org

Wilson, A. (2013). A social work student's developing understanding of fetal alcohol spectrum disorder from medical and social perspectives and implications for practice. *First Peoples Child & Family Review, 8*(1), 26-40. Retrieved from http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/view/199

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal

Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Fair

Hamza Hussain,[1] Yuktha Kowlessur[2]

[1] Ross Drive Public School, Brampton, Ontario, Canada
[2] Ross Drive Public School, Brampton, Ontario, Canada

Abstract

The grade 3/4 and grade 7 class at Ross Drive Public School worked together to learn about treaties, Shannen Koostachin, and Shannen's Dream. The students were asked to think about what a safe and comfy education might look like and why it is unfair that Shannen Koostachin had to fight for this right. This poem reflects what two students, Hamza and Yuktha, learnt.

This is not fair, while my school is safe yours is in need of aid.
It is insanity that you have to live in this profanity that we have chosen.
I sigh that I have to go to school; you smile because you get to.
Yet, you have to walk a mile in this freezing ice,
you have to survive the harshness of our government.
Whereas I laugh and enjoy my life when at school, I get bored.
You are proud and happy, but scared.
We need schools to be equal not illegal.
Cracked stalls and torn walls;
they say that the schools will get better, that everything will be fair . . .
But instead they leave plenty of promises empty;
improper schools and broken tools.
We live in a world where justice is a lie,
being someone else is a crime.
Indigenous kids are not in proper learning environments, they get diseases, their schools are not sanitary . . .
and their lives aren't fair.
We have to stop, help;
we are all humans and we all have rights.
No one should be left out, we should all be equally treated.
First Nations kids should not be forgotten but honoured.
They might be of a different colour or race, but kids need a change;
we need to honour the treaties and stop the injustice.
It is time, time to make it right.

First Nations Child & Family Caring Society of Canada

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Indigenous peoples and empowerment via technology[1]

Katalina Toth,[2] Daisy Smith,[3] and Daphne Giroux[4]

[2] The Sacred Heart School of Montreal, Montreal, Canada
[3] The Sacred Heart School of Montreal, Montreal, Canada
[4] The Sacred Heart School of Montreal, Montreal, Canada

Corresponding author: Katalina Toth, katalinaltoth@gmail.com.

Abstract

This article considers how increased access to communications technology could improve the lives of Indigenous peoples in Quebec. The authors describe the digital divide between Indigenous and non-Indigenous peoples in Quebec with respect to the speed, reliability, and cost of communications infrastructure, and how existing barriers can be overcome. The authors describe some ways in which the use of technology has already been incorporated by Indigenous communities to support education and healthcare, and how bridging the digital divide can be a tool to increase access to these fundamental services. Although technology is not a panacea, it has the potential, if implemented in accordance with Indigenous values, traditions, and goals, to empower Indigenous communities, particularly those in remote regions of Quebec, and alleviate some of the difficulties associated with accessing education and healthcare.

Keywords: *technology, digital divide, education, healthcare, Quebec*

Introduction

Equality rights are at the centre of the *Canadian Charter of Rights and Freedoms* (Department of Justice, 2017). However, there is an enduring inequality between Indigenous and non-Indigenous peoples in all aspects of life in Canada. Below, we specifically address some problems Indigenous peoples in Quebec encounter when trying to access basic services like technology, education, and healthcare. We propose that improved access to technology can address some of the issues in education and healthcare in a way that is consistent with Indigenous goals and priorities.

---

[1] An earlier version of this article was submitted by the authors to Olympes de la Parole, a secondary school competition organized by the University Women's Club of Montreal Inc., for which the authors were awarded the accolade of *best essay*.

The digital divide

Indigenous peoples constitute 5% of the population in Canada, or 1.6 million people (Statistics Canada, 2017). Approximately 180,000 Indigenous people in Canada live in Quebec. According to the Government of Quebec, there are 55 Indigenous communities within the province (Secrétariat aux Affaires Autochtones Québec, 2018). Some of these communities, like Kahnawake, are within reach of metropolitan centres like Montreal, but many are in remote regions, stretching from James Bay all the way to Nunavik.

The digital divide is “the very large difference in opportunity between those who can easily access computers and the internet and those who cannot” (Oxford Learner’s Dictionary, 2018). An early survey of internet access for Indigenous communities in Canada found that 37% of residents had no internet access at all, and 42% used dial-up internet (Aboriginal Canada Portal, 2004; Smillie-Adjarkwa, 2005). The latter is a type of internet that is one-tenth the speed of the slowest broadband connection and cannot be used if someone needs to make a phone call from the landline simultaneously. Ten years after this survey was conducted, access is still very limited: the Canadian Radio-television and Telecommunications Commission (CRTC) confirms that in Quebec, Indigenous peoples only have access to terrestrial broadband internet in urban areas. This is the kind of internet that is available to 94% of private dwellings in Canada (CRTC, 2016; CRTC, 2017). For a large proportion of Indigenous people that are in remote regions, the main access to internet is by satellite and has a maximum speed of less than 1.5 megabits per second (Mbps) (compared to speeds of 30 Mbps for basic high-speed in Montreal). Further, it frequently disconnects, making high bandwidth applications such as downloading large files and video-conferencing difficult to impossible (CRTC, 2016; CRTC, 2017).

There is hope that in the next few years remote communities will have access to some of the internet services metropolitan areas take for granted. For some Cree communities in Northern Quebec, this situation recently improved with a collaboration between the Canadian federal government, Distributel, and Cree-owned Eeyou Communications. Together, they launched broadband terrestrial high speed for the Northern Cree communities near James Bay (Larochelle, 2018). For the Inuit in Nunavik, upgrades to fibre optic connectivity are forthcoming (Rogers, 2017). The Kativik Regional Government obtained $15 million of support from the Canadian federal government (Government of Canada, 2017) and financing from the Quebec government to: 1) extend fibre optic lines to communities along the coast of Hudson Bay by 2019; 2) install fixed wireless radio tower links to fibre optic networks farther south; 3) increase bandwidth for communities served only by satellite; and 4) provide the infrastructure for 3G cell phone service, a first in Nunavik (Rogers, 2017).

However, an issue with internet access, whether by broadband terrestrial or by satellite, is cost (Smillie-Adjarkwa, 2005). For example, the people of Kahnawake reserve in Montreal can access high speed internet through broadband terrestrial connection, but the median household income in Kahnawake was only 70% of the median household income in Montreal ($37,000 versus $53,000) (Kahentineson-Jacobs, 2011; Statistics Canada, 2017). Thus, internet access is significantly less affordable for families in Kahnawake. In rural and remote areas, the cost of internet is much higher and the speeds are much slower (Saltzman, 2016). Monthly data charges in remote regions frequently run into the hundreds of dollars for slow service and low data caps (Roth, 2014).

One solution to the burden of cost for individuals could be creating public spaces equipped with computers and free access to internet. In Quebec, communities typically set up computer access within public libraries, which is a Western model. Creating a model that incorporates Indigenous approaches to knowledge-sharing and community could allow technology to reinforce community and culture rather than undermine it through Westernization. An Indigenous community that has successfully integrated technology and used it to strengthen their culture is the Maori of New Zealand. When the Maori began to adopt technology, they set up computers and Wi-Fi in what were called virtual *Marae*, where *Marae* were a central place for community and knowledge-sharing in Maori culture (Greenwood, Harata Te Aika, & Davis, 2011). Thus, Maori culture incorporated technology into existing social structures rather than adopting Western models. In Inuit culture, the *qargit* were traditional social institutions where Inuit families gathered and shared oral traditions but were largely dismantled when Western culture introduced schools and churches (MacLean, 2004). Recently, a Canadian teacher won the Global Teaching Prize for her success as an educator in Nunavik (Batrawy, 2017). One of her key insights was that while Western cultures value isolated, abstract learning that takes place in schools where families are not involved, the Inuit model of learning is applied learning incorporated into the fabric of family and community (Wang, 2017). A similar observation had been made in a study of First Nations cultures that found pedagogical approaches emphasized “learning through observing and doing, [and] learning through authentic experiences” (Battiste, 2002, p. 18). This includes understanding that “meanings are to be found in the social world of individuals, families and communities” (Battiste, 2002, p. 20). Providing free, high-speed access to technology in a community meeting place that unifies learning, meetings with elders, children’s centers etc. can strengthen rather than undermine Indigenous cultures. It can further provide additional opportunities for Indigenous peoples to bridge distance divides, develop economic opportunities, and otherwise utilize technology in a way consistent with self-determination.

Access to education

Education is an area where computer technology has the potential to significantly improve the lives of Indigenous peoples. Educational attainment is a key determinant of health and well-being (National Collaborative Center for Health and Well-being, 2017), and a parent’s education level is a critical predictor of a child’s future success (Davis-Kean, 2005). Thus, it is critical that education systems be optimized to foster student success. Currently, 60% of the Indigenous population in Quebec do not graduate high school compared to 26% percent of the non-Indigenous population (Arriagada, 2016). Interventions that increase graduation rates can help by providing people with more employment opportunities and by passing on social, intellectual, and economic benefits to their children which would in turn increase their chance for academic success.

An examination of the educational experiences on reserves can shed light on the troublesome graduation statistics. Funding for schools on reserves is inadequate. The Federal government invests 30% less education funding per Indigenous student than other students in Canada (Porter, 2016). The level of government funding provided to schools is insufficient to pay for educational necessities such as a library, gym equipment, textbooks, and computers (Syed, 2018). Without the resources that other students in Canada take for granted, it is more challenging for Indigenous students to succeed in school.

Another difficulty is the remote location of many Indigenous communities. Even for students who finish high school, for many, higher education is physically unattainable. Most Indigenous communities are not near post-secondary institutions, so pursuing a higher education often involves leaving family, friends, and a way of life to go the city where cultural barriers and loneliness are major challenges (Billson & Mancini, 2007). Creating additional difficulties, for many young Indigenous women moving away can mean leaving children behind; about one quarter of Indigenous women have children between the ages of 15 and 24 compared to 8% of non-Indigenous women (Statistics Canada, 2017b).

Increased access to communications technology has the power to address some of the challenges in education. Greater availability of computers in schools and in the community would provide access to distance learning, permitting residents to remain in their communities, and to gain the necessary training to meet individual and community needs. In a recent review of technology in northern Canada, Alexander (2011) describes an effect of increasing access to technology for Inuit:

> *Technology has played a key role in graduating the first 21 Inuit students in . . . the first graduate degree program offered in Nunavut, enabling Inuit students to study part-time through face-to-face courses in two communities . . . and critically important, through online learning* (Alexander, 2011, p. 86).

Making education accessible without forcing people out of their community respects the relationship between Indigenous people and the land, and provides hope by making the route to change visible to those in the community. The Masters of Education program that Alexander (2011) describes works with educators to improve local leadership in education. The program specifically uses decolonizing methodologies to ground the programs, including recognition of the right to self-determination and recognition of the marginalization of Indigenous cultures, languages, traditions, and worldviews (Walton et al., 2009). They do this in part by creating a learning environment that is bilingual and bicultural, so that Indigenous students feel validated and recognized. In the past the goal of Indigenous education was, as stated by Canada's first Prime Minister, to "take the Indian out of the child" (Macdonald as cited in Fine, 2017, para. 6). Now, in at least some instances, the goal is explicitly to strengthen Indigenous identity because a strong child is more likely to be a strong youth and adult.

Improved access to instruction in technology and programming can empower Indigenous people to reinforce and disseminate their culture by creating their own online content. Carpenter et al. (2016) observe that, "By generating their own digital visibility and legibility, Indigenous communities become 'present' online, and thereby exert increasing control over the terms of their own representation" (Carpenter et al., 2016, p. 4) rather than being represented by others. Recently, a pilot project by Pinnguaq Association explored this approach (Frizzell, 2017). A week-long coding workshop was run to teach Inuit children to use open source software to create their own online content, that is, to see computers as tools to create rather than passively consume (Frizzell, 2017). After the workshop, the children were given refurbished laptops from the Canadian federal government that came preloaded with Windows 10 and programming software so they could continue using it without having to download over unreliable internet connections. In one week, the workshop participants were able to record traditional throat singing and create remixes as well as develop a computer game (Frizzell, 2017). If courses in programming, web development, and computer literacy were widely accessible to Indigenous children and adults, they could develop a greater online presence that could be used to strengthen their culture, foster connections with communities, and create business opportunities. They can also use technology as a tool of advocacy to make aspects of their situation better known, and thus gain the public's support in lobbying the government for meaningful interventions.

Access to technology in education can also be used to incorporate Indigenous languages into the classroom. Education in one's native language is recognized by the United Nations as an Indigenous right (United Nations, 2008). Students educated in a system that includes their language and culture do better academically and are more likely to stay in school (United Nations Educational, Scientific and Cultural Organization, 2012). In Quebec, First Nations and Inuit continue to speak Indigenous languages: 40% of First Nations people in Quebec speak an Indigenous language as their mother tongue and can carry on a conversation in that language and 90% of the Nunavik residents speak Inuktitut (Statistics Canada, 2016). A survey of Indigenous youth and adults found that an important priority was Indigenous language instruction by Indigenous language speakers (Indigenous and Northern Affairs Canada, 2017). However, in many Indigenous schools, teachers are non-Indigenous, so there is a lack of bilingual teachers and teaching resources, and students receive minimal instruction in their native language (Indigenous and Northern Affairs Canada, 2017).

In their report on Indigenous languages in Canada, Carpenter et al. (2016) argue that "[d]igital technologies do not, cannot and will not save languages," but added that "speakers might use [technology] to do work that will" (2016, p. 4). Technology has the potential to support language instruction in the classroom. For example, interactive applications to teach syllabics to children ages 3 to 7 have been developed for iPads (CBC News, 2017). iPads preloaded with these applications can be provided to childcare centers to prepare students to begin writing and to reinforce the value of their culture. For older children and adults, the Nunavut government and Pirurvik (an education center in Iqaluit) recently released applications that allow writing in Inuktitut syllabics on iPads and iPhones (CBC News, 2015). If Indigenous classrooms and community centers were provided with computers and iPads preloaded with syllabic keyboards, students could use traditional syllabics for their writing in school and for online communication in social media. This would make syllabic writing relevant in a way that it cannot be when it is not included in the school curriculum and when it is not used in electronic communication. Access to these kinds of technological advances could strengthen the use of Indigenous languages in schools, tighten the connection between the school curriculum and the students' culture, and support Indigenous languages becoming more relevant to the younger generations.

Access to healthcare

Indigenous peoples in Quebec face significant barriers to accessing healthcare in their communities. In Northern Quebec there is one 29-bed hospital serving the Northern Cree, while Nunavik is served by two small health centers that have inpatient beds. Both have limited capacity to deal with major health problems. For example, Chisasibi hospital in James Bay does not offer surgery, cancer treatment, childbirth services, or diagnostic magnetic resonance imaging (MRI) (Cree Board of Health and Social Services of James Bay, 2015; Ordre des Sages-Femmes de Quebec, n.d.).

From Nunavik, 8,000 flights a year are made to Montreal by patients and an accompanying family member to access health care (Ross, 2018). These trips are profoundly disruptive for families. A nurse working in Nunavik reported that many of these visits are necessary because nurses do not have access to medical expertise that would allow them to decide definitively whether the person can be treated safely on site, so they err on the side of caution and send patients south (Ross, 2018). If remote Indigenous communities had access to more technological advances like remote patient monitoring and teleconferencing with specialists, it could significantly reduce the need for these trips.

High-risk pregnancies and teen pregnancies are another significant issue in Indigenous health that is exacerbated by reduced access to health care. Indigenous peoples have higher rates of pregnancy complications such as high blood pressure, diabetes, bleeding, extreme birth weights, and greater rates of premature birth and infant mortality than non-Indigenous people in Canada (Duhaime, Caron, & Levesque, 2015). Infant mortality among Indigenous populations is roughly three times the national average in Canada, and in Nunavik it is four times the national average (Duhaime et al., 2015). Prenatal care has a high correlation with positive pregnancy outcomes (Partridge, Balayla, Holcroft, & Abenhaim, 2012). A maternal health survey found that Indigenous women are four times more likely to receive inadequate prenatal care than non-Indigenous women (Heaman, Gupton, & Moffatt, 2005).

In isolated Indigenous communities, mothers are often transported south to give birth. For example, in the communities of the Cree Territory of James Bay, mothers are transported south many weeks in advance of their due date and give birth in Val D'Or, almost 1,000 kilometers from home (Cree Board of Health and Social Services, 2017). This would be traumatic for any mother, but for Indigenous mothers this can be compounded by language and cultural barriers, negative stereotypes about Indigenous people that can influence hospital experiences, and the intergenerational trauma associated with the government's history of removing Indigenous children from their families (Ross, 2018). However, telehealth interventions for high-risk pregnancies have been implemented successfully (Odibo, Wendel, & Magann, 2013). These two-way video-feeds allow midwives in remote locations the ability to access the advice of a doctor, allows the doctor to conduct fetal monitoring, and reduces the need to transport mothers for childbirth (Odibo et al., 2013). With the improvement of communication technology, medical video-conferencing can be implemented in all remote Indigenous communities in Quebec. Additionally, when access to high-speed connectivity is implemented, subsidized provision of iPads or tablets to hospitalized individuals and their families could reduce the trauma of prolonged separation for health care by allowing families to stay connected through Skype, Facetime, and other face-to-face communication applications.

Another vital aspect of healthcare that can be addressed with technology is substance abuse. Substance abuse is a common health problem among Indigenous peoples (Chansonneuve, 2007). Drug abuse rates are four times higher within Indigenous communities than non-Indigenous communities (Fortin, Bélanger, Boucher, & Muckle, 2015). The Kahnawake Health Report identifies substance abuse, including alcohol, as the number one health concern of the community, with current health services on the reserve being inadequate to deal with the heavy caseload (Kahentineson-Jacobs, 2011). Kahnawake chief Carl Horn, speaking about the opioid epidemic said: "We're moving on from marijuana, to the point where kids are crushing oxycodone, snorting it and injecting it" (Horn, 2016 as cited in MacArthur, 2016, para. 4). He continued; "It's a serious issue in our community, and it's getting worse and worse" (Horn, 2016 as cited in MacArthur, 2016, para. 4). This issue is not limited to the urban Indigenous populations: the James Bay Cree report that almost half the population binge drink several times a month (Cree Board of Health and Social Services of James Bay, 2005). From the physical point of view, alcohol causes cirrhosis of the liver and more generally, is a leading risk factor for death in Canada (Public Health Agency of Canada 2015). From a social point of view, alcohol addiction can have devastating effects on educational and occupational achievement, family structure, and financial resources (Government of Canada, 2016). Although addiction is difficult to address through technology, access to technology can encourage people who are trying to abstain or remain sober to gain support from online resources. For example, Our Spirit: Sober Strong provides online support, contact, and friendship for Indigenous people trying to stay sober (Native American Indian General Service Office of Alcoholics Anonymous, 2018). Telehealth interventions can be effective in addiction treatment (Ohinmaa, Chatterley, Nguyen, & Jacobs, 2010) and could allow the six addiction treatment centers for Indigenous people located in Quebec (Government of Canada, 2018a) to extend their reach; currently they offer only on-site treatments, and have web presence that acts primarily as online pamphlets. Extending their reach through telehealth and online support groups would allow Indigenous people living in remote communities to access resources that are otherwise scarce and inadequate, even in urban regions. Although in many remote regions, telehealth two-way conferencing is difficult due to connection speed and inconsistency (Whiteduck, Tenasco, O'Donnell, Whiteduck, & Lockhart, 2012), investment in video conference services optimized for satellite connections has made video conferencing possible in Nunavut (Zarate, 2010). Further, the Telehealth Network has a library of recorded webcasts on topics relevant to Indigenous health (First Nations Telehealth Network, 2018) which make lower demands on bandwidth than videoconferencing, and can be accessible as soon as remote networks are upgraded and communities are provided with computers in publicly accessible spaces. Finally, Indigenous peoples can use the internet to find information, such as online hotline services that support people during the crises often associated with addiction.

Depression and suicide are also critical issues for Indigenous health. Suicide is the number one reason for death among Indigenous peoples aged 44 and younger (Centre for Suicide Prevention, 2013). One hundred and twenty-six out of 100,000 Indigenous males aged between 15-24 commit suicide compared to 24 out of 100,000 non-Indigenous males in Canada; for Indigenous women the rate is 35 out of 100,000 compared to five out of 100,000 for non-Indigenous women (Centre for Suicide Prevention, 2013). Suicide rates among Inuit are 11 times higher than the national average in Canada, and Inuit rates of suicide are among the highest in the world (Kral, 2016). It has been shown that communities with some type of self-government, ownership of traditional lands, local control of healthcare, and education and community facilities that preserve culture have lower suicide rates (Centre for Suicide Prevention, 2013). Therefore, an important factor in reducing mental illness that leads to suicide is recognizing and respecting Indigenous peoples' power of self-governance, supporting them in the development of autonomy, and working with them to strengthen their communities which were weakened by colonization. Government in the modern age requires technology: one cannot create a budget, administer justice, track health care outcomes or communicate with constituents without the internet and computers.

But there are many young people in Indigenous communities who need help now. In remote Indigenous communities, therapists are few and are hard to reach. Jordan's Principle is a child first principle unanimously supported by the House of Commons in 2007 and guarantees First Nations children – and soon Inuit children (Rogers, 2018) – equitable access to public services such as health care and education (Government of Canada, 2018b). However, the gaps in health care access remain chasmic. Between July 2016 and February 2017, only 4 children in Quebec were identified for funding for care made available through Jordan's Principle, a weak record that was attributed to a lack of infrastructure to identify underserved children (Tasker, 2017). Increased access to technology would allow case workers to identify children and enter information to central databases to speed up the process. Technology might also help address the shortfall of psychological services in remote communities: for example, Nunavik has only two psychologists for 14 communities (Commission des droits de la personne et des droits de la jeunesse, 2007). Technology allows those in remote locations virtual access to mental health professionals and potentially combat feelings of depression and isolation by allowing people to connect with online support groups.

Summary

Indigenous peoples in Quebec face enormous barriers obtaining education and healthcare, barriers that are compounded by the digital divide. In education, improved computer technology could increase access to higher education in remote regions and strengthen Indigenous cultures. Web development and programming courses could help Indigenous people share their language and culture, create economic opportunities, and provide a means of airing grievances and contacting government officials.

Improved computer technology can also be utilized to address some of the many health care issues Indigenous peoples encounter. Internet access can: allow consultation with specialists in remote regions via telehealth applications; reduce the need for transportation to urban centres for treatment; improve Indigenous peoples' ability to influence government health policy; strengthen connections among Indigenous communities, and; create more opportunities to access online support for issues such as addiction, depression, and suicide prevention.

Computer technology is by no means a perfect, all-encompassing solution to the various and abundant issues encountered by the Indigenous communities in Quebec. However, the digital divide has played a vital role in keeping Indigenous people in situations of vulnerability and powerlessness. Closing the digital divide would help move Quebec society in the direction of equal access to education and health care, both of which are universal human rights (United Nations, 2015), and could ultimately help secure the right of Indigenous self-determination (United Nations, 2008).

References

Aboriginal Canada Portal. (2004). *2003 Report on Aboriginal Community Connectivity Infrastructure*. Retrieved from http://digitalaboriginals.ca/acp/site.nsf/vDownload/connectivity2003report/$file/2003ROAC.pdf

Alexander, C. (2011) From igloos to iPods: Inuit Qaujimajatuqangit and the internet in Canada. In P. R. Leigh (Ed.), *International Exploration of Technology Equity and the Digital Divide: Critical Historical and Social Perspectives* (pp. 80-105). Charlotte NC: Internet Age Press.

Arriagada, P. (2016). First Nations, Métis and Inuit Women. Retrieved from http://www.statcan.gc.ca/pub/89-503-x/2015001/article/14313-eng.htm

Batrawy A. (2017, April 14). Canadian Maggie McDonnell wins $1-million Global Teacher Prize. *The Globe and Mail*. Retrieved from https://www.theglobeandmail.com/news/national/canadian-maggie-macdonnell-wins-1-milli on-global-teacher-prize/article34342898/+&cd=1&hl=clnk&gl=ca

Battiste, M. (2002). *Indigenous knowledge and pedagogy in First Nations education: literature review and recommendations*. Retrieved from https://www.afn.ca/uploads/files/education/24._2002_oct_marie_battiste_indigenousknowledgeandpedagogy_lit_review_for_min_working_group.pdf

Billson, J. M., & Mancini, K. (2007). The promise and price of education. In *Inuit Women: Their Powerful Spirit in a Century of Change* (pp 315-334). Lanham, MD: Rowman and Littlefield Publishers.

Carpenter J., Guerin A., Kazcmarek M., Lawson G., Lawson K., Nathan L. P., & Turin M. (2016). *Digital access for language and culture in First Nations communities*. Retrieved from http://fnhssm.com/peke/wp-content/uploads/2017/08/report_2016_digital_language_access.pdf

CBC News. (2015, June 17). Inuktitut iphone, ipad keyboards help strengthen Inuit language. *Canadian Broadcasting Corporation*. Retrieved from http://www.cbc.ca/news/canada/north/inuktitut-iphone-ipad-keyboards-help-strengthen-inuit-language-1.3117261

CBC News. (2017, March 9). Nunavut language app bring Inuit language to life for preschoolers. *Canadian Broadcasting Corporation*. Retrieved from http://www.cbc.ca/news/canada/north/uqausiit-pinnguarutiit-language-app-1.4015268

Centre for Suicide Prevention. (2013). *Suicide Prevention Resource Toolkit*. Retrieved from https://www.suicideinfo.ca/wp-content/uploads/2016/08/Indigenous-Toolkit_Print.pdf

Chansonneuve, D. (2007). *Addictive Behaviours Among Aboriginal People in Canada*. Retrieved from Aboriginal Healing Foundation: http://www.ahf.ca/downloads/addictive-behaviours.pdf

Commission des droits de la personne et des droits de la jeunesse. (2007). *Nunavik: Report, conclusions of the investigation and recommendations*. Retrieved from http://www.cdpdj.qc.ca/Publications/rapport_Nunavik_anglais.pdf

Cree Board of Health and Social Services of James Bay (2005). The Evolution of Health Status and Health Determinants in the Cree Region (Eeyou Istchee): Eastmain-1-A Powerhouse and Rupert Diversion Sectoral Report: Volume 2: Detailed Analysis. Retrieved from http://www.gcc.ca/pdf/QUE000000012.pdf

Cree Board of Health and Social Services of James Bay (2015). Air Creebec to offer medical air charter for Cree patients in Northern Quebec. Retrieved from http://www.creehealth.org/news/community-stories/air-creebec-operate-medical-air-charter-cree-patients-northern-quebec

Cree Board of Health and Social Services of James Bay (2017). Midwifery and birthing. Retrieved from http://www.creehealth.org/miyupimaatisiiun-department/midwifery-and-birthing

Canadian Radio-television and Telecommunications Commission. (2016). Broadband Internet Service Coverage in Canada. Retrieved from https://crtc.gc.ca/eng/internet/internetcanada.htm

Canadian Radio-television and Telecommunications Commission. (2017). Communications monitoring report 2017: Telecommunications sector overview. Retrieved from https://crtc.gc.ca/eng/publications/reports/policymonitoring/2017/cmr5.htm#s53

Davis-Kean, P. (2005). The influence of parent education and family income on child achievement: The indirect role of parental expectations and the home environment. *Journal of Family Psychology, 19*(2), 294-304.

Department of Justice. (2017). Rights and freedoms in Canada. Retrieved from http://www.justice.gc.ca/eng/rp-pr/cp-pm/just/06.html

Duhaime G., Caron A., & Levesque, S. (2015). Nunavik in Figures 2015. Retrieved from Université Laval: http://www.chaireconditionautochtone.fss.ulaval.ca/documents/pdf/Profil-2015-anglais-24-08-2015.pdf

Fine, S. (2015, May 28). Chief Justice says Canada attempted 'cultural genocide' on aboriginals. *The Globe and Mail*. Retrieved from https://www.theglobeandmail.com/news/national/chief-justice-says-canada-attempted-cultural-genocide-on-aboriginals/article24688854/

First Nations Telehealth Network. (2017). First Nations Telehealth Network. Retrieved from http://www.firstnationsth.ca/Portals/0/April%20%202017%20Newsletter_1.pdf

Fortin, M., Bélanger, R., Boucher, O., & Muckle, G. (2015). Temporal trends of alcohol and drug use among Inuit of Northern Quebec, Canada. *International Journal of Circumpolar Health, 74,* http://doi.org/10.3402/ijch.v74.29146

Frizzell, S. (2017, February 18). Iqaluit kids go home with free laptops after coding workshop. *Canadian Broadcasting Corporation*. Retrieved from http://www.cbc.ca/news/canada/north/coding-course-free-laptop-1.3989314

Government of Canada. (2016). *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2015: Alcohol Consumption in Canada*. Retrieved from https://www.canada.ca/en/public-health/services/publications/chief-public-health-officer-reports-state-public-health-canada/2015-alcohol-consumption-canada.html

Government of Canada. (2017). Digital Canada 150: Announced Connecting Canadians Projects. Retrieved from https://www.ic.gc.ca/eic/site/028.nsf/eng/50044.html

Government of Canada. (2018a). Addiction Treatment for First Nations and Inuit. Retrieved from https://www.canada.ca/en/indigenous-services-canada/services/addictions-treatment-first-nations-inuit.html

Government of Canada. (2018b). Definition of Jordan's Principle from the Canadian Human Rights Tribunal. Retrieved from https://www.canada.ca/en/indigenous-services-canada/services/jordans-principle/definition-jordans-principle-canadian-human-rights-tribunal.html

Greenwood J., Harata Te Aika, L., & Davis, N. (2011). Creating virtual marae: An examination of how digital technologies have been adopted by Maori in Aotearoa New Zealand. In P. R. Leigh (Ed.), *International Exploration of Technology Equity and the Digital Divide: Critical, Historical and Social Perspectives* (pp. 58-79). Hershey, PA: IG Global.

Indigenous and Northern Affairs Canada. (2017). Let's talk on-reserve education: Survey report. Retrieved from https://www.aadnc-aandc.gc.ca/eng/1509019844067/1509019955553

Heaman, M. I., Gupton A. L., & Moffatt, M. E. K. (2005). Prevalence and predictors of inadequate prenatal care: A comparison of Aboriginal and non-Aboriginal women in Manitoba. *Journal of Obstetrics and Gynaecology Canada, 27*(3): 237-248.

Kahentineson-Jacobs, B. (2011, November). *Kahnawake Community Health Plan Health Transferred Programs*. Retrieved from http://www.kmhc.ca/chp_report/Community%20Health%20Plan %202012-2022%20Update d%2003192013_compressed.pdf

Kral, M. J. (2016). Suicide and Suicide Prevention among Inuit in Canada. *Canadian Journal of Psychiatry 61*(11), 688–695. http://doi.org/10.1177/0706743716661329

Larochelle, S. (2018, May 22). Plan Nord: Bien plus que 800km de fibre optique. *La Presse*. Retrieved from http://www.lapresse.ca/affaires/portfolio/plan-nord/201805/22/01-5182743-plan-nord-bien-plus-que-800-km-de-fibre-optique.php

MacArthur, C. (2016, October 14). Kahnawake Mohawk council chief calls for banishment of known drug dealers. *Canadian Broadcasting Corporation*. Retrieved from http://www.cbc.ca/news/canada/montreal/kahnawake-mohawk-chief-drugs-banishment-1.3803559

MacLean, E. A. (2004). Two children adrift. In B. Swann (Ed.), V*oices from Four Directions: Contemporary Translations of the Native Literatures of North America* (pp. 51-80). Lincoln NB, University of Nebraska Press.

Native American Indian General Service Office of Alcoholics Anonymous. (2018). NAIGSO-AA Home Fires: Online AA Email Meetings. Retrieved from http://www.naigso-aa.org/directories_AAonline.html

National Collaborative Center for Health and Well-being. (2017). Education as a social determinant of First Nations, Inuit and Métis health. Retrieved from https://www.ccnsa-nccah.ca/docs/determinants/FS-Education-SDOH-2017-EN.pdf

Odibo, I. N., Wendel, P. J., & Magann, E. F. (2013). Telemedicine in obstetrics. *Clinical Obstetrics and Gynecology 56*(3), 422–433. doi:10.1097/GRF.0b013e318290fef0

Ohinmaa, A., Chatterley, P., Nguyen, T., & Jacobs, P. (2010). *Telehealth in substance abuse and addiction: Review of the literature on smoking, alcohol, drug abuse and gambling*. Retrieved from Institute for Health Economics: http://www.ihe.ca/documents/Telehealth%20in%20 Addiction-Final%202%20Arto.pdf

Ordre des sages-femmes du Québec. (n.d.). *Aboriginal Midwifery and Midwifery Fact Sheet*. Retrieved from http://aboriginalmidwives.ca/files/toolkit/Quebec-1.pdf

Oxford Learner's Dictionary. (2018). Definition of digital divide noun from the Oxford Advanced Learner's Dictionary. Retrieved from https://www.oxfordlearnersdictionaries.com/definition/english/digital-divide

Partridge, S., Balayla, J., Holcroft, C. A., & Abenhaim, H. A. (2012). Inadequate prenatal care utilization and risks of infant mortality and poor birth outcome: A Retrospective analysis of 28,729,765 U.S. deliveries over 8 years. *American Journal of Perinatology 29*(10), 787–794. doi:10.1055/s-0032-1316439

Porter, J. (2016, March 14). First Nations students get 30% less funding than other children, economist says. *Canadian Broadcasting Corporation*. Retrieved from http://www.cbc.ca/news/canada/thunder-bay/first-nations-education-funding-gap-1.3487822

Public Health Agency of Canada. (2015). *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2015: Alcohol Consumption in Canada*. Retrieved from https://www.canada.ca/en/public-health/services/publications/chief-public-health-officer-reports-state-public-health-canada/2015-alcohol-consumption-canada.html

Rogers, S. (2017, December 4). Nunavik to get cellular service in 2018. *Nunatsiaq News*. Retrieved from http://nunatsiaq.com/stories/article/65674nunavik_to_get_cellular_service_in_2018/

Rogers, S. (2018, July 3). Ottawa says it will create an Inuit equivalent of Jordan's principle. *Nunatsiaq News*. Retrieved from: http://nunatsiaq.com/stories/article/65674ottawa_says_it_will_create_an_inuit_equivalent_t o_jordans_principle/

Ross, S. (2018, Jan 29). Quebec Inuit and the impossible dilemma. *Canada's National Observer*. Retrieved from https://www.nationalobserver.com/2018/01/29/news/quebec-inuit-and-impossible-dilemma

Roth, L. (2014, May 10). Digital self-development and Canadian First Peoples of the North. *The World Association for Christian Communication*. Retrieved from http://www.waccglobal.org/articles/digital-self-development-and-canadian-first-peoples- of-the-north

Saltzman, A. (2016, October 7). No connectivity: the internet 'blackout zone' that is rural Canada. *Canadian Broadcasting Corporation*. Retrieved from http://www.cbc.ca/news/business/no-connectivity-the-internet-blackout-zone-that-is-rural-canada-1.3792786

Secrétariat aux Affaires Autochtones Québec. (2018). Aboriginal communities of Québec. Retrieved from: http://www.autochtones.gouv.qc.ca/nations/liste_communautes_en.htm

Smillie-Adjarkwa, C. (2005). Is the internet a useful resource for Indigenous women living in remote communities in Canada, Australia and New Zealand to access health resources?. Retrieved from http://www.yorku.ca/anthna/DigitalDivide.pdf

Statistics Canada. (2016a). Aboriginal Peoples: Fact Sheet for Quebec. Retrieved from http://www.statcan.gc.ca/pub/89-656-x/89-656-x2016006-eng.htm

Statistics Canada. (2016b). Inuit: Fact Sheet for Nunavik. Retrieved from http://www.statcan.gc.ca/pub/89-656-x/89-656-x2016016-eng.htm

Statistics Canada. (2017a). Focus on Geography Series, 2016 Census. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-pr-eng.cfm?Lang=Eng&GK=PR&GC=24&TOPIC=9

Statistics Canada. (2017b). Early motherhood among off-reserve First Nations, Métis and Inuit women. Retrieved from https://www150.statcan.gc.ca/n1/pub/75-006-x/2017001/article/54877-eng.htm#a3

Statistics Canada. (2017c). Census Profile, 2016 Census. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

Syed, S. (2018). Second-Class Schools for Canada's Indigenous Youth. *The McGill International Review*. Retrieved from https://www.mironline.ca/second-class-schools-canadas-indigenous-youth/

Tasker, J. P. (2017, February 9). Health Canada having trouble finding First Nations kids to help because of 'broken' system. *Canadian Broadcasting Corporation*. Retrieved from: https://www.cbc.ca/news/politics/health-canada-jordans-principle-broken-1.3972924

United Nations Educational, Scientific and Cultural Organization. (2012). *Why language matters for the Millennium Development goals*. Retrieved from UNESCO Bangkok: http://unesdoc.unesco.org/images/0021/002152/215296E.pdf

United Nations. (2008). *United Nations Declaration on the Rights of Indigenous Peoples*. Retrieved from United Nations: http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

United Nations. (2015). *Universal Declaration of Human Rights*. Retrieved from United Nations: http://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf

Walton, F., McAuley, S., Tompkins, J., Fortes, E., Frenette, D., & Burgess, J. (2010). *Lighting the Qulliq: The First Master of Education Program in Nunavut*. Retrieved from University of Prince Edward Island: http://projects.upei.ca/nunavut/files/2013/09/Nunavut_Report_2006-2009.pdf

Wang, A. X. (2017, July 10). How the winner of the world's most prestigious teaching prize succeeds with no resources in the Arctic. *Quartz Media*. Retrieved from https://qz.com/1020830

Whiteduck, G., Tenasco, A., O'Donnell, S., Whiteduck, T., & Lockhart, E. (2012). *Broadband-Enabled Community Services in Kitigan Zibi Anishinabeg First Nation: Developing an e-Community Approach*. Retrieved from http://firstmile.ca/wp-content/uploads/2015/03/2012-KZA-Australia-final.pdf

Zarate, G. (2010, October 1). Nunavut Broadband rolls out new services. *Nunatsiaq News*. Retrieved from http://nunatsiaq.com/stories/article/987678_nunavut_broadband_roles_out_new_services

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal

Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Give children all rights

Aliya Garasia[1]

[1] Ross Drive Public School, Brampton, Ontario, Canada

Abstract

The grade 3/4 and grade 7 class at Ross Drive Public School worked together to learn about treaties, Shannen Koostachin, and Shannen's Dream. The students were asked to think about what a safe and comfy education might look like and why it is unfair that Shannen Koostachin had to fight for this right. This poem reflects what one student, Aliya, learnt.

Safety is key so you can all see,

just how important safety can be.

All children should be able

to study in a place that's stable.

Kids should be in a clean space

no matter their age, gender or race.

In some places our schools are sweet,

while others feel poor and they ain't such a treat.

Our schools should be where we go to learn,

and not for you and the money you earn.

We need to keep it all balanced and equal,

by making unfair schools illegal.

So, let's fix all those busted pipes,

and give children all rights!

First Nations Child & Family Caring Society of Canada

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Live-In Family Enhancement (LIFE): a comprehensive program for healing and family reunification

Lawrence Deane,[1] Jenna Glass,[2] Inez Vystrcil-Spence,[3] Javier Mignone[4]

[1] Associate Professor, Faculty of Social Work, University of Manitoba, Winnipeg, Manitoba, Canada
[2] Master's of social work candidate, University of Manitoba, Winnipeg, Manitoba, Canada
[3] Master's of social work candidate, University of Manitoba, Winnipeg, Manitoba, Canada
[4] Associate Professor, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, Manitoba, Canada

Corresponding author: Lawrence Deane, lawrence.deane@umanitoba.ca

Abstract

Family enhancement is an approach to child protection that has been recommended by numerous reviews of child welfare practice. A recent example emerged from a comprehensive review of the child welfare system in Manitoba, Canada. The inquiry recommended that family enhancement be utilised in all child welfare cases, and be funded at levels reasonable enough to allow comprehensive support for families seeking to re-unify. Agency staff told the inquiry, however, that current resources permitted only limited service, for insufficient time, and for only a small percentage of families in care.

An Indigenous agency in Manitoba, Metis Child, Family, and Community Services*, has devised an innovative approach in which parents were fostered along with their children. This allows the agency to make a wide range of resources available to families on a 24-hour basis for 8-to-12-month periods. The costs do not appear to exceed those of regular fostering of children.*

This Live-In Family Enhancement (LIFE) program was extensively evaluated in 2015. The findings show a significant set of benefits to families such as stronger attachment between parents and children, improved parenting skills for caregivers, strengthened social support for families, newly acquired household management skills, successful completion of employment training, and significantly improved trust in social workers and the agency. Many of these factors are correlated, in research, with increased rates of family reunification. The paper documents these findings, and recommends that this approach be expanded for use in prevention as well as reunification.

Keywords: *Family enhancement, Live-In Family Enhancement, child welfare, family reunification, prevention*

First Nations Child & Family
Caring Society of Canada

In 2013, a Commission of Inquiry in the Province of Manitoba released its report on the *Circumstances Surrounding the Death of Phoenix Sinclair* (Hughes, 2013). The inquiry had been called by the provincial government to investigate the death of a young girl for whom Winnipeg Child and Family Services had opened case files 13 times during her short five years of life. The inquiry heard that the child welfare agency had failed to notice the girl's disappearance until nine months after she was murdered by her parents (Hughes, 2013).

The inquiry undertook a comprehensive survey of the appropriateness, effectiveness, strengths, and challenges of Manitoba's child welfare system. A consistent theme throughout the testimony was the need for a differential response approach to each child welfare case. Central to this approach is family enhancement. Family enhancement was defined by the inquiry as an intervention in which risk is less immediate than for protection cases and in which agencies can provide supports to families to develop secure and nurturing homes for children (Hughes, 2013). Family enhancement is defined in similar ways in other contexts (Alberta, 2018; Manitoba Family Services, 2014).

Metis Child, Family, and Community Services (MCFCS) in Manitoba, whose program will be discussed in this paper, gives a typical description of family enhancement:

> *[Family enhancement is] a supportive service focusing on the overall needs of the family and the well-being of the children . . . Planning builds on identified strengths and focuses on needs identified through an assessment process with the family. Sharing circles, with the support of the program's cultural worker, and planning meetings with extended family members, are used to broaden families' support networks* (Metis Child, Family, and Community Services, 2018, para. 11).

The goal of family enhancement is to strengthen the family and to avoid bringing a child into care. Expert witnesses at the Phoenix Sinclair inquiry recommended that social work interventions include family enhancement at every phase (Hughes, 2013).

While extensive use of family enhancement was endorsed by virtually all witnesses at the inquiry, a key impediment to implementation was described by agency directors as a lack of both human and financial resources. The commission was told that agency budgets for family enhancement were only $1,300 per family per year. This was to cover all the supports a family might need. However, to place a family support worker in a home for only six hours per week for 20 weeks would cost an agency $5,000. In the opinion of one agency director, families usually needed such support for at least a year to be able to make changes in their behaviour patterns (Hughes, 2013). Because of budget constraints, agencies ration their resources, and only a minority of families receive family enhancement. Six hours per week of family support leaves no additional budget for other important services such as attachment therapy, Fetal Alcohol Spectrum Disorder training, parenting classes, assistance with employment, or even such essential needs as transportation and adequate nutrition. The inquiry's final report recommended that resources for family enhancement be increased to "reasonable levels" (Hughes, 2013, p. 42) and that family enhancement be "embedded in all ongoing services to families" (Hughes, 2013, p. 37).

At the same time as these recommendations were being made by the inquiry, a child welfare agency in Winnipeg, MCFCS, was experimenting with a program called Live-In Family Enhancement (LIFE) (Metis Child, Family, and Community Services, 2018). Rather than placing a family support worker in a home for a few hours per week, and exhausting resources for additional programming, the LIFE model had parents and children move in full-time to a foster home together with a family mentor (Metis Child, Family, and Community Services, 2014a). The client families received coaching and support in parenting on a moment-to-moment basis, seven days per week, and had access to a full range of other supports such as attachment-based parenting training, anger management training, substance abuse relapse prevention, employment assistance, help with nutrition and budgeting, support with issues at school or daycare, and a range of other resources needed to become competent and nurturing families (Metis Child, Family, and Community Services, 2014a).

The LIFE program was provided not as an alternative to apprehension but rather as a process for family reunification. The funds for the support worker and ancillary supports were drawn not from supplementary budgets of $1,300 per family per year but from per diem amounts normally paid to foster parents. To access these resources the program fostered the parent(s) with the child and provided support and mentoring that could help ensure successful reunification (Metis Child, Family, and Community Services, 2014b).

The LIFE model was of great interest to funders of MCFCS. In September 2014, MCFCS engaged the authors of this paper to conduct an evaluation of the implementation and outcomes of the LIFE program. The evaluation team consisted of two Master of Social Work students, their thesis supervisor, and another university professor who specializes in program evaluation. The team submitted their report to MCFCS in August 2015.

This paper is a summary of the findings of the report and a discussion of some of the potential benefits of the LIFE program. This paper briefly describes some of the outcomes for families that emerged from the evaluation study, relates these to a brief literature review on reunification of child welfare families, and describes the innovative funding model that was used by MCFCS and that could be utilized by any agency. Finally, this paper discusses the potential expansion of the LIFE model beyond a reunification objective and more broadly for prevention.

The LIFE program provided service for 8-12 months. During the period covered by the evaluation (January 2008 and August 2015), the program worked with 27 families involving a total of 39 children. At the time of writing this paper, the program had worked with a further 6 families for a total of 33 families. It is not known if all the families in the LIFE program were Métis. In Manitoba, a family has the right to choose the agency from which they wish to receive services (Hughes, 2013; Milne, Koslowsky, and Sinha, 2018). Such decisions may be made for a variety of reasons. However, 90% of children in care in Manitoba are Indigenous, and it is therefore likely that families in the LIFE program reflected this level of representation (Manitoba, 2017). Seventy-five percent of children whose families completed the LIFE program were able to stay with their families and have not re-entered care (LIFE Program Director, personal communication, August 9, 2018).

Evaluation approach and methodology

In discussion with MCFCS, the evaluation team applied a utilization-focused evaluation approach following the guidelines developed by Patton (1997, 2008). This approach assumes that significant participation in the design of research, and analysis of its findings, by users of the evaluation will increase the likelihood that research results will be utilized (Patton, 2008).

The evaluation followed a series of iterative steps, starting by identifying the primary intended users of the information and creating a working group that included representation from different stakeholders. Stakeholders included representatives from the Manitoba Government Child Protection Branch (funder), the Metis Authority, and staff members of MCFCS including the Executive Director, LIFE program Supervisor, LIFE program Treatment Worker, and the Director of Resources. This working group met five times between October 2014 and August 2015. The working group made all significant decisions in terms of evaluation questions, design, data collection, and methodology. The working group oversaw the approach to data collection and analysis while more detailed analysis was done by the graduate students. The types of analysis used, interpretation of data, and decisions on utilization of findings were determined by the working group.

Evaluation questions were of two types: those designed to measure outcomes; and those designed to assess implementation effectiveness. Only the findings of the outcome questions will be discussed in this paper. These questions, as developed by the working group, were: 1) what impact has participation in the LIFE program had on parents, children, and the entire family, and; 2) how effective was the training and support provided to the mentors and to biological parents?

To answer these questions the group chose a sample of ten LIFE families. This was a purposive sample based on maximum variation of criteria such as entry year, presenting issues, age of parent, relationship status of parent, number of children, age of children, location of the mentorship home, agency providing case management support, successful or non-successful graduation, and length of time in the program. This diversity sample was expected to provide a comprehensive range of data about the program. As Patton (1990) points out, there is greater significance of shared patterns emerging from diverse cases than from a homogeneous sample.

The evaluation team conducted document reviews including general files, transfer summaries, structured decision-making tools, Signs of Safety Maps, parental capacity assessments, weekly logs for the program, case notes prepared by social workers and LIFE program mentors, and reports and certificates from outside agencies such as therapists and the Addictions Foundation of Manitoba. These were expected to provide significant information on issues, goals, and progress of each family. Initially, the intent was to conduct a file review for the entire sample. However, when eight of ten file reviews were completed it was found that the information was similar to that gathered by interviewing multiple actors involved with a family. Due to the considerable time required to carry out file reviews, the working group decided to discontinue file reviews for the last two families and focus only on interviews.

The evaluation team eventually conducted interviews with eight participating LIFE families. One of the families in the file review could not be contacted, and one declined to be interviewed. These 8 families constituted 30% of the 27 families that had completed the LIFE program as of August, 2015. The ten families had a total of six LIFE mentors. All six mentors were also interviewed, along with LIFE staff related to three LIFE families who were able to take part. Seventeen interviews in all were carried out. All interviews except one were audio recorded and transcribed (one parent declined to be recorded and, in this case, handwritten notes were taken). The graduate students identified themes that emerged both according to evaluation questions and those that emerged inductively from the data. The graduate students analyzed transcripts separately and then compared emerging themes identified across the interviews. Emergent findings were presented to the stakeholder group for discussion and interpretation.

Reunification of child welfare families

Child welfare agencies in Canada, the United States, the United Kingdom, and Australia all prioritize the reunification of families after children have been taken into care (Chambers, Brocato, Fatemi, & Rodriquez, 2016; Landers & Danes, 2016; Esposito et al., 2014). Research over the last two decades in the United States, using large samples, indicates that only 51% of American children in out-of-home care return to birth parents and only 43% return in the first 12 months of care (Akin, 2011; Chambers et al., 2016; Landers & Danes, 2016). The average time in out-of-home care is 28 months (Chambers et al., 2016). These figures vary somewhat according to jurisdictions.

Findings over the past two decades suggest a consistent set of factors that are correlated with increased likelihood of reunification. These include age of the child, reasons for placement, length of time in care before reunification, emotional or behavioral difficulties of the child, the child's ethno-cultural background, the number of placement changes, and family social and economic disadvantages (Chambers et al., 2016; Landers & Danes, 2016; Akin, 2011; Esposito et al., 2013; Yampolskaya, Armstrong, Strozier, & Swank, 2017).

While these correlates provide a starting point for understanding potential for reunification, they do not specify actual processes that lead to, or improve, the rates of restoration of families. Esposito et al. (2014) state that for Canada there are no "province-wide longitudinal studies on the case dynamics that influence reunification" (p. 279). According to these authors "child protection authorities make decisions relying on professional intuition, descriptive cross-sectional annual service statistics, and research evidence drawn from other countries that have child protection systems structurally different than that in Québec [or other Canadian jurisdictions]" (p.279).

Chambers et al. (2016), Carnochan, Chris, and Austen (2013) and Yampolskaya et al. (2017) reviewed the literature on factors that are linked to improved potential for reunification. Some of these include regular family visits at the child's home (versus public environments such as fast food restaurants) and involvement of parents in making decisions (Carnochan et al., 2013). Matching family needs to services such as mental health, housing, family counseling, and substance abuse treatment, has been shown to increase reunification significantly (Choi & Ryan, 2007). Cheng (2010) and Cheng and Lo (2012) found that families who received financial assistance and housing services were more likely to reunify. Some studies indicate that families that wanted to reunify were not able to receive services they needed. Marcenko, Lyons, and Courtney (2011) found that of 809 mothers who were seeking to reunify, one third did not obtain family counseling services, and 20% did not receive necessary medical treatment.

Some factors leading to improved reunification rates were characteristics of agencies and not of families or services. High caseloads for protection workers and staff turnover have been shown to have negative effects on reunification and permanency outcomes (Chambers et al., 2016). The Child Welfare League of America recommends caseloads per worker of 12 to 15 (Hughes, 2013). The Manitoba Children's Advocate endorses this standard (cited in Hughes, 2013). The American Public Human Services Association (cited in Chambers et al., 2016) found that average caseloads were double that at 24 to 31. The Phoenix Sinclair Inquiry commented that excessive workloads were a problem for child welfare across Canada and perhaps everywhere in the world (Hughes, 2013). Child protection workers in Winnipeg often have caseloads of 40 while the department's funding model assumes caseloads of 25 (Hughes, 2013). Experts at the inquiry recommended caseloads of 12-15 (Hughes, 2013).

Staff turnover can also have a negative impact on reunification. Flower, McDonald, and Sumski (2005) found that children who had only one worker had reunification and permanency rates of 74.5%. When two workers were involved, reunification and permanency rates dropped to 17.5%. The Family to Family initiative in the United States covering 60 agency sites across 19 states, reduced caseloads and allocated only one worker per case as part of a package of measures to increase reunification rates (Chambers et al., 2016). Evaluation studies found that workers with smaller caseloads achieved reunification rates of 40% compared to 16% for control groups. Families that had multiple workers took 76% longer to reunify. Chambers et al. (2016) argue that programs that incorporate parental involvement in case planning, match services to needs, address financial and housing needs, have reasonable workloads for caseworkers, and avoid transfer of cases among workers, are generally able to increase reunification rates and to sustain reunification over the long term. The LIFE program generally provided one mentor per participant family over the course of 8-12 months and endeavoured to make a range of services available that met the needs of both parents and children (Metis Child, Family, and Community Services, 2014a). In so doing it incorporated many of the correlates that research suggests improve potential for reunification.

Parent coaching and training programs are considered to be widely needed services for families who are seeking to reunify (Dozier, Meade, & Bernard, 2014; Oxford et al., 2016; Troutman, 2015). Such programs generally fall into two types, behavioral interventions and approaches aimed at building secure attachment (Troutman, 2015). Both kinds of programs have been extensively evaluated (Stratton-Webster, 2014; Dozier, Meade, & Bernard, 2014). They have demonstrated positive outcomes, though they differ in the outcomes achieved (Dozier, Meade, & Bernard, 2014; Troutman, 2015). Child welfare authorities often consider successful completion of a parenting course as a factor in family readiness to reunify.

While the LIFE program design was based largely on practical experience rather than formal research, the program can be seen to have incorporated many factors correlated with successful reunification. This will be discussed further in the sections below.

Findings

As mentioned above, the two key research questions developed by the stakeholder group in the evaluation were: what impact has participation in the LIFE program had on parents, children, and families, and; how effective was the training and support provided to the mentors and to biological parents? Six themes emerged from the responses of staff and participants in the evaluation interviews. These were: 1) establishing predictable routines; 2) developing self-esteem and competence in parenting; 3) building trust in the agency and others; 4) broadening the circle of support and repairing relationships; 5) managing the household; and 6) obtaining secure housing and income. This section of the paper represents some key quotations of participants in the program that illustrate these themes.

Establishing predictable routines

One of the outcomes of the LIFE program most frequently identified in interviews with both families and agency staff was the development of predictable routines for the family. When asked about outcomes of the program, comments such as the following were typical:

> *Well, I know he has a routine. He didn't have one much . . . because I didn't have a routine . . . so now he has one . . . he has more consistency* (Parent 1, Interview, June 25, 2015).

Another parent identified this as a positive change in her child:

> *Changes in my children? Well she has got in her routine very well. Like every day she's a very happy girl . . .* (Parent 2, Interview, June 12, 2015).

A mentor commented on a parent's progress:

> *[M] just couldn't get her head wrapped around that these kids needed a routine . . . But you know, over time, I just pointed out to her "okay, you see what routine is doing?" You're now getting some sleep because the kids are going to bed at a decent hour. They're eating at a decent time and now you gotta' get yourself into a routine so that you can sleep so that you're prepared for the next day* (Mentor 2, Interview, February 24, 2015).

This outcome is likely the result not only of the mentoring but also of the Dragonfly attachment training program which includes a family routine as an important objective in its training (Metis Child, Family, and Community Services, 2014b). The LIFE program enrolled all participants, along with their family mentors, in the Dragonfly Reunification Program at the Aulneau Renewal Center in Winnipeg. This is an attachment-based intervention designed specifically to assist in reunification of families in child protection programs (Aulneau, 2018, Metis Child, Family, and Community Services, 2014a). Dragonfly assumes that the majority of parents with children in care have had disrupted attachments themselves (Aulneau, 2018). The program provides an attachment counselor and a reunification coach and includes both counseling sessions and supportive coaching in the client's home. The program addresses trauma and loss, substance misuse, domestic violence, and self-esteem. It is designed to provide "more comprehensive service than is normally available to agencies" to improve family functioning (Aulneau, 2018, para. 3).

Developing self-esteem and competence in parenting

Parents and mentors also described improvements in parenting skills for LIFE participants. One parent responded:

> *I learned more about . . . the children's needs, and more of their emotional needs. The Circle of Security [attachment training] was a good one. I learned how to . . . help the kids organize their feelings. I learned more detailed things about the kids - not just like their physical needs . . . but their emotional needs* (Parent 2, Interview, June 12, 2015).

Another parent stated that without the LIFE program:

> *I don't think I would have had the skills in order to properly look after my kids to the point where I felt I was successful instead of just being stressed all the time* (Parent 5, Interview, February 11, 2015).

Asked about the participant's parenting when she first arrived, a mentor stated:

> *Oh, it was pandemonium . . . she had a hard time with two busy kids . . . But really, with [B], if she makes a decision to take information and run with it, she'll run with it* (Mentor 2, Interview, February 24, 2015).

Another parent stated:

> *I was just holding onto a lot of anger and dealing with that and then having her crying- it was hard . . . I'm not holding onto all this anger any more . . . [I learned the importance of] playing with her - like showing her how to do some things - like the shape thing . . . and blocks . . . I take more interest in playing with her. Whereas before I wasn't really sure what even to do with her* (Parent 3, Interview, January 23, 2015).

Building trust in the agency and others

While many parents stated that there were significant issues of trust to overcome, they consistently reported that the LIFE program engendered confidence, not only in their mentors but also in the agency. In describing mentors one parent stated:

> *Well [M], like I'm really comfortable talking with her. She cares about me lots and she lets me know . . . Because she's like easy to talk to and we get along good. I trust her lots . . . Actually, it kind of feels like she's my mom* (Parent 2, Interview, June 12, 2015).

Another parent stated:

> *CFS? I didn't trust them. And it took me a while to get used to [T] [the mentor]. Then I met [C] . . . it took me a long time to . . . be okay with her and really I didn't trust her.* (Parent 3, Interview, January 23, 2015)

Later in the same interview, however, this parent described her mentor as "a great friend" (Parent 3, Interview, January 23, 2015). She described how she continued to consult the mentor after leaving the program and was invited to spend Christmas with the mentor's family (Parent 3, Interview, January 23, 2015).

Another parent wrote two letters to her former mentor after her time in the LIFE program. She stated:

> *It's hard for me to express appreciation but I really do . . . You gave me so much and all I do is be rude to you. It's not intentional. It's just hard for me to accept when someone is so nice to me. As well, I've had so much resentment toward CFS that I took it out on you and that was wrong . . . It's just hard hearing the truth . . . I see the wonderful person you are. No one's perfect, but you come close . . . Thank you for showing what unconditional love looks like* (Staff 2, Interview, May14, 2015).

Another LIFE parent stated:

> *I was a permanent ward of CFS as of the age of 4 and I know from my own life experiences through CFS all they want is your kid. They don't care about the parents whether or not it's false allegations or not* (Parent 4, Interview, March 6, 2015).

Later, this same parent had significant praise for all of the workers involved with his family. Asked how it was to try and build trust with MCFCS, he stated:

> *Honestly? For me it was hard. It took quite a bit . . . To this day, I thank [M] and the two workers that we had. [K] proved that they were actually working for us* (Parent 4, Interview, March 6, 2015).

When he described their second mentor he stated:

> *I'd swear he was a CFS kid himself . . . He knows what we've been through* (Parent 4, Interview, March 6, 2015).

The LIFE program was not successful in all cases. One parent stated:

> *Honestly, I'm not getting much support from [my mentor]. She's supposed to help me more than she has been . . . Like by asking me if I need help or doing a check-in . . . So I'm really not happy here . . . I sent complaints to [E] and [N] [supervisors] . . . and I don't really fully trust that my son is in good hands when I leave . . . I'm not getting any help . . . I don't know who to talk to and I need to talk to someone (Parent 1, Interview, June 25, 2015).*

The evaluation team passed on these concerns to the agency.

Broadening the circle of support and repairing relationships

In evaluation interviews LIFE parents were asked, "what do the supports look like since you have been in the program?" Most of the parents indicated that their support networks had improved. One parent indicated that family, her mentor, and agency staff were now her supports:

> *Oh, my sister, especially. Staff at BNL. [S], my social worker. [M], my mentor. Basically, the people I work with. I feel comfortable with them now and I can talk with them* (Parent 3, Interview, January 23, 2015).

Many participants in the LIFE program indicated that although they were at very difficult points in their lives when they entered the program, and were vulnerable because of fractured relationships, they were now able to reconcile with siblings, friends, and extended families. The Dragonfly training placed a particular emphasis on this aspect:

> *While I was in the LIFE program, one of my friends started talking to me again and she was a long-time friend of eight years. We had stopped talking and it was because, I like, wasn't myself because I was doing drugs and stuff . . . But, so – yeah – she's become a big support now . . . I also have my sister. I was really angry with her for calling CFS on me so – but now we are, I guess, a lot closer now* (Parent 3, Interview, January 23, 2015).

Managing the household

The LIFE program provided the practical, day-to-day skills that many families needed to carry out routine activities of household management. These outcomes were evident in the program. A mentor commented on [D], a young mom who was parenting at the age of 17:

> *[D] was 13, going on 14, when she got pregnant . . . She is still a child trying to do adult stuff . . . She couldn't parent when she had the kid so she gave the kid to her mom . . . Her mom's kids got taken away so her kids got taken away [with them] . . . She said, "oh, I don't want my child in care . . . I want to take care of her myself" . . . So they told her, . . . "You have to live with a LIFE parent and . . . learn life skills" – parenting . . . budgeting, and all that stuff. She learned how to cook some meals . . . she started doing laundry . . . I taught her how to use the machine and how to take out the lint and all that stuff . . . She was cleaning her room . . . cleaning the bathroom . . . she was supposed to go open an account . . . so she could be putting some of her allowance in there . . . we were able to put together some documents to get her . . . a photo ID* (Mentor 3, Interview, February 24, 2015).

Obtaining secure housing and income

Although it was not a central goal of the LIFE program, one of the contributing factors in successful reunification was that some of the parents' housing and income problems were addressed. Many LIFE families were in very precarious financial and housing circumstances when they entered the program. Two families entered the program early because they found themselves without housing. Another family came to the program from a shelter. She described her situation this way:

> *I lost everything [when my kids were apprehended] . . . I had already paid $950 for my rent. I was barely getting anything from welfare. Like, I'm on disability so I get (a little extra) money but . . . when [they] took the baby one hundred percent off my name, I was only getting $50 and $200 for child taxes . . . So I was living on next to nothing. And then when they got taken I couldn't even afford that house any more. So, yeah, I lost almost everything* (Parent 5, Interview, February 11, 2015).

Families in the LIFE program must go on Employment and Income Assistance (EIA) (social assistance) and contribute their incomes to the household budget. In return, they get stable housing and a reasonable living standard for themselves and their children for 8 to 12 months. A number of studies have shown that child apprehensions related to neglect are often outcomes of poverty and housing instability (Trocmé et al., 2013). Cheng (2010) showed a positive correlation between appropriately addressing financial and housing needs and increased rates of family reunification. While the LIFE program stabilized families for 8 to 12 months, it also gave some families an opportunity to improve employability. Meeting families' housing and financial needs, and helping with employability, could prove to be low-cost interventions that can help keep families together.

A couple who went through the program both finished their high school diplomas. One spouse had worked as a bouncer and vendor staff for the liquor lounge in a local hotel. He stated:

> *I never thought I'd have the opportunity to go back to school. I got that opportunity through the LIFE program to do it and I did graduate . . . I finished and I got all my credits* (Parent 4, Interview, March 6, 2015).
>
> Shortly after the interviews he was due to start college.

Program financing

A number of expert witnesses at the Phoenix Sinclair Inquiry (Hughes, 2013) stated that improved child welfare outcomes could be achieved if family enhancement were provided at all stages of child protection cases. At the same inquiry, however, agency directors stated that a lack of resources was a barrier to providing this comprehensive care (Hughes, 2013). One of the most significant contributions of the LIFE program was to find an innovative means of funding the range and duration of assistance that families require. It does so by using per diem resources that are already available for fostering children. The LIFE program utilized a fostering per diem of $22.11 per day for children under two years plus $10 per day for respite care that is available in regular foster care. Added to this was the $100 per day stipend paid to foster parents for a total of $132.11 per day. This translates to $4,018 per month per family, or $48,220 per year. In addition, children in foster care have budgets available for special treatment. The LIFE parent was expected to pay the $285 per month for rent and $150 per month for food that was available through provincial Employment and Income Assistance. These amounts combine to create the kind of supportive intervention that families need on a comprehensive and long-term basis. A financial officer from the child welfare authority, who took part in the evaluation steering committee, informally calculated that the costs of the live-in mentor program were no greater than those normally paid for child foster care.

Discussion

The LIFE program paid attention to a comprehensive range of needs including parenting skills, household management, social support, sobriety, financial stability, and employability. The evaluation findings of the program suggest that for most parents the outcomes on these areas were positive or promising. Much of this seemed to be possible through the trust relationships that were built by sustained day-to-day interaction over a significant period. As the Phoenix Sinclair Inquiry stated, issues of trust and mistrust were key factors in whether an agency can work effectively with a family, and that mistrust of the child welfare system is a barrier that prevents many families from engaging with that system in a productive way (Hughes, 2013). Training parents in pragmatic skills such as budgeting and household management was important in avoiding conditions that lead to allegations of neglect. Such allegations often arise from circumstances outside of parental control, such as poverty and poor housing (Blackstock, Prakash, Loxley, and Wein, 2005; Trocmé et al., 2005). Participation in a program such as LIFE may help reduce the instances of such allegations. While these aspects were important supports, the priority in the program was developing sound parent-child relationships through secure attachment and development of predictable household routines.

The study did not seek to statistically assess LIFE program rates of family reunification. To do so would have required a representative sample and comparison with a non-intervention group. However, the study does show that families who participated in the LIFE program received a comprehensive range of important benefits, and that these were of the type regularly correlated with improved rates of family reunification. This was done with little additional strain to existing budgets. Virtually all experts agree that child welfare agencies must transform from reactive, disruptive, and often traumatising methods of intervention, to those that are more supportive, constructive, and restorative (Gerlach, Browne, Sinha, Elliott, 2017; Hughes, 2013; Prilleltensky, Peirson, & Nelson, 2001; Mandell, Clouston Carlson, Fine, &

Blackstock, 2007; Trocmé et al., 2013). Trocmé, et al. (2013) showed that these approaches can be used without compromising safety.

Given the intrinsic benefits of the LIFE program, and its affordability within existing child welfare budgets, it is reasonable to recommend that this approach be expanded to purposes beyond family reunification and applied to prevention. A significant body of research has demonstrated that apprehension, in and of itself, can be traumatic for both parent and child. For example, Wall-Wieler et al., (2017) found that "mothers who lose custody of their children have numerous mental health and social issues; these issues worsen in the two years after their child is taken into care" (p. 6). These mothers experience significantly increased rates of anxiety and substance use disorders, hospital visits, use of prescription drugs, and physician visits. These authors advocated increased supports to mothers within the first two years of apprehension so that these outcomes do not become further barriers to reunification.

Trauma is also evident in children who are apprehended. Children in foster placements in Manitoba tend to have poorer educational outcomes than children not in care. Brownell et al. (2015) found that 89% of children who were never in care graduated from high school. However, 66.8% of children receiving services from Child and Family Services (but not in care) graduated, and only 33.4% of children in care graduated. Clausen et al. (1998) found that children who have been removed from their homes likely had difficulties with attachment prior to apprehension because of abuse and neglect. They "suffer(ed) further due to an inability to separate in a healthy way. Indeed, the movement from . . . home to the foster home engender[ed] feelings of rejection, guilt, hostility, anger, abandonment, shame and associative reactions in response to the loss of a familiar environment and the separation from family and community" (Clausen, et al., 1998, p. 284). This paper argues that such trauma should be avoided if possible. A program such as LIFE can add the supports a family needs to begin to function well and to greatly reduce the need for apprehension. Such practice may require some budgetary adjustments. For instance, funds allocated for fostering could not technically be used for prevention, since foster care can only occur after a child is removed. However, a reallocation from foster care budgets to those for earlier stages of intervention could resolve this. Such reallocation would likely be cost neutral, and may very well produce cost savings. Certainly, such preventative work would be warranted in terms of improved family functioning, increased trust in agencies, and avoidance of parental and child trauma. An emphasis on prevention would likely reduce the numbers of children in care. This is an outcome called for in numerous reviews of current practice (Hughes, 2013; Gerlach, et al., 2017; Office of the Children's Advocate, 2006).

The findings of this study warrant further examination of the possibilities of comprehensive support for families. This could move child welfare work significantly toward the supportive and constructive approaches that many have recommended, and that are likely to be the most effective and culturally appropriate ways of helping families.

References

Akin, B. A. (2011). Predictors of foster care exits to permanency: A competing risks analysis of reunification, guardianship, and adoption. Children and Youth Services Review, 33, 999-1011.

Alberta. (2018). Family Enhancement. Retrieved from http://www.humanservices.alberta.ca/abuse-bullying/17181.html

Aulneau Renewal Centre. (2018). Dragonfly Reunification Program. Retrieved from https://aulneau.com/cfs/dragonfly-reunification-program/

Blackstock, C., Prakash, T., Loxley, J., & Wien, F. (2005). Wen:de: We are Coming to the Light of Day. Retrieved from First Nations Child and Family Caring Society of Canada: https://fncaringsociety.com/publications/wende-we-are-coming-light-day-0

Brownell, M., Chartier, M., Au, W., MacWilliam, L., Schultz, J., & Guenette, W. (2015). The educational outcomes of children in care in Manitoba. Manitoba Centre for Health Policy. Retrieved from http://mchp-appserv.cpe.umanitoba.ca/reference/CIC_report_web.pdf

Carnochan, S., Chris L., & Austen, M. J. (2013). Achieving Timely Reunification. Journal of Evidence-based Social Work, 10, 179-195.

Chambers, R. M., Brocato, J., Fatemi M., & Rodriguez, A. Y. (2016). An innovative child welfare initiative: Results and outcomes. Child and Youth Services Review, 70, 143-151.

Cheng, T. C. (2010). Factors associated with reunification: A longitudinal analysis of long-term foster care. Children and Youth Services Review, 32, 1311-1316.

Cheng, T. C. & Lo, C. C. (2012). Racial disparities in access to needed child welfare services and worker-client engagement. Children and Youth Services Review, 34, 1624-1632.

Choi, S., & Ryan, J. (2007). Co-occurring problems for a substance abusing mothers in child welfare: matching services to improve family reunification. Children and Youth Services Review, 29, 1395-1410.

Clausen, J. M., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, A. (1998). Mental health problems of children in foster care. Journal of Child and Family Studies, 7, 283–96.

Dozier, M., Meade, E., & Bernard, K. (2014). Attachment and biobehavioural catch-up: An intervention for parents at risk of maltreating their infants and toddlers. In S. Timmer & A. Urquiza (Eds.), Evidence-Based Approaches for the Treatment of Maltreated Children: Considering core components and treatment effectiveness. doi:10.1007/978-94-007-7404-9_4

Esposito, T., Trocmé, N., Collin-Vézina, D., Shlonsky, A., Sinha, V. (2014). Family reunification for placed children in Québec, Canada: A longitudinal study. Children and Youth Services Review, 44, 278-287.

Flower, C., McDonald, J., & Sumski, M. (2005). Review of turnover in Milwaukee county private agency child welfare ongoing case management staff. Retrieved from Bureau of Milwaukee Child Welfare: www.sw.uh.edu/_docs/cwep/national-iv-e/turnoverstudy.pdf

Gerlach, A. J., Browne, A. J., Sinha, V., Elliott, D. (2017). Navigating structural violence with indigenous families: The contested terrain of early childhood intervention and the child welfare system in Canada. The International Indigenous Policy Journal, 8(3). doi:10.18584/iipj.2017.8.3.6

Hughes, T. (2013). The legacy of Phoenix Sinclair: Achieving the best for all our children. Retrieved from http://www.phoenixsinclairinquiry.ca/

Landers, A. L., & Danes, S. M. (2016). Forgotten children: A critical review of the reunification of Indian children in the child welfare system. Children and Youth Services Review, 71, 137-147.

Mandell, D., Clouston Carlson, J., Fine M., & Blackstock, C. (2007). Aboriginal Child Welfare. In G. Cameron, N. Coady, & G. R. Adams, (Eds.), Moving toward positive systems of child and family welfare: Current issues and future directions (pp. 115-159). Waterloo: Wilfred Laurier University Press.

Marcenko, M., Lyons S., and Courtney M. (2011). Mothers' experiences, resources and needs: The context for reunification. Children and Youth Services Review, 33, 431-438.

Manitoba. (2017). Discussion Guide. Review of Child Welfare Legislation. Retrieved from https://www.gov.mb.ca/fs/child_welfare_reform/pubs/discussion_guide.pd

Manitoba Family Services. (2014). Changes for Children: An Overview of Accomplishments – By Theme. Retrieved from https://www.gov.mb.ca/fs/changesforchildren/pubs/overview_accomplishments.pdf

Metis Child, Family, and Community Services. (2014a). Annual Report 2013-2014. Retrieved from http://www.metiscfs.mb.ca/annual_reports.php

Metis Child, Family, and Community Services. (2018). Alternative Placement Services. Retrieved from http://metiscfs.mb.ca/alternative_placement_services.php

Milne, L., Kozlowski, A., & Sinha, V. (2014). Manitoba's Child Welfare System. Retrieved from cwrp.ca/sites/default/files/publications/en/MB_final_infosheet.pdf

Office of the Children's Advocate. (2006). Strengthening the commitment: An external review of the child welfare system. Retrieved from http://www.childrensadvocate.mb.ca/wp-content/uploads/2014/04/Strengthen-the-Commitment-September-29-2006.pdf

Oxford M. L., Marcenko, M., Fleming C. B., Lohr, M. J., & Spieker, S. J. (2016). Promoting birth parents' relationships with their toddlers upon reunification: Results from Promoting First Relationships from visiting program. Children and Youth Services Review, 61, 109-116.

Patton, M. Q. (1990). Qualitative Evaluation and Research Methods (2nd ed.). Newbury Park: Sage.

Patton, M. Q. (1997). Utilization-focused evaluation: The new century text (3rd ed.). Thousand Oaks: Sage.

Patton, M. Q. (2008). Utilization-focused evaluation (4th ed.). Thousand Oaks: Sage.

Prilleltensky, I., Peirson, L., & Nelson, G. (2001). Mapping the terrain: Framework for promoting wellness and preventing child maltreatment. In I. Prilleltensky, G. Nelson, & L. Peirson (Eds.), Promoting family wellness and preventing child maltreatment: Fundamentals for thinking and action. Toronto: University of Toronto Press.

Trocmé, N., Fallon, B., Sinha, V., Ven Wert, M., Kozlowski, A., & MacLaurin, B. (2013). Differentiating between child protection and family support in Canadian child welfare system's response to intimate partner violence, corporal punishment, and child neglect. International Journal of Psychology, 48(2), 128–140. http://dx.doi.org/10.1080/00207594.2013.765571

Trocmé, N., MacLaurin, B., Fallon, B., Knoke, D., Pitman, L., & McCormack, M. (2005). Mesnmimk Wasatek - Understanding the Overrepresentation of First Nations Children in Canada's Child Welfare System: An Analysis of the CIS-2003. Toronto, ON: Centre of Excellence for Child Welfare

Troutman, B. (2015). Integrating behaviourism and attachment theory in parent coaching. doi:10.1007/978-3-319-15239-4_2

Wall-Wieler, E., Roos, L. L., Bolton, J., Brownell, M., Nickel, N. C., Chateau, D. (2017). Maternal health and social outcomes after having a child taken into care: population-based longitudinal cohort study using linkable administrative data. Journal of Epidemiology and Community Health, 71(12). http://dx.doi.org/10.1136/jech-2017-209542

Webster-Stratton, C. (2014). Incredible Years Parent and Child Programs For Maltreating Families. In S. Timmer and A. Urquiza (Eds.), Evidence-Based Approaches For the Treatment of Maltreated Children. doi:10.1007/978-94-007-7404-9_4

Yampolskaya, S., Armstrong, M. J., Strozier, A., Swank, J. (2017). Can the actions of child welfare case managers predict outcomes? Child Abuse and Neglect, 64, 61-70.

volume 13 | number 1

First Peoples Child & Family Review 2018

An Interdisciplinary Journal

Honoring the Voices, Perspectives and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews

Une honte nationale

Katalina Toth[1]

[1] The Sacred Heart School of Montreal, Montreal, Canada

Corresponding author: Katalina Toth, katalinaltoth@gmail.com.

Abstract

Cette transcription a été initialement prononcée en français par Katalina Toth pour d'art oratoire, un concours d'expression publique organisée par l'Association des écoles privées du Québec. Katalina Toth est étudiante à The Sacred Heart School of Montreal. Une liste des références utilisées pour la recherche de ce discours est fournie à ceux qui voudraient en savoir plus sur les avis d'ébullition de l'eau dans les réserves et d'autres injustices semblables.

[This speech transcription was originally delivered in French by Katalina Toth for Art Oratoire, a public speaking competition organized by the Quebec Association of Independent Schools. Katalina Toth is a student at The Sacred Heart School of Montreal. A list of references used to research this speech is provided for those who would like to learn more about the on-reserve boil water advisories and other similar injustices.]

Keywords: *Boil water advisories, urban infrastructure, access to medicine, nutrition*

Version originale

« Pas d'eau courante. Pas d'infrastructure urbaine. Pas d'accès à la médecine du 21e siècle. Si ces faits ne vous surprennent pas, vous les envisagez probablement dans le contexte d'un pays du tiers monde à l'autre bout du globe dont vous avez entendu parler maintes et maintes fois aux nouvelles. Ce que vous trouverez peut-être surprenant, cependant, c'est que ces faits s'appliquent à un groupe des dizaines de milliers de personnes, dont plusieurs vivent à moins de cinq heures de route d'où nous sommes dans le moment. Je parle de la population autochtone du nord du Canada. »

[English translation]

[No running water. No urban infrastructure. No access to medicine of the 21st Century. If these facts do not surprise you, you probably imagine them in the context of a third world country on the other side of the globe that you have heard about time and time again in the news. What you may find surprising, however, is that these facts apply to a group of tens of thousands of people, many of whom live within a 5-hour drive from where we are now. I am talking about the Indigenous population in northern Canada.]

First Nations Child & Family
Caring Society of Canada

« Plus de 99 % des Canadiens ont accès à l'eau potable et à son assainissement. La grande majorité des 1 % qui n'y ont pas accès sont des autochtones. Dans de nombreux villages indigènes du Nord du Québec, des avis d'ébullition de l'eau sont en vigueur depuis des décennies. Cela veut dire qu'il y a des gens de notre âge qui n'ont jamais pu utiliser leur douche parce qu'elle causerait des éruptions cutanées, qui ne peuvent pas boire l'eau de leurs robinets parce qu'elle pourrait les envoyer à l'hôpital. Il y a des parents qui doivent veiller à ce que leurs enfants soient à l'abri de leur eau courante pendant que nous nageons dans une piscine contenante 2,500,000 litres d'eau traitées. »

[More than 99% of Canadians have access to clean water and sanitation. The vast majority of the 1% who do not have access to it are Indigenous. In many Indigenous communities in northern Quebec, boil water advisories have been in effect for decades. This means that there are people our age who have never been able to use their showers because the water could cause rashes, and who cannot drink water from their taps because it could send them to the hospital. There are parents who must protect their children from running water while we swim in a pool containing 2,500,000 litres of treated water.]

« Dans le moment, vous pourriez être en mesure de penser : « C'est un problème tellement important - quelqu'un au gouvernement doit sûrement être en train de travailler pour le résoudre. » J'aimerais pouvoir vous dire que vous avez raison. Bien que le gouvernement ait fait des promesses à maintes reprises pour corriger la situation, très peu de progrès a été réalisé et on prévoit que pour de nombreuses collectivités, il faudra peut-être des décennies avant que l'eau potable n'arrive. Cela signifie que pendant que nous, les gens du sud, obtenons des diplômes, occupons des emplois et construisons nos vies en essayant de pouvoir nous offrir une belle voiture, des vacances dans les Caraïbes ou d'autres articles de luxe, les Autochtones du Nord continueront à se battre pour l'eau, un droit humain fondamental. »

[Right now, you might be thinking, "This is such an important problem - someone in government must be working to solve it." I wish I could tell you that you're right. Although the government has made promises on many occasions to correct the situation, very little progress has been made, and it is expected that for many communities it may take decades before drinking water arrives. This means that while we, the people of the South, are graduating, getting jobs and building our lives by trying to afford a nice car, a Caribbean vacation or other luxury items, the Indigenous people of the north continue to fight for water, a fundamental human right.]

« La deuxième grande violation des droits humains des communautés autochtones est leur manque d'accès à la nourriture. Dans les collectivités du Nord, une boîte de céréales Rice Krispies qui coûtent un peu plus de quatre dollars ici coûte vingt dollars. Les fruits et légumes peuvent être plus que cinq fois plus chères et les produits de base tels que la farine et le sucre sont

[The second major violation of the human rights of Indigenous communities is their lack of access to food. In northern communities, a box of Rice Krispies cereal that costs just over four dollars here costs twenty dollars. Fruits and vegetables can be more than five times more expensive, and staples such as flour and sugar are on the market at exorbitant prices. It would be

sur le marché à des prix exorbitants. Il serait difficile pour de nombreuses familles de la classe moyenne ici de s'en sortir dans cet environnement, sans parler des autochtones qui vivent dans ces régions, ou l'âge médian est de 24 ans et plusieurs familles sont menées par des jeunes mères célibataires. »

« Parce que la plupart de la population du Nord ne peut pas se permettre les produits plus chers à l'épicerie, ils doivent recourir aux aliments moins chers : la malbouffe. La conséquence de cette pauvreté nutritionnelle est grande. Les taux de malnutrition sont si élevés que le pourcentage de diabètes et de maladies cardiaques monte en flèche. Non seulement les enfants mangent souvent de la mauvaise nourriture, mais certains jeunes mangent à peine. Au Nunavut et dans le nord du Québec, neuf enfants sur dix sautent souvent des repas et passent régulièrement un jour sur trois sans manger du tout. »

« Dans une initiative récente intitulée Nutrition Nord, le gouvernement a fait un effort pour remédier à la situation en subventionnant des aliments sains pour les populations autochtones. Cependant, il y a un problème. Un nutritionniste du gouvernement a décidé quels aliments étaient sains sans tenir compte de leur culture traditionnelle. Par exemple, le fruit du dragon était fortement subventionné même si presque ne personne dans au Nord connaît ce fruit. Le pain fait dans les usines au sud est subventionné tandis que la farine, un aliment de base que les Inuits emploient pour faire de la bannique, n'est pas subventionné. Le programme est donc structuré d'imposer les préférences de la culture du sud, au lieu de respecter les préférences des autochtones du nord. »

« Le problème est que personne qui détient un réel pouvoir ne veut pas fournir de l'argent à cette population, parce que les victimes sont trop pauvres pour être capables de faire du bruit et que

difficult for many middle-class families here to get by in this situation, not to mention the Indigenous people living in these areas, where the median age is 24 years and many families are being led by young single mothers.]

[Because most of the northern population can not afford the more expensive products at the grocery store, they have to resort to cheaper foods: junk food. The consequence of this nutritional poverty is great. Malnutrition rates are so high that the percentage of diabetes and heart disease is skyrocketing. Not only do children often eat bad food, but some young people hardly eat. In Nunavut and northern Quebec, nine out of ten children often skip meals and regularly spend one day out of three without eating at all.]

[In a recent initiative called Nutrition North, the government made an effort to address the situation by subsidizing healthy food for the Indigenous population. However, there is a problem. A government nutritionist decided which foods were healthy without regard to their traditional culture. For example, dragon fruit was heavily subsidized even though almost no one in the north knows this fruit. The bread made in factories in the south is subsidized while flour, a staple that the Inuit use to make bannock, is not subsidized. The program is therefore structured to impose the preferences of Southern culture, instead of respecting the preferences of the northern Indigenous people.]

[The problem is that no one who holds real power wants to provide money to this population, because the victims are too poor to be able to make noise, and concealing the problem allows us to

cacher le problème nous permet de continuer à nous dire que notre beau pays est ouvert à la diversité culturelle, tandis que nous ne pouvons même pas accepter et soutenir les cultures de ceux qui étaient là avant nous. Il est grand temps de cesser de jouer à l'autruche. »

continue to tell ourselves that our beautiful country is open to cultural diversity, while we cannot even accept and support the cultures of those who were here before us. It is high time to take our heads out of the sand.]

References

Agence France-Presse (2014, March 27). Neuf enfants autochtones sur dix dans le nord canadien ne mangent pas à leur faim. *The Huffington Post*. Retrieved from https://quebec.huffingtonpost.ca/2014/03/27/neuf-enfants-autochtones-sur-dix-dans-le-nord-canadien-ne-mangent-pas-a-leur-faim_n_5043659.html

First Nations People and Heart Disease. (n.d.). Retrieved from http://www.hricanada.org/about-heart-disease/first-nations-people-and-heart-disease

Galloway, T. (2017). Canada's northern food subsidy *Nutrition North Canada*: a comprehensive program evaluation. *International Journal of Circumpolar Health, 76*(1). doi: 10.1080/22423982.2017.1279451

Goraya, J. (2016, October 02). Access to Health Care on Aboriginal Reserves. Retrieved from https://ppgreview.ca/2016/04/06/access-to-health-care-on-aboriginal-reserves-2/

Government of Canada. (2017, May 11). What we heard about Nutrition North Canada. Retrieved from http://www.nutritionnorthcanada.gc.ca/eng/1465233643322/1465234133331

Government of Canada. (2017, September 18). Nutrition North Canada. Retrieved from http://www.nutritionnorthcanada.gc.ca/eng/1415385762263/1415385790537

Harris S. B., Bhattacharyya O., Dyck R., Naqshbandi Hayward M., Toth E. L. (2013). Type 2 Diabetes in Aboriginal peoples. *Canadian Journal of Diabetes,* 37(1), S191-S196. https://doi.org/10.1016/j.jcjd.2013.01.046

Human Rights Watch. (2017, June 06). Make it Safe: Canada's obligation to end the First Nations water crisis. Retrieved from https://www.hrw.org/report/2016/06/07/make-it-safe/canadas-obligation-end-first-nations-water-crisis

Josselin, M. (2017, September 23). Se nourrir au Nunavut quand la boîte de céréales coûte $ 19. Retrieved from https://ici.radio-canada.ca/nouvelle/1057488/expedition-c3-nunavut-nourriture-cout-eleve

Pratka, R. (2012, March 22). Access to water on Canada's reserves. Retrieved from http://rabble.ca/news/2012/03/reservations-about-water-canadas-reserves

Rioux, M-C. (2017, February 9). Des communautés autochtones sans eau potable pendant encore plus de 5 ans. Retrieved from https://ici.radio-canada.ca/nouvelle/1015725/autochtones-eau-potable-rapport-fondation-suzuki

Russell, A. (2018, January 27). Reality Check: Can Liberals really end boil water advisories on First Nations by 2021? Retrieved from https://globalnews.ca/news/3989986/trudeau-government-end-boil-water-advisory-2021-fact-check/

Stastna, K. (2014, April 12). Shacks and slop pails: Infrastructure crisis on native reserves. Retrieved from http://www.cbc.ca/news/canada/shacks-and-slop-pails-infrastructure-crisis-on-native-reserves-1.1004957

Statistics Canada. (2017, October 25). Aboriginal peoples in Canada: Key results from the 2016 Census. Retrieved from http://www.statcan.gc.ca/daily-quotidien/171025/dq171025a-eng.ht